PEM Salary Survey Included in this issue.

patient education MANAGEMENT

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

vol. 18, no. 9, September 2011
pages 97-108

IN THIS ISSUE

Financial Disclosure:
Editor **Susan Cort Johnson**, Executive Editor **Joy Daughtery Dickinson**, and Consulting Editor **Magdalyn Covitz Patyk** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

AHC Media

Improve patients' colonoscopy prep, or increase risk of missed polyps

Good prep for a colonoscopy could be the difference of life and death for a patient. Five percent of colon cancers can develop in patients who have had a colonoscopy because the procedure is not perfect. However, on-third of those cancers are due to poor prep. If done correctly, the prep may have prevented those colon cancers, says **G.S. Raju**, MD, FACG, FASGE, a professor in the department of Gastroenterology, Hepatology and Nutrition of Medicine at the University of Texas MD Anderson Cancer Center in Houston.

A study by physicians at Columbia University Medical Center in New York City found that when bowel preps are not good, physicians may miss 42% of all adenomas (polyps) and 27% of advanced adenomas, suggesting that suboptimal bowel preparation has a substantially harmful impact on the effectiveness of a colonoscopy.[1] Therefore, healthcare institutions should work to make sure the steps to prepare patients for a colonoscopy are effective. Good preparation not only includes the proper steps, but education to make sure they are followed correctly.

At the University of Michigan Health System in Ann Arbor, the literature and research shapes the options patients have for prep. As a result, the institution's instructional sheets are rewritten as research uncovers best practice for prep, says **Grace H. Elta**, MD, a physician at the University of Michigan Internal Medicine Gastroenterology. Elta, along with a nurse educator and a nurse manager on the endoscopy unit, co-authored the prep instructions.

EXECUTIVE SUMMARY

A study done at Columbia University Medical Center in New York City found that as many as one in four patients might have suboptimal bowel prep when undergoing a colonoscopy. As much as one-third of colon cancers can be traced to poor preparation. Good education on bowel prep includes:

- detailed instruction sheets;
- verbal discussion of good preparation;
- emphasis on the importance of good prep.

According to Raju, a quality improvement project helped shape prep instructions. A 16% poor prep rate among patients was reduced to 8% by going from a single dose, 4 L cleansing solution to a split dose. Patients prepare for the procedure by drinking a 2 L cleansing solution in the evening before their appointment and a 2 L solution the next morning. When laxatives were added to the prep process, the poor prep rate dropped to 2%, says Raju.

Once good prep instructions are in place how do you make sure they are followed?

"We are attuned to the fact that education is critical to the quality of the prep," says Elta.

Patient Education Management™ (ISSN 1087-0296) is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Patient Education Management™, P.O. Box 105109, Atlanta, GA 30348.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcmedia.com. World Wide Web: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $82 each. (GST registration number R128870672.)

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for nurse managers, education directors, case managers, discharge planners, hospital clinicians, management, and other health care professionals involved in designing and/or using patient education/staff education programs. It is in effect for 24 months from the date of publication.

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EDITORIAL QUESTIONS

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

Editor: **Susan Cort Johnson**, (530) 256-2749.
Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey**.

Patients who come to the Gastroenterology Clinic at the University of Michigan meet with a nurse who goes over the instructions with the patient before providing a copy. During the educational session, the nurse emphasizes the importance of quality prep and how it impacts the effectiveness of the exam. Also emphasized is the importance of following the instructions completely, which includes drinking all the cleansing solution.

Some patients refuse to take the time to go over the instructions with the nurse, Elta says. Also, many patients are referred to the clinic by primary care physicians who provide the instruction sheets but might not have the time to discuss the preparation process.

Sometimes patients are compliant, but they might obtain only fair quality prep due to a sluggish gut, says Elta. In such cases, she writes on the report that the prep was only fair and the patient might need two-day prep when he or she has another colonoscopy. *(For more information on improving bowel habits in patients for better colonoscopy results, see article on p. 99.)*

Provide detailed instructions

Raju has several steps for educating his patients about the preparation for a colonoscopy. He refers them to the MD Anderson web site to view short videos made with the patient education office for YouTube. *(For more information on these videos see resources, p. 99.)* Also, written instructions created by the education department are provided.

Instructions need to be detailed, says **Jane C. Frank**, MPH, a senior health education specialist at the Patient Education Office of MD Anderson Cancer Center. Recently she worked with the director of the endoscopy clinic to create updated instructions for colonoscopy preparation for patients on blood thinners and those who are not on blood thinners. *[A copy of these instructions for colon prep are included with the online issue of* Patient Education Management *available to subscribers at http://www.ahcmedia.com. On the right side of the page, select "Access your newsletters." You will need your subscriber number from your mailing label. For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]*

Raju makes a telephone call to patients to review the instructions they have been given. He tells them that they will know they have accomplished good prep and that their colon is clean if they are able to see the bottom of the toilet following elimina-

tion once they have consumed all the solution. He also explains that without good prep, polyps can be missed.

To help patients achieve success, he tells them to drink the solution with a straw so it is siphoned to the back of the throat missing the taste buds on the tip of the tongue. He learned this trick from a patient. Also he advises patients to wear adult disposable underwear during the night if they are fearful of soiling the sheets and when driving to the clinic for the appointment, if they are traveling two hours or more, to avoid soiling their clothing.

If people are willing to go through the preparation process for a colonoscopy, healthcare practitioners need to provide the education for them to do it right, says Raju.

"If you educate people everyone will work hard to get the best results out of the ordeal they go through," he adds.

REFERENCE

1. Lebwohl B, Kastrinos F, Glick M, et al. The impact of suboptimal bowel preparation on adenoma miss rates and the factors associated with early repeat colonoscopy. *GIE* 2011; 73:1,207-1,214. ■

SOURCES/RESOURCES

For more information about educating patients on good colonoscopy prep or creating educational pieces, contact:

• **Grace H. Elta**, MD, University of Michigan Internal Medicine Gastroenterology, Ann Arbor. E-mail: gelta@umich.edu.
• **Jane C. Frank**, MPH, Senior Health Education Specialist, Patient Education Office, The University of Texas MD Anderson Cancer Center, Houston, TX. Telephone: (713) 563-8182. E-mail: jcfrank@mdanderson.org.
• **G.S. Raju**, MD, FACG, FASGE, Professor, Department of Gastroenterology, Hepatology, and Nutrition of Internal Medicine, The University of Texas MD Anderson Cancer Center. Telephone: (713) 792-4283. E-mail: gsraju@mdanderson.org. Web: http://www.gsraju.com.

Online video colonoscopy preparation is available at Raju's web site: www.gsraju.com. Click on "Patient Education." Short videos include "About Colon Cancer;" "About Colonoscopy;" and "Prepare for Colonoscopy."

To access the video on MD Anderson Cancer Center web site, go to www.mdanderson.org. In the middle of the page, under "Cancer Centers and Clinics," click on the drop-down arrow and select "Cancer Prevention Center." On the right navigation bar, under the "Related Topics" box, select "Cancer Screening Recommendations." In the "Multimedia" box to the right, the video title is listed under "Colonoscopy Information" in six parts. ■

Good bowel habits boost colonoscopy prep

Teach patients steps to regularity

To make sure patients are able to accomplish good bowel prep before a colonoscopy, find out if they have regular bowel movements, advises **Annette Bisanz**, RN, BSN, MPH, clinical nurse specialist for bowel and symptom management at University of Texas MD Anderson Cancer Center in Houston, TX.

"Assess patient's bowel habits," Bisanz says. If a patient eats three good meals a day, he or she should have a daily bowel movement.

"Health care professionals can assess the patient and see if he or she is having adequate elimination. If there are signs in the history the patient is packing up with stool, they need to do something before the bowel prep," she explains. For example, if the patient has hard, ball-like stools, he or she might need mineral oil to soften the stool and a bottle of magnesium citrate to clean out the bowel.

Patients need to be educated on good bowel habits, Bisanz says. She tells her patients if they do not have a bowel movement by 4 p.m. on the day they expect it, they should take 4 oz of prune juice and follow it with a hot liquid, such as tea, coffee, or soup. Prune juice is a natural laxative, and the hot liquid increases gastrointestinal motility, she says. If they don't have a bowel movement by bedtime, they should take a mild laxative, such as Milk of Magnesia.

People should respond immediately to prevent constipation, says Bisanz. Also, they need to routinely practice healthy habits to prevent problems. These habits include drinking 64 oz of fluid a day that includes water. At least 50% of the fluids should be non-caffeinated. Their menu should include 25-40 g of bulk-forming fiber as well, such as Fiber One cereal. Fluids and fiber are the front-line therapy for constipation, explains Bisanz.

When medications are prescribed, people need to know if constipation could be a side effect so they can be proactive as well. They can offset constipating effects of medicines by taking a stimulant laxative and stool softener, she adds.

A good assessment for healthy bowel habits should include how much fluid a person drinks,

how much fiber they eat, what medications they take, how often they have a bowel movement, and whether it is quantity sufficient. A stool is quantity sufficient if it is the same size daily when meal size is the same. For example, if a person usually has a 12-inch stool and now it is 6 inches each day, yet eating patterns have not been altered, he or she is not having adequate elimination.

Constipation accounts for 2.5 million physician visits annually, and people spend $400 million on laxatives, Bisanz says. "Bowels have never been the emphasis in healthcare," she says. "It is a neglected field."

SOURCE

For more information about assessing good bowel habits or educating patients on this topic, contact:

• **Annette Bisanz**, RN, MPH, CNS, Clinical Nurse Specialist for Bowel and Symptom Management, MD Anderson Cancer Center, Houston, TX. Telephone: (713) 792-6012. E-mail: abisanz@mdanderson.org. ■

Spanish pain brochure explains symptoms

Good communication leads to proper diagnosis

In response to an increasing demand for Spanish-language resources to educate Hispanic Americans about all aspects of chronic pain, the Baltimore, MD-based American Pain Foundation has produced a free brochure available in Spanish and English titled "Explain Your Pain."

The brochure helps patients engage in productive dialogue with their healthcare provider. *(To obtain a copy of the brochure, see resource information, p. 101.)*

"Explain Your Pain" is a resource to address the cultural and language barriers that prevent Hispanic Americans from seeking help with pain management. According to **Ricardo Vallejo**, MD, director of research at Millennium Pain Center in Bloomington, IL, and a spokesperson for the American Pain Foundation, many Hispanics are taught that complaining about pain is a sign of weakness. They often wait to report pain, and when pain becomes chronic, it impacts the psychic of the patient, adds Vallejo.

The American Pain Foundation describes chronic pain as ongoing or recurrent pain that lasts beyond the usual course of an acute illness or injury, or more than 3-6 months, and negatively affects a person's well-being. If untreated or undertreated, pain can negatively impact a person's quality of life and make daily activities difficult.

Tools to improve communication

In addition to educating Hispanics on the importance of reporting pain early to manage it effectively, tools for communication between patients and providers are needed.

"Explain Your Pain" gives an outline of a body on which the patient can shade areas where pain occurs; a zero to 5 happy/sad face pain chart; a pain checklist with descriptive words; and a pain questionnaire.

Vallejo says the list of terms in the checklist such as "shooting," "tingling, "numb," "deep," or "sharp," translated into Spanish, puts the symptoms into words that help physicians discover the nature of the pain, which leads to a proper diagnosis and treatment.

"You can determine if it is neuropathic pain coming from nerve entrapment or some other condition," explains Vallejo.

The patient/healthcare provider communication is important because a magnetic resonance image (MRI) or X-ray does not explain how a patient feels pain, he says. Up to 67% of patients experiencing pain can have a normal MRI, says Vallejo. If a person's car does not start, the mechanic doesn't ask for a photo of the engine to make the appropriate repair, he adds. In healthcare, imaging is not the best way to determine the source of the pain either, Vallejo maintains. Instead, a thorough patient history, physical examination, and sometimes the help of images are needed. However, most important is the patient's description of the pain, says Vallejo.

"Understanding the nature of the pain can help

EXECUTIVE SUMMARY

A new brochure titled "Explain Your Pain" is available in English and Spanish to help Hispanic Americans, and other patients, communicate with their healthcare provider. It is published by the Baltimore, MD-based American Pain Foundation. The brochure has a self-assessment worksheet that answers the following questions:

- Where does it hurt?
- How does it hurt?
- When does it hurt?

the physician make the proper diagnosis," he says. "With the proper diagnosis, a treatment plan can be established that is specific for the individual."

RESOURCE

To download the free brochure "Explain Your Pain" or obtain more information contact:
• **American Pain Foundation**, 201 N. Charles St., Suite 710, Baltimore, MD 21201-4111. Telephone: (888) 615-7246. The brochure can be downloaded at www.painfoundation.org/explainyourpain (English) or www.painfoundation.org/describasudolor (Spanish). ■

Good database keeps inventory on track

Know what you have, what you need

Written materials are a mainstay of patient education. As a result of their value, the inventory can become quite large, which requires the need for a good tracking system.

To track materials, many healthcare institutions have created a database. At Miami Valley Hospital in Dayton, OH, all titles approved by the patient education committee, whether commercially purchased or written in-house, are kept in an Access database, reports **Janet L. Petty**, MLIS, AHIP, associate librarian at Craig Memorial Library.

The following information is entered for each item: title, type (handout, brochure, booklet), online edition, readability level, assigned subject heading, item number, publication date, shelving location, deletion date, other location information, notes, date record, and last updated.

Petty says the advantage of using Access database is that items can be tracked according to use by day, month, year, and departments. A number of reports can be generated from the data file. For example, a usage report can help staff determine quantities of commercial brochures to order or if a title should be discontinued. *(To learn various ways to distribute written materials, see article on p. 102.)*

Inventory of patient education materials at Mount Carmel East Hospital in Columbus, OH, is overseen by **Karen Guthrie** RN, MS, manager of community and patient education. The materials are provided to two other hospitals within Mount Carmel Health and outpatient facilities as needed. Inventory is kept in two files on a shared intranet site: a purchased/vendor materials file and Mount Carmel print materials. Both files are in alphabetical order and provide a quick way for staff to check resources.

The in-house education booklets on topics such as joint replacement, stroke, and heart failure are printed and stored at an outside company that sends a monthly report on inventory. Guthrie tracks the inventory levels so the booklets can be reviewed and updated a few months before the supply runs out. *(For information on how to keep teaching materials up-to-date, see article on p. 102.)*

A good inventory tracking system makes it possible to discontinue vendor materials when an in-house piece has been written on the topic, says Guthrie.

Although patient education at Ronald Reagan UCLA Medical Center in Los Angeles is decentralized, clinicians and departments that create educational handouts are encouraged to put it in a "forms" portal on the Intranet. Clinicians throughout the medical center print off appropriate educational materials for their patients and families, says **Laurie Reyen**, RN, MN, CNS, a nutrition clinical nurse specialist and co-chair of the Patient Education Committee. It is useful for patients undergoing procedures in all clinical settings to have materials developed by the experts at UCLA. For example, staff in the Neurology Department developed materials on radiology and neuroimaging studies that are common procedures in their patient population. These educational materials can be given to patients in other clinical settings when they have been referred for those procedures. Many in-house materials are specific to the programs offered at the facility, says Reyen.

"Everything is catalogued so all clinicians can access the material," she adds.

The medical center also uses Micromedex handouts (www.micromedex.com), which are available to clinicians via the computer. The commercially produced educational handouts focus on medica-

EXECUTIVE SUMMARY

For patient education materials to be used effectively in teaching, healthcare institutions need to set in place a system for tracking inventory. A good database for inventorying materials should:
• track all titles;
• provide staff a list of all titles;
• help staff know when to eliminate titles;
• make updating doable.

tions and disease states, and they can be printed in English or Spanish.

SOURCES

For more information about keeping an inventory of written patient education materials, contact:

• **Karen Guthrie**, RN, MS, Manager, Community and Patient Education, Mount Carmel East, Columbus, OH. Telephone: (614) 234-6062. E-mail: kguthrie@mchs.com.
• **Rose Healy**, RN, MS, CNS, Diabetes Clinical Nurse Specialist, Ronald Reagan UCLA Medical Center, Los Angeles, CA. E-mail: RHealy@mednet.ucla.edu.
• **Diane Moyer**, BSN, MS, RN, Associate Director, Patient Education, The Ohio State University Medical Center, Columbus, OH. Telephone: (614) 293-3191. E-mail: Diane.Moyer@osumc.edu.
• **Janet L. Petty**, MLIS, AHIP, Associate Librarian, Craig Memorial Library, Miami Valley Hospital, Dayton, OH. Telephone: (937) 208-2624. E-mail: JLPetty@mvh.org.
• **Laurie Reyen**, RN, MN, CNS, Nutrition Clinical Nurse Specialist, Ronald Reagan UCLA Medical Center, Los Angeles, CA. E-mail: LReyen@mednet.ucla.edu. ■

Make written materials easily accessible

Intranet not always best for distribution

Making written handouts readily available to clinicians interacting with patients is an important element of patient education.

At Miami Valley Hospital in Dayton, OH, a patient education listing on the intranet gives staff the ability to print most items from a computer in their department, explains **Janet L. Petty**, MLIS, AHIP, associate librarian at Craig Memorial Library. The rest, such as commercial pamphlets, are ordered online, or via e-mail, fax, or a phone call to the patient education department that is operated by the medical library under the guidance of the medical staff-driven multidisciplinary Patient and Family Education Committee. When materials are ordered, the department is notified when items are ready. Staff members come to the library to pick up their order.

All materials are distributed free of charge, and there is one budget for written educational items. When departments are asked to pay for their materials, it is usually because they are specific to their discipline and not used elsewhere in the hospital, says Petty.

Within the patient education department at Mount Carmel East in Columbus, OH, a coordinator tracks supply levels with the help of two volunteers. Vendor items are ordered by an electronic purchasing system. When in-house materials need to be printed, a requisition is sent to the Creative Services Department, according to **Karen Guthrie**, RN, MS, manager of community and patient education. "While some of our staff advocate for only electronic access and printing, it can be an inconvenience for staff to print handouts that are given out frequently," says Guthrie.

She encourages departments to use the preprinted in-house materials only for topics that they frequently cover during patient education, she says. The versions that come from the print shop are more attractive with a color header, and they are sturdier with a slightly heavier paper, Guthrie says.

The commercial and print materials are picked up by staff in the receiving departments or delivered by the education department. A courier delivers items to off-campus sites.

Most patient education materials at The Ohio State University Medical Center in Columbus are created in-house and distributed on the Intranet. This system not only makes materials accessible across the health system, but it also allows for consistent information to be distributed, says **Diane Moyer**, BSN, MS, RN, associate director of patient education at the center.

The purchased materials that are used are coordinated and distributed by other departments. For example, the cancer hospital purchases some brochures and materials and distributes them to units. Also, the librarian at the consumer library coordinates ordering commercial materials distributed to the public at that location. To obtain copies of the pamphlets, people visit the library in person, or the material is distributed by mail to people who call asking for information, explains Moyer. ■

For current materials, establish regular review

Be prepared for unexpected changes

On any given day, there are 1,000 titles on the revision list for written educational materials, and it is the job of the patient education department to keep up with it, says **Diane Moyer**, BSN, MS, RN, associate director of patient education at The Ohio State University Medical Center in Columbus.

"Our policy is to review documents every three

years for revisions," Moyer says.

A tracking tool in the inventory database identifies revision dates. Generally a set of titles is pulled each quarter and assigned for review to the appropriate clinician. For example, dietary handouts would go to the dietitian representative on the patient education committee, who might perform the review or ask another dietitian to complete it. The feedback from the review is incorporated into the new document.

In addition to reviewing documents by dates, those who oversee patient education inventory must be ready to update documents more frequently as policy, rules, or treatments change, says Moyer.

There are many ways to stay abreast of these more frequent changes. At The Ohio State Medical Center, staff in the patient education department and clinicians throughout the system receive professional publications and make note of changes. For example, clinicians in the Obstetrics Department report updates to state or federal guidelines for maternity and newborn care. "We are very fortunate that our clinicians are willing to work with us to keep the information up-to-date," says Moyer.

At Mount Carmel East in Columbus, OH, **Karen Guthrie**, RN, MS, manager of community and patient education, participates in the meetings of the Patient Care Council, nursing directors, and clinical educators. "This keeps me in the loop on new technology or changes in policies, procedures, or clinical focus, Guthrie says. "I also repeatedly encourage clinicians to contact me with any changes, and they do let me know when a handout needs updating."

Follow the evidence

Although Ronald Reagan UCLA Medical Center in Los Angeles, has decentralized patient education, staff members in all departments know that it is the institution's policy that teaching materials are evidence-based. Therefore when the evidence changes, materials must be updated, says **Rose Healy**, RN, MS, CNS, a diabetes clinical nurse specialist and co-chair of the Patient Education Committee.

Members of the Clinical Practice Committee will take selected clinical topics and review the evidence, existing policy, and guidelines and update them. As part of the process, they develop the patient and family education materials that reflect the current evidence, adds **Laurie Reyen**, RN, MN, CNS, a nutrition clinical nurse specialist at Ronald Reagan UCLA Medical Center and co-chair of the Patient Education Committee.

With an online inventory, updates can be done fairly quickly, and accuracy can be maintained. When print versions are kept on units, updating is more of a challenge, says Guthrie.

In-house booklets are printed in large quantities as a cost savings. Therefore a handout is inserted if information needs to be added, and on occasion, a high quality "sticker" is placed over a section of text with updated information. This process is time-consuming for volunteers.

When updated versions of commercial materials are ordered, the two coordinators in the patient education department replace the outdated versions on the units and recycle them. However, there is the potential that outdated versions will remain on a clinical unit.

"I always keep an eye out for outdated materials when I am in the clinical areas. I also send out to all leaders and educators a quarterly patient education resources update, which includes a listing of revised and new materials," says Guthrie. ■

Do staff speak up about patient dangers?

Address missing skills, or risk harm

A new nurse was called into the OR for a lengthy case. At the end of the case, the nurse turned to break down the back table and noticed the indicator strip in the instrument pan had not changed.

"We had done the whole case with unsterile instruments, and it was entirely my responsibility for not noticing it when I was first setting up my case," says **Jan Davidson**, MSN, RN, perioperative education specialist at the Association of peri-Operative Registered Nurses (AORN). Davidson turned to the vascular surgeon and said, "I need to tell you what I did." "He never once became angry with me," she says. "He knew how devastated I was."

The following day, they went to meet with the patient and the family. "He presented it to them in a way that made it sound as if 'we, the team' have let you down; never 'she, the scrub nurse,'" Davidson says. "I worried about that patient for several years, always afraid he would get an infected graft that would be detrimental to him. As

far as I know, with the administration of strong postoperative antibiotics, he never did."

Davidson scrubbed for many years with that surgeon, and he never mentioned the incident again. "Without his support, without the support of my manager, without the support of the anesthesiologist, and without the support of my fellow nurse who was circulating the case, I don't know that I would have continued to work in the OR and perhaps would have left nursing altogether," she says. "Instead, I felt supported for speaking up and empowered in knowing I could speak up again if I felt we were not practicing safe patient care. That was over 30 years ago, and we are still working on fostering that culture!"

Her views are seconded by a recently released report titled "*The Silent Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives*," conducted by the Association of periOperative Registered Nurses (AORN), the American Association of Critical-Care Nurses (AACN), and VitalSmarts, which is a corporate training company in Provo, UT. The study collected data from more than 6,500 nurses and nurse managers who were members of AACN and/or AORN. *(For the full study results, go to http://silenttreatmentstudy.com and select "Download the study.")*

The Silent Treatment found that 85% of respondents have been in a situation in which a safety tool warned them of a problem. Of the nurses who had been in situations where safety tools worked, 58% percent had been in situations in which they felt unsafe to speak up about the problems or in which they were unable to get others to listen. The implications are serious: Upward of 195,000 people die each year in U.S. healthcare facilities because of medical mistakes.

Is your staff taking shortcuts?

The Silent Treatment concludes providers fail to raise concerns about shortcuts when risks are known, which undermines the effectiveness of current safety tools.

Eight-four percent of respondents say that 10% or more of their colleagues take dangerous shortcuts. Of those respondents, 26% say these shortcuts have harmed patients. Despite these risks, only 17% have shared their concerns with the colleague in question.

Dangerous shortcuts are absolutely a problem, Davidson says. Volume equals money, she points out. For example, in the operating rooms, "Staff may take shortcuts in an effort to get their rooms turned over quickly," Davidson says.

Staff might inadequately wipe down the surfaces of the OR table and equipment between cases. "In the pre-op area, you may see the nurses, in an effort to be efficient and prepared, spike all their IV bags and prime the tubing at the beginning of the day so they are all ready when the patient comes in to be admitted," Davidson says. "This is a prime source of infection." The Association for Professionals in Infection Control and Epidemiology (APIC) recommends that spiked IV solutions be used within one hour of being prepared.

Members of the staff need to feel empowered to speak up about potential harm to a patient when they are pressured to quickly turn over rooms or admit patients, Davidson says. "In their haste to be efficient and fit in that 'one more case for the day,' they risk putting their patient in harm's way, which could result in an event far more costly than the revenue they generated from that one more case," she says.

Another potential problem area is postop care, says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI. "One of the concerns is, do they have adequate monitoring, and is the patient kept there an adequate time, or is he/she sent home sooner than they should be," Trosty says. If employees have not been adequately trained, and they aren't monitoring patients closely enough, "you can have a potential negative result," he says.

The Silent Treatment signals a need for zero tolerance regarding workplace behavior that threatens patient safety, says **Linda Groah**, RN, MSN, CNOR, CNAA, FAAN, executive director/chief executive officer of AORN and a co-researcher on the study. "Shortcuts are not acceptable. Incompetence will be reported, and those without adequate judgment and skills will be held accountable," she says. "Disrespect will not be tolerated, and managers have the responsibility to respond and to react to the information they receive from their staff. It is their responsibility to support their staff and be respectful in their communications." *(For more information on incompetence and disrespect, see stories, p. 105.)*

The study also underscores the need for teamwork, Groah says. "It is a call to action for members of the surgical team to sit down together and map out clear strategies that will result in a culture of safety," she says. "That means a culture of trust in which all members of the perioperative team are encouraged to provide safety-related data and are

acutely aware of the distinction between acceptable and unacceptable behaviors." ■

Managers: Don't fail to train staff

'Incompetency' might be lack of education

While "incompentence" showed up as a primary patient safety issue in the recent study "The Silent *Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives*," this problem is not specific to any one setting, says **Jan Davidson**, MSN, RN, perioperative education specialist at the Association of periOperative Registered Nurses (AORN). AORN sponsored the study, along with the American Association of Critical-Care Nurses (AACN) and VitalSmarts, a corporate training company in Provo, UT.

For example, "it should never be assumed by anyone that working in an outpatient setting is somehow an easier job and that the nurses that work in such a setting are somehow not as skilled as the nurse that works in another perioperative setting," Davidson says. "That is far from the truth."

However, outpatient surgery staff often work with limited resources, she adds. "Managers need to hear them when they say, 'help us to be better by allowing us time for regular and ongoing education.'"

Nurses and other clinicians in outpatient surgery wear many hats. "We fail them when we don't provide them with the necessary tools and/or training they need to also assume the role and responsibility for something they have never had to do before, such as the facility radiation safety officer or the infection prevention specialist," Davidson says. "We also fail them when we don't provide them regular and consistent time allotted for continuing education and in-services."

Managers need to provide tools and/or training to refine staff members' critical thinking skills and/or their critical care skills such as with advanced cardiac life support (ACLS) and pediatric advanced life support (PALS), she says. In "The Silent Treatment" study, 82% of respondents said that 10% or more of their colleagues are missing basic skills and, as a result, 19% say they have seen harm come to patients. Only 11% have spoken to the incompetent colleague.

Stephen Trosty, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI, says, "The question is, are you making sure your personnel have adequate training in CPR, if patients have heart-related problem, and that you not only know how to respond, but you have adequate equipment to respond and stabilize them before 911 or emergency personnel can get there?"

Have an emergency plan, Trosty advises. "There should be an early indication of basic skills and understanding, to help prevent potential harm to a patient, should one of these potentially negative events occur," he says. ■

Issue with safety? R-E-S-P-E-C-T missing

Is a respectful attitude missing among your staff? It has to come from the top down, says **Stephen Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp., in Haslett, MI.

For example, in the operating room, while surgeons traditionally are seen as captains of the ship, "that doesn't mean [they] need to be discourteous, rude, curt, or insulting toward [their] employees," Trosty says.

The same advice goes for nurses toward each other, and clinicians toward clerical staff, he says. Any time you're a negative team, you're putting patients at a greater risk, Trosty says.

Disrespect showed up as a primary concern in the recent study "The Silent *Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives*," sponsored by the Association of periOperative Registered Nurses (AORN), the American Association of Critical-Care Nurses (AACN), and VitalSmarts, a corporate training company in Provo, UT. Eighty-five percent of respondents said that 10% or more of the people they work with are disrespectful and therefore undermine their ability to share concerns or speak up about problems. Only 16% have confronted their disrespectful colleagues.

One solution is a code of conduct, as required by The Joint Commission. The code of conduct, which includes information on how to handle disrespectful behavior, should be reviewed with new employees, says **Jan Davidson**, MSN, RN, perioperative education specialist at the Association of periOperative Registered Nurses (AORN).

"Disrespectful behavior amongst peers or physi-

cians should never be allowed, and there should be language in the medical staff bylaws and the employee handbook that emphasizes a zero tolerance for disrespectful behavior," Davidson says. *(For more information on this topic, see The Joint Commission's brochure on having a code of conduct can be accessed at http://www.jointcommission.org/Code_of_Conduct.)* ■

Low health literacy linked to added risks

More deaths, ED care, admissions found

Low health literacy in older Americans is linked to poorer health status and a higher risk of death, according to a new evidence review by researchers at RTI International -- University of North Carolina (RTI-UNC) Evidence-based Practice Center.

Seventy-seven million English-speaking adults in the United States have limited health literacy, which makes it difficult for them to understand and use basic health information. Rates of limited health literacy are higher among seniors, minorities, lower-income Americans, and those with less than a high school education.

The evidence review, published in the July 19 issue of *Annals of Internal Medicine,* is an update of a 2004 review of the literature based on 96 new studies published in English. The review was supported by the Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ).

The researchers found an association between low health literacy in Americans age 18 and older and poorer use of healthcare services, including more frequent use of emergency departments (EDs) and more hospital admissions, a lower likelihood of getting flu shots and of understanding medical labels and instructions, and a greater likelihood of taking medicines incorrectly compared to adults with higher health literacy. Additionally, the review found evidence linking low health literacy among adult women and underuse of mammograms.

"Our updated review should enhance the public's awareness that low health literacy can play a substantial role in the interrelationship among patient characteristics, use of health care services, and resulting health outcomes," said **Nancy Berkman**, PhD, a senior research analyst at RTI International and the study's lead author. "Finding ways to reduce the effects of low health literacy on health outcomes warrants the attention of policymakers, clinicians, and other stakeholders."

The review also showed a link between low health literacy and poorer health outcomes including poorer health status and higher mortality rates among elderly persons.

Furthermore, evidence from a small but growing body of studies suggests that differences in health literacy level are related to racial and ethnic disparities, such as health status and flu shot rates among seniors, enrollment of children in health insurance programs, and taking medications as instructed by a healthcare professional. "Evidence is emerging that lower health literacy at least partially explains racial disparities in health outcomes," Berkman said. "This evidence was demonstrated across several studies we looked at, each one measuring a different outcome."

The evidence review was conducted by AHRQ's RTI-UNC Evidence-based Practice Center, a collaboration between RTI and the five health professions schools and the Cecil G. Sheps Center for Health Services Research at UNC. ■

Language barriers can increase med error risk

Language barriers slow down access to healthcare, can compromise the quality of care, and might increase the risk of harmful medical events among patients with limited English proficiency (LEP), according to data and research studies released recently by the Pennsylvania Patient Safety Authority in Harrisburg.

Events reported to the Pennsylvania Patient Safety Authority from June 2004 through May 2010 were reviewed to determine what types of events most frequently affect patients with LEP. Falls, errors related to a surgical procedure, and medication errors were the top three types of events reported for LEP patients during this time frame. *(For the full report, go to http://patientsafetyauthority.org and search for "Managing patients with limited English proficiency.")*

Of the 232 event reports, 114 (49%) involved patient falls, 62 (27%) involved errors or complications related to a surgical procedure, and 14 (6%) involved medication errors or adverse drug reactions. One hundred nine reports (47%) were for LEP patients over age 65. Of the 232 reports, 128 (55%) reports specifically mentioned the primary language spoken, whereas the remaining reports (104) did not. Where the language was specifically documented,

Spanish was most frequently mentioned.

The report cites the top three events that affected LEP patients based on the reported events:

• falls among LEP patients were often due to the patient not understanding or following instructions;

• reports of errors or complications related to a surgical procedure showed problems with obtaining consent or locating an interpreter before the procedure, causing delays;

• medication errors or adverse drug reactions due to misinterpretation of instructions. ■

Online safety resource available for clinicians

Healthcare-associated infections targeted

The Office of Healthcare Quality in the Department of Health and Human Services (HHS) has released *"Partnering to Heal: Teaming Up Against Healthcare-Associated Infections,"* an interactive learning tool for clinicians, health professional students, and family caregivers.

The training videos include information on basic protocols for universal precautions and isolation precautions to protect patients, visitors, and practitioners from the most common disease transmissions. The training promotes six key behaviors: teamwork; communication; hand washing; vaccination against the flu; appropriate use of antibiotics; and proper insertion, use, and removal of catheters and ventilators. These resources support the new Partnership for Patients, a national public-private partnership with hospitals, medical groups, consumer groups, and employers that aims to prevent millions of injuries and complications in patient care over the next three years. To access the videos, go to http://www.hhs.gov/ash/initiatives/hai/training/index.html. For more on Partnership for Patients, go to http://www.healthcare.gov/center/programs/partnership/index.html. ■

COMING IN FUTURE MONTHS

■ Innovative methods of education

■ Making teach-back second nature

■ Keeping templates from becoming wordy

■ Avoid time constraints with online classes

Patients urged to consider care options

The Agency for Healthcare Research and Quality (AHRQ) has announced a new multimedia ad campaign, "Explore Your Treatment Options," to encourage patients to become more informed about their options before choosing a treatment for a health condition or illness.

The goal of this campaign is to increase consumers' involvement in their care by providing easy access to unbiased information about treatment options and tools to encourage patients to work with their doctors, nurses, pharmacists, and other clinicians to make healthcare decisions. It features television, radio, print, web, and outdoor ads that encourage

continued on p. 108

CNE INSTRUCTIONS/OBJECTIVES

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

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.

continued from p. 107

consumers to visit AHRQ's Effective Health Care Program web site to find plain-language guides that summarize the scientific evidence on treatments for numerous medical conditions, including diabetes, osteoarthritis, high blood pressure, high cholesterol, and more.

As part of the campaign, AHRQ's Effective Health Care Program web site features personal stories from patients with chronic conditions who achieved better health results by exploring their treatment options. In addition, a new Health Priorities Snapshot tool features questions about common daily activities and allows users to rate the importance of quality-of-life concerns. Patients can print a list of their own health priorities and share it with their clinicians during medical appointments. The tools are available at http://www.effectivehealthcare.ahrq.gov/options. ■

CNE QUESTIONS

9. Poor bowel prep for a colonoscopy is only 2% of patients at MD Anderson Cancer Center because the following steps are taken?
   A. Use of split dose cleansing solution.
   B. Use of online videos.
   C. Use of a laxative as part of the prep.
   D. A & C

10. Patients need to be educated on good bowel habits that include which of the following, according to Annette Bisanz, RN, BSN, MPH, clinical nurse specialist for bowel and symptom management at MD Anderson?
    A. Drinking 64 oz of fluid daily.
    B. Eating 25-40 g of fiber daily.
    C. Being proactive when prescribed medications that cause constipation.
    D. All of the above.

11. A checklist in a brochure titled "Explain Your Pain" produced by the American Pain Foundation, has descriptive words such as "shooting" or "tingling" that help patients put symptoms into words. According to this organization, the tool can help lead to the proper diagnosis and treatment of chronic pain.
    A. True
    B. False

12. Accessing written materials on an Intranet is the best way to manage inventory, therefore patient education managers should not make any print copies available.
    A. True
    B. False

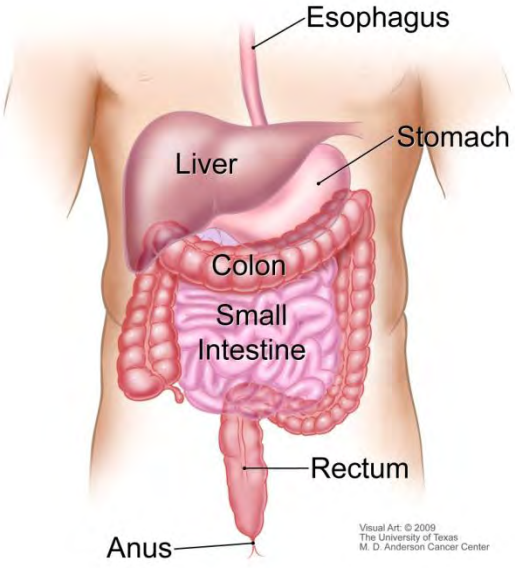
Colonoscopy Procedure Preparation

Using GoLytely®, NuLytely® or CoLyte®
With Additional Instructions for Patients Who Have Diabetes or Taking Blood Thinners

All patients scheduled for a colonoscopy can use these instructions to properly prepare for the procedure. If you have diabetes or take Coumadin®, Plavix® or other blood thinners pay close attention to specific sections concerning your condition or medicine.

A colonoscopy is a test in which your doctor looks at the inner lining of your large intestine, also called colon (see image). This is done using an instrument called a colonoscope, which is a long, flexible, lighted instrument. The colonoscope is inserted through the anus and is gently guided through the colon.

During your colonoscopy, the doctor may take a small amount of tissue (called a biopsy) from the inside of your colon for examination under a microscope. Polyps (flat lesions that grow on the lining of the colon) may be removed. Other procedures may be performed to control or prevent bleeding or stretch an area that is narrowed.



The colon and nearby organs in the digestive system

Sometimes, due to the shape of the patient's colon, the doctor cannot examine the entire colon. If this is your case, the doctor will arrange for an X-ray of the colon to complete the exam.

Tell your nurse or doctor if you are pregnant.

Preparation for Your Procedure

The following information will help you prepare for the procedure. Please carefully follow these instructions.

- Tell your doctor about all the drugs you take, including over-the-counter medicines, herbs and vitamins.
- **If you have diabetes**, please clarify with your doctor whether you need to adjust the way you take your insulin or other medicines to control blood sugar.
- You may receive sedation medicine intravenously (through a vein in your arm) that will make you sleepy during the test. You must have an **adult family member or friend come with you** to sign you out, take you home or to your hotel and help care for you. **If you do not** have a responsible adult with you, your appointment will be postponed.

  If an adult family member or friend is not available to come with you, you may want to use a caregiver service that is available for a fee and requires a minimum of four hours. A caregiver service can provide a variety of services after your procedure and help you when you return home.

  For information on companies that provide caregiver services, contact MD Anderson's Department of Social Work at 713-792-6195.

Five Days before Your Procedure

To help lessen the risk of complications and blood clots, you may need to change the way you take blood thinners before the procedure.

Instructions for Patients on Plavix® or Effient®

If you are scheduled for one of the extended procedures listed below and take Plavix (clopidogrel) or Effient (prasugrel), please ask your cardiologist or internist if it is okay to stop this medicine. If your cardiologist approves, stop Plavix or Effient **five days** before the procedure. If your cardiologist or internist does not approve of stopping the medicine, call the endoscopy department at 713-792-2329 and ask to speak with a nurse. You may also contact the endoscopist who will perform your procedure or his or her physician assistant (PA) by calling 713-794-5073.

Continue taking aspirin as prescribed by your doctor. If you do not take aspirin, consider taking a baby aspirin (81 milligrams) daily in place of Plavix or Effient (if you stop taking Plavix/Effient). Taking aspirin will help reduce the risk of blood clots during the procedure.

Extended endoscopic procedures – Group A:

- Colonoscopy with polypectomy (examines the colon and removes a polyp)
- Dilation of a stricture (procedure to help stretch a narrowed or closed area)
- EGD with placement of a stent (a flexible metal tube is inserted to help open a blocked or narrowed area)
- EGD to treat Barrett's Esophagus (treatment using heat or cold to remove tissue in the esophagus)
- Endoscopic mucosal resection (procedure to remove lesions in the digestive system)
- ERCP with sphincterotomy (examines and treats the bile ducts and pancreas)

- EUS with fine needle aspiration (a procedure that removes a tissue sample using ultrasound)
- PEG (procedure for placing a feeding tube)
- Treatment of esophageal varices (treatment for enlarged veins in the lower part of the esophagus)

Instructions for Patients on Coumadin®

For Group B procedures – If you are scheduled for one of the procedures listed below, and take Coumadin (warfarin), have your weekly blood test (protime INR) the week before the procedure. If the blood test shows that your protime INR is above 3, contact the doctor who prescribed the Coumadin or call the endoscopy department at 713-792-2329 to speak with a nurse. You may also contact the endoscopist who will perform your procedure or his or her physician assistant (PA) by calling 713-794-5073.

Endoscopic procedures (Group B):

- EGD with biopsy (examines the esophagus and stomach and removes a small tissue sample)
- Colonoscopy with biopsy (examines the colon and removes a small tissue sample)
- EUS (examines organs in the digestive system)
- ERCP with stent insertion (procedure to insert a stent into the bile duct to help it drain)

For extended endoscopic procedures (Group A) – If you take Coumadin and are scheduled for a procedure listed in **Group A** (see "Extended procedures" list on **page 2**), ask your cardiologist or internist if it is okay to stop this medicine. If your cardiologist approves, **stop taking Coumadin five days** before the procedure. Your primary MD Anderson doctor or cardiologist may require you to take other blood thinners, such as Lovenox©, during this time. If you have questions, please call the endoscopy department at 713-792-2329 and ask to speak with a nurse. You may call also contact the endoscopist who will perform your procedure or his or her physician assistant (PA) by calling 713-794-5073.

You may continue taking aspirin before your procedure.

Use this chart to help you take your blood thinners.

Type of Procedure	Instructions if You are Taking Plavix	Instructions if You are Taking Coumadin
Group A	Stop taking five days before procedure, if this is okay with your cardiologist. Begin taking your usual dose of Plavix the day after the procedure.	Stop taking five days before if this is okay with your cardiologist. Your cardiologist or primary MD Anderson doctor may prescribe other blood thinners for you at this time. After the procedure, resume your usual dose of Coumadin

Type of Procedure	Instructions if You are Taking Plavix	Instructions if You are Taking Coumadin
		that evening, unless you receive other instructions from the endoscopy staff.
Group B	Continue taking daily dose	Check INR level

Buy These Items Before You Begin the Bowel Prep

Medicines	Food and Drinks Allowed
• **Bowel preparation solution -**Your doctor, the assigned physician assistant (PA) or designated health care provider will give you a prescription for the recommended solution. Call your doctor if you have not received a prescription or lost your prescription. You can purchase the solution from a drug store or pharmacy. Three brands of bowel preparation solution are available: GoLytely®, NuLytely® and CoLyte®. Read the instructions carefully. All brands work the same way, but some are flavored. • **Milk of magnesia** (**optional;** discuss this with your doctor) • **Dulcolax® laxative tablets** – These can be purchased without a prescription at drug stores, pharmacies and grocery stores. • **Gas X® or simethicone tablets** – These can be purchased without a prescription at drug stores, pharmacies and grocery stores.	• Clear liquids: water, tea, coffee and sports drinks (like Gatorade® or Powerade®) • Lemon-flavored drink mix, such as Crystal Light® • Milk and cereal (for breakfast only, the day before the procedure) • Fruit juice without pulp • Jell-O® (any color but red and without fruit) • Soups: Fat-free chicken or beef broth, consommé, bouillon and clear soups without meat and vegetables

! You need to **completely empty your colon**. If you do not, you may have to repeat the exam at another time. Body waste (called stool) in the colon can hide diseases and tumors and may cause the procedure to last longer than usual. To improve the outcome, efficiency and safety, please follow the preparation instructions as carefully and completely as possible.

Bowel Preparation

Two Days Before the Procedure	
• If you have problems with constipation, discuss this with your doctor. Your doctor may suggest drinking 1 ounce (30 ml) of milk of magnesia so that you are not constipated on the day you begin taking the preparation solution. • Do not take Metamucil® and do not eat foods with small seeds such as bread with sesame seeds, kiwi and cucumbers.	
Day Before the Procedure	
6-8 a.m.	• **Eat a light breakfast.** You can: 1) eat cereal without nuts, with milk; 2) drink

	juice without pulp and coffee or tea; and 3) drink all the clear liquids you like. • **You may take routine medicine** unless your doctor gave you other instructions. • **Prepare the bowel preparation solution** and chill it in the refrigerator until ready to use at 4:30 p.m. If the solution is not flavored, you may add one or two packets of lemon-flavored drink mix, such as Crystal Light®.
Noon	• **Take two Dulcolax laxative tablet**s and drink two large glasses of clear liquids, such as water, iced tea, soda or ginger ale. • **Limit your lunch to liquids only.** You are allowed liquids and clear soup of any kind without meat and vegetables.
4 p.m.	• **Take two Dulcolax laxative tablets** and drink two large glasses of clear liquids, such as water, tea, sports drinks or ginger ale.
4:30 p.m.	• **Begin drinking 2 liters of the bowel preparation solution**. **Drink one 8-ounce glass** (0.25 liter) of the solution **every** 10 to 20 minutes until you have drunk 2 liters of solution. (Store the rest of the solution in the refrigerator for the next morning.) It is best to keep the liquid chilled and drink each glass quickly rather than slowly sipping it. Most of the fluid will move through your system in an hour. The solution will cause you to have many liquid bowel movements, so stay close to toilet facilities. If you vomit while drinking the solution, stop for one hour, and then begin drinking again. If you vomit again, stop the prep and call your doctor for instructions. Plain hot tea may help settle your stomach. • **Chew one Gas X** or simethicone tablet to help relieve gas bubbles.

Morning of the Procedure

If your procedure is scheduled before 12 noon, take two Dulcolax laxative tablets and drink the remaining 2 liters of solution by 4 a.m. **or**

If your procedure is scheduled after 12 noon, take two Dulcolax laxative tablets and drink the remaining 2 liters of solution by 8 a.m.

Do not eat or drink anything other than the solution before you leave home.

Day of the Procedure

Before You Leave Home	At the Hospital
• It is okay to take routine prescription medicines such as blood pressure and pain medicines with a small amount of water unless your gastroenterologist or anesthesiologist tells you otherwise. • If you have diabetes, please follow your doctor's instructions about taking your medicine. Check your fasting blood sugar level and report this number to the nurse when you arrive in the Endoscopy department.	• Be prepared to spend half a day at the hospital. There may be many reasons why your appointment runs late. Our goal is to provide the best care for all of our patients. • The medical team will: – Explain the procedure to you – Answer any questions you have – Ask you to sign a consent form before the procedure begins and – Check your blood pressure, pulse and breathing rate

- **Bring a list of all your medicines**, including over-the-counter medicines, herbs and vitamins.
- **Dress** in loose-fitting, comfortable clothing. Wear shoes with a closed toe, a closed heel and a sturdy sole, such as sneakers. For women having a menstrual period, it is okay to wear a tampon. Leave all jewelry and valuables at home. MD Anderson is not responsible for lost or stolen items. The Endoscopy clinic does not have lockers available to store personal items.
- Check your **arrival time** on your patient appointment schedule. At this time, report to the endoscopy department located in the Main Building, Floor 5, near Elevator C.
- **You will need to bring a responsible adult with you to your appointment who can take you home. Your appointment will be canceled** if you do not have a responsible adult with you. Your family member, friend or sitter should remain in the Endoscopy clinic during your procedure and recovery (usually 1 ½ to 2 hours).

- In the procedure room, you will receive medicine through an IV that will make you more comfortable during the colonoscopy. An IV is a small tube through which you receive fluids and medicine. You will feel sleepy, but you will wake up easily after the procedure.
- If you have pain, tell your doctor or nurse. A nurse and a doctor will remain with you during the procedure.

After the Procedure

- You will be moved to a recovery area where you will stay until most of the effects of your medicine have worn off and your doctor or nurse believes it is safe for you to leave.
- If you received sedation medicine, you will be allowed to go home with the assistance of your adult family member, friend or sitter.
- Your doctor will tell you when you may eat and drink after the procedure and give you any special instructions on diet, medicine and home care.

Chemotherapy Patients

If you received chemotherapy one to two weeks before your scheduled colonoscopy, you will need to have a complete blood count (CBC) with differential 24 hours before the procedure. If you live outside of Houston, you may have your blood test at a clinic near you and have the results faxed to your primary clinic at MD Anderson. A member of your health care team will review the results to determine if you will be able to have the colonoscopy or if the colonoscopy will be rescheduled.

Home Care

- If you have irritation in your anal area, use medicated pads (such as Tucks®) and petroleum jelly (such as Vaseline®) to help soothe the skin.
- **Do not** drive a car, operate machinery or go to work, until the day after your colonoscopy.
- A nurse or physician assistant will call you the next business day after the procedure to ask how you are feeling and to discuss follow-up care. If you do not receive a call within seven days, please call the endoscopy department at 713-792-2329.
- If tissue was removed from your colon, call your doctor five business days after the procedure for the results.

Medical Problems or Emergencies

Call the endoscopy department at 713-792-2329 or your endoscopist (the doctor who performed the colonoscopy) at 713-794-5073 between 8 a.m. and 5 p.m. if you:

- Have a temperature of 101°F (38.3°C) or higher any time during the first 72 hours after the procedure
- Vomit any blood or have any rectal bleeding
- Have severe abdominal pain

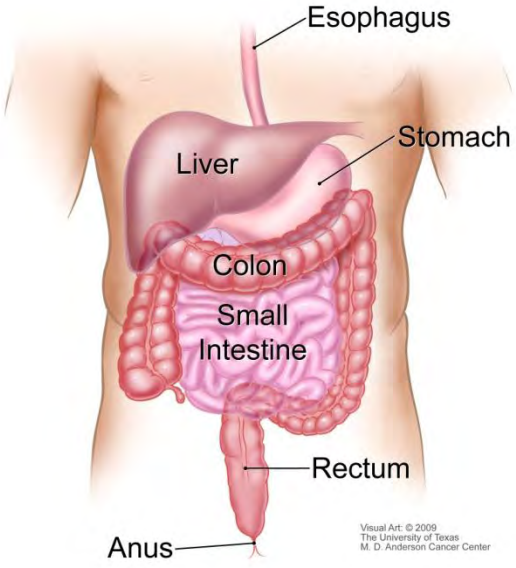
A doctor from the gastrointestinal (GI) center is available after clinic hours and on weekends. If you have an urgent need during these times, call 713-792-2121 and ask the operator to page the GI fellow on call.

For medical emergencies after normal business hours and on weekends and holidays, please call 911 or go to the nearest hospital emergency center. MD Anderson's Emergency Center is open 24 hours a day, every day. From Holcombe Boulevard, turn at Entrance Marker 3. The entrance is on Bates Street near Garage 2. From inside the Main Building, go to Floor 1, near The Fountain, Room P1.3000.
For non-emergencies during business hours, please call your care center.

Colonoscopy Procedure Preparation
Using GoLytely®, NuLytely® or CoLyte®

This handout gives a condensed version of instructions for preparing for a colonoscopy procedure. If you have diabetes or are taking Plavix®, Coumadin® or other blood thinners, you should follow a different set of instructions that is available from your nurse or by calling the endoscopy department at 713-792-2329.

You are scheduled for an examination of your colon, called a colonoscopy. You must clean out your colon the day and evening before the procedure (see image). This handout will explain how to prepare for the colonoscopy. Please follow these instructions carefully.



The colon and nearby organs in the digestive system

Because you will receive sedation medicine to make you sleepy during the procedure, please arrange for a responsible adult to come with you to your appointment. **If you do not, your procedure will be postponed.**

Items You Will Need

- The preparation (prep) solution - Brands of bowel preparation solution include: GoLytely®, NuLytely® and CoLyte®. You will need a prescription to buy the solution. If you do not have a prescription, call the endoscopy department at 713-792-2329 between 8 a.m. and 5 p.m.
- Dulcolax® laxative tablets – These can be purchased without a prescription at drug stores, pharmacies and grocery stores.
- Clear liquids – These are liquids that you can see through, such as water, tea, broth and sports drinks (like Gatorade® and Powerade®)
- A laxative – If you have problems with constipation, take a laxative, such as milk of magnesia, two days before the procedure or before drinking the solution.

The Day before the Procedure

1. Drink only clear liquids; do not eat solid food.
2. At noon, take two Dulcolax tablets with a large glass (more than 8 ounces) of clear liquids.
3. At 4 p.m., take two more Dulcolax tablets with a large glass of clear liquids.
4. At 4:30 p.m., start drinking the first 2 liters of the bowel prep solution. Try to drink 8 ounces every 10 to 20 minutes. Place the remaining 2 liters in the refrigerator.
5. If you have discomfort from gas, you may take Gas X® or a simethicone tablet, both are available over-the-counter at drug and grocery stores.

The Day of the Procedure

1. In the morning, take two Dulcolax tablets and drink the remaining two liters of the solution. It is important to finish drinking the solution **three hours** before your scheduled appointment time. If your procedure will include TIVA (total intravenous anesthesia), you must finish all the solution **six hours** before your appointment time.
2. **Do not** eat or drink after you finish the solution.
3. Bring all your medicines in their bottles with you to your appointment.
4. Nurses will help you prepare for the procedure and help you when you are recovering. Plan to stay at the hospital at least four hours.
5. You can resume your normal diet after the procedure.

If you have questions about these instructions, call the endoscopy department at 713-792-2329.

Chemotherapy Patients

If you received chemotherapy one to two weeks before your scheduled colonoscopy, you will need to have a blood test called a complete blood count (CBC) with differential. This should be done twenty-four (24) hours before the procedure. If you live outside of Houston, you may have your blood test at a clinic near you and have the results faxed to your primary clinic at MD Anderson. A member of your health care team will review the results to determine if you will be able to have the colonoscopy or if the colonoscopy will be rescheduled.

Home Care

- If you have irritation in your anal area, use medicated pads (such as Tucks®) and petroleum jelly (such as Vaseline®) to help soothe the skin.
- **Do not** drive a car, operate machinery or go to work, until the day after your colonoscopy.
- A nurse or physician assistant will call you the next business day after the procedure to ask how you are feeling and to discuss follow-up care. If you do not receive a call within seven days, please call the endoscopy department at 713-792-2329.

Medical Problems or Emergencies

Call the endoscopy department at 713-792-2329 or your endoscopist (the doctor who performed the colonoscopy) at 713-794-5073 between 8 a.m. and 5 p.m. if you:

- Have a temperature of 101°F (38.3°C) or higher any time during the first 72 hours after the procedure
- Vomit any blood or have any rectal bleeding
- Have severe abdominal pain

A doctor from the gastrointestinal (GI) center is available after clinic hours and on weekends. If you have an urgent need during these times, call 713-792-2121 and ask the operator to page the GI fellow on call.

For medical emergencies after normal business hours and on weekends and holidays, please call 911 or go to the nearest hospital emergency center. MD Anderson's Emergency Center is open 24 hours a day, every day. From Holcombe Boulevard, turn at Entrance Marker 3. The entrance is on Bates Street near Garage 2. From inside the Main Building, go to Floor 1, near The Fountain, Room P1.3000.
For non-emergencies during business hours, please call your care center.

Patient Education Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Select your answers by filling in the appropriate bubbles **completely.** Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- O A. vice president
- O B. patient education coordinator
- O C. director, health wellness
- O D. director, staff education
- O E. consultant
- O F. other _____

2. What is your highest degree?

- O A. LPN
- O B. ADN (2-year)
- O C. diploma (3-year)
- O D. bachelor's
- O E. master's
- O F. PhD
- O G. Other _____

3. What is your sex?

- O A. male
- O B. female

4. What is your age?

- O A. 20-25
- O B. 26-30
- O C. 31-35
- O D. 36-40
- O E. 41-45
- O F. 46-50
- O G. 51-55
- O H. 56-60
- O I. 61-65
- O J. 66+

5. What is your annual gross income from your primary health care position?

- O A. Less than $30,000
- O B. $30,000 to $39,999
- O C. $40,000 to $49,999
- O D. $50,000 to $59,999
- O E. $60,000 to $69,999
- O F. $70,000 to $79,999
- O G. $80,000 to 89,999
- O H. $90,000 to $99,999
- O I. $100,000 to $129,999
- O J. $130,000 or more

6. Where is your facility located?

- O A. urban
- O B. suburban
- O C. medium-sized city
- O D. rural

7. In the last year, how has your salary changed?

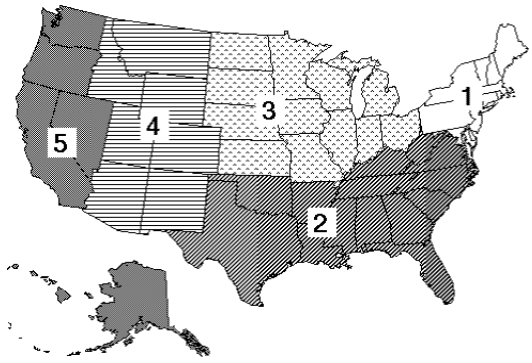
- O A. salary decreased
- O B. no change
- O C. 1% to 3% increase
- O D. 4% to 6% increase
- O E. 7% to 10% increase
- O F. 11% to 15% increase
- O G. 16% to 20% increase
- O H. 21% increase or more

8. What is the work environment of your employer?

- O A. academic
- O B. agency
- O C. health department
- O D. clinic
- O E. college health service
- O F. consulting
- O G. hospital
- O H. private practice

9. Please indicate where your employer is located.

- O A. region 1
- O B. region 2
- O C. region 3
- O D. region 4
- O E. region 5
- O F. Canada
- O G. other



10. Which best describes the ownership or control of your employer?

- O A. college or university
- O B. federal government
- O C. state, county, or city government
- O D. nonprofit
- O E. for profit

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11. How long have you worked in patient education?

- O A. less than 1 year
- O B. 1-3 years
- O C. 4-6 years
- O D. 7-9 years
- O E. 10-12 years
- O F. 13-15 years
- O G. 16-18 years
- O H. 19-21 years
- O I. 22-24 years
- O J. 25+ years

12. How long have you worked in health care?

- O A. less than 1 year
- O B. 1-3 years
- O C. 4-6 years
- O D. 7-9 years
- O E. 10-12 years
- O F. 13-15 years
- O G. 16-18 years
- O H. 19-21 years
- O I. 22-24 years
- O J. 25+ years

13. What is your certification?

- O A. RN
- O B. COHN-S
- O C. NP
- O D. CIC
- O E. CHES
- O F. LVN
- O G. CCM
- O H. Other_____

14. How many hours a week do you work?

- O A. less than 20
- O B. 20-30
- O C. 31-40
- O D. 41-45
- O E. 46-50
- O F. 51-55
- O G. 56-60
- O H. 61-65
- O I. 65+

15. If you work in a hospital, what is its size?

- O A. <100 beds
- O B. 101 to 200 beds
- O C. 201-300 beds
- O D. 301 to 400 beds
- O E. 401 to 500 beds
- O F. 501 to 600 beds
- O G. 601 to 800 beds
- O H. 801 to 1,000 beds
- O I. >1,000 beds
- O J. I don't work in a hospital

Deadline for Responses: Oct. 15, 2011

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, AHC Media, P.O. Box 105109, Atlanta, GA 30348.