Patient Education Management™

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

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Form provides compliance for JCAHO patient education documentation

Simple, well-organized forms that are accessible work best

A good form does not guarantee that all staff from all hospital disciplines who may be teaching a patient will comply with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) documentation requirements. However, it is an important element in boosting compliance in documentation of patient education.

"The design is extremely important because, in my experience, compliance with documentation is better at the hospitals that have more user-friendly forms," says **Yvonne Brookes**, RN, clinical learning program coordinator and patient education liaison at Baptist Health South Florida in Miami.

Brookes, who is involved with five hospitals, says when time is spent designing a form that is short and easy to use, more people will utilize it. It also is important to take into account the needs of everyone who may be teaching the patient. For example, to accommodate the needs of a dietitian, there must be a place to document teaching about the patient's diet.

To make sure the documentation form met everyone's needs, it was designed by the multidisciplinary patient education committee at the hospitals within the Baptist Health system. Before a design concept was created,

EXECUTIVE SUMMARY

Documentation of patient education often is a problem. While there are many reasons staff members do not document teaching, one reason is poor form design. This issue of *Patient Education Management* explores problems with forms that could present a barrier to consistent documentation. Methods for creating a form that fits the needs of your institution also are discussed.

every committee member had to gather at least five forms from colleagues at other institutions for committee review.

Using the best elements from each form, the committee designed the documentation tool with the help of the graphics department and a representative from medical records to ensure that the layout would work and the form could be kept in the electronic archives. Brookes says one of the forms from Baptist Health South Florida is used by the JCAHO in their literature as an example of a good documentation form.

User-friendly forms are important, agrees **Diane C. Moyer**, MS, RN, program manager for Consumer Health Education at The Ohio State University Medical Center in Columbus. "The less time involved in being able to fill out the form, the better it is as far as compliance," she says.

If forms are standardized throughout the institution or across several departments, the staff within the various hospital disciplines will more readily understand the format and comply with documentation, says Moyer. "Keep in mind who is going to be using the form and what they have been used to in the past, such as filling in the blanks or check boxes," she advises.

Also, it is important to make sure staff are not asked to document the same information on two forms. If the information is documented in another area, simply make a note on the new form that indicates where it can be found.

To increase compliance for documenting patient education, the form at the Deborah Heart and Lung Center in Browns Mills, NJ, was redesigned to mirror the interdisciplinary care plan. The old form for documenting patient education was six pages long, had too much redundancy, and did not flow well, recalls **Laura Gebers**, BSN, RN, BC, PCS programs health education coordinator at the health care facility.

"Our staff found the new form easier to understand. The information was organized and easily found to document appropriately," she explains. Compliance increased from 40% to 90% when the new form was introduced.

Gebers created the concept design for the form with the advice of the health education advisory council. "Each discipline made suggestions for what information should be present to ensure completing their documentation was worth their time," she explains.

Is that all there is?

While a form must be succinct, there is more to documentation compliance than the form design, says **Ruthie Gohl**, MSN, director of medical services at Southwest Washington Medical Center in Vancouver.

Before a team of staff nurses at the health care facility tackled the problem of noncompliance in

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documenting patient education, they explored the reasons for noncompliance. A survey indicated that staff were spending about 90 minutes per patient teaching and documenting what was taught. As a result, compliance for documentation was around 40%.

Staff members teach all the time, but they don't always document. The solution was to design a system that prompted documentation, explains Gohl.

First, a patient education record was designed, which increased documentation by about 15%. That form was followed by the implementation of a plan of care for various diagnoses. All material needed to teach the patient about the particular diagnosis comes with the plan of care along with the education record and a daily planning record that prompts the appropriate education for the day.

The education record is printed with areas for documenting what was covered in the care plan by codes to keep documentation simple.

For example, if a patient with congestive heart failure is taught smoking cessation, the teaching material is included in the plan of care including information on why the patient should quit smoking, what will happen when he or she quits, and community resources available for support. Areas for documenting the review of this material with the patient are preprinted on the education record for ease of documentation. Also on the record is the standard education process for educating a patient, such as the assessment for readiness to learn, teaching method, and how the education is evaluated.

The staff nurse group that designed the system determined that, if they did not have to find information in a file on the floor or pull it off the computer and print it every time they needed it, they were able to provide better education and comply more readily with documentation requirements.

It has worked, says Gohl, and documentation now is at 88%. In addition, follow-up surveys indicate the amount of time it takes to document patient education has been cut in half.

Documentation forms that mirror teaching flow sheets tailored to particular units or disease processes provide a convenient method for documentation at The Ohio State University Medical Center. Required teaching can easily be checked off on the form, says Moyer.

Prompts or triggers for documentation can be key — not only on the form, but in other areas as well, says Brookes. For example, an area on the admission form can prompt nurses to initiate the teaching record. Also, it is a good idea to have a patient education discharge-teaching tab in the medical record so staff will know where to look for the teaching record for documentation.

Codes, such as letters, on forms work well to streamline documentation, says Brookes. "Use the documentation form as a summary and have it refer to the tools used, such as a handout that was reviewed or video," she advises. Everything can have a code — from barriers to learning, such as pain, to the method for evaluating teaching, such as question and answer or demonstration and return demonstration.

If a form has been updated, streamlined, or redesigned, staff must be advised of changes before it is implemented.

When a new form is introduced at Baptist Health, a patient education liaison takes it to his or her unit to explain how it works. In addition, large posters of the form are printed that have short descriptions of each area with arrows pointing to them. And before the form is introduced, articles about its implementation are run in the employee newsletter.

At the Deborah Heart and Lung Center, members of the Health Care Advisory Council were accessible on their units to help staff with form

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completion when the new design was introduced. The form was essentially the same tool used before only streamlined with a better design, says Gebers.

While form redesign can improve documentation, Moyer warns that often it is not the form that is the problem with low compliance in documentation of patient education.

"Often it is more a matter of being certain that the staff identify and recognize the importance of the documentation, and knowing that it captures the teaching they are doing. They see and value the information as an important part of the patient's care," she explains.

Many staff members think no one reads the education record, so it is a waste of time to write down what was taught, says Moyers.

Janice Reynolds, RN, OCN, a staff nurse who chairs the patient education team at Mid Coast Hospital in Brunswick, ME, says, although many attempts have been made to streamline the documentation of patient education, compliance still is low.

The facility has been using computer documentation for about three years, first providing an education section where staff could access various subjects such as pain management and simply click on what was taught, who was taught, materials reviewed, and patient and family response to teaching. When they received various complaints about the time it took to go to a special section, patient education was added to the flow sheet where nurses do 90% of their documenting. The simple point-and-click documentation was used.

Reynolds says many nurses at the community hospital do not see the documentation of patient education as priority. In a class on effective documentation and communication, she teaches annually, she tells nurses that patient education is one area for malpractice that they are held responsible.

If documentation of patient education is a problem, before changing the form, find out what prevents staff from documenting teaching and then address the problems, suggests Moyer. It could be the form is not easily accessible. Or it could be staff do not value it as an important part of the care that is provided.

Staff members must understand, although they may not see their health care team looking at the education documentation form, it is a key piece for the long-term record of care provided for a patient, she says . ■

Facilities comply with JCAHO patient ed regs

New tracer survey methodology successful

The new tracer methodology for surveying the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) implemented in January 2004 is working well, according to **Michael Alcenius**, MS, PA, associate director for the Standards Interpretation Group.

It is a much better way of evaluating a patient education program at an institution than the old method, he says. In the past, surveyors sat in interviews with leadership in organizations responsible for managing patient education. These dedicated educators could explain policies and what went into development of education programs, but surveyors were never able to observe whether the system set in place really was working, says Alcenius.

Now that the surveyors actually go to the point of care, select a sample of patients, and use their medical records as the tracer tool to follow the patient through their treatment and care, they are able to focus on various areas including education, he explains.

For example, if the patient is admitted for diabetes, the surveyor observes how insulin administration is taught as well as nutrition in relation to his or her disease process. The surveyor also checks to see if the patient's learning needs assessment is being addressed.

"We go to the medical record to look for those keys to indicate compliance with patient education standards. We then discuss it with staff and the patient to make sure that what the staff is telling us, what the record documentation indicates, and what the patient is telling us is consistent," says Alcenius.

JCAHO is finding that organizations really are quite compliant with patient education standards. Quarterly, the agency publishes the top 10 challenging standards areas, and patient education is not one of them. "We have not seen a significant amount of noncompliance issues with patient education," he says.

Since patient education standards were introduced more than 10 years ago, they have undergone a considerable amount of revision to make them clearer. The modifications consistently improved the standards making them easier to implement, and patient education has become an

established part of most health care facilities.

Therefore, when JCAHO integrated the patient education standards with those covering assessment, care, and continuum of care in a new chapter titled "Provision of Care" at the same time it changed the method for surveying there was no adverse impact.

Surveyors look for evidence

Alcenius describes the patient education standards as prescriptive but open. They are purposely written this way to fit the needs of a wide range of health care facilities from small, home care organizations that provide respiratory care for patients, to university-based medical centers that provide complex care.

"The way they are written, they require organizations to all do essentially the same thing, but they allow them to determine how best to come into compliance with the standards," says Alcenius.

For example, the standards require that institutions conduct a learning needs assessment to determine the patient's motivation to learn and if there are any physical or cognitive limitations or cultural and religious beliefs that need to be considered when teaching. Some organizations have a formal needs assessment in place, and others address this standard in the nursing assessment notes, he notes. "The requirement is there, but how the organization meets compliance is up to them, [as long as] they can evidence attention to those particular requirements," Alcenius explains.

According to Alcenius, there are two areas in which many health care institutions need improvement. One is documentation of patient education. "Frequently, I find there is much more education occurring than what has been documented," he says.

Documentation is important to JCAHO because it assures a continuity of education. Without knowing what was taught the day before, a provider cannot pick up where his or her colleague left off and continue the education process.

There are many ways to meet the requirement for documentation without making it a burden for staff, says Alcenius.

For example, some institutions use the SOAP note, which is a format for an encounter with a patient as explained below:

- **S**ubjective — what the patient is telling the provider; their complaint and their own perception
- **O**bjective — refers to the clinician's observation
- **A**ssessment — considers both the patient's and clinician's observations, so a diagnosis can be made
- **P**lan of care

"Organizations that use this format may add a [second] SOAP — one plan for treatment and one for education, where they write what they discuss with the patient from an educational standpoint," says Alcenius.

In addition to documentation, another area for improvement is the learning needs assessment. Once patients have been assessed on how they learn best and for barriers to learning, the findings must be taken into account when teaching.

"You may see sort of a template approach to patient education that really isn't in the spirit of our standard. We want everything — care plans and patient education plans — to be specific to the patient and the needs of the patient," explains Alcenius. ■

Using learning needs assessments with children

Observation while working with family is key

While a learning needs assessment for a child is not formal, it is important to determine how they can learn and how much they can learn, says **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta.

The assessment takes place while working with the child and helps determine if the child's developmental level fits his or her age so education can be tailored accordingly.

"You approach a child at age 3 or 4 differently than at age 8 or 9," says Ordelt.

While honesty is fitting when teaching children at any age, the information should be delivered in an age-appropriate, nonthreatening way. For example, young children often take statements literally so, instead of saying something will burn, it is more appropriate to say that it will feel warm.

"You need to use words that will not produce fear so they aren't superanxious at the start of a procedure," says Ordelt.

Props, such as dolls, models, and picture books, also help when teaching children. She says children learn best in hands-on activities; therefore, she suggests that those working with children allow them

SOURCE

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to do medical play when preparing for a procedure. If a family is going to learn catheterization for a bladder program, give the child instruction with a catheter kit and a doll, Ordelt adds.

A health care professional can observe play to determine if the child is ready to handle the next step in his or her care.

When a child is the patient, health care professionals need to be able to instruct parents or guardians according to adult learning principles, and then work with the child at his or her developmental level.

All five senses should be incorporated into lessons for children including smell, taste, touch, sights, and sounds. For example, let children know that something will feel cold or wet so they know what to expect.

Part of the hands-on teaching that also can serve to assess what children will be able to handle should include letting them help when preparing for a procedure, suggests Ordelt. For example, when nurses are doing a central line dressing change, they can ask the child if he or she would like to help gather the supplies.

"Take those steps with the children to see how much they will be able to handle, and sometimes you [can] even involve siblings because they go through the crisis too when a brother or sister is ill," she explains.

During the assessment process, a health care provider is not just trying to determine how much information to give a child, but when to give it. Preschoolers should be given information immediately before a procedure because they have no concrete sense of time, and will therefore become anxious. "Right before a procedure, teach them what it will be like," says Ordelt.

Teenagers, on the other hand, want control and should be given information at least a week ahead of time so they can prepare for the event.

Children's ages don't necessarily indicate their developmental stage; therefore, it is important to determine what a child can do. Also determine if the family will give the child permission to participate, and if his or her involvement will work with the family dynamics, says Ordelt.

When a child is diagnosed with cancer or another devastating illness, clinicians work with the entire family. Therefore, it is important to assess the family system to know when to give information, how much to give, and when to give it, she explains.

(Editor's note: For information on conducting a learning assessment when preparing to teach adults, see article in Patient Education Management, *April 2005, p. 37.)* ■

Improve communication with the right tool

Poor communication major cause of adverse errors

Abington (PA) Memorial Hospital will soon roll out a pilot program for a planned SBAR (situation background assessment and recommendation) initiative the program's proponents say will improve communications and reduce errors at the facility.

The link between poor communication and errors is well recognized in the health care community. In fact, the Joint Commission on Accreditation of Healthcare Organizations recently identified communication as a major cause of adverse events.

"We've had instances where there have been adverse events, and where we did not see proper communication, and it turns into a doctor/nurse 'he said, she said,'" notes **Doron Schneider**, MD, associate program director, internal medicine residency, at Abington.

"People say they were not aware of certain vital signs, or the primary nurse's concern was 'X,' and the physician thought it was 'Z.' We want to make sure that when the physician makes an important call, they have received all the pertinent information," he explains.

"We've noted 60% to 70% of medication errors are related to communication, so the way we deliver information and anticipate delivery as a receiver of information can go a long way to alleviating some patient safety problems," says Schneider.

Interestingly, Schneider and some of the nursing leadership at Abington both heard about SBAR within a short period of time — at separate

industry meetings. "It was initially introduced to me at the National Patient Safety Foundation meeting last year in Boston, and a month later, our nurse leadership went to a conference and also heard about it," he recalls. "It's a tool that is really gaining acceptance nationally."

At the heart of SBAR is a form that is filled out and shared with the other health care professionals treating the patient. It is divided into four sections:

- **Situation**: This includes patient identification information, code status, vitals, and the nurse's concerns.
- **Background**: Information is noted on patient's mental status, skin condition, and whether he or she is on oxygen.
- **Assessment**: Here the nurse indicates what he or she believes to be the problem.
- **Recommendation**: Physician follow-up actions are suggested, including possible tests.

Before a potential rollout to the entire hospital, Schneider says a pilot program will be conducted in the critical care unit (CCU), as part of a totally new overall approach to quality. "The tool is not going to start as a permanent part of our medical record, but it will be on the nurse's flowsheet as a reminder of how to communicate information surrounding unstable changes in clinical status," he explains.

In short, it will serve as a unidirectional form of communication — someone on the ground reporting up the chain of command. "It will communicate something of importance from nursing to the physician," Schneider says. "We will later be looking at how residents communicate with attending physicians."

Education of staff is critical, he continues. "We want to make sure we not only educate nursing about the fact that we expect them to use this tool, but we also will educate the docs, so they know they are supposed to receive this information."

This will start with the residents, who will receive a revamped introduction/orientation to CCU when they rotate, which they do monthly. "They will hear about things they have not heard about before, like goal-setting checklists, a bundle project to decrease CAP [community-acquired pneumonia], insulin drips that are now pretty much protocol — a lot of quality initiatives," Schneider notes.

"As part of that, they will be oriented to SBAR, so that when a nurse talks to them in a way they were not previously used to, they will understand what they are communicating."

Once the nurses have been educated, he adds, "We want to make sure they have reviewed the chart, know the admitting diagnosis, know the right doctors to call, have an updated meds list, and have the latest vital signs — even before they make the call [to the doctor]."

At the end of the pilot program, residents and nurses will be debriefed. "We will be able to look very quickly at their attitudes and experience, to see if the form has validity and if people think it helped," Schneider says. "The real outcome, of course, will be a decrease in adverse events and fewer transitions to a higher level of care — once the tool has been rolled out to the general medical floors."

Eventually, the form will become part of the record. "The nurses will just pull one of these sheets out, and it will almost be like a fill-in-the-blank," he predicts. ■

How to discuss AEs with patients and families

Establish a foundation of trust

To make full disclosure work, you first have to remember that it is not a "program" or an "effort," or a "policy," says a leader at one hospital that has undergone a major change in the way adverse events (AEs) are discussed with patients and families. Full disclosure is more of a philosophy and an overall way of working with people, says **Julie Morath**, RN, MS, chief operating officer and vice president of care delivery at Children's Hospitals and Clinics of Minnesota in Minneapolis.

"If you want to be patient and family-centered, that requires a foundation of trust," she says. "If our patients and families can't trust us to be honest with them and tell the truth, to disclose when there has been an error, an accident, a failure in their care, I don't think we can enter a true therapeutic relationship."

Implementing such a philosophy takes time. Children's spent more than a year carefully crafting policies and procedures and even choosing the right words to use. Some semantic differences proved important. For instance, Children's asks "What happened?" instead of "Who did it?" after an AE.

The hospital also created an Office of Patient Safety that analyzes patient safety data and acts on reports from physicians and staff.

"It was important that they see that something happened to the information they took the time to report," Morath explains. "We work from the premise that everyone comes to work to do a good job and do no harm, so we wanted to create an environment that values people who step forward to let us know about failure points or where they personally got tripped up."

Disclosure policy prompts bigger change

Morath explains that the change began when the Children's board of directors endorsed a policy of full disclosure to families as part of its overall patient safety agenda. The policy is designed to achieve these goals:

- Improve patient and staff safety by decreasing system vulnerability to future accidents.
- Evaluate and improve care provided.
- Reduce the chances for patient morbidity and mortality.
- Restore patient, family, employee, provider, and community confidence that systems are in place to assure future accidents are not likely to recur.
- Emotionally, professionally, and legally support staff who have been involved in events.
- Ensure disclosure of the accident, near miss, or sentinel event to the family, as well as ongoing communication of system improvements to family and caregivers involved in the accident.

When an event occurs, Children's conducts a full analysis to understand the multicausal components that produced the conditions allowing the event to occur. Morath says that immediately following an accident or near miss, a "sequence-of-event" analysis is conducted.

"This is followed by a causal analysis study with all key stakeholders to seek to learn what contributing variables existed, and steps to take to eliminate system vulnerabilities and latent error that could realign to produce a future accident," she says. "Formal procedures and resources are used to guard against blame, attribution, and hindsight bias — all of which are human tendencies in conditions of a devastating event."

While maintaining confidentiality of the patient and providers involved, a case study is created to inform others about the risks so actions are taken to prevent such an event from happening again. That analysis is designed with these goals in mind:

- Understand what happened.
- Identify opportunities for improvement.
- Support caregivers, patients, and their families.
- Incorporate this learning into our daily work.

Morath says in the disclosure process, a presumption of truth-telling guides all discussions. Generally, the physician managing communication should presume all information that describes the specific event affecting a patient can and should be disclosed, with the exception of identifying the specific staff members involved in the accident, if unknown to the family.

The disclosure is a thoughtful, well-defined process meant to re-establish confidence and maintain a therapeutic relationship, she reports.

A key to the Children's philosophy is that "disclosure is not a confessional," Morath says. "This is not just an opportunity to get it off your chest so you can feel better. It is a professional activity. It has to be approached with the same knowledge base, skill, and discipline as any other intervention. Disclosure isn't just an outpouring of one's soul."

The disclosure begins with an apology, possibly the most important part of the discussion, she says. From there, Children's offers the patient and family as much information as possible and the assurance that more will be forthcoming as the investigation proceeds.

Physicians and staff are trained how to disclose, and senior staff such as Morath are available to either accompany others during disclosure or to conduct the disclosure if the other person is either too uncomfortable or unwilling.

"We don't name names in the disclosure process by pointing the finger at someone like the nurse who just happened to be last person in a long line of system failures that made the accident possible," she says. "We indicate what has happened, what the consequences to the patient are as we know them today, that an analytic review will take place, that the family will know the results of that review, and what changes will be made to reduce the probability that this will ever happen again."

No punishment for reporting errors

Another important part of the disclosure philosophy at Children's is the blameless reporting system. Simply promising employees that they will not be punished for reporting accidents is not enough, Morath says. They must see over time that you mean what you say.

Under the reporting policy at Children's, staff members who promptly and appropriately report accidents to a patient's immediate caregiver,

manager, or Children's safety office "will not be subject to retaliation and will receive the administrative support of Children's in all matters relating to the accident. This does not require Children's to protect staff members who engage in intentional acts of malfeasance that compromises patient safety."

The hospital devoted a lot of time and resources to educating staff about AEs and the new system for reporting events and concerns. Targeted learning packets about patient safety were provided to leadership and clinical staff, and different packets for patients and families.

For staff, the safety guides reiterate the importance of moving from a culture of blame and secrecy to one of open communication and analysis of systems, Morath says. For families, the packets are intended to help them understand their role as partners in care, encouraging them to ask questions and participate in ongoing communication with caregivers.

Modeling its reporting system on the type used in the airline industry, Children's adopted a new incident report the form of a "safety learning report" that is mostly text, rather than a series of questions or boxes to check off.

"You mostly learn about systems through the stories, what happened, what the conditions were at the time, and what you think could have prevented this," Morath says. "One thing we learned was that near misses or vulnerabilities that are not dealt with can reconfigure at another time in a way that actually harms the patient. So we started asking 'Have you ever seen this before?' to help us become aware of recurrent problems."

She notes that forms asking a person to check off boxes are good for data management, but not so much for learning. It's a different kind of data analysis that is needed for improving patient safety, she adds.

"We have reading groups that do content analysis and abstract the patterns," Morath says. "Once we land on an issue and create an improvement project, then we measure the data and analyze it. But the narrative description in the original reports is what shows the need for improvement."

One example is how Children's discovered that the lab was getting too many unlabeled specimens. Leaders were first alerted by the narrative reports in which staff explained that specimens were arriving without proper patient identification, and that prompted an investigation. The root cause turned out to be far upstream in the first-line patient identification, which led to an improvement project regarding the reliable identification of every patient, every time, with two identifiers.

"We've completely eliminated mislabeled specimens because the lab won't accept them any more," Morath reports. "The system depends on staff first alerting someone that something is wrong or could be improved."

Commit to real culture change

Morath suggests that risk managers interested in embracing full disclosure more thoroughly "look far upstream." The changes at Children's required a wholesale revamping of philosophy at the hospital, not just the implementation of a new policy handed down by risk management.

The new approach is a culture change, along with some very practical skills training and tools for disclosure, Morath says. Staff and hospital leaders must be prepared for significant changes in their roles, she says.

Children's found that a very traditional risk management, a legal approach focused mainly on limiting the liability of the organization, did not fit well with the new philosophy of full disclosure. That old-school approach did not promote a good relationship with the patient and family, at a time when they need your support.

"We really reconceptualized our risk management program here," she says. "Protecting the assets of the organization certainly is critical, but even more important is protecting those we care for. We determined that we want legal counsel to advise us of our risk, but the malpractice risk and legal concerns do not form the philosophy or define the relationship with those who depend on us for care." ■

Many teens still lack info to prevent pregnancy

Parent-child communication needed

Information from the National Survey of Family Growth offers a mix of good and bad news: While sexually active teens are more likely to use contraception, many teens are uninformed about birth control choices.[1] The research also indicates that the number of women ages 15-44 at risk of pregnancy but using no method of contraception

rose from 7.5% in 1995 to 10.7% in 2002.[2]

While this 3.2% rise may appear small in numbers, it translates into potentially large problems with unintended pregnancy, says **James Trussell**, PhD, professor of economics and public affairs and director of the Office of Population Research at Princeton (NJ) University. In 1994, the last year for which data are available, the small minority (7.5%) of women using no contraception contributed almost half (47%) of the 3 million unintended pregnancies in the United States,[3] he reports.

"What we have witnessed is a 43% rise in that small minority, which would lead, everything else held constant, to an 18% rise in unintended pregnancies," he explains.

The National Survey of Family Growth (NSFG) is conducted periodically by the Centers for Disease Control and Prevention's National Center for Health Statistics in Hyattsville, MD, with researchers collecting information on several topics, including contraception, infertility, pregnancy outcomes, and births. Since the survey is so large and is known for its accuracy, reproductive health experts see the newly reported increase as a worrisome trend.[4]

What factors may be impacting women's nonuse of contraception? Declining insurance coverage, increasing costs of contraceptives, and the inability of publicly funded family planning services to keep up with inflation all could be contributing to the decline, says **Sharon Camp**, president and chief executive officer of the New York City-based Alan Guttmacher Institute (AGI).

Camp also points to the increase in abstinence-only sex education and what she terms "government-sponsored misinformation" as possible contributors to a lack of knowledge or misconceptions about the effectiveness, safety, and side effects of the various contraceptive methods available, particularly among teens and young adults. (For an overview of challenges to information on reproductive health, check AGI's review, "Top 10 Ways Sexual And Reproductive Health Suffered in 2004" on the organization's web page, www.guttmacher.org.) Among older women, a mistaken belief that they are unable to become pregnant may influence their contraceptive decision making, she surmises.

Are teens better off?

What do the survey findings show when it comes to teens? Information from the NSFG indicates good news on the adolescent front:

- The proportion of never-married females ages 15-17 who had ever had sexual intercourse dropped from 38% in 1995 to 30% in 2002. At ages 18-19, 68% had had intercourse in 1995, compared with 69% in 2002.
- For male teens, the percentage of those who were sexually experienced dropped in both age groups: from 43% to 31% at ages 15-17, and from 75% to 64% at ages 18-19.
- Teens are more likely to use contraception when they begin having intercourse (79% in 1999-2002, up from 61% in the 1980s).

Teens are more likely to have used contraception at their most recent intercourse (83% in 2002, up from 71% in 1995). At their first premarital intercourse, teens were most likely to choose condoms for birth control; 66% reported using a condom when they became sexually active.[1]

However, the survey results also highlight some troubling developments:

- Many teens are not learning about birth control in school; one-third of teens report having received no formal instruction about contraceptive methods before age 18.
- Half of young women ages 18-19 and about one-third of men of similar age, said they had talked with a parent about birth control before they turned 18.[1]

"Although more teens are delaying first sex, and those who are sexually active are more likely to use contraceptives than they were previously, the fact that so many teenagers lack the information and services they need to protect themselves from unintended pregnancy and sexually transmitted infections is particularly alarming," says Camp. "As more schools move toward abstinence-only-until-marriage education that talks about contraception only in the context of its failure rates, family planning providers may increasingly find themselves on the front lines as teens' primary source of medically accurate information about consistent and correct contraceptive use."

Is mandatory notice OK?

When it comes to obtaining contraceptives, one in five teenagers would have unsafe sex if their parents had to be notified before they could receive prescription birth control at a family planning clinic, according to just published nationally representative data.[5]

Results from the new study show that many teens — three in five — had parents who already knew about their clinic visit, usually because

teens told them or their parents suggested it. But among those adolescents whose parents were unaware of their visit, 70% said they would stop coming to the clinic, and one-quarter said they would continue to have sex but would rely on withdrawal or not use any contraception if parental notification were mandated. Just 1% of all teens surveyed said they would stop having sex.[5] Researchers surveyed more than 1,500 women younger than 18 who were seeking sexual health services, including contraceptives, at family planning clinics in 33 states.

Texas and Utah now require parental consent for state-funded family planning services, and a similar restriction is in place in one Illinois county (McHenry), where research has found an increase in teen birthrates while other counties experienced declines.[6] In 2004, bills to impose new requirements for parental consent for adolescents seeking contraception were introduced in Congress and several states, including Kentucky, Minnesota, and Virginia.

While the rate of teen pregnancy has dropped over the last decade, about 850,000 teenagers still get pregnant each year, with most such pregnancies unintended, according to the AGI, which performed the new study. Forcing parental involvement could drive teen pregnancy rates up, reproductive health experts contend.

Research shows that family planning clinics can play an important role in fostering parental/teen communication.[7] National research conducted in 1999 found that 43% of agencies had one or more educational program to improve parent-child communication.[8]

The practices and educational programs provided by many family planning clinics are intended to improve parent-child communication around sexual health issues, explains **Rachel Jones**, PhD, senior research associate at AGI and lead author of the study. Some clinics incorporate this issue in one-on-one counseling sessions with teen clients, such as offering to help teens come up with strategies for talking to parents about sex and birth control, she notes.

"Formal educational programs — which can be directed at teenagers, parents, or both — often provide skills and information to improve communication around sexuality issues," states Jones. "Notably, educational programs are often labor-intensive, require a physical space to hold classes, and cost money, so clinics are less likely to be able to provide this resource to clients and community members."

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1. CDC National Center for Health Statistics. *Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2002.* Hyattsville, MD; 2004.
2. CDC National Center for Health Statistics. *Use of*

CE instructions/objectives

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.**The semester ends with this issue.** You must complete the evaluation form provided and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

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. ■

COMING IN FUTURE MONTHS

- Use liaisons for better continuum of care
- Journals for improved patient/physician communication
- Strategies for evaluating education programs
- Introducing non-English-speaking patients to American health care
- Technology as a teaching tool

CE Questions

21. User-friendly forms for documenting patient education include which of the following elements?
    A. Covers needs of all hospital disciplines
    B. Short and easy to use
    C. Are not redundant
    D. All of the above

22. Although JCAHO finds that most organizations comply with the standards on patient education, surveyors have found which area to be weak?
    A. Evaluating teaching
    B. Providing written information
    C. Tailoring education to individual patients
    D. Conducting learning assessments

23. JCAHO recently identified communication as a major cause of adverse events.
    A. True
    B. False

23. Which of the following are goals of the full discloser policy at Children's Hospitals and Clinics of Minnesota in Minneapolis?
    A. Improve patient and staff safety by decreasing system vulnerability to future accidents.
    B. Restore patient, family, employee, provider, and community confidence that systems are in place to assure future accidents are not likely to recur.
    C. Emotionally, professionally, and legally support staff who have been involved in events.
    D. All of the above

Answers: 21. D; 22. C; 23. A; 24. D.

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3. Henshaw SK. Unintended pregnancy in the United States. *Fam Plann Perspect* 1998; 30:24-29, 46.

4. Connolly C. More women opting against birth control, study finds. *The Washington Post*, Jan. 4, 2005:A01.

5. Jones RK, Purcell A, Singh S, et al. Adolescents' reports of parental knowledge of adolescents' use of sexual health services and their reactions to mandated parental notification for prescription contraception. *JAMA* 2005; 93:340-348.

6. Zavodny M. Fertility and parental consent for minors to receive contraceptives. *Am J Pub Health* 2004; 94:1,347-1,351.

7. Jones RK, Boonstra H. Confidential reproductive health services for minors: The potential impact of mandated parental involvement for contraception. *Perspect Sex Reprod Health* 2004, 36:182-191.

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