AMERICAN HEALTH CONSULTANTS

Patient Education Management™

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

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Anthrax scare reveals need to initiate plan for information dissemination

Are you sure your facility's ready?

Most health care facilities have in place plans for an emergency response to a bioterrorist attack, yet recent events have revealed the need to take a second look. That's exactly what senior personnel at New York Presbyterian Hospital did, forming a task force with another hospital and other health care agencies.

"The purpose of the task force is to ensure we are in a maximum state of readiness to prepare for and respond to any emergency arising from biological agents," says **Virginia A. Forbes**, MSN, RNC, CNA, patient education coordinator at the hospital in New York City. The task force is focusing on three areas — surveillance and public health, consumer and health provider education and information,

EXECUTIVE SUMMARY

The terrorist attack on Sept. 11 and the subsequent anthrax scare that soon followed identified a new need for educational materials on bioterrorism. In addition, it created a scenario where factual, up-to-date information needed to be developed and disseminated swiftly. Ways to create and distribute factual materials on biological agents must be part of any emergency preparedness plan.

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COMING IN FUTURE ISSUES

- Providing quality education on a tight budget
- Recruiting high-caliber volunteers to meet staff shortages
- Creating a health fair on complementary therapy
- Assessing noncommunicative patients for pain
- Designing educational web pieces for kids

and hospital response and readiness.

Information and updates to staff are delivered in a timely fashion through department heads, memos, and e-mail. The task force provides information to reduce fear and uncertainty and to help staff understand the facts about biological agents, says Forbes. "Memos and e-mails are written in simple question-and-answer format to direct attention to commonly asked questions," she says.

Being able to provide updates on information promptly and being flexible are important, says **Adam Brase**, a communications consultant at the Mayo Clinic in Rochester, MN. "You need to be proactive, but you need to be ready to react because obviously, you don't know what is going to come around the next corner. In some cases, you have to wait and see what happens and react to it," he says.

During the spread of anthrax through the U.S. Postal Service in the fall of 2001, staff at Mayo worked diligently to educate health care providers issuing information on a daily and sometimes hourly basis. Delivering pertinent facts meant tracking calls to determine what types of questions people were asking and keeping tabs on what was happening in the news media, says Brase.

During the time anthrax was being spread through letters in the mail, medical staff were issued information on anthrax and other biological agents via e-mail in question-and-answer format. Physicians were provided the latest guidelines from the Centers for Disease Control and Prevention in Atlanta. The employee newsletter also covered the topic with one issue listing all the biological agents that could potentially be used and providing background information on them and what their real threat was to staff. **(For more information on where to go for timely information, see article on p. 4.)**

"Before the anthrax incident, there was some question about what biological agents there are out there, and we initially started on that track, but then the focus changed to anthrax. Now we are seeing a little bit of a shift again," says Brase.

Providing more than facts

Following the terrorist attacks on the World Trade Center and Pentagon and the subsequent anthrax scare, Northwestern Memorial Hospital in Chicago took a holistic approach to staff education through addressing mind, body, and spirit. An expert from the outpatient psychology department addressed managers at a hospitalwide meeting

SOURCES

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discussing post-traumatic stress, says **Magdalyn Patyk**, MS, RN, a patient education consultant at the health care facility. Also mentioned were the systems of support that are in place for employees.

The employee newsletter listed employee assistance programs in the outpatient psychology area to help staff cope with any emotional problems from the recent events that might affect their work. Also, two short pieces on post-traumatic stress disorder that cover what people can do for themselves as well as others was placed on the hospital's Internet home page. **(For information about addressing the fear for both staff and consumers arising from uncertain times, see article, right.)**

With more calls coming into the Health Learning Center from consumers concerning bioterrorism, two web site links were placed on the hospital's Internet site and on its intranet. These were:

- www.mlanet.org/resources/caring/resources;
- www.nlm.nih.gov/medlineplus/biologicaland chemicalweapons.html.

"Staff in the learning center are not qualified to field specific questions. They are there strictly to provide information," says Patyk. Therefore, they are armed with a list of resources, such as the number for "Ask a Nurse," while at the same time have appropriate Internet sites marked so that they can provide information on bioterrorism.

While people are clamoring for factual information, such as the signs and symptoms of anthrax exposure or how to overcome the fear of bioterrorism, spiritual healing after a disaster is important as well. The chaplains at Northwestern Memorial Hospital conducted a Day of Remembrance service following the terrorist attacks. "A mind, body, spirit approach is important. People need more than an information sheet with the facts," says Patyk. ■

Gaining control over the fear factor

Accepting what can and can't be done

The spread of anthrax through the mail brought a lot of media attention and with that a barrage of questions about bioterrorism. As a result, both health care workers and consumers alike are feeling anxious. Many find it difficult to get back to a normal routine. Therefore, it's important that people obtain the skills they need to return to normalcy. How does a person gain control of fear?

"People don't have control over a fearful thought that just pops into their mind but they can develop control over how long that thought stays there," says **Linda Sapadin**, PhD, a psychologist in Valley Stream, NY, and expert on overcoming fear. One way to become calm is to understand what it is that can and can't be done about the situation, she says.

People need to know that when something is disturbing on the news, it is important not to exaggerate it by allowing their minds to picture the worse scenario but rather to shift from the unnerving thought to what is promising, says Sapadin. For example, acknowledging that the risk of contracting anthrax is much smaller than the risk of getting the flu and even dying from it.

Can facts about biological agents such as anthrax help people put things in perspective? That depends, says Sapadin. In today's society there is an overabundance of data and what is needed as useful information. "It's important to strike a balance between living your life, functioning effectively, and letting the fear take over," she says. When fear overcomes people, they need to settle their body and mind and ask if there is anything they need to do at that moment.

An invisible, unpredictable, and uncontrollable threat such as anthrax makes people feel helpless which contributes to their fear, says **Linda L. Carli**, associate professor of psychology at Wellesley (MA) College. Sometimes it helps if

SOURCES

For more information about overcoming fear and anxiety caused by the threat of a bioterrorist attack, contact:

- **Linda L. Carli**, PhD, Associate Professor of Psychology, Department of Psychology, Wellesley College, Wellesley, MA. Telephone: (781) 283-3351.
- **Linda Sapadin**, PhD, Psychologist, Valley Stream, NY. Telephone: (516) 791-2780.

people gain a sense of control over the situation by taking some action. This might include putting together a plan for an emergency evacuation from their neighborhood by stocking such essentials as bottled water.

It also helps to put the risk into perspective. "The odds of an individual's mail being contaminated with anthrax are extremely remote. People need to look objectively at the situation. There are many more risky behaviors they engage in all the time, yet aren't concerned about," says Carli.

Health care workers need to know the most recent data on anthrax and other biological agents, but the general public should know the means of transmission and the symptoms. Obsessively gaining lots of knowledge about biological agents is not helpful for most people, and thinking about such things all the time fuels anxiety, says Carli.

People who cannot sleep or concentrate on their work may want to seek professional help. In general both health care workers and the public need to continue their lives in a very normal manner. They also need to participate in activities they enjoy, says Carli. ■

Information at your fingertips aids in education

Getting the scoop on bioterrorism for staff, patients

When anthrax hit the headlines, The Patient Education Institute at the University of Iowa in Iowa City accelerated the development of its module on anthrax and added a section on bioterrorism.

"Anthrax by itself is a rare infectious disease and it had a low priority on our list of modules under development for our X-Plain learning system," says **Moe Ajam**, PhD, company president.

Once completed, the interactive program was made available to organizations to download onto their web sites so that the public could be more easily educated.

There are several ways health care and corporate staff can use the Anthrax and Bioterrorism module, says Ajam. His suggestions include the following:

- To run the multimedia module, they can link to The Patient Education Institute web site: **www.patient-education.com/anthrax/anthrax.html.**
- To run the multimedia module and review other resources, they can link to MedlinePlus: **www.nlm.nih.gov/medlineplus/anthrax.html.**
- They can download the module and have their webmasters install it on their web sites: **www.patient-education.com/anthrax/.**
- They can print the Reference Summary PDF file that comes with the module and provide it to their patients and consumers: **www.patient-education. com/anthrax/anthrax.html.**

As the public clamors for information, the need to act quickly is vital for patient education managers. Staff need reliable information so they can address consumers' questions quickly. Here are a few more contacts to aid you in your search:

- **www.mayoclinic.com** — click under "Coping with war" to read article on anthrax that expands into mental health issues;
- **www.healthri.org** — this is the Rhode Island Department of Health's Bioterrorism Preparedness Program web site, written by Greg Banner, an international expert on bioterrorism. The information also is available in Spanish;
- **www.hopkins-biodefense.org** — prepared by the Johns Hopkins Center for Civilian Biodefense Studies in collaboration with the Infectious Diseases Society of America, and designed to aid clinicians in their approach to identifying and treating anthrax.

For information to help consumers cope with the psychological aspects of bioterrorism try the following web sites:

- **www.apa.org** — the American Psychological Association's information on coping with terrorism;
- **www.aacap.org** — the American Academy of Child and Adolescent Psychiatry has information on talking with children and helping them cope with trauma;
- **www.psych.org** — the American Psychiatric Association has information on disaster responses and coping;
- **www.ncptsd.org** — the National Center for

SOURCE

For more information about the educational module on anthrax produced by The Patient Education Institute, contact:

- **Moe Ajam**, PhD, President, The Patient Education Institute, The University of Iowa, Iowa City, Iowa. Telephone: (319) 335-4614. E-mail: moe-ajam@patient-education.com.

Post Traumatic Stress Disorder offers self-help for managing post traumatic stress disorder linked to the Sept. 11 attack;

• **www.nimh.nih.gov** — the National Institute of Mental Health has information on post traumatic stress disorder, depression, anxiety disorders, and coping strategies for adults, children, and adolescents. ■

Make pain management a collaborative effort

Must determine if interventions work

To manage pain effectively in compliance with standards implemented by the Joint Commission in January 2001, health care providers must assess for pain and routinely reassess to determine if interventions are working. Both staff and patients should be educated about the process to ensure assessments are performed correctly.

Patients at the University of Washington Medical Center in Seattle are given a pain management brochure explaining their right to have pain managed, but also the responsibility to participate in the process. Their participation includes asking for pain medication or a non-pharmacological intervention when pain is first detected, describing their pain, asking about pain management options, and alerting staff as to what interventions are working or not working. "We try to educate patients about the collaborative effort of pain management," says **Joan Ching**, RN, MN, a pain management clinical nurse specialist at the medical center.

The brochure has a brief description of the types of pain medications used and the nonpharmacological therapies that are available as well as examples of the three pain scales used at the facility. These include the numeric pain intensity scale of 0-10; a verbal rating scale with five adjectives — no pain, mild, moderate, severe and excruciating; and the Wong faces scale often used with pediatric patients that has faces with expressions from smiling to grimacing.

EXECUTIVE SUMMARY

Assessment for pain and reassessment to determine if the intervention is effective is an important element of pain management. Yet many health care facilities struggle to ensure that it is consistently performed to comply with the standards implemented by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL. In the fourth article in our series on pain management, we examine ways to ensure that assessment and reassessment for pain takes place and is documented through the education of staff and patients about the process.

Getting the word out

When patients are admitted to Grant/Riverside Methodist Hospitals in Columbus, OH, they are given a copy of the patient rights for pain and a teaching handout called "Describing Your Pain." Posters at the elevators reinforce the information with rights about pain assessment posted. (**To learn how to assess pain when patients can't participate, see article on p. 6.)**

On each unit, nurses review the information about pain scales and assessment, and a poster in the patient's room depicts the pain scales. "If appropriate, the patient is provided with a pain diary when discharged," says **Lisa Hartkopf Smith**, RN, MS, AOCN, a clinical nurse specialist in pain management at the Riverside Methodist campus. The diary is used to record pain assessment information at home to be shared with health care professionals at future appointments or hospitalizations.

The handout "Describing Your Pain" explains that patients and their family are part of the pain management team, that patients are responsible for reporting their pain and the effectiveness of pain management and interventions, and the different pain scales used to assess pain. There's also information on describing pain that prompts the patient to include its location, intensity, character, pattern, duration, aggravating and alleviating factors, associated symptoms, and the impact of pain

SOURCES

For more information about educating staff and patients about pain management, contact:

- **Joan Ching**, RN, MN, Pain Management Clinical Nurse Specialist, University of Washington Medical Center, 1959 N.E. Pacific, Box 356153, Seattle, WA 98195. Telephone: (206) 598-6843. E-mail: jching@u.washington.edu.
- **Lisa Hartkopf Smith**, RN, MS, AOCN, Clinical Nurse Specialist, Pain Management, Grant/Riverside Methodist Hospitals, Nursing Administration, 3535 Olentangy River Road, Columbus, Ohio 43215. Telephone: (614) 888-0175. E-mail: smithagary@aol.com.
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on daily life such as sleep or social relationships, explains Hartkopf Smith.

Before patients even arrive at a health care facility, staff members must learn the pain assessment process and where to document pain. "The Joint Commission pain standards apply to any clinician or anyone who comes into direct patient contact. Therefore, when we did our housewide education we not only targeted nurses, but we educated physicians, physical therapists, social workers, radiology, and some unit assistants," says Ching.

The education included familiarizing staff with the pain standards and the standardized pain intensity tools used by the medical center, and teaching them about assessing for pain and documenting it. **(To learn about the assessment and reassessment process, see article, right.)**

New employees that do not have direct patient contact are given a general overview of the importance of pain management and that it is a patient right during their initial orientation, but not taught how to do the assessment. It has not yet been determined how frequently staff will be re-educated or if pain management will be an annual staff training module.

All direct care providers at Grant/Riverside Methodist Hospitals receive a one-hour lecture on pain assessment and management in orientation and RNs receive three additional hours of pain content in orientation when they are hired, says **Deb Jeffers**, RN, IV/pain specialist at Grant/Riverside Methodist Hospitals. When the pain management protocols were first initiated, existing staff attended mandatory inservices covering pain assessment and management.

A pain resource nurse program also is in place so that one RN on each unit serves as a resource on pain issues. These nurses also attend additional education programs on pain, says Jeffers.

To ensure that competency in pain management is kept at the forefront, it has been made part of an RN's annual evaluation. If deficiencies are noted at that time, the RN must complete an additional education program, says Jeffers. ■

Get it to be an automatic question

'Yes' answers yield further research

Screening for pain is an automatic process at the University of Washington Medical Center in Seattle, whether a patient comes into a clinic on an outpatient basis or is admitted to the hospital. Patients are asked if they are presently in pain or if they have had pain in the last several weeks.

If their answer is "yes," they are asked if their pain control has been a problem. Also, a comprehensive pain assessment is initiated that includes a pain intensity rating based on a pain assessment scale and a description of the type of pain, such as burning, sharp, stabbing, dull, or electrical. Patients also are asked what makes the pain better or worse, says **Joan Ching**, RN, MN, pain management clinical nurse specialist at the University of Washington Medical Center.

In the hospital setting, screening for pain is part of the admission medical history nurses must complete within 24 hours. If there is pain upon admission, the physician intervenes and nurses document the effectiveness of therapy whether pharmacological or nonpharmacological. Pain management is documented on a computerized charting system on the vital sign flow sheet in a section titled "Comfort."

In the outpatient setting, patients are given a self-assessment survey; if they answer "yes" to the question about pain being present, they are asked to answer the questions about the intensity and description of their pain. It becomes part of the progress notes in their medical record.

"If pain is identified as a problem upon the

initial assessment at the clinic, it is added to the problem list. We have a running problem list in the medical record," says Ching. It prompts reassessment for pain on each visit.

All patients are screened for the presence or absence of pain on admission to Grant/Riverside Methodist Hospitals in Columbus, OH, its emergency department, or ambulatory care areas unless the patient is there for noninvasive diagnostic testing, says **Lisa Hartkopf Smith**, RN, MS, AOCN, clinical nurse specialist in pain management. If pain is identified as a problem, the physician and/or RN completes an in-depth pain assessment before a plan of care is initiated. The content of pain assessment includes:

- location;
- intensity;
- character, such as burning, shooting;
- duration and pattern;
- current pain management interventions;
- aggravating factors;
- alleviating factors.

Time and place for pain assessment

In hospital areas pain is assessed with routine physical assessment, with new reports of pain by the patient, and after pain management interventions. The timing of each assessment following an intervention depends on the situation. For example, following pharmacological pain management interventions, pain intensity is assessed at intervals dependent on the medication and route of administration, says Hartkopf Smith.

Pain assessment information is initially documented in the admission database at Grant/Riverside Methodist Hospitals with subsequent assessments documented in the nursing daily flow sheet and/or physician progress notes. When other disciplines assess for pain, it is documented on a multidisciplinary progress note.

"The pain assessment is included as part of existing forms, rather than separate forms to decrease the number of forms the nurse must complete," says Hartkopf Smith. Cues on the documentation forms help assure that the necessary information is assessed and documented, she says.

To make sure that pain is managed well, patients set a comfort function goal daily. This is the pain intensity rating at which patients can perform activities related to satisfactory recovery or improved quality of life. Most patients use the 0-10 pain scale to set their goal with zero being no pain and 10 being intense pain.

"The goal is used to manage the effectiveness of the pain management plan," says Hartkopf Smith. When the pain rating is higher than a patient's comfort function goal, the nurse administers medication according to the physician's orders and performs nonpharmacological interventions as needed. If these do not work, the physician is called for additional orders.

While having plans for the assessment and reassessment of pain in place is an important step in pain management, there also must be a plan to determine if staff are following policy. At Grant/Riverside Methodist Hospitals, nursing documentation audits are conducted every other month on inpatient nursing units to ensure compliance.

Tracking documentation of pain assessment and reassessment is important, says Ching. Management is able to run a report each month via the computer identifying all patients assessed with pain at an intensity greater than five who are not satisfied with their pain management. A second report checks pain intensity ratings and satisfaction two hours later. "These reports give us an idea of what our follow-up rate is like and all nurse managers get that report every month," says Ching. ■

When patients can't participate, staff intercede

Special groups get special approach

To make sure that all patients have their pain effectively controlled, it is important to address the needs of special populations. When patients are unable to provide self reports of pain because they are confused or have decreased levels of consciousness, nurses at Grant/Riverside Methodist Hospitals in Columbus, OH, follow special guidelines for the assessment and documentation of pain, says **Lisa Hartkopf Smith**, RN, MS, AOCN, clinical nurse specialist, pain management at the Riverside Methodist campus.

The guidelines include the following:

- Pathological conditions or procedures that usually cause pain are strong indicators that pain may be present, despite the patient's inability to report.
- Assess behaviors indicating pain such as crying or grimacing. However, patients with chronic

pain or who have adapted to their pain may not demonstrate these behaviors.

• Proxy pain ratings, or pain ratings provided by family members or significant others, may be used. Document who provides the pain rating.

In addition to guidelines that address special cases several types of pain scales are available in case the 0-10 pain scale is not suitable for the patient. Other choices include the faces pain scale, verbal descriptor scale, and visual analogue scale. Pain scales are available in 30 languages.

At the University of Washington Medical Center in Seattle, about 90% of the patients use the numeric pain scale, but nurses are told that they can't just intervene on the basis of a pain score, says **Joan Ching**, RN, MN, pain management clinical nurse specialist. "Nurses know not to just use the numbers, but to look at what the patient is able to do or not able to do," she says. For example, are they able to get out of bed and walk around to speed their recovery?

A patient may say that he or she is a 3 or 4 on the pain scale but then refuses to get out of bed because he or she is in too much pain, explains Ching. In that case, a pain intervention should be implemented. ■

Proactive approach makes errors plummet

Safety errors move to forefront

Identifying ways to improve patient safety has become a high priority at New Mexico Veterans Affairs (VA) Health Care System in Albuquerque, and communication between patients and health care workers and staff and management is the key to its success, says **Melanie Douglas**, RN, patient safety manager.

Safety issues are brought to the forefront through incident reporting, which is a written report about an error or close call, or staff can call on a reporting line and give a narrative of the incident. The narrative reports can be given anonymously if the caller doesn't wish to leave his or her name.

Proactively, the medical center receives safety alerts from several organizations including the Joint Commission. Staff in the safety department also stay alert to incidents reported by the media, such as the death of a 6-year-old boy in an MRI when an oxygen tank crushed his head. **(Learn more about how to identify safety issues and prevent errors in article on p. 9.)**

"Whatever comes our way, we gather the appropriate group together and find out what we are doing to prevent this error and how we are ensuring that it won't be a problem for us," explains **Sharon Hartzell**, RN, the utilization review and patient safety coordinator. For example, shortly after the newspaper report of the boy's death, members of the MRI team at the VA medical center in Albuquerque and the supervisor met to discuss the steps they had in place to prevent a similar occurrence and review their safety practices.

When a safety issue is identified, a matrix is used to score the problem to determine if a root-cause analysis (RCA) is needed. If an RCA is needed, an interdisciplinary team best suited to examine that particular incident is assembled. "It is a systems approach looking at how we can prevent this from happening, rather than trying to single out a particular individual to blame," says Douglas.

Thorough review implemented

To come up with a set of actions that need to be taken, the team interviews staff and patients, reviews documentation, and often visits the scene where an accident or medical error occurred. The steps to improve safety are presented to senior

EXECUTIVE SUMMARY

In July 2001, the Joint Commission on Accreditation of Healthcare Organizations based in Oakbrook Terrace, IL, put into effect patient safety standards. These standards address several issues including the need for health care facilities to implement patient safety programs; the responsibility of their leadership to create a culture of safety; the prevention of medical errors through analysis and redesign of vulnerable patient systems; and the requirement to alert patients when they have been harmed by the care provided.

The Department of Veterans Affairs (VA) has created a patient safety program that is a good example of how these standards might be met. In this issue of *Patient Education Management,* we look at how the program is being implemented at the New Mexico VA Health Care System in Albuquerque.

SOURCE

For more information about creating a culture of safety and teaching staff and patients to participate, contact:

- **Melanie Douglas**, RN, Patient Safety Manager, New Mexico VA Health Care System, 1501 San Pedro Drive S.E., Albuquerque, NM 87108. Telephone: (505) 265-1711, extension 4785. E-mail: Melanie.Douglas@med.va.gov.

management who review them and either sign off on each one or provide additional feedback.

If revisions are recommended, they are made by the team. Once the set of actions receive final approval, they are given to the appropriate personnel with a timeline for completion. The safety coordinator follows up to ensure the steps were implemented.

For example, when the wrong medication was administered to a patient in the emergency department, it was determined that similar IV mixtures were kept in too-close proximity, side-by-side on the same shelf. Therefore, steps to improve safety included changing the labels on the IV mixtures and storing them in separate places. When a safety alert covered the dangers of leaving concentrated potassium chloride on units, it was removed before it was administered by mistake. The vial was similar to other medication containers, says Douglas.

"We are all human and we make mistakes, so it is important to try to eliminate safety hazards, such as storing IV mixtures side-by-side on a shelf, to eliminate the potential for error," she says.

To help staff become more comfortable with the process, they are given information on reporting incidents and potential mistakes during staff meetings and also in the quality improvement newsletter. They also attended a hospital wide inservice about the new nonpunitive systematic analysis approach the VA has taken. However, many fear a reprisal and are still hesitant to report close calls. This attitude is slowly changing as more and more staff members are assigned to RCA teams to conduct an analysis and see how the teams can come up with good recommendations for changes.

Educating patients about the role they play in eliminating the potential for mistakes is also important. A patient pamphlet is being implemented that teaches patients how they can help prevent medication errors by knowing which medications they are to receive and identifying them before the nurse administers them, says Hartzell. The pamphlet also advises patients of potential medication and dietary supplement interactions that could be harmful and the importance of reporting the supplements they are taking, such as vitamins and herbs, to their physician.

"It is important to create a culture of safety so staff will call and say, 'This wasn't an accident, but it sure could have been. How can we work to fix it?'" says Douglas. ■

To improve safety, ask your patients

Make patients part of team

To determine how to create a safer environment at your health care facility, ask patients about safety during the patient satisfaction survey, suggests **Patricia Staten**, RN, MSA, associate director, The Standards Interpretation Group at the Joint Commission on Accreditation of Healthcare Organizations based in Oakbrook Terrace, IL.

A simple question on the survey form such as, "Did anything happen during your hospitalization that you did not expect?" might uncover an unanticipated outcome or medical error that could lead to safety improvements.

Also, it's important to incorporate the patient as an integral member of the health care team to enhance the safety of health care delivery, says Staten. Many health care facilities give patients a description of their medications so that they can help to reduce medication errors. A medication profile would have a description of the medicine, such as the size of the pill and its color.

Patient safety can be greatly increased by noting what patients are worried about and targeting those issues for process improvements, says Staten. ■

SOURCE

For more information on compliance with Joint Commission standards, contact:

- **Patricia Staten**, RN, MSA, Associate Director, The Standards Interpretation Group, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60180. Telephone: (630) 792-5964. E-mail: pstaten@jcaho.org.

Supplement claims often too good to be true

Patients need to know the risks

Supplements — both herbal and nonherbal — are popular among consumers, and many are basing their choices on information gleaned from the media and the Internet, which is not always accurate.

That's why education is the No. 1 priority for **Emil Faithe**, PharmD, RPh, owner of Natural Pharmacy Consultants in Albuquerque, NM.

In his work, he counsels health care facilities about product lines and protocols for professional staff on how to implement and augment existing prescription regimens with natural supplements. Faithe works with people individually as well. "People want to know what is safe and what to take because headlines on magazines often announce the magic supplement. It all sounds good, and often when I see them, they have a bag of 20-30 supplements," says Faithe.

It is important for people to understand what the supplement is for and why they are taking it. They need to know if the supplement enhances a prescription medicine's effects because serious health problems could develop if it does. For example, people shouldn't take natural medicines or supplements that thin the blood while taking a prescription blood thinner, explains Faithe. Some supplements stimulate the immune system and can exacerbate symptoms of autoimmune disorders, he says.

When people want to use a natural medicine for a health problem, such as high blood pressure, instead of prescription medicine, Faithe suggests that they augment the prescription medicine with a supplement, slowly reducing the prescribed dosage until they are only taking the natural medicine. "We overlap these therapies with the hope of reducing their prescription medicine for that condition with their doctor's approval," he says.

Another point that needs to be made is that natural does not always equate with safety because many consumers do equate the terms safe and natural. Natural medicines can have unhealthy interactions with prescription medicines and cause side effects that people need to be aware of, says Faithe.

Another mistake people make is to pick up herbal supplements, vitamins, and minerals along with the broccoli while shopping at the grocery store. "Many brands are loaded with fillers, additives, and colors and aren't good choices or the potencies are much lower and the quality assurance standards are not known," says Faithe. For optimum results, people should purchase quality brands. He advises them to check the labels for fillers such as yeast, soy, dairy, wheat and corn additives. There should never be more than one filler and one binder, he says.

The natural medicine industry is poorly regulated and standardized, so it's wise to speak to a knowledgeable person at a health food store before purchasing a product. Consumers can also contact the manufacturer and ask for their quality assurance reports. It is important that the producers of natural products have an outside agency do the evaluation; otherwise, they are creating their own standards and their own quality assurance checks. Also find out where they get their raw materials for the products and if these are of the purest quality, advises Faithe.

Natural regimen for health

While many people look for natural medicines to heal them of ailments they have already developed, supplements can be used to prevent health problems. When Faithe speaks to groups, he often provides information on six supplements that he recommends for optimum health. These complement a healthy lifestyle that includes a good diet, exercise, limited alcohol, and refraining from smoking or consuming foods with additives. "I want to make sure that when I talk about supplements, everyone knows that they are a supplement to good living, and that means getting as many nutrients as possible from quality foods," says Faithe.

The regular supplements recommended by Faithe include the following:

- **A high-potency multiple vitamin.**

This supplement should be high in the B vitamins and contain a good amount of vitamin A and E.

- **Calcium and magnesium.**

A supplement that combines these two minerals is a good combination, says Faithe. Most people are deficient in magnesium, yet this mineral is good for the neuromuscular system, he says.

- **Acidophilus.**

This supplement helps to heal the gut and is a great immune stimulant. It is good for irritable bowel syndrome or food allergies and is the core of all his regimens, says Faithe.

SOURCE

For more information about education pertaining to herbal and nonherbal supplements, contact:

- **Emil Faithe**, PharmD, RPh, Natural Pharmacy Consultants, 6501 Wyoming Blvd. N.E., Suite C-115, Albuquerque, NM 87109. Telephone: (505) 280-0599.

• **Flaxseed oil.**

This oil is an immune modulator, says Faithe. If the immune system needs a boost, the oil provides it; or if the immune system is too active, it helps to regulate it. "If someone is going to take only one natural medicine, I would recommend flaxseed oil," he says.

• **Broad-spectrum digestive enzyme.**

A digestive enzyme helps to break down the foods that we eat and prevent such digestive problems as irritable bowel syndrome and food allergies, says Faithe.

• **Milk thistle.**

This is the only herb in his recommended regimen to prevent health problems. "I would say that 70% of what I use is nonherbal," says Faithe. This product keeps the liver in good health, he says. ■

Emergency preparedness good stress buster

Terrorist attacks on America increased the level of stress for many people, making them feel vulnerable. However, people can reduce their amount of stress by exerting a measure of control according to the American Red Cross. They suggest that families develop a disaster plan. This plan should include selecting an out-of-town contact who family members can telephone or e-mail after a disaster so if they become separated, it will be easier to find out if everyone is all right. It also is a good idea to establish a predetermined meeting place. A disaster supply kit that can be quickly grabbed during an evacuation should contain special-needs items such as medications and copies of important family documents. It might also contain first-aid supplies, a change of clothing, food, bottled water, and bedrolls for each family member. For more complete instructions, have consumers call their local chapter of the Red Cross and ask for the brochure titled "Your Family Disaster Supplies Kit" (stock number A4463). ■

Would you be a good *PEM* guest column author?

Do you have any insights into persisting problems in patient education or new ideas that have improved patient education? If so, we invite you to share them with readers of *Patient Education Management* as a guest columnist.

Topics covered by past guest columnists include an innovative educational material review process, ways to motivate changes in behavior so the patient is not only learning information but applying it, and gaining insight into creating a better form for documentation of

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BIOTERRORISM WATCH

Preparing for and responding to biological, chemical and nuclear disasters

Flu or anthrax? First inhalational cases yield clues for clinicians to make the critical call

Use case history, blood work, X-rays, rapid tests

There is a postal worker in your emergency department (ED) with flulike symptoms.

That once insignificant observation about occupation and illness now triggers a detailed algorithm created by the Centers for Disease Control and Prevention (CDC) in Atlanta. **(See algorithm, p. 2.)** Is it flu or inhalational anthrax? Whether a realistic question or not, it is what many of your incoming patients may be asking — particularly if another wave of anthrax scares coincides with a nasty influenza season. Many of the initial symptoms are similar, but investigators dealing with the first inhalational anthrax cases have gleaned out key indicators that will help clinicians make the call.

"It is important to take a careful history from the [patients] when they present," says **Julie Gerberding**, MD, acting deputy director of CDC's National Center for Infectious Diseases. "If the [patients are] mail handlers in a professional environment — where they're dealing with large amounts of mail that is not their own — then the index of suspicion should be raised and more testing should be done to be sure there aren't additional clues to suggest that it is not a common viral infection."

Using the first 10 cases of inhalational anthrax as a baseline patient profile, the CDC reports that the median age of the patients was 56 years (range: 43-73 years), and seven were men.[1]

The incubation period from the time of exposure to onset of symptoms when known (seven cases) was seven days (range: five to 11 days).

The initial illness in the patients included fever (nine) and / or sweats / chills (six). Severe fatigue or malaise was present in eight, and minimal or nonproductive cough in nine. One had blood-tinged sputum. Eight patients reported chest discomfort or pleuritic pain. Abdominal pain or nausea or vomiting occurred in five, and five reported chest heaviness. Other symptoms included shortness of breath (seven), headache (five), myalgias (four), and sore throat (two). The mortality rate was 40% for the 10 patients, much lower than historical data indicated. Indeed, one of the critical reasons to recognize inhalational anthrax early is that it is far more treatable than originally thought.

The CDC gathered comparative data on the symptoms and signs of anthrax and influenza, finding, for example, that only 20% of the anthrax patients reported sore throat.[2] Flu sufferers report a sore throat in 64% to 84% of cases. Likewise, 80% of the anthrax cases reported symptoms of nausea and vomiting. That symptom is reported in only 12% of flu cases. Shortness of breath appears to be another key distinguishing symptom, affecting 80% of the anthrax patients but seen in only 6% of flu patients.

"One of the other clues that we are noticing is that the patients with inhalation anthrax actually do not have nasal congestion or a runny nose,"

(Continued on page 3)

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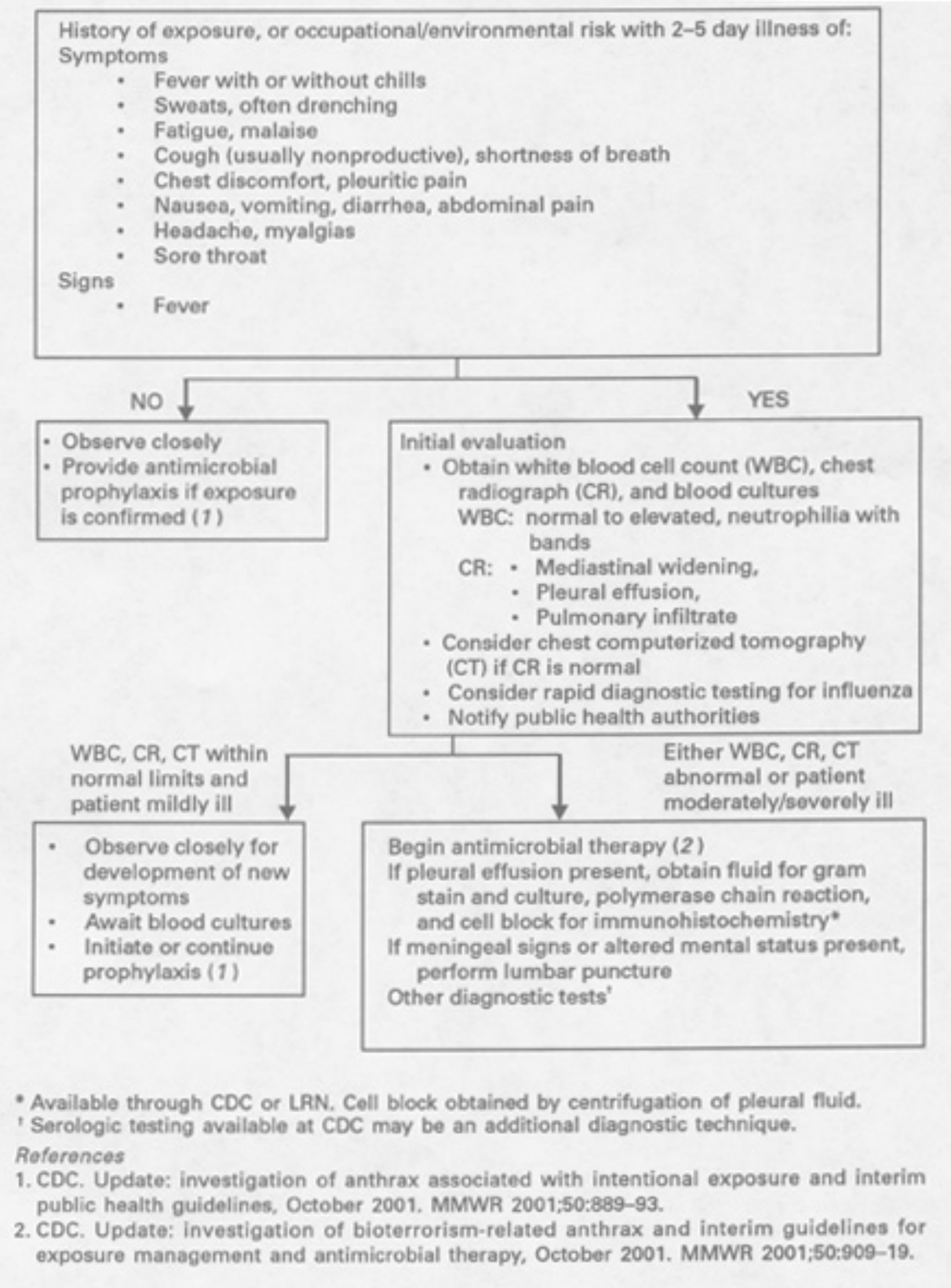
Clinical Evaluation of People with Possible Inhalational Anthrax



Source: Centers for Disease Control and Prevention. Update: Investigation of bioterrorism-related anthrax and interim guidelines for clinical evaluation of persons with possible anthrax. *MMWR* 2001; 50:945.

Gerberding says. "They don't have the symptoms of an upper-respiratory tract infection. They have a more systemic chest presentation, and that may be another distinguishing characteristic."

Another finding on initial blood work is that none of the inhalational anthrax patients had a low white blood cell count (WBC) or lymphocytosis when initially evaluated. Given that, CDC officials note that future suspect cases with low WBC counts may have viral infections such as influenza. Chest X-rays were abnormal in all patients, but in two an initial reading was interpreted as within normal limits. Mediastinal changes including mediastinal widening were noted in all eight patients who had CT scans. Mediastinal widening may be subtle, and careful review of the chest radiograph by a radiologist may be necessary, the CDC advises.

Complementing the CDC's effort, are the observations of the few clinicians who have actually seen inhalational anthrax cases come into their hospital systems. Two inhalational anthrax cases, both of which survived, were admitted to the Inova Healthcare System in Fairfax, VA (near Washington, DC).

"Clinically, I think the history of the people who presented here is useful," says **Allan J. Morrison Jr.**, MD, MSc, FACP, health care epidemiologist for the Inova system. "They stutter-stepped toward their pulmonary symptoms. That had some mild symptoms and then they were sort of 'meta-stable.' They were not relentlessly progressing. Then they progressed with symptoms more aggressively. Whereas with influenza — in our experience — once you start to get sick, it just keeps on progressing with very high fevers, chills, muscle aches, and pains. As a consequence, we feel there should be a good way to differentiate the two."

Since anthrax is a realistic concern in the Washington, DC, area, what about the aforementioned scenario of symptomatic postal workers in the ED?

"We would take a very aggressive history, not only of occupation but physically where they have been," Morrison says. "If they are symptomatic and have been in or work around a 'hot zone' — a location from which anthrax has either been cultured environmentally or patients have come from there — we will err on the side of being very aggressive about working up anthrax. By that I mean chest X-rays, chemistry profile, [etc.]"

In addition, the hospital system pushed early flu vaccination programs for staff and the surrounding community. "We want to move toward herd immunity," he says. "We are also working with our local hospitals to make sure that they have access to the rapid influenza tests. So for diagnosis — for obvious reasons — it is very helpful to make that distinction early."

One such rapid test is ZstatFlu (ZymeTX Inc., Oklahoma City), which the company claims can yield a diagnosis of influenza A or B some 20 minutes after a throat swab. The test detects neuraminidase, an influenza viral enzyme. However, Gerberding cautions clinicians not to rely solely on such tests. Rather, they should use the results of tests in combination with the patient history and clinical presentation, she says.

"So it is a constellation of history, clinical findings, and laboratory tests," she says. "Hopefully, when we get these all together, we'll be able to at least reduce the anxiety among some people and help clinicians diagnose those patients who really do require the antibiotic treatment. What we don't want to have happen is for everybody coming in with the flu to get an antibiotic because that undermines a whole other set of public health issues relating to antimicrobial resistance and proper management of influenza."

Even the vaccinated can still have flu

Complicating the issue is the fact that the flu vaccine efficacy can vary annually, but is usually 70% to 90% protective, says **Keiji Fukuda**, MD, a medical epidemiologist in the CDC influenza branch. Thus, depending on how well the vaccine matches the circulating strain, a certain portion of flu patients will tell clinicians they have been immunized. But in addition to vaccine breakthrough infections, there is a plethora of other viral and respiratory pathogens that will be creating similar symptoms, he says. In a somewhat sobering reminder — given that at this writing, the total anthrax cases remained in the double digits — Fukuda notes that a typical flu season will send 114,000 people to the hospital and 20,000 to their graves.

"There has been an awful lot of attention on the [anthrax] cases, but the bottom line is that there have been few cases, and these cases generally have occurred in a limited number of communities within a limited number of groups," he says. "And so the epidemiologic message is that anthrax really has not been diagnosed in most parts of the country, whereas we expect to see millions and millions of flu cases all over the place."

If facilities are faced with an onslaught of patients with respiratory illness there are several measures they can take, he notes. Those include:

- Reduce or eliminate elective surgery.
- Relax staff-to-patient ratios within the limits of your licensing agency.
- Emphasize immunizing staff so more staff are available.
- Identify ways to bring in extra staff to help out with the patients.
- Set up walk-in flu clinics to triage the patients.

Reference

1. Centers for Disease Control and Prevention. Update: Investigation of bioterrorism-related anthrax and interim guidelines for clinical evaluation of persons with possible anthrax. *MMWR* 2001; 50:941-948.

2. Centers for Disease Control and Prevention. Consideration for distinguishing influenza-like illness from inhalational anthrax. *MMWR* 2001; 50:984-986. ■

CDC moving quickly on smallpox front

Immunizations, training, vaccine dilution studied

Though officially stating it has no knowledge of any impending use of smallpox as a bioweapon, the Centers for Disease Control and Prevention (CDC) is scrambling with conspicuous speed to be ready for just such an event.

CDC workers from a variety of specialties are not only receiving smallpox vaccinations, they are being trained to give them to others using the old bifurcated needle scarification technique. And, even as creation of a new vaccine is fast-tracked, researchers are trying to determine if the current stockpile of 15.4 million doses can be expanded fivefold by simply diluting the vaccine.

Based on such actions, it is fair to say the agency is at least highly suspicious that the known stocks of smallpox virus are not safely ensconced in their official repositories in Russia and the United States.

"CDC is putting together a number of teams, which will probably total [more than] 100 employees, that could be quickly dispatched in a moment's notice to assist state and local health departments and frontline clinicians investigate suspect cases of smallpox," **Tom Skinner**, a spokesman for the CDC, tells *Bioterrorism Watch.*

"They are Epidemic Intelligence Service (EIS) officers, laboratorians, and others. Part of this includes vaccinating them against smallpox," he explains.

But while confirming that the CDC teams are being trained to administer the vaccine, Skinner would not specify who would be vaccinated following a smallpox bioterror event. "We have a smallpox readiness plan," he says. "Issues around vaccination are covered in that plan. That plan is being finalized. It is considered an operational plan. If we have a case tomorrow, it could be implemented. It covers who should be vaccinated and when."

The general consensus among bioterrorism experts is that those exposed would be vaccinated because the vaccine can prevent infection and possibly death even if given several days out. Likewise, health care workers and their family members would want vaccine if they were expected to care for the infected. Some aspect of quarantine would no doubt come into play because, unlike anthrax, it will be critical to separate the first smallpox cases and their contacts from the susceptible population.

Another aspect of CDC preparations includes the smallpox vaccine dilution study, which is being headed up by **Sharon E. Frey**, MD, associate professor of infectious diseases and immunology at Saint Louis University School of Medicine.

The vaccine, known as Dryvax, is no longer produced, but there are 15.4 million doses left. Frey and colleagues are looking at dilution studies that could maintain vaccine efficacy while increasing the available stock by millions of doses. In a study last year, Frey tried a one to 10 vaccine dilution, which would create a stockpile of more than 150 million doses. However, the resulting vaccine had only a 70% effective rate.

"The undiluted vaccine has about a 95% take rate," she tells *BW*. "It is not perfect, but we would like to be as close to that as we could be."

The new study will include a one to five dilution, which should show greater efficacy while increasing the stockpile to more than 75 million doses.

"We are looking at a 'take' rate for the vaccine, in other words how many people actually develop a typical lesion and whether they have a strong neutralizing antibody response to the vaccine," Frey says. "We know that the vaccine is still good. We actually titered the vaccine and it is very similar to its original titer," she adds. ■

CE/CME Questions

1. The recent threat of bioterrorism from the spread of anthrax revealed which of the following educational needs of staff and consumers?

A. Need for timely updates.
B. Need to react quickly.
C. Need to address psychological issues.
D. All of the above

2. To help manage pain, patients need to participate in their pain management regimen in which of the following ways?

A. Report pain and intensity level.
B. Grin and bear it.
C. Take an herbal remedy.
D. Demand a strong medication.

3. To uncover safety hazards and make necessary changes before a medical mistake occurs, it is a good idea to follow up on reported incidents from staff, read safety alert messages from outside organizations, and keep your eye on the news.

A. True
B. False

4. When putting together a health fair booth aimed at children, it is important to consider:

A. age and medical experience of children.
B. timeline for activity.
C. available space.
D. all of the above

patient education. If you would like more information about the column format, a copies of previously printed columns, or to inquire about a topic you would like to cover as a guest columnist, please contact Susan Cort Johnson, editor *Patient Education Management,* at: (530) 256-2749. E-mail: suscortjohn@onemain.com. ■

Promotion of events on patient education

If your organization is sponsoring a future event pertinent to patient education managers, send us the information at least two months prior to the scheduled date and we will help you get the word out. Details should include event title, theme and purpose, dates and times, and cost. Information can be sent via e-mail to Susan Cort Johnson, Editor, *Patient Education Management:* suscortjohn@onemain.com, or by mail: P.O. Box 64, Westwood, CA 96137. ■

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

Make health fairs a lesson in opportunity

Planning is key to success

Health fairs shouldn't just target adults but kids, too. "Don't think that parents are your only customer. The way children react to an institution will affect the parents," says **Hallie Bloom**, MS, MA, CCLS, director of Child Life at St. Jude Children's Research Hospital in Memphis, TN.

Therefore, health fairs provide an opportunity to help children develop a more positive perspective about health care and have some control that can make a big difference in their behavior the next time they have to go to the doctor, she says. For example, creating a huge medical collage is a way to help children become familiar and comfortable with medical equipment in a nonthreatening environment. They add syringes, cotton swabs, gauze pads, and masks to the huge art project.

Providing booths for children at health fairs is a good way to help them become familiar with medical interventions that they may have, agrees **Chris Brown**, MS, CCLS, director of Child Life and Education at The Children's Hospital of Philadelphia. One idea she uses at school health fairs is finger casting, where each child gets a plaster cast on his or her finger while learning about the purpose of a cast and how bones heal. "If they ever do break a bone and end up in the emergency department, the knowledge empowers them and helps them feel they have control over the situation," she explains.

While a booth targeting children is a good idea, there are several factors to consider when planning an activity, says **Pauline King**, MS, RN, CS, director for children's programming and psychosocial clinical nurse specialist at James Cancer Hospital and Solove Research Institute in Columbus, OH.

Plans for a health fair booth aimed at children should consider the following:

- **Projected number of children.**

Ask the organizers how many children they expect at the fair, says King. It helps when determining a budget for supplies and the number of personnel needed to work the booth. King sets up an educational booth for children each year at the Columbus Arts Festival where she has an opportunity to reach more than 1,600 kids in two days.

Tailor event to audience

- **Type of population attending.**

It's important to know the different ages of the children attending and what medical knowledge they have. Some children have never had experiences with doctors, hospitals or health care and others may have had a lot, explains Bloom.

For example, at one health fair, she set up a video camera and let children tell their doctor what they liked best about the medical experience, what they would like to see changed, and what frightened them. While the video gave children an opportunity to express themselves, it also helped staff when they were given an opportunity to review it.

- **Flow of people through booths.** It is important to have the line at the booth move swiftly; therefore, the intervention should not take too long. Select an activity where you can reach many people in a short period of time, suggests King. One year, King had a skin cancer prevention booth with the message "Block the Sun, not the Fun."

To reinforce the message "Slip on a shirt, slap on

SOURCES

For more information about creating booths for children at health fairs, contact:

- **Hallie Bloom**, MS, MA, CCLS, Director Child Life, St. Jude Children's Research Hospital, 332 N. Lauderdale, Memphis, TN 38105-2794. Telephone: (901) 495-2753.
- **Chris Brown**, MS, CCLS, Director Child Life and Education, The Children's Hospital of Philadelphia, 34th St. and Civic Center Blvd., Philadelphia, PA 19104. Telephone: (215) 590-2001. E-mail: brownc@email.chop.edu.
- **Pauline King**, MS, RN, CS, Director for Children Programming and Psychosocial Clinical Nurse Specialist, James Cancer Hospital and Solove Research Institute, 300 W. 10th Ave., Room 004, Columbus, OH 43210. Telephone: (614) 293-4138. E-mail: king-4@medctr.osu.edu.

a hat and slop on the SPF 15 sunscreen," children were given sunscreen and decorated a painter's hat with fabric blow pens that they could wear home. To expedite the process, Styrofoam dummy heads were set up all around the station.

Also, there should be enough staff on hand to allow for breaks without slowing down the activity at the booth. "We usually have someone outside our booth who talks about what can be done at our station and what to do to keep things going smoothly," says King.

• **Available space.** Space can be very limited at health fairs, so you should make do and set up your station in a way that is most efficient in serving a number of kids at one time, says King.

• **Way to get theme across.** "Give your project or intervention a label that immediately tells your prospective clients what you are focusing on," says King. For example, one booth she organized had an anti-tobacco message, so the label was "No Excusing for Using." Slogans are good ways to make the message brief and memorable, she says.

To drive home the anti-tobacco message, King provided felt squares and children who pledged not to use tobacco products traced their hand on the square and filled the outline with sparkle color. Later all the squares were sewn together to create a communal anti-tobacco quilt that is hung in libraries and schools to provide continuing education on the topic.

Health fairs at schools are a good way to reach children but in general families may not attend a regular health fair because it is just one more thing for them to do, says King. It's best to find opportunities for health education at other major community events such as an arts festival or at an event at the zoo. In that way, families are more likely to come, she adds. ■

Teach parents sports injury prevention

Organized sports seem like a healthful activity for children, yet they could be hazardous to their health. Serious injuries occur time and again, but they can be prevented if parents take a few precautions before signing their child up for a sport, says **Michelle Klein**, executive director of the National Youth Sports Safety Foundation in Boston.

What steps do parents need to take to prevent sports injuries in their children? Following are a few suggestions from Klein:

• **Schedule a pre-participation physical.** Before children play sports, they should see a physician who specializes in sports medicine, says Klein. Such a specialist will know to look for misaligned hips and knees, leg length discrepancy, and tight muscles, which can put children at risk for injury. Such problems can put stress on different joints and cause fractures or pulled muscles, she says.

• **Screen the coach.** Parents should find out if the person who will be coaching their child is trained in CPR and first aid and has taken a coaching certification course. It's a good idea to ask if the coach has played the sport and at what level, says Klein. "Also talking to other parents whose kids have been in the program is a good resource."

• **Help the child get in shape.** The first day of practice should not be the first time in months the child is playing sports. Children should be training for several weeks prior to team practice. Those who aren't in shape are more likely to be injured, says Klein.

• **Purchase good equipment.** Parents should purchase the appropriate sports shoe for their children that fit properly. Poorly fitting shoes can cause back, knee, and hip problems, says Klein. Good safety equipment is also important. If sports require elbow pads or kneepads, children should wear them. For football, a properly fitted helmet is essential. "A helmet should fit snugly on the head with a chin strap. We see incidents where the helmet is too loose and they blow off the head at the wrong moment, and the child is struck and rushed into brain surgery," says Klein.

• **Provide proper nutrition and supervision.** It is important that children who play sports eat a well-balanced, healthy diet and get enough sleep. In addition, parents need to keep an eye on their children, and when they go through a growth spurt, make sure that they cut back on training. When children continue to train at the same pace, they often injure themselves, says Klein.

The final piece of advice Klein has for parents is to make sure that safety is the priority of any sports program they enroll their children in, not winning. ■

SOURCE

For more information about sports safety, contact:

- **Michelle Klein**, Executive Director, National Youth Sports Safety Foundation Inc., 333 Longwood Ave., Suite 202, Boston, MA 02115. Telephone: (617) 277-1171. E-mail: nyssf@aol.com. Web: www.nyssf.org.