Patient Education Management™

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

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Patient education remains strong one year after JCAHO changes

Accepted as an integral component by JCAHO and health care administrators

The Children's Hospital of Philadelphia was surveyed by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in February 2004. In the aftermath of this survey, **Linda S. Kocent**, RN, MSN, coordinator of patient-family education at the institution, is convinced patient and family education still is a critical concern of the accrediting agency.

However, she did not like the idea of eliminating the separate chapter on patient education and integrating these standards with those covering assessment, care, and continuum of care in a new chapter titled "Provision of Care," which the Joint Commission introduced in January 2004.

"I thought it diminished the importance of patient and family education. I had to keep in mind that patient and family education is part of everything that we do, so blending it into the big picture was logical. The survey itself convinced me that it is still a critical concern of JCAHO," says Kocent.

Like Kocent, many patient education managers were concerned about the impact the elimination of the separate chapter would have on patient

EXECUTIVE SUMMARY

Patient education managers discuss the new survey method implemented by JCAHO in January 2004 as well as the change in how patient education standards now are presented. Although the changes were not embraced at first, all those interviewed by *Patient Education Management* have found the change to be beneficial.

A representative from the Joint Commission said the organization would be in a better position to assess the issues this spring when it has more compliance data available.

education. In an article published in the October 2003 issue of *Patient Education Management,* many stated that the separate chapter had given patient education prominence, and they feared it would no longer be emphasized. Now many see that the change shows education is an integral part of patient care.

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Editor: **Susan Cort Johnson**, (530) 256-2749.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Jayne B. Gaskins**, (404) 262-5406, (jayne.gaskins@thomson.com).
Senior Production Editor: **Nancy McCreary**.

Editorial Questions

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

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"Over the 22 years that I've been a patient education manager, patient education has progressed from being seen as 'fluff' to being well accepted as an integral component of care. The fact that patient education is woven into the Provision of Care chapter underscores that acceptance," says **Annette Mercurio**, MPH, CHES, manager of patient, family, and community education at City of Hope National Medical Center in Duarte, CA. The integration of the chapters has advanced the role of patient education as an integral part of care, she says.

In preparing for a March survey by the Joint Commission, the medical center has been conducting biweekly tracers since June 2004. The Joint Commission implemented the tracer survey methodology in January 2004, where a patient's care experience is traced from admission to discharge.

"How the patient's educational needs are being addressed is assessed when we conduct practice tracers with staff, just as all other aspects of the patient's care are examined. Patient education is treated as part of the care process — not as a separate activity," she explains.

During a February 2004 survey at The Children's Hospital of Philadelphia, education was evaluated as part of each tracer, says Kocent. Staff, patients, and families were asked about education, and the surveyors asked to see handouts and patient-family education flowsheets. Also, they asked to see how education was reflected in the electronic documentation in the ambulatory care centers.

"Education was never an afterthought," she says.

Patient education now is where it should be — interwoven with the fabric of patient care, says **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta.

Most of the questions from the surveyors during the institution's September survey were directed to frontline staff, she says. They looked at both care and patient education from a continuum perspective to make sure that all caregivers were on the same page and that the information was communicated from one point of care to the next. Also, the surveyors consistently looked to see if education and documentation was interdisciplinary.

Patient education gets more exposure

Education now seems to have many opportunities for exposure. As the coordinator of patient and family education, Ordelt is responsible for

the institution's compliance with the patient education standards. Therefore, she is part of the team that overlooks the Joint Commission's Provision of Care chapter, the team for the Leadership chapter, and the Patient Rights chapter because all contain patient education standards.

Patient education also is well represented at City of Hope National Medical Center, with Mercurio facilitating the Provision of Care Functional Team and also a member of the institution's survey preparation steering committee.

Mercurio has found that the preparation for the new form of survey helps uncover areas that need improvement. The biweekly tracers have shown that they continue to have gaps in documentation of patient education.

"I will soon be helping to conduct tracers in patient care areas and will be able to review patient education documentation as I'm looking at documentation of specific patient's care," she says.

To improve the continuum of patient education across the areas of care before the 2004 survey date, **Cindy Latty**, BSN, RN, and **Maureen Battles**, BSN, RN, patient education coordinators for pediatrics at Riley Hospital for Children, Clarian Health Partners in Indianapolis, developed a new multidisciplinary care plan that addresses planning patient care on a multidisciplinary level. They are beginning to see the results of this change along with a new pain management flowsheet that was also implemented.

While survey preparation helps improve patient education, the new surveying method also is beneficial. "In the past, our preparations for the survey were focused on meeting the standard for the sake of being accredited. Now our preparations really look at patient outcomes and patient care, and our results more clearly reflect what we need to do to improve the quality of care," says **Mary Szczepanik**, MS, BSN, RN, manager of Cancer Education, Support, and Outreach at OhioHealth Cancer Services in Columbus.

While constantly improving, patient education has become an established part of most health care facilities; therefore, the changes the Joint Commission made in 2004 has not had an adverse impact.

"Patient and family education are so well integrated into our policies and procedures that the change in the JCAHO system didn't affect our practice," says Szczepanik.

OhioHealth has a dedicated patient education coordinator and several people like Szczepanik in service lines such as oncology, neuroscience, women's health, orthopedics, and heart that have responsibility for patient education. There are clinical nurse specialists and nurse practitioners who provide education, she says. Also clinical pathways for several major diseases include patient education, and they work as an automatic reminder to the nurse to teach and document teaching.

Patient education had a systemwide focus before the changes were made by the Joint Commission and still does at Riley Hospital for Children. "New staff are oriented to patient education, and we continue to look at new and innovative ways to educate our staff," says Latty.

The new survey format may provide a better showcase for patient education as well. "Though we personally have not experienced a true test of

SOURCES

For more information about the impact of the new tracer methodology used in Joint Commission surveys or implementing patient education standards, contact:

- **Zeena Engelke**, RN, MS, Patient Education Manager, University of Wisconsin Hospital and Clinics, 3330 University Ave., Suite 300, Mailbox Drop 9110, Madison, WI 53705. Telephone: (608) 263-8734. Fax: (608) 265-5444. E-mail: zk.engelke@hosp.wisc.edu.
- **Linda S. Kocent**, RN, MSN, Coordinator, Patient-Family Education, The Children's Hospital of Philadelphia, 34th Street and Civic Center Boulevard, Philadelphia, PA 19104. Telephone: (215) 590-3661. E-mail: kocent@chop.email.edu.
- **Cindy Latty**, BSN, RN, or **Maureen Battles**, BSN, RN, Patient Education Coordinators, Pediatrics, Riley Hospital for Children, Clarian Health Partners Inc., 702 N. Barnhill Drive, Indianapolis, IN 46202. Telephone: (317) 274-8845. E-mail: clatty@clarian.org or mbattles @clarian.org.
- **Annette Mercurio**, MPH, CHES, Manager, Patient, Family and Community Education, City of Hope National Medical Center, 1500 E. Duarte Road, Duarte, CA 91010-0269. Telephone: (626) 301-8926. E-mail: amercurio@coh.org.
- **Kathy Ordelt**, RN-CPN, CRRN, Patient and Family Education Coordinator, Children's Healthcare of Atlanta, 1600 Tullie Circle, Atlanta, GA 30329. Telephone: (404) 785-7839. Fax: (404) 785-7017. E-mail: kathy.ordelt@ choa.org.
- **Mary Szczepanik**, MS, BSN, RN, Manager, Cancer Education, Support and Outreach, OhioHealth Cancer Services, 3535 Olentangy River Road, Columbus, OH 43214. Telephone: (614) 566-3280. E-mail: szczepm@ ohiohealth.com.

the new system, I believe it has the potential to offer a more accurate reflection of actual patient care services within an organization. By tracing an episode of care, you get a real snapshot of that situation across settings and with a variety of disciplines," says **Zeena Engelke**, RN, MS, patient education manager at the University of Wisconsin Hospital and Clinics in Madison. ■

Attracting consumers to your resource center

If you build it, they won't necessarily come

The Family Resource Center, a pediatric consumer health information library at St. Louis Children's Hospital, has a multitude of books, videos, DVDs, and brochures on children's health and wellness from birth to adolescents. Some of the materials are from an adult perspective, others from that of a child.

Information is stacked from the floor to ceiling, and Internet access provides an opportunity to retrieve resources beyond the four walls of the 600-square-foot facility.

When parents have questions about their child's diagnosis, one of two pediatric nurses or the medical librarian who works part time at the library will pull together a packet of information and deliver it to the hospital room or mail it to the family. Staff fill about 260 requests each month.

However, patrons were not rushing through the doors when the facility opened five years ago. When the library opened, it averaged about 300 patrons each month until marketing efforts boosted the number to 1,200.

The goal is to get the word out about the resources available at the library so staff will be able to get the information into the hands of the people, says **Kimberly Crosby**, RN, director of Guest Services at St. Louis Children's Hospital.

"We think there are a lot of people who still don't know as much as they need to know about their child's health, so we need to grow the business to increase their knowledge about their child's health," she explains.

Frequently, children with complex disorders are admitted to the hospital. These disorders can be difficult to explain because the parents do not have knowledge of basic anatomy. For example, the child may have a complex cardiac defect, but the parents don't understand the heart needs to have four chambers and how they work.

"If we can help them understand the basics, then they can begin to understand why their child's defect is so serious. We really work hard to try to level the playing field and give them something to work from so they are equipped to ask intelligent questions and to be able to carry on a conversation with a physician to better make decisions for their child," says Crosby.

Strategies to increase business

To build business, staff members at the health information library introduce people to the services offered in a variety of ways. "We find that once a family has been a customer, they become a customer for life. We have a lot of repeat customers," says Crosby.

Following are a few of the marketing strategies used to increase business:

- **Educate new employees.**

During orientation, the nursing staff are told about the library and the resources that are available. They are encouraged to make referrals on behalf of the family.

Also nurses are encouraged to telephone the library and request a packet of information on a particular diagnosis for a family. Once the packet is assembled, it is delivered to the hospital room and the family is told their nurse requested it on their behalf.

- **Review admissions.**

Each day, staff members at the library review the admission sheet to see if children with new diagnoses were admitted to the hospital. "We put together a packet and drop it off at the bedside because families may not even have a chance to consider what they don't know. We include a brochure about the family resource center and invite them to visit us for more information," says Crosby.

The charge nurses on the units also are contacted on a daily basis for a list of people with new diagnoses.

- **Make rounds.**

Often one of the staff members will go room to room asking families if they have heard of the family resource center. To draw them to the center, they'll tell parents that they can check their e-mail. In addition to Internet access, people can send faxes, make copies, hook up their laptop computers, or make telephone calls. Once they are in the library, staff members use their customer service

skills to help the families find any information they might need.

• Partner with departments.

Staff members at the library work with the various departments at the children's hospital to stock brochures and books to benefit their patients. For example, the psychology department wants families with children who have been diagnosed with attention deficit disorder to receive a certain booklet, but at a cost of $2 a piece, it is difficult for the psychology department to supply it. However, because the library is generously funded by the hospital foundation, it is able to keep the booklets in stock.

Therefore, the psychology department refers families of patients with attention deficit disorder to the library for the brochure and, at that time, they are shown books on the subject that they might want to check out.

"Their families get the information they need, and we get the referrals that we crave," says Crosby.

• Give presentations.

Staff members give presentations on library services to the nurses and pediatricians at clinics. The physicians' offices are provided a small display board with brochures. The board has a reminder to refer patients to the library if they have questions.

The same presentations are given to community groups such as parent and teacher organizations as well. These talks often establish connections with schools. The resource center will fax information to school nurses when they have a student with a particular disease and even prepare a packet for the nurse to drop in the students' backpacks.

"A couple of schools had children die, so we prepared packets for the counselors with information on dealing with the death of a child," says Crosby.

• Distribute marketing keepsakes.

The library purchases marketing materials such as pens with its logo and contact information and magnets consumers can stick on their refrigerator. "We send a magnet out with every packet that we prepare," she notes.

While drawing people into the library provides an opportunity to put health information in the consumer's hands, volume also brings the operating cost per patron down. Crosby creates reports and graphs with such data for upper management.

"By looking at things like cost per patron, I am speaking in ways that my upper management understands. Using reports and graphs to show the benefits of the resource center is what will allow us to grow in size, hours, and staffing," she adds. ■

SOURCE

For more information about creating and increasing interest in a family resource center, contact:

- **Kimberly Crosby**, RN, Director of Guest Services, St. Louis Children's Hospital, One Children's Place, St. Louis, MO 63110. Telephone: (314) 454-2767. E-mail: kac1293@bjc.org. Web site: www.stlouischildrens.org.

EDUCATOR *Profile*

Expert reveals how to meet the needs of a large system

Incorporate all disciplines in process, be creative

As patient and family education coordinator for a large Miami-based health care system, **Sharon Sweeting**, MS, RD, LD, CDE, is the resource person for the bedside or clinic-based educators. She makes sure that they have the strategies to teach and as many resources as the budget of a publicly funded health care facility will allow.

"We are publicly funded; therefore, we don't have enough of anything — money, time, people, or resources — so we get quite creative," says Sweeting.

Other duties include making sure the Jackson Health System adheres to the guidelines for all accrediting agencies that cover patient/family education from the Joint Commission on Accreditation of Health Care Organizations based in Oakbrook Terrace, IL, to the Commission on Accreditation of Rehab Facilities.

Jackson Health System is comprised of two hospitals with a total of 1,800 beds, 12 primary care centers, two homeless clinics, seven school-based clinics, two long-term care facilities, seven clinics in correctional health, an HMO, and a downtown medical office.

Sweeting is responsible for all the content editing for written patient education materials distributed within the system. She also manages the patient education section on the web site, the Plain-Language Library of Medical Information.

In addition, Sweeting teaches continuing education classes and coordinates the patient education committee, which has representatives from every area of the system.

Patient education is within the department of education and development. There are 25 employees in the department, and Sweeting is the only one assigned to patient education — the rest are involved in staff education. All report to the director of education, who reports to the senior vice president of patient care services.

During new employee orientation every two weeks, Sweeting provides a half-hour of instruction on patient education, and part of it covers adult education strategies.

Before taking the position of patient education coordinator seven years ago, Sweeting was manager of patient services within nutrition services at Jackson Memorial Hospital. She held that position for eight years, and prior to that, she was the chief dietitian at the main hospital within the same system.

According to Sweeting, the move from nutrition to patient education was a natural evolution because she has taught night classes at four universities for 15 years.

Sweeting's bachelor of science degree and master of science degree are both in nutrition. Also she is a certified diabetes educator, a CPR instructor, first-aid instructor, insulin pump trainer, and is certified in adult weight management.

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

Question: What is your best success story?

Answer: "Drawing in all the health care providers as content authors for patient education. Traditionally, most of the products that were produced were [created] by the nursing staff. When I came into the position of patient and family education coordinator, I reached out to everyone else, including respiratory therapists, pharmacists, dietitians, social workers and radiology techs. Now education is truly interdisciplinary — from the product, to the delivery, to the documentation. Everybody has a piece, and I think the product reflects that."

Question: What is your area of strength?

Answer: "I am a leader, and I am not afraid to take chances. I have a real passion for the underserved, particularly giving them the information about health literacy they need, and I am able to ignite that passion in other people [by] encouraging them to do things out of the box.

"Health literacy is a huge challenge. It is amazing what people, regardless of their backgrounds, don't know about their bodies that we assume is common knowledge. In new employee orientation, I pick a geographical direction, and I have those people attending point to it. I get seven or eight different hands going in different directions. I use that as an illustration to show that not everybody has the same body of knowledge so, when teaching, you need to be sympathetic to that."

Question: What lesson did you learn the hard way?

Answer: "Three years ago, I tried to get an interdisciplinary documentation form approved and in place prior to our Joint Commission Survey. One step before implementation, it was stopped. I learned a couple of things from that experience. Change in the arena of documentation is not easy, and interdisciplinary documentation of anything is a challenge at best. So if you don't take something familiar and make it accessible to everybody, you are doomed to failure.

"We took our patient education protocols and made [them] so that everyone on the team could use them rather than create a new form. Familiar is better and less threatening."

Question: What is your weakest link or greatest challenge?

Answer: "I am very impatient, and I am not a passive individual. Sometimes that works for me, and sometimes against me. I would really like to have the ability to get things done quicker, but when you work in a large organization you have to be patient. It takes a while to get consensus."

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

Answer: "I am a big proponent of self-management. I think, in the future, health literacy is going to be a huge issue — it is now. Equipping people to deal with self-management issues of chronic disease by the use of kiosks in the mall,

the Internet, newsletters, or audio — I think we will see more and more of that. We need to equip people to make the best choices for themselves, and I think we are going to do that through more outlets. You never have enough communication."

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

Answer: "We have much more information on our intranet and the web, and it is simpler. Our corporate standards for readability are fourth to fifth grade. Our corporate partners have used the plain-language library a lot, making it the second most active piece of our web site. The information is translated into low-literacy Spanish, and there is very little of that on the web.

"In a system as large as ours geographically, people can't always come down to the main hospital or wait for me to ship materials when they need it, so the intranet is very helpful.

"Also, making the material as simple as we can is helpful. Our corporate standard is one page. We don't do books or booklets because people throw those away, and that is expensive.

"We tend to use a question/answer format, and I have a pamphlet on how to write for the Jackson Health System [that includes] templates. For example, if someone is creating a medication brochure, it lists the questions he or she needs to answer. The templates have encouraged a lot of content authors that ordinarily wouldn't have tried at all."

Question: When creating and implementing new forms, patient education materials, or programs, where do you get information and ideas?

Answer: "We go to the patients and families. Also I go to the patient education listserv and throw questions out to get immediate answers.

"I try to read the popular information that comes across on the media and be sensitive to that as well as the professional information. Also, [whenever] product lines are being developed, we try to have a companion piece available for that." ■

SOURCE

For more information about the ideas and issues covered in this article, contact:

- **Sharon Sweeting**, MS, RD, LD, CDE, Coordinator, Patient and Family Education, Dept. of Education and Development, Jackson Health System, 7th Floor, Jackson Medical Towers, 1500 N.W. 12th Ave. Miami, FL 33136. Telephone: (305) 585-8168. E-mail: ssweetin@um-jmh.org.

Hospital, patients survive battering by Hurricane Ivan

Effective communication helped 2,000 people

It was about 2 a.m., Sept. 16, when Hurricane Ivan roared into Pensacola, FL, with 130-mph winds, battering the boarded-up windows of Sacred Heart Hospital, knocking out the electricity and forcing the hospital to operate on emergency generators.

"It was pitch-black outside, and we heard the awful sound of that wind, but we couldn't see anything," recalls **Susan Kearney**, LCSW, manager of social services. Although the windows were boarded up, staff were concerned they might buckle and decided to move the patients from their rooms and into the halls.

At the same time, the hospital staff became concerned about hundreds of visitors who were sleeping in the lobby, which had large, vulnerable windows. They woke them up and moved them to the basement, where it was quieter and safer.

The next few days called for creativity and patience on the part of the staff and patients, Kearney says. The hospital regained electricity fairly quickly, but neither the staff's cell phones and pagers nor the hospital's e-mail system worked in the early days after the storm.

Communication system challenged

"The communication system was really challenged," says **Mike Burke**, public relations manager for the 449-bed acute-care facility, which includes Sacred Heart Hospital, Sacred Heart Children's Hospital, and Sacred Heart Women's Hospital.

Managers and leaders from all over the hospital gathered every four hours in a central area to share information about what was happening.

"This is one of the most helpful things we did as a team. This allowed us to be in constant communication with each other, and we could take what we learned back to the staff who were hungry for information in a time of crisis," Kearney says.

Marketing and public relations staff attended the meetings, typed up a summary, and walked through the hospital distributing them to all staff.

"All of the essential functions of the hospital kept going during the storm. We delivered babies,

did heart catheterization, and emergency surgery," Burke says.

In the two weeks after the storm, the hospital's emergency department (ED) visits went up by 40%. Among the injuries were 40 patients injured by chain saws and other serious injuries from falling limbs and falls. The Federal Emergency Management Agency sent a Disaster Medical Assistance Team to the hospital. It set up tents outside the ED to handle minor injuries.

As soon as the storm was over, the social workers and case managers started trying to determine which nursing homes could take patients who were ready for discharge and which patients could be discharged to home safely. They made calls to area grocery stores, pharmacies, home health care agencies, and durable medical equipment companies to compile a list of available resources for patients and employees.

They went over the list of patients ready for discharge on a case-by-case basis and thoroughly documented the medical records when the patients couldn't be released because they had no home to go to or no electricity and water. It took as long as 12 days for electricity to be restored to some parts of Pensacola and more than a week before the water was declared safe to drink.

Will insurance pay?

The hospital still is waiting to learn whether the extra days will be covered by the patients' insurance. "We wouldn't have done it any differently. These patients couldn't go home, and we have plenty of documentation as to why their discharge was delayed," Kearney says.

About a week before Hurricane Ivan struck the Florida panhandle, the hospital started preparing to implement its disaster plan and assigned duties for when the hurricane hit.

Four days before the hurricane hit, the hospital began discharging as many patients as it could. Patients who were not ambulatory and who lived in areas that are vulnerable to flooding stayed in the hospital. "When discharges were postponed, we documented as carefully as we could as to the rationale," she says.

The day before the hurricane, the social workers and case managers shifted their attention to the duties they were assigned to handle during the storm. The social work department was assigned to staff the hospital day care center during the time they were no longer needed for duties on the floor.

The case managers were assigned to the ED to direct people who did not need to be admitted to the hospital to special-needs shelters and other facilities. "We had a lot of frail elderly and people who were on oxygen who came to the hospital because they were afraid. The case manager's role was to direct these patients to appropriate shelters and assist in getting them safely to those shelters," Kearney says.

Her first advice to hospital staff: Accept the fact that a disaster may happen and plan accordingly.

Although the hospital was well prepared for the storm, Kearney contends her department could have been better prepared. She would have stocked up on powerful flashlights, batteries, bottled water, and food for her department.

"Although the hospital fed employees at no cost for two weeks after the storm, we all wished we had planned ahead. We had little flashlights, and trying to make our way around a dark hospital with those little lights was a real challenge," she says. "Prepare as if the disaster is going to hit you head-on."

Communication is the most vital part of preparation, and hospitals should prepare to operate without their usual communication equipment, Kearney adds.

Make sure your staff have up-to-date information about where the shelters are, what kind of patients they can accommodate, and what kind of patients they can't take, she advises. ■

Hands off or on when it comes to patient care?

Offering simple comfort can be thwarted

For as long as humans have been taking care of other humans who are sick or hurt, the rendering of solace and physical comfort has been the core from which all other types of aid have grown. But a nurse and ethicist in California says that ignoring the value of giving of solace and comfort amounts to turning away from the prime reason for the practice of medicine.

Rapid advances in technology, cultural differences between nurses and patients, and the current nursing shortage have all contributed to a hands-off approach by some nurses, says **Patricia Benner**, RN, PhD, professor in the

department of social and behavioral sciences and department of physiological nursing at the University of California at San Francisco.

"One colleague felt like it didn't occur to nurses to reach out, physically, to patients, and to offer comfort other than medication, and I think that's a real deterioration of the practice," says Benner. "It's a loss of self and ethos of the practice."

Benner disagrees with the opinion that nurses are not being taught in school the value of being there for patients, or presencing (being present and available to the patient) oneself, and offering comfort.

But she agrees that cultural differences and concerns about the possibility of unwelcome touch possibly offending the patient or family members have led some nurses to not engage in hands-on comforting.

The basis of all nursing

Offering comfort of the human type, and not just medications and technology, is what nursing has always been about, says Benner, a belief echoed by American Hospital Association president **Dick Davidson**.

"There will always be personal contact and caring," Davidson says. "We will always have hands touching patients. Everything we do is about human need. That's the constant over time."

Nursing and medical students are still being taught the arts of gentle touch and hands-on comfort measures, such as simply being present in a reassuring manner, says Benner, who works as a consultant in the development and enhancement of delivery of nursing care. "However, there are threats to this central nursing practice, it is invisible, it is rarely charted, and it is never mentioned in a nursing care plan."

This leaves nurses to decide individually, patient by patient, what role comfort and presencing will play.

It all depends on the patient

Just how much physical comfort a nurse should impart on a patient — if at all — is a largely going to depend on the patient.

"It always — *always* — has to be lodged in the relationship," says Benner. "Just as you can't suggest that you'll do it for all patients, it would also be very wrong to say you won't do it at all.

"And of course, if a patient does not want comforting, it would be wrong to force it," she adds.

Cultural diversity plays a role as well; some cultures have deeply ingrained attitudes toward physical touching.

"You have multiculturalism on the side of both nurses and patients, and both groups are diverse [in their ethnicities]," Benner says. "And the language of presencing and comforting practices are deeply cultural.

"And there are even status barriers that might prevent a nurse from offering solace, or prevent the patient from accepting it."

Benner says that for medical staff to know how to give a patient the comfort and solace he or she needs, and to the degree that he or she needs it, the clinician must first get to know that patient to determine what his or her needs and preferences are.

Staffing can have an impact on what kind of care can be rendered. If manpower is short, so is the time a nurse or physician can spend with individual patients.

"If you are short-handed, there isn't going to be lots of time for sitting with a patient, listening, just presencing," Benner points out. "But with adequate staffing, there's no reason comfort and caring can't be part of the delivery of care."

Veterinarians as role models?

Delivery of comfort is taught in medical and nursing schools, Benner says, and is an integral part of the ethos of the practice.

"You really couldn't have good judgment or trust without good relational care, at least in some specialties."

One specialty, in particular, gets it right when it comes to giving patients individualized, hands-on, comforting care.

"I've always felt it was very sad that veterinarians give much more individualized care to their patients than we who take care of humans," says Benner.

Without that human element — the willingness to sit and hold a patient's hand, to listen, to massage

SOURCE

For more information about providing physical comfort to patients, contact:

- **Patricia E. Benner**, RN, PhD, FAAN, Professor, Thelma Shobe Endowed Chair in Ethics and Spirituality; and Chair, Department of Social and Behavioral Sciences; Joint Appointment, Department of Physiological Nursing, University of California at San Francisco. Telephone: (415) 476-4313. E-mail: benpat@itsa.ucsf.edu.

cramping legs or bed-weary backs — "we have nothing but a technical enterprise of delivering goods and services to patients," she adds.

When someone is ill, Benner notes, that person needs more than just the best drugs and most advanced treatment available. "They need more than justice and rights — they need comfort and goods."

Simply being there for a patient, even without offering anything in the way of real care, is more and more difficult as hospitals continue to struggle with staffing. But it's a care delivery method that patients really shouldn't have to do without, Benner says.

"Presencing yourself when someone is in distress — not abandoning them — is a very important comfort strategy," she says. "This is especially true when someone is trying to get his own equilibrium back, regulate his breathing, get his heart rate back in tow.

"Just having someone with them can be a real source of comfort." ■

Can't get no satisfaction? Communication is the key

Tips for communicating about pain management

Everyone who works in health care has a list of ideas for what needs to be done to improve client satisfaction, but one theme appears to be a common thread throughout: communication.

"Communication is always a challenge," says **Jan Jones**, RN, BSN, FAAMA, president and chief executive officer of Alive Hospice in Nashville, TN. "We're looking at how we communicate with the families and how to improve tools we use to communicate," she says. "Pain management is an area where we certainly perform well, but we also feel there are ways we can improve in terms of communicating with families about pain management efforts being made."

Honing employees' listening skills is a goal of Bayada Nurses in Moorestown, NJ, says **Mark Baiada**, president of the company. Bayada has more than 115 home care offices nationwide that work with hospices and care for patients with terminal illnesses.

Nurses are trained to listen actively and observe clients' facial expressions to look for nonverbal communication, he says. "We teach them to look at the person's face to see if the person is communicating fear, discomfort, or worry. The patient may be fearful and cannot express how he's really doing."

Communication skills constitute an important aspect of coordinating patient care among a multidisciplinary team, says **Christie Franklin**, RN, CHCE, vice president of professional services, acquisitions, and start-up for AseraCare of Fort Smith, AR.

When facilities coordinate care, it's important for the patient and caregiver to understand which services will be provided, she notes. "The case manager will review that with the patient and family, and with the facility staff if the patient is in a facility."

There are other important aspects of improving client satisfaction that health care facilities need to implement. Jones, Baiada, and Franklin offer these additional suggestions for improving client satisfaction:

• Focus on pain management, even if patients do not have complaints.

"Typically, we find that families perceive pain to be at a higher level than patients do," Franklin says. "This is something that we're working on, an area where we might be able to do something differently."

AseraCare has held a series of inservice training sessions on pain management this year, offering a focused approach to palliative care, Franklin says. After AseraCare began to use the family satisfaction survey promoted by the National Hospice & Palliative Care Organization of Alexandria, VA, pain management was one of the top three priorities identified in survey results, she notes. "We always focus on pain management, and one of the indicators we are focused on is the amount of pain medication received," Franklin says. "We really look at pain management, how often the patient was treated with respect, and the overall rating of hospice care."

Pain management education has included instruction by pharmacists, who join in conference calls with health care staff, she says. "We have some drug formularies that we review for educational purposes, and we give an overview of all the medications utilized for a facility," Franklin explains. "We had courses in Pain Management I and II, plus the overview of medications and how to use them."

• Improve staffing and access after hours.

"One thing that's always a challenge for us is how after-office care is delivered," Jones says. "As a result of information gathered on patient

and family satisfaction surveys, we've made changes in our after-hours staffing."

For example, several people surveyed said the facility didn't have someone to respond in a timely fashion after hours, she recalls. "So that's our trigger to look more in depth at what's happening with our triage system and our after-hours staff and how we need to build it into our budget for more staff," Jones says.

This is how a quality improvement project should work once a problem is identified, she notes. "When we see a trend like that, we delve more deeply, and we certainly go to patient records and talk to family members and get specifics about what their issue was," Jones adds. "We talk to staff, including triage staff, to find out what it was they experienced, and from that we begin to gather data and look at what needs to be changed, where the gaps are, and what our expectations are for what was delivered."

For instance, management realized that the after-hours staff were dealing with a higher volume of calls than they used to. As a result, it was unrealistic to expect them to handle all of these cases as rapidly as management wanted, so the facility included another triage position in its budget, Jones says.

• Put the client first.

One speaker who taught Bayada's staff about pain management said this to the nurses: "Remember one thing when you come to the door of a [patient]: Just remember to show love," Baiada recalls. "When you show love, you're helping patients with all of the needs they have, including the physical and emotional. So you have to prepare yourself to be of service in a loving and caring way, and to be reliable and have the skills in place so you can do a good job."

• Families must be able to trust staff.

Likewise, the client's satisfaction is more important than scheduling concerns, he says. "If the family is dissatisfied with a nurse, then bring in someone new. Especially in hospice care, staff support is so important because it's a time of crisis for most families, and if one thing goes wrong, they lose trust."

• Educate staff about client satisfaction surveys and quality improvement.

AseraCare hospices provide short educational sessions through the "lunch-and-learn" training program, Franklin reports. These hour-long sessions are conducted by teleconference and are attended by executive directors and directors of clinical services first, she says.

AseraCare held these training sessions to show staff how the company planned to use a new client satisfaction survey, including details about the scoring guide, frequently asked questions, and some sample information on the reports generated from the survey information, Franklin explains.

A second teleconference session teaches staff how to complete the survey's spreadsheet and provides them with data to enter during the call, she adds. "We go through the steps of entering data and have the information technologies department on conference call to answer any follow-up questions," Franklin says. "Then we go over the reports and how those are to be reviewed and utilized, and we continue with the training." ■

CE instructions

Nurses and other patient education professionals participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- Achieve optimal care outcomes through patient education
- Education's role in meeting the National Patient Safety goals
- Adapting teaching to learning styles in large groups
- Innovative ways to use the intranet/Internet in teaching
- Creating good policy for interpreter services

CE Questions

1. The tracers used to prepare for the Joint Commission survey can help uncover gaps in patient education, such as documentation, that can be improved before the actual accreditation survey.
A. True
B. False

2. Which of the following methods were used to attract consumers to the Family Resource Center, a pediatric consumer health information library at St. Louis Children's Hospital?
A. Staff partnered with departments
B. Staff gave presentations
C. Staff made rounds to patient rooms
D. All of the above

3. Which of the following is NOT an obstacle to offering patients physical comfort and solace, according to nurse ethicist Patricia Benner?
A. Cultural views
B. Time pressures
C. The desire of the patient to receive comfort and solace
D. Fear of offending the patient

4. How many patients were at Sacred Heart Hospital in Pensacola, FL, when Hurricane Ivan hit?
A. 150
B. 200
C. 360
D. 75

Answers: 1. A; 2. D; 3. C; 4. C.

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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. ■