Patient Education Management™

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

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IN THIS ISSUE

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Making patients part of the safety effort; tip sheet helps reduce medical errors

Teach patients how to be their own best advocates for safety

While medical errors are not a new phenomenon, they suddenly are becoming high profile due to government reports, media coverage, and standards to improve patient safety by such accrediting agencies as the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations.

According to the Agency for Healthcare Research and Quality in Rockville, MD, more people die from medical errors than from motor vehicle accidents, breast cancer, or AIDS. These mistakes occur in all areas of health care, including medication errors, surgical mishaps, incorrect diagnosis, equipment problems, and confusion with lab reports.

To help reverse these statistics, health care facilities are working on ways in which to partner with patients to create the safest care experience. To determine the best way to teach patients how to be part of the safety team, a committee was formed at the University of Washington

EXECUTIVE SUMMARY

Patient safety currently is an important education focus in health care institutions as staff members try to determine how to incorporate the patient and his or her family into the safety team. While providing patients with information on how to ensure their safety is one part of the education process, there is another. Patients must learn a new role and also how to speak up when a safety issue arises. In the this issue of *Patient Education Management,* we look at how health care institutions are teaching patients their role in safety. We will continue to cover this topic in future issues by featuring the efforts of different institutions.

Medical Center in Seattle. This committee developed a tool that can be used in any clinical area throughout the institution.

"The overall objective of the committee was to create a tool that would clearly help patients understand what their role is in the partnership to create a safe care experience," says **Cezanne Garcia**, MPH, CHES, manager of patient and family education services at the University of Washington Medical Center.

Staff selected to sit on the committee looked at such issues as communication and advocacy, infection control, specific treatment procedures, access to medical records, medication, falls, pain management, and how to deal with a medical error if it happens.

The educational piece the committee created gives patients tips about being involved in their care, about how family members and friends can help with their care, how they can help prevent the spread of infection, what they should know about their medications and medical record, and how to respond if a medical error should occur.

During the process of creating this tool, several issues that impact patient safety became apparent. For example, people do not all have the same definition of patient safety. Some think of fall prevention while others think of patient safety as wearing seat belts.

When the first draft of the patient safety tip sheet was complete, eight consumers were asked to evaluate it. During the open-ended dialogue about the piece, it became apparent that they all had a different perspective of patient safety, says Garcia. "It wasn't until they had read the tool that they understood what patient safety was," she says. **(To learn more about the evaluation process for the implementation of the patient safety tool at the University of Washington Medical Center, see article on p. 88.)**

Empowering patients to speak up

Another issue that surfaced through discussion with consumers is that they did not always feel comfortable following some of the instructions to help create a safe environment. For example, several consumers told the surveyors that they would be uncomfortable asking their physician to wash his or her hands before providing care.

Therefore, the committee changed the copy and instructed patients to ask everyone to wash their hands, visitors and health care providers alike. In that way, they would become used to the practice.

Another barrier to patients or family members fully becoming a part of the safety team is the reluctance to question or challenge a health care worker who is in charge of their care, says Garcia. Patients and family members might feel vulnerable, she says.

In addition, while it is possible to coach patients to speak up to prevent medical errors, there is no control over how they convey the information to staff. Often, patients are under extreme stress and discomfort.

Also, the issue may not always be a safety factor, but staff need to be appreciative when the information is offered and not brush the patient off. "I

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Editor: **Susan Cort Johnson**, (530) 256-2749.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Christopher Delporte**, (404) 262-5545, (christopher.delporte@ahcpub.com).
Production Editor: **Nancy McCreary**.

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Editorial Questions

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

think there is a lot of legwork that needs to be done with staff. We need to create a climate where our staff responds positively when patients and families draw attention to key issues," says Garcia.

In a self-study module created for nursing staff at Baptist Health South Florida titled "Promoting a Culture of Patient Safety," nurses are told that it is through open, ongoing communication and education that patients can be incorporated into health care decisions. "Teaching patients and family members to observe, question, and assist in the proper manner can contribute to the patient's care in a safe, effective way," the manual reads.

The manual lists several key aspects of education that will promote a culture of safety that:

- includes the active involvement of the patient and family;
- instructs the patient to provide all information including prescribed medications, over-the-counter medications, herbals, and alternative therapies being used;
- informs the patient to provide information about allergies and adverse reactions;
- informs patients to ask questions in the hospital, in the physician's office, and at the pharmacy to be sure they understand prescriptions;
- informs patients to ask questions about their treatment plan to be sure they understand what will be done;
- provides patients with written information;
- teaches patients about their condition and helping them to be knowledgeable about their health, history, and medications;
- teaches patients to follow instructions on medications or other treatments to obtain the desired outcome.

Safety starts at admission

Providing instruction for patients on how to participate in their safety begins upon admission to one of the hospitals within the Baptist Health system. At that time, patients are given a patient safety tip sheet that covers a variety of issues, including medication safety, and the prevention of infections and falls, says **Geri Schimmel**, RN, MS, educational consultant at Baptist Health South Florida and co-author of the self-study module. **(See sample of the tip sheet inserted in this issue.)**

Safety is further promoted through instruction. Patients are given information on all the medications the physician prescribes while they are in the hospital. It is not uncommon for either the patient or a family member to question a new medication if he or she has not received instructions, which is what the tip sheet advises him or her to do, she says.

Physical therapy not only teaches patient safety in the hospital environment but also about preventing falls at home.

In addition, the nurse that coordinates the patient's care also can ask for multidisciplinary screenings to help with educational needs. For example, if the nurse determines that a patient's family needs some additional instruction on diet he or she can ask for a consult with the dietitian. It is not the nurse who is assessing and teaching on diet, but the nurse contacts the discipline with the expertise.

Education ultimately does work to create the safest care experience, agrees Garcia. For example, teaching patients how to prepare for surgery creates a safer surgical experience, she says. Yet patients need to understand their part in promoting safety and that is the new focus.

The most difficult part of the patient safety tip sheet to create was the section on responding to medical errors, says Garcia.

"In an ideal setup there is a straightforward acknowledgement and admission of error, but if we talk to our risk managers, they want more caution," she says.

The guidelines currently read:

- Ask for a full explanation of the error;
- Expect an open discussion;
- Ask about how your error will affect your health status;
- If you feel your questions are not being answered, ask to talk to our patient relation staff to assist you in finding answers to your questions;
- If you have suggestions on how to prevent errors, share them with your care provider or our patient relation staff. ■

SOURCES

For more information about creating tip sheets on patient safety, contact:

- **Cezanne Garcia**, MPH, CHES, Manager, Patient and Family Education Services, University of Washington Medical Center, 1959 Pacific St. N.E., Box 358126, Seattle, WA 98195. Telephone: (206) 598-8424. E-mail: ccgarcia@u.washington.edu.
- **Geri Schimmel**, RN, MS, Educational Consultant, Education Services, Baptist Health South Florida, 8900 N. Kendall Drive, Miami, FL 33176-2197. Telephone: (305) 273-2510. E-mail: geris@baptisthealth.net.

Pre-testing patient safety tool helps ensure success

Evaluation helped create clear copy for patients

The University of Washington Medical Center in Seattle is in no hurry to implement a tool an ad hoc committee created to teach patients their role in safety issues. It is running it through a series of pre-tests before implementing it housewide.

Evaluation began with eight patient advisors who were sent the tool and then interviewed on the telephone. It was a good way to identify problems before the committee proceeded with more structured pre-testing of the tool, says **Cezanne Garcia**, MPH, CHES, manager of patient and family education services.

Five of the eight people said that they would feel uncomfortable asking their health care provider to wash his or her hands, so the instructions were changed to prompt the patient to ask everyone to wash their hands.

The advisors also said they liked the sections of the tool that had bulleted information vs. the parts that had narrative instruction. As a result, the committee changed the tool providing bulleted lists in all sections.

On the advice of the reviewers, the title was changed as well. The original title was "Patient Safety: Be Our Partner." The new title is "Partnering with You to Make Health Care Safer." There was some confusion on the exact meaning of patient safety and that prompted the change.

Once the tool was revamped, the second phase of the testing began. In this phase, 30 patients in the inpatient and outpatient oncology setting were given the tool along with an evaluation form and asked to provide feedback on whether they found the tool useful and easy to understand.

In patient care rooms, the tool and evaluation form was left by the interviewer who returned in about 15 minutes to pick up the evaluation sheet. In the waiting room, the materials were distributed to several patients and then the interviewer simply waited until all had completed the task.

One patient who reviewed the tool wrote, "These are clearly the basics, but they give me a good solid foundation to know what I can do."

Once the tool is fine-tuned, it will be implemented in three inpatient cancer areas and an affiliate. "We are going to implement it systemwide for a particular patient group. One of the things we want to learn a little bit more about is how we can best prepare our staff who work in these areas for what may be a potentially stronger advocacy voice that patients or family members may present by use of this tool," says Garcia.

Oncology service was selected as the test site because the instructions are aligned with the current practices in this patient care area. Hand washing is a paramount issue with oncology patients as well as infection control, as is careful monitoring of medication.

Once it is clear how best to orient staff to the tool that will be given to patients at admission or in appointment packets, it will be launched housewide, says Garcia. This should take place in three to six months, she says. ■

On-line fact sheets provide patient safety education

Free and easy downloadable information

Before creating a tool to help patients and their families understand their roles in patient safety, **Cezanne Garcia**, MPH, CHES, manager of patient and family education Services at the University of Washington Medical Center in Seattle, conducted a literature search to determine what information was available.

Although the committee assigned to the task decided to create a tool that was more institution-specific, Garcia uncovered a multitude of educational sheets on patient safety created by the Rockville, MD-based Agency for Healthcare Research and Quality (AHRQ). All can be downloaded for free at the agency's web site: www.ahrq.gov/consumer/index.html.

The following is a summary of the information on some of the educational handouts to improve patient safety:

- **Five steps to safer health care**

The first step to safer care is for patients to voice their concerns and insist on answers to their questions in terms they can understand.

Keeping a list of all medicines taken whether prescription, over-the-counter medicines, or herbal supplements is the second step for safe health care according to AHRQ. This list, along with drug allergies, needs to be shared with a patient's physician and pharmacist.

SOURCE

For more information about patient safety material, contact:
- **Agency for Healthcare Research and Quality**, 2101 E. Jefferson St., Rockville, MD 20852. Web site: www.ahrq.gov.

Step three is to insist on receiving results from tests or procedures either in person, on the phone, or in the mail. It's also important to know what the results mean in terms of personal health care.

Step four instructs patients to discuss options with their health care team if they need to be hospitalized. Some hospitals specialize in certain procedures and may be a better choice. Before leaving the hospital patients should be sure they understand the discharge instructions and know how to get follow-up care.

The final step is for patients to be sure they understand what will happen if they need surgery. For example, they need to know exactly what will be done, how long the surgery will take, and how they will feel during recovery.

• 20 tips to help prevent medical errors

This instructional piece advises patients to be an active member of their health care team. A good portion focuses on medicine instructing patients to not only provide their physician information about the medicines they take but to get information about prescribed medications. They should be sure they understand how to measure medications and the correct dosage.

The final instruction to patients is to learn as much as they can about their condition and treatments not only from their health care provider but from other reliable sources as well.

A tip sheet focusing on the prevention of pediatric medical errors is similar in content to this fact sheet.

• Quick tips — When getting medical tests

According to this AHRQ tip sheet, a study found that between 10% and 30% of the Pap smear test results that were labeled "normal" were not. That's why patients need to make sure that tests are done correctly. This government agency advises patients to ask which lab the clinic uses and why that particular laboratory was selected. It may be that the patient's health plan requires that tests go to that lab.

Patients should check to see if the lab is accredited. The College of American Pathologists [(800) 323-4040] and the Joint Commission on Accreditation of Healthcare Organizations [(630) 792-5800] both accredit labs.

The Food and Drug Administration approves facilities that do mammograms; therefore, there should be a certificate hanging on the wall.

• Quick tips — When talking with your doctor

It's important for patients to give physicians a complete health history without waiting to be asked, according to the AHRQ. That includes personal information that the patient might find embarrassing. Patients should keep an up-to-date written health history.

They also should give their physician a list of the medications they take that includes the dosage and frequency. Alternative medicines and complementary therapies should be disclosed as well. Other medical information that should be given to a patient's physician is past test results and X-ray film.

In addition to providing information, patients should come prepared to get information. That means writing down questions in advance with the most important ones listed first. To remember what is said, patients might try taking notes or asking permission to use a tape recorder. Requesting information to take home, such as written instructions, is another way to remember what was discussed during the visit.

Patients need to take the initiative to follow up once they leave their physician's office. That means they need to call the clinic if they have questions, their symptoms get worse, or they don't receive their test results. Also, if their physician has told them to have certain tests or to see a specialist, they need to call for an appointment. ■

Health care education week is a time for outreach

Plan events to get word out on patient education

After participating in Health Care Education Week last year, staff in the Patient, Family, and Community Education Department at City of Hope National Medical Center in Duarte, CA, decided to participate again this November. What they will do depends on their budget, says **Benjamin T. Laroya**, RN, BSN, OCN, patient and family education coordinator.

Last year, they kept activities simple because they were working on a limited budget and didn't have much lead time, says Laroya.

EXECUTIVE SUMMARY

This year's Health Care Education Week is Nov. 2-9. Its purpose is to acknowledge the important role of the educator in health care, as well as to promote patient, family, and consumer education. To help patient education managers plan activities, *Patient Education Management* will print activities used by health care institutions to celebrate the observance in this issue and the September and October issues as well.

They set up a display table in a busy hallway where they could reach both staff and patients. Each day, a different department worked the table, offering materials and demonstrations on what it did in the area of patient education. For example, the respiratory department promoted its smoking cessation program.

Topics covered by various departments during Health Care Education Week included lung cancer detection, breast cancer prevention, lymphedema program, fatigue, pain education, cardiovascular risk reduction program, and the diabetes education program. There also were CancerHelp kiosk demonstrations daily. One evening, an "Ask the Experts" outreach program was scheduled, titled "Living and Coping with Cancer During the Holidays."

Prompting good teaching

To help improve teaching, Laroya printed out slips for writing tips on teaching and invited clinical staff to submit their ideas. He placed a collection box on the table where people could drop the finished forms.

Because nurses often are busy and might not have time to come by the display, Laroya visited clinical areas to hand out the forms as well. He would go back later to collect the teaching tips or someone from the unit would bring them to the collection box.

Participants were given a small gift. Also, their teaching tips were included in the quarterly newsletter on patient education that is distributed to clinical staff.

Before Health Care Education Week, Laroya created a small pamphlet that was an 8-by-12-inch sheet of paper with examples of teaching tips so staff would get an idea of the types of tips that would be useful. The tips in the pamphlet, which had been gathered at a conference, also helped improve staff patient education. **(For a list of tips included in the pamphlet, see article, p. 91.)**

Prior to the observance of Health Care Education Week, Laroya handed out nomination forms for the Outstanding Patient Educator Award. An ad hoc committee was assembled to review the forms and select a winner. Anyone who provided direct patient care was eligible and one individual per unit or department was recognized.

According to selection criteria selection, nominees were expected to:

- go beyond what is expected of patient educators in fostering interdisciplinary teamwork;
- possess unique qualities that distinguish him/her from other employees in the delivery or development of patient and family education;
- demonstrate a commitment to providing patient and family education as an integral part of care (as demonstrated, for example, by consistently documenting educational needs);
- seek feedback from patient/family (e.g., return demonstration, asking questions that require patient to apply/verbalize learning, etc.) and use that feedback to improve teaching;
- use tools and resources such as written materials, videos, referring patients to the Supportive Care Resource Desk/Patient and Family Learning Center, etc.

The education department at Southwest Washington Medical Center in Vancouver does not do anything special for Health Care Education Week. Instead, staff perform special educational activities throughout the year.

For example, during the health care institution's skills fair, which staff attend to get information on all the things they are required to know, the department sets up a table with all its health education materials, says **Mary Paeth**, MBA, RD,

SOURCES

For more information about the ideas for the celebration of Health Care Education Week, contact:

- **Benjamin T. Laroya**, RN, BSN, OCN, Patient & Family Education Coordinator, Patient, Family and Community Education, City of Hope National Medical Center, 1500 E. Duarte Road, Duarte, CA 91010-3000. Telephone: (626) 359-8111, ext. 63826. E-mail: blaroya@coh.org.
- **Mary Paeth**, MBA, RD, Patient/Community Education Coordinator, Education Department, Southwest Washington Medical Center, P.O. Box 1600, 400 N.E. Mother Joseph Place, Vancouver, WA 98668. Telephone: (360) 514-2230. E-mail: mpaeth@swmedctr.com.

Put teaching tips in handout form for staff

During Health Care Education Week at City of Hope National Medical Center in Duarte, CA, **Benjamin T. Laroya**, RN, BSN, OCN, patient and family education coordinator, assembled a list of teaching tips to handout to staff who came by the display on patient education.

He divided the tips into several categories to make them easy to read, which include the following tips:

• Seize every opportunity

— Every time you walk into the patient's room, you have a teaching opportunity.

— Consider patient-nurse interaction on a daily basis. Doing assessment and interaction, and answering patients' questions while providing daily bedside care is patient education.

• Make it personal

— Look for the patient's strengths — family support, the patient's own intelligence and personality style — and tailor your teaching to their strengths. Start at the beginning with hands-on involvement of patient and family.

— Find out how much the patient already knows. Assess the patient's emotions and readiness to learn.

— Individualize education to each patient.

— Good communication is key. Really listen to the patient's concerns.

— Take the time to hear the patient's feelings coming through in his or her words.

— Use open-ended questions. Use anecdotes, life stories, and share experiences. Patients verbalize their feelings or may ask advice.

— Have patient write down questions. With personal matters, have family leave room if patient agrees.

— Talk to them as you would a family member.

— Develop a trusting comfort level with patient.

— Address sexual issues related to the patient's disease and treatment;

— Always include the patient in his/her care. Present the teaching-learning process as being a mutually agreed-upon team goal. Give patients choices to allow control over their situation.

— If the patient comes with his/her family, teach the family as well.

• Timing is everything

— Choose the right time and use simple instructions.

— Wait some time after patient's discussion with doctor, to limit anxiety. Repeat information and follow up throughout the stay.

• Don't bite off more than you (or your patient) can chew

— Keep it simple, short, specific and in laymen's terms.

— Use simple explanations when educating patient and family.

— Choose only one subject at a time.

— Teach a little bit at a time. Too often, educators can provide too much information at once.

• Practice makes perfect

— Ask for return demonstration, hands-on practice.

— Do teaching in several sessions with reinforcement of previous information.

— Repeat, repeat, repeat.

• What and why?

— Make sure that you explain not only what needs to be done, but also why it is done.

— If patient refuses a certain drug, ask why. That can help-may need to change the regimen.

• Use the tools

— Provide teaching record for patient to read and take home, including a phone number to call if they have questions.

— Know where patient resources can be obtained (i.e., booklets, classes, supportive care services, etc.).

— Verbal and written instructions should be provided to patient at all times when teaching is performed so patient can refer back to the instructions when needed. Written materials also allow the patient to ask questions at a later time if they don't understand things at the time of teaching.

— Use visual aids.

— Written information regarding medication side effects along with signs and symptoms is been helpful.

— Set a clear goal and be creative. ■

patient/community education coordinator.

The display includes closed-circuit TV, a computer terminal that can access the intranet to show material, and the *Patient Handbook and TV Guide,* which is the main communication for families, says Paeth. The staff fill out a form after visiting the display that reflects their knowledge of the health education materials available. Questions asked include:

• What is a patient education program from TV channel 13, 14, or 22 I can use?

• Which written handout from the intranet can I use?

• What is a topic my patient can use from the *Patient Handbook and TV Guide?*

For completing the form, employees are entered in a drawing for gift baskets donated by vendors.

The education department currently is soliciting applications from clinical staff who might benefit from attending an education conference sponsored by the Oregon Council of Healthcare Educators that will be held in October. The

department has set aside a small amount of money to pay the registration of a handful of patient educators, says Paeth.

To apply, employees must write a paragraph in the space provided on the form that describes how they have done one of the following:

- gone beyond what was expected of a patient educator in fostering interdisciplinary teamwork;
- shown unique qualities distinguishing them in the development or delivery of patient education;
- demonstrated a commitment to the provision of patient education as a vital component to health care;
- demonstrated excellence in the use of adult/child learning principals;
- made a contribution that had a positive impact on the practice of patient education;
- demonstrated expertise in the development of population-specific patient education.

"Although we haven't done anything during the week that is picked, the things we have tried could be used for a special week if that is what works for the facility," says Paeth.

[Editor's note: The Health Care Education Association (HCEA) and Pritchett & Hull Associates sponsor Health Care Education Week. A packet with various activities and promotions is available for $8 by contacting Pritchett & Hull at 3440 Oakcliff Road N.E., Suite 110, Atlanta, GA 30340. Telephone: (800) 241-4925 or (770) 451-0602. The packet is free to HCEA members.

If you have used Health Care Education Week to promote patient education, we'd love to hear from you about the details of your event. Contact Susan Cort Johnson, (530) 256-2749, or suscortjohn@onemain.com. Please put "Idea for Health Ed Week" in your message title when e-mailing.] ■

Patient educator never tires of research role

A passion for learning keeps job fresh

Barb Petersen, RN, BSN, is patient education coordinator at Great Plains Regional Medical Center, a 116-bed facility in North Platte, NE. While meeting a variety of patient needs, she says a passion for learning keeps her job fresh. Petersen reports to the education director, as do the staff education coordinator, physician and community educator, and computer trainer. All four of these positions in the patient education department are full time.

The most time-consuming part of Petersen's job is producing and distributing patient education materials that have been through the proper review process and are at an appropriate reading level for the medical center's patient population, she says.

Another time-consuming aspect of her job is the diabetes education department that she oversees. It is an American Diabetes Association-certified program and therefore must meet and maintain the required standards. One full-time and one part-time diabetes educator works under her supervision.

She also coordinates the support groups that meet at the medical center making sure that they all are publicized whether a sponsored group, which an employee of the medical center facilitates, or an outside group. Extra duties include supervising health fairs.

Petersen worked her way into the job of patient education coordinator when she needed some extra hours following a maternity leave. "The hospital was getting ready for a Joint Commission visit and needed someone to organize the patient education material. I volunteered to do that, and then a position came open and I slid on over," she says.

She was hired as patient education coordinator in November 1999. Before that, she worked in same day surgery and also with employee health helping with physical screenings and immunizations of newly hired staff.

Petersen went back to school for her bachelor's degree in nursing in 2002 and now is enrolled in a nurse practitioner program. "I enjoy school, so I want to keep going. It opens up a lot of new opportunities whether it be in this position or others there is a lot of room to grow," she says.

In an interview with *Patient Education Management*, Petersen shared many strategies that other patient education coordinators might find helpful. The following is the information she shared:

Question: What is your best success story?

Answer: Petersen recently resolved an educational problem the nursing staff were having with a patient's caregiver on one of the floors. The caregiver's husband was being discharged with a feeding tube following a stroke and she needed to learn such tasks as giving medications through the tube and flushing it. She had refused to take her husband to a nursing home.

Petersen set aside an hour and a half to teach the patient, which floor nurses could not do. She

also pulled together a variety of resources, finding materials on the Internet.

"I put together a custom package just for her. There was some concern about her ability to read, so I focused on videos, pictures, and hands-on instruction," says Petersen.

A love for learning

Question: What is your area of strength?

Answer: "I love to learn. I take on things as a challenge, and I am very organized," Petersen replies. She tells all nurses during orientation that if they can't find the right handout or video for teaching, or if they have a patient with a diagnosis with which they aren't familiar, to give her a call. She likes to find the perfect material for patients and investigate disorders for which she is not familiar.

She manages a heavy workload by creating to-do lists and tracking projects on a calendar. On one side of Petersen's desk are projects she's working on. On the other side are those she has not yet completed. A separate file holds items that other staff members are working on, so she doesn't lose track of anything.

Question: What lesson did you learn the hard way?

Answer: "There is a certain procedure you need to follow in a large organization and you need to make sure you go through the correct channels and get everyone involved when working on policy or a new patient handout," says Petersen.

This often means involving three more committees, but when you try to cut corners, you often end up redoing the handout, she says. If all the proper people are involved, you get better support for the project once it is completed.

Question: What is the most challenging part of your job?

Answer: "There's just so much to do I can't get it all done. With so many demands from the job things pile up and that is frustrating," Petersen says. She likes to complete projects in a systematic fashion, checking them off her list once they are finished, but her workload is overwhelming at times.

Question: What is your vision for patient education for the future?

Answer: "Providing patients with accessible educational materials so that they can take the initiative for learning about their disease or diagnosis would be ideal," says Petersen. To help accomplish this, she would like to have her office in a patient education resource center near the front door of the hospital. She also would like to have patient education kiosks located throughout the health care facility.

SOURCE

For more information about patient education practices at Great Plains Regional Medical Center, contact:

- **Barb Petersen**, RN, Patient Education Coordinator, Great Plains Regional Medical Center, 601 W. Leota, North Platte, NE 69101. Telephone: (308) 535-8640. E-mail: Petersen@mail.gprmc.com.

Preparing for Joint Commission

Question: What have you done differently since your last Joint Commission visit?

Answer: "We have been doing a lot more chart audits to see if patient education and pain assessment are being documented," Petersen says. Another important area is medication safety, so she also has been auditing charts to make sure that staff are providing proper information on medications to patients and documenting their efforts. Petersen was added to the hospital's Joint Commission Team, which helps her keep abreast of the areas of concern for the next survey.

Question: When trying to create and implement a new form, patient education materials, or program, where do you go to get information/ideas from which to work?

Answer: "[The forms] are often so specific to our facility, it is easiest to see what staff want and create something," Petersen says.

Staff will call to let her know that they don't have a handout for a certain medication or they are seeing a lot of patients with a particular diagnosis and they don't have educational materials available to support their teaching.

Once a request is made, Petersen starts with national organizations to find the latest information on the topic. She also e-mails other patient education coordinators with whom she networks and puts a request for information on a patient education listserv to see how others are educating patients on a particular topic. She often seeks input from medical directors and general practitioners as well.

"Basically, I draw from wherever I can," says Petersen. ■

Group focuses on ovarian cancer education efforts

Awareness efforts go hand in hand with research

Building awareness of the signs and symptoms for ovarian cancer is the mission of The National Ovarian Cancer Coalition based in Boca Raton, FL. While other organizations raise money for research, the coalition uses its funds to educate the general public and physicians.

There are no early detection tests for ovarian cancer; and by the time there are symptoms, the cancer usually is in an advanced stage, says **Shelly Rozenberg**, community relations director for The National Ovarian Cancer Coalition. Only about 10% of ovarian cancer is found in the early stages.

Women need to know the signs and symptoms of ovarian cancer and they need to know their body, says Rozenberg. In this way, they can see their physician at the first hint that there is a problem. "We say it whispers, so listen. The symptoms are so silent," she explains.

Usually, a woman who is bloated is diagnosed as having gas or some other health problem that is causing the bloating. Often she goes from physician to physician until she is diagnosed with ovarian cancer, but it usually is not the first thing physicians look for because the symptoms are so reflective of other health problems.

The symptoms of ovarian cancer that every woman should know include:

- unexplained change in bowel and / or bladder habits such as constipation, urinary frequency, and / or incontinence;
- gastrointestinal upset such as gas, indigestion, and / or nausea;
- unexplained weight loss or weight gain;
- pelvic and / or abdominal pain or discomfort;
- pelvic and / or abdominal bloating or swelling;
- a constant feeling of fullness;
- fatigue;
- abnormal or postmenopausal bleeding;
- pain during intercourse.

"Often, women will put their pants on and not be able to close them. That [can be] a sign," says Rozenberg.

Women who know the signs and symptoms of ovarian cancer can be proactive, says Rozenberg. In that way, when a physician tells them not to worry because it's just hormones, they can ask to be tested, she says.

Ultrasound can be used to examine the ovaries for malignancies. It uses high-frequency sound waves to create pictures of the area being examined to differentiate healthy tissue from fluid-filled cysts and tumors. There also is a blood test that measures the level of a tumor marker called CA-125 in the bloodstream. More than 80% of women with advanced ovarian cancer will have an elevated CA-125 level.

Women at high risk and those older than age 35 should routinely have a rectovaginal exam where the physician inserts fingers in the rectum and vagina simultaneously to feel for abnormal swelling and to determine tenderness. This is done during the annual vaginal exam. Women at high risk also should talk to their physician about having a transvaginal sonography, says Rozenberg.

Understanding risk

It's important for women to know their risk for ovarian cancer so that they can be more vigilant in detecting the disease. According to The National Ovarian Cancer Coalition, women with one or more of the following risk factors have an increased chance of developing ovarian cancer and should be more observant in watching for symptoms:

- personal or family history of breast, ovarian, endometrial, prostate, or colon cancer;

EXECUTIVE SUMMARY

September is Ovarian Cancer Awareness Month. Because this cancer is difficult to detect in the early stages, awareness of signs and symptoms is vital according to The National Ovarian Cancer Coalition based in Boca Raton, FL. Increasing awareness may help to save lives. The organization has lots of materials to support outreach efforts.

SOURCE

For more information about Ovarian Cancer Awareness Month or ovarian cancer education, contact:

- **Shelly Rozenberg**, Community Relations Director, The National Ovarian Cancer Coalition, 500 N.E. Spanish River Blvd., Suite 14, Boca Raton, FL 33431. Telephone: (561) 393-0005. Web site: www.ovarian.org.

• hereditary nonpolyposis colorectal cancer or syndrome;
• increasing age;
• unexplained infertility, no pregnancies, and no history of birth control pill usage;
• use of high-dose estrogen for long periods without progesterone may be a risk factor;
• North American or North European heritage and / or Ashkenazi Jewish heritage;
• living in an industrialized country.

The National Ovarian Cancer Coalition has 46 divisions throughout the United States that are volunteer-run. Most have a speaker's bureau to help educate the public. The organization also has a lot of literature available. During Ovarian Cancer Awareness Month, these local divisions gladly partner with health care facilities, says Rozenberg. ■

HCEA schedules patient education conference

The Health Care Education Association has schedule its sixth annual Health Care Education Association's Institute on Sept. 25-27 at The George Washington University Hospital in Washington, DC. The meeting is designed for health care educators involved in staff development as well as patient and community education. The program offers attendees the opportunity to be exposed to vendors with education products; colleagues' poster displays with ways to enhance education; and to network with colleagues to learn about professional resources. Sessions are offered at novice, intermediate, and advanced levels.

Some of the topics will include:

• regulatory readiness and compliance;
• training modalities;
• web-based education;
• computerized interdisciplinary documentation;
• business issues to ensure funding;
• bioterrorism education;
• competency assessment programs;
• patient diversity;
• lay health programs.

Watch for registration information and the program agenda on patednet listserv (patednet@lyris.med.utah.edu) or the Health Care Education Association web site at www.hcea-info. For more information, send an e-mail to hcea03@cox.net. ▼

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* at suscortjohn@onemain.com. Or mail information to: P.O. Box 64, Westwood, CA 96137. ■

COMING IN FUTURE MONTHS

■ Teaching pediatric medication safety
■ What baby boomers don't know about strokes
■ Creative patient safety teaching ideas
■ Developing relationships with home care nursing services
■ Managing a diverse group of employees

CE Questions

For more information about the continuing education program, please call (800) 688-2421. E-mail customerservice@ahcpub.com.

5. Patient safety education usually includes which of the following topics?
A. Infection control
B. Seatbelt use
C. Falls
D. A & C

6. It is important for women to know their bodies and the signs and symptoms for ovarian cancer so they can identify possible warning signs quickly, get a diagnosis, and begin treatment because the signs usually indicate advanced cancer.
A. True
B. False

7. When educating parents and patients about ostomy care, it is a good idea to use which of the following teaching techniques?
A. Demonstration on a doll with an ostomy
B. A video that provides step-by-step instruction
C. A detailed booklet to take home
D. All of the above

8. To educate teens, child life specialists frequently teach the lesson in rap music
A. True
B. False

Answers: 5. D; 6. A; 7. D; 8. B.

CE instructions

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

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

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

Prepare parents and child before ostomy surgery

STOMA acronym helps to reinforce steps

Teaching parents and children about ostomy care takes more than straightforward instruction because this form of surgery is an emotional issue, says **Marie Oren**, RN, BSN, CWOCN, a wound, ostomy, continence nurse at Children's Healthcare of Atlanta.

During surgery, a physician makes an artificial opening in the body to allow the release of urine from the bladder or feces from the bowel. Parents no longer have a "normal" child, and the parents, as well as the child, must adjust to a different way of managing the bowel or bladder function, says Oren. For adolescents, the surgery often is a self-esteem issue. **(For information about teaching the adolescent age group see article on p. 2.)**

To help prepare families for the change, education must begin before surgery. Oren discusses the ostomy with parents to make sure that they understand what it is. She also addresses their concerns and fears. If children are at least 4 years old, she teaches them as well usually using a life-like doll that has an ostomy. In this way, families see what an ostomy looks like prior to surgery.

"It is important for them to know what it looks like because an ostomy is very physically altering. It is your intestine on the outside of your body, and it is something we don't normally see. It is important for parents and kids to be familiar with it so they aren't in shock after the surgery," says Oren.

The purpose of the ostomy also is discussed. When this surgery is performed on children, often it is temporary and not something they will have for the rest of their lives. The reason for the ostomy might be trauma, frequently from a seatbelt injury. Other reasons for ostomies include Crohn's disease, a long-term swelling bowel disease; ulcerative colitis, a chronic inflammatory disease of the large intestine and rectum; Hirschsprung's disease, the absence of nerves in the muscle wall of the colon resulting in poor squeezing motion to eliminate feces; inborn defects of the anus; and general health issues related to premature babies.

Following surgery, Oren meets with parents to explain the tubes and drains their child has because they are vital to recovery. They often help with bodily functions until the ostomy is working correctly, says Oren.

The discussion about the drains usually takes place the day after surgery. At that time, parents are given a booklet on ostomies. The booklet discusses Oren's role; explains the digestive and elimination system; shows photos of different ostomies and the pouch that covers the stoma, which is the cut in the wall of the abdomen; ostomy care; and information on how a child can adapt physically participating in such normal activities as school, swimming, and other sports.

"I give them a book up front so that they can learn how to take care of their child before they actually have to do it. By involving them, they feel useful. They don't feel so helpless," Oren explains.

On the third day following surgery, parents watch Oren change a pouch, either on their child if he or she is well enough or on the doll. Immediately following the demonstration, parents watch a video about changing the pouch, which helps to reinforce the teaching. It also shows them a variety of techniques from which they might choose.

The word stoma turned into an acronym and used to teach parents the steps for changing the pouch. The letters are a reminder to:

- S — set up the supplies;
- T — take off the pouch;
- O — observe the skin;
- M — measure the new pouch;
- A — apply the new pouch.

The pouch has to be cut so that it is the same size as the stoma. In that way, it will fit around the stoma and stick to the skin, says Oren. The pouches are made with a sticky barrier to keep the skin from coming into contact with the stool or urine.

SOURCE

For more information about teaching ostomy care, contact:

- **Marie Oren**, RN, BSN, CWOCN, Wound, Ostomy, Continence Nursing, Children's Healthcare of Atlanta, Scottish Rite Campus. Telephone: (404) 250-2491. E-mail: Marie.Oren@choa.org.

In addition to instruction on changing the pouch, parents learn about the disposal of the stool or urine, which needs to be done when the bag is a third to a half full. Older children can sit on the toilet to empty the bag.

Oren teaches children ages 10 and older how to empty and change the pouch. Once home, parents can teach smaller children. It is similar to potty training, says Oren. "A child should be able to empty the bag and do a basic emergency pouch change, meaning cutting the hole and putting the pouch on, by the time he or she is in school."

Prior to discharge, the parents do a pouch change on their child or on the doll so they have hands-on experience. If the child feels up to it, he or she also will do a pouch change.

Oren instructs parents to set up a routine for changing the pouch. Older children need to change the pouch every five to seven days or when it is leaking, and younger children need a pouch change more often depending on their level of activity.

The various methods of instruction Oren uses when teaching ostomy care seem to work well. "I like to incorporate reading a book, watching a video and hands-on [teaching] because they use all the senses and people learn differently," she says. ■

OK to teach teens as adults, but be creative

Teens can think abstractly about health info

Adolescence is the age when children begin to be able to rationalize consequences and think abstractly. They can understand how an illness or procedure might impact their future, says **Lindsay Damron**, CCLS, a child life specialist on the Comprehensive Inpatient Rehab Unit at Children's Health Care of Atlanta Scottish Rite Campus.

The cognitive ability usually begins around age 13, yet regardless of their age, they can be very immature or very mature adolescents. Therefore, it's a good idea to use general assessment skills when providing education. Start with basic information and then assess their comprehension. Make it a game, telling the teens that you will give them a little quiz, she advises. If they have understood the information, build upon the lesson.

Generally speaking, mature adolescents can be taught as adults. "I would talk to them just as I would talk to an adult off the street who didn't have a lot of medical background," says Damron.

Someone who has reached middle adolescence might be approached as an adult that doesn't have a lot of education. They have adult reasoning, but it is not yet well developed, she explains.

Those in early adolescence are at the end of the school-age developmental stage and need even less information. "If you give too much information, they will get confused," says Damron.

"If they were to have a chronic illness that would severely impact their life in five years, that would be too much information. They need to know what will happen this week," she explains. For example, they could learn what medicine they will be taking and their treatment, but the impact five years in the future would need to be taught when they were more mature.

Peers are extremely important during adolescence, for they act as a child's support system. While they are starting to find their own identity, they are doing that in the realm of being accepted by their peers. They want to fit in, but they also are searching for the kind of person they are and what they have to offer.

A good way to educate teens is to get them in a group setting with a physician or nurse present to answer questions. If you can create a spark to get them asking questions, you will create a nice dialogue for learning, says Damron. "They will fuel off each other," she explains.

Also important to teens is privacy and their body image. She tells health care workers to knock on the door when entering the room of a teen patient. "If you are educating teen-agers about something that has had a huge impact on their physical appearance, that is foremost in their thoughts."

While it is important to discuss emotional issues such as a physically altered appearance, educators first must foster a relationship in order for teens to feel comfortable discussing their thoughts and feelings. Often simply beginning with basic information will lead to a discussion of emotional issues, she says.

Education for adolescents works best if it is fun and informal. Damron often plays the card game Uno with teen-age boys. Every time they put down a red card, they must state something about their illness that makes them angry.

In addition to games, education can be incorporated into a craft or cooking, something that results in a finished product. "They can listen as well as ask questions. It is a little more comfortable than a teacher-and-student setting," says Damron. ■