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Patient Education Management™

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

INSIDE

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Patient education is paramount during new employee orientation

A thorough program at the beginning makes the best impact

During orientation for new employees, patient education is just one of many topics covered. With so much new information taught, it is difficult to predict just how much is remembered. That's why many patient education managers create methods that make learning about techniques for teaching patients and about hospital policy on education stand out.

Until recently, the patient education portion of orientation for newly hired nurses at Christiana Care Health System in Newark, DE, was fairly routine. A one-hour lecture on the patient education system was incorporated into the weeklong orientation. Those interested in a more hands-on lesson could enroll in a four-hour workshop on patient education referred to as an enhanced orientation option, says **Susan Lewis**, RN, BSN, a health education specialist at Christiana Care.

Now the four-hour workshop is the patient education portion of orientation. It includes information on tailoring education to the literacy of the patient, effective teaching strategies, and exercises in critical thinking through the use of case studies.

EXECUTIVE SUMMARY

Often, patient education is squeezed into new employee orientation along with all the other information that needs to be covered in a short amount of time. Therefore, it is difficult to know how much information new employees retain. Yet there are ways to make the information memorable. In this month's cover story, we explore a few ways to provide more in-depth instruction to make the whole process more effective.

To develop the eight case studies used in orientation, Lewis looked for patient types that historically had been difficult to prepare for discharge. These included patients with diabetes, those with new ostomy appliances, and even mothers with new babies. "We wanted nurses to start thinking about these difficult cases as they began their orientation to Christiana Care and know that early discharge planning is valued at Christiana," says Lewis. **(To learn more about the case studies and how they are developed, see article on p. 27.)**

During the overall orientation process at the University of Colorado Hospital in Denver, the patient services department provides specifics on patient education for all disciplines involved in teaching patients. This includes nursing, social work, physical therapy, and pharmacy. During the session, the importance of patient education is emphasized, says **Valerie Siml**, RN, MSN, MA, an instructional development specialist at the health care facility.

"We try to get across the idea that patient education isn't just sitting down and talking with the patient for 30 minutes, but anything that you do to help move them along the health continuum in a positive manner is really patient education," she says.

To teach basic patient education techniques such as barriers to learning and uncovering learning styles, a 15-minute videotape, "Patient and Family Education, Learning for Life," produced by Envision Inc. in Nashville, TN, is shown **(For information on how to contact this company, see editor's note at end of this article.)**

An educator on each unit provides details that are specific to the area in which the new employee will work. Using a checklist that helps ensure that all information is covered, the educator goes over documentation of patient education on the unit, where educational materials are stored, and the new employee's responsibility in educating patients. The competency checklist also includes a section where the educator watches the new employee teaching a patient.

Documentation used to be covered in the general patient education orientation, however Colorado Hospital now is in the process of switching to computerized charting. About half the units now document patient education on the computer and the other half still use paper; therefore, it is easier to have documentation covered by the educator on the unit, says Siml.

Tiered orientation on education

A preceptor on each unit provides job-specific orientation for new employees at MeritCare Health System in Fargo, ND, as well. During this process, the preceptor signs off on a patient education intervention by the new employee.

The orientation system at MeritCare first focuses on the health system as a whole, then the employee's role, and finally training in the area where each employee will work, says **Roberta Young**, BSN, RN, LCCE, coordinator of consumer health education.

All new employees receive an associate reference guide that includes a philosophy statement on patient education. This statement includes reasons MeritCare provides patient education, such as to

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decrease anxiety, create an atmosphere of informed decision making, and to form partnerships with patients and their families. Last year, MeritCare oriented 1,600 new employees.

Role-specific orientation for the nurses includes instruction on how to navigate the health system's intranet where everything from policies to patient education manuals is kept. They learn about the strategic initiatives at MeritCare as well, which currently include patient safety and pain management.

"That may change depending on the initiative for improving patient care," says Young.

Nurses also are given a one-page description of the self-efficacy model used at MeritCare that includes information on how it relates to one-on-one or group patient education.

With this model, patient education strategies that increase a patient's confidence in their ability to learn skills for self-care are interwoven throughout the education process, says Young. When programs or teaching strategies are evaluated, determining whether the format boosted confidence levels is critical. For example, in the childbirth classes, the evaluation is about how confident patients are in being able to use relaxation techniques during labor.

Young even uses the self-efficacy model developed by Kate Lorig, RN, DrPH, director of the Stanford Patient Education Research Center in Palo Alto, CA, when selecting patient-education materials. She looks to see if the materials have success stories that might bolster a patient's confidence or photos of the people whom the material was written for.

"I look to see if the materials have problem-solving techniques for people rather than dos and don'ts," says Young.

To help those who teach patients understand the self-efficacy model better, two classes are offered on a quarterly basis at MeritCare. One is "Patient Education Getting the Bang for Your Buck," a class that lasts about an hour. The second is a more in-depth version of the topic titled, "A Tapestry of Patient Learning, Unraveling the Threads."

Patient education managers have found that carving out a distinct place for patient education in the orientation process has many benefits. Making the majority of the education unit-based at the University of Colorado Hospital helps new employees learn the specifics, such as the techniques for documentation, says Siml.

Removing pieces that are more unit-specific from the general patient education piece during the orientation allows for time to review the basics. "It gives us time to have some overview. I know that people supposedly learn how to do patient education in school, but the video we show is a very good overview and a good reminder for people," she says.

The videotape now is used in staff meetings for a general overview, and all staff take a computerized skills test based on the information as part of their competency testing. There are 13 questions on the test that cover such information as readiness to learn and assessing barriers to learning. Staff must get 80% of the questions correct to pass.

By including case scenarios as part of the patient education orientation at Christiana Care, patient care should improve.

"The benefit is that our service to our patients should improve, our patients should be ready for discharge, and hopefully we will have a staff of nurses that are able to educate and comfortable with educating," says Lewis.

[Editor's note: To find out more about the videotape, "Patient and Family Education, Learning for Life," contact: Envision Inc., 1111 16th Ave. S., Nashville, TN 37212. Telephone: (615) 321-5066.] ■

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Case studies teach new hires problem solving

Tackle tough discharge planning situations

To prompt nurses to begin thinking about difficult cases and planning early for discharge, **Susan Lewis**, RN, BSN, a health education specialist at Christiana Care Health System in Newark,

DE, created eight case studies to include in new employee orientation.

She presents each study to the group of newly hired nurses and asks what education they need to provide to prepare the patient for discharge. Once the nurses have exhausted their ideas, she makes suggestions. During the discussion, Lewis introduces resources that are available at Christiana Care that might help the nurses with their teaching.

The resources not only include written materials but employees that can be called upon when nurses can't seem to get the message across to the patient. They include three health educators; three wound, ostomy, and continence nurses; and a nutrition therapy nurse.

The scenarios used for educational purposes cover difficult cases such as congestive heart failure patients, patients with diabetes, and patients going home with a new tracheotomy. One case scenario, for example, is an unsafe discharge. In it, Lewis describes an elderly gentleman who is a little confused, lives at home alone, and hasn't been very good about taking his medications. When he was admitted, he was unkempt; and the physician is discharging him.

"I am trying to incorporate situations where nurses would need to assess the situation critically and determine what help they might need," she says.

To include case studies in the patient education portion of orientation, Lewis advises patient education managers to identify their resources first, or what is available to teach the patient. For example, are there diabetes educators available or pharmacists that can teach about medications?

Also determine what the problem areas have been in the past, she says. For example, having situations arise where newly diagnosed diabetes patients are ready to be discharged yet they have not had any teaching, and the educator is called at the last minute identifies a hot spot.

"Either use your experience or consult people that are experienced in that problem area to assist you in developing some sort of scenario that would apply to that specific problem," says Lewis. ■

Alarming stats for elderly depression and suicide

Teach signs and symptoms of depression

The statistics are alarming. According to the National Institute of Mental Health, in 1997 adults age 65 and older accounted for 19% of all suicide deaths although they only comprise 13% of the U.S. population. The suicide rate for white men ages 85 and older was six times the national average. The main reason for suicide at any age is depression.

There is a myth that depression is not dangerous, yet 20% of the people who suffer from depression die by committing suicide. "It is a dangerous and fairly fatal illness. Most people who commit suicide are depressed," says **Elizabeth Harris**, RN, APRN, BC, health education coordinator for behavioral health at New York Presbyterian Hospital in New York City.

Although the experts are not sure why the figures are so high for suicides among the elderly, there may be several contributing factors. It is much more difficult for the elderly to survive or recuperate from a suicide attempt, just as it is more difficult for them to recover from a fall or other accident. Also, there are many stresses to which the elderly are more susceptible, says Harris. They have more illnesses, experience more deaths of people they love, and experience loss of independence.

The best way to prevent suicide is to diagnose depression early and treat it, she says. Therefore, the elderly as well as their caregivers should know the signs and symptoms. There must be a cluster of symptoms, at least five, that last for two weeks.

A depressed mood or absolutely no interest or pleasure in anything must be present first of all. "I think that is why depression goes undetected. You don't have to feel depressed; all you have to feel is that you just don't care anymore," says Harris.

In addition, a combination of four of seven symptoms must be present. They include:

- problems with appetite, either undereating or overeating;
- problems with sleep, either oversleeping or not being able to sleep;
- physical restlessness or physically slowing down;
- a loss of energy, fatigue, or tiredness;
- feelings of worthlessness or excessive guilt;
- poor concentration or extreme indecisiveness. For example, a person might cry for half an hour because he or she can't decide what cereal to eat for breakfast;

Preventing depression in elderly family and friends

Proper nutrition and exercise are important

To help safeguard against the onset of depression, elderly adults should take care of their overall health, says **Elizabeth Harris**, RN, APRN, BC, health education coordinator for Behavioral Health at New York-Presbyterian Hospital in New York City. That includes eating a well-balanced diet, getting adequate sleep, and regular exercise.

"Exercise is an important way to prevent depression and treat it if it should occur," says Harris.

Relatives or caregivers of the elderly need to remember the benefits of exercise. Scheduling a half-hour stroll on a daily basis with an elderly mom or uncle can help. "It is remarkably helpful. There's no pressure to talk, but the person has the company and gets exercise," says Harris.

Learning stress-management techniques is another way to avoid depression. Taking a yoga class or doing deep-breathing exercises are two examples.

When a person makes one of the changes connected with growing old, it is helpful to plan it in a way that will make the transition easier, says Harris. For example, when moving out of a house they have lived in for 45 years, the elderly should arrange to have other people sell the excess furniture they no longer need and help with the entire moving process.

It's also important for the elderly to arrange regular visits with family members during the transition so they do not feel isolated. Anything they can do to make the change a little easier is a good idea, she says.

Friendships are extremely important to prevent social isolation. The elderly should get involved in clubs, their church or synagogue, a senior citizen center, or volunteer opportunity so they interact with other people regularly, says Harris. ■

SOURCE

For more information about teaching the signs and symptoms of depression in the elderly, contact:

- **Elizabeth Harris**, RN, APRN, BC, Health Education Coordinator, Behavioral Health, New York-Presbyterian Hospital, New York City. Telephone: (914) 997-5888.

• thoughts of death and suicide or just wishing to be dead.

The elderly or their caregivers often confuse the signs of depression with aging. Many people believe that you sleep more as you get older, and that is not true. The elderly sleep the same amount of hours, but their sleep is lighter and broken, says Harris. If they are sleeping more it could be depression.

It is not depressing to be old, either. Although more friends die as a person ages and their health has a tendency to deteriorate, depression is not a natural result.

People often confuse depression with Alzheimer's disease because one of the symptoms is loss of memory. "People who are depressed will say they forget everything, and they don't remember where they put anything," Harris explains. "They forget appointments, and they forget to call people. For many people, it is a very profound symptom of depression."

Too much concern for physical health could be a sign of depression. The elderly become overly concerned because they feel tired and can't sleep, or they are sleeping all the time and can't think right. This often causes them to seek out their physician, which is a good place to start when signs of depression appear, says Harris.

"What we try to do when we diagnose depression is get a clear view of the person's overall health," says Harris. The signs and symptoms for anemia and an under-active thyroid are similar to depression. In fact, there are a lot of physical conditions that look like depression, she says. **(For information on how the elderly can help prevent depression, see article, left.)**

It is important for the elderly to think about their condition before going to see their physician, says Harris. They need to determine if there have been changes in their sleep, in their appetite, or in their spirit. Have they had any suicidal ideas?

They also should be prepared to give a complete personal and family history of depression. A fair amount of detective work is needed to figure if any family members suffered from depression; because years ago, people didn't seek help and frequently weren't diagnosed, says Harris.

There is no personality profile for depression.

However, a couple of studies revealed that people with particular character traits might be more likely to become depressed.

People who think negatively much of the time, in other words, those who are pessimists, were identified as well as those who have strong dependency needs and those with low self-esteem who in general feel powerless. People more likely to commit suicide are impulsive. "Those who tend to have very powerful feelings and impulsively act on them are more likely to commit suicide," says Harris.

While many believe that only people who suffer from severe depression commit suicide, that is not true. Moderately depressed people who are intoxicated with drugs or alcohol may commit suicide. "It depends on how impulsive the person is feeling and if he or she has taken any substances. You could be only moderately depressed and kill yourself if you have been using drugs and are in a very impulsive way," says Harris.

If an elderly relative seems suicidal, it is wise to ask him or her if he or she has thought of suicide, Harris advises. Simply say: "You seem so sad. I am wondering if you would consider suicide?" Also, if there are signs of depression, help the person seek diagnosis and treatment.

"It is very rare to find someone who doesn't respond to treatment," she says. ■

Follow-up calls improve discharge instructions

Contact helps with problems, reinforces opportunity

A process for making follow-up calls after new moms are discharged with their babies from Sacred Heart Medical Center in Spokane, WA, has helped to improve discharge instructions at the health care facility. Performance-improvement projects have been initiated by reviewing the answers to the questions asked during the interview. This process can work just as well in other areas.

This helps pinpoint areas where the information taught might not be clear, says **Julie Emery**, RN, assistant nurse manager at the Women's Health Center. For example, if many of the women have questions about sore nipples while breast-feeding, more education may be needed on this topic, she says.

Postpartum follow-up calls are made 24 hours after discharge; again at 72 hours, and a third call is made if the mother is having difficulties with the baby. Registered nurses who work the help line at the center make the calls.

The calls are scripted so all nurses ask the same questions. A comment section on the assessment form is used to note details on each patient because the nurse that makes the call 24 hours after discharge doesn't necessarily call back at the 72-hour interval.

The questions focus on both the mother and the baby. For example, the nurse will ask the mother questions about her breasts to uncover problems such as engorgement. Questions about the baby include the position he or she is sleeping in, because Sacred Heart recommends that babies sleep on their back to help prevent sudden infant death syndrome.

The calls provide an opportunity to remind new mothers about their baby's immunizations and follow-up visits. A general question about how staff at Sacred Heart could have made their stay better also is included.

Very often, a new mother has problems with breast-feeding. If the RN making the call can't answer her questions, a lactation consultant takes the call. "We always have one lactation consultant working the help line," says Emery. The new mothers can make an appointment to see one of the lactation consultants at the Women's Health Center as well.

If patients cannot be reached at the 24- or 72-hour intervals a message is left on their answering machines only if they have given their permission to do so. "If we can't reach them at all after the 72 hours, we send a postcard and tell them to call us any time," says Emery.

Teaching for new parents is initiated before the birth of the baby during a one-hour pre-delivery visit at the Women's Health Center. Information about the visit is mailed to the couple so they can go over the questions before their appointment. Teaching includes care of the mother and baby following delivery, safety concerns, and breast-feeding. The couples also create a birth plan.

SOURCES

For more information about follow-up calls after discharge, contact:

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"We get their chart started here, and then we take it over to the birth place and it is continued there. This gives us an opportunity to get to know them a little bit before we talk with them later on the phone after they deliver," says Emery.

Initiating other calls

The postpartum calls through the help line at the Women's Health Center have been so helpful to patients that the nurses have begun calling women following such surgeries as hysterectomies, mastectomies, and bladder repairs.

The calls are made 72 hours following discharge, with questions covering such issues as pain, care of their incision, problems with drains, whether they have enough help at home, and if they have made their follow-up appointment with their physician.

If pain is not being controlled effectively, the patients are told to call their physician. When a problem is detected, the physician is notified and the Health Center faxes the comment sheets to his or her office.

"We are in the process of expanding our program and will be calling more people," says Emery. Next, women who have to return for additional views following a mammogram will be called to ensure that they make their appointments and to answer any questions they may have.

"In health care, I think follow-up calls are beneficial in all areas," says Emery. People often don't understand the information they are given or they don't have enough time with their physician to have all their questions answered, she explains. ■

Teaching aids: Surveys keep resources on track

Pamphlets and videos are valuable tools

Educators often emphasize the fact that it is the nurse, pharmacist, dietitian, or other discipline who does the teaching, and handing a pamphlet to a patient is not teaching. Yet most would agree that pamphlets and videos are valuable tools in that teaching process.

There are a variety of ways to ensure that all those involved in educating patients have the tools they need for teaching. At City of Hope National Medical Center in Duarte, CA, needs assessments are conducted among staff and patients. For example, staff in the education department recently conducted interviews among staff in radiology and surveyed patients at the same time.

"As part of our needs assessment among staff, we ask, 'What are your greatest challenges in educating patients and their families?' Asking them to identify the 'greatest' challenges helps us in identifying priorities among the various needs that staff may identify," says **Annette Mercurio**, MPH, CHES, manager of patient, family, and community education at City of Hope.

Identify barriers

Lack of patient-teaching resources, such as printed handouts and audiovisual aids, only is one barrier to teaching. Lack of time, language barriers, and even difficulty with access to the patient can hamper education. Staff can select any one of these as the most challenging barrier to teaching patients, but if resources were pinpointed as a problem, they would become a priority. **(See examples of City of Hope's survey methods inserted in this issue.)**

Another question on the staff survey that helps identify materials needed on specific topics reads: "If patient, family, and community education could help meet one patient education need within respiratory therapy, what need would you like us to work on?"

Choices include:

- consultation regarding best approaches to use when teaching our patients;
- obtaining or developing printed patient teaching materials on topics such as (insert topics);
- obtaining or developing video patient teaching materials on topics such as (insert topics);
- obtaining additional comments.

Staff at University of Wisconsin Hospital and Clinics in Madison most often approaches the education department with requests and suggestions for resources. "In addition, I follow the organizational strategic initiatives to ensure that we have materials pertinent to those highly visible clinical areas," says **Zeena Engelke**, RN, MS, patient education manager at the health care system.

Calls from staff to the learning center asking about resources and how to deal with difficult issues help pinpoint difficult areas of teaching that need to be addressed.

The department representatives who sit on the

SOURCES

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patient education committee are good connections and helpful for material needs, says **Diane Moyer**, MS, RN, program manager for Consumer Health Education at The Ohio State University Medical Center in Columbus. These representatives also act as the contact in between committee meetings and deliver requests for videos and written materials.

Word about patient education difficulties staff are having also comes from these representatives. Inservices that address particular concerns or issues of staff on units often are offered. At that time, Moyer evaluates the need for additional materials to aid in teaching. Sometimes staff simply aren't aware of available resources in the system, says Moyer.

A tracking system that can be used to identify material use often helps to uncover which resources need to be better promoted among the staff. At the University of Wisconsin Hospital and Clinics, a database tracks use of resources by unit and clinic and other vital statistics such as the last time the material was revised.

Periodically, staff in patient education look at the data to determine if the right units and clinics are using Health Facts, says Engelke. "If they aren't, it's usually a matter of letting the staff know that they're available. More often than not, it's a lack of knowledge of the available resources rather than resistance to use them," she says.

At City of Hope, the education department orders materials for all patient care areas, so if an area isn't requesting material, it indicates that the resources aren't being used, says Mercurio. Also, focused studies, usually surveys, are used. With this method, staff are asked a series of questions about integration of materials into teaching and barriers to use of materials.

For example, on one unit, staff indicated on a survey that lack of a well-organized collection of materials on the unit was the top barrier to their use of materials. As a result, the patient education department worked with a designated nurse on that unit to catalog and reorganize their collection of materials. "We conducted a follow-up survey and found improvement on all measures related to materials use," says Mercurio.

Other factors that often signal the need for new resources or updated materials include changes in technology, treatments, new equipment, and changes in service areas, says Moyer. ■

Good posture can avert musculoskeletal woes

Include the rule of opposites and micro-breaks

Good posture is important because that is when the musculoskeletal system works best, says **Scott Bautch**, DC, past president of the Occupational Health Council for the Arlington, VA-based American Chiropractic Association (ACA) and a practicing chiropractor in Wausau, WI. "Muscles, ligaments, vertebrae, disks, and nerves are meant to be in good posture," he says.

When people sit with their head forward reading, they strain their upper back, shoulders, and neck. Good posture allows the muscles to work more efficiently and the joints to remain in their correct position only carrying weight that they were designed to carry, says Bautch. If joints have to work harder because of poor posture, they degenerate faster.

According to the ACA, musculoskeletal conditions in the United States cost an estimated $254 billion a year. They report that one out of seven Americans has a musculoskeletal impairment. **(For more information on how to correct these problems, see article on p. 34.)**

For people to have good posture, they need to be aware of where their joint is most comfortable, says Bautch. Neutral posture for the wrist is when hands are hanging down at the side and the wrist is not curved up or down and left or right. Good posture for the neck is directly over

SOURCES

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the top of the shoulders; and for the back, directly over the top of the hips. "The further a person gets away from neutral posture, the more unfriendly it is to the joint," he adds.

People have good posture when standing if someone can look at them and draw a line through their ear toward the middle of their shoulder right through the hip joint on the outside of the leg to the bone that sticks out on the side of the ankle, says Bautch.

Good posture while sitting means that the normal curves to the spine remain. The part of the back above the beltline should have a small concavity or look like a reversed C, says Bautch. The mid-back should be fairly straight, and there should be a slight curve at the neck.

Teach the micro-break habit

"People have a hard time keeping good posture for more than 10 minutes if they are sitting in the same position," says Bautch. That is why jobs that require a person sit at a computer for long periods of time can cause pain and injury. **(To learn more about creating a workstation that promotes good posture, see article, p. 34. To learn about how computers impact children and other factors that contribute to poor posture in children, see article, right.)**

Even when a workstation is set up correctly, the body needs to move. Therefore, it is important that those working at a computer take regular micro-breaks. "A micro-break is what I call the rule of opposite. I need to use the muscles I am resting and rest the muscles I am using. If I am leaning forward even a little bit I need to bend backwards," says Bautch.

For example, when people turn their head to the left to see materials they are typing, they need to turn their head to the right and backwards during their micro-break. If arms are down to the side and palms down typing, they need to straighten their arms out away from the body and then take them behind them, turning the palms out.

People need to start out in good posture with a good workstation, then take a break about every 10-15 minutes for one to four seconds and do something during the break that changes the posture.

With good posture, there must be motion and that equals micro-breaks, says Bautch. Doing something that puts a person in an awkward position or not moving at all is equally hard on the joints. Everyone will develop problems at the computer unless he or she does something to intervene. About 80% of the people who work at the computer for more than six hours a day develop neck, shoulder, upper back, or wrist pain within three years, he says.

The rule of opposite applies to all activities. When people work on an assembly line twisting to the right all the time, their posture will be right and forward, says Bautch. Therefore, their micro-break should include movement in the opposite direction. People who play tennis or golf should take a few minutes to swing the club or racket with the opposite hand. People shouldn't even sit in the same chair every night to watch TV or to eat dinner, he says.

Because most people walk with their chins out in front of them, everyone can benefit by stretching backwards, says Bautch. This should include shoulder rolls, putting hands on the hips and stretching backwards, and putting hands above the head and leaning back as far as possible.

"It's important to remember the rule of opposites in everything we do," he says.

(Editor's note: The American Chiropractic Association has designated May as Correct Posture Month.) ■

Good posture important in developmental years

Build good posture habits when children are young

From the moment a child begins to walk, gravity takes its toll on the body with poor posture, says **Scott Bautch**, DC, past president of the Occupational Health Council for the Arlington, VA-based American Chiropractic Association (ACA) and a practicing chiropractor in Wausau, WI. Therefore, it is important to develop good habits when the child is young.

Children develop their postural tendencies between the ages of 4 and 6, so this is a good time to teach them how to maintain good posture in

all they do, says Bautch. By the time they are 8 years old, they have developed posture habits, either good or bad. If the teaching takes place during adolescence, it is even more difficult to develop good posture and change bad habits.

Children too sedentary

It's important to help children develop a habit of motion. In the United States, most are too sedentary, playing computer games for hours or watching TV. Motion is part of good joint maintenance, says Bautch.

In addition, children need to learn good posture when sitting at the computer or reading a book and even sleeping. Sleeping on their stomach is hard on their body, and parents should not let children form this bad habit, says Bautch.

If a child's feet don't touch the floor while using the computer, a footrest or box should be placed under their feet. Parents also might consider purchasing a smaller table for homework, so their children's feet touch the floor. The computer monitor should be at or below a child's eye level, according to the ACA.

The enormous backpacks children lug around are detrimental to good posture as well. If children carry a heavy backpack on one shoulder during their growing years, it might take the spine a long time to return to neutral position once the weight is removed, says Bautch. It may even cause permanent changes in the spine, he says.

The ACA recommends that children use both straps on their backpack and that the contents not weigh more than 10% of the child's body weight. Also, the straps should be padded.

By the age 14, 7% of children have back pain that affects their daily living as a result of poor posture, says Bautch. ■

Pain is a telltale sign of poor posture

Uncover cause to correct problem

Pain could be a sign that a person has had poor posture for a long time. It often occurs after the body has adapted as far as it can to poor posture, says **Scott Bautch**, DC, past president of the Occupational Health Council for the Arlington, VA-based American Chiropractic Association (ACA) and a practicing chiropractor in Wausau, WI.

That is why it is important for massage therapists, chiropractors, and other practitioners to try to determine what caused the pain, not simply treat it. For example, if a baseball pitcher has pain in the shoulder, it is important to find out how he throws, says Bautch.

"Treating the pain is certainly important, but the lifestyle change is what keeps [people] healthy," says Bautch.

Pain may be traced to poor posture at the computer and signal the need to analyze the workstation and take frequent micro-breaks. **(For information on what a proper workstation should look like, see article, below. For details on micro-breaks, see article on p. 32.)**

Pain also might be traced to poor sleep posture, or perhaps a woman has been carrying a purse on one shoulder, changing her gait, posture, and structure of the spine.

Even normal trauma should not cause great amounts of pain. When people step off a curb wrong and as a result develop pain in their spine, it probably is because years of poor posture has developed stiffness or lack of flexibility, says Bautch.

When people sleep with a different pillow at a hotel and their neck gets stiff or they travel in a car for a period of time and their body aches, they often blame it on age, but the cause is aging joints. Joints age faster when posture is poor, says Bautch.

The joints can once again become stable, but it takes work, he says. It usually is a combination of exercise and lifestyle change. ■

For best posture, begin with a good workstation

Make station fit from the floor up

To achieve good posture, it is important to make computer stations fit the person as best as possible, says **Scott Bautch**, a practicing chiropractor in Wausau, WI.

Because the average work station from computer keyboard, to screen, and even the desks and chairs are designed for a person who is 5 feet, 10 inches tall and weighs 155 pounds, most people do not fit the workstation. Therefore, they need to work from the floor up for a proper fit.

This means people need to work around whatever is nonadjustable, says Bautch.

If the keyboard and desktop are nonadjustable, then the chair must be adjusted so arms and hands are at the right height. Also, the floor must be adjusted so that legs are at the right angle and that a person's feet are touching.

A chair fits correctly if there are two inches between the front of the seat and back of the legs, according to the ACA. Feet should be flat on the floor, and knees should be at a 90-degree angle. If they are not, then a footrest should be used.

For good neck posture, the middle of a person's chin should be aligned with the middle of the computer monitor. Also, the chair should provide support behind the lower back, says Bautch. ■

New guide improves staff education efforts

Are you one of the many readers of *Patient Education Management* who wears more than one hat? To help with multitasking and multiple responsibilities, a new book has just been released that may help. The Joint Commission Guide to Staff Education is a collaborative effort between the Joint Commission on Accreditation of Healthcare Organizations and the Health Care Education Association (HCEA), provides advice from experts in the field and examples from organizations breaking new ground in health care staff education.

Topics covered in the guide include:

- competency assessment;
- orientation for new staff mentoring, preceptorship, and coaching;
- technological advances in learning mediums;
- ensuring administrative support;
- budgeting;
- using consultants vs. in-house resources;
- linking staff development to business strategy;
- documentation.

The cost of the 235-page book is $55 and $46.75 for HCEA members. To order, visit: www.jcrinc.com or call (630) 792-5800. ■

Share your success stories with *PEM*

Have you created patient education programs that provide solutions to persistent problems in patient education or come up with innovative teaching ideas? If so, we would like to profile your program or idea in *Patient Education Management*. We are interested in all types of topics including educational materials, teaching methods, improved documentation techniques, and staff development. We also have opportunities for guest columnists.

If you would like more information or want to suggest an article idea or column, please contact Susan Cort Johnson, editor, *Patient Education Management,* at: (530) 256-2749 or suscortjohn@onemain.com. ■

COMING IN FUTURE MONTHS

- HIPAA-related patient/family education issues
- Understanding the aging process and its impact on patient education
- Nonpharmacological methods for pain control in children
- Educational tactics to prevent teen pregnancy
- Prompts for patient education

CE Questions

For more information on the continuing education program, contact customer service at (800) 688-2421, e-mail: customerservice@ahcpub.com.

9. Which of the following methods help new employees remember what they are taught about the patient education process during orientation?
A. Presenting case studies
B. Serving refreshments during the session
C. Providing a packet with samples of resources
D. All of the above

10. To help prevent the onset of depression in the elderly, they should be taught:
A. To eat a balanced diet
B. To learn stress-management techniques
C. To avoid social isolation
D. All of the above

11. To determine if staff have the tools needed for teaching, it is a good idea to survey both staff and patients?
A. True
B. False

12. The pathway for asthma education created at Children's Hospitals and Clinics in Minneapolis to help prevent readmissions includes which of the following components?
A. Instruction on over-the-counter medications
B. A class taught by pharmacists
C. Teaching on good nutrition
D. Education on playing sports with asthma

Answers: 9. A; 10. D; 11. A; 12. B

Promotion of events on patient education

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

CE objectives

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

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

Focus on Pediatrics
PATIENT EDUCATION MANAGEMENT'S MONTHLY SUPPLEMENT

Hospital's asthma pathway treats and teaches patients

Program returns patients to normal living

An asthma pathway was implemented at Children's Hospitals and Clinics in Minneapolis because this chronic disease is the No. 1 hospital admission. The pathway creates a plan for the course of the patient's hospitalization that helps to get the asthma under control, educates the patient and family members, and gets the patient back to a normal lifestyle quickly.

The average length of hospital stay is 2.4 days, and during this time patients undergo intense education. The teaching is a collaborative effort between nursing staff, respiratory therapists, and pharmacists, says **Diane Alexander**, RPh, a clinical leader with the department of pharmacy.

Getting started

The nurses get the patients and their families started by distributing a packet of educational materials. Nurses discuss things that may trigger the patient's asthma and what to avoid.

The respiratory therapist teaches about peak flow meters and how to use them to monitor lung capacity and administer medications accordingly. He or she also teaches about the use of a nebulizer and the metered-dose inhalers.

Pharmacy teaches a class Monday through Friday that families are to attend before the child is discharged. Children are encouraged to attend the class if they are old enough to understand the information.

"We usually figure that if they are using a metered-dose inhaler, they can understand their treatment. If they are 7 or older, we would like them to come with their parent to the class," says Alexander.

The pharmacist knows what medications the patient is going home on, tailors the teaching to these specific medications, and answers any questions the family has. The pharmacists try to limit the class size to two patients, because any more than that makes the classes too long with so much of the information individualized.

It usually isn't difficult to keep the class size down because the hospital admits about two asthma patients a day. If a family can't make the class, a pharmacist tries to do the teaching session in the patient's room, but that request is harder to accommodate, says Alexander.

What to cover

Class curriculum covers inflammation, triggers and what to avoid, how the different prescribed medications are used to control asthma and their importance, and compliance. A flip chart is used to guide the educational session to ensure that all pharmacists cover the same information with all families. About seven pharmacists teach on a routine basis.

During the class, patients receive a red/yellow/green zone sheet that the pharmacist fills out so patients know which medications to take when their peak-flow meter readings indicate that they are in a yellow or red zone. The respiratory therapist has filled in the peak-flow meter numbers at the top of the sheet.

"They know by their peak-flow numbers if they are going into that zone and they start adding therapies if they need to depending on what their red, green, and yellow zone tell them to do," says Alexander.

The main goal of the pathway is to reduce the number of readmissions, and the health care system has accomplished this. With the education program, patients and their parents recognize the signs and symptoms of an asthma problem early and know what they should be doing next, she says. ■

SOURCE

For more information on using a pathway to guide education for pediatric asthma patients, contact:

- **Diane Alexander**, RPh, Clinical Leader, Department of Pharmacy, Children's Hospitals and Clinics, 2525 Chicago Ave. S., Minneapolis, MN, 55404. (612) 813-6542. E-mail: diane.Alexander@childrenshc.org.

Binder puts cancer info in its place

Standardized teaching with room for special inserts

When children are diagnosed with cancer, a lot of education needs to take place. Yet it doesn't happen all at once, but over time through several hospital admissions and outpatient clinic visits.

That is why the AFLAC Cancer Center at Children's Healthcare of Atlanta uses a three-ring binder filled with all the information — both generic and specific — needed to teach families.

"It makes it easy for staff because instead of having to pull all the information individually each time a patient is diagnosed, it is all in one place," says **Winnie Kittiko**, RN, BSN, MS, a clinical educator at the AFLAC Cancer Center. The binder also provides a checklist for teaching, because all the topics to be covered are included in the binder.

The sections in the binder cover many topics. One covers the roles of the health care team members. Included is the family support team, which consists of a chaplain, social worker, child-life specialist, and schoolteacher. Also reviewed are the daily routine of the hospital and the plan of care.

Another section covers the diagnostic workup that is done when trying to diagnose the disease and how to prepare the child for the appropriate procedures. However, this is taught before families receive the binder. "We don't give the binder to the family until we know for sure there is a cancer diagnosis," says Kittiko.

The binder has information on the informed consent process because about 90% of children are treated for childhood cancer on a clinical trial or at least a treatment protocol, she says. Children's Oncology Group in Bethesda, MD, is the primary research organization for childhood cancer and directs all the treatment protocols. The consent forms average 12 pages.

After the informed consent section, there is a section that prompts the review of the child's treatment protocol and the road map. To qualify for a clinical trial, a child's lab test must be within a certain range, and he or she must have good kidney and liver function. "If children don't meet all the qualifications, they can still be treated according to the protocol, but they won't be entered in the study," says Kittiko.

The road map explains such things as what point the child will be given certain drugs and what tests he or she may need. During the education on the treatment protocol, families learn about the drugs the child will be taking and their side effects. There usually are many side effects to cover, says Kittiko. These include anemia, loss of appetite, weight loss, nausea, vomiting, and diarrhea.

Other topics covered include home care, such as giving intravenous fluids and pain management.

Routine medical information also is covered, such as immunizations, because children with cancer usually don't keep their regular pediatrician appointments during the treatment.

Although all patients need education on the topics in each section, the specific information is not the same for all patients. For example, patients will have different tests and be given different drugs. In such instances, individual teaching sheets are given to families to insert in the proper section of their binder.

A file cabinet contains information on each drug and easily is accessible for teaching purposes. Nurses also have access to teaching sheets online. Frequently used sheets can be ordered from the materials management area in packets of 100, yet staff is encouraged to pull the sheets offline and print as needed to ensure that the latest information is being given.

Currently, the information in the binder is being standardized, with the two hospitals within the system merging their manuals so all patients receive the same information. During this process, a patient and family education record is being developed. The five-page document mirrors the headings on the binders and health care professionals can look in those binders for specific details on what was taught.

It is an interdisciplinary record, so the chaplain, social worker, and child-life specialist document on the sheet in addition to other disciplines such as nursing.

In addition to teaching sheets, parents are given copies of lab results and test results to keep in the binder. It is Kittiko's goal to eventually have the entire binder translated into Spanish. ■

SOURCE

For more information on creating a binder for pediatric cancer patients to standardize education, contact:

- **Winnie Kittiko**, RN, BSN, MS, Clinical Educator, AFLAC Cancer Center, Children's Healthcare of Atlanta, 1001 Johnson Ferry Road N.E., Atlanta, GA 30342-1600. Telephone: (404) 250-2368. Winona.Kittiko@choa.org.