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Patient Education Management™

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

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IN THIS ISSUE

In This Issue **continued on next page**

Patient/staff partnerships lead to better pain management

Lessons on assessment, pain control methods a must for JCAHO compliance

Pain has become a major focus of education since the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, added specific instructions to its standards this year. These instructions include appropriate assessment for pain and its cause and education of staff and patients on pain management.

The medical systems that already had pain management programs in place have simply had to tweak them to fit the standards. For example, in 1997, St. Francis Medical Center in Honolulu established standards for pain management that include education of patients and staff. They also added pain assessment into their patients' rights policy and incorporated pain as a fifth vital sign. The one improvement made since the standards were implemented is to focus more on how all disciplines assess for pain, rather than just focusing on nursing, says **Amy Krueger**, RN, MSN, FNPC, a nurse practitioner in pain management at St. Francis.

The Ohio State University Medical Center in Columbus had developed several education sheets on pain relief and had implemented a procedure for pain assessment, but a task force has now been assembled to make sure the medical facility has addressed all the issues covered in the standards.

In This Issue **continued from page 49**

COMING IN FUTURE ISSUES

- Addressing cutting-edge patient education issues
- Incorporating complementary therapy into routine health care
- Outreach strategies curb domestic violence
- Educational methods for improving medication compliance
- Fine-tune education methods in your emergency department

"The task force is looking at process improvement initiatives on pain management, revising the pain assessment process, looking at pain management initiatives across the continuum of care, staff education in pain management, and producing pain management handouts specific to patient populations such as the elderly," says **Sandra Cornett**, RN, PhD, program manager for consumer health education at the medical center.

The Joint Commission standards on pain education and management are long overdue, says **Patricia Collins**, RN, MSN, clinical nurse specialist in oncology / pain at Baptist Health Systems of South Florida in Miami. While pain management and education were already addressed at this multihospital health care system, the standards provide an impetus to get every discipline on board. "When the standards came into place, it created more of an awareness and more of an urgency with getting everyone up to speed," says Collins.

While the standards are an incentive to fine-tune programs and spur people on to perfection, what do you do if you are starting from scratch? The institutions that had a framework in place before the standards were implemented are good examples for those institutions struggling to implement policies and procedures.

Physicians need advice on pain management

Most facilities have a system that establishes experts who can provide advice to clinicians on pain management. At The University of Texas MD Anderson Cancer Center in Houston, the Symptom Control & Palliative Care Center acts as a consultative service for both inpatient and outpatient areas. If a clinician diagnoses a patient as having pain, nausea, cachexia, or any symptom caused by cancer, the clinician can request a consult through this service, explains **Karen Stepan**, MPH, CHES, health education coordinator at MD Anderson.

Following a comprehensive interdisciplinary assessment, members of an interdisciplinary team work together to establish a plan of care that includes pain management. An institutional initiative is under way to include the Symptom Control & Palliative Care Center team as an integral component of all disease-specific clinical pathways. Upon clinician request, the team would provide a symptom assessment and overall plan of care for patients with advanced cancer.

To help clinicians on a routine basis, the Symptom Control & Palliative Care Center created

cancer pain guidelines that provide a step-by-step decision making process on how to treat the type of pain the patient is having. The center also created a preprinted prescription pad that identifies pain treatment options based on severity of pain, says Stepan.

Baptist Health Systems has a Pain Resource Nurse (PRN) program in place systemwide and has trained 300 nurses to provide help with complex pain problems or patient education issues that may arise on the units. This program, which is patterned after a model created at City of Hope Cancer Center in Duarte, CA, also is used at St. Francis in Honolulu. "Those caring for the patient need resources readily available. We would like to have one PRN on each shift," says Krueger. St. Francis also has a pain management service that can be contacted for patient consultations. The team of experts includes nursing, physical therapy, spiritual services, social work, psychiatry, and neurology.

In addition to having a resource for expert advice on pain management, it is important to educate both staff and patients about pain and its assessment. "The biggest issue of pain management is the myths and misconceptions about it and proper assessment," says Krueger. Many clinicians were taught to look for behavior cues for pain and now they must be taught to rely on what the patient tells them. Most patients at St. Francis are asked to assess their pain on a scale of one to 10, with one being very little or no pain and 10 being excruciating pain.

Patients as partners

"Patients must be taught that they are an important partner in their pain management," says Collins. To be effective partners, patients must understand how their pain will be assessed. That's why they are given a tip sheet upon admission to Baptist Health Systems that explains the importance of pain assessment and what questions they will be asked. For example, staff will want to know where patients' pain is located, what it feels like, how bad it is on a zero-to-10 scale, what helps their pain, what makes it worse, and how the pain interferes with their ability to eat and sleep.

To help patients better manage their pain, educational materials should be provided. When patients are admitted to St. Francis, they are given a patients' rights brochure that includes information about patients' right to receive pain assessment and management. They also receive a sheet titled "Talking About Your Pain" that reviews the pain assessment process. Handouts specific to the course of therapy also are available, such as cancer pain management or post-op pain management. **(For examples of pain education sheets, see pain education handouts from The Ohio State University Medical Center, inserted in this issue.)**

Patients who receive a consultation with an interdisciplinary team from the Symptom Control & Palliative Care Center at MD Anderson are given a medication record and a written and audiotaped version of their plan of care and question-and-answer period with the team. The patient can easily use the tape as a reference, explains Stepan.

Before creating a plan of care, the team completes a thorough assessment of the patient. Tools used to evaluate patients' pain include a symptom assessment that rates a patient's perception of pain, fatigue, nausea, depression, anxiety, drowsiness, shortness of breath, appetite, sleep, and feeling of well-being on a scale of zero to 10. Also used are a Mini-Mental State Examination to screen for cognitive impairment and a Cage Questionnaire used to assess the patient's coping mechanisms and the likelihood of a patient using chemicals to cope with stress.

The Mini-Mental State Assessment was developed by Marshal F. Folstein, MD, at Medford,

SOURCES

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MA-based Tufts University School of Medicine. The CAGE Questionnaire was developed by staff at Johns Hopkins University in Baltimore. Both assessments, along with instructions for their use, can be obtained from the Edmonton Palliative Care Program at the University of Alberta Department of Oncology **(www.palliative.org)**.

To help complete the partnership, staff also must receive education on pain management. At St. Francis, in addition to a basic four-hour pain management class, staff can go on rounds with the pain management service once a week to discuss patients who are currently on the service and their pain etiology and treatment, says Krueger. Those who go on rounds can receive continuing education credits. **(For more information about pain etiology, see article on chronic pain management, below.)**

A big issue for both patients and staff is the fear of addiction, says Collins. "Many patients think addiction and medication for pain go hand-in-hand. They don't understand that addiction is when people take pain medications for reasons other than pain. We spend a lot of time on this subject, and it is discussed on the patient tip sheet," she says. The topic also must be addressed in staff education.

Policies and procedures similar to the ones described in this article can easily be designed to fit your health care system and implemented in compliance with Joint Commission standards. "Our program has been in place for some time," says Krueger. "We have pretty much covered all the pain management standards, and it is not an overwhelming task to do so. The standards are very basic."

[Editor's note: The Joint Commission standards, including those on pain education and management, can be found on its Web site at: http://www.jcaho.org.] ■

Combine strategies to target chronic pain

Teaching self-management of chronic benign pain

Diabetic patients are taught to become active self-managers of their chronic condition, and that same concept can be applied to the management of chronic benign pain. At Kaiser Permanente Northern California in Oakland, a behaviorally based education program was developed to increase function so people with chronic pain can return to their normal activities of daily living. The program focuses on the physical, psychological, and social elements of pain management.

"Through the program, we try to move patients into an active self-management role of their chronic pain condition so that they feel they are in charge, instead of their chronic condition being in charge of them," explains **Andrew Bertagnolli**, PhD, chronic pain management program coordinator in the health education department of Kaiser Permanente Northern California.

Kaiser uses a multidisciplinary approach in its chronic benign pain management program. The team includes a physician to examine medication use and discuss the physical cause of pain and a health psychologist to address cognitive behavioral interventions for chronic pain, such as management of mood, assertiveness training, and cognitive reconditioning. Also included on the team are a physical therapist to address physical reconditioning and a nurse to handle the care management role.

Chronic pain is described in the literature as pain that lasts in duration for more than six months and well past the time a person would expect it to stop. With acute pain, there is a finite limit — the pain will end eventually — but with chronic benign pain, it will not. Chronic pain often has a snowball effect. The pain causes physical problems that begin to grow over time, leading to disruptions in mood, relationships, activities, and work functioning. "We may not be able to eliminate the physical source of the pain, but we can help people manage moods and other people and manage their activities," says Bertagnolli.

One of the main challenges of dealing with chronic benign pain is that it is subjective and varies from person to person. Its intensity is influenced by cultural, spiritual, and ethnic beliefs, and is also situational. "For some people, a prayer or meditation is going to be intuitively appealing based on their cultural background. For other people, that is not going to be part of a comprehensive pain management strategy," says **Arne Boudewyn**, PhD, chronic pain management program coordinator for Kaiser Permanente Northern California.

The program uses proven tactics such as behavioral reactivation, management of mood, management of other people, and management

SOURCES

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of activities. These topics and concepts are introduced to patients through a treatment group, and they learn to fit these concepts into their belief system.

For example, cognitive restructuring, or unhelpful thinking, would focus on negative attitudes. If a patient woke up in the morning with so much pain that he or she didn't want to get out of bed, the team would work with the patient to help him or her develop a more positive outlook. The team might encourage patients to think instead of how much better they would feel after getting up and doing a few stretching exercises. "We help them identify unhelpful thoughts or unhelpful thinking patterns and challenge them into developing more helpful strategies in terms of new thoughts," explains Bertagnolli.

Cognitive restructuring is an important element of the program. People with chronic benign pain need to identify unhelpful thinking styles and begin to develop more helpful thinking patterns if pain is to be controlled. Other elements of the program include developing a daily physical exercise regimen and daily relaxation exercises to prevent pain flare-ups.

To learn techniques and strategies that fit their treatment plan, patients participate in a group educational setting for eight to 10 weeks. The sessions run about two hours each week and offer a mix of education and application. The physical therapist might cover posture positioning to control pain. The physician may talk about the pros and cons of pain medication and how pain is communicated to the body. Each week, patients do homework in order to apply what they are learning.

The program helps participants overcome many barriers to pain management. In addition to negative thought processes, many people are fearful of doing anything that will exacerbate the pain. They are used to the acute pain model in which the pain signals that something is wrong. With chronic pain, the signal is still there, but there is no damage occurring.

Also, patients sometimes feel that the only answer is passive treatment, such as taking a medication or having a procedure. Yet, when they assess their pain on a scale of one to 10 and look back over time, they are able to see how some of the strategies of the program have reduced their pain. "Many feel that their pain is at a constant level and never varies, and that makes it unbearable. The scale shows them that it varies," says Bertagnolli.

The pain may be a nine one day and a seven the next because the patient went to a movie and was distracted or the patient exercised or did something he or she enjoyed. Generally, most people who suffer from chronic pain cut out the pleasant activities first so they have the energy to do their chores. This can lead to depression.

"We want to shift them away from being a passive recipient to an active self-manager," says Bertagnolli. ■

Seniors struggle with complicated regimens

Sheer number of drugs taken impairs compliance

A high number of hospital admissions for the elderly are due to problems with medication compliance. Because confusion or lack of understanding can cause seniors to take their medication incorrectly, education plays a vital role in senior medication compliance, says **Nina Resch**, PharmD, primary care clinical pharmacist at the Veterans Affairs Medical Center in Albuquerque, NM.

In the first of a series of articles on medication education to improve compliance, we focus on seniors and their educational needs. In this piece, we discuss ways to help them fit complicated regimens into their lifestyle and avoid duplicating prescriptions and taking medications that don't mix. In future articles, we will target other patient populations, as well as specific medications that cause compliance problems.

Tailor teaching methods to elderly

Consider lighting, need for repetition

Use a variety of teaching methods when educating seniors about their medication, advises **Linda Mosel**, MSN, RN, CS, geriatric clinical nurse specialist at Good Samaritan Hospital in Dayton, OH. Combine verbal, written, and visual instruction whenever possible. In addition, the teaching style needs to be adapted for seniors, she says.

Following is a list of tips for teaching seniors in order to improve medication compliance:

• **Go over one thing at a time.**
Slow your pace, covering one thought at a time. "Sometimes we have to break what we are teaching into steps and then go over one step at a time, or they won't be able to absorb it," explains Mosel.

• **Make print materials senior-friendly.**
Written materials should be in 14-point fonts and dark print whenever possible. Also, printed materials should never have a blue, green, or violet background, because there is not enough contrast. Handouts should be printed on light-colored, non-glossy paper to eliminate glare.

• **Allow for hearing problems.**
Because many seniors are hearing-impaired, face the patient when teaching, speak slowly, and don't put your hand over your mouth.

• **Preparing patient for learning.**
Before starting an education session, find out whether the patient needs to use the bathroom. It's good to ask, because the patient might not mention it. Also, ask if the patient is comfortable or in pain. During the teaching session, watch to see if the patient is becoming fatigued.

• **Provide direct lighting.**
The light should focus on the paper or whatever the elderly patient is looking at so he or she can see well.

To aid you in your education efforts, The National Institute on Aging has a variety of age-appropriate educational materials on its Web site at www.nih.gov/nia/. "They are copyright-free, and free," says Mosel. ■

"I make sure seniors keep an updated list of their prescription medications, herbal supplements and vitamins, and over-the-counter medications and show that to their physician and pharmacist. Many people have multiple places where they get their care, or they may not pick up all their prescriptions from the same pharmacy," says Resch. The list helps to prevent duplicating prescriptions or mixing medicines that would cause drug interactions.

Linda Mosel, MSN, RN, CS, geriatric clinical nurse specialist at Good Samaritan Hospital in Dayton, OH, encourages seniors to put all their prescription medications and over-the-counter drugs into a paper bag once every three months and review them with their pharmacist or physician. The hospital frequently sponsors brown-bag medication chats with the pharmacist. The pharmacist goes over the medications on an individual basis and helps participants troubleshoot their regimens if they are having problems.

The sheer number of drugs elderly patients take is one of the major barriers to compliance, explains Mosel. They may take one 30 minutes before meals, one with meals, one two hours after meals, one three times a day, and another every six hours. "The medication regimens are very lifestyle-prohibitive. We need to simplify the regimen for them and get them on long-acting drugs that are once-daily doses, if that is possible, and really look to see if they can be taken off some of the medications," says Mosel.

Using pillboxes and sticky notes

If the medications are a must, it's important to help seniors fit them into their lifestyle. Pillboxes work well, especially those that separate the various doses for each day, says Resch. However, it is important to teach patients how to use the pillbox correctly, rather than just hand them one.

If patients have difficulty differentiating among colors such as blues, greens, violets, whites, and yellows, pillboxes won't work well. Instead, help them make a calendar-type chart so they can mark off when they take a dose of medication, or have them write sticky notes, says Mosel.

Also, go over patients' daily routines with them to determine what they do on a regular

basis, so the activity becomes a prompter for taking medicines. "If patients brush their teeth twice a day, certain medications could be kept near the toothbrush, or if they have coffee each morning, medications could be kept with the coffee," says **William A. Hopkins**, PharmD, professor at Mercer University School of Pharmacy in Atlanta.

During the day, when patients often are away from the house, they can set their watch alarm as a reminder, suggests Resch.

Address barriers to learning

None of these methods will work if there is a memory problem, so barriers to learning must be assessed up front. Ask about hearing and vision problems, language barriers, and religious beliefs. To assess for knowledge, ask patients to explain their medications, including why they take them and how they take them, says Resch. **(For more information on asking the right questions to improve medication education, see article, below right.)**

Often, other disciplines will need to be called upon to overcome barriers to medication compliance. For example, a patient may refuse to take a narcotic for religious reasons, believing these drugs to be addictive. If the physician can't persuade the patient to take the drug, a chaplain could be called in to explain that in this case the drug is not addictive, says **Karen Pegram-Felix**, RN, a nurse manager at New York Presbyterian Hospital in New York City.

If the patient is having trouble swallowing the pills, an occupational therapist would be asked to do an assessment, says Pegram-Felix. Pills can often be crushed and put in apple sauce or mashed banana to improve compliance.

When patients are being discharged from the hospital on a complicated medication regimen, it is important that education take place throughout the hospital stay so patients are prepared to take the drug properly when they go home. "Each time nurses give a patient medication, they go over what it is for. They also show them the pill so they recognize the color and shape," says Pegram-Felix. At discharge, the education is reinforced with preprinted medication sheets that describe the medication, how to take it, and side effects it might cause. ■

SOURCES

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Teach patients and staff what to ask

The right questions boost medication compliance

In today's health care environment, communication across the continuum of care connecting physician, pharmacy, and home care on senior drug compliance can be difficult. That is why it is important to educate patients on ways to manage their medication regimens and communicate effectively with their provider and pharmacist, says **Nina Resch**, PharmD, primary care clinical pharmacist at the Veterans Affairs Medical Center in Albuquerque, NM.

Patients need to be taught the importance of building a relationship with their pharmacist by making sure the pharmacist knows all the medications they are taking and asking about over-the-counter medications before making a purchase, she says.

It's important to help patients understand their part in the drug regimen process, agrees **Linda Mosel**, MSN, RN, CS, geriatric clinical nurse specialist at Good Samaritan Hospital in Dayton, OH. Make sure patients are aware of the need to talk with their pharmacist and doctor about the natural home remedies and herbs they use so there will be no adverse interactions with their medications.

Also, let patients know that if they experience any change in function, such as being more tired than usual, or if they seem to have a memory problem, they should talk to their physician. Patients need to know that there are not just two alternatives — to stop taking the drug or to endure the side effects. The physician can change the prescription or the dosage.

Teach patients that it is OK to tell the physician they cannot afford a drug, because the physician often can prescribe something less costly. Seniors who find themselves in this situation often say nothing and then cut back on the dosage to save money or simply don't fill the prescription, explains **William A. Hopkins**, PharmD, a professor at Mercer University School of Pharmacy in Atlanta. Also, patients who have trouble opening the pill containers need to know to ask the pharmacist for non-safety closing caps when they fill their prescriptions.

Staff members who educate patients about their medications play a key role in their compliance, not just by providing patients with the appropriate information but by making sure they understand it. "The most important thing that staff can do is verify the patient's understanding of why they are taking the drug, what results they should expect, and how they are supposed to take it," says Hopkins.

How will patient schedule doses?

Ask how patients are going to take the prescription if it is new and how they have been taking the prescription if it is a refill, he advises. If the instructions state that the medication is to be taken three times a day, verify that the patient understands the directions by asking how he or she will schedule that. When the instructions state that patients should take the medication at a certain time, such as before meals, they need to understand why that it is important. For example, it will keep the drug from upsetting their stomach.

Use open-ended questions when teaching, advises Hopkins. For example, don't ask the patient, "Have you experienced any problems while taking the drug?" Instead, ask this: "What types of problems have you had while taking the medication?"

In addition to educating patients about the medications they are taking, staff need to address other compliance issues during the education session, says Mosel. For example, to address cost and transportation issues, the nurse might ask patients how they will get the prescriptions filled and get them to their house.

When new prescriptions are part of a hospital discharge plan, it is best to educate seniors about their medications in their homes because they are more relaxed and the nurse can note factors that might hinder compliance, such as the lack of a refrigerator or working phone. "The information the patient received as an inpatient is probably not going to be absorbed until someone follows up after they are released from the hospital," says Mosel. ■

Reader Questions

Forms guide individualized discharge instruction

Categories prompt correct response in all areas

Question: "How do you individualize discharge instructions for each patient and maintain a record of the individualized written instructions for the patient record in compliance with Joint Commission standards?"

Answer: *Patient Education Management* interviewed several patient education coordinators to compare the various systems in place. Following is a brief summary of the information garnered from each institution:

- **Children's Healthcare of Atlanta.**

Standardized discharge forms are used most often at Children's Healthcare of Atlanta, with the forms individualized to each patient by writing the information in each table. For example, the instructions for a teenager going home on a clear liquid diet following surgery are different from a child with asthma going home on a regular diet.

The nurse writes in the discharge instructions per physician order. The family and nurse sign the form; one copy goes to the family, while the second is placed in the medical record.

In addition to the general discharge form, the health care system has created discharge teaching forms specific to patient populations, such as oncology. The template has information that is

specific to that patient group, says **Kathy Ordelt**, RN, Patient & Family Education Coordinator at Children's Healthcare of Atlanta.

For example, the form might have information that instructs patients to call their physician if their temperature reaches 101 degrees. These forms also have boxes for individualized information. "The preprinted forms are for staff convenience to make it easier to capture all the information so it doesn't have to be written every single time," explains Ordelt.

No matter where the patient enters the health care system including the emergency department, primary care setting, or inpatient setting, there is a discharge record that can be individualized. "They are formatted in a similar fashion, but they all contain different content that makes it appropriate for that clinical practice setting," says Ordelt.

• Michael Reese Hospital and Medical Center.

An interdisciplinary discharge education form was created at Michael Reese Hospital and Medical Center in Chicago so more than one department can use it. It is divided into sections with clear headings so it is easy for patients to find the information they want. Headings include diet, drugs, dressings, home health, and contact information for the nursing unit, the case manager, and physician.

A follow-up appointment is written on the sheet, if known, or instructions to call for an appointment within a given time are written. "This form is in triplicate, and one goes to the patient, one on the medical record, and one to the attending MD as needed," explains **Michele Knoll Puzas**, RNC, MHPE, pediatric nurse specialist at Michael Reese.

Post-discharge phone calls are randomly made to assess the effectiveness of discharge teaching. In pediatrics, a problem with discharge education is seldom uncovered, but parents frequently have new questions that staff can answer.

• St. Francis Hospital and Health Center.

The discharge instruction sheet at St. Francis Hospital and Health Center in Blue Island, IL, is a three-part form so there is a copy for the patient, the physician, and the chart. It is meant to be an education summary, says **Allison M. Reid**, MS, RNC, an educator at the health care facility.

In addition to categories for medications, bathing, diet, wound and incision care, and follow-up care, there is a place for post-hospitalization instructions, such as a lab test the patient needs to have done in a week. The form also has a section for rehabilitation instructions, equipment, and community services.

• University of Missouri Hospitals & Clinics.

Patient Teaching Records that reference use of approved patient education materials were developed at the University of Missouri Hospitals & Clinics in Columbia and are written with outcome statements for the patient to meet. If the outcome is met, staff document by dating and initialing the "outcome met" column. "If outcomes are individualized or additional content is taught, it should be documented in detail on the patient teaching record," says **Ceresa Ward**, MS, RN, manager of Health Improvement Services at the medical center. Space is available for additional comments to note patient or family questions, response, or other details of teaching.

The Discharge Orders / Instructions forms used for all patients leaving the hospital complement the Patient Teaching Records with brief general information that gives choices the provider can check or use one to two lines to write in specifics. The topics covered include activity, bathing, wound care, driving, diet, medications, signs of infection, follow-up appointments, and dispensation arrangements such as the number of the home health agency.

The form is signed by the patient or caregiver who receives a copy with a second copy placed in the chart. ■

SOURCES

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Relieve tension to reduce stress-related illness

Reflexology helps people cope with stressful world

Experts say that when people wring their hands during an anxiety-inducing situation or rub their aching feet at the end of a hard day, they are instinctively using reflexology to reduce stress. It works because there are reflexes in the feet and hands that correspond to every part of the body. For example, the palm of the hand corresponds with the diaphragm, spine, and internal organs. Thus, by rubbing the palm, abdominal tension is relieved.

"Reflexology is a method that uses the fingers and the thumbs to work the reflex areas on the feet or hands that correspond with glands and organs in different parts of the body. It helps relieve stress, improve circulation, and enhance nerve function. It helps nature normalize the body," says **Catherine Smith**, CMT, a reflexology therapist, massage therapist, and Bowman technician at All Seasons Day Spa in Sacramento, CA.

Most people seek a reflexology therapist for stress-related ailments such as headaches or lower back pain because it is a good relaxation technique. While complaints such as back pain are noted at a session and the area of the foot corresponding to the spine is worked, reflexology therapists don't diagnose or treat a specific condition, says Smith. Clients are also warned that the relief they get from reflexology will not last long if they don't address the stressful situation that is causing the problem. Reflexology should be one element of a holistic health care regimen.

Reflexology is a good relaxation technique for most people, but some precautions need to be taken. For example, sessions on elderly clients should be limited to 10 to 15 minutes on each foot, because it tends to exhaust them, says Smith. Also, when reflexology is used on a pregnant woman, the area corresponding with the uterus should not be worked.

Eunice Ingham, a physical therapist who practiced in the 1930s, developed the reflexology technique used today. It is based on the belief that the body consists of 10 zones, and reflexes on the foot correspond to the body parts in each of the zones. Charts provide easy diagrams to follow, and people are encouraged to learn reflexology techniques. The method is more than a foot massage, however, and requires practice.

A session with a reflexology therapist would begin with a verbal assessment to discover areas for concentration. For example, if the client has diabetes, the therapist would be sure to work the pituitary gland, liver, spleen, and pancreas, says Smith. Following the verbal assessment, the therapist works the foot with the thumb, searching for areas that need concentration.

"I take a person's foot, push back their toes, and look for white bumps in their feet. Clients also tell me what is going on with them and that helps me analyze what to do with their feet," explains Smith. The bumps indicate calcium deposits that reflect where the circulatory system might be clogged and slowed down, she says.

It is very important to loosen and relax the foot before work begins, because many people don't like to have their feet touched. A good reflexology session will last an hour and cost about $30 per foot. When looking for a reflexology therapist, contact massage therapists. Because many massage therapists practice the technique, they are a good place to start your search.

However, potential clients should ask where reflexology practitioners have studied, how long they have been practicing, and whether they are certified. Certification is not as important as a good education and longevity in the field because practice leads to perfection, says Smith. "A lot of times, massage therapists will massage the feet, but they don't use the thumb to stimulate a reflex response," she explains.

SOURCES

For more information about reflexology, contact:

- **Catherine Smith**, CMT, Reflexology Therapist, All Seasons Day Spa, 1422 28th St., Suite D, Sacramento, CA 95816. Telephone: (916) 737-7546.

More reflexology information can be found in the following books, available through the Web site Amazon.com:

- *Better Health with Foot Reflexology* by Dwight C. Byers, 1987, $24.95.
- *Hand and Foot Reflexology: A Self-Help Guide* by Kevin Kunz, 1992, $10.40.
- *Reflexology, Art Science and History* by Christine Issel, 1996, $17.95.
- *The Complete Guide to Foot Reflexology* by Barbara Kunz, 1993, $15.95.
- *The Complete Illustrated Guide to Reflexology: Therapeutic Foot Massage for Health & Well-Being* by Inge Dougans, 1996, $19.96.

Patient education mangers creating an information sheet on reflexology would want to explain what it is and how it works. A workshop that teaches people the basic techniques is a good way to have people practice stress management at home. "I recommend that families massage each others' feet while watching TV. It helps people sleep better," says Smith. ■

To save time, go on-line

Six recommended Web sites from your colleagues

Many patient education managers looking for guidance on program development and management techniques or educational materials for patients turn to the World Wide Web. Therefore, we asked experts what their favorite patient education-related Web sites were. Here are the answers we received:

• **Cezanne Garcia**, MPH, CHES, manager, patient and family education services, University of Washington Medical Center, Seattle:

"It is very difficult to select just one site, because different sites serve and meet different needs based upon a day's work," says Garcia. Web sites she finds helpful include:

http://www.discern.org.uk/ — DISCERN is an instrument that has been designed to help users of consumer health information judge the quality of written information about treatment choices. Some of the information available on treatment choices is poor quality, and only a small proportion of it is based on good evidence, explains Garcia. Many information sources provide inaccurate or confusing advice, and it may be hard to know which information to use and which to discard. This Web site helps you be more discerning, she says.

http://www.updateusa.com/clibip/clib.htm — Cochrane Review Methodology Database is a bibliography of articles on the science of research synthesis. Several databases are included in The Cochrane Library. One of them, The Cochrane Database of Systematic Reviews, contains Cochrane reviews; another, The Cochrane Controlled Trials Register, is a bibliographic database of controlled trials.

http://uncweb.carl.org/reveal/ — UnCover Reveal is an automated current awareness service that delivers the table of contents of your favorite journals directly to your e-mail box. "With Reveal, you can also create search strategies for your favorite topics. Keyword or author searches result in a list of individual article citations," says Garcia. Articles may be ordered from UnCover by reply e-mail, or you can print the list and fax the order to UnCover.

http://www.ncbi.nlm.nih.gov/PubMed/ — PubMed is a project developed by the National Center for Biotechnology Information at the National Library of Medicine of the National Institutes of Health. PubMed was developed in conjunction with publishers of biomedical literature as a search tool for accessing literature citations and linking to full-text journals at Web sites of participating publishers.

• **Joan Greathouse**, MEd, president, Joan Greathouse Consulting Co., Seattle:

http://fergusonreport.com — This Web site is the Newsletter of Consumer Health Informatics and Online Health, written by Tom Ferguson, who was an early proponent of accurate, credible on-line health information, says Greathouse. "I have been

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developing trainings on self-care and consumer empowerment, and on-line health information is an important piece of the equation," Greathouse says. "The on-line newsletter keeps me up to date on issues of using the Web as a tool to gather health and self-care information and on the effects of consumers and health care providers using the Web for health information," she explains.

Greathouse likes the site because the information is credible and the articles are timely and informative. The newsletter is free, and those who subscribe receive e-mail messages about other sources of information on on-line health.

• **Fran London**, MS, RN, health education specialist, Phoenix (AZ) Children's Hospital:

http://www.profusion.com — "I have not found one patient education Web site that has it all," London notes. "However, one site I use is the ProFusion metasearch engine. It uses many search engines to get results, and there is a health-related subset of choices that helps hone down its findings." Some of the materials on the site may not be written for lay readers, but you can get specific material in a hurry, she says. On the left of the ProFusion screen is a list titled "On Target" with "health" listed as one choice. Click on "health" to arrive at a new search screen that offers several health and medical search engines.

[Editor's note: From time to time, Patient Education Management *will print a list of the favorite patient education-related Web sites of patient education professionals. If you have a favorite Web site, please contact Susan Cort Johnson, Editor, at (916) 362-0133 or via e-mail at suscortjohn@earthlink.net. Tell us how you use the site in your work and why you like the site. Be sure to include the Web address for the site.]* ■

• **Institute on Nursing Informatics and Classification** — June 10-13, 2000, Iowa City, IA. For more information, contact: Jennifer Clougherty, program associate for Organizations, Systems, and Community Health Area of Study, University of Iowa, College of Nursing, Iowa City, IA 52242. Telephone: (319) 335-7119. Fax: (319) 335-7129. Web site: http://www.nursing.uiowa.edu/orgsyscom/conted.htm. ■

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

Graduation to booster seats remains a secret

Parents must be educated on dangers

It has become second nature to restrain infants and toddlers in child safety seats when traveling in an automobile. This safety habit has been formed largely due to laws requiring young children of a certain age, height, and weight to be transported in this manner. Yet, once a child outgrows these seats, many parents assume it is safe to allow him or her to use the lap or shoulder safety belt system found in most cars.

Not so, says **Barbara Shoemaker**, RN, MSN, clinical nurse specialist pediatric orthopedics at Shriners Hospital for Children Northern California in Sacramento. "In actuality, the safety belt system in our automobiles is made for the adult body. It would be much safer to move the child to a booster seat, which helps position the shoulder and lap belt appropriately on a young child," she says.

The reason is simple. Seat belts can cause intra-abdominal and spinal injuries to children during an automobile collision. Excessive forward movement, or hyperflexion, of the body around a fixed lap belt causes these injuries.

A young child between the ages of 5 and 10 years does not have a body that is mature enough for seat belts to fit properly, explains Shoemaker. The child's pelvis is small and narrow, so the lap belt does not sit low over the hips but has a tendency to ride up into the abdomen.

While the hyperflexion that results in intra-abdominal or spinal injury in children occurs most commonly with lap belts, young children often use shoulder harness belts incorrectly, making them just as dangerous. Because the belt hits them at the neck, causing discomfort, they tuck it underneath their arm, which puts the harness behind their back, essentially creating a lap belt restraint system.

To prevent these injuries, families need to be told that there are safety seats designed for young children, called booster seats or belt positioning boosters. "Many families are not aware that there are booster seats available. They trust that their automobiles' safety systems will secure their child," says Shoemaker.

A good time to teach parents about these seats is during well-child checkups at the pediatrician's office or clinic. Health care providers educate expecting parents about infant seats and the dangers of air bags. As the child gets older, these same providers need to talk to parents about the graduation from a toddler seat to a booster seat. "I think adding this information to the guidance given to families during well-child checks is probably one of the biggest teaching opportunities we have," says Shoemaker.

The seats are not difficult to use and typically work in conjunction with the shoulder lap belt system of the automobile. There are different designs, and parents should select one that best suits the style of seat restraint in their car, says Shoemaker.

Shriners Hospital for Children Northern California has a safety seat loan program for its patients and their families. Infant seats, toddler seats, booster seats, and special-needs automobile restraints are available. To make sure staff can teach parents to use the seats properly, 13 staff members at Shriners were selected to attend an intensive training program in April designed by the National Highway Traffic Safety Administration. **(For more information on this training program, see next article in this issue of *Focus on Pediatrics*.)**

Part of the admission assessment at Shriners includes questions about safety practices, such as the use of car seats. This information helps indicate families that would benefit from the loan program. "We also have written materials available in English and Spanish on car seat safety that we share with our families," says Shoemaker. ■

SOURCES

For more information on booster seat safety, contact:

- **Barbara Shoemaker**, RN, MSN, Clinical Nurse Specialist Pediatric Orthopedics, Shriners Hospital for Children Northern California, 2425 Stockton Blvd., Sacramento, CA 95817. Telephone: (916) 453-2145.

Misuse renders child safety seats worthless

Lessons on selection and installation a must

Child seat safety laws were implemented to reduce injuries to children in automobile accidents. However, the laws have little impact if parents use car seats incorrectly. At present, about 80% of all adults misuse car seats in some way, according to the National Highway Traffic Safety Administration (NHTSA) in Washington, DC.

"There are all kinds of gross misuse," says **Cathy Morris**, program director for Buckle Up Baby in Roseville, CA. People don't put the seat belt around the car seat, they don't put the shoulder harness around the child, or they position the infant seat facing forward too soon, putting the baby at greater risk for spinal cord injuries, she explains.

"People don't understand crash dynamics or what happens in a car crash. Also, a lot of parents just don't read the instructions that come with the car seat," says Morris. Another big problem is that parents often purchase car seats that aren't compatible with the seat belt system of their car. Some seat belts are too narrow for certain safety seats. Therefore, parents must consider the make of their car when purchasing a car seat.

To combat this problem, Morris conducts four-day child passenger safety workshops for law enforcement, health care professionals, and firefighters. At the end of the workshop, participants are child safety seat technicians and are qualified to teach parents the proper use of car seats and to conduct safety seat checks.

During the class, participants learn about the various vehicle systems, including seatbelts and air bags. The lesson is hands-on, and the trainees actually identify the seat belt systems in an array of cars. They also learn about the different car seats and how to determine if one is appropriate for a child based on age, weight, and physical tolerance. For example, a 2-year-old who weighs 45 pounds has outgrown the standard 40-pound harness, but is not yet mature enough for the lap/shoulder belt system in the car. This child would need to graduate to a 60-pound harness instead.

Although the laws in most states require a child to remain in a car safety seat until the child reaches a certain age or weight, NHTSA wants children to graduate to a booster seat. "We are seeing lots of injuries because seat belts don't fit kids properly. Normally, a seat belt doesn't fit a child until they are 60 to 80 pounds, so the booster seat lifts them off the vehicle seat and helps position the lap and shoulder belt properly," explains Morris.

The workshop includes information on the misuse of car seats and ends with a live check, where parents are invited to have their car seats inspected for proper use. One of the key points the safety seat technicians learn is that they are not an installation service, says Morris. They don't install the car seats for parents, but teach them how to use them correctly. Many times, families just want the seat installed, but it is unrealistic for them to think they will never have to move the seat, she explains.

Health care facilities that train technicians will find many opportunities to teach parents about car seat safety. They can be included in parenting classes before the baby is born so parents-to-be can purchase the correct seat and install it before the baby arrives. "A lot of times, parents show up at the hospital with the car seat in the box. We like them to shop and make sure it is right for the vehicle before they have the baby," says Morris.

Day care centers present another good opportunity. Because a lot of the children are 2 and 3 years old, it is a good time to discuss moving the child up to a booster seat.

The safety seat technician program is a national program. Although the laws in each state may differ slightly, the information taught in the class is the same, says Morris. However, the requirements for each class may vary. Morris, who runs Buckle Up Baby with grant funding, does not charge for the workshop as long as the institution sponsoring the class provides lunch for the participants. The workshop materials are provided by NHTSA.

To find an instructor in your area, contact your state office of traffic safety or visit the NHTSA Web site at www.nhtsa.dot.gov/. The site has a lot of safety materials that can be downloaded for health and safety fairs, says Morris. ■

SOURCES

For more information about child safety seat workshops, contact:

- **Cathy Morris**, Program Director, Buckle Up Baby, 401 Oak St., Roseville, CA 95878. Telephone: (916) 772-6300. Fax: (916) 772-6353. E-mail: cathy@buckleupbaby.org. Web site: www.buckleupbaby.org.
- **National Highway Traffic Safety Administration**, 400 7th St. S.W., Washington, DC 20590. Telephone: (202) 366-9550. Web site: www.nhtsa.dot.gov/.