AMERICAN HEALTH CONSULTANTS

Patient Education Management™

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

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Quality care is missing from most education efforts

Internet provides a wealth of resources

Americans are savvy shoppers. Often when purchasing a big-ticket item, they spend time researching the product to make sure it meets certain quality standards. Yet few use their investigative skills when it comes to the quality of their health care. That's because the general public does not know how to evaluate quality of care, says **Marilyn H. Oermann**, PhD, RN, FAAN, a professor at the Wayne State University College of Nursing in Detroit.

Oermann and her colleagues have conducted several studies on quality of care and have found that many people do not know there are performance

EXECUTIVE SUMMARY

Many health care facilities have put into place programs and educational efforts to motivate patients to take a more active role in their health care. Facilities have taught such things as questions patients should ask their physician about treatment. Yet one area that is lacking is education on quality care, how it is measured, and how to assess the quality of care patients are receiving. This gap in education can easily be closed with the use of the Internet. A study found that the Internet is a good source of information on quality care and a good teaching tool.

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COMING IN FUTURE ISSUES

- Making the patient connection with mall-located resource center
- The pros and cons of using a separate documentation form for patient education
- Special tools that improve patient education
- Specialty Service providing health care information for travelers
- Joint Commission's recent survey strategy on patient education

data available. Many consumers believe that hospitals have to be accredited to admit patients, yet they can't define accreditation and have never heard of the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations even though it is one of the nation's oldest and largest accrediting agencies.

Also, they have views about the role of health care that are not always correct. For example, they think their health care provider will remind them when to schedule tests for preventive care.

To help American's become savvy health care consumers, patient education managers should teach patients how to use the Internet to learn about quality care, says Oermann. In a recent study published in the Joint Commission's *Journal on Quality Improvement,* Oermann and her colleagues evaluated Internet documents on quality care. They also looked at the documents' effectiveness in improving consumer understanding of the quality of health care.[1] Post-test scores showed that after reading documents selected by the researchers from five web sites, participants had a better understanding of quality care and important concepts of health care quality. The documents selected for this study include:

- *Improving Health Care Quality: A Guide for Patients and Families,* published by the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD.
- *Now You Have a Diagnosis: What's Next?,* published by AHRQ.
- *20 Tips to Help Prevent Medical Errors,* published by AHRQ.
- *Making Medicare Choices: Medicare Options,* published by the American Association of Retired Persons (AARP) based in Washington, DC.
- *In Search of Quality Health Care,* published by Consumer Reports in Yonkers, NY.

It is important for patients to know how quality care is measured, how to use quality reports, how to choose providers and hospitals, and how to assess the quality of their own care, says Oermann.

The Internet is a good resource because it does not rely on busy physicians or nurses to teach about quality of care. Staff at clinics with computers in the waiting areas or patient resource centers can bookmark web sites. Patient education managers can distribute lists of such sites as well, says Oermann.

Also, the information can be tailored to the specific needs of patient populations. For example, seniors would be interested in the AARP web page on Medicare choices that includes the

advantages and disadvantages of various options. **(For a list of web sites that provide information on quality care, see article, below right.)**

Learning to use information

Many of the documents on reliable web sites include checklists and guides so that people can easily apply the information, says Oermann. It also is important for people to know why the information is important and how to evaluate it, she says.

Understanding the purpose and value of the information is important as well, says **Mark Forstneger**, a spokesman for the Joint Commission on Accreditation of Healthcare Organizations based in Oakbrook Terrace, IL. It is not enough to know that a facility is accredited. Consumers should look at the evaluation, he adds.

The quality check on the Joint Commission's web site includes information on an organization's accreditation status, its accreditation history, its overall evaluation score on its last triannual survey, comparative information on a national basis, and requirements for improvement, if any.

"Consumers should know that accreditation is a voluntary endeavor. Organizations are bringing in an independent, objective, outside group to do a quality audit. We tell the health care organizations what they do well and what they can do better, working with them to help them learn best practices," says Forstneger.

Some of the knowledge evaluated in pre- and post-tests during Oermann's study, before participants read the information selected from designated web sites and after they had a chance to learn from the documents, included:

- how quality care is measured;
- purposes of accreditation and what it means to consumers;
- frequency of medical errors and what a consumer can do to prevent them;
- how consumers can use report cards;
- how consumers can best use their health plan for care and prevention.

Teaching about quality care will help patients understand the health care system better and how to use it appropriately. Rather than grumbling about not receiving a treatment and leaving the clinic dissatisfied, they will be able to discuss the issue with their physician and learn why the treatment might not be appropriate. "An informed consumer makes a happier consumer because they know what questions to ask and they can get the information up front," says Oermann.

SOURCES

For more information about teaching consumers about quality care, contact:

- **Mark Forstneger**, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000.
- **Marilyn H. Oermann**, PhD, RN, FAAN, Professor, College of Nursing, Wayne State University, 168 N. Cranbrook Cross, Bloomfield Hills, MI 48301-2508. Telephone: (248) 594-6933. Fax: (248) 594-6934. E-mail: moermann@msn.com.

Reference

1. Oermann M, Lesley M, Frances Kuefler S. Using the Internet to Teach Consumers about Quality Care. *Journal on Quality Improvement*. February 2002;Vol. 28, No. 2. ■

Web sites that teach quality care, patient ed

During a research study conducted at Wayne State University College of Nursing in Detroit, Professor **Marilyn H. Oermann**, PhD, RN, FAAN, and her colleagues evaluated 90 Internet documents on quality health care. Following is a list of web sites she recommends for patient education on quality care:

- **ahcpr.gov/consumer/qntlite/qntlite.htm** — Improving Health Care Quality: A Guide for Patients and Families
- **www.ahrq.gov/consumer/ncpiebro.htm** — Prescription Medicines and You
- **www.ahcpr.gov/consumer/diaginfo.htm** — Now You Have a Diagnosis: What's Next?
- **www.aarp.org/hcchoices/medicare/makechoice/options.html** — Making Medicare Choices: Medicare Options
- **www.ahcpr.gov/consumer/20tips.htm** — 20 Tips to Help Prevent Medical Errors
- **www.lib.wayne.edu/shiffman/chis/qualityhealthcare/index.html** — A web page developed by researchers at Wayne State University to teach consumers about quality health care using Internet sites. ■

Put educational goals in place in order to evaluate

Verbalization, demonstration tell if goals are met

To measure the effectiveness of teaching, goals must be set at the very beginning of the educational session. "You can't teach unless you have a goal," says **Linda Kocent**, RN, MSN, coordinator for patient-family education at Children's Hospital of Philadelphia. Everyone involved in the education needs to know what the goal is and who is responsible for what portion of the teaching, she says.

At Children's Hospital, there are teaching plans for most diagnoses and procedures so that the goals for teaching already are established. For example, if a patient is a newly diagnosed diabetic, the teaching plan for basic survival and safety skills would be implemented, and patient and family members would be taught such skills as how to give insulin, says Kocent.

"It is always important to set goals before beginning a teaching session," agrees **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, support, and outreach at Grant/Riverside Methodist Hospital in Columbus, OH. Goals can be established according to topic areas. For example, does the patient need to learn about medications, self-care at home, rehabilitation, or community resources?

Goals also are based on the patient's readiness to learn, which is measured by several factors, including the stage of adaptation to the illness the person has, the home situation, and the sensory or cognitive deficits, says Szczepanik. **(To learn about assessing learning readiness, see the second part of article series on teaching published in *Patient Education Management,* April 2002, p. 40.)**

To determine whether or not the goals for teaching are met, the patient's understanding of the lesson must be evaluated. For example, if a newly diagnosed diabetic is learning to use a blood glucose monitor at Children's Hospital, the parent first would be sent to the learning center for basic teaching. The educator would demonstrate the procedure and then have the parent return demonstrate. "In the learning center, we would document that we demonstrated the procedure, and they demonstrated for us either successfully or not," says Kocent.

The teaching record is returned to the nursing unit and the nurse documents as parent's practice the procedure on their child during the hospital stay. "If it is a skill that was taught, parents need to be able to demonstrate that they can perform it, they can trouble shoot when something goes wrong, and they know when to ask questions and call for help. If it is about a diagnosis or medication, they need to just be able to verbalize their understanding of it," says Kocent.

The best way to know if a learner can apply what he or she learned is to watch him or her try to do it if the task involves psychomotor skills, says Szczepanik. At home, patients may need to refer to written instructions or a video to complete the task, and it's OK for them to use a diagram during a return demonstration.

To evaluate learning, listen to their conversation to see how comfortable they are at doing the procedure. "The more successful people think they will be, the more successful they will actually be," says Szczepanik.

Also watch for mistakes that could be a problem. For example, if it's a sterile procedure, watch to see if people break the sterile field to check their directions. **(See example of teaching and evaluation on p. 53.)**

If verbal understanding is warranted, have the patient describe a medication regimen or treatment in his or her own words, says Szczepanik.

Steps for evaluating learning domains

There are three learning domains to evaluate during the education process to make sure that learning is taking place, says Szczepanik. The following is a list of questions that can help determine if learning is taking place in these domains:

- **Cognitive domain**

— Can the person recall information?

— Can the person understand information

EXECUTIVE SUMMARY

In the March issue of *Patient Education Management,* an article on the components of good teaching launched a series on teaching staff to teach. In April, we covered the learning assessment in detail, discussing the best techniques for assessing readiness to learn and learning needs along with the barriers to learning and how to assess for them. In the third and final part of our series, we look at how to evaluate our teaching.

Return demonstration good evaluation method

"The best way to know if a learner can apply what he or she has learned when psychomotor skills are involved is to watch them try to do it," says **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, support, and outreach at Grant/Riverside Methodist Hospital in Columbus, OH.

The following is an example of the steps involved in patient teaching for central venous catheter care and the evaluation process that ensures learning:

- **Review verbally:**
  - — Reason for catheter
  - — Reason for home care
  - — Potential complications
  - — Troubleshooting
  - — Whom to call if you need help
- **Demonstrate:**
  - — Skin care
  - — Dressing application
  - — Injection cap change
  - — Flushing
  - — Troubleshooting
- **Return demonstration:**
  - — Each skill listed above, one at a time
- **Provide:**
  - — Written step-by-step instructions (with photos or illustrations) and/or a videotape. ■

well enough to draw conclusions?

— Can the person adapt rules to specific problems?

— Can the person distinguish between facts and myths?

— Can the person use food exchange lists to develop weekly menu plans?

— Can the person evaluate the effectiveness or value of the information?

- **Psychomotor domain**

— Can the person assemble the necessary equipment and environment for the task?

— Can the person do the task under supervision?

— Can the person do the task without instruction or intervention from the instructor?

— Is the person accurate? For example, can he or she read a thermometer to within 0.2°?

— Can a person adapt procedure to add a new step or adapt to a new piece of equipment (such as going from a disposable colostomy pouch to a reusable one)?

- **Affective domain**

— Is the person paying attention?

— Is the person reacting to stimuli the teacher provides?

— Is the person making definitive plans for how to do the procedure at home?

— Can the learner tell the educator where and how he or she will do the required activity or procedure or make the behavioral change?

"Good education is based on realistic learning outcomes being set at the start, on evaluating and constantly reevaluating the patient's readiness and ability to learn, and then measuring the patient's progress toward those goals," says Szczepanik. ■

SOURCES

For more information about evaluating teaching, contact:

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Reader Question

Time and topic help shape staff education method

Creativity gets the word out

Question: "What techniques do you use to educate staff? Which have worked the best and why? Does the technique to be used depend upon the topic or do other factors affect its selection? Please give a detailed description of one of your best staff education efforts, and explain why you believe it worked."

Answer: "We have found that case-based

scenarios are the best way to facilitate critical thinking skills when educating staff," says **Jean A. Just**, RN, MS, CS, director of nursing staff development and patient education at The James Cancer Hospital and Solove Research Institute in Columbus, OH.

This teaching technique initiates lots of involvement and interaction with staff. It promotes discussion. When staff problem-solve the case presented, it shows instructors that staff have learned how to apply the information, says Just.

To select appropriate cased-based scenarios, Just looks at her learning objectives. It's important to make sure that the case that is covered relates back to the learning objectives, she says. For example, if the lesson is about identifying restraint alternatives, the case used would need to provide opportunities for staff to identify alternatives for restraint use. During the exercise, staff would demonstrate critical thinking throughout the process, says Just.

Computer-based training modules also have been used and are good for staff education because each person can fit it into his or her schedule. The health care facility has purchased commercial programs and developed its own. Yet if the training modules are developed commercially, a health care facility must have the option of customizing the information, says Just.

"Computer-based training can be effective because it is self-paced, and the learner can go back and repeat information or review information depending on how it is set up. There is continual reinforcement," says Just.

Several techniques are used to educate staff at New York Presbyterian Hospital Weill Cornell Campus in New York City. The decision on which method would be appropriate depends on the topic, the amount of content to be covered, whether it is a topic that must be taught hospital wide, and the length of time the teaching might take, says **Barrie F. Friedenberg**, BSN, MA, an instructor in nursing education at the institution.

Formal, scheduled classes are mandatory and usually are lecture and discussion but may include a group activity. Such a class would be warranted for something like a new piece of equipment. For example, when the hospital got new blood glucose monitors, there were lengthy new policies the staff had to learn, and everyone had to do a return demonstration. So, a formal, mandatory class was scheduled.

"Sometimes, we do short, quick inservices unit-to-unit, but it has to be information that can be given in 15-minutes or less," says Friedenberg.

SOURCES

For more information on techniques for teaching staff, contact:

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With this method, the educator would go to a unit and quickly gather the nurses or just talk to one person at a time. The short unit-to-unit inservices usually are used for topics that are not complicated such as a new procedure or a new piece of equipment that is simple to explain like a new specimen container.

Another quick inservice that sometimes is used is the 'read-and-sign' method. With this method, information such as a new policy is posted and staff are responsible for reading it and signing their name to show that they saw it. As with the unit-to-unit inservices, the information must be something that is simple and doesn't warrant an hour-long class.

Several creative methods have been used to reach busy staff. Sometimes inservices are given throughout the day, every hour on the hour, or the information might be gotten out via a poster session. "If we have a lot of different things for the staff to learn, we will set up stations, and staff can go from one station to another on their own time," says Friedenberg.

To get information to staff about patient teaching, **Dorothy A. Ruzicki**, PhD, RN, director of the educational services department at Sacred Heart Medical Center in Spokane, WA, has found that the best method is to include the information in a clinical conference. Nurses may not attend a conference devoted to patient teaching, but they will go to one on current clinical topics, she says. "If patient teaching in that specialty is covered in a breakout session or part of the presentation of the

main speaker, the nurses will be a captive audience," says Ruzicki.

Determining how to have learning occur, yet make it fun, is the creative part of staff education, says Just. During the month of October, staff in the education department at James Cancer Hospital set up stations that related to all the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations chapters on standards. Instructors at the stations dressed in costume and gave treats to all who participated.

"The stations were interactive where staff would need to either complete a puzzle or do a game, and as a result, there would be some learning that would take place related to the specific standard," says Just. The stations were staffed for a 24-hour period to reach all shifts. **(For more information on using games to teach Joint Commission standards to staff, see article below.)**

An inservice fair worked well for several years at New York Presbyterian Hospital. The hospital would rent the gym at Cornell University and invite 50 representatives from equipment companies who would demonstrate their product throughout the day and supply giveaways for raffles. "It was fun and educational," says Friedenberg. Although the equipment wasn't new to the hospital, it provided an opportunity for review.

The fair always had a theme with the appropriate decorations and food, and all instructors dressed to fit the theme. For example, for a carnival theme Friedenberg dressed as a clown. The event was advertised on every unit, including bringing balloon bouquets onto each floor with a lot of signage.

Last summer as part of a Joint Commission standards focus, Ruzicki e-mailed a diabetic teaching situation to all nurses and gave simple prizes for their correct responses.

"Educators must be able to identify the best teaching methodology for the overall goals and objectives they are trying to accomplish within their educational program. Then they need to look at leveraging the resources they have available to them," advises Just. ■

Q & A reinforces teaching JCAHO standards

Competition and fun help formal teaching

A question-and-answer game on the patient education standards of the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations is helping staff at the Veterans Affairs (VA) Gulf Coast Veterans Health Care System in Biloxi, MS, prepare for an upcoming accreditation survey.

"I teach staff what the standards are in a classroom setting and then go back and reinforce the teaching with a fun way of learning," says **Lynda Duhe**, MSN, RN, patient and family health education coordinator at the health care system.

Education 'Jeopardy'

She rolled out the first version of "Patient Education Q & A" in 1999 and is in the process of revamping it to prepare for an upcoming survey. She visits clinics and hospitals within the VA Gulf Coast Veterans Health Care System during interdisciplinary treatment team meetings and assembles teams to play the game.

To play, participants are divided into two teams. Each team is given play money and a device to signal when they want to answer the question. The questions are worth $20, $40, $60, and $80 in four categories that include general, assessment, documentation, and required. There also are $200 bonus questions.

An impartial person starts the game by drawing a category from a box for the $20 question. Whichever team gets the answer right can pick the next category and price of the question. "It's a good learning experience because if the team that rang in to answer the question doesn't give a complete answer the opposing team will complete it so everyone is constantly learning," says Duhe.

A question on documentation might read: "Who is responsible for documenting patient teaching?" The team that rings in first might name all the disciplines that might be a part of the teaching reinforcing that documentation is an interdisciplinary collaborative process, she says. Once a question is answered, Duhe marks it, and it isn't asked again.

Medical media department staff created the board with the questions on flaps that pull up to reveal the answers. Once all the questions have been answered, teams count their money to see who won. The team with the most money gets to pick from several prizes that might include mugs,

SOURCE

For more information about using the "Patient Education Q & A" game to help staff prepare for a Joint Commission survey, contact:

- **Lynda Duhe**, MSN, RN, Patient and Family Health Education Coordinator, VA Gulf Coast Veterans Health Care System, 400 Veterans Ave., Biloxi, MS 39531. Telephone: (228) 563-2609.

pens, and pillboxes. After the first team makes their selections the second team gets to choose prizes. "I send everyone who has played a thank-you note," she says.

In the version for the preparation for the 1999 Joint Commission survey, questions were simple and straightforward. They included:

Assessment Category:

• How do you determine learning needs of patients and families?

Answer: Assessment

• What variables are considered in assessing patients learning needs, abilities, and readiness to learn?

Answer: Cultural and religious practices, emotional barriers, desire and motivation to learn, physical and cognitive limitations, and language

General Category:

• How do you know when patients and/or families have understood the teaching?

Answer: Feedback and/or return demonstration

• What do you do if the patient does not understand?

Answer: Repeat instructions and/or involve support person

Required Category:

• What instructions do you give the patient and/or family regarding discharge from the present level of care?

Answer: Information about community resources, how to obtain further treatment, and managing continuity of care

• How do you teach patients and families about food-drug interactions?

Answer: An interdisciplinary (provider, dietitian, nurse, and pharmacist) team approach is used.

Documentation Category:

• Who is responsible for documenting patient teaching?

Answer: All members of the health care team

• What is documented for patient education?

Answer: Advice or instructions, patient's response, and whether the instructions were understood

The game Duhe is creating for the next survey will have questions that require participants to give the intent of the standard in their answer. She changed the way the game is played because Joint Commission surveyors no longer interview the patient education coordinator but go directly to staff on the floor. One of the new questions in the general category is:

• How do you know when patients and families have understood the teaching?

Answer: It is an interactive ongoing process that staff give the patients information, but they have to illicit feedback to make sure that the information is understood. If the patient can demonstrate or explain what they have learned then they know that they have learned. Staff then have to identify areas in which the patient needs further education or to reinforce previous teaching.

"Answers will require more detail. When we start to play the game, I will say 'What else, what else, what else,' as they answer the question," says Duhe. ■

In therapy, a picture is worth a thousand words

Art provides window to patients' emotions

People can have trouble expressing themselves in verbal therapy. They often bury feelings and emotions so deeply that they don't verbally surface. In such situations, art therapy can help. "Often problems, situations, or things that people aren't quite aware of are discovered by accident because of what is put down on the paper," says **Sally Altenburg**, MA, a therapeutic art educator in Columbus, OH. Also, people have learned how to hide true emotions with words, but they don't know how to lie with pictures.

For example, when helping teenagers work through their grief after the loss of a loved one, Altenburg asks them to draw something in a storm. What they don't know at the beginning of the session is that what they draw represents themselves.

Many draw a tree bent by wind and shrouded in dark storm clouds. To help them make the connection, she may have them write a poem about their picture or answer such questions as 'What is the tree doing to survive?' or 'What does the tree

have to offer the world?' "It all applies to them, and they have no idea," says Altenburg.

During the exercise, one teen-age boy drew a newspaper covered with very light writing because he didn't have much strength, but his purpose of surviving the storm was to tell his story. When the teen and Altenburg talked following the session, he made the connection. "When we talked about the picture afterwards, he said it was true that he had a story and that he didn't feel very strong at the moment," says Altenburg.

The type of artwork used during therapy depends upon the goal of the session. When trying to help people release anger, an art therapist may have them make a sculpture with wood and nails. The pounding helps patients get rid of their anger. Clay is another good art medium for working out anger, as well as anxious feelings, says Altenburg.

With people who are out of control, Altenburg might give them crayons, markers, or pencils to work with because these art tools are very controllable. Their art project might be tracing an object, which helps them feel as if they can bring their life back into control. "When clients are too controlled, I might give them paints where they can really make messes. It is difficult for them to do, but with the right support and encouragement, they can let go of some of that control. I match the media to the client I am working with," says Altenburg.

Artistic talent not required

While many hesitate to use art therapy to work through problems because they believe they have no talent, Altenburg says that people don't have to be artistic to participate in art therapy. Abstract art reveals a lot through the artist's choice of colors, shapes, and the placement of objects on the paper, says Altenburg. For example, blacks and reds tend to express anger and negative feelings, while light colors such as yellows and oranges might show positive feelings about a situation.

A typical art therapy session will begin with discussion to build rapport before the art project is introduced. During a typical session, people might be asked to draw a figure on a piece of paper taped to the wall. Then Altenburg would ask patients to color in where they hold their love, where they hold their sadness, where they hold their anger, and so on, selecting colors they feel would appropriately describe these emotions. "Afterwards, we take a moment or two to sit down and look at the drawing they have made," she says.

Drawing the picture may be helpful, but if they are having trouble with what they have drawn, more work is needed. In this case, she may ask them to tell what the picture would say if it could talk. Or she may have the person draw the anger draining out of their body. It's important for the art therapist to make sure people are comfortable with what has gone on during the session before they leave, explains Altenburg.

When choosing art therapy to work through grief, stress, depression, anxiety, and other problems, people need to know that one picture will not tell the whole story. They need to understand that it is a safe process and they are in control.

"If it is done correctly, the therapist will do very little interpretation of the artwork, and the interpretation will be left up to individuals so they don't feel that their therapist is going to know more about them than they do," says Altenburg. When selecting an art therapist, people should make sure that he or she has had experience and is registered.

One aspect about art therapy that sets it apart from regular therapy is that it can be done at home long after the sessions with the therapist have ended. People can learn how to interpret the art and then use it when they are stressed or depressed. "Really, the patient is their own therapist throughout the session while the art therapist is the guide," says Altenburg. ■

SOURCE

For more information about art therapy, contact:

- **Sally Altenburg**, MA, Therapeutic Art Educator, Columbus, OH. E-mail: saltenbu@columbusrr.com.

Reward for documentation increases compliance

An inexpensive acknowledgment of a job well done

Documentation of patient education often is a struggle at many health care facilities. While patient education managers are certain education takes place, they know that there must be a record of teaching in order to prove it.

To improve documentation on the multidisciplinary education record at Southwest Washington Medical Center in Vancouver, WA, **Mary Paeth**, MBA, RD, patient/community education

coordinator, initiated an award system for good documentation. The plan was set in place with the approval of the patient education committee in preparation for a survey from the Joint Commission on Accredita-tion of Healthcare Organizations based in Oak-brook Terrace, IL, and to improve use of the new documentation form.

The awards pushed documentation of patient education up by about 20% housewide over a five-month period, and patient education received good marks from the Joint Commission.

"There are several reasons why the awards program helped," says Paeth. "It was quick to implement and efforts at documentation were swiftly recognized. Also, it acknowledged the actual person who documented. So often we reward the whole group, and there may have only been 10% that made the effort."

It was easy to implement because the details had been laid out at a poster session at a national conference Paeth attended and she followed them, although her system was less formal than that used at the Florida hospital where the original awards program was created.

Paeth rewarded units as a whole one month, and individuals the next beginning in September 2001 and ending in January 2002 when the Joint Commission surveyed the health care facility.

To determine if units as a whole were documenting patient education, she assigned one employee to conduct closed chart audits. To keep the project manageable and provide quick feedback, the designated employee did two to five chart audits per unit. "Our point was to give staff a frequent summary," she explains.

In September, two units were named winners of the "Patient Ed" Award because they had the highest percentage of charts showing that education was completed and documented on the multidisciplinary education record. "Patient Ed" is a bookworm toy that Paeth found at a local toy store and uses as a mascot to represent learning and education.

Winning units displayed the mascot and received a certificate that explained the reason they were receiving the award. Employees were given individual rewards. The first month apples for the teachers were delivered and after that employees were given packages of gummy worms. The individual rewards had stickers on them that read: "In recognition of your documentation on the patient education form." A copy of the information about the award also was printed in the medical center's clinical newsletter.

In November, the criterion for judging units was most improved documentation in the medical record and multidisciplinary education record. In January, the Patient Ed Award was given to two units that had maintained their record during the time of the competition.

"I was fortunate enough to find two little mascots and bought them at the same time in case that happened. Because I only had two, each time I looked for something that separated two units from the others, and that became the reason they were awarded," says Paeth.

In the months of October and December, individuals were rewarded for their documentation efforts. To identify them, Paeth went to various units with a basketful of candy and looked at open charts. She made a list of all the signatures on the multidisciplinary education record. If the staff members were at work, she handed them a package of the candy and personally thanked them for their documentation of patient education.

"They were usually very surprised to receive a reward for doing something that was their job," says Paeth. If they weren't working, she put the reward in the person's employee box or folder. She delivered the rewards to all disciplines that had documented and that included physical therapy, nutrition, social work, and pharmacy, as well as the nursing staff.

The awards program was very inexpensive. Paeth bought the packages of candy through the hospital gift shop at cost for about $200. The apples she gave as the reward the first month were purchased from the food service department. She switched to the candy because it stored for a longer period of time and took less space than the apples.

The patient education committee decided to continue the Patient Ed Awards program following the Joint Commission survey to support documentation. The medical center is considering expanding the program systemwide, giving awards for all documentation efforts rather than

SOURCE

For more information about the Patient Ed Awards program for better documentation, contact:

- **Mary Paeth**, MBA, RD, Patient/Community Education Coordinator, Southwest Washington Medical Center, P.O. Box 1600, Vancouver, WA 98668. Telephone: (360) 514-6788. E-mail: mpaeth@swmedctr.com.

singling out patient education.

"Realizing their work was noticed always catches people off guard and makes them more diligent in doing their work," says Paeth. ■

Toll-free hotline simplifies poison emergencies

One national toll-free number simplifies the process of getting help in a poison emergency. Panicked parents and caregivers can call (800) 222-1222, a hotline that links callers from anywhere in the country to medical experts at local poison control centers. The calls are routed to the nearest center based on the caller's area code. While the local numbers for poison control centers will continue to work, people can't always find them in an emergency situation. Now people only need to remember one number no matter where they are, whether at home, at work, or traveling.

The poison control centers across the United States handle more than 6,000 calls a day with their poison experts treating about three-quarters of the poison exposures over the telephone. Experts not only help in emergencies, they answer questions about medicines, insect bites, household products, and other potentially dangerous substances. ▼

Promotion keeps anxiety screening on target

May 1 is National Anxiety Disorders Screening Day. Health care sites interested in doing the screening will find that Freedom From Fear, the Staten Island, NY-based organization sponsoring the event, will provide all the tools necessary to screen the public — whether screening takes place on the designated observance or another date. That includes educational brochures, promotional flyers, screening forms, a video about the various anxiety disorders and their symptoms, bookmarks, and instructional information for running a screening.

"We do a lot of publicity and promotion to remove the stigma around mental illness, specifically anxiety and depressive disorders, by educating the public," says **Jeanine Christiana**, associate director of Freedom From Fear.

Education prior to the screening also helps to draw members of society that may possibly suffer from these disorders to the screening. It's a good idea to publicize the symptoms before hand, says Christiana. These symptoms include:

- **Depression:** Not able to concentrate or eat.
- **Obsessive-Compulsive Disorder:** Repetitive obsessive thoughts and compulsive behavior such as washing.
- **Social Anxiety Disorder:** Fear of doing things in front of others because of being scrutinized or humiliated.

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Editorial Questions

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CE Questions

17. To help patients become better health care consumers they need to learn about quality care. This should include which of the following?
A. How quality care is measured.
B. How to choose providers and hospitals.
C. How to assess their quality of care.
D. All of the above

18. To measure the effectiveness of teaching, educators should do which of the following?
A. Set goals at the beginning of the session.
B. Ask for a return demonstration.
C. Ask participants if they understood the lesson.
D. A & B

19. The awards program for documentation of patient education at Southwest Washington Medical Center in Vancouver worked because it was quick to implement and efforts at documentation were swiftly recognized.
A. True
B. False

20. Children in a passenger safety seat are more likely to be injured in the case of a car crash when which of the following occurs?
A. Children are not properly fitted for the seat.
B. The seat is the wrong type for the child's age.
C. The seat is positioned incorrectly.
D. All of the above

• **Panic Disorder:** Panic attacks that come out of the blue and cause shortness of breath, sweating, and rapid heart rate.

• **Post-traumatic Stress Syndrome:** Those who have experienced a traumatic event and are having flashbacks, problems sleeping, and the tendency to relive the event over and over.

The organization advises health care facilities to use licensed mental health professionals at the screenings to evaluate the forms. These could include social workers, psychiatric registered nurses, psychiatrists, and psychologists. "It takes about 10-15 minutes to review the form with the individual and, if they screen positive, to provide them with referrals," says Christiana. Screenings are free and also can be anonymous.

For more information contact Jeanine Christiana, National Anxiety Disorders Screening Day, National Mental Illness Screening Project, Freedom From Fear, 308 Seaview Ave., Staten Island, NY 10305. Telephone: (718) 351-1717. Web site: www.freedomfromfear.org. ■

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

Safety seat inspection best way to save lives

Connect parents to local sites, expert information

Most parents put small children in a safety seat while driving in a car thinking that their child is protected in case of an accident. However, if children are not properly fitted for the seat, parents are using the wrong type of seat for the child's age, or the seat is positioned incorrectly, injury can result during a crash, says **Elly Martin**, MIA, MSJ, a spokeswoman for the National Highway Traffic Safety Administration (NHTSA) in Washington, DC.

The NHTSA estimates that more than 80% of child passengers under the age of 8 are not properly restrained in child safety seats, yet motor vehicle crashes are the leading cause of death for children ages 4 to 14.

While information about child passenger safety can save lives, the best education for parents is a visit to a fitting station, says Martin. "We can offer broad guidelines and general instructions, but to get the specifics to suit a child, there is nothing that beats going to a fitting station," she says. As the child grows and graduates to another seat, the process of visiting a fitting station must be repeated.

No seatbelt use for kids younger than 8

Children should not prematurely graduate to seatbelts, warns Martin. "A child should be in a safety seat until 8 years old unless they are unusually tall. Otherwise, the seatbelt will hit them improperly and there is potential for abdominal injuries and other problems if there is a crash," she explains.

Young children ages 4 to 8 who weigh more than 40 pounds and are shorter than than 4 feet 9 inches tall should ride in a belt-positioning booster seat. Toddlers older than 1 year who weigh between 20 and 40 pounds should ride in a convertible forward-facing seat. Parents who have infants from birth to 1 year should use an infant only or rear-facing convertible safety seat.

All children age 12 and younger should ride in the back seat of the car. "The back seat is the safest position for all occupants, but particularly for children who are fragile and vulnerable behind airbags," says Martin. Frontal collisions are twice as common as side or other collisions, she says.

The NHTSA trains and certifies technicians to work at child-passenger-safety inspection sites. This February, the federal agency awarded grants for the establishment or expansion of these inspection sites to 10 hospitals and health systems in conjunction with National Child Passenger Safety Week.

However, inspection sites are not always located at health care facilities. Law enforcement facilities frequently set up inspection stations either on a regular or intermittent basis, and car dealerships often have stations, says Martin. To create a list of local child-passenger-safety inspection sites, Martin advises patient education managers to contact the NHTSA office in their region. A list of these offices is available on the NHTSA web site at www.nhtsa.dot.gov.

The web site also has lots of educational information. A dictionary of child safety seat terms helps parents understand such terms as five-point child restraint harness, retractor, and tray shield. A one-minute safety seat checklist provides illustrations and instruction on age-appropriate safety seats. The various types of seats on the market are described in detail on another web page, including convertible seats and high-back booster seats. There also is a child safety seat recall list, a use chart, and child-passenger-safety laws. ■

SOURCE

For more information about child passenger safety seat education and inspection, contact:

- **Elly Martin**, MIA, MSJ, Spokeswoman, National Highway Traffic Safety Administration, 400 7th St., S.W., Washington, DC 20950. Telephone: (202) 266-0651. Web site: www.nhtsa.dot.gov.

Keeping vaccines current is aim of observance month

Prevent diseases by maintaining records

Vaccines have made more of an impact on public health than any other strategy except safe drinking water, according to the National Partnership for Immunization (NPI) in Bethesda, MD. Yet vaccine-preventable diseases still occur in the United States.

According to NPI, pneumococcal disease causes approximately 17,000 cases of invasive disease among children younger than 5 years old, resulting in 700 cases of meningitis and 200 deaths each year. However, failure to keep children's immunization schedules up to date not only impacts their health in childhood, it often puts them at risk in adulthood as well. The risk of complications and death from chickenpox is 10-20 times greater for adults than children. Because chickenpox is endemic in the United States, anyone who is not vaccinated is at increased risk for contracting the disease in adulthood.

For these reasons and many others, NPI has designated August as National Immunization Awareness Month. They encourage health care organizations to schedule community outreach events to educate the public about the benefits of immunization during this month. There are several areas for education that fit this year's theme, which is "Are You Up to Date? Vaccinate!"

One area that needs to be covered is the need to keep adolescent immunization records up to date, says **David A. Neumann**, PhD, director of the National Partnership for Immunizations. Many Americans think that vaccines are for infants and children, but recommended vaccinations begin soon after birth and should continue throughout life.

For example, the last time most adults had a tetanus shot they were on their way to summer camp, yet this vaccine should be given every 10 years. In addition, many adolescents and adults could be at risk for hepatitis A and B and would benefit from these vaccinations.

Some adolescents need to be vaccinated for meningitis. Last year, there was an outbreak of meningitis among college students with several deaths, yet many people don't know it is a vaccine-preventable disease. There is an increased incidence of meningitis among students living in dormitories, particularly among first-year students, says Neumann.

Myths about vaccines are another area that needs to be addressed. There are a substantial number of parents in this country who believe that their children are not at risk for such diseases as measles and chickenpox because they rarely are seen in the United States, says Neumann.

Last year, the Atlanta-based Center for Disease Control and Prevention did its annual nationwide telephone survey to provide estimates of the proportion of children that have received each of the recommended vaccines and found that the numbers had dropped a bit, he says. While it is not enough of a drop to be a public health threat it does reveal that health care organizations need to be vigilant.

When a child is born, he or she has temporary immunity to many common childhood diseases because disease-fighting antibodies were passed through the placenta from the mother to the child. However, the immunity quickly wears off. Therefore, by age 2, children need 16-20 doses of vaccines for full protection against 11 diseases.

Another myth that prevents parents from vaccinating their children is that the disease can be contracted from the vaccination. According to NPI, this is the greatest fear among parents. However, when the vaccine is made from dead bacteria or viruses or just part of the bacteria or viruses it is impossible for a child to contract the disease.

Immunizations made from weakened live viruses can cause a mild form of the disease, but it is always much less severe than if the child had been exposed to the actual disease-causing virus, according to NPI. Immunizations made from weakened live viruses include measles, mumps, rubella, and chickenpox.

A third area educational coordinators can target is the pockets of underimmunized children that exist in their area. Providing access to vaccinations in neighborhoods where there is poor health care coverage is one way to increase coverage.

In general, regular physician visits for small children improve vaccination rates. ■

SOURCE

For more information about immunizations or National Immunization Awareness Month, contact:

- **David A. Neumann**, PhD, Director, National Partnership for Immunization, 4733 Bethesda Ave., Bethesda, MD 20814. Telephone: (301) 656-0003. Web site: www.partnersforimmunization.org.