# Patient Education Management™

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

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## IN THIS ISSUE




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# To save lives, increased CPR training and public access to AEDs needed

*For best results dispel fear of AEDs and encourage hands-on CPR education*

Although more and more people are beginning to learn cardiopulmonary resuscitation, not enough have mastered this skill, states **John Mouw**, technical training supervisor for Baptist Health in Miami.

If someone were to experience sudden cardiac arrest on a city street and 10 bystanders came to help, probably none would know CPR, he says.

Yet the American Heart Association (AHA) has developed researched-based curriculum for training people in CPR and also has gathered statistics on the effectiveness of CPR. (See p. 28 for guidelines.)

When CPR is not administered following sudden cardiac arrest the victim's chance of survival drops 7% to 10% for every minute of delay before defibrillation.

According to the AHA, 95% of sudden cardiac arrest victims die before

### EXECUTIVE SUMMARY

The American Heart Association (AHA) is continuing to fine-tune its guidelines on CPR. Every five years it provides updates based on the latest research and in November 2005 it released changes that increased chest compressions from 15 for every two rescue breaths to 30.

The recommendations continue to encourage greater implementation of automated external defibrillator programs in public locations such as airports, casinos, and sports facilities.

In this issue of *Patient Education Management* we explore how to increase public awareness about the importance of learning CPR and making sure AEDs are available at public gathering places.

reaching the hospital. Why? Because few attempts at resuscitation are successful if CPR and defibrillation are not provided within minutes of collapse. Within four to six minutes following cardiac arrest brain death begins to occur if CPR and defibrillation are not administered.

While it is important for the average citizen to learn CPR, the only effective treatment for cardiac arrest is the use of an automated external defibrillator (AED). CPR will buy time either for the ambulance to arrive or for someone to obtain an AED. Therefore when the 911 emergency call is made someone should get the AED at the same time, says **Dana M. Layne**, instructor for organizational development education at Ohio Health Corp. in Columbus.

That is why the AHA encourages public access defibrillation campaigns to inform people of the need for AEDs in public places.

The national average response time for medical crews is 10 minutes, explains Layne. In that time frame a person's survival rate is minimal when he or she has experienced cardiac arrest. However, with CPR the time frame is extended and if a bystander did CPR and defibrillation then the survival rate can jump to 75%.

"If defibrillation is utilized for sudden cardiac arrest within the first three to five minutes then survival is as great as 75% — that is an amazing statistic," says Layne.

When a person's chance of survival drops by as much as 10% for every minute that goes by without an electric shock administered by an AED if it takes the paramedics eight minutes to arrive the survival rate is 20%, calculates Mouw. "That is not very good," he adds.

## Public access advised

To increase access to AEDs Baptist Health supports public access defibrillation programs. Recently the city of Miami obtained a grant to place AEDs in such public places as parks and Baptist Health will provide training and information to carry it out, says Mouw.

**Deborah R. Belknap**, RN, CDE, an instructor with Community Health Education Resources for Inland Northwest Health Services in Spokane, WA, chairs the Public Access Defibrillation Committee for the city. She has been an AHA basic life support instructor for more than 20 years.

The committee was formed to educate the public about the importance of AEDs and how easy they are to use.

Belknap says to demonstrate their ease of use when they were first introduced, AHA instructors grabbed a janitor from the hallway and had him walk to the mannequin, turn the AED on and administer the shock according to the machine's instructions. He had administered the first shock correctly within 90 seconds.

Mouw says AEDs are foolproof. The pads have a diagram of where to place them and once the machine is on it has self-prompts. For example, it instructs the person administering the electric shock to attach the electrodes. Once the machine analyzes the victim experiencing cardiac arrest it will charge if a shock is required and instruct the user to push the button with the flashing red light.

"There is no way to harm the victim because

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even if you misplace the electrodes the machine will recognize they are not placed right and not charge up. If there is no need for a shock, no matter how many times you hit the shock button, it cannot defibrillate because it will not charge," explains Mouw.

The mission of the citywide committee in Spokane is to get an AED in every public building, says Belknap.

However one of the biggest stumbling blocks in this campaign is the fear of being sued for using them. That's why the committee held a breakfast meeting for CEOs and safety officers of various companies at which a lawyer was the featured speaker. According to the lawyer there is more of a liability for companies that do not have an AED than for those who do. Belknap says one reason is that the automated machines will not shock a person who is not in cardiac arrest.

Mouw agrees. "It is difficult to get businesses to realize they won't get sued for using it but they might get sued for not having it," he says. He says a Good Samaritan law protects businesses when companies properly train staff in the use of the AED.

"There is much data that shows that AEDs and CPR combined will save a life. The trouble is getting enough people trained in its use," says Mouw.

### Making training available

At Baptist Health families of cardiac patients who are at high risk are offered free CPR training. If the patient hasn't had an internal defibrillator placed inside their body staff suggest they purchase an AED. The cost is about $1,200.

In addition community outreach courses are offered regularly.

Ohio Health also offers community pediatric and adult CPR classes on a monthly basis. These include classes that provide credentialing and those that help people become familiar with CPR but don't offer certification. "There are a variety of classes based on the needs and experience of the audience. We really support the American Heart Association's mission, which is to train as many people as possible," says Layne.

Ohio Health also offers CPR training at its cardiac rehab center for cardiac patients and their family members. School outreach programs, which teach CPR to grade students, are offered as well.

It's best to hold public outreach classes on a Saturday or Sunday afternoon or evening because when people have worked all day their mind and physical stamina are not suited for the teaching, says Layne. They learn better when they are well-rested.

Best practice for CPR training is to show people a skill and then have them try it, says Layne. Once a step is mastered the class progresses to the next skill, tying everything together at the end. By the time a person leaves the class he or she will have a memory of what to do. About 80% of the class should be hands-on practice, says Layne.

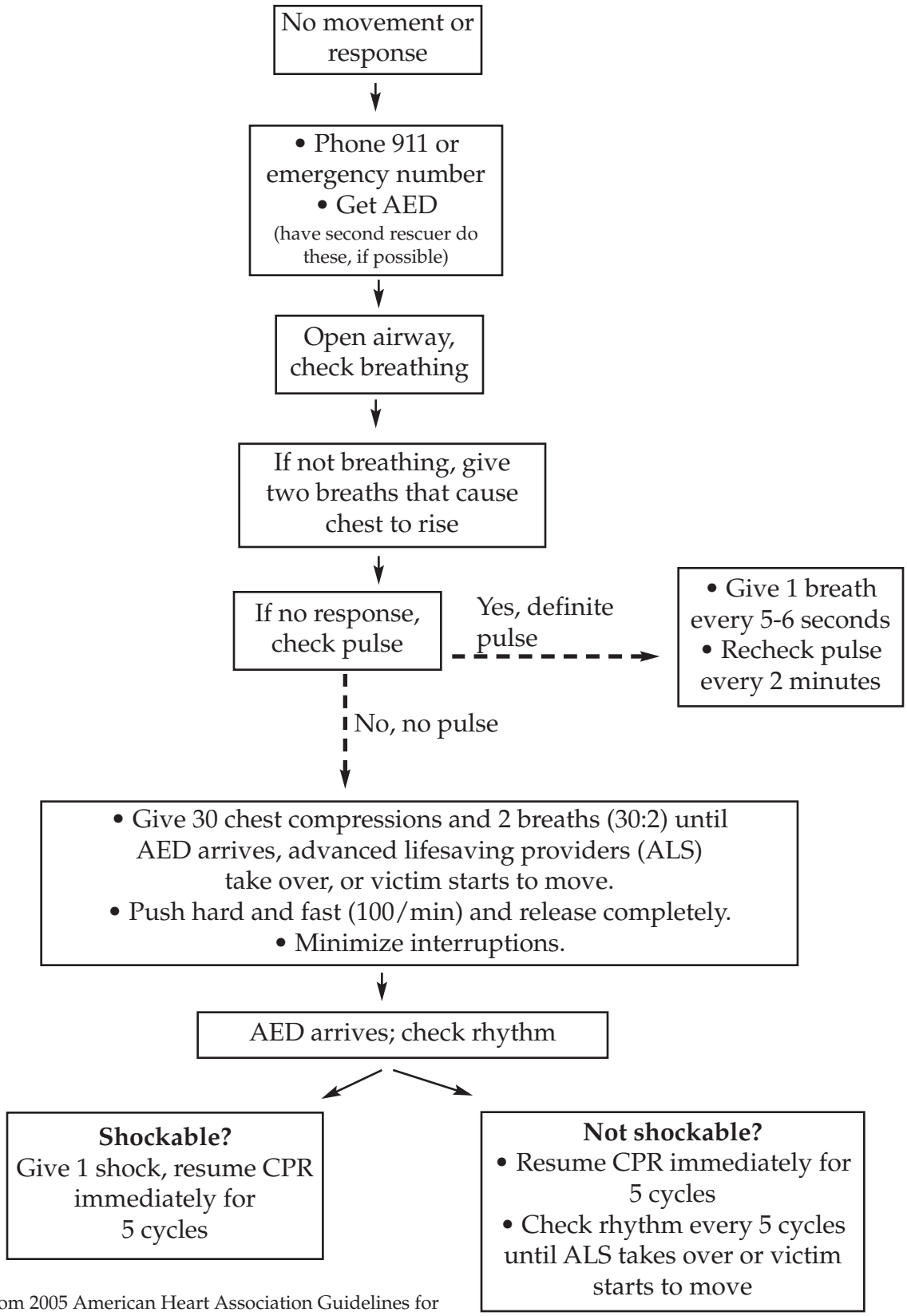
"Practice is most important because if people don't do CPR correctly it is like they are not doing it at all. If you breathe into someone's mouth and his or her chest doesn't rise it is as if you didn't do it. If you push on a person's chest and you don't push deep enough and hard enough and straight down you can injure them and you won't pump any blood, which is the point of pushing on someone's chest," explains Layne.

To make sure everyone is able to practice there should be no more than eight students per instructor and classes work best when there are only six students per instructor, says Mouw. The idea is that people repeat the steps so many times CPR becomes routine, so a few months later they are still able to do it efficiently, he says.

Programs pushing public access to AEDs as well as CPR training throughout the general public are vital, says Layne.

"The more people who know CPR and are competent in responding to an emergency the more lives you are going to save," says Layne. ■

# 2005 Guidelines for Basic Life Support and CPR




Adapted from 2005 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care: Adult Basic Life Support. Circulation 2005;112 [Suppl I]:IV-19-IV-34.

# Unusual NICU cases require extensive education

*Teaching begins at admission, continues through stay*

The neonatal intensive care unit at Children's Healthcare of Atlanta is not your usual NICU. It receives babies that need some sort of specialized care from hospitals throughout Georgia and neighboring states.

For example, babies are sent to Children's Healthcare when they are born with omphalocele, a protrusion of the internal organs through the umbilical cord, or gastroschisis in which the large intestine and other internal organs protrude through the abdominal wall.

"There are so many reasons why they come to us. All the babies we get are babies that other hospitals don't deal with if they are born in a regular nursery. While a lot of hospitals have what they call a NICU, they are basically for premature care," says **Patricia Abernathy**, RN, assistant nurse manager for neonatal services at Children's Healthcare of Atlanta.

While the health problems the children arrive with vary, the education process is the same for all the parents.

"We initiate education immediately with our families," says Abernathy.

To help orient families to the NICU who will be visiting their baby for several weeks and even months, a neonatal handbook has been written with both English and Spanish versions.

This book has generalized information about the conditions of the children being treated on the NICU, information on lab work that might be done, as well as pictures of the monitors and other machines seen on the unit and a description of the sounds that are commonly heard. Various terminology parents may hear for the first time is also included in the handbook. "This is a book they can keep going back to," says Abernathy.

Parents who are able to spend time with their baby at the hospital are encouraged to learn various techniques, such as the use of a feeding tube while the nurses administer care, if it is something the baby will need following discharge. "In that way we are not educating them at the last minute," says Abernathy.

To aid in the continuum of care the goal is to have a primary nurse assigned to every patient who will be hospitalized for 48 hours or more. Associate nurses also can ask to work with certain babies and are assigned to that child if the primary care nurse is not on duty. The only exception to the rule is when a new nurse is being oriented and it provides a good learning opportunity.

"It never happens near discharge when the primary nurse needs to be working with the family; it is more over the course of the time the baby is hospitalized," explains Abernathy.

Having a primary nurse assigned helps ensure that everything is complete by discharge, including the education that needs to be done. In addition, families become comfortable talking with the nurse and are able to ask questions and address issues they might be less likely to discuss with strangers.

### *Experts part of the mix*

While the nurses working with the baby do a lot of the teaching, clinicians who have expertise in different areas are also brought in to educate families. If a baby is on an extra calorie formula a nutritionist does the teaching. There is a lactation specialist to consult with mothers who are breast feeding.

Experts are also called in for certain procedures. For example, a nurse specializing in tracheostomies does the discharge teaching for patients who have a tracheostomy.

To help bolster education, families are given educational materials to read and review. There are teaching sheets for each diagnosis and books on certain procedures such as an ostomy. There are also information sheets on each medicine a baby is taking.

To help track education there is a discharge list that is part of the admission packet, and as items are taught they are checked off. Abernathy says there are a lot of items on the list. For example, there needs to be a car seat test before discharge to make sure the baby can sit in a car seat without being stressed or having problems.

Also there are routine teaching sheets that are completed as the families are educated. For example, there are sheets for ostomy care, G tube care or G tube insertion. Those provide guidelines for teaching family members that help to standardize teaching as well as documentation of teaching.

"Documentation of education is vital because there is so much teaching that needs to be done," says Abernathy.

## SOURCES

For more information about situations when intensive education is required in a NICU, contact:

• **Patricia Abernathy**, RN, assistant nurse manager, neonatal services, Children's Healthcare of Atlanta. Phone: (404) 785-0417.

Sometimes families must attend a class to learn a procedure. For example, many parents are required to learn CPR before discharge. These classes are offered Monday, Wednesday, and Friday but if families have problems getting to a class individualized teaching must be arranged.

If a child will need a monitor at home or oxygen a representative from the home care company completes the teaching and provides a contact person to call if problems occur. This is usually done a few days before the baby is discharged.

While education for families has been carefully planned, there are many barriers to effective teaching. Often families live out of town and can only come to the hospital on weekends. Those who live in town may only be able to come to see their baby late at night once they have gotten home from work and a sitter has arrived to watch their other children.

As a result the teaching must take place in shorter periods of time. Frequently these parents don't speak English fluently, therefore language barriers further hamper the teaching. Interpreters are always used, however Abernathy says it is more difficult to teach.

"It is hard when you are not the one physically doing the talking. A lot of them shake their head but you are not sure they fully understand until they actually are physically doing the work. If they aren't at the hospital that often you are teaching when they can come and then they aren't around to keep practicing with their learning," says Abernathy.

To make sure all parents are comfortable with their baby's care before they take him or her home those who cannot spend much time at the hospital on a routine basis must stay a couple nights caring for the baby before discharge.

"It is not mandatory for parents who have been in and out and staying all along as long as they are comfortable with the care. It is really for those who have not been able to stay and do the care," says Abernathy. ■

# Nursing students access on-line teaching sheets

*Use could improve students' patient education skills*

This semester the University of California at San Francisco School of Nursing is using Krames On-Demand in the classroom.

The school received this electronic print-on-demand patient education system through a program the American Association of Critical Care Nurses (AACN) initiated three years ago called "Technology for Nursing Schools."

This program offers corporations the opportunity to partner with AACN in making contributions that help student nurses work with current patient care technology before they begin their clinical experience.

The word "technology" is used to describe all the things that nurses eventually use in patient care. It includes everything from print information to actual technologic devices, explains **Ramon Lavandero**, RN, MA, FAAN, director of development and strategic alliances for AACN based in Aliso Viejo, CA.

Nursing school skills labs have a limited budget, therefore contributions from businesses can be very beneficial. However, when a product is offered a representative from AACN approaches the school to see whether it is willing to accept the donation. There could be any number of policy reasons that prevent the school from accepting it or the donation may not be appropriate for the school, explains Lavandero.

The Krames On-Demand system was appropriate for the University of California at San Francisco, which offers a master's degree or a PhD in nursing. "Our advanced practice nurses can use this system to learn better ways of teaching patients and families," says **Dorrie Fontaine**, RN, DNSc, FAAN, the associate dean for academic programs at UCSF School of Nursing.

The Krames system provides Internet-based content that can be customized for patients and printed as needed. Within the system are 2,200 topics, in both English and Spanish, created in conjunction with practicing specialists to provide accurate, up-to-date information on everything from conditions and procedures to self-care and preventive care.

"The expectation is that teaching sheets will become part of the routine for education. That is

### SOURCES

For more information about the AACN Technology for Nursing Schools program or the use of Krames On-Demand in the classroom, contact:

• **Dorrie Fontaine**, RN, DNSc, FAAN, associate dean for academic programs, UCSF School of Nursing, 2 Koret Way, Room 319G, Box 0604, San Francisco, CA 94143-0604. Phone: (415) 476-9710. E-mail: dorrie.fontaine@nursing.ucsf.edu.

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the goal. What that starts is something in nursing that is so crucial. Nurses are becoming more and more knowledge workers, bringing knowledge to patients, families, and health team members. They need to be able to access that knowledge easily and it needs to be current, accurate, and relevant to what they are doing," says Lavandero.

He says the assumption is that if a nursing student learns by using a particular product then whether a health care company at which they work uses the same product or another vendor's version they will be familiar with it and use it.

Often there are challenges that must be overcome. At UCSF School of Nursing, staff needed to make sure Krames On-Demand could be installed on its server/network in the computer lab so students could have access to learning the program.

Also they had to find a core course that specialty advanced practice nursing students all took and then develop an assignment to use the program, says Fontaine.

"I worked with our staff and faculty to install the program on 30 computers in the computer lab and secured a faculty advocate to use the program in a pharmacology course for the adult nurse practitioners," says Fontaine.

Currently it is being tested in the pharmacology course but Fontaine anticipates the students will be enthusiastic about the content and the opportunities it offers to obtain information for patients.

"After we use it in one group of nurse practitioner students, we plan to offer it to more classes and specialties," says Fontaine. ■

# Nurse liaison must communicate well

*Translate 'medicalese' into plain talk*

Nurse liaisons can quickly become a highly appreciated member of your staff, say experts.

"The staff in the pre-op area see the nurse liaison's interaction with patients and families as having a calming effect on the patient and family members, especially when there are delays, and [post-anesthesia care unit] nurses are relieved that the family is being taken care of so they can concentrate solely on the patient's needs," explains **Maureen Spangler**, RN, CNOR, director of perioperative services at Lexington Medical Center in West Columbia, SC.

A nurse liaison is only beneficial if the right person is in the position, and not all RNs are right for a nurse liaison position, she warns. Excellent communication skills are essential, she points out. After excellent communication skills and solid perioperative knowledge, the next most important quality the clinical nurse liaison must have is the ability to work with people, including patients, families, nursing staff, volunteers, and physicians, Spangler says. "The nurse liaison must also be able to work under pressure and multitask."

The nurse liaison must be able to explain everything to the family members in everyday terms, says **Lorraine Osborne**, RN, CPN[C], perioperative clinical educator of Kingston General Hospital in Kingston, Ontario. "The liaison also should be comfortable talking to all types of people and able to deal with people who are very emotional," she adds. Liaisons should be able to communication with people from a wide range of backgrounds, races, and socioeconomic levels, she adds.

Make sure your liaisons have the resources they need to do their job, suggests Spangler. "Give the liaisons the authority to use service recovery items such as gift baskets, meal tickets, or gift certificates when appropriate," she says. "It is a stressful role, and we have allowed them to identify ideas for service recovery based upon their own experiences."

For example, nurse liaisons were given beepers they can distribute to families if family members want to leave the facility, Osborne says. Another suggestion from the nurse liaisons was a cell phone for each nurse so they would be available at any

time in any location, she explains. "They also make their cell phones available for patients or families to use if they need to make phone calls."

Don't forget to offer education to liaisons that is pertinent to their position. "We had the nurses work with guest services for two weeks prior to beginning their role," explains Spangler. In addition to reviewing communications skills, nurses also spent time learning how to identify and handle the different ways in which people react to stress, she says.

"Some people withdraw and others become aggressive, so it's important for the liaison to recognize these behaviors as stress-induced and talk with them in a manner that relieves the stress without taking their behavior personally," she explains. ■

# Are you talking about HPV, cervical cancer screening?

*Providers not discussing cancer/HPV with women*

As you review which talking points to cover with your next patient, are you planning to include dialogue on the link between human papillomavirus (HPV) and cervical cancer? Chances are you're not, according to the results from a national survey released by the Washington, DC-based Association of Reproductive Health Professionals (ARHP).

The survey results show that while 88% of women rely on their health care providers to learn about gynecological issues, only 19% say their providers have talked to them about cervical cancer and its major cause, HPV. The survey was conducted by Greenberg Quinlan Rosner Research, of Washington, DC.

While great strides have been made in reducing the impact of cervical cancer in America, 2005 statistics from the American Cancer Society (ACS) estimate about 10,370 cases of invasive cervical cancer will be diagnosed in the United States.[1] About 3,710 women will die from cervical cancer in the United States during 2005, according to the ACS.[1]

It is now known that some strains of HPV account for most cervical cancer cases; in the United States, HPV 16 alone accounts for more than half of all cervical cancer cases, followed by HPV 18, 31, and 45.[2]

"It is really surprising to me that so many women don't know what the connection is between human papillomavirus and cervical cancer," says **Beth Jordan**, MD, ARHP medical director. "I think one of the key things for providers to do is to just ask, 'Do you know why you're having Pap smears? Do you know what the connection is? If not, let's talk.'"

In 2003, the Food and Drug Administration (FDA) approved DNAwithPap, manufactured by Digene Corp., of Gaithersburg, MD, to help distinguish women at increased risk from those at very low risk of developing the disease. The test combines the company's Hybrid Capture 2 High-Risk HPV DNA test with a Pap test.

The FDA approved the dual test as a primary screening option for women 30 years of age and older. The test is not intended to substitute for regular Pap screening, nor is it intended to screen women younger than 30 who have normal Pap tests, states the FDA.[3]

The ACS issued guidelines in 2002 calling for Pap tests beginning at age 21 or three years after a woman first has sexual intercourse.[4] Until age 30, screening should be done every year with the regular Pap test or every two years using the liquid-based Pap test. After age 30, women who have had three normal Pap tests in a row can wait two or three years for their next Pap.

Women with a negative HPV test and a normal Pap smear need not be screened again for three years. Women with a positive HPV test and a normal Pap test should be retested in six months to a year, according to the ACS guidelines.

According to the ARHP survey, women age 30 and younger, who are least at risk for cervical cancer, are most knowledgeable about its cause and more likely to discuss HPV openly with their health care professionals. However, women age 30 and older are less knowledgeable about the virus, the survey results indicate. They are more likely to have persistent, high-risk forms of HPV that can lead to cervical cancer and therefore may benefit from HPV testing along with their Pap test.[5]

HPV testing also is appropriate for the following situations:

- triage after a test result of atypical squamous cells of unknown origin (ASC-US);
- triage after colposcopy does not detect precancer in women with low-grade squamous intraepithelial lesion (LSIL);
- testing one year after known cervical intraepithelial neoplasia (CIN-1) biopsy;
- testing the cervix after cryosurgery or a loop electrosurgical excision procedure (LEEP) to treat precancerous dysplasia;
- HPV testing for anal lesions.[6]

**RESOURCE**

**The Association of Reproductive Health Professionals** has devoted an entire issue of *Health & Sexuality* to the topic of cervical cancer prevention and HPV DNA testing. To download the publication, go to the ARHP web site, www.arhp.org. Click on "Healthcare Providers," "Online Publications," "Health & Sexuality Magazine," and "Cervical Cancer Prevention and HPV DNA Testing." Answers to frequently asked questions about HPV are on pp. 11-12.

"In our study of 338 women undergoing screening for cervical cancer, only 34% of women were aware that HPV testing was a part of the follow up for an abnormal Pap test," says **Carmen Radecki Breitkopf**, PhD, assistant professor in the department of obstetrics and gynecology at the University of Texas Medical Branch in Galveston.

### Check Pap knowledge

Breitkopf and her fellow researchers questioned women undergoing cervical screening at two Texas clinics to evaluate their knowledge and informational needs about Pap testing.[6]

Results of their study indicate that minority women and those of low socioeconomic status had poor understanding of Pap testing.[7] Identifying misunderstandings and improving patient education on the most basic aspects of Pap testing may increase adherence to follow up when abnormalities are detected, researchers conclude.[7]

Despite the benefits of Pap test screening, not all American women take advantage of it, according to the ACS. Between 60% and 80% of American women with newly diagnosed invasive cervical cancer have not had a Pap test in the past five years, and many of these women have never had a Pap test.[8] In particular, elderly, African-American, and low-income women are less likely to have regular Pap tests, says the ACS.[8]

Why aren't clinicians talking to women about cervical cancer and HPV?

"The communications gap between providers and patients related to cervical cancer and HPV is an issue that is largely due to time constraints and a reluctance to discuss a sexually transmitted infection with women," says Jordan. "But because new techniques, including improved types of diagnostic testing, now make cervical cancer a disease that can be better prevented, we're encouraging women to discuss with their health care provider their HPV risk, get regular screenings with the Pap test and, if they are age 30 or older, ask about HPV testing as well." **(ARHP has prepared answers to frequently asked patient questions on HPV. Check the resource box for directions on how to access them.)**

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# Bad news bearers: Telling patients about infections

*Straightforward apology can head off lawsuit*

As patient safety becomes more of a mainstream movement, the issue of disclosing and apologizing for infections, medical errors, and other adverse events is coming to the fore. No longer is the preferred strategy to see, hear, and speak no evil.

That said, it should surprise no one that the primary obstacle to patient disclosure of an adverse event is fear of litigation.

"I think we would all agree that the main reason that people do not want to tell [patients] what happened is because we are afraid we are

going to get sued," said **Janet Frain**, RN, CIC, CPHQ, CPHRM, director of infection control, risk management, and quality improvement programs for Sutter Medical Center in Sacramento CA. "Can we get sued anyway? Absolutely."

Indeed, roused by national legislation and highly publicized reports of medical errors and nosocomial infections, patients have come to expect more openness and accountability in health care. When they are met with it, they actually may be less likely to sue following a bad outcome. "We have seen a huge evolution of how we manage patient events," Frain said recently in Baltimore at the annual conference of the Association for Professionals in Infection Control and Epidemiology (APIC).

"Disclosure of adverse outcomes is not easy," she explained. "It is one of the parts of my job I look forward to the least. It can be very emotionally charged, but it does bring closure to some patients." Some patients or family members, however, are traumatized by the event and may want to call and talk about it months later, Frain noted.

An ICP since 1975 and a risk manager for a decade, Frain recounted personal experiences with informing patients or family members of such events as a surgical fire in the operating room, inadequately cleaned bronchoscopes, and a patient fatality after an overadministration of pain medication. While ICPs will have to consult their own policies and state laws, Frain generally erred on the side of full disclosure and a carefully worded apology.

"There is a fear that if I apologize to a patient that means I am going to admit fault or negligence," she said. "An apology and admission of fault or negligence are totally different. We can let the courts decide fault or negligence."

The health care culture is not exactly apology-friendly, Frain explained. "Why is it so hard in medicine? Physicians are trained to be infallible. There is again that big fear that if I apologize to a patient I will get sued. But I will tell you, from working with patients, sometimes that is all they want."

She cited survey data that showed patients are 50% less likely to sue if the medical error is disclosed with an apology. "Forty-one percent of people who sue say they would not have taken that action if the health care team had apologized," Frain said. "So it really gives us pause and makes us consider how we approach an apology."

State laws may vary, but in California, statements and gestures of sympathy are not admissible as evidence. "That means if we write a letter to a patient or tell them we are sorry this happened, that is not admissible as evidence in court. Statements that actually reflect fault or responsibility are admissible," she added.

In addition, malpractice insurers have differing opinions on disclosure and may place hospitals at odds with their independently insured physicians. "Many malpractice carriers will give mixed messages to their insured," Frain said. "Our malpractice carrier supports full disclosure. However, many of our physicians' malpractice carriers do not support full disclosure."

If the hospital policy is to disclose and apologize following a medical error, the process must be thought out carefully and handled delicately. Know what the hospital policy is on disclosures and what exactly is going to be disclosed. "This is where the risk manager can help you in terms of framing how information is going to be disclosed to a patient," she said.

Agree on who should be present and who will do the disclosure. "One of the things you don't want to do is gang up on the patient," Frain said. "You don't want six people in the room."

In addition to an apology, patients often want to be assured that the event will never happen to anyone else. "They really want to know what will be done to prevent a recurrence," she explained.

Tell the patient exactly what happened, and explain what measures have been done to prevent it happening again, Frain advised.

Don't personalize the event or assign blame to a particular staff member. "It's OK to say, 'I'm sorry.' You don't want to cast blame." she said. "You don't want to say the name of the staff involved. You don't want to say, 'Nancy gave you way too much medication and now we have fired her.' That is not the information you give to patients."

Many patients will want the person responsible fired, but they should be told only that the hospital is following its human resources policies for all employees involved in the error. "Don't disclose any actions during the peer-review process," Frain added. "Remember, peer-review information is protected in most states."

Disclosure meetings are emotional. It comes

with the territory. "You have to bring Kleenex into these meetings, and you may want to a have a social worker or pastoral care colleague there," she said. Likewise, separate meetings with the staff involved also are very emotional, as those involved in the error may feel great remorse. They generally should not be involved in the meeting with the patient.

"Sometimes, the patients are so angry at either the physician or the nurse that we do not put the two of those people together," Frain noted.

"[However], we usually try to get the physician to help us with the disclosure process. Most of the time, that is with whom the patients have the relationship," she said.

Don't talk about money during disclosure, but give the patient a hospital contact to handle any such claims or provide other information. "They need time to think about it, process, and think about other questions that may come up," Frain said.

A somewhat unpredictable element is how the patient is going to react to the disclosure of an adverse event. "We have had a time or two when we had security outside the office," she said. "You can almost always expect a reference to legal action. Disclose everything you know anyway."

Bad press certainly is a possibility, so involve the public relations staff in the event from the onset, she recommended. Document in the patient's medical record that a meeting was held with the family and note who were present and what was disclosed. "We are not hiding anything," Frain said. "Remember, they have a right to that record. Explain how you are going to follow up. For example, with the [surgical fire] patient we had to transfer to another hospital, we wrote the whole plan of [follow-up] care."

After reviewing the main strategies, she went through a couple of hypothetical cases. For example, imagine you are an ICP at a hospital and a patient has died of *Legionella* infection. It is the first case of *Legionella* you have had at the hospital.

"You do a full epidemiological investigation including culturing tap water," Frain said. "The tap is positive for the organism. Would this be something at this point in time you would disclose to a family member? No. We don't have enough information. All we know is that we have a potential problem here."

The patient's death is unexpected so you conduct a root-cause analysis as required by the Joint Commission on Accreditation of Healthcare Organizations. As you assemble your team and begin investigating, you find that the respiratory therapy department was using tap water rather than sterile water to rinse out the patients breathing equipment. This is against hospital practice but was done because there was no sterile water available. Asked if they would now disclose the incident to the patient's family, some of the audience hesitated.

"I will argue with you that we have, in fact, found a medical error, haven't we?" Frain said.

## 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. After completing this activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

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** patient education programs based on existing programs from other facilities. ■

## COMING IN FUTURE MONTHS

- Using consumers for material evaluation
- Must-have research materials for the office
- Pharmacies' role in patient education
- Intranet teaching sheets — write or purchase?
- A treasure chest of translated teaching sheets

## CE Questions

9. According to the American Heart Association 95% of sudden cardiac arrest victims die before reaching the hospital because of which of the following reasons?
A. Within minutes of collapse CPR and defibrillation is not administered.
B. Brain death begins within four to six minutes without CPR and defibrillation.
C. Survival drops 10% for each minute of delay.
D. All of the above.

10. To prevent last minute teaching before discharge parents are encouraged to learn from the nurses as they care for their baby on the NICU at Children's Healthcare of Atlanta.
A. True
B. False

11. What type of human papillomavirus accounts for more than half of all cases of cervical cancer in the United States?
A. Type 16
B. Type 18
C. Type 31
D. Type 45

11. Patients are 50% less likely to sue if the medical error is disclosed and the hospital team:
A. offers a cash settlement
B. describes its countersuit policy
C. fires the employee involved
D. apologizes

**Answers: 9. D; 10. A; 11. A; 12. D.**

"When we have people taking shortcuts bypassing processes, we have found a medical error. I would argue that at this point someone should tell the patient's family what happened. When you find that you have medical errors that contributed to a patient's death, that patient's family deserves to know that information."

On the other hand, consider the all too frequent case of a patient who develops a methicillin-resistant *Staphylococcus aureus* (MRSA) infection.

"I find this to be one of the most difficult conversations we have," Frain pointed out. "We don't know if there is a medical error around MRSA, unless you have outbreak going on and you know you have an index [case]. You have to differentiate patient education from disclosure of a medical error or an adverse event. Those are two different conversations. Ninety-nine percent of the time we never know where that MRSA came from. Is it likely the patient got it in the hospital? Probably. Is there definite causation? We don't have that information. So in that case, we are not really doing disclosure. It is more patient and family information." ■



**Correction**

In "Focusing prevention of smoking in young best way to curb lung cancer," which ran in the November 2005 issue of *Patient Education Management*, it should have said there is a 3.9% chance of dying for a person who had a lung cancer detected by screening and resected in the I-ELCAP screening trial.