Patient Education Management™

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

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IN THIS ISSUE

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Find ways to support verbal education for patients who don't speak English

Language barriers encourage educators to be creative

Addressing the educational needs of non-English-speaking patients is becoming increasingly difficult, given the influx of immigrants and foreign visitors to the United States.

"It gets harder and harder to maintain [support for] every language for every situation that comes around," says **Eileen Troutman**, RN, BSN, OCN, senior oncology nurse for community cancer education at OhioHealth in Columbus.

Interpreters can provide verbal translations via telephone, but reinforcing verbal education isn't always easy. Non-English-speaking patients are no different from those who speak English in at least one way: Patients taught verbally retain about 20% of what they hear, says **Kathy Ordelt**, RN, patient and family education coordinator at Children's Healthcare of Atlanta.

Patients verbally taught at the bedside and then given a handout or video retain 50% of the information. When verbal teaching is accompanied by hands-on instruction, retention jumps to 90%, says Ordelt.

Patient education managers are developing new ways to help non-English-speaking patients increase retention of the information they're taught. One method is collecting an inventory of materials in languages most frequently spoken by the non-English-speaking patients who visit a

EXECUTIVE SUMMARY

The April issue of *Patient Education Management* presented the first of a two-part series on the translation and distribution of in-house written materials for non-English-speaking patients. This issue addresses creative methods for reinforcing verbal education with both written and non-written material, discovering outside resources, and keeping the written inventory up to date.

health care facility. Managers also are acquiring teaching tools to foster communication when language is a barrier and discovering ways to reinforce teaching when written materials and videos are not available.

Children's Healthcare of Atlanta is a pediatric facility, so dolls with central lines, tracheotomy sites, and other models of medical interventions are common teaching tools. The dolls allow non-English-speaking parents to learn about self-care on the doll first and then translate this information to their child at the bedside, just as English-speaking parents would do, says Ordelt. Staff members are comfortable with this teaching technique because they already use the dolls successfully with English-speaking patients and families.

"Having the parents work with the doll and then with their child gives us the biggest bang for our buck as far as them learning what to do. So a lot of the teaching is hands-on reinforcement," says Ordelt.

The time needed to teach non-English-speaking patients is a drawback. When interpreters are added to the teaching team, the time required for teaching doubles or triples, says Ordelt.

Pictures often are used to teach people with low literacy skills, and these tools also are a good method for teaching non-English-speaking patients, says **Teresa Towne**, MSN, RN, inpatient educator at Bayhealth Medical Center in Dover, DE.

Bayhealth uses a handbook titled "Do You Understand?" that is published by the Literacy Volunteers of America in Syracuse, NY. "The book has great picture resources that are ideal as an assessment tool, particularly when the nurse is admitting the patient," says Towne.

Sometimes educational efforts can be tailored specifically to the culture. For example, people from Somalia enjoy storytelling, and most do not learn from the printed word. Therefore, a good way of disseminating information to this patient population might be through an audiotape having a native speaker teach the patient by telling a little story, says **Sandra Cornett**, PhD, RN, director of The Ohio State University AHEC Health Literacy Program in Columbus.

When the written word is necessary

No matter how education takes place, written materials often are necessary to give patients a resource to which they can refer if they forget certain steps to a procedure or other important information.

Maintaining teaching sheets in every language for patients admitted to a health care institution is difficult. Fairview-University Medical Center in Minneapolis uses staff from Interpreter Services to provide both verbal information and written material.

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To ensure patients receive the written information they need to reinforce teaching, staff in the Patient Learning Center at Fairview-University Medical Center developed simple instruction sheets in English that contain the most essential information for each of the units or classes taught.

"We ask that the interpreter make notes in the person's language on those cards. That way, we are sure the patient is getting the most up-to-date information in his or her language," says **Nancy Goldstein**, MPH, patient education program manager at Fairview-University.

OhioHealth looks for materials in the languages needed to teach on certain topics rather than translating materials, because the cost is $100 per page. "If there is something that has already been written that meets our standards, we would purchase that rather than paying to convert all of our materials," says Troutman.

When purchasing materials from outside sources, it is important to establish criteria, adds Troutman. The material must have an English version so medical staff know what information is being given to patients. Also, the information cannot conflict with anything the physicians at OhioHealth teach.

To make sure materials from outside sources are reputable, staff members at OhioHealth first look to medical educational resource publishers that have a good reputation.

Networking with colleagues is another way to find reliable education resources, says **Jennifer Robinson**, RN, MHS, South Carolina Hospital Association patient education liaison. By interacting with others in the field, she has discovered reputable resources on the Internet and in other places. **(To learn about some of the resources Robinson has uncovered, see box at right.)**

Children's Healthcare of Atlanta made a commitment a few years ago to translate all teaching materials into Spanish. Whenever new materials are created, whether written copy or a video, they now automatically are produced in Spanish as well as English. This policy also pertains to materials purchased from outside vendors.

"When I order something from the outside in English, I also order the Spanish version if it is available," says Ordelt.

Children's Healthcare has been able to focus on Spanish because most of its non-English-speaking patients are from Mexico. However, this may change soon because Atlanta's multicultural community is rapidly growing, says Ordelt.

Resources for Non-English Educational Materials

Web Sites

• **New York Online Access to Health: www.noah-health.org**
Provides teaching sheets in English and Spanish

• **Family Doctor: www.familydoctor.org**
Offers multilingual material

• **EthnoMed: http://ethnomed.org**
Provides information on various cultures as well as multilingual teaching sheets

Pictographs

Interactive Therapeutics makes pictorial booklets in English and Spanish to help people communicate without the spoken word. To learn more about the products, contact the company at: P.O. Box 1805, Stow, OH 44224-0805. Telephone: (800) 253-5111. Web site: www.interactivetherapy.com

Books

• "Speedy Language Phrasebooks" is a pocket reference guide for nurses that provides help in German, Spanish, Italian, Russian, French, and Japanese. Contact: Speedy Language Phrasebooks, P.O. Box 4151, Santa Barbara, CA 93140. Telephone: (800) 962-4028 or (805) 962-4029.

• Mosby's "Pocket Guide to Cultural Assessments" by Elaine Geissler provides information on the practices and beliefs of different cultures. The guide is available from Mosby Times Mirror Co., 11830 Westline Industrial Drive, St. Louis, MO 63146.

• Many other organizations, such as the Dallas-based American Heart Association, have booklets in foreign languages. Also, medical supply and pharmaceutical companies frequently have materials in a variety of languages.

*(Editor's note: These resources were provided by **Jennifer Robinson**, RN, MHS, patient education liaison for the South Carolina Hospital Association.)*

About 10% to 12% of the patients seen at the system's hospitals are Spanish-speaking. At some satellite clinics, the patient population is about 50% Spanish-speaking.

Whenever a health care facility commits to using materials in foreign languages, these teaching sheets and booklets fall under the same policy for keeping the inventory up to date as the English-language materials. At Children's

SOURCES

For more information on teaching non-English-speaking patients, contact:

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- **Eileen Troutman**, RN, BSN, OCN, Senior Oncology Nurse for Community Cancer Education, OhioHealth, Columbus, OH. Telephone: (614) 566-9889. E-mail: etroutma@ohiohealth.com

Healthcare, this means the education materials inventory is reviewed every three years unless protocols have been changed or new medical information has been introduced.

With 800 teaching sheets in Spanish and English posted on its intranet, Children's Healthcare of Atlanta relies on its contracted translating services to update the Spanish materials. A template of the sheet in question is sent to the company, and once the changes are made, it is uploaded onto the intranet. ■

Keys to effective education project management

Allow time for unforeseen problems

A patient education manager often juggles many tasks, including oversight of educational programs and special projects such as the creation of education materials. It's often difficult to keep projects on track and make sure they are completed on time.

Good project management begins with the committee structure. It is important that the members of the team collaborate and agree on deadlines, says **Virginia Forbes**, MSN, RN, program director of patient and family education at New York-Presbyterian Hospital in New York City.

To ensure the right group is assembled for a project, ask the core members which other staff should be involved. This will help prevent loose ends from dangling at the end of the project, says Forbes. If approvals are required, get the right administrator involved. If it is a clinical project, have the right clinicians involved. And if it is a multi-site project, be sure to bring in the right people from each of the areas, advises Forbes.

Bring all involved departments together

For **Mary Paeth**, MBA, RD, patient/community education coordinator at Southwest Washington Medical Center in Vancouver, WA, there are two types of projects for which she works with teams. With the first, a group convenes to discuss a specific need and to develop a plan to meet it.

For example, the medical center needed better osteoporosis/fall prevention education, but no one was sure how such a program should be structured. The orthopedic physicians asked for patient classes because they could not cover all the information in an office visit. The pharmacy department offered to conduct screenings, and physical therapy wanted to assess patients to determine if they were at risk for falls.

By bringing all departments together to talk about the need, the skills available, and the way to work together for maximum results, Paeth and her team were able to develop a program that met everyone's needs, she says.

The second method for creating a program is to start with a plan and invite the participants to join in a specific role.

Whichever method is used, it is important that the key people commit to the project and attend group meetings, says Paeth. It also is important to establish a time frame for the work that must be completed.

"Over time, I have gained an understanding of how long it takes to complete the various steps in a project. For many projects, it is my responsibility to help others who have never done it before

SOURCE

For more information about completing projects in a timely manner, contact:

- **Virginia Forbes**, MSN, RN, Program Director of Patient and Family Education, New York-Presbyterian Hospital, 525 East 68th St., New York, NY 10021. Telephone: (212) 746-4094. E-mail: vforbes@nyp.org
- **Mary Paeth**, MBA, RD, Patient/Community Education Coordinator, Education Department, Southwest Washington Medical Center, P.O. Box 1600, 400 NE Mother Joseph Place, Vancouver, WA 98668. Telephone: (360) 514-6788. E-mail: mpaeth@swmedctr.com

to learn the time requirements for each step," says Paeth.

If no one is familiar with the process or sure of the exact time line, have the team examine the project and take it apart step by step to determine how much time will be needed to complete each task, says Forbes. Once the timeline is established, increase it by about one-third, she adds.

It is important to build some flexible time into the project, agrees Paeth. Factor in time for illness, weather, emergencies, workload fluctuations, reflection on a piece for a while, and other eventualities, she says.

Once a time line is established, make sure all key members agree to it. "They are the ones that will make or break the deadlines, so they must feel it is reasonable," says Paeth.

Providing support

To help the committee members meet deadlines, Forbes sends reminders and offers assistance if anyone is having difficulty meeting the deadline. While she may not have all the answers to a problem, she can help find the right person to consult.

Effective communication always is important when trying to keep to a timeline, says Forbes. At New York-Presbyterian Hospital, groups working together can set up a team web site on the health care system's intranet. This gives them a place to post information for feedback and corrections from other committee members.

Busy schedules often make it difficult for people to attend meetings, so communicating by e-mail, telephone, and a team web site helps move the project along without conflicting with committee members' schedules.

To help meet the time line for a class or community outreach event, Paeth established a checklist with the program essentials on it. "Not only does it help remind me what must be done, it also helps others see all of the pieces and what I will need from them," she says. **(See program checklist example, inserted in this issue.)**

Always make sure people understand which tasks they are responsible for, says Paeth. Write summaries of what is to be done and by whom for each assignment at the end of each meeting, and make sure the minutes reflect each assignment correctly, she advises. ■

Using creativity in patient education

Educator discusses creating materials on a budget

Laura Gebers, BSN, RN, BC, has a wealth of experience in the field of patient education. Currently, she is Patient Care Services programs health education coordinator for Deborah Heart and Lung Center in Browns Mills, NJ. She also has worked as health education coordinator at Community Medical Center in Toms River, NJ, and as a member of the patient education committee in the home health and hospice industry.

In her current position, Gebers is responsible for all patient and health education within the 161-bed specialty hospital, which includes reviewing, developing, and approving resource materials. Although the facility uses Micromedex CareNotes and DrugNotes, it also has 400 in-house educational documents that Gebers has cataloged and made available via the facility's intranet.

Gebers also oversees community outreach. She determines if requests from outside organizations for speakers meet the criteria of the health care facility; if they do, she secures the speaker most qualified to address the topic. In addition, she coordinates health fairs and screenings.

She works with a cultural diversity and sensitivity committee to educate staff on these issues. Because Deborah is a specialty facility, patients come for heart, lung, and vascular procedures from throughout the United States and all over the world.

Gebers is in charge of the support groups for Deborah Heart and Lung Center, including the Zipper Club, where patients who have had open

heart surgery meet with people having a similar procedure to help them through a difficult time.

To help her with her duties, she has an administrative assistant and several volunteers. "Health education is interdisciplinary, so I meet with many of the [staff working with different medical] disciplines, and there are people that I can go to and elicit their support," says Gebers.

In a recent interview with ***Patient Education Management***, Gebers discussed her job, her philosophy on patient education, the challenges she has met, and the skills she has developed that help her do her job well.

Q: What is your best success story?

A: "While at Community Medical Center, I was part of an interactive Internet-based education program that allowed us to roll a computer kiosk into a patient's room to provide education on cardiac problems, women's health, and orthopedics. Patients viewed an educational video and took a test. If they answered the questions incorrectly, they were tutored until they answered the questions right.

"At the end of the session, the information was uploaded to a patient's personal Internet web page that they could access at home. In this way, they were able to continue their education. Also, health care providers could view the patient's progress and make more learning modules available to the patient via the web site."

When the company that produced this product folded, Gebers obtained money to continue to use the content on the computers in the kiosks. She added an introduction to the video that welcomed the patient to the medical center and encouraged him or her to watch the video. She also added a closing that discussed the resources available at the health care facility and what the patient's follow-up treatment might be.

In addition, she secured a program called "Deaf Talk" so the computer-enabled kiosks could be used to access an interpreter to sign for deaf patients in emergency situations.

Q: What is your area of strength?

A: "I really like to do things that other people have not yet done, so I am always thinking outside the box. I try to determine how to do something differently, how to do something better to improve a process, and how to reach my consumer. That can be other health care providers within the facility that are involved with patient education, or it can be the patients and community at large."

A good example of Gebers' thinking is her above-mentioned idea for a new use for the facility's computers and kiosks when the company that produced the interactive Internet-based education product folded. Gebers also submitted educational videos produced in-house in collaboration with Action Media Productions to national awards competitions. The facility won an award for these videos, and the company that provided funding for the videos realized it was a quality product and provided additional funding. This was a way to get funding for projects when no money was budgeted for them.

Q: Are there special problems you still need to overcome?

A: "Even though we have a plethora of materials available, whether hard copy, intranet, videos, CDs, or even support groups, some health care providers don't take the time that is really necessary to provide these educational materials for our patients, and that is very disheartening."

Although educational resources are promoted, chart reviews show they are underused. Deborah has received recognition from the New Jersey Peer Review Organization for exceptional patient education efforts with all indicators reviewed.

Q: What is your weakest link or greatest challenge?

A: "I think, overall, not having the financial support [for] the technology needed to bring information to the public is a weak link. There are so many things I would like to do with community outreach."

For example, a partnership between Deborah Heart and Lung Center and Pfizer, a pharmaceutical company, has resulted in screenings that help consumers determine their risk of having a cardiac event within the next 10 years. Based upon these results, patients often undergo healthy behavior changes, such as losing weight, eating more nutritious meals, stopping smoking, and getting their cholesterol under control. With a laptop computer and a printer, Gebers can conduct these screenings herself without having to rely on the pharmaceutical company.

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

A: "I would like to see health education accessible for anyone who wants the material. I think if we would have kiosks in the malls where consumers would be able to do blood pressure

SOURCE

For more information about using creativity in patient education, contact:

- **Laura Gebers**, BSN, RN, BC, PCS Programs Health Education Coordinator, Deborah Heart and Lung Center, 200 Trenton Road, Browns Mills, NJ 08015. Telephone: (609) 893-1200, ext. 5258. E-mail: gebersl@deborah.org

screenings and use a touch screen to learn about a particular diagnosis or treatment, people might be more encouraged to see their physician. Once they learn that a treatment involves a physician visit or health practitioner interaction, they would be more likely to make an appointment."

Currently, Deborah Heart and Lung Center offers "Ask a Question" on its web site to help reach people who are ready to learn.

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

A: "The whole survey is different. In the past, I needed to create evidence books so that no matter what the standard was, I had all the documents ready to go to support our position on how we were meeting and exceeding the expectations within a certain standard. Now the surveyors are using what is called tracer methodology, where they follow a patient from admission through discharge. **[See related story in *Patient Education Management*, March 2004.]** The Joint Commission is looking to see that in each area the standards are met, thus heightening staff awareness of the importance of documenting completely before sending a patient to another area."

To improve communication, Gebers recently revised the interdisciplinary documentation sheet, which makes it easy to determine what was taught, who did the teaching, and the current educational needs of the patient. Deborah Heart and Lung Center will be surveyed in January 2005.

Q: When you implement a new program or create new materials, where do look for information and ideas?

A: "A lot of it is experience. I have a wealth of experience as far as preparing and presenting programs. Sometimes I will contact another colleague. I attend national conferences every year and find that they are very informative. Conferences are great for networking and a good way to become informed." ■

New infection control standard proposed by JCAHO

Prepare for expanded care over an extended time

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, has proposed a new infection control standard. As part of emergency management activities, organizations should prepare to respond to epidemics or infections likely to require expanded care capabilities over an extended period of time.

Health care organizations constitute an important resource for a community's continued functioning. An organization's ability to deliver services is threatened when it is ill-prepared to respond to widespread infectious disease emergencies.

Therefore, it is important for an organization to plan how to prevent the introduction of the infection into the organization, how to quickly recognize that this type of infection has been introduced, and how to contain the spread of the infection . This plan may include a broad range of options, including the temporary halting of services, limiting visitors within an organization, and fully activating the organization's emergency management plan. The actual plan depends upon issues such as the extent to which the community is affected by the spread of the infection, the types of services offered by the organization, and the organization's capabilities.

The concepts included in these standards can be found elsewhere in the JCAHO manual. However, they are emphasized in a separate section because of risk to an organization, associated personnel, patients, and the entire community if an epidemic or an infection likely to require expanded care capabilities over an extended period of time is recognized slowly or not well-contained, or an inadequate response is mounted.

Elements of Performance for IC.6.10

1. The organization determines its role, if any, in the potential provision of care, treatment, or services to patients in the event of an epidemic or infections likely to require expanded care capabilities over an extended period of time.

2. If the organization plans to continue to accept patients, it has a plan for managing an ongoing influx of potentially infectious patients over an extended period of time.

3. As part of planning:

A. The organization determines how it will keep abreast of current information about the emergence of epidemics or new infections that may result in the organization activating its plan.

B. The organization sets parameters for when it will activate its plan.

C. Resources in the community through local, state, or federal public health systems for obtaining information are identified.

D. Mechanisms for interacting with these organizations are established. ■

JCAHO strengthens infection standards

Renewed interest in HAIs spurs agency to action

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, has approved revised standards to help prevent the occurrence of deadly health care-associated infections (HAIs). The standards retain many of the concepts embodied in existing standards but sharpen and raise expectations of organizational leadership and of the infection control program itself. The requirements for ambulatory care, behavioral health care, home care, hospital, laboratory, and long-term care organizations will take effect in January 2005.

"There has been, over the last number of years, renewed interest in the amount of HAIs in the country," notes **Robert Wise**, MD, vice president of the division of standards at the Joint Commission. "The CDC [Centers for Disease Control and Prevention] continues to publish data that show somewhere between 2 million and 4 million health care-associated infections exist, with 90,000 deaths per year associated with those HAIs."

An October 2002 CDC guideline for hand hygiene in the health care setting — the culmination of 20 years of data — indicates that handwashing is a main way to stop cross-infection. "Yet health care professionals are doing an abysmal job of washing their hands," Wise asserts. "And we have more and more people in hospitals who are susceptible, immunocompromised, and at greater mortality and morbidity risk."

For years, the health care profession has recognized HAIs were too high but has argued about how many of the infections were preventable, he notes. "But now we have identified a method that can clearly reduce them — just by washing our hands. So if even the basic things are not being done, we realized we needed to look at overall strategies."

An extensive dialogue

The new CDC guideline laid the groundwork for a group of experts to have an extensive dialogue on the topic, Wise says. The group was formed in early 2003. "There are two ways we vet standards," he explains. "With something as technical as this, we go out and find the people who are experts in the area [infection-control practitioners, hospital epidemiologists, physicians, nurses, risk managers, and other health care professionals], such as John Boyce, one of the main authors of the CDC guideline for hand hygiene, as well as health care organizations and major stakeholders. Then, it will be put out [to all accredited organizations] for field review across the country."

The field review will include two new issues — emerging antimicrobial resistance and the management of epidemics and emerging pathogens — that have been identified since the group began its work. For the Joint Commission, prevention represents one of the major safety initiatives that a health care organization can undertake. The revised standards focus on the development and implementation of plans to prevent and control infections, with organizations expected to take these steps:

- Incorporate an infection control program as a major component of safety and performance improvement programs.
- Perform an ongoing assessment to identify risks for the acquisition and transmission of infectious agents.
- Effectively use an epidemiological approach, which includes conducting surveillance, collecting data, and interpreting the data.
- Effectively implement infection prevention and control processes.
- Educate and collaborate with leaders across the organization to participate effectively in the design and implementation of the infection control program.

Another key aspect of the revised standards is an increase in the pressure placed upon top-level management in health care organizations. "This is a pretty important point," Wise points out. "One of the issues that kept coming up concerning the problems with infection control programs is that they are too low down in the organization. The practitioners who run them don't reach the people

who are high enough to help; they have trouble getting resources and training. So what you get is a nice program on paper, but [one that is difficult] to implement. You *need* a leadership voice; this is not a program that sits in a single unit or department — it only works if it is organizationwide."

Taking a realistic approach

The Joint Commission is expecting a lot from health care organizations, but it also is being realistic when it comes to those expectations. "There is no organization today that has the amount of money needed to handle every infection problem, and we appreciate that," Wise says. "There is, however, an expectation that each organization understands where its greatest vulnerabilities are. We expect a thoughtful plan to be put together that indicates it knows exactly where its greatest threats exist. It could be surveillance data, not being able to get the proper staff, or training problems; whatever they are, they need to be addressed," he explains.

Essentially, the process improvement must include an understanding of what the goals are, why the facility chose those goals, a description of the problems within the organization, an attempt to fix those problems, and if they are not fixed, an explanation of why they were not fixed, Wise says. The revised infection controls standards will not be a part of the scored survey until January 2005, he notes. "But because they are so important, we will release them in July 2004," Wise stresses. "If an organization is surveyed in the last half of the year, there will be consultations on these standards, indicating how they might have been scored and what problems would have been cited."

The Joint Commission also has made the CDC's recently updated hand-washing guidelines a 2004 National Patient Safety Goal for all accredited organizations. Further, the Joint Commission has advised accredited organizations that HAIs resulting in death or serious injury also should be voluntarily reported to the Sentinel Event database. ■

SOURCE

For more information, contact:

- **Robert Wise**, MD, Vice President, Division of Standards, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL. Phone: (630) 792-5890. Web: www.jcaho.org

Medication errors targeted in new JCAHO survey process

Examining the six steps of medication process

In light of so many providers having difficulty meeting the standard of care for medication administration, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, is taking action.

One its 2004 national patient safety goals is to improve the safety of using high-alert medications. In addition, newly organized medication standards from the Joint Commission focus more on medication processes as a system than on individual standards, says **Michael Jarema**, associate project director of the Division of Standards and Survey Methods at the Joint Commission. For all surveys that take three days or longer, surveyors will walk through the six steps of medication process:

- **Selection and procurement:** This is the process by which the organization decides which medications to have available and the process by which it obtains medications, including what to do if there is a shortage of a medication.
- **Storage:** The provider addresses issues of medications that sound alike and look alike, as mentioned in the National Patient Safety Goals, including control of medications.
- **Ordering and transcribing:** This area includes consideration of computerized physician order entry, verbal orders, and written orders, etc. It covers approved abbreviations, use of generics, indications for use, precautions, and 13 orders that require special attention, including an incomplete or illegible order.
- **Preparing and dispensing:** This area covers preparation, issuance, and accountability for doses of a prescribed medication by a pharmacist or authorized individual. It includes review of medication orders for appropriateness, safe preparation, labeling, dispensing practices, and medication recalls.
- **Administering:** The standards addressing this process cover giving a prescribed dose of a medication to a patient and describes safe administration processes such as verifying the medication, dose, route, time, and patient.
- **Monitoring:** The standards addressing this process within an organization's medication management system focus on the responsibility

for monitoring effects of medications and the organization's response to actual or potential adverse drug events and medication errors.

The surveyors might pinpoint a specific medication and "walk it through" the organization, Jarema says. They may ask, "How would you determine how you're going to use this drug in your facility? What are storage issues? How do you train staff?" For new medications, they might ask, "Does this medication require anything unique?" Surveyors might pull a patient's chart and ask about any medications the patient is taking that are considered high risk, such as warfarin. They might ask staff, "How is the medication approved for use in your organization? How did you decide to use it? How frequently do you review the medication you're using? How do you know providers are competent to use them?" If surveyors see a drug is administered in a specific area, such as pre-op, they may go to that area and talk to staff about storage and other safety issues, he explains.

Also, the Joint Commission requires facilities to have a regulation that provides a process for a nurse to contact a physician when an order isn't legible or is the wrong dose, adds **F. Dean Griffen**, MD, FACS, surgeon at the Highland Clinic at Shreveport, LA. ■

Facility makes patients partners in safety efforts

Beaumont defined patients' role in safety

In its recent initiative to minimize medical errors, William Beaumont Hospital in Royal Oak, MI, has made its patients "Partners in Safety." That's the name of the new program, which was launched in 2002. "We knew it was the right thing to do," says **Kay Beauregard**, RN, MSA, director of hospital accreditation and nursing quality.

"It's not unusual to open a paper or a journal that tells patients what they should do to prevent medical errors. The community was seeing it in the lay press — 'Protect yourself from infection when you go to the hospital!' 'Save yourself from medical error!' We wanted our patients to know that we firmly supported their active role, that we appreciated their questions, and that we felt it was of value in preventing errors," she says.

Before Beaumont could put the "patient" in "patient safety," it first needed to change the overall culture of the organization. That effort began in 2000. "This involved the creation of a learning environment, so we could learn from our medical errors, and the creation of a nonpunitive environment, so people would, in fact, report errors or potential errors," Beauregard notes.

It was in 2002 that Beaumont staff seriously addressed the question, "How can our patients be partners with us? First, we had to define what we felt the patient's role was in safety," she says. The facility put together a brochure for patients, titled "You and Your Caregivers: Partners in Safety." "It tells the patient that safety is a top priority and that they play an important role in safety efforts. Basically, it says, 'Please help your caregivers give you the care you expect.'"

The brochure provides an itemized list of things patients can do to enable staff to provide safe care. The list was developed from a number of sources, including the Joint Commission on Accreditation of Healthcare Organizations and the National Patient Safety Foundation, as well as a review of the literature. "We took what was out there and put it in a format that was comfortable to our culture," Beauregard says.

The brochure is divided into several key areas:

- **Patients are encouraged to ask questions and share their concerns.** To facilitate this process, patients are told to bring a family member or friend with them whenever possible. Patients should feel free to ask questions about what a medication is for, what test is going to be performed, or why something is being done. Customer hotlines also are provided.
- **Patients are told to pay attention to the care they are receiving.** Patients are informed about the wristband ID they receive and are told to make sure their nurse or physician checks the band before administering any medication or treatment. Surgical patients should be sure the physician marks the area to be operated on and to ask questions about it. Health care workers should introduce themselves when they enter the room; patients should look for their name badges. It's OK to ask anyone who touches you whether they have washed their hands. Patients should tell the nurse or physician if something doesn't seem quite right.
- **Patients should know what meds they are taking and why.** Patients are told to carry a list

of *all* meds they are taking, including herbals and over-the-counter drugs. They should tell physicians and nurses about any allergies or side effects. They are told that staff expect them to ask questions about meds.

• **Patients should educate themselves about their diagnosis, treatment plan, and medical tests.** Patients are encouraged to ask their physician or nurse for information about their condition; they should make sure all the information they need is written down. Patients should be sure they know how to use any equipment needed for home care.

• **Patients should be part of all decisions about their treatment.** Patients should share all information about their condition, including special needs, with their caregivers. They should provide details about their medical history, as well as the symptoms they are having. Patients should be sure to understand the information they receive and ask questions as often as needed.

Implementation of Beaumont's patient safety initiative involved distribution of the brochure through several different venues. "We put it into all patients' information packets they received when admitted," Beauregard adds. "Also, our chief of medical staff sent it out to all our physicians with the message, 'This is our approach; we support it; we encourage our patients to ask questions.'" The brochures also were distributed via community education programs, which reach 15,000 to 25,000 community members a year. "We felt this was a good opportunity to give them a brochure, so when they do have to interact with our facility or another facility, they can be safer," she explains. The brochures also were stocked in the waiting rooms.

Of course, ensuring nursing staff were on board was critical. "We left it to the nursing departmental leaders to deliver the message — to make sure every employee received the brochure and discussed it at their various meetings," Beauregard says. During these meetings, nurses were asked questions such as, "How will you react if a patient questions the meds you are giving them, or if you are asked if you washed your hands?"

SOURCE

For more information, contact:

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"What we want them to do is say thank you, and then answer the question," she notes. "They need to understand *why* patients are our partners."

Another vehicle for disseminating the key messages at Beaumont is executive patient safety rounds, which include a hospital administrator, a medical administrator, and department directors, who talk to staff about patient safety issues. "During those rounds, they also talk to patients, so here we again demonstrate how to involve patients in safety," Beauregard observes.

Surveys conducted by Beaumont indicate that progress has been made, but, she asserts, "We still have a way to go with it." The number of patients and family members who say they

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

- ■ Look at projects from all sides before implementing
- ■ Developing policy for interpreter services
- ■ Components for positive program outcomes
- ■ Creating a patient education culture
- ■ Incorporating consumer input into educational programs and policy

CE Questions

17. Which of the following methods might assist health care providers in educating non-English-speaking patients?
A. Pictorial booklets
B. Hands-on demonstration
C. Hand signals
D. A and B

18. When working on a project, it is a good idea to make deadlines tight so it will be completed in a timely manner.
A. True
B. False

19. When verbal teaching is accompanied by hands-on instruction, retention jumps to:
A. 90%
B. 85%
C. 50%
D. Does not increase

20. Which of these steps are organizations expected to take under the revised JCAHO standards for the prevention of health care-associated infections?
A. Incorporate an infection control program
B. Perform an ongoing assessment to identify risks
C. Educate and collaborate with leaders across the organization
D. All of the above

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

received the written materials has gone up from 50% to 70% during the past two years. "Even though we provide a packet for *all* patients, the managers feel some of those brochures are not being actively read, so we are continually looking for new strategies," Beauregard observes. "We're looking at more and better ways to provide information to patients, considering options such as putting it on a closed-circuit TV system," she says.

"We're also looking at translating the brochure into different languages. This is very important; one of the biggest obstacles to patient questions and learning properly about their diagnoses is cultural barriers." Currently, Beauregard is considering translating the brochure into Arabic, Spanish, Russian, and Ukrainian. ■

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. ■

Program Checklist

Program:	Date:	Time:	Speaker:

Action	Completed		
1) Room reserved			
2) Food ordered			
3) Speaker confirmed			
a) Bio requested			
b) Salary honorarium			
c) Contract Signed			
4) Publicity			
a) Reviewed by speaker			
b) To Marketing Coordinator			
c) To graphics			
d) Draft to speakers			
e) Draft approved & to print			
5) Handouts			
a) Requested from speaker			
b) Received from speaker			
c) To print			
d) Returned from printer			
6) AV equipment ordered			
7) Room set-up ordered			
8) Registration to Secretary			
9) Help with registration secured			
10) Parking security (if day program)			
11) Clarification on payment for: — Staff/prep time — Copies, brochures, decorations booth — Publicity mailing card — Door prizes — Bags — Signage — Catering			
Registration list			
Handouts			
Pens/pencils			
AV equipment			
Bio introductions			
Cash box			
Receipts			
Evaluations			
Evaluations tallied			
Thank you to speaker			
Evaluation to speaker			
Evaluation to Rich			
Summary stats done			
Speaker paid			

Source: Mary Paeth, MBA, RD, Patient/Community Education Coordinator, Southwest Washington Medical Center, Vancouver, WA.