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

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Find solutions to those gaps that break the continuum of education

Teaching plans, learning centers, and Intranet access all contribute to seamless education

Patient education managers describe education across the continuum of care in many ways. Yet all agree there are certain crucial components. To ensure a smooth continuum of education, your educational system should:

- provide a consistent message reinforced by providers in different settings;
- build on previous teaching, because teaching doesn't always take place in optimal learning situations (for example, the patient might be in pain);
- be structured around a planned sequence of educational events consisting of integrated teaching components by multiple disciplines;
- provide for a patient's ongoing educational needs at an appropriate level of education wherever that patient receives care, whether it is within different departments in a single facility or in separate facilities.

The only trouble with these recommendations is that they are easier said than done. However, that doesn't mean they can't be accomplished. There must be a written teaching plan in place, says **Zeena Engelke**, RN, MS, senior clinical nurse specialist at the University of Wisconsin Hospital and Clinics in Madison.

Engelke's institution has set in place a method for teaching across the continuum for several surgeries,

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Proven Solutions for Old Problems – Part 3 of 3

Support program decisions with good research

To determine if a teaching technique is effective or if a program will work, patient education managers often must find published studies that provide evidence. The best way to find these studies is to conduct a literature search, but the work doesn't end there. With studies in hand, PEMs must evaluate the work to make sure the research is valid 44

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Focus on Pediatrics **Insert**

Striving to manage pediatric asthma

With asthma in children on the rise, the CDC is encouraging health care facilities to provide educational intervention. While they don't yet know what is causing asthma cases to increase, they do know that emergency department visits and hospital admissions can be avoided if families are taught to self-manage the disease. 1

Taking education to the streets

Inner-city children with asthma often lack medical care. To help remedy this problem, Phoenix Children's Hospital operates the Breathmobile, implemented by the Arizona Asthma Coalition. This mobile unit provides clinical care for the underserved population and education on self-management of asthma for families. Children obtain access to the Breathmobile through the public school system 1

COMING IN FUTURE ISSUES

- Tailoring outreach to underserved communities
- Stretching those dollars after a budget cut
- Outreach strategies to curb domestic violence
- Assessment tools to improve evaluation methods of patient education
- Tailoring discharge instructions to patients' needs

including hip and knee replacement, cardiac surgery, and mastectomy or lumpectomy surgery. The teaching is integrated with the learning center.

"The driving force is the teaching guidelines," says Engelke. Each guideline is designed with four columns. The first lists the outcomes the education is designed to provide; the second gives the content and time frame; the third lists the available resources and written materials for teaching; and the fourth identifies the disciplines responsible for teaching.

When a patient is scheduled for hip or knee replacement, the patient's physician gives the patient a packet of information and asks the patient to read it. When the patient comes in for a pre-surgery work-up, the patient visits the learning center first to learn how to prepare for surgery and to receive some post-op information, such as what to expect when returning home after surgery.

During the work-up, the physician or nurse practitioner provides details about each patient's particular surgery. The day before the surgery, a nurse from the work-up area telephones patients to see if they are prepared for surgery. In the post-op area, a nurse continues education using materials from the original packet.

Other surgeries would be slightly different. For example, mastectomy patients usually have same-day surgery, so the home care nurse continues the teaching. However, in each case, the educational sequence, the person who provides the education, and the appropriate time for teaching are all planned.

"We used the learning center to carry out certain components of the teaching guideline, and I think that helps the system. Without the learning center involved, not everyone would get the information at the same point in time, and there could be inconsistencies in the delivery of the message," says Engelke.

Time education along course of disease

There needs to be a plan regarding what is going to be taught across the continuum and when it's appropriate to teach the information, agrees **Kerry Harwood**, RN, MSN, director of the cancer patient education program at Duke University Medical Center in Durham, NC. It's important to understand when people are ready for certain kinds of teaching during the disease process. Some of the curriculum is determined by an individual patient assessment, but some is

determined by listening to patients who have a similar condition and can therefore be fairly predictable, says Harwood.

For example, women with breast cancer receive intensive treatment and education for several months. As time goes on, women are scheduled for follow-up appointments less and less frequently. There isn't a lot of time for education in the short follow-up sessions, but women have certain questions that need to be addressed at particular stages of cancer survivorship.

Therefore, Harwood and a social worker designed a patient education intervention to give these women the information they needed. "We noticed the same questions were being asked over and over again, and there wasn't enough time within a 10- or 15-minute follow-up appointment to address the issues the patient had. So we designed a different way of meeting the patients' needs," says Harwood.

The program featured a guest speaker who addressed a topic of concern for breast cancer survivors during a dinner meeting once a month. When it was learned that women were driving 250 miles to attend the meeting, the medical facility began to host an all-day annual conference instead. The program charge is $25, with scholarships available. The conference has many breakout sessions, so women can design their own education package. "This same model would work for any chronic illness. Just determine what people's education needs are at any point in time," says Harwood.

Care team members must communicate

When there isn't time for education, it's important that health care providers don't assume that someone else will do it, says **Kathryn J. Conrad**, RN, MSN, MA, AOCN, program leader, Cancer Education and Standards Integration for clinical support services at the University of Pittsburgh Cancer Institute. In today's health care environment, patients are in and out of the treatment setting very quickly, whether inpatient or outpatient. This leaves little time for teaching.

"If you are dealing with a higher volume of patients coming in, it is harder to do the follow-up and get that information out to other members of your health care team. It's also difficult to read everything other people have sent to you on the patient," Conrad explains.

To solve this problem, communication is key, says Conrad. All members of the health care team should meet to discuss the teaching process and discover where the gaps are. At the University of Pittsburgh, teams have created teaching plans on some of the common interventions that are consistent with clinical practice guidelines. For example, the guidelines for chemotherapy not only direct patients' care; they also provide direction for the education and teaching resources.

At Southern Arizona Veterans Affairs Health Care System in Tucson, patient education guidelines and handouts were developed to help standardize educational objectives and content in different areas. Also, standardized discharge forms were created to assist in comprehensive discharge instructions, says **Connie S. Wilkinson**, PhD, RN, MPH, program director for staff development. In addition, forms were created to support each educational guideline so documentation would be easier for providers.

It's important to know what patients receive at every stage of the education process, says Engelke. At the University of Wisconsin, the clinics are part of the health care system, but even when hospitals work with several clinics outside their system, patient education managers need to find out what information is given, she says.

Health resource centers being developed at many health care institutions have great potential when it comes to filling gaps in education, says **Magdalyn Patyk**, MS, RN, advanced practice nurse, patient education at Northwestern Memorial Hospital in Chicago. "We can reinforce the information the physician provided or clarify it. We can also provide information on treatment modalities that the patient can discuss with his or her physician," she says.

Patyk recently kicked off a new program for Type II diabetes to fill the gap between when patients are diagnosed and when they are able to see a diabetes nurse clinician and dietitian for detailed teaching. Patients often are just given a prescription and a few guidelines at the physician's office, so they come to the learning center.

At the center, Patyk has an hour-long patient education intervention that teaches the basics of Type II diabetes. The session includes a video and one-on-one teaching. She worked with the diabetes nurse clinician and dietitian to make sure she was only giving patients the basics. "I have 14 videos and lots of information on diabetes, but when you are newly diagnosed, you don't need all that information at one time," says Patyk.

Making sure patients have the information they need without being overwhelmed can be a

SOURCES

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problem when there isn't always a designated time in which a patient can be taught. Duke University Medical Center faced this problem with cancer patients who live a three- or four-hour drive away from the hospital. These patients often are treated by telephone triage. The nurse practitioner or physician might change a medication or order a test following a phone assessment, for example. At these times, there was no opportunity to properly educate the patient about the test or medication.

To remedy this problem, a patient education notebook was created that is customized for each type of cancer and also for each patient, because materials can be added as needed. Information on medications and tests that the patient might have is included, and the patient is told this when given the book. Then, during telephone triage, patients are asked to get their notebook and turn to a certain page.

No matter where education is delivered, it is important that patients get a consistent message, says Patyk. To aid in this process, she included copies of all the videos found in the hospital's closed-circuit TV system in the learning center video collection. "In this way, they have access to them again on an outpatient basis, and we are providing that consistent message across the continuum," she explains.

It's even possible to deliver consistent information between different health care institutions, says Harwood. For example, a statewide asthma program with consistent information was designed by a coalition in North Carolina with representatives from hospitals, health departments, and clinics. "Primary care providers will be using these consistent asthma patient education materials on a statewide level," she says.

Technology is making it easier to deliver a consistent message. More and more institutions are putting educational materials on an Intranet so standardized materials are always available, says Harwood. "The Duke Intranet gives our affiliates access to our materials. They may be located two or three hours away, but if they are seeing our patients in follow-up, they can access our materials," she says. ■

How to juggle the workload in a one-person department

You need to convince all to lend a hand

Time can be the No. 1 enemy of patient education coordinators in one-person departments. "I cannot be everywhere at once. There is probably an infinite potential for each service line and department to use my services, and that is something I can't do as a one-person department," says **Donette Lasher**, MAT, patient education coordinator at York (PA) Health System.

To get a handle on time, patient education coordinators must find allies within the organization, prioritize tasks, incorporate others into the process, learn to use time efficiently, and be a strong advocate for patient education.

"I have a half-hour during hospital orientation every other week to convince the new hire that patient education is not just my job, it is everybody's job at this institution," says **Sharon Sweeting**, MS, RD, LD, CDE, patient and family education coordinator at Jackson Memorial

Gather evidence to prove your worth

Data reports and summaries help define job

No matter how obvious it seems, it is always a good idea to keep track of goals, objectives, and accomplishments in patient education to prove the value of your job, says **Janet Swift**, RN, BSN, patient education coordinator at Memorial Hospital of Sheridan County in Sheridan, WY.

Swift creates a monthly summary restating her goals for patient education and listing which ones have been met and which ones she's still working on. She categorizes the summary to reflect her job duties. For example, there is a section on diabetes education, because her job is 50% patient education coordinator and 50% diabetes educator. There also is a section on inpatient education and the consumer resource room.

"The summary helps me reorient myself once a month to what we are doing, where we are going, and what is important," says Swift. She submits the summaries to her supervisor, who keeps them in a binder so the information is handy should administrators ask. The summaries reflect how much time Swift devotes to projects and what she has accomplished.

Another good way to justify your existence is by tracking data on your computer and creating reports, says **Donette Lasher**, MAT, patient education coordinator at York (PA) Health System. She tracks before-and-after data on patient education projects. For example, she compares the before-and-after reading level and appearance of pamphlets that are being reworked. Also, orders for patient education materials are tracked. "I note who orders them, how often, and which materials are the most popular," she says. ■

Hospital in Miami. Education is part of the mission and vision statement for the health care system that consists of a 1,200-bed hospital, five satellite centers, and 21 primary care clinics.

To get staff to value patient education, it's important to keep it in the forefront. Sweeting embraces every opportunity to publish information relating to the topic. For example, she writes pieces pertaining to patient education for the employee newsletter that is distributed with paychecks, and also for the system's bimonthly magazine. Such pieces can be simple, such as a health tip with resources for more information, rather than a lengthy article.

To keep education at the forefront, **Janet Swift**, RN, BSN, patient education coordinator at Memorial Hospital of Sheridan County in Sheridan, WY, conducts open chart reviews and leaves a note on the chart to individuals who did not document correctly. For example, the note might remind someone about completing the learning assessment.

She also conducts closed chart reviews and uses the information to graph the patient education efforts in each department. "The graph will show if the assessment of learning barriers and learning needs were documented correctly, if education resources were used appropriately, and which departments did patient education. I present the graphs at clinical manager's meetings or to the department heads," says Swift. **(For information on techniques to prove the value of your job, see article, above.)**

To ensure that patient education is being done correctly, it is important to develop allies and get others to share in the workload. Lasher developed relationships with the physician leaders in each service line at the health care facility. "They were able to identify which physicians were really excited and motivated about patient education, so I would know whom to contact and work with," she says.

Another option is to build a liaison network, advises Sweeting. There is someone in every department with an education focus, and it is important to discover that person through networking. To develop relationships with physicians, she sends information about programs and materials via e-mail or through interoffice mail. She also has developed relationships with case managers and the public relations director. "The public relations person knows about resources I don't and can put me in contact with people," explains Sweeting.

The patient education committee can help carry the workload. Lasher educates the members of the patient education committee on the principles of good reader-friendly material, so they can take the responsibility for work on education materials in their area. Sweeting created a brief manual that explains how to write, edit, and

SOURCES

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review patient education tools within her health care system.

When the workload falls on your shoulders, it is important to prioritize tasks. "I know what the systemwide priorities are and what projects are most important to administration and therefore the best use of my time. That helps me prioritize tasks," says Lasher.

If you don't report to someone at the administrative level, establish a connection before creating goals and objectives for patient education to make sure they are in line with the goals of the health care organization.

Don't reinvent the wheel

Loretta Anderson Glaze, RN, education and quality improvement coordinator at North Lincoln Hospital in Lincoln City, OR, devotes time to patient education tasks that the patient education task force identifies. For example, staff needed resources to teach newly diagnosed diabetes patients, so she developed a resource cart to keep on the units and a check sheet that lists what to teach and what information to give the patient.

In addition to patient education, Glaze divides her time between staff development, management training, and community education. Therefore, she must work on a needs-oriented basis.

Yet, even with tasks prioritized, it's important to work efficiently and make the best use of time. To work more efficiently, communicate with colleagues so you don't have to reinvent the wheel, says Anderson Glaze. She belongs to the Oregon Council of Health Educators, which meets quarterly and has a listserv for e-mail communication. She also uses the Patient Education Network listserv, which is monitored by The University of Utah Hospital and Clinics office of patient education. **(For more information on this listserv, see editor's note at the end of this article.)**

Learn to be proficient in all the computer programs you have available, especially if you don't have clerical support. That's a good way to work more efficiently, says Lasher. Also, don't get caught up in tasks such as filling orders or mailing flyers. Contact the volunteer department and get help for these labor-oriented jobs.

Another good way to work more efficiently is to make a list of the meetings that have high attendance, such as the nurse manager's meeting. "Use those meetings to share information quickly and get an idea of what is going on throughout the health care system. It is easy to get isolated when you are a one-person department," says Lasher.

(Editor's note: Find information on how to use the Patient Education Network listserv on the University of Utah Hospital and Clinics' Web site at www.med.utah.edu/pated/patednet.) ■

Have your teaching session and test it, too

Roll staff education, competency testing into one

Two factors triggered the development of a program to teach staff at York (PA) Health System to teach patients effectively. One was the fact that management had not developed a good way to evaluate the competency of staff in teaching patients. They used a self-learning packet followed by a multiple-choice test. Also, the health care system had no clearly defined expectations for patient education, nor were tools provided to accomplish it in a short time period.

To remedy the situation, the patient education committee created a subcommittee to design a pilot program for staff education. This team consisted of the patient education coordinator, director of community health, an education specialist, and a nurse from the cardiovascular service line, which was the area that would pilot the program.

"We decided the theme of the program would be teaching patients in the amount of time you have and also the importance of patient participation in teaching," says **Donette Lasher**, MAT, patient education coordinator at York Health System. To design the curriculum, each team member looked through resources at hand, such as books and conference materials. They selected three techniques that either saved time, required patient participation, or both. The curriculum included the following:

• Agenda setting and assessing importance and confidence in the agenda.

This technique helps health care providers identify an agenda or topic of discussion, to which the patient agrees, and assesses its importance to the patient and the patient's confidence in achieving the teaching objective. For example, cardiovascular patients would be shown a card with graphics representing lifestyle changes like losing weight, modifying diet, exercising or managing stress. Patients then are asked to choose the behavior they are ready to address. Then they would be asked how important making the change is to them on a scale of one to 10 and how confident they are in making the change.

Ask open-ended questions about content

• Content, participate, and review (CPR) cycle.

Using this technique, the content is the portion of the teaching that provides information to the patient such as a medication schedule. During the participation phase, the nurse asks the patient open-ended questions about the content. For example, the nurse might ask, "What problems do you anticipate with following the medication schedule?"

"The more actively patients participate in the planning, the more likely they will follow through, because it's their solution, not the nurse's," says Lasher. The review is a simple statement to wrap up the teaching. For example, the nurse might say: "So let's review. You have agreed to set your watch alarm at noon so you remember to take your medicine on time."

• Documentation and patient teaching tools.

Documentation was included in the curriculum because it is a communication tool that saves time by preventing duplication of teaching. Education materials provide written follow-up to teaching.

Once the curriculum was determined, the team decided on the format to deliver the information and evaluate the competency of the learner. They considered many different methods, including a workshop, the self-learning module, and a video accompanied by an information packet.

They modeled their program after the competency evaluation format, where nurses are checked off as they go from station to station, demonstrating their competency. "We had three stations, which took about 15 minutes each because we were doing some education and not just evaluating the competency," explains Lasher. There were two to three nurses at each station at every session. This meant that only three nurses from each unit were at the station at any one time, so no area in the cardiovascular services line was strained.

At station one, two presenters demonstrated the agenda-setting tool and explained how to assess for importance and confidence in the selected topic. This was followed with a role-playing session in which one person represented the nurse and another the patient. Through conversation with the nurses, the presenters would assess their understanding of the benefits of using the tools.

At station two, one presenter gave a PowerPoint presentation of the CPR cycle and provided an example of how to use the CPR cycle to teach a patient about discharge medications. Participants then picked another topic, such as a low-sodium diet or monitoring daily weight, and demonstrated the use of the cycle in teaching a patient.

The third station covered documentation and the use of patient education materials. At this station, all standardized patient education materials pertaining to cardiovascular problems were displayed in order to raise awareness. Also, the presenter reviewed the documentation form and

SOURCES

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gave examples of how to document patient education in each session. "This station was really an opportunity to clarify their misunderstandings and answer questions about the form," says Lasher.

The 125 staff who participated in the pilot program that ran in November and December 1999 were asked to evaluate whether or not the presenters met the objectives set for each station and comment on the format. Staff found the mandatory sessions helped them improve their teaching skills. However, the team that created the program found that it was not a very efficient use of the presenters' time. The stations were scheduled over a two-month period on five separate days with four groups attending each day.

"The conclusions we made were that it is an effective format, but it needs to be condensed into one or two days and made larger so we accommodate more people," says Lasher. They are considering having a cafeteria-style format with 20 stations available and staff being required to select five of the stations. This would help meet the patient teaching needs of a variety of disciplines. For example, outpatient surgery would have different teaching needs from the cardiovascular service line. ■

Support program decisions with good research

If the patient education study isn't valid, toss it!

Every patient education manager occasionally needs to find research studies that support an idea for a program, help determine if a particular teaching technique is effective, or find information to prepare for a class. Therefore, it's important to develop two skills: learning how to find good patient education studies and evaluating the research to make sure it is valid.

There are no journals where patient education studies can automatically be found. These studies are published in a variety of publications. The best way to find them is to conduct a literature search on the Internet, says **Kate Lorig**, RN, DrPH, director of the Stanford Patient Education Research Center in Palo Alto, CA. A literature search entails using a database's search function to look for key words describing your topic. For example, if the topic is diabetes, you might start with "diabetes, patient education evaluation," explains Lorig. Lorig often conducts literature searches on Medline (http://www.ncbi.nlm.nih.gov/PubMed/).

Determine exactly what you are looking for, and then ask a librarian to help you select key words to use in your search, advises **Mary Szczepanik**, MS, BSN, RN, manager, cancer education, support and outreach for Grant/Riverside Methodist Hospitals in Columbus, OH.

"Librarians do searches all the time and are very good. If you talk with them for five minutes about what you want to find, they can give you 20 key words to use," she explains.

If you live near a university library, start there, because it likely subscribes to a large variety of research-based journals or has a license to obtain copies of articles from search engine sites. If not, go to the medical library at your hospital, says Szczepanik.

Abstracts, bibliographies contain key words

Once you've found a couple of articles, the search gets easier, because key words for the article are found in the abstract or on the first page of the article. This makes it easier to find additional articles pertaining to your topic, explains Szczepanik. Also, look at the bibliography at the end of the article for related studies.

It is important to evaluate the articles you find to determine if good research methods were used. Before spending time on this task, however, look at the abstract to determine if the researcher's findings are relevant to your purposes, says Szczepanik. For example, will the studies help you design a program or help you determine if a given teaching technique is useful?

Strong studies measure more than patients' knowledge or behavior changes, says Lorig. "For patient education, I want studies that look at health status change or health care utilization," she says. For example, if patients participate in a successful asthma education program, they not only learn about their asthma triggers, but they avoid them, and therefore they have fewer visits to the emergency department.

Once studies are selected, it's important to look carefully at the research methods and the evaluation of the data to determine if the conclusions are valid. Look at the study design, says Szczepanik. Ask several questions, including:

- How did the researchers collect the data?
- How many people were in the study?
- How did the researchers get their sample?

The instruments used to collect the data must be proven methods. "If it is survey research, it is important to know who did the survey and if there are any factors that might have influenced the way people answered the questions," says Szczepanik. The sample size is important as well. The smaller the sample, the harder it is to apply the results to the general population, she says.

The stronger studies always are randomized trials, says Lorig. "If it is not a randomized study, I would look for a study that has a comparison control group," she says.

The study authors should explain how they analyzed the data. If the analysis was performed incorrectly, the study's results could be wrong, says Szczepanik. If you don't understand statistical analysis, take the article to someone who does, she advises.

The study should include a description of the results and a discussion of the findings. In the discussion, the authors should answer the original research questions raised in the introduction. They also should address how the results support or differ from the findings they uncovered in the literature review they completed before conducting the research. The conclusion will offer the authors' opinion about the research findings.

"If you find all these components in an article, then it is worth reading. However, you must check to see if rules and regulations for good research were followed," says Szczepanik.

Another good way to find sound research studies for patient education is to determine if the journal in which they are published is peer reviewed. A peer-reviewed journal is a must, says Lorig. ■

SOURCES

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Learn about aromatherapy so you can teach patients

Provide accurate information and resources

Interest in aromatherapy is growing, evidenced by the shelf space given products at variety stores and specialty shops springing up. Aromatherapy is a complementary therapy that requires education on proper use of the products, according to the Seattle-based National Association for Holistic Aromatherapy (NAHA), which encourages consumer education.

Aromatherapy is the practice of using essential oils derived from plants to obtain psychological and physical well-being. "In the form of inhalations or massage, incorporating essential oils derived from specific plants into aromatherapy has a wealth of applications," says **Julia Meadows**, LMT, an aromatherapist based in Ojai, CA, who is public relations director for the National Association for Holistic Aromatherapy.

To facilitate consumer education about aromatherapy, NAHA is designing an educational brochure for distribution at wellness centers and consumer resource centers within health care systems. The brochure will discuss the evolution of aromatherapy in the U.S., professional practice, safety issues, and essential oil purity. Information on accessing true aromatherapy products and services also will be included. **(For contact information, see source box at the end of this article.)**

What additional information can patient education managers provide? It is important for consumers to understand the purpose of aromatherapy and how it works. They need to know about the tools of aromatherapy and how to use them in self-care. Also, they need to know how to select a professional aromatherapist.

Health care professionals can use aromatherapy to prepare patients for stressful procedures or surgery. It's most beneficial when used for stress-related conditions, nervous and emotional complaints, skin disorders, respiratory problems, and women's health issues such as premenstrual syndrome or menopausal problems, says Meadows.

"The purpose of aromatherapy is to reduce stress symptoms, address physical complaints in a natural and noninvasive manner, bring balance to both body and mind, and promote a feeling of harmony and well-being," she explains. **(For a list of essential oils and their uses, see p. 46.)**

Mixing and matching essential oils

Each has a distinct use

The essential oil most commonly used is lavender, says **Julia Meadows**, LMT, an aromatherapist in Ojai, CA, who is public relations director for the National Association for Holistic Aromatherapy in Seattle. "Lavender is a broad-spectrum oil with almost universal benefits in treatment. Its clean fresh aroma is well-liked by both male and female patients, and it is a soothing oil with excellent effects on the nervous system," she says.

Other common essential oils are rosemary and eucalyptus, which are used for their stimulating effects and to treat respiratory disorders. Grapefruit and sweet orange are good oils to diffuse in institutional settings because they are well-liked by patients and residents for their sweet, familiar, uplifting aromas and their psycho-aromatherapeutic properties, says Meadows. Rose oil and geranium are classic oils for treating women who have menstrual cramps.

"If a patient is taking a particular medication, they may wish their doctor to be aware of their therapy to ensure that there are no contraindications involved in the use of a particular essential oil," says Meadows.

Following is a short list of essential oils, with a description of each oil's aroma and some of its uses:

- **Anise.**

Has a rich, sweet scent of licorice. Often used for bronchitis, colds, coughs, and muscle aches.

- **Bay.**

Has a fruity, spicy herbaceous aroma. Often used for hair care, oily skin, poor circulation, and sprains.

- **Jasmine.**

Has a floral, exotic aroma. Often used for depression, dry skin, labor pains, and sensitive skin.

- **Lavender.**

Has a fresh, sweet floral scent. Often used for anxiety, burns, cuts, headache, scars, sores, stress, and stretch marks.

- **Nutmeg.**

Has a spicy, sweet, woody aroma. Often used for constipation, fatigue, nausea, poor circulation, and slow digestion.

- **Parsley.**

Has a herbaceous, woody aroma. Often used for griping pains, indigestion, and rheumatism.

- **Pine, scotch.**

Has a fresh, woody, earthy aroma. Often used for colds, coughing, rheumatism, and sinusitis.

- **Spearmint.**

Has a minty, slightly fruity aroma. Often used for exhaustion, fever, headache, nausea, and vertigo. ■

When inhaled, the aromatic molecules of essential oils are transported through the limbic system of the brain, triggering responses that involve emotion and memory. "Inhalation of diffused essential oils is at the heart of psycho-aromatherapy," says Meadows.

The oils have energizing, balancing, or sedative effects. Oils applied to the skin are thought to be transported through the bloodstream before being excreted. The method for application is frequently body massage.

Before the essential oils are applied to the skin, they are diluted in a carrier base such as sweet almond oil, grapeseed oil, or fresh, cold-pressed vegetable oil. Fragrance-free lotions and gels also can be used as carriers.

While aromatherapy is safe and effective, people should understand that essential oils are much stronger than most other herbal products and should not be confused with herbal extracts or tinctures, says Meadows. **(For additional information on herbal remedies, see *Patient Education Management*, March 1999, pp. 27-30.)** Essential oils should not be taken internally or applied directly to the skin without being greatly diluted by a carrier oil. For body care, the proper mixture should be 2% to 3% of essential oil to 97% to 98% carrier oil.

To begin using aromatherapy at home, consumers can purchase several essential oils and an device for diffusing the oils via heat into the immediate atmosphere for inhalation. Such devices use heat from either an electrical source or a candle. Consumers also should purchase a carrier oil or lotion for skin care and massage applications. Meadows also recommends consumers read a good book on aromatherapy. **(For information on resources, see list on p. 47.)**

Resource list for further aromatherapy study

To learn more about aromatherapy, you can visit the Web sites or read the books listed below.

The following books can be ordered through amazon.com on the Internet or purchased at your local bookstore for less than $20:

- *375 Essential Oils and Hydrosols* by Jeanne Rose. Frog, Ltd., 1999.
- *Essential Oil Safety: A Guide for Health Care Professionals* by Robert B. Tisserand and Tony Balacs. Churchill Livingston, 1995.
- *The Aromatherapy Workbook* by Shirley Price. Thorsons, 1993.
- *The Complete Book of Essential Oils & Aromatherapy* by Valerie Ann Worwood. New World Library, 1991.
- *The Illustrated Encyclopedia of Essential Oils* by Julia Lawless. Element Books, 1995.

Web sites:

- **www.aromaweb.com** — This site has information on the history of aromatherapy, use of oils and diffusers, safety information, and a list of 70 essential oils.
- **www.earthmed.com** — This holistic health site has information on conditions, treatments, practitioners, and products.
- **www.goodhealthdirectory.com** — This site conducts searches for specific Web sites based on such information as illness or ailment, therapy or treatment, remedy, and other key words.

Premium-quality essential oils can be found through specialty stores and catalogs, over the Internet, and through practitioners. A trained aromatherapist will be familiar with the plant species of the essential oils he or she uses, including its origins, growing conditions, and methods of extraction and processing.

"When seeking a professional aromatherapist, consumers should be sure the therapist is knowledgeable in these areas and is not an untrained individual associated with enterprises involved primarily in the commercial sale of oils," advises Meadows. An aromatherapist should use only natural botanical oils. Synthetic scents or fragrance oils such as musk, gardenia, or strawberry are never used in the practice of true aromatherapy, she says.

Most aromatherapists use between 50 and 100 essential oils in their practice, custom-blending the oils to create mixtures specific to each client's needs. The blends are modified as the client's health profile changes.

The therapist works with a therapeutic index, which designates the most effective essential oils to use for each of the bodily systems. Oils are selected after a comprehensive evaluation of the client's health profile, usually during the first visit, says Meadows.

If arranged beforehand, the initial consultation would include an "aromassage" of one to one and a half hours in duration, using pre-blended oils or a custom blend created for the client at the time of the appointment, explains Meadows. Depending on the aromatherapist's specialization, the treatment might include lymphatic drainage techniques, shiatsu, deep tissue work, craniosacral work, or reflexology. Also, hydrotherapy, sauna, color, music, and movement therapies might be included in an aromatherapy session.

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- **Julia Meadows**, LMT, Public Relations Director, Executive Committee, National Association for Holistic Aromatherapy, 205 North Signal St., Ojai, CA 93023. Telephone: (805) 640-1300. Fax: (805) 640-1413. E-mail: nahapr@west.net.
- **National Association for Holistic Aromatherapy**, 2000 2nd Ave., #206, Seattle, WA 98121. Telephone: (888) ASK-NAHA. Web site: www.naha.org.

A professional aromatherapist can be found by contacting a professional association such as NAHA; by asking for a referral at a local health food store, massage school, or complementary medical clinic; and by looking in the local telephone directory under aromatherapy, massage, or spas.

Before making a selection, a consumer should find out how the aromatherapist was trained, the duration of the aromatherapist's training, and how long he or she has been in business. "A visit to the aromatherapist's business office and an initial mini-consultation by the therapist at no charge to the prospective client would be a good indication of professionalism in the field," says Meadows. ■

Riding the coattails of the public library

No room for a patient education resource center at your health care facility? Collaborate with your local librarian, advises **Loretta Anderson Glaze**, RN, education, quality improvement coordinator at North Lincoln Hospital in Lincoln City, OR.

The librarian provided shelf space for Anderson Glaze to stock a variety of health related brochures so consumers would have easy access to health materials.

For more information on using the local library to distribute health resources, contact: Loretta Anderson Glaze, RN, Education and Quality Improvement Coordinator, North Lincoln Hospital, 3043 N.E. 28th St., Lincoln City, OR 97367. Telephone: (541) 996-7113. Fax: (541) 996-7219. E-mail: glazlo@nlhospital.org. ■

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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. ■

Focus on Pediatrics
PATIENT EDUCATION MANAGEMENT'S MONTHLY SUPPLEMENT

Asthmatic kids need self-management tools

Key is to educate parents

The need to respond to the increased number of asthma cases is urgent, according to the Centers for Disease Control and Prevention (CDC) in Atlanta. Statistics reveal that the number of asthma sufferers more than doubled between 1980 and 1998. There were 17.3 million people with asthma in the United States in 1998, and about 4.8 million were children.

While it is not known why asthma is on the rise, the effects of the disease are clear. Asthma is the single largest reason children miss school — and when kids stay home, parents miss work. Although there have been many improvements in the clinical treatment of asthma, the CDC says visits to the emergency department and hospitalizations continue to increase. The CDC estimates that asthma-related costs will exceed $14.5 billion this year.

What can health care institutions do to address this problem? First, make sure children who have asthma are being diagnosed correctly, says **Stephen Redd**, MD, chief of the Air Pollution and Respiratory Health Branch at the National Center for Environmental Health, a division of the CDC. Teach parents and school teachers how to recognize the symptoms, which include shortness of breath (especially at night), coughing, and chest tightness. Once a child is diagnosed with asthma, families must learn how to manage the disease.

"Like diabetes, asthma is a disease where the patient has to be able to do a lot of the management," says Redd. Education should include lessons on how to administer medicine, which is frequently inhaled and is therefore more difficult to take than a pill. Parents and children need to learn what symptoms to watch for, how to measure breathing function with a peak flow meter, and what environmental factors trigger asthma. Exposure to cats, cockroaches, house dust mites, and cigarette smoke can trigger asthma.

While the steps for education seem simple, there are many barriers to the management of the disease. Controlling indoor triggers of asthma requires commitment from an asthma sufferer's family. Children with asthma often feel different from other children, which makes them reluctant to use inhalers. Also, many people, especially those in inner-city neighborhoods, have limited access to medical care.

To get a handle on childhood asthma, patient education managers must target parents providing education on how to manage the disease. There is currently no information on what parents can do to prevent the onset of asthma, says Redd. ■

Phoenix 'Breathmobile' educates at schools

Mobile asthma unit reaches inner-city kids

The Breathmobile doesn't look much like the Batmobile driven by the Batman, but it probably has the potential to save more lives than this comic book hero ever has. That's because it reaches inner-city kids who suffer from asthma, providing the clinical support and education they need to manage their disease.

Every six to eight weeks, the mobile unit, which is staffed with clinicians from Phoenix (AZ) Children's Hospital, rolls into a school on a cyclical schedule. "Our primary purpose is to serve children in their schools. There are a lot of barriers to care in inner-city Phoenix. It is medically underserved, underinsured, and primarily an indigent population," says **Judy Harris**, MS, RN, CPNP, program director for the Breathmobile and a pulmonary nurse practitioner at Phoenix Children's Hospital.

The program, which is aimed at grades K-8, is patterned after a mobile program in Los Angeles. The mobile asthma clinic is a custom-designed recreational vehicle. Phoenix Children's Hospital started the asthma outreach program in the fall of 1999, while the mobile unit was still on order.

They worked out of the school nurse's office until the Breathmobile could be implemented. Wal-Mart has committed $300,000 a year for three years to help fund the Phoenix Breathmobile project. It was implemented by the Arizona Asthma Coalition, of which Phoenix Children's Hospital is a part.

When a new school joins the program, staff from the Breathmobile educate the teachers, school nurses, and principal about asthma and the program's interventions. They also explain how to recognize asthma symptoms in children. The teachers are asked to send questionnaires home with the kids for the parents to fill out and send back. These questionnaires are designed to discover children who may have asthma but have never been diagnosed, and those who have been diagnosed but aren't managing their asthma well.

The response rate from parents has been very good, says Harris. This is due in part to the relationship the Breathmobile team builds with the community before bringing the program into a school. Both parents and children from the community are invited to sit on the advisory board to discuss how the community can best use the Breathmobile.

School board members, principals, and community organizations also are involved in the planning process. "It takes a large amount of energy to identify these children and get them into services they need; there are a lot of barriers. If we would have just come rolling down the street in our RV, we probably wouldn't be very successful," says Harris.

Education designed to meet goals

The program has two primary goals. The first is to identify children with asthma and help them control it so they will be able to enjoy normal activities without visits to the emergency department, being admitted to the hospital, or missing school. The second goal is to identify children who don't have insurance and get them into primary health care. "If they are not getting general health care, it will be very hard to manage their asthma," says Harris.

To accomplish these goals, Breathmobile staff review the questionnaires that are returned, looking for children who might need an evaluation. If they have questions about the answers on the survey, they call the parents. If it appears a child would benefit from a further evaluation, an appointment is set up for the parent and child. Parents come to the school for the clinic appointment and the child is pulled out of class.

The visit begins with a screening for insurance eligibility. If possible, children are placed in a federal or state-funded insurance program so they can gain access to primary health care. After the screening, the parent and child see a clinician for an asthma history and physical.

When diagnosed with asthma, the children undergo a pulmonary function test and are educated on methods for self-management. The program also includes 24-hour follow-up and case management so parents can call any time to ask for guidance.

During the education session, parents and children learn to look for signs and symptoms that indicate asthma-related problems. They also learn how to identify asthma triggers, when and how to use medications, and to use peak flow meters and inhalers properly to help monitor and control asthma. "There are a lot of issues that go into helping families manage asthma in the home. Often, they are used to waiting until the last minute and going to the emergency department if they need to," says Harris.

With 24-hour case management available, the parents can call for advice before episodes escalate. At these times, education takes place over the phone. For example, parents learn how to determine what has triggered the asthma episode so the child can avoid these triggers.

After the initial visit to the Breathmobile, children are scheduled on a regular basis so their asthma can be monitored. Parents are asked to be present at each appointment as well. During subsequent visits, staff try to determine if the child's asthma symptoms have improved and if self-management fits into the family's lifestyle. Also, medication is adjusted and further education takes place as needed.

"We want children to learn the importance of taking care of themselves at a young age. Improperly controlled asthma can actually lead to permanent lung damage as an adult," says Harris. ■

SOURCES

For more information on the Breathmobile asthma program, contact:

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