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

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To comply with new TJC standards, toss out restrictive visitation policies

Create processes that support participation of families, other partners in care

A set of guidelines for changing hospital visitation policies and practices released in August 2010 by the Bethesda, MD-based Institute for Patient-and Family-Centered Care (IPFCC) will help health care institutions meet standards for patient-centered communication issued by The Joint Commission and set to take effect in January 2011, says **Joanna Kaufman**, RN, MS, an information specialist with IPFCC.

In particular, the template addresses two standards created to enhance patient-centered communication. These standards, which appear in the section on patients' rights, read as follows:

- The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.
- The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

According to Kaufman, hospitals would definitely comply with these two

EXECUTIVE SUMMARY

In the October issue of *Patient Education Management*, we discussed the new patient-centered communication standards released by The Joint Commission and their impact on patient education.

In this issue, we discuss guidelines for changing hospital visitation policies and practices that can help health care institutions comply with these new standards. Also discussed is the role a patient education manager might have in the implementation of "Guidelines for the Presence and Participation of Families and Other Partners in Care." The guidelines were created by the Institute for Patient-and Family-Centered Care (IPFCC), based in Bethesda, MD.

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standards by using “Guidelines for the Presence and Participation of Families and Other Partners in Care — A Template” to revamp restrictive visiting policies.

The implementation of this policy could impact the duties of patient education managers in several ways. They may be asked to use their expertise in clear communication to assist in providing information to patients and families about open visiting policies and what they entail. Clarification on the role of a partner of care may fall to the education department.

Patient education managers may be asked to

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produce educational materials on ways a partner in care can assist in patient safety efforts by asking clinicians if they have washed their hands before examining the patient or inquiring about the medications the patient receives to ensure the patient receives the right medicine.

In addition, the guidelines for changes in visitation policies could improve patient education, because four ears are always better than two, says Kaufman. Having a family member or designated partner present during teaching — listening and actively involved — is a way to reinforce the message, she adds. To support patient education further, the hospital could ask patients to identify a “partner in care” who will participate in the education that takes place during the hospital stay.

The initial report, titled “Changing Hospital ‘Visiting’ Policies and Practices: Supporting Family Presence and Participation,” states that in order to change the prevailing view of families as visitors, they must be “respected as part of the care team — never visitors — in every area of the hospital, including the emergency department and the intensive care unit.”

The guidelines for creating patient- and family-centered visitation policy suggests institutions develop systems and processes to “determine which family and friends the patient designates as ‘partners in care,’ and how they will be involved in care and decision-making as part of the admission process.”

This may be the time when someone may be designated to participate in any education regarding the patient’s care following discharge, says Kaufman. The person whom a patient designates to be present for comfort may or may not be the person who will monitor medications or assist with a special diet at home and thus be involved in education, she adds. Patients may need to be informed about the various ways family and friends can be involved, so they can make informed decisions.

In order to develop good policy on the presence and participation of families and other partners in care and materials to help educate on these policies, patients and families must be involved, says Kaufman. A consumer’s point of view must be part of the process.

Kaufman adds that should a patient arrive at the hospital emergency department unconscious, staff should welcome whoever has arrived with the patient. This may be the next-door neighbor, but he

or she should be allowed contact with the patient and valued as a source of information about key people the patient may want as partners in care.

Educating on roles

There are several ways a patient education manager can be valuable in implementing new policies and practices that support family presence and participation, according to Kaufman.

For example, the recommendations for change created by a task force of 14 people that included patients and their families suggest that institutions “provide guidance for patients and their families and other ‘partners in care’ that will help them be respectful of other patients and families who share the same patient room.” Information on how to share rooms respectfully could be an area of education.

Also encouraged is providing information to families and other partners in care on “how to support the patient during the hospital stay and during the transition to home and community care.” Details on supportive measures could be written up as an information sheet to reinforce education provided by the clinicians.

Clarification on what are considered disruptive behaviors and unsafe practices need to be provided for patients, families, other partners in care, and front-line staff.

“Having open visitation and involving patients and families doesn’t mean there are not any rules,” says Kaufman. What the IPFCC has found is that when patients are involved with the creation of policy, instructions, and plans, the rules are designed for the greater good of all patients. Therefore, this input strengthens the policy.

Kaufman explains that should a family protest because policy allows only one person to spend the night with the patient, they can be told the rules were created with patient and family input to serve most people with respect to the nurses and physicians in the hospital, as well as patients and families.

There may be areas of the hospital where special rules need to be applied, such as a newborn nursery, which may be locked to prevent babies from being stolen, says Kaufman. In these cases, families need to understand they may have to ring a bell before coming to see a new baby. Kaufman says there should be dialogue and discourse about the rules with patients and families along with written explanations.

Another area in which patient education manag-

ers might help patients and their partners in care is within the realm of good communication. Patients, families, and partners in care need to know they have the right to ask questions about the care being given.

In addition to helping patients and their partners in care understand their rights, patient education managers can help them better understand what questions they might ask to improve care and safety, says Kaufman.

Kaufman was one of the authors of the guidelines, and she says they support the philosophy of the IPFCC, which recognizes patients and families as essential members of the health care team.

The guidelines support a memo written by President Barack Obama to the Secretary of Health and Human Services in April 2010 that indicates a hospitalized patient has the right to decide who can visit them, participate in their plan of care, and make decisions for them in medical emergencies.

Kaufman said one reason the memo was written was to protect same-sex partners who were not allowed into the hospital room, because they were not recognized as husbands or wives. Sometimes people died without seeing the people they loved, she added.

The memo came out at the same time the IPFCC was conducting a large training seminar in Dallas. It was shared with the audience, and the nurses, physicians, administrators, and families in attendance asked if the institute could create a task force to address the concerns of the president. Although the policy was in the making for a long time, the memo provided a catalyst, said Kaufman.

Changes to visitation policies need hospital-wide participation, according to the IPFCC. An interdisciplinary committee should be involved in implementing, monitoring, and evaluating the guidelines. Committee members should include patient and family advisors and representatives from clinical areas, patient relations, security, housekeeping, dietary, risk management, and other relevant departments.

SOURCE

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Advance directives keep communication flowing

A good health care proxy speaks up

Completing advance directives should not be seen as a legal task. While there is a legal component to the document, it is primarily a communication task, says **Charlie Sabatino, JD**, director of the American Bar Association Commission on Law and Aging in Washington, DC.

When a patient is incapacitated, the person he or she has designated as the health care proxy becomes the voice of the patient. At a time when The Joint Commission, based in Oakbrook Terrace, IL, is putting standards in place that emphasize effective communication, ensuring patients have a clear understanding of advance directives makes sense.

Since 1990, when Congress passed the Patient Self-Determination Act, hospitals have been required not only to ask patients if they have advance directives when admitted, but also to provide education about them to consumers and staff, says Sabatino.

Yet surveys indicate that only about one-third of the adult population has some form of advance directive, he says. For people over the age of 65, survey data indicates that more than 50% have advance directives, he adds.

“But that doesn’t tell us how effective they are or how well thought-out they are,” says Sabatino.

What information do consumers need to create advance directives that are well thought-out, effective communication tools?

Important to know is that advance directives do not need to provide detailed instructions about the type of care consumers would like to receive based on medical scenarios. “My advice is that specific instructions are useful to the extent they

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According to **Charlie Sabatino, JD**, director of the American Bar Association Commission on Law and Aging in Washington, DC, advance directives can consist of one or both of two types of documents: a living will, which can provide instructions on medical care; or a document that names power of attorney or proxy who becomes the authorized spokesperson and decision maker for a person who has lost decision-making capacity. In this article, we discuss how to make this document an effective communication tool.

are based on a person’s actual medical history and not imagined ideas or stories about what you might encounter in the face of life-threatening conditions,” says Sabatino.

He adds that the canned instructions included in living wills don’t really address the real circumstances, which are usually quite complicated and unique. Generalized instructions about nutritional hydration or respirators don’t really turn out to be very applicable or helpful, he explains.

However, patients in their 80s who have lived with chronic obstructive pulmonary disease for years and have had experience with ventilators may have specific instructions based on personal knowledge — not abstract scenarios, says Sabatino.

He explains that advance directives should be seen as a developmental process, and that is why he prefers the term advance care planning. People in their 20s may simply choose a person they wish to have power of attorney. Yet at age 50 and beyond, people may have come to some decisions based on experience they would like to express.

“Depending on what stage of life and health you are at, you are going to approach this somewhat differently,” says Sabatino.

The planning process

There are two parts to creating advance directives. The first part is a discussion about values and priorities in regard to health care with family, friends, and a person’s physician. The second part of the process is documenting the decisions made.

“The much harder part is thoughtful conversations about one’s goals and priorities,” says Sabatino.

Many of the growing number of resources present a workbook approach to the process that even provides guidance on how to have the discussions, he says. For example, the ABA has a “Toolkit for Healthcare Advance Planning” on its website. The National Hospice and Palliative Care Organization in Alexandria, VA, has guidelines on its site (www.caringinfo.org), as does Aging with Dignity (www.agingwithdignity.org), based in Tallahassee, FL, to name a few.

Choosing a health care proxy is a thoughtful process, with consideration given to what the person is asked to do, says Sabatino.

It is not necessarily next of kin that you would want to be the decision maker, he says. While it is probably true that a majority of married couples

would name their spouse, if the couple were honest, they would realize a spouse may have the most difficult time letting go at the point requested, he explains.

Also, one criterion for a good health care proxy is that he or she is present at the location a person lives. Therefore, if someone winters in another state, it is a good idea to find a proxy at that location for that time period, says Sabatino.

Once a health care proxy is selected, he or she needs to be educated regarding the job description. "Providing some resources to someone who has to play that role is critically important and is often overlooked," says Sabatino. The ABA has guidelines for making health care decisions for someone else on its website.

There is no guarantee a seriously ill person's medical record will follow him or her to another facility when transferred, so it is the proxy who needs to make sure the provider at each location is aware of the directives and has a copy, says Sabatino.

A medical emergency or pending procedure is not the time to think about advance directives. People really need to receive the information time and again until they finally become open to taking the necessary steps, says Sabatino. He suggests hospitals provide educational materials to their primary care physician network. If physicians ask patients if they have named a health care proxy and provide information on the process, such patients are more likely to put advance directives in place, he adds.

SOURCE

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Assessing websites and low health literacy

Simple review guidelines

Patient education managers faithfully assess written materials to make sure they are appropriate for people with low health literacy or poor reading skills. They must be just as diligent when selecting websites for educational purposes, says **Abigail Jones**, MLIS, MA, consumer health librarian

at the Library for Health Information in the Atrium at The Ohio State University Medical Center in Columbus.

"It is important to be able to evaluate websites and know where to direct people for good, easy-to-read information, so they have the opportunity to have the best information available to them," says Jones.

As a consumer health librarian, Jones has become skilled at selecting websites that provide appropriate information for patients and families who may not read well or are unfamiliar with medical terminology or certain diseases and health issues.

The first step in evaluating a website is the assessment of the general cyber information to determine if it will be a valuable health resource for consumers, Jones explains. Determine if the information is current by looking for a notation of the last update. If it is a website with lots of pages and documents, look to see if each is dated and when updates occur.

Another important aspect, according to Jones, is the source for the information. Often, there is an "about us" tab or link that tells the user the author of the material or website sponsor. It's important to ask what makes the source an expert and, if he or she has credentials, what those are, says Jones.

Also important is objectivity or absence of bias. Determine if the website has a board or oversight group in addition to the authors or editors of the material, Jones advises. She adds, "Is there information on the website about the review policy or editorial policy?"

Sometimes the organization sponsoring the website is enough of an authority that people would know everything on the site is authoritative and has been written by experts, says Jones. This is the case with MedlinePlus, a consumer health website from the National Library of Medicine and National Institutes of Health.

"They have an extremely rigorous review policy, and the site is supported by those two governmental review bodies. It is the gold standard of consumer health information," says Jones.

The information should not be opinion, but evidence-based. Determine if medical research or

EXECUTIVE SUMMARY

Websites are a good source of health information, but they are not always suitable for consumers with low-health literacy or reading difficulties. A consumer health librarian shares a few guidelines for assessing websites.

medical practice supports the material offered on the site, advises Jones.

It's also a good idea to recommend only those websites that are without advertising, because a consumer may assume the advertising is part of the authentic, objective, health information, says Jones.

Good teaching resource

Once it is determined that the website has current, medically sound information, it is time to assess whether it is a good teaching resource. Many of the rules for plain language or clear communication that apply to written copy also apply to the website text.

The format of the text is important as well. This would include such matters as white space, font style, and font size.

With technological advances, websites can be tailored for specific audiences. MedlinePlus created a site for older adults who may have poor eyesight, called seniorhealth.gov. Readers can enlarge the text, choose to have the information read out loud, or increase the contrast so the text is easier to read. (*See more easy-to-read websites recommended by Jones on pp. 126.*)

"That is an excellent example of making sure that — physically — the website is easy to see," says Jones.

Low literacy websites can incorporate many features that make it easier for consumers to grasp the information. Designers can include online tutorials or tests. Short films or slide shows can be incorporated into the text to increase understanding. Jones says often these clips can be downloaded to review later, and the information can be printed out for future reference. Illustrations within the text, such as photos or line drawings, are also helpful, she adds.

"I think a variety of vehicles are important for delivering the same message in health information, because we have a wide range of reading abilities that can come through our doors at a consumer health library," says Jones.

In addition to looking at the information, it is a good idea to look at how easy it is to navigate a website. If it is a directory-style website where people point and click to access information, categories need to be obvious. Often the alphabet is used to access information, with the letter "D" uncovering topics such as diabetes, for example. If a website has a search engine, it must be quick and extremely intuitive in recognizing natural language, says Jones.

The health consumer library at The Ohio State University Medical Center uses a lot of consumer health subscription databases, because they are current, says Jones. However, there are many specialized, free websites consumers are encouraged to use.

"People assume they will be able to get health information from websites, and they also assume they are the best navigators. Often, people do not realize the depth and extensive scope of health information that is out there, so they overlook sites that are available," says Jones.

Therefore, one of the services of the consumer health library is to act as a human search engine for patients and family members directing them to websites that are reliable, objective, and written in lay language, says Jones.

SOURCE

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(Editor's Note: Jones says patients and families will sometimes state they are not good readers. If they do not provide this information, she provides at least three items of information on the same topic at different reading levels. For example, one would be easy-to-read at a grammar school reading level, the second a high school reading level, and the third a longer, encyclopedia-style article.) ■

Websites providing easy-to-read info

Quick reference guide for PEMs

As a consumer health librarian at The Ohio State University Medical Center in Columbus, **Abigail Jones**, MLIS, MS, has become skilled at selecting websites that provide appropriate information for patients and families who may not read well or have low health literacy.

Following are a few of her favorites:

— **MedlinePlus** (http://www.nlm.nih.gov/medlineplus/all_easytoread.html)

This website has information on how to write easy-to-read materials in four steps. Information covers planning and research, organizing and writ-

ing the information, language and writing style, and visual presentation and representation. The health education documents written in this easy-to-read format are listed in alphabetical order.

— **KidsHealth** (<http://kidshealth.org/>)

KidsHealth has three sections, with materials for parents, kids, and teens. “For low-literacy adults, I often use the kids’ site, not the parent site,” says Jones.

Categories in the kids’ section include information on illnesses, injuries, and health problems and a medical dictionary. The parent section includes selections on general health, infections, emotions and behaviors, growth and development, nutrition and fitness, medical problems, first aid and safety, and medications.

— **NIH SeniorHealth** (<http://nihseniorhealth.gov/>)

Jones says this website is an excellent example of good design and layout. Topics can be accessed alphabetically. The site provides a printer-friendly version in its entirety on selected sections such as symptoms and diagnosis.

Buttons at the top of the page allow site users to enlarge the text, change text color, or hear the text read aloud.

— **Health information websites**

The Ohio State University Medical Center and Arthur G. James Cancer Hospital and Richard J. Solove Research Institute has produced handouts that include guidelines for evaluating health information on websites along with a list of trustworthy and up-to-date sites for consumers.

These include the following:

— General health websites (<http://medicalcenter.osu.edu/patiented/materials/pdfdocs/general/lhi-websites.pdf>)

— Nutrition and food websites

(<http://medicalcenter.osu.edu/patiented/materials/pdfdocs/nut-diet/nut-other/food-websites.pdf>)

— Cancer related websites

(<http://medicalcenter.osu.edu/patiented/materials/pdfdocs/dis-cond/cancer/cancer-internet-resources.pdf>). ■

Pay attention to literacy levels

Toolkit offers guidance and support

It is no surprise that patients have trouble understanding what health care professionals tell them when you consider that 29% of the population

has basic literacy skills and 14% of the population has below basic literacy skills. Another 5% of Americans are not English-literate. This means half the adults in the United States have trouble using written documents to accomplish everyday tasks, according to a report on health literacy from The Joint Commission.¹

Most Americans (44%) are classified as having an intermediate level of prose literacy that means they can use information from text and make simple inferences. Unfortunately, the majority of health care information is complex and overwhelming for most Americans.

The need to communicate in language and in a manner that ensures patient understanding is important for all providers and educators, says **Darren DeWalt, MD**, associate professor of medicine at University of North Carolina School of Medicine and lead author of a health literacy toolkit funded by the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD. (*See page 128 for description of toolkit.*) “Initially, the toolkit was developed for use in primary care practices, but the tools can be applied to any setting,” he says. “We were trying to put together a resource that helps an organization evaluate how well they address literacy and identify ways to improve.”

The Health Literacy Universal Precautions Toolkit provides users with easy-to-follow steps to evaluate communications within the organization, steps to take to improve written and spoken communications, and resources to support implementation of a health literacy program. As the committee put together the research and tools for the toolkit, there were no surprises,

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Although there are many proven strategies to increase comprehension in patient education, not all organizations implement the most effective strategies consistently. The Health Literacy Universal Precautions Toolkit, a free publication funded by the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, not only offers strategies and tools that can improve communications with patients, but also provides an assessment tool to help organizations identify areas in which they need to focus.

- Almost half of the adults in the United States have trouble using written documents to accomplish everyday tasks.
- Strategies such as teach-back give educators a chance to verify patients’ comprehension of information.
- Effective literacy programs ensure consistent use of methods by incorporating responsibility for use of methods into job descriptions and performance evaluations.

says DeWalt. “We found that many organizations may endorse the use of the teach-back method, or asking patients to demonstrate their understanding, as part of their patient education program, and some nurses or educators may use it; but it is not used consistently throughout the organization,” he says. Inconsistent use was true for many of the strategies included in the toolkit. “No method of improving communication is effective unless it is used consistently,” he points out. “This means that it takes every doctor, nurse, and educator to apply these strategies in every situation for an organization to improve health literacy among patients,” he adds.

Proof that the toolkit can be applied to larger organizations as well as smaller physician practices can be found at Carolinas Healthcare System in Charlotte, NC. The pediatrics department started out as a pilot site for the literacy toolkit while it was being tested and is now being implemented throughout the system, says **Laura Noonan**, MD, director of the healthcare system’s Center for Advancing Pediatric Excellence. “The tools and strategies can be applied to inpatient as well as outpatient settings with minor modifications,” she says.

The key to implementing a health literacy program is to incorporate teaching methods and staff education into a complete program that hardwires the organization to sustain the program, says Noonan. The best way to ensure consistent use of teaching methods and tools is to make adherence to health literacy strategies part of every employee’s job description and evaluations, she suggests.

“The biggest reason for failure to successfully implement literacy programs is that we often do a lot of planning to come up with a solution to a problem, then we implement without testing,” says Noonan. “The best way to implement a literacy program is to test it, tweak it, adapt it, and then implement it,” she says.

One reason that Noonan likes the Health Literacy Universal Precautions Toolkit is that the evaluation process actually identifies which tools in the kit will address the organization’s weaknesses. “You don’t have to search through all of the tools to find the right one for your organization’s needs,” she says. “Instead, you have a choice of tools described as beneficial to most beneficial for your issue.” By focusing on the tools that are best designed to meet your organization’s issues, you don’t waste time, she says. “No one will use all 20 tools, and it is important to prioritize your efforts.”

There may be challenges to overcome when

introducing new teaching methods, Noonan says. “It’s common to hear concerns that using the teach-back method will lengthen the time it takes to educate a patient,” she says. “I always point out that if you don’t use teach-back, the patient will likely end up back in the emergency department and create a greater burden on our time and resources. It is always better for the organization and the patient to do it right the first time.”

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SOURCES

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RESOURCE

To access a copy of the free Health Literacy Universal Precautions Toolkit go to www.nchealthliteracy.org/toolkit/. ■

20 tools address literacy needs

Toolkit offers range of resources

Some of the “tools” in the Health Literacy Universal Precautions Toolkit may not be the typical forms or handouts that many toolkits provide, but they are effective, says **Laura Noonan**, MD, director of the Center for Advancing Pediatric Excellence at Carolinas Healthcare System in Charlotte, NC.

For example, one of the tools is a list of recommendations to improve one-on-one communication with patients. In addition to the description of tips, such as greeting patients with a smile and speaking at a moderate pace, the tool includes links to other teaching methods that should be incorporated into one-on-one teaching.

The toolkit addresses four areas:

1. Improve spoken communication.
2. Improve written communication.
3. Improve self-management and empowerment.
4. Improve supportive systems.

One area that surprises many people is the section on supportive systems, says **Darren DeWalt**, MD, associate professor of medicine at University of North Carolina School of Medicine in Chapel Hill and lead author of the toolkit. “We found that even when you make sure the patient understands the importance of taking medication, if the patient can’t afford the medication or has no transportation to go to a pharmacy, the medication won’t be taken,” he explains. For this reason, a number of tools to identify community resources to address barriers beyond literacy are included in the kit, he says.

A few of the tools included in the kit are:

- the teach-back method
- telephone considerations
- brown bag medication review
- how to address language differences
- culture and other considerations
- design easy-to-read material
- welcome patients: helpful attitudes, signs, and more
- encourage questions
- improve medication adherence and accuracy
- get patient feedback
- link patients to non-medical support. ■

Patient ed affects patient satisfaction

Use survey results to improve services

What role does patient education play in patient satisfaction scores for health care organizations? How important is patient education to the patient’s opinion of the entire health care experience?

“There is a lot more interest around the topic of the correlation of patient education to patient satisfaction,” says **Christy Dempsey**, vice president of clinical and operational consulting at Press Ganey, a South Bend, IN-based quality improvement company. “We have found that when education begins at the first contact with a patient, the patient reports a higher level of satisfaction,” she says. Conversations with patients should always include a discussion of expected time frame for discharge,

she suggests. When a nurse or patient educator talks in terms of discharge, such as, “Are there any questions you have about your medication before you go home tomorrow?” the patient has time to think about questions when he or she is not on the way out the door, she explains. “This increases the patient’s perception that nurses and educators are trying to make sure instructions and teaching [are] thoroughly understood,” she adds.

A focus on patient education does mean that the mean score for two of the measurements in Press Ganey’s national patient satisfaction survey have increased over the last seven quarters. The level of satisfaction with instructions given for care at home have increased from a mean score of 86.0 in January 2009 to 86.8 in July 2010; and the level of satisfaction with explanations of tests and treatments have risen from a mean score of 85.0 in January 2009 to 85.8 in July 2010.

Hospitals will continue to place an emphasis on improved patient education as reimbursement is tied to outcomes, including patient satisfaction reports on HCAPS [Hospital Consumer Assessment of Healthcare Providers and Systems], says Dempsey.

Patient satisfaction surveys can also provide important feedback on how to improve your service to patients, says **Kimberly A. Hume**, MSN, RN, FAHCEP, manager of the Family Resource Center at St. Louis Children’s Hospital in St. Louis. “I think that most resource centers conduct some sort of satisfaction survey,” she says. “We include a survey form in every packet of information we provide to patients,” she explains. Although it is nice to be able to report levels of patient satisfaction to show that you and your staff are doing a good job, don’t let your review of satisfaction surveys stop at numerical ratings for your service, she suggests.

EXECUTIVE SUMMARY

Patients’ perception of the value of education they receive from a patient educator or nurse affects the patients’ overall satisfaction with the health care experience. Patient educators and health care administrators are now looking at ways to improve education and use patient satisfaction surveys to improve educational services.

- Education-related questions in the national Press Ganey satisfaction survey address patients’ perception of the information given to them regarding tests, treatments, and home care.
- Satisfaction surveys can identify needs of patients in order to improve educational services.
- Surveys can be used to identify new ways to provide information.

“We want to do more than satisfy the patient’s or family’s immediate need; we want to establish a relationship so that they come back to us in the future or recommend us to others who need information,” says Hume. Questions on her survey form ask if the resource center was easy to use, if the information provided was easy to read and understand, and if the family member or patient would recommend the center to other people, she says. “We also ask how the information was received, because we want to know if our customers want to receive written information, e-mailed information, or print information mailed to their homes,” she says.

As a result of the survey information, Hume’s resource center now tailors delivery options to the recipient’s preferences, she says. “We’ve gone from mailing all information to the homes, to a combination of e-mail, fax, and mail,” she explains. “If a patient is still in the hospital, we give families an option of visiting the resource center to pick up information or asking us to deliver it to the patient’s room,” she says. The most important thing Hume’s staff learned from satisfaction surveys is that patients and their families want to be asked how they prefer information to be delivered to them. She adds, “Just asking them how we can make the process easier increases their satisfaction with our service.”

SOURCES

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African-American women respond to stories

Personal approach better than didactic

African-American women were more open to learning about breast self-exam and mammography when stories about cancer survivors

were included in an informational video, according to a report published in *Patient Education and Counseling*.¹

Participants in the study were 489 African-American women age 40 years and older who had received at least one prior mammogram. The women completed surveys before and after watching a video about mammography and breast cancer. Women were divided into two groups, with one group watching a narrative video that included personal stories and one group watching a video that used a didactic, information approach to teaching.

Women who watched the narrative video experienced more positive and negative emotions, found it easier to understand the video, and had more positive evaluations of the video. They also reported a strong identification with the source of the message, saying they trusted or liked the speaker and identified with her message.

The authors suggest that stories of other women’s experiences may be a powerful way to encourage African-American women to get a mammogram as compared to didactic presentations.

REFERENCE

- McQueen A, Kreuter MW. Women’s cognitive and affective reactions to breast cancer survivor stories: A structural equation analysis. *Patient Educ Couns* Published online Sept. 17, 2010. doi:10.1016/j.pec.2010.08.015. ■

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CNE instructions/objectives

Nurses and other patient education professionals participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you.

Upon completion of this educational activity, participants should be able to:

- identify the management, clinical, educational and financial issues relevant to patient education
- explain the impact of the management, clinical, educational and financial issues relevant to patient education on health care educators and patients
- describe practical solutions to problems health care educators commonly encounter in their daily activities
- develop patient education programs based on existing programs.

COMING IN FUTURE MONTHS

- Evaluating videos according to health literacy standards
- Educating to reduce obesity
- Using the latest technology to teach patients
- Be ready to educate the deaf
- Expanding resources for preferred learning methods

CNE QUESTIONS

17. Guidelines for the Presence and Participation of Families and Other Partners in Care suggests institutions develop systems and processes to “determine which family and friends the patient designates as ‘partners in care’ and how they will be involved in care and decision-making as part of the admission process.”

- A. True
- B. False

18. To create effective advance directives, consumers should know which of the following?

- A. Their wishes for various medical scenarios.
- B. Canned instructions in living wills are good blueprints.
- C. Process should depend on stage of life and health.
- D. Personal medical history is not helpful.

19. Once a possible health care proxy is identified, he or she needs to be educated on the job description.

- A. True
- B. False

20. The use of technology can be used to make websites with health information easier to read and understand. Which of the following might enhance learning?

- A. Ability to hear text read.
- B. Films or slide shows within text.
- C. Tutorials or tests.
- D. All of the above

Answers: 17. A; 18. C; 19. A; 20. D

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