# Patient Education Management™

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

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## IN THIS ISSUE




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# Collaborative, family-centered approach results in better care

*Caregiver must be active part of the entire health care process*

A letter from a mother who was upset by the treatment she had received while her baby was in the neonatal intensive care unit at Vanderbilt Children's Hospital in Nashville, TN, triggered a change in the way the hospital provides health care.

After beginning a dialogue, hospital administrators realized that parents were very important members of the health care team. As a result, a family advisory council was created that consisted of families that had experience with the hospital to make health care delivery more family-centered.

"We were startled to realize that these people were experts in our systems, and they could tell you what worked well in the business office and what didn't work well, and what worked well in the parking garage and what didn't work well. It was not easy to hear what these people had to say," says **Terrell Smith**, MSN, an administrative director at Vanderbilt Children's Hospital.

### *EXECUTIVE SUMMARY*

According to **Rosalie Parrish**, MEd, program specialist for family partnerships at the Institute for Family-Centered Care in Bethesda, MD, patients and families naturally want to have a say in their own health care, but medical tradition has set the tone that "doctor knows best." "In truth, patient and family knowledge and experience are very useful information, and more health care providers are realizing this," she says. When a partnership has been established, a patient/family member typically is more likely to heed the advice of their health care providers and will take better care of him- or herself, requiring shorter hospital stays and fewer hospital admissions, which means a decrease in health care costs.

The hospital implemented several suggestions from the family advisory council. One was the creation of a booklet for parents who had to admit their children to the hospital following a doctor's visit. This booklet explains what to pack and what to leave at home. It also has maps to the hospital and information on parking as well as recommended references for preparing children for the hospital experience. The booklet is distributed to local pediatrician offices.

"They actually wrote the book. The parents told us what they needed to know if they were sitting in the doctor's office," says Smith.

The council also initiated the creation of a hospital directory similar to those found in hotel rooms that familiarize guests with all the services available. Some of the information parents wanted to be included in the directory was a list of all the local churches within three miles of the hospital and a sheet that explained the initials for the degrees on all the health care professionals' nametags such as RN and MSN. In this way, they would know who was coming into the room, explains Smith.

According to the Institute for Family-Centered Care in Bethesda, MD, family-centered care is "an approach to the planning, delivery, and evaluation of health care that is governed by mutually beneficial partnerships between health care providers, patients, and families." During health care delivery, patients and family members are part of the team. It is characterized by a "collaborative approach to caregiving and decision-making. Each party respects the knowledge, skills, and experience the other brings to the health care encounter." **(To learn the four principles of family-centered care, see article on p. 123.)**

## Part of the decision-making process

Physicians and other health care providers need to listen to their patients, says Smith. A mother who has a nonverbal child with chronic ear infections often can diagnose the problem before the physician's exam just by the way the child cries.

It's important to get across to the medical team that parents and other caregivers should be included. "Make them part of the decision process, the planning process and the entire health care process because they are the ones that are taking the child home. They become the caregivers," says Smith.

When caregivers are incorporated into the process of care they become competent and confident and better able to take care of a patient when he or she is discharged, says **Rosalie Parrish**, MEd, program specialist for family partnerships at the Institute for Family-Centered Care. For example, when parents have the opportunity to participate in the care of their baby in an intensive care unit, helping with such tasks as feeding and diaper changes, they are better equipped to care for a fragile child upon discharge. They also learn to successfully operate the kinds of medical equipment that their infant might need after being brought home.

Education should be woven into the whole care experience, says Parrish. This would include

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## The four principles of family-centered care

*Patients, family become part of health care team*

Family-centered care, a partnership between health care providers, patients, and families in the planning, delivery, and evaluation of health care, is characterized by four principles according to the Institute for Family-Centered Care in Bethesda, MD, which include:

**1. People are treated with dignity and respect.**

Health care professionals need to remember that patients are in a vulnerable position and do all they can to make sure the patient maintains his or her dignity in the health care setting, says **Rosalie Parrish**, MEd, program specialist for family partnerships at the institute. For example, health care professionals should remember to knock before entering the room when a procedure is being done.

Also, once members of the health care team have discussed the options with a patient, they need to respect the patient's final decision.

**2. Health care providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful.**

Patients and family members as well as health care providers must share all information. One of the ways to do this is to provide patients access to their medical chart. Although not yet widely accepted, in some family-centered practices, patients are also allowed to write in the chart, says Parrish.

"A health care professional can share information; but to actually have open communication, that means accepting information as well," she says.

**3. Patients and family members build on their strengths by participating in experiences that enhance control and independence.**

If patients and family members are given information, resources are shared, and their choices are respected, it is a lot easier for them to participate in their own care, says Parrish.

This principle most easily is seen in critical care when family members are included in patient care allowed to come and go at their convenience.

**4. Collaboration among patients, family members, and providers occurs in policy and program development and professional education, as well as in the delivery of care.**

It is essential to include consumers — the people who use the health care services — when shaping policies, evaluating the quality of care or programs, and reviewing health care practices.

For family-centered care to occur, consumers need to be placed on committees as fully active participants. "They aren't there as token members, but come in with ideas and personal experiences," says Parrish. ■

sharing information with caregivers or patients through bedside conversation, including them in medical rounds, encouraging and supporting patient/family participation on hospital committees, providing a means for patients and families to give feedback about the care they are receiving and the priorities and concerns of their family, or simply providing families with educational materials. For example, parents of premature babies might receive a packet of information on the care required for a premature baby as well as the resources and services available within the community.

### *Growing in popularity*

The concept of family-centered care is becoming more widely supported, says Parrish. The Institute for Family-Centered Care tracks organizations that support the concept.

The Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations launched its Speak Up program, which encourages patients and families to play an active role in the health care experience to ensure safety and quality of care.

In 2002, the National Association of Emergency Medical Technicians and the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services published a position statement titled "Family-Centered Pre-Hospital Care: Partnering with Families to Improve Care." It recommends that emergency medical technicians use the family as a source of information and assistance in patient care and that they be given the option of being present during care, procedures, transport, and reports to other health care teams.

In 2001, the Des Plaines, IL-based Emergency Nurses Association published the position statement, "Family Presence at the Bedside During Invasive Procedures and Resuscitation." The position statement includes the following information:

"Several investigators documented the benefits of family presence during invasive procedures and cardiopulmonary resuscitation, which include knowing that everything possible was being done for their loved one; reducing anxiety and fear; feeling of being supportive and helpful to the patient and the staff; sharing critical information about the patient and the patient's condition; maintaining the patient-family relationship; closure on a life shared together; and facilitating the grieving process in the emergency department and later at home."

As part of its "Protocols for Practice" series titled "Creating a Healing Environment" the American Association of Critical-Care Nurses (AACN) in Aliso Viejo, CA, published guidelines on family visitation and partnership in the critical care unit. The AACN recommends that families be prepared for the experience of critical care and on how to support their loved one. Also, they state that the attitudes and beliefs of nurses on the unit must be changed so that they will know how to work with families.

The Dallas-based American Heart Association recommended in its guidelines for cardiopulmonary resuscitation and emergency cardiovascular care published in 2000 that health care providers give family members the opportunity to be present during resuscitation. However, the organization noted that such a policy takes advance planning and the commitment to work through initial problems.

## Can be a slow process

Making patients and family members an integral part of the health care team begins with an assessment to determine what is already in place at an institution and what resources are available, says Parrish. Change can begin with something as simple as positive signage that makes it easier for families to find their way around the health care facility or having educational materials in multiple languages easily accessible. **(For information on how the institute can assist with change, see article on p. 125.)**

Other changes require more effort. For example, a change in hospital visiting policy might involve a change in design such as providing beds in patient rooms so that parents can spend the night with an ill child.

To make Vanderbilt Children's Hospital a family-centered facility, physicians, patients, and families were asked two questions: "What does it look like when care is going well?" and "What does it look like when care is not going well?"

The hospital administrators then analyzed the data and came up with a list of values that was given the acronym, FOCUS. This acronym stands for: **F** — family-centered care; **O** — one team; **C** — continuous improvement; **U** — unique environment for children; **S** — service excellence.

Hospital policies and processes were revamped to reflect these new values. For example, visiting policies were changed so that parents could spend more time with their children and come and go.

### SOURCES

For more information about family-centered care, contact:

- **Rosalie Parrish**, MEd, Program Specialist for Family Partnerships, or **Beverley H. Johnson**, President/CEO, Institute for Family-Centered Care, 7900 Wisconsin Ave., Suite 405, Bethesda, MD 20814. Telephone: (301) 652-0281. Web site: www.familycenteredcare.org.
- **Terrell Smith**, MSN, Administrative Director, Vanderbilt Children's Hospital, Nashville, TN. Telephone: (615) 322-0111. E-mail: terrell.smith@vanderbilt.edu.

Construction of a new hospital will be completed in December and the critical care unit will have beds for the parents to sleep near their children.

## Families and committees

To create an environment for family-centered care at the new facility, family members were part of the planning committees and interacted with the architects just like any other committee member, says Smith. In addition, the architects took the plans to the family advisory council to ask if the space was family-friendly.

Family members are included in all areas of Vanderbilt Children's Hospital. The chair of the family advisory council sits on the leadership council with all the department heads and also was on the interview team for the new CEO last year, says Smith.

However, to incorporate patients and families so completely in a health care system does require a change in culture through staff education. When Vanderbilt created its FOCUS values, everyone was schooled on them, including physicians and board members. "We have woven those principles into our orientation process," says Smith.

Yet, it is not enough to educate staff about family-centered care in one orientation session. "As far as the educational process, you need to find various ways to keep this message alive, and it is not all just classroom lecture. You have to weave this into the culture of the organization," says Smith.

Highlight examples in the in-house newsletter or print appreciative letters from parents that reinforce family-centered care, she suggests.

Once the hospital invited a columnist and her young daughter who had written a book titled "Olivia's Rules for Doctors" to do a medical grand rounds which is usually reserved for the latest

research or clinical issues. The child wrote the book after spending 65 days in the hospital. "We are trying to do education for physicians that is tailored to what families have to say," says Smith.

*(Editor's note: Next month, learn how Dana-Farber Cancer Institute in Boston uses patient and family advisory councils to create a culture of family-centered care. This piece will cover how to set one up, select council members, and operate a family advisory council.)* ■

# Nonprofit offers services for family-centered care

*No need to go it alone*

The Institute for Family-Centered Care, a nonprofit agency in Bethesda, MD, provides consultation, training, and technical assistance to hospitals embarking on a process of family-centered change. Specialists from the institute work with hospital personnel, patients, and families to develop a plan that reflects the priorities and needs of each institution. Below are the services the institute provides:

**• On-site consultation**

Many hospitals request an initial on-site consultation as they begin an assessment process and develop a plan for change. This usually is a two- or three-day visit conducted by a consumer/professional team from the institute. The consultation includes an introductory presentation on family-centered care for key personnel. The institute also can provide a follow-up written report with recommendations for action.

**• Document review**

Institute staff review key documents for consistency with family-centered philosophy and principles, which include:

— mission and vision statements;
— hospital or departmental philosophy statements;
— recent annual report;
— hospital strategic plan;
— design plans or drawings;
— descriptions of staff positions (e.g., for nurse, social worker, physician, unit clerk);
— sample performance appraisal forms;
— charting forms;
— patient/family information materials;
— patient/family satisfaction questionnaires;
— continuous quality improvement standards and indicators;
— critical pathway or care maps;
— history and accomplishments of a family advisory council or a description of other ways that patients and families serve as advisors to the hospital.

**• Comprehensive assessment**

Institute staff conducts a comprehensive assessment of current hospital policies, programs, and practices. This process involves systematic data collection from hospital personnel at all levels, as well as from patients and families served by the hospital. The assessment is conducted over several months and a number of on-site visits are usually necessary. As part of the assessment, the institute can provide a written report and a detailed action plan.

**• Consultation and technical assistance**

Institute staff can provide consultation and support to hospitals at selected intervals throughout the change process on-site or by telephone.

**• Product development**

The institute helps hospitals develop materials for staff, patients, and families that reflect family-centered principles.

**• Training and education**

The institute provides workshops, seminars, inservices, train-the-trainer sessions, and customized training program development. Training and education areas include:

— family-centered principles and practice;
— family/professional collaboration;
— the development of family advisory boards;
— The process of change;
— facilitating family-to-family support;
— family-centered communication;
— building effective multidisciplinary, family/professional teams;
— delivering services across cultures;
— developing linkages with community organizations;
— family-centered environments;
— family-centered care for physicians and physician educators;
— family-centered personnel policies and practices;
— family-centered charting and documentation.

**• Conference planning**

Institute staff plans and conducts retreats for hospital personnel, the governing board, or other small groups, and organizes communitywide conferences on family-centered issues.

**• Environment and design**

**SOURCE**

For more information about services provided, contact:
- **Institute for Family-Centered Care**, 7900 Wisconsin Ave., Suite 405, Bethesda, MD 20814. Telephone: (301) 652-0281. Web site: www.familycenteredcare.org.

Institute specialists offer expertise in environment and design issues affecting health care facilities. Consultation and technical assistance services are available in the following areas:

— creating family-centered, developmentally supportive environments;

— building effective planning teams;

— strategies for involving families in the design process;

— identifying design goals;

— designing and allocating space to support family-centered principles;

— unique needs and special requirements of health care facilities serving special populations;

— trends in health care design;

— facilitating the selection of sites to visit.

**• Research**

The institute works with hospitals to develop evaluation and research initiatives to measure family-centered change within the institution and with other hospitals engaged in similar efforts. ■

# Teaching is a must for mammography callbacks

*Explain with as much detail as possible*

Education can help ease anxiety when a problem is detected on a screening mammogram. That is why all imaging centers within the OhioHealth system have a breast health nurse call patients who need additional views.

During the telephone conversation, patients are told what is showing up on the mammogram, what will be done to try and rule out whether there is a problem, and that they can expect to be met by a breast health nurse on their return appointment, says **Pam Rudmose**, RN, BSN, a breast health nurse and coordinator of the multispecialty Second Opinion Breast Cancer Clinic at OhioHealth in Columbus.

On the return visit, the breast health nurse again explains what the radiologist saw on the mammogram or ultrasound and what will be done that day. The nurse also explains that the radiologist will look at the films as soon as they are processed and provide an answer about the particular issue before the woman leaves the center that day.

For example, if an area of calcification were detected on the right breast in the mammogram, the patient would be told that these are not unusual and they form all over the body as part of the aging process. To determine if further evaluation is required, the calcification needs to be magnified.

"I try to make sure that they understand that we will be able to tell when we magnify [the image] what needs further follow-up and what doesn't," says Rudmose.

If a radiologist determines that follow-up is needed, the breast health nurse calls the referring physician to ask what surgeon he or she wants the patient to schedule an appointment with and then works with the patient to set it up.

## *Quick calls, quality care*

The goal is to determine if there is a problem or not by biopsy within five days from the moment that the phone call about the abnormality is made. Therefore, most surgeons will try to schedule an appointment within 24-48 hours when the breast health nurse makes the call, says Rudmose.

"If it is something that needs further work-up, the patient is very worried at that point, so we try to get them in quickly to the surgeon and get the abnormality evaluated," she says.

At Inland Imaging in Spokane, WA, patients are given a slip of paper when they have a screening mammogram that helps prepare them for a follow-up visit should one be required. The note, which is printed on tear-off tablets for easy distribution, reads:

"A screening mammogram is a procedure used to screen for potential problems in the breast due to the denseness and complexity of breast tissue. Additional tailored imaging may be needed in order for the radiologist to complete the interpretation of your exam. If additional imaging is required, you will be informed by phone or letter at which time you need to contact our office to schedule another appointment. The need for additional imaging does not necessarily mean there is a problem just that more information is needed to complete the

**SOURCES**

For more information about educating patients when further follow-up is needed after a screening mammogram, contact:

- **Jan Robbins**, RT, Mammography Coordinator, Inland Imaging, 12420 E. Mission, Spokane, WA 99216. E-mail: jrobbins@inland-imaging.com.
- **Pam Rudmose**, RN, BSN, Breast Health Nurse and Coordinator for the Multispecialty Second-Opinion Breast Cancer Clinic, Breast Health Program, OhioHealth. Grant/Riverside North East Health Center, 6200 Cleveland Ave., Columbus, OH 43231. Telephone: (614) 566-0569. E-mail: prudmose@ohiohealth.com.

interpretation of your breast exam. There will be a charge for additional imaging, but it is generally covered by insurance."

The people who make the follow-up calls are given guidelines on what information to provide and appropriate language, says **Jan Robbins**, RT (RM), mammography coordinator at Inland Imaging. For example, they are not to say that there is a mass in the breast, because that term frightens women.

The person making the phone call has the report and simply provides information on why the patient is being asked to return. For example, there may be an area that is denser than the surrounding tissue and needs to be compressed.

"I try not to have [representatives] on the phone tell patients too much. If a patient is asking too many questions they are to get a technologist to answer the questions," says Robbins.

About 10% of the women who are screened for breast cancer at Inland Imaging must return for a diagnostic mammogram.

### *Education along the continuum*

At OhioHealth, when a diagnostic mammogram reveals that further evaluation is needed by a breast surgeon, Rudmose lets patients know that 80% of the time it is nothing. However, if there is a problem, a breast health nurse is involved with the patient's care all along the continuum.

Should a woman need surgery, she is referred to an inpatient breast health nurse who completes pre-op teaching and post-op discharge instructions. The nurse also follows up at home making calls to be sure that the patient is OK and is following discharge instructions.

Women who are diagnosed with breast cancer also can go to the Second Opinion Breast Cancer Clinic to see all the different specialists who treat breast cancer. Specialties include surgeons, plastic surgeons, medical oncologists, radiation oncologists, pathologists, and radiologists.

At the time of her appointment, the patient is assigned a lead physician based on the reason for her evaluation. If she were coming to the clinic to decide what type of surgery she wants, her lead physician would be a surgeon.

The lead physician does an initial history and exam and then meets with the group of specialists to present the case and review the patient's imaging studies. When the team reaches a consensus, they meet with the patient who asks questions. The lead physician facilitates the discussion pulling each specialist into the conversation so the patient knows how this specialty relates to her.

Once the doctors formulate the patient's treatment recommendation, it is sent to her referring physician and she receives some education from the breast health nurse depending upon her need at the time.

There are all different types of teaching sheets available for various procedures, in addition to a pre-op surgery class for women undergoing breast surgery, says Rudmose.

"We don't want to overwhelm patients by giving them all the information at once. We take it step-by-step depending on where the patient is and how much they are ready to learn. The role of the breast health nurse is to provide education and support to both the patient and family through this whole process," says Rudmose. ■

# Striving to make education a priority

*Education coordinator: 'What I'm doing counts'*

"Our leadership and our system really puts a lot of emphasis on our education as well as that of our patients and families," says **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator for Children's Healthcare of Atlanta, which is comprised of two campuses, Children's at Scottish Rite and Children's at Egleston, as well as 16 satellite facilities throughout the metro Atlanta area.

Children's Hospital, one of the largest pediatric

facilities in the United States with 430 beds, is committed to both staff and patient education. This commitment is reflected in the name of the department that oversees education — Learning Services.

As coordinator of patient and family education, Ordelt has three main "jobs." She is in charge of inservices for staff on patient education. She teaches staff how to teach, how to write educational materials for families, and how to use the computer for patient education purposes.

Also, she is in charge of monitoring the distribution of patient and family education materials. An index of approved education resources is kept that includes commercial and in-house materials. Clinical experts write most handouts that are created in-house; however, Ordelt does the editing and makes sure the copy is in the correct format.

Her third focus is to maintain readiness for surveys conducted by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations. To do so, she takes the lead on the implementation of patient education standards initiated by the Joint Commission.

Ordelt has one part-time nurse that assists her in the processing of teaching sheets, working on an as-needed basis approximately eight to 16 hours a week. As one of the arms of developmental education, she reports to the director of clinical staff development, who in turn reports to the chief learning officer for Learning Services, which has about 35 employees.

A nurse for 35 years, Ordelt has worked in a variety of positions that include patient care, management, and various staff and patient/family education roles. These diverse roles have provided a good overall background that help her to provide the best education for the patients and families that use the services of Children's Healthcare of Atlanta.

In a recent interview with *Patient Education Management*, Ordelt discussed her job, her philosophy on patient education, challenges she struggles with, and the skills she has developed that helps her to do her job well. Following are the answers to the questions posed:

**Question**: What is your best success story?
**Answer:** "Abstractly, the largest amount of success that I enjoy is knowing that what I am doing counts for something. My motivation is making a difference in the life of a child because that child is my boss. That is whom I report to, essentially. Concretely, the greatest success was getting all our patient education materials on the intranet and launching the patient and family education intranet web site for our staff."

Technology has helped to make information readily available to health care staff saving time because they no longer have to go look for patient handouts in a notebook and make copies. However patient education is totally dependent upon the caregivers' time to provide it and there is a time crunch in health care that is totally out of control, says Ordelt. She says all she can do is provide the best tools and training and hope that staff will find the time for appropriate education that includes assessment of needs and evaluation of learning.

**Question:** What is your area of strength?
**Answer:** "Organizationally I think it is the amount of importance this organization places on learning both for staff and patients and families. Personally, I think my strengths lie in motivation, team building, getting consensus, working at problems and facilitating groups. People skills are probably one of the best strengths that I have."

An entire building across the street from Learning Services is devoted to classroom space for staff education and community outreach. Learning Services coordinates the classroom space and classes.

The hands-on patient and family teaching takes place at the two hospitals and satellite centers. Developing tools for this teaching can be difficult when all parties involved do not agree. However, Ordelt is able to get people around a table or on an e-mail circuit to discuss the issues in order to reach a common goal.

**Question:** What lesson did you learn the hard way?
**Answer:** "We have physicians review all our material and it is difficult sometimes to get them to return things in a timely manner. Getting them to sign off on material is probably one of the hardest lessons to learn how to do."

To get work completed in a timely manner, Ordelt has had to learn the nuances of what works for each physician. Some want to communicate by e-mail while others instruct her to call their office manager. Each time a new physician is incorporated into the process, Ordelt must learn the doctors' individual styles and how they like to receive information.

**Question:** What is your weakest link?

## SOURCE

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**Answer:** "I wouldn't call it my weakest link, but my biggest challenge is translation of patient education materials. One of the things we have been committed to at Children's is translating everything into Spanish. We are doing 100% translation for about 400 teaching sheets, all our booklets, and all the videos we produce. It is a lengthy process."

Both campuses at Children's Healthcare of Atlanta have an interpreter department and those on staff translate materials in any spare time that they have, which is not much. Therefore, Ordelt also contracts with individuals and companies outside the health care system for translation services.

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

**Answer:** "My vision would be to have the patient and family in the driver's seat directing their care and their education. If we could ever get good enough at equipping them with what they need to put them in the driver's seat, then we could be the crew in the pits."

A quote from former U.S. Surgeon General C. Everett Koop sums up Ordelt's philosophy about education. He said: "There is no prescription more valuable than knowledge." If everyone in health care made knowledge a priority then patient and staff education would be of primary importance rather than something that had to be done, she says. She believes that Children's Healthcare of Atlanta does fairly well, but there always is room for improvement.

**Question:** What have you done differently since your last JCAHO visit?

**Answer:** "If this was next year and we were under the new survey process, I would probably have a lot more to say but I think mainly it is just maintaining continual readiness. I have a patient and family Joint Commission team, and we meet quarterly and we have done so in between the last few surveys so we don't let go we keep meeting to assess and talk about what we need to do differently or better."

The Joint Commission will next survey children's Healthcare of Atlanta in September 2004.

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

**Answer:** "I go to a lot of sources depending on what I need. They include conferences, patient education sites on the computer, books and journal articles on patient education topics, and telephone conversations or e-mail with colleagues. It helps me to hear what other people are doing."

Sometimes when there seems to be no solution to a problem just talking with other people about it will trigger an idea, she says. ■

# Facility type shapes safety concerns, policy

*Rehab facility takes safety seriously, asks patients*

Patient safety is a concern at all health care facilities. However, the issues at a medical clinic are not the same as at an acute care hospital, and neither institution mirrors the concerns of a rehabilitation center.

To help determine the safety concerns of patients at Craig Hospital in Englewood, CO, the safety committee asked **Terry Chase**, ND, RN, a patient education clinical specialist, to create a survey. She did so, and for two years has distributed it to a representative number of patients at the 70-bed facility for patients with spinal chord and brain injuries. The committee has asked that the survey be distributed annually.

### Getting patient feedback

Chase says although she tries to distribute the survey evenly between patients with spinal chord injuries and brain injuries, the cognition and communication problems of the later group make this difficult.

The survey is short, consisting of five questions:

1. Do you have any concerns about your safety in any of the following areas: hospital grounds; hospital community areas such as the cafeteria, hallways or gym; therapy areas; patient rooms; other?
2. Who would you report safety concerns to if they occurred: doctor; nurse; rehab tech; therapist; housekeeping; don't know?
3. Would you feel comfortable reporting safety concerns?
4. What do you consider the greatest safety risk as a patient at Craig Hospital?
5. What suggestions do you have to improve or enhance patient safety?

The results of the survey are used to improve patient safety by changing policy, making repairs or additions to physical landscapes and buildings, and through the education of patients and staff.

In question No. 2, most patients said they would report safety concerns to nursing. Therefore, Chase plans to share the information in a newsletter called "Nursing Notes" to congratulate nurses for being the No. 1 contact for patients with safety concerns and to remind them that the patients rely on them for a lot of things including safety.

Both years the survey was taken, patients said that they felt comfortable in reporting safety concerns. When patients are admitted to Craig Hospital, they receive a patient and family orientation handbook that has a section on patient rights and responsibilities. This section covers safety issues. For example, patients have the right to receive care in a safe environment. They also have the responsibility of reporting perceived risks in their care and safety concerns.

### Safety and education

For the two years the survey has been used to assess safety, patients reported that their greatest safety risk was falls caused by everything from tripping off the curb outside on the sidewalk while in their wheelchair to falling out of bed and falling during transfers.

The hospital does have a safety committee dedicated to preventing falls. In addition, education about how to handle the wheelchair is part of the spinal chord patient's rehabilitation process. The physical therapy department provides the education on both an individual and group basis. Chase, who was a patient at Craig Hospital 15 years ago, says that being fearful of falling is common with new spinal chord injury patients. When first in a wheelchair, she was fearful of going on a sidewalk and on driveways that slant.

When a patient is close to being discharged, they attend a session on what to do if they fall out of the wheelchair. In this session, the patient, with the help of the therapist, undergoes a slow, controlled fall and then learns how to get back up.

When answering question five, one patient in the most recent survey suggested that staff install


**COMING IN FUTURE MONTHS**

- Strategies for timely project completion
- Must-have books and resources
- Effective community outreach
- Partner with home care nursing for continuum of education
- Managing a diverse group of employees

## SOURCE

For more information about how Craig Hospital addresses safety issues and concerns, contact:

- **Terry Chase**, ND, RN, Patient Education Clinical Specialist, Craig Hospital, 3425 S. Clarkson St., Englewood, CO 80110. Telephone: (303) 789-8211. E-mail: TMChase@CraigHospital.org.

more bubble mirrors on the ceiling at blind intersections in hallways where it is difficult to see someone coming around the corner. Chase went around with the patient who had made the comment picking specific sites that needed to be improved.

While physical safety issues are a top priority at Craig Hospital due to patients' conditions, safety concerning the distribution of medications is important as well because many patients are prescribed drugs for pain, to control muscle spasms, and for depression. Antidepressants often are given for nerve-related pain as well.

Patients receive a booklet, "Managing Your Medications" and nurses provide one-on-one education each time they distribute medicine. At that time, nurses often ask patients to tell them the reason that they are taking each pill.

In addition, spinal chord injury patients attend a group class on medication safety taught by Chase and at least one pharmacist. Brain injury patients have difficulty with group learning, so this teaching method is not used for these patients.

Before class, a list is printed of all the medications each patient attending the session is taking. Each patient is given his or her list of medications and asked to write, in one word, the reason for taking it.

"Once everyone can identify their medications we use the rest of the class time to discuss the importance of knowing the purpose of your medication and the interaction of drugs with alcohol and herbal products," says Chase.

A good portion of the class covers the dangers of mixing alcohol with certain types of medication.

Safety concerns at Craig Hospital are different from other facilities because patients do not remain in bed but are up and moving around. A lot of their therapy is outside the hospital. Patients go on outings, such as to the local mall. While staff members accompany them, the ratio is not one-to-one. Sometimes the trip is made using public transportation to help assimilate patients back into the community.

Overall, there is a general attention to safety issues by staff at Craig Hospital, says Chase. They are aware and watchful of safety concerns. ■

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## CE Questions

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.

17. Family-centered care is an approach to health care that is governed by mutually beneficial partnerships between health care providers, patients, and families to impact which of the following areas of health care?
A. Planning
B. Delivery
C. Evaluation
D. All of the above

18. To help ease a patient's anxiety when called back for follow-up after a screening mammogram, health care professionals should:
A. Provide as little information as possible
B. Give all the details so she will come back
C. Explain reason for callback and procedures to be done
D. Send an information packet through the mail

19. To make sure that spinal chord injury patients at Craig Hospital in Englewood, CO, are able to manage their medications safely, patients are given the list of medications that they take during a class on medication safety and asked to write in one word why they take the drug.
A. True
B. False

20. Instruction at The Children's Hospital of Philadelphia for parents on inserting an NG feeding tube predominately uses which of the following teaching methods?
A. Video
B. Demonstration and back demonstration
C. Book
D. Education by home care nurse

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



## 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

# Practice makes perfect with NG tube insertion

*Hands-on learning essential for success at home*

When health care providers refer parents or caregivers of pediatric patients to the learning center at The Children's Hospital of Philadelphia to be taught nasogastric (NG) tube insertion, they can be sure that the education is thorough.

The class where participants are taught how to insert an NG tube through the nose into the stomach for feedings is about one and a half hours. If a pump is used to administer the feedings, the additional teaching requires another hour and a half.

The lesson plan has proven successful. Eighty-five percent of families taught NG tube insertion and care at the learning center were independent in inserting the tube and providing enteral feeds, and 88% of families were confident and prepared to care for their child at home. The initial visit time for a home care nurse was reduced by 62% for families taught in the learning center, says **Linda S. Kocent**, RN, MSN, coordinator of patient-family education at The Children's Hospital of Philadelphia.

Education begins with a handout that is distributed to families prior to their appointment at the learning center to help prepare them for the lesson. Kocent says the most difficult part of the lesson for parents is conceptualizing doing an invasive procedure on their child.

"The inpatient parents are more prepared for they have watched the nurse insert an NG tube, seen their child's reaction, and have accepted that they will have to perform the procedure on their child," says Kocent.

On the other hand, outpatient families only have the information their physician has provided along with the educational handouts, so they aren't totally prepared for how their child might react. The emotional aspect is the hardest part for parents, says Kocent.

Toddlers are especially challenging because they cannot understand what is happening to them. Parents must hold them still while inserting the NG tube. Also, they frequently pull the tube out so that it has to be inserted time and again during the time that NG feeding is required.

When an outpatient family arrives at the learning center for teaching, the child is included if he or she is at an appropriate age to either insert the tube or help. However, if the child is young and not able to sit still for three hours of teaching, a child-life specialist works with him or her in preparation for the procedure.

With the aid of a model, the nurse begins the lesson by giving families basic information on how the GI system works. Tube placement is critical because the esophagus is close to the trachea and therefore the tube can be placed down the wrong passage entering the lung rather than the stomach, says Kocent.

The next step is to familiarize parents with the equipment such as the tube, the wire inside it that helps with insertion, along with lubricants that are used. The nurse then demonstrates on a mannequin how to insert the tube, secure it with tape, and check for correct placement. Placement can be monitored with pH paper that turns a certain color if the tube is inserted into the lungs and another color if the tube is in the stomach.

"Parents have an opportunity to practice everything the nurse did and ask questions. When they feel comfortable and the nurse thinks they are ready, they transfer their newly learned skills to their child," says Kocent.

Those parents who have children in the hospital practice the technique at bedside under the supervision of a nurse. The skills are reinforced by the home care nurse at the families' homes for both outpatient and inpatient teaching scenarios.

## SOURCE

For more information about NG tube insertion classes at the learning center at The Children's Hospital of Philadelphia, contact:

- **Linda S. Kocent**, RN, MSN, Coordinator of Patient-Family Education, The Children's Hospital of Philadelphia, 34th Street and Civic Center Blvd., Philadelphia, PA 19104. Telephone: (215) 590-3661. E-mail: kocent@email.chop.edu.

Children vary widely in their cooperation with the NG tube insertion. "It's very individual. Every year older is a year developmentally stronger, so the potential for cooperation is higher. It also depends on a child's history," says Kocent.

Nurses at the learning center have taught a 6-year-old to insert the tube while teens sometimes must rely on their parents to complete the procedure. Children with ongoing medical problems who have spent time in the hospital are often more used to invasive procedures. Techniques to help the child concentrate on swallowing, such as drinking through a straw, are frequently taught.

"If all goes well, it takes a couple of minutes for an NG insertion. If a child is tensed up and not cooperating, it can take a half hour," says Kocent.

When parents are not educated properly, they may not understand the importance of using the NG tube and it may impact the child's ability to grow and thrive normally, or it could impact the healing process if used following a surgery. The pump may not be programmed correctly and the child could be overfed or underfed. Also, the tube could be inserted incorrectly into the lung rather than the stomach.

The success of the education program at The Children's Hospital of Philadelphia is reflected in the number of sessions taught. NG tube insertions are one of the most frequent teachings at the learning center, comprising 15% of all classes. The learning center averages 200 classes per month. ■

# Clinic shows parents best safety seat installation

*Program corrects mistakes, provides additional info*

Motor vehicle crashes are the leading cause of death and disability to children, says **Sharon A. Welsh**, RN, EMT, trauma injury prevention coordinator at UMass Memorial Health Care in Worcester, MA. That's why she has made education on child safety seats a priority.

Every Wednesday, she provides a clinic where parents or others involved in the care of a child can come and have their safety seat checked by certified technicians. The technicians, who are from all walks of life, including nurses, medical students, police officers, firefighters, and state troopers, volunteer their time.

"We've seen a number of problems. Sometimes straps aren't pulled tight enough, the seat might be facing the wrong direction, or the child might be too large for the seat," says Welsh.

Installing a car seat correctly can be difficult because there are many different styles of cars as well as car seats, and it isn't until a person attempts to install the car seat that issues arise, says Welsh. Car seats must be secured properly so they don't move more than an inch. Also, there are different categories of car seats designed to fit children of a certain age or weight.

Parents often purchase products such as toys or little baby bags that have been designed to attach to the car seat. However during the safety inspection the technicians tell parents only items that come in the box with the car seat should be used because they alone have been safety tested.

Also, unsafe features of the car are pointed out, such as the roll shades affixed to windows that could be tossed around in the vehicle if they come off in an accident or during a sudden stop.

"We suggest to parents that anything that is hard plastic or metal should be secured in a bag on the floor, in the trunk, or in another part of the vehicle," says Welsh.

In addition, each person who comes to the child safety seat inspection clinic receives a bag of information with key points about safety in the vehicle. Parents are told to look over the information in the bag and if they have questions or need more information to call.

Information on the inspection clinic is printed in the medical center's consumer newsletter. Flyers also are distributed at family education classes. New parents who are transporting a child for the first time make most of the appointments at the inspection clinic, says Welsh.

"Children's safety is our main priority. These inspections are one way we can provide parents and caregivers important information and promote child injury prevention," says Welsh. ■

## SOURCE

For more information about establishing a child safety seat inspection clinic, contact:

- **Sharon A. Welsh**, RN, EMT, Trauma Injury Prevention Coordinator, Program Coordinator: Injury Free Coalition for Kids/Worcester, UMass Memorial Health Care, Room H5-343, 55 Lake Ave. N., Worcester, MA 01655-0333. Telephone: (508) 856-6994. E-mail: WelshS@ummhc.org.

Patient Education Management™

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

# Patient education managers in position to impact different areas of health care

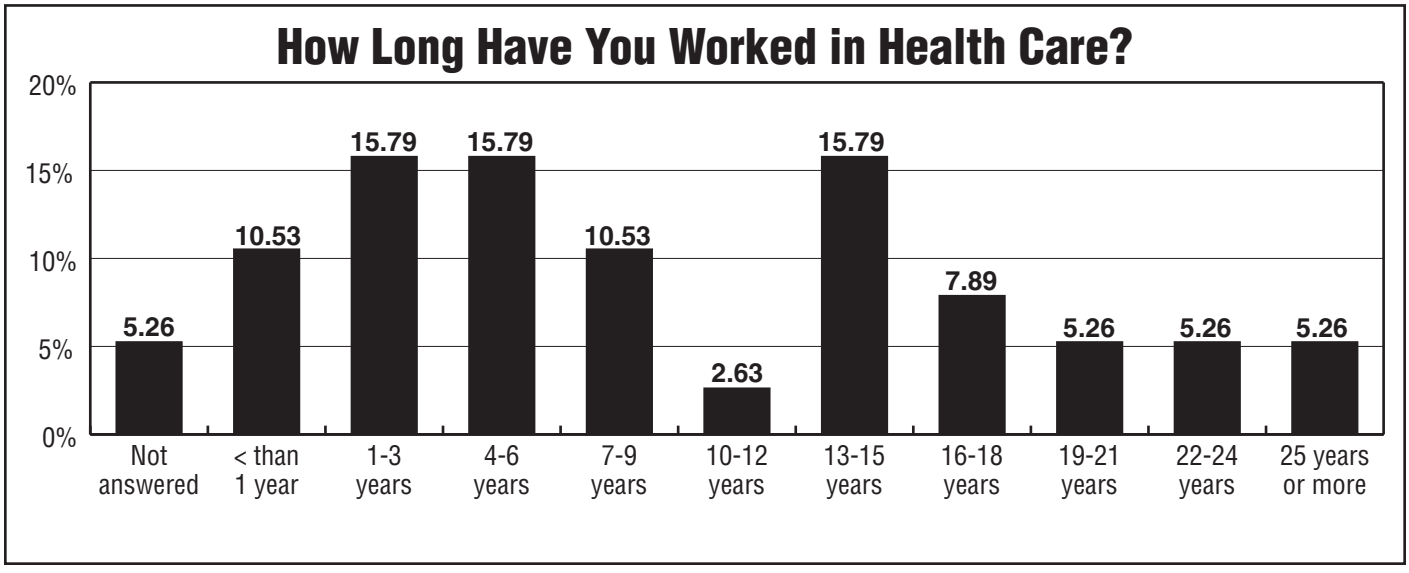
*Bar raised on level of expertise and leadership skills needed to do job*

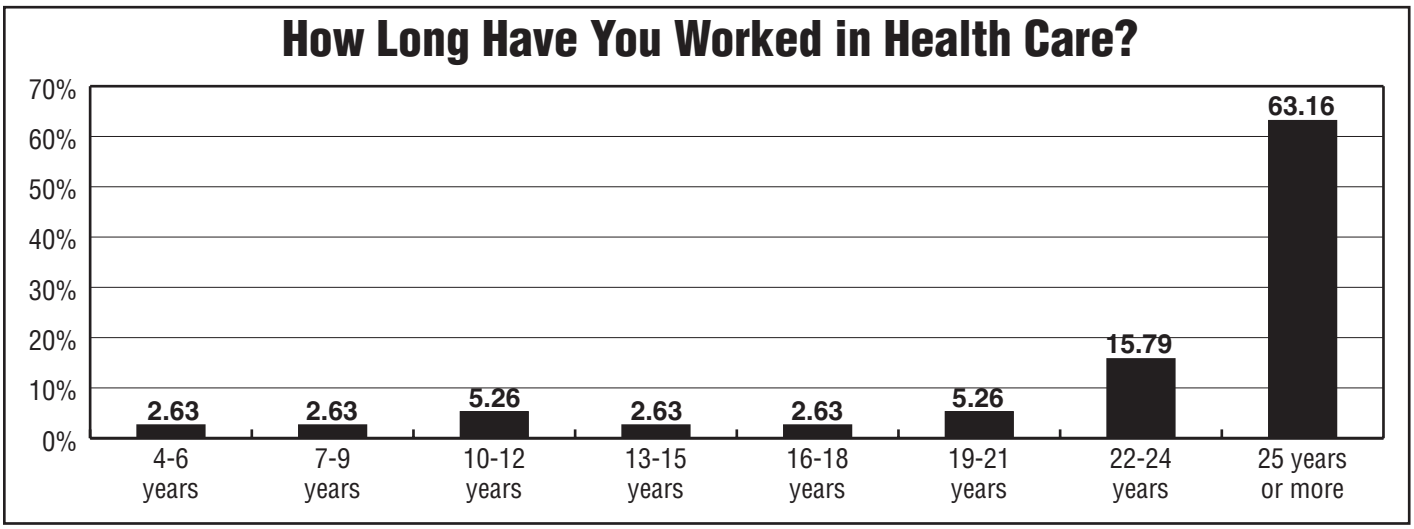
Having expertise in patient education management is no longer enough to do well in the field. Having well-developed management and health care leadership skills has become increasingly important.

"Patient education managers need to be savvy in finance, systems operations, etc. This has always been true to some extent, but I think the bar has been raised on the level of management expertise required," says **Annette Mercurio**, MPH, CHES, manager of patient, family, and community education at City of Hope National Medical Center in Duarte, CA.

Patient education managers are in an extraordinary position to contribute to institutional priorities such as patient safety, disease management, patient satisfaction/quality improvement, and patient-centered care. To make the most of this, opportunity patient education managers need outstanding health care leadership/management skills, she says.

Organizational and patient and family needs






for better partnership in the care experience is shaping the job duties of the patient education manager, says **Cezanne Garcia**, MPH, CHES, manager of patient and family education services at the University of Washington Medical Center in Seattle.

Also impacting the role of patient education manager is the need for education early in the continuum of care such as in the outpatient area rather than during hospitalization. "There is increasing evidence in the literature and in experience to support education early in the continuum of care," she reports.

While patient education has the potential to impact many areas, those in charge of creating the systems, resources and tools don't always have the power to ensure that they are being used.

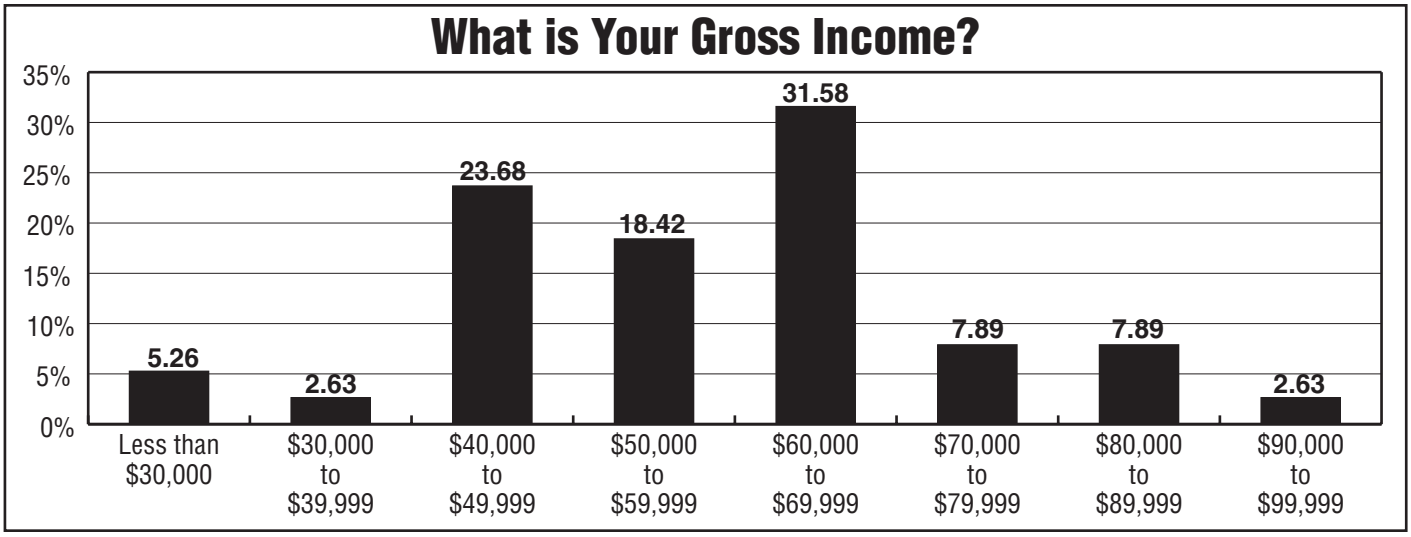
"The nursing shortage is shifting priorities to areas other than education which impacts what is done," says **Mary Paeth**, MBA, RD, patient/community education coordinator at Southwest Washington Medical Center in Vancouver.

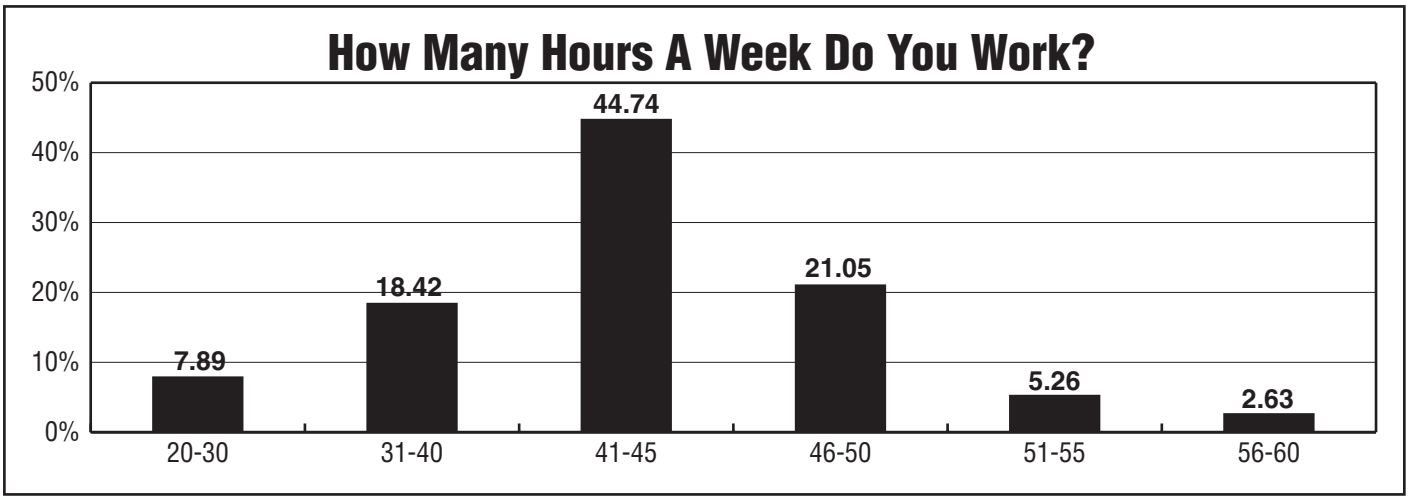
However, efforts on behalf of patient education can bring lucrative rewards. A good percentage of those responding to this year's *Patient Education Management* salary survey earned between $60,000 and $69,999.

There are many issues that impact salary, according to patient education managers. The classification of the position plays a role, with a position in clinical management compensated at a higher level than health educator classifications generally earn, says Mercurio.

Geography also effects salary. Paychecks will be higher in competitive salary markets and where cost of living is higher.

Someone who has been in a position for many years would probably be in a higher salary range as well, says Mercurio. "There are usually step increases in salary range for positions," she says. With each annual performance evaluation salary goes up in the range until the maximum step is reached or the organization extends range maximums for all positions in that group.

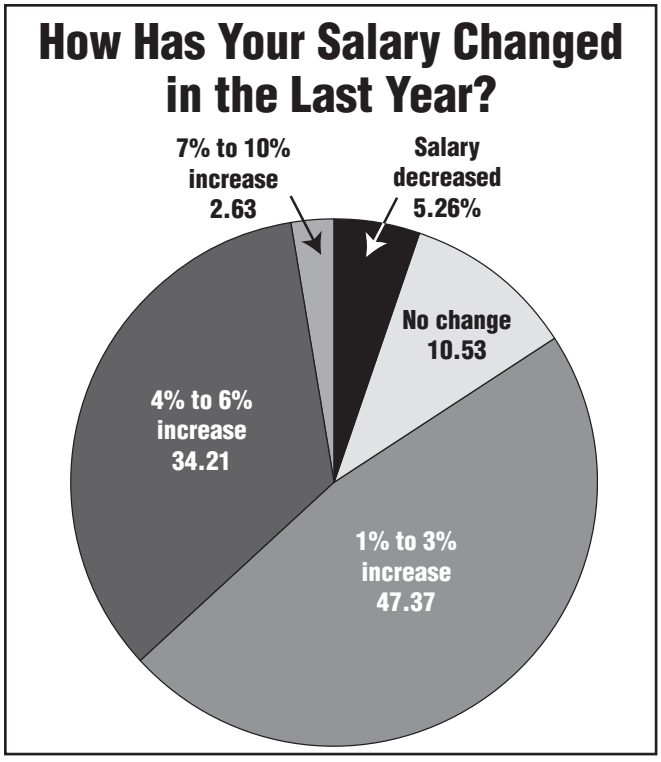





The degree a person possesses could matter. Sometimes someone with a nursing background can command more than someone with a degree in health education, says **Louise Villejo**, MPH, CHES, the executive director of the patient education office at M.D. Anderson Cancer Center in Houston.

The type of organization would also impact salary, says **Yvonne Brookes**, patient education liaison/performance consultant at Baptist Health South Florida in Miami. State institutions often offer lower salaries than private institutions.

It is not surprising that most of the readers who answered the salary survey worked for a nonprofit organization. "This type of organization would be more inclined to support patient/family education in a formal, organized way and also community programs, as their mission is to give back to the community," she explains.




## *Salaries inch up*

Salary increases in the past year were within the 1% to 3% range or 4% to 6% range, according to the survey responses.

For nonprofit organizations, 3% is typical, says **Magdalyn Patyk**, MS, RN, BC, patient education consultant at Northwestern Memorial Hospital in Chicago.

If a person works at a state hospital, raises are usually based on state raises, says Garcia.

"The increases granted in the salary survey fall right into the ranges I've seen for increases," says Mercurio. At the beginning of the year, organizations usually announce what the salary increase will be and then performance dictates what increase within the range an employee receives. The range set by an organization depends on a number of factors, she adds. In very tight years, there are no salary increases and a range up to 6% is an excellent year.

A 41- to 45-hour workweek was about average; however, an even numbered group on either side of this category answered the survey with one group working 31-40 hours and the other spending between 46-50 hours on the job.

The number of hours worked probably depends on how effective patient education managers are at setting boundaries between work and private lives, says Mercurio. "Truly, I suspect that most full-time patient education managers could work an 80-plus-hour week and still feel like they could tackle additional needs," she says.

Garcia agrees. The scope of responsibilities and commitment to the importance of the work discourages letting too much go without completion, she says.

"As you develop your leadership role in an organization, you become sought out for your institutional knowledge and experience to help with items that perhaps don't directly benefit patient/family education but do benefit overall organizational development," says Garcia.

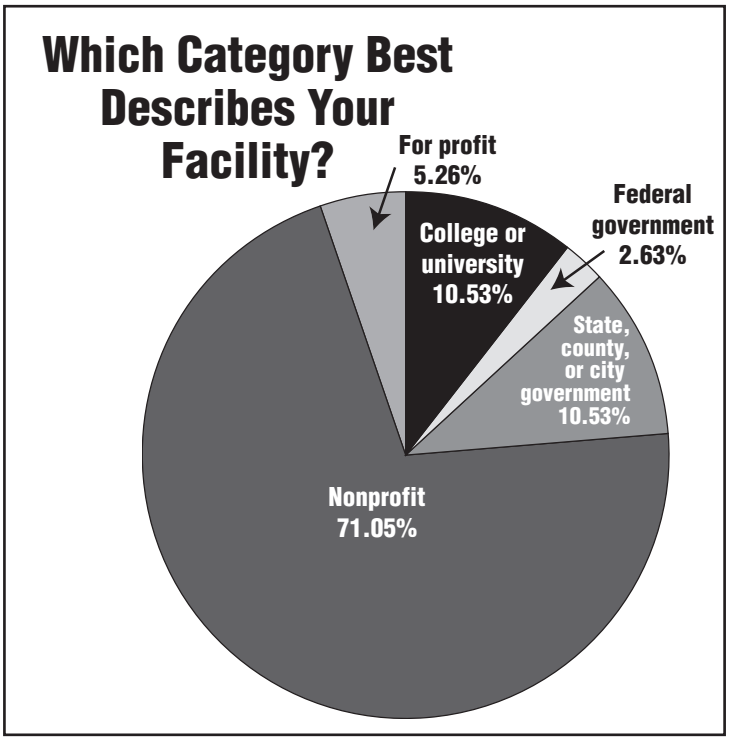
There is absolutely too much to do in too little time, says Villejo. In addition, those in the field of patient education often are altruistic and dedicated to what they are doing.

It is a young field, but it has been growing in the last 20 years, that is why there are a good number of experienced people and more coming into the field regularly, says Villejo.

The data from the survey supports this point of view. The time that people had worked in the field of patient education varied. Some only one to three years, others four to six years, and some a lot longer working in the field 10-12 years, 13-15 years and beyond.

The growth in patient education is driven by consumer demand for information, which led to the explosion of learning centers and health/patient educators, says Villejo. The education standards implemented by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations helped to bring the importance of patient teaching to the forefront, she says.

Even though people have worked in the field a varying number of years, most patient education managers are in their 50s. This is the average age of nurses and the field of patient education still is dominated by nurses although it is much more multidisciplinary now, says Villejo.




## SOURCES

For more information about the comments made in regard to the 2003 salary survey, contact:

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The fact that most patient education managers are RNs probably is the reason that most answering the survey had been in health care for 25-plus years. "To be selected for a patient education coordinator role, a RN would need to have project coordination skills and a breadth of skills and experience typically gained through supervisory and special project roles over a number of years," says Mercurio.

It is hard to be a leader in a field without having actually done the work you are teaching others to do, says Paeth. As a result, many patient education coordinators have been in several jobs and have extensive experience teaching and working with patients and staff, she adds.

Many patient education managers got into the field because they wanted a break from bedside care and when the Joint Commission patient education standards were implemented, they had the experience to develop the patient education processes, says Brookes. ■