

# Patient Education Management™

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



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## Foreign-language material reinforces teaching and improves outcomes

*To meet the needs of culturally diverse patients, turn to the written word*

Providing written materials for a multicultural population is a high priority for many health care institutions.

If an educational piece is important for teaching English-speaking patients, then it equally is important that non-English-speaking patients receive the piece as well, says **Etta Short, MS**, a health educator at the University of Washington Medical Center in Seattle.

"We want to serve the non-English-speaking patient in the same and equal way," she explains.

Similar to English-speaking patients, non-English-speaking patients rarely remember all the verbal instructions they are given. Therefore, it is good to reinforce the lesson with a written handout, reports **Diane Moyer, BSN, MS, RN**, program manager for consumer health education at The Ohio State University Medical Center in Columbus.

"Often we don't provide materials for our non-English-speaking patients because we don't have them available," she says. This leads to

## EXECUTIVE SUMMARY

There are many issues that impact the translation and distribution of patient education materials. One of these is determining which publications should be translated and into which language. Another issue is containing costs as the price for translation services continues to escalate.

In the first of a two-part series on creating a patient education inventory for non-English-speaking patients, *Patient Education Management* addresses those two issues. Next month's issue will address uncovering outside resources, maintaining the inventory, and methods for reinforcing verbal education in addition to the written word.

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problems. For example, sometimes non-English-speaking patients fail to prepare for diagnostic tests properly because they can't remember what the interpreter told them at their last visit.

"In such cases, the test has to be rescheduled. It is difficult to have good utilization of resources when we can't communicate well," says Moyer.

However, there are many barriers to providing written materials to patients from other cultures, and the greatest of these is the expense.

Moyer has \$5,000 in her budget slated for the translation of patient education materials. The cost of translation for patient information materials such as consent forms, patient rights, and parking directions is covered by funds in the customer service budget.

Yet at \$40 a page for translation, not many educational documents are printed annually.

To help stretch her budget, Moyer has partnered with the patient education managers at the other two large health care systems in Columbus. They plan to pool their money for the translation of general patient education materials that are of common use to all three systems, and together they also applied for grants to help cover the cost of translation.

When they first met, they discovered that they all had the same translated inventory, such as baby care and pregnancy information. They all had selected these topics because they are considered high-need and high-risk.

"We found that none of us has the budget to translate a lot of the other types of educational materials such as those for chronic disease or tests and procedures," says Moyer.

Yet these topics are not system-specific. Generally, heart failure is heart failure whether the patient is at a health care system in Ohio or elsewhere, she adds.

The three patient education managers plan to make the generic materials they have translated available on their intranets so that they are accessible to all clinicians within their systems. However, they also will be available to the community at large so that clinicians outside the three health care systems who serve the Central Ohio multicultural populations will also have access to the materials.

"The material will be available in dual languages so that English-speaking clinicians who don't know these foreign languages will be able to know what they are handing out," says Moyer.

To make sure the materials meet the needs of the target populations, the patient education managers will assemble a few community focus groups consisting of members of each target cultural population. In this way, they can get an idea of the issues the various cultures have with health care and incorporate the information into the pieces. "Also, we will find out if there are some particular items that we need to incorporate related to rituals, beliefs, or practices," says Moyer. **(To learn more**

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### Editorial Questions

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

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**about writing materials for different cultures, see article on p. 40.)**

In addition to pooling resources for translation to make better use of funds, the partners hope to contain costs by conducting an extensive search to determine what is available in the public domain. "We want to see what is currently available that we could link to or import somehow into our inventory to make available to our clinicians," says Moyer.

They also hope to partner with other health care systems that are willing to share documents. Frequently, staff at other health care institutions will contact Moyer to ask if they can translate one of the patient education items that is posted on The Ohio State University Medical Center's web site. If the other institution will allow Moyer to use the translated copy and include it in the inventory on the medical center's site, she gives permission.

Without enough funds to translate all educational materials from English to the foreign languages most frequently spoken by patients seen at the health care facility, patient education managers must determine where to spend their money. They must figure out which publications would be the most cost-effective to translate, says Moyer.

At the University of Washington Medical Center, staff in patient and family education services created guidelines for the selection and translation of written materials into the foreign languages spoken by its diverse patient population. These languages include Amharic, Chinese, Korean, Farsi, Russian, Somali, Spanish, Tagalog, Tigrigna, and Vietnamese.

With the aid of the guidelines, the medical center is able to translate between 12 and 18 English-version documents in up to five languages, adding between 30 and 50 documents to its collection each year, says Short. "We have a certain amount of funds we can use for translation each year, so we

want to be able to serve our patients the best we can with the funds we have to do the translations."

The best way to determine which teaching materials to translate is to go to the departments and ask, she says. Therefore, each April, patient and family education services sends out a request for proposed translations.

During the solicitation period each clinical services area identifies five frequently used patient education documents authored by the medical center that need to be translated into one or more languages. To help make the determination, staff can use data from interpreter services but generally they know which ethnic groups they see, says Short.

Departments are requested to prioritize the documents selected for translation and to identify the estimated number of patients per month that could be given the material. They have one month to submit their requests for translation.

Once the requests are on file, Short checks the patient and family education database to determine if the material has been translated or is in the process of being translated before submitting it to a multidisciplinary task force for review.

The task force ranks each publication according to set criteria. With the aid of the criteria the review process takes about two hours. **(To learn more about the criteria used in the selection process see article on p. 40.)**

Generally, everything that receives a 3.5 rating and above is submitted for translation. However, before the list is finalized, Short has a translation vendor that has been approved by the medical center provide a cost estimate to ensure that the project remains within budget.

The list of approved translations is completed by June, and a letter is sent to each department contact with the titles of documents and the languages that have been approved or rejected. If a document is not accepted for translation, the reasons it did not meet the criteria is included in the letter. (Short is willing to share the complete guidelines for the selection and translation of materials with anyone who asks. **See source box, above left.**)

Once the materials are translated and available as patient handouts, it is important to get the word out so they will be well used by clinicians to educate patients.

A newsletter that goes out every quarter at the University of Washington Medical Center lists all patient education materials that were printed or published for that quarter, both English and

## For cost-effectiveness, set translation criteria

*A point system helps to determine need*

Translating patient education materials into foreign languages is costly; therefore, it is important to select those that would benefit the greatest number of patients. Yet without criteria to evaluate each piece, it is difficult to determine which ones should be translated.

To take the guesswork out of the process, the University of Washington Medical Center (UWMC) in Seattle created a set of criteria.

"Our criteria was put together by the patient and family education committee in 1996 and it has worked, says **Etta Short**, MS, a health educator in Patient and Family Education Services.

Each year, a task force uses the criteria to determine which educational materials to translate. The pieces are ranked by a point system and must receive at least 3.5 points to be considered for translation.

A document may be rejected because the volume or material required is too low, a similar tool may be available in the desired

language from another source, or authorship is not the UWMC.

The following are the criteria used:

- High volume of non-English-speaking patients. If a department could distribute the educational piece to five or more patients each month, it receives one point.

- Patient instructions are used in other clinical settings at UWMC. If materials are used in other clinical settings, the piece receives one point.

- The material has been reviewed for accuracy within the last three years. If the material is up-to-date, it receives one point.

- The material targets high-risk/problem-prone patient groups. If the written piece helps to educate high-risk/problem-prone patients, it receives one point. These include pre-surgery instructions, insulin regimens, and instructions for after-procedure care such as a coronary intervention.

- The material is authored in house. If the University of Washington Medical Center produced the piece, it receives half a point.

- Patient education material is not available through another vendor. If the material is not available in desired language(s) from commercial sources, it receives half a point. ■

translated information. Also, all translated pieces are in the on-line inventory so clinicians can do a search and then print them out, says Short.

Currently, The Ohio State University Medical Center is upgrading its intranet, and part of the project includes flagging English titles that have versions in other languages. Titles also can be found in language subcategories such as Spanish or Somali.

"We are trying to do more cross-referencing so that staff know the translated pieces are there," says Moyer. ■

## Accurate translation is not always enough

*Rules for creating culturally appropriate materials*

When creating written materials for a multicultural population, translation from English to the target language is not enough.

There are many other factors that must be taken into account to make sure the target audience understands the information.

Health literacy is more than just being able to read the information, it is being able to act on it, says **Sandra Cornett**, PhD, RN, director of The Ohio State University AHEC Health Literacy Program in Columbus.

"Culturally and linguistically appropriate materials must include not only the words people understand but also the logic they use and a connection to their experience," she explains.

Even exact translations may not make sense to the target audience. People's background and culture often provide a different frame of reference than the one Americans are accustomed to, and this creates barriers to understanding.

For example, Latinos often are put off by facts, says Cornett. They like to have information given in the context of family or community participation rather than having everything presented as an individual effort.

Cornett offers the following tips to help patient

## SOURCE

For more information about writing culturally appropriate materials, contact:

- **Sandra Cornett**, PhD, RN, Director, OSU/AHEC Health Literacy Program, Office of Health Sciences, The Ohio State University, 218 Meiling Hall, 370 W. Ninth Ave., Columbus, OH 43210-1238, Telephone: (614) 292-0716. E-mail: cornett.3@osu.edu.

education managers make sure that teaching materials are culturally appropriate:

- **Get target audience involved.** One way to learn how other cultures prefer their message framed is to get them involved in the developmental process from the start.

“Find out what the intended audience wants and how they perceive the issue, then write the material from their perspective,” says Cornett.

In this way, the material is more likely to be consistent with the reader’s beliefs about health, the cause of illness, methods of curing, and death. The recommended treatments and diets will be something they are more likely to follow as well. For example, a person from another culture may not think that his or her illness is a result of germs but rather a mind/body disconnection.

- **Don’t assume that the medical process is understood.** People from other cultures may not know what to expect in a medical encounter within the American health care system. Therefore, this information may need to be included.

For example, people from other cultures may need to be told that the physician will take a medical history by asking them several questions. If they don’t understand this, they may think the physician is not skilled.

Or patients may need to be told that the physician may give them a prescription for medication and what to do with the piece of paper. In their culture, they may not get medications from pharmacies.

### **Presentation of information**

- **Consider appropriateness of the presentation.** The organization and sequence of information can be different with other cultures. Pamphlets for people born in the United States often begin with an overview or the big picture followed by specific steps. People in other cultures may want to learn gradually and not have so much information included in the introduction.

In addition, a symbol that is common in the United States may not be understood by other cultures. For example, not everyone eats with a knife and fork.

While cartoons and cartoonlike figures may be appropriate in pamphlets designed for an American patient population, humor may be seen as offensive to people of other cultures. In some cultures, health care is seen as serious. Therefore, humor would not be used to provide information on a health issue.

- **Use graphics to support message.** Pictures and visual cues help supplement the message and graphics reinforce key concepts. However, the images must match the intended audience in terms of ethnicity, dress, age, gender, income level, and activities in which they engage.

- **Field test materials.** When writing for other cultures, it is important to field test the material to make sure that it is in keeping with cultural norms and not offensive in any way. There are many different dialects, and a Spanish word that might be appropriate for people from Puerto Rico might be offensive to patients from Mexico.

Also, there may not be a word for the English equivalent of a certain condition or body part. Therefore, a description will replace it. For example, there is no Vietnamese word for cervix. It’s important to know that the content is understood.

- **Provide information in multiple ways.** Print is not the only or necessarily the best way to communicate health information with people from other cultures. Audiotapes, pictorial materials, stories, props, or role-playing may be good ways to disseminate information, especially with people who are not literate in their own language.

Written materials might be more effective if they are formatted in ways that are culturally appropriate. For example, Latinos like novellas with the material presented from the perspective of what the family is experiencing and written like a story. ■

## **Notebooks designed to fill the gap help rural patients**

*Long drive to city not always an option*

Although Valley View Hospital in Glenwood Springs, CO, had used grant money to purchase a comprehensive breast cancer notebook, it did not fit its patient population.

“It was a great resource; but it wasn’t entirely applicable to our valley, so we customized it,” says **Susan Laws**, RN, MS, education resources manager, for the 80-bed rural facility located about 180 miles from Denver.

Because the notebook focuses on local physicians’ practices and resources that easily are accessible within the community, patients say that it is more useful than anything else they have been given. People often assume that patients can drive to Denver for medical care and resources, yet it is not always appropriate or necessary, says Laws.

To create a notebook suitable for its rural patient population, Valley View Hospital created a committee to determine what information to include from the purchased workbook and what needed to be changed. Laws then put together a rough draft for review by the oncologists on staff, the radiologist, internal medicine physicians, the oncology department staff, and the general surgeons. On average, 75 are distributed to patients each year.

The notebooks are good news and bad news, says Laws. The good news is that they are being used, and the bad news is that they are needed.

The notebook is about 130 pages and is very comprehensive. The emotional aspects of having breast cancer are included with much of this information coming from the original book.

There also is quite a lot of information on sexuality and breast cancer that was obtained from M.D. Anderson Cancer Center in Houston. Laws obtained permission to use copyrighted materials from other health care organizations.

Information that is specific to the area includes local insurance coverage, the case management process at Valley View Hospital, and the Colorado CPR directive that provides instructions for emergency medical service workers. Also included are listings of support groups, supportive care at the end of life, and a comprehensive resource list with local and national contacts.

There is a lot of general information in the booklet, such as the different types of breast cancer, its stages, tests physicians might order, treatment options, self-care, and a glossary of medical terms.

Laws worked with a physical therapist at the hospital on a section about lymphedema. This section complements a book that is included with the material titled *Recovering from Breast Surgery* by Diana Stumm, published by Hunter House in Alameda, CA.

A piece on breast reconstruction after a mastectomy was written by the hospital’s plastic surgeon, and Laws worked with the oncology nurses on the chemotherapy section.

“Most patients receive the notebook in the general surgeons office when they get their diagnosis. Patients are finding it gives them a lot of information on what they can expect,” says Laws.

They learn that the emotions they are feeling are normal and where to find resources in the valley such as a wig if they choose to wear one after chemotherapy treatments.

### ***Workbooks meet other needs***

Following the success of the breast cancer education notebook, Laws looked for other areas that would benefit from a comprehensive education packet. She based her decision for notebook topics upon needs assessments from staff.

A cardiac rehab notebook is given to patients who participate in the cardiac rehab program. Initially, Laws worked with a cardiac rehab specialist on the material to be included before health care providers who work with these patients reviewed it. There is an extensive section on cardiac medications, information on nutrition, and also depression. Specialists in these areas helped write the copy.

A notebook on heart failure was just introduced. It came about following a needs assessment with the nursing staff on the acute care unit. They were having difficulties finding time to hit all the details that should be covered when teaching heart failure patients according Medicare mandates.

“There are core measures that have to be tracked on several different diagnoses, and one is heart failure,” says Laws.

These include exercise, diet, medications monitoring, signs and symptoms, and follow-up. The heart failure notebook covers these topics extensively as well as a discussion of what heart failure is. It also contains a glossary of medical terms.

There isn’t as high a need for the cardiac rehab and heart failure notebooks as there are for the breast cancer notebooks. Laws initially printed 25 of the notebooks to support teaching in the cardiac rehab program and 20 for heart failure patients. But the notebooks are expensive. One printer wanted \$150 per notebook to print them.

Therefore, Laws uses a computer printer to make copies that include color. However, she hopes to obtain a grant to purchase a color copier.

## SOURCE

For more information about creating notebooks to support teaching in a rural health care setting, contact:

- **Susan Laws**, RN, MS, Education Resources Manager, Valley View Hospital, 1906 Blake Ave., Glenwood Springs, CO 81601. Telephone: (970) 947-5576. E-mail: susanl@wh.org.

This year, she budgeted \$32,000 for supplies such as notebooks and dividers.

The hospital has enough Spanish-speaking patients to warrant the translation of the material, and Laws is working on that.

About half the breast cancer notebook is translated, and the others will be next in line. The hospital is using an in-house translator on the project, she says.

A notebook for diabetes containing information on self-care also is distributed to patients. Most of this material is from a commercial vendor and the American Diabetes Association. ■

## Avoid PCA errors with education, wise selection

*Don't let family members administer medication*

**M**edication errors associated with patient-controlled analgesia (PCA) pumps most often are caused by inadequate patient and staff education, misuse by well-intentioned family members, and improper patient selection, according to results of a recent survey by the Institute for Safe Medication Practices in Huntingdon Valley, PA.

"Although our survey was informal, the health care practitioners who responded identified a number of reasons for PCA errors," says **Hedy Cohen**, RN, BSN, MS, vice president of the nonprofit organization that reviews and provides education on medication errors and adverse events to the health care industry.

One of the most frequently cited practice-related problems is incorrect programming of the PCA pump, she says. Staff may misplace a decimal point, misread a prescription, or neglect to double-check settings before beginning infusion, Cohen reports. "It is essential that staff members not only receive initial training on the pump, but that they also be retested on the pump's use frequently."

Because different brands of pumps require staff members to learn a variety of programming steps, it is best to choose one pump for the entire facility, Cohen adds. "It is not only more efficient but also more effective if your nurse has to learn how to program and how to teach the patient to operate only one pump," she says.

Another frequent reason for misuse of PCA pumps is a well-meaning family member, Cohen points out. One of a PCA pump's safety features to prevent an overdose of medication is a lockout interval that prevents a patient from administering a dose within a certain time period, she says. "Patients are supposed to evaluate their own pain level and administer medication when they feel the need. This means that a drowsy, sedated patient won't push the button for more medication."

Unfortunately, well-meaning family members or nurses may push the button and think that they are helping the patient avoid pain, when, in fact, they may be oversedating the patient, she says.

While PCA pumps are designed to prevent over-medication, this safety feature works effectively only when the patient is pushing the button, Cohen explains. If a patient already is drowsy or sedated from anesthesia or pain medication administered in the recovery area, the patient won't push the button for more medication because he or she feels comfortable, she explains. If, however, a family member decides to push the button to help the patient avoid pain, the pump may administer the medication because the request for medication falls within proper time frames and doses, she says.

"This extra medication has resulted in over-sedation, respiratory depression, and even death," Cohen adds. One way to avoid "PCA by proxy" is to hang a sign on every PCA pump that clearly states that the patient is the only person who should push the button, she suggests. "It's also important to emphasize this fact to nurses in their own education and to family members during patient education."

Proper patient selection also is critical when determining who will use a PCA pump, adds Cohen. "The patient must be mentally alert and capable of managing his or her own pain in order to be issued a PCA pump," she says.

When an infant, small child, or cognitively impaired elderly patient is assigned PCA, the staff are relying upon PCA by proxy, and that process often has errors associated with it, she adds.

PCA is an effective, safe way to control pain, Cohen explains. "The only problem is that we've

## RESOURCES

A copy of the report on patient-controlled analgesia can be viewed at no cost on-line at [www.ismp.org](http://www.ismp.org). Choose "Medication Safety Alerts" from the top navigational bar, then choose "Archives." The report is in two parts and appears in the July 10, 2003, and July 24, 2003, issues. For more about the *ISMP Medication Safety Alert* that reviews safety issues with patient-controlled analgesia, contact:

- **The Institute for Safe Medication Practices**, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006. Phone: (215) 947-7797. Fax: (215) 914-1492.

For a free review of patient-controlled analgesia pumps conducted by ECRI, a nonprofit health research organization in Plymouth Meeting, PA, go to: [www.ecri.org](http://www.ecri.org) and click on the "Patient Safety" button on the right side of the home page. Scroll down the left navigational bar to "Health Devices Alerts Special Reports," and choose *JCAHO's 2003 National Patient Safety Goal for Infusion Pump Free-Flow Protection: Assessing General-Purpose and Patient-Controlled Analgesic Pumps*.

become complacent because 99% of the time, there are no problems," she says. "We need to make sure we stay alert to the errors that can occur infrequently." ■

## Ergonomics program gives a lift to morale

*Hospital survey shows satisfaction*

Ergonomics is more than a way to lift patients. As Butler (PA) Memorial Hospital found, it can lift morale and employee satisfaction as well. The challenge is to overcome negative perceptions and convince staff that hospital administration is serious about reducing injuries, says **Karen Bosley**, RN, manager of the employee health service of the western Pennsylvania hospital.

In a five-question survey, she found that employees did not feel they had adequate training or equipment. The survey indicated that employees believed that injuries were not a high priority to hospital administration. As a consequence, the employees paid little attention to the ergonomic devices the hospital provided. "We found we had employee reluctance to take the time to either use the equipment or get additional

staff [to help with a lift]," Bosley explains.

During the following year, the hospital spent \$80,000 on equipment, developed a training program, and initiated an incentive program to reward employees who complied. Visible support for ergonomics was evident from administration. Injuries declined by 33%, and related medical costs were reduced by \$123,000. Just as important, however, was the change in attitude, as demonstrated in a post-implementation survey. "It's absolutely amazing," she says. "Now people think administration cares. They know they've gotten education. They know we've got equipment."

Ergonomics now has become one aspect of the hospital's efforts to be an "Employer of Choice" — a hospital that has an edge in recruitment and retention. Butler Memorial actually began to investigate ergonomics because of concern over several serious injuries. It was not just the cost that concerned Bosley; although at \$400,000 in workers' compensation, the cost was significant. "We identified employees who had been injured previously, whose quality of life had been [permanently] changed." Employees had undergone back surgery, including fusions and discectomy, due to work-related injuries, she says.

"They're still working here, but they are not able to do the job they were doing before," Bosley points out. "They are RNs who will probably never be able to go back to the nursing job they did before. Most of them are in nonpatient care-related jobs, such as data collection or staff education. We didn't want any other person to have to go through that. We wanted to see what we could do to prevent future injuries."

In July 2001, the hospital's safety committee decided to create a subgroup to investigate the injuries and develop a plan of action. The committee included Bosley, the safety officer/risk manager, an ergonomist, an employee educator, a floor nurse, the physical therapy director, and the systems improvement manager.

### **Identifying cause**

The causes identified by the team are common ones: Employees used poor transfer and lifting techniques. The hospital had no policy defining safe lifting techniques. It lacked adequate equipment. Employees needed patient assessment tools to define when equipment should be used, and employees were reluctant to take the time to use equipment or get additional staff. Bosley and her colleagues wrote a policy and developed

patient assessment algorithms. But they knew that was just the first step.

The safety team sought strong administrative support as well as employee buy-in. She and her colleagues were able to get a commitment for \$80,000 to purchase equipment — and the team agreed to be accountable for results. They assured administrators they would achieve a reduction in lifting injuries by at least 25% and a savings of \$100,000 in related costs. “We really were adamant that we could do it,” Bosley stresses. “We asked for this money and asked for a chance to prove that we could make a difference.”

The survey of 1,500 employees provided a way to measure another outcome: employee satisfaction. The safety team was very hopeful it would improve after the intervention.

Staff and managers were an integral part from the start of the program. Employees helped evaluate and select the lifting equipment. They acted in a video that became the training tool for the lift devices. Supervisors added ergonomics to their annual staff competency testing. Additionally, the

hospital’s ergonomist went to office workstations to make adjustments and improve comfort.

They also faced a common challenge: How do you keep employees motivated to use the equipment? She uses an incentive program to reward staff who were observed using lifts, Hover mats, gait belts, or other ergonomic items. Employees receive \$5 gift certificates for pizza, ice cream, movie theaters, and other local stores, along with a congratulatory note. “It wasn’t a great deal of money, but it’s made a tremendous impact,” explains Bosley, who estimates she spent about \$1,000 on the incentives. “People really do appreciate that they’ve been noticed.”

She adds that she was recently pleased when she learned of two employees who followed the appropriate lifting policy when a patient lost her balance and began to fall. The nurses eased her gently to the floor. Then, instead of manually lifting her, one stayed with her while the other got a lift. “They didn’t put their own backs at risk,” says Bosley. “The patient wasn’t injured, and neither were the employees. It’s a win-win.” ■

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## Watch for SADS signs; killer runs in the family

*History and thorough exam lead to diagnosis*

**H**heart problems that cause sudden death in children often are uncovered following a tragedy. At that time, health care professionals look at other members of the family to see if there is a heredity disorder that resulted in the death.

That’s why public awareness of Sudden Arrhythmia Death Syndrome (SADS) is important, says **Peggy Strieper**, MD, director of pacing and electrophysiology at the Sibley Heart Center at Children’s Healthcare of Atlanta. People need to know the warning signs so they will recognize a problem in a child before a death occurs and an evaluation of the family is conducted in retrospect, says Strieper.

SADS encompasses a number of different cardiac arrhythmia problems that can cause sudden death in the young. These conditions include long QT syndrome, hypertrophic cardiomyopathy, and arrhythmogenic right ventricular dysplasia.

One of the most common electrical abnormalities of the heart is long QT syndrome, which is an abnormal electrical resetting of the heart. With long QT syndrome, the electricity takes longer to reset

itself when it travels from the top chamber to the bottom chamber of the heart. The measurement on the electrocardiogram (EKG) of the electricity moving down through the lower chambers and then resetting itself is called the QT interval. The QT interval represents the duration of ventricular depolarization and subsequent repolarization, beginning at the initiation of the Q-wave of the QRS complex and ending where the T-wave returns to isoelectric baseline. QT interval prolongation creates an electrophysiological environment that favors the development of cardiac arrhythmias. When patients have long QT syndrome, it takes longer for the resetting to occur, so there is a longer measurement on the EKG.

“If it takes longer and your heart all of a sudden starts beating faster, you almost have a collision of the electrical forces with the electricity coming down from the top chamber and it hasn’t reset itself yet,” says Strieper.

People who have long QT syndrome frequently have fainting episodes. However, these are not your usual episodes where a person gets light-headed and dizzy, begins to see spots before his or her eyes, followed by tunnel vision, and then passes out. People who have long QT syndrome faint without any sort of warning sign, says Strieper.

This fainting episode might happen during exercise, an emotional outburst, when an alarm

## SOURCES

For more information about long QT syndrome, contact:

- **Peggy Strieper**, MD, Director of Pacing and Electrophysiology, Sibley Heart Center, Children's Healthcare of Atlanta. Telephone: (404) 256-2593.
- **The Sudden Arrhythmia Death Syndromes Foundation**, 508 E. South Temple, Suite 20, Salt Lake City, UT 84102. Telephone: (800) 786-7723 or (801) 531-0937. Web site: [www.sads.org](http://www.sads.org).

clock sounds, when there is a loud noise, or when a person is out in the water swimming. "Those are all red flags that need to be evaluated," says Strieper.

In addition to fainting, some patients complain that their heart is beating faster or irregularly. An irregular heartbeat during or immediately after exercise and fainting while playing sports or immediately after may be signs of long QT syndrome.

### Making the diagnosis

One way a diagnosis is made is to have the patient run on a treadmill to see if it will induce a ventricular tachycardia or abnormal lengthening of the QT interval on an EKG. Normally, when people exercise, their heart rate goes up; it takes less time for the heart to reset itself, so the QT interval shortens and shortens, says Strieper. People with long QT syndrome have inappropriate lengthening of the QT interval with exercise and if the timing is just right, they can end up inducing ventricular tachycardia.

For children, it is a good idea to have a pediatric cardiologist do the tests, says Strieper. Although adults have fairly standard EKGs, they can vary with children. As a result, someone who is used to evaluating pediatric EKGs needs to interpret it.

"The diseases that we deal with are so different than what an adult cardiologist deals with it would be like having a 70-year-old [patient] come and see me to discuss coronary artery disease," said Strieper.

If long QT syndrome is found, the pediatric cardiologist will test other family members because the condition tends to run in families. If the mother or father has long QT syndrome, there is a 50% chance that their child will inherit it. Often when a child is referred, although he or she may have been diagnosed correctly, no family

members have been screened, such as the siblings and cousins.

"If you forget to look at everyone, you could still have a tragedy," says Strieper.

In addition to an EKG to see if the QT interval is long, pediatric cardiologists also get a detailed family history. Usually when asked if there is a family history of sudden death, families will say no. However, when questioned more carefully, they will say that an uncle drowned even though he was a good swimmer or drove off the road and was killed in a car crash. These could be signs that long QT syndrome runs in the family.

Anyone who works with children, including teachers and coaches, needs to be aware of long QT syndrome. If a child passes out after exercise or complains of an irregular heartbeat, he or she needs to see a physician. Most importantly, when parents suspect that their child has been misdiagnosed, they must ask to see a specialist.

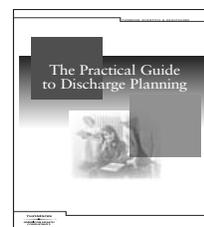
"It is always difficult, but parents need to be their child's advocate," says Strieper. ■

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# Campaign promotes kids' E.N.T. health

*Web site source of reliable info*

After well-child visits, three of the top five reasons parents take their children to pediatricians are for ear, nose, and throat problems such as ear infections, sinusitis, and tonsillitis. Parents need education on how to manage these common conditions in an era of resistant antibiotics.

Therefore, the American Academy of Otolaryngology-Head and Neck Surgery, located in Alexandria, VA, has created Kids E.N.T. (ears, nose, and throat) Health, a web site with good, reliable information that health care professionals and consumers can use. **(To learn how to access information on the web site, see editor's note at the end of this article.)**

Health care professionals can distribute the fact sheets to patients or simply give them the web address. The information is invaluable, says **Jerry Schreibstein**, MD, president of the Massachusetts Society of Otolaryngology and a clinical assistant professor of otolaryngology at Tufts School of Medicine in Boston.

He frequently uses the information to help educate parents. For example, when he tells parents that their child needs a tonsillectomy and adenoidectomy because enlarged tonsils and adenoids are blocking the upper airway resulting in sleep apnea, they have many questions. They want to know the definition of sleep apnea. Also, many parents do not know where the tonsils and adenoids are located in the body, though most have heard the terms, or the indications for surgical removal, the different techniques for removal, and the common problems people might encounter afterward.

While physicians can distribute handouts from Kids E.N.T. Health, the site is a good resource for parents as well. It is difficult for parents to know if they are getting reliable information when researching topics on the web and there is a lot

## SOURCE

For more information about Kids E.N.T., contact:

- **American Academy of Otolaryngology**, Head and Neck Surgery, One Prince St., Alexandria, VA 22314-3357. Telephone: (703) 836-4444. Web site: [www.entnet.org](http://www.entnet.org).

of misinformation available, says Schreibstein.

For example, many people believe that if a child's tonsils and adenoids are removed, he or she will be more susceptible to infection, but other lymph nodes process bacteria and viruses to create antibodies to fight infections.

In addition to accessing reliable information, parents can use the web site to determine if their child's ear, nose, or throat problem requires a visit to their physician. For example, it is not uncommon for a child to snore, but it may be a sign that he or she has sleep apnea. Signs of sleep apnea might be choking episodes at night or excessive sleepiness during the day.

If a child is having a tonsillectomy or getting ear tubes, parents can watch the procedure on videos accessed through the web site. They also

## 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. ■

## COMING IN FUTURE MONTHS

■ The wisdom of prevention education

■ Creating a patient education culture

■ Strategies for timely project completion

■ Must-have books and resources

■ Jump-start discharge planning upon admission

## CE Questions

13. When building a library of materials for non-English-speaking patients, it is a good idea to do which of the following in order to stay within budgets and meet patient needs?
- A. Partner with other institutions
  - B. Create selection guidelines
  - C. Limit materials to commercial vendors
  - D. A & B
14. Which of the following health literacy factors should be considered when creating materials for non-English-speaking patients?
- A. Possible difference in logic
  - B. Climate of patient's native country
  - C. Politics of patient's native country
  - D. All of above
15. According to a recent survey conducted by the Institute for Safe Medication Practices, medication errors associated with patient-controlled analgesia pumps most often are caused by inadequate patient and staff education, misuse by well-intentioned family members, and improper patient selection.
- A. True
  - B. False
16. Patients with long QT syndrome frequently have fainting episodes that come without warning, which can be triggered by:
- A. A loud noise
  - B. An emotional outburst
  - C. A & B
  - D. None of the above

**Answer: 13. D; 14. A; 15. A; 16. C.**

can watch the video with their child if they determine the material is appropriate.

"The Kids E.N.T. campaign has been striving to provide a good reliable source of information that pediatricians and ear, nose, and throat specialists can use to educate parents," says Schreiberstein. The campaign will last for five years.

*(Editor's note: Kids E.N.T. Health is an on-line resource offering the latest information from otolaryngologists throughout the United States. Information includes a glossary of terms as well as articles and fact sheets. To access, go to: [www.entnet.org/kidsent](http://www.entnet.org/kidsent).)* ■

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## 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. ■