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

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IN THIS ISSUE

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Editor Susan Cort Johnson, Editorial Group Head Coles McKagen, and Managing Editor Jill Robbins report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Magdalyn Patyk reports a consultant relationship with Pritchett and Hull Association.

JANUARY 2007
VOL. 14, NO. 1 • (pages 1-12)

Family-centered care evolves as more and more collaboration occurs

As two perspectives come together, the quality of care improves

Institutions that are working to make the delivery of health care patient- and family-centered know it can't be done without full participation of the people they serve.

"The richness of having families involved in helping us improve our system is that they are not like us, they don't think like us and they understand things we don't," says **Stephen Muething**, associate director of clinical services in general and community pediatrics at Cincinnati (OH) Children's Hospital Medical Center.

The mindset at the health care facility had been that parents would be frightened if given all the medical information about their child or they would not understand. However, input from families has changed that philosophy and resulted in information sharing. Health care providers at Cincinnati Children's Hospital now believe when families are given information, better outcomes from the child usually result, says Muething.

The charts in the hospital are open to families and there is a place for par-

EXECUTIVE SUMMARY

Family-centered care is becoming a popular way to deliver medical care. With this model, health care professionals and patients and family members work as a team, not only in making medical decisions but also in shaping hospital policy and programs.

In the second of a three part series on family-centered care, we discuss how patient and family advisors are used to create a family-centered care model. In the next issue, we will cover the role of patient education in family-centered care and how resource centers aid in information sharing.

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ents who have children with complex conditions, such as a liver transplant or cystic fibrosis, to document their observations. Also, these families are given password-protected access to a secure portal with their child's medical records that they can access following discharge. If a child is rushed to an emergency department in a distant city, parents can log on to the system and provide the attending physician with all the child's reports and X-rays.

To implement family-centered care, there must be openness to changing the culture. It is changing the way people think and behave and that is complex and takes awhile, says Muething. "The simple idea is that families should be involved in everything about their care," he adds.

How families are incorporated into the system must in some degree be tailored to the individual medical center, says **William Tietjen**, (MSW) director of social work and family services at The Children's Hospital of Philadelphia.

While a patient and family advisory council has become one of the first steps in implementing family-centered care, most institutions don't limit involvement to one central committee.

For example, The Children's Hospital of Philadelphia recruited parents of children who received their health care at the facility as employees to act as family consultants. These consultants provide leadership for family-centered care, educate people on the core concepts, and provide services to families.

Their job duties include meeting with families during a coffee hour in the lounge area on a unit or at the learning center, as well as teaching first-year medical students about family-centered care. All are assigned to a clinical team in different areas of the hospital and may be asked to speak with a parent or caregiver about the decisions that lay ahead in the care of a child.

Increasing participation

At Cincinnati Children's Hospital Medical Center, in addition to a family advisory council for the entire organization, each unit and condition has an improvement team that includes family members. These teams focus on improving clinical outcomes and also outcomes in such categories as safety, satisfaction, and timeliness. **(To learn about participation from a family member's point of view, see p. 3.)**

Taking what appears to be a great idea for quality improvement to families for input is not nearly as valuable as having the family as part of the team, says Muething.

In fact, family members help greatly in identifying areas that need improvement. For example, with family participation the team for cystic fibrosis came to the conclusion there needed to be improvement in the way families were first informed of the diagnosis.

Now, the physician meets briefly with the family to let them know the diagnosis and then volunteers work with them to get them through the emotional aspects of the news and help them understand what they are facing before the rest of the clinical team, such as the nurses and nutritionists, begin their work.

Muething says Cincinnati Children's Hospital does not look for family-centered care projects.

Patient Education Management™ (ISSN 1087-0296) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient Education Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcmedia.com. World Wide Web: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $489. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $82 each. (GST registration number R128870672.)

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Editorial Questions

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

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Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity is intended for nurse managers, education directors, case managers, discharge planners, hospital clinicians, management, and other health care professionals involved in designing and/or using patient education/staff education programs. It is in effect for 24 months from the date of publication.

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Editor: **Susan Cort Johnson**, (530) 256-2749.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Jill Robbins,** (404) 262-5557, (jill.robbins@ ahcmedia.com).

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SOURCES

For more information about the use of patient and family members in quality improvement initiatives that shape family-centered care, contact:

• **Stephen Muething**, MD, associate director of clinical services in general and community pediatrics, Cincinnati Children's Hospital Medical Center, OH. Phone: (513) 636-0404. E-mail: Stephen.Muething@cchmc.org.

• **William Tietjen**, (MSW) director of social work and family services, The Children's Hospital of Philadelphia, PA. Phone: (215) 590-2072. E-mail: TIETJEN@email.chop.edu.

Because the institution has family-centered care as a core value, improvements are made according to the concepts of family-centered care. These include dignity and respect, information sharing, participation, and collaboration, although some institutions have added more concepts.

Family-centered care is a continuous improvement process, says Tietjen. Recently, The Children's Hospital of Philadelphia formed a team for an initiative called Advancing Family-Centered Care. One issue this team will address is forming a database of families willing to be involved. Currently, 38 family members serve on the advisory council, but people from various departments are always looking for family participation and more people are needed.

"Families and staff are saying they want more participation and figuring out what that mechanism will look like in a sustainable fashion for years ahead is an important developmental challenge for any health care organization," says Tietjen.

He says it must be a mutually beneficial partnership. For example, it is difficult to find family members to work on a project that will require four month's time, with meetings scheduled the second Wednesday of each month from 1 p.m. to 3 p.m. However, if alternative methods of participation are tried, such as e-mail or a web-based system, it may be easier to find people who can participate, says Tietjen.

"It requires members of the staff to think about how to engage families and get out of the 'I want you to participate by my framework' attitude," he explains.

Wherever families are used it is important that health care providers remember they may not understand all the medical language used; it is important to provide background information and definitions so they can be better participants, says Tietjen.

In addition, sometimes staff members need to gain insight into the medical experience of families. At Cincinnati Children's Hospital family members suggested that staff walk in their shoes. Many staff members have gone through a medical experience with families, such as accompanying them during a visit to the emergency department. The experience can be eye opening.

"Someone in the emergency department may say they will be right back and mean it, but they don't come back for an hour. How does that make a family feel? Being in the room with the family and watching them go through that experience really changes your perspective," explains Muething.

Including families on committees, a task force, or process improvement team, is not difficult. Family members that can provide quality input are everywhere.

"At first we didn't know how to find them and then we realized it is the family I have been working with, it is the next family I am going to see. You realize they are everywhere. Finding families that are interested and want to help has not been an issue," says Muething. ■

Family partnerships key to family-centered care model

Different points of views sought for programs

When two of **Juliette Schlucter's** children were diagnosed with cystic fibrosis at The Children's Hospital of Philadelphia in the early 1990s, she and her husband soon came to the conclusion that the way care was delivered needed to be changed.

"Immediately, my husband and I had a lot of thoughts about the experience. What it felt like to be given difficult news in a crowded hallway, what it meant to our family, what kind of support systems we needed and had difficulty identifying, and more than anything how to get our arms around information quickly so we could prepare our family for what was to come," says Schlucter.

What they did not realize at the time was that leadership at the health care facility also had recognized that changes needed to be made in the

delivery of care.

Schlucter became one of the parents that partnered with health care professionals at the hospital to implement the concept of patient- and family-centered care.

In 1995, she was hired as a family consultant and worked in that position until 2004. Currently, she is consulting on a special project at The Children's Hospital of Philadelphia to advance family-centered care. This project is analyzing the needs of future families so they will feel supported and partnered with health care professionals. It is identifying best practices for family-centered care through individual surveys and making sure families have a consistent experience across the continuum of care.

Barb Precht began volunteering at Cincinnati (OH) Children's Hospital Medical Center when her son was diagnosed with juvenile rheumatoid arthritis at age 2. Although her son is now in college, she is serving a second term as a member of the family advisory council.

Precht says her son never thought he would be able to go away to college but is able to manage his chronic illness because the medical center at which he received care was family centered. When family-centered care began to be implemented, her son had the opportunity to be involved in his care and the decisions that were made even at a young age.

"With family-centered care, our children have a better understanding of their disease and how they can take control of it," explains Precht.

There are enormous benefits to patient- and family-centered care, agrees Schlucter. For example, if Schlucter told the physician there was a change in the way one of her children were breathing he or she would listen. The communication promotes trust, says Schlucter, and high-quality safe, effective care.

Different point of view

It is important to have the voice of patients and family members in the decision-making process because staff look at issues differently, says Precht.

For example, it was family members sitting on the family advisory council at Cincinnati Children's Hospital that brought up the need for valet parking. Parents who have children in wheelchairs or with other special needs can have difficulty getting from the parking garage to their destination especially in bad weather. They may have additional items to carry and other siblings to escort.

Precht, who worked on the sub-committee for this project, telephoned people at hospitals in various cities and states to find out how they operated a valet parking service. After the information was gathered, members of the committee worked with parking staff at Cincinnati Children's Hospital to write a proposal that included information about obtaining bids from outside companies to operate the service. The committee presented the plan to the board and it was approved.

Another important improvement that made the hospital more family friendly was the redesign of the surgical waiting room. A softer, more comfortable style of furniture was introduced and several reclining chairs were purchased so families waiting for a long period could recline for a while if they wished.

In addition, portions of the waiting room were partitioned off to provide privacy for families when the surgery was not going well. A playroom separated from the waiting area by glass also was added.

Before programs are implemented at Cincinnati Children's Hospital, input from members of the family advisory council, which consists of staff and family members, is sought. For example, when the pulmonary department wanted to make the entire medical center a nonsmoking facility the idea was presented to the advisory council.

One woman advocated for smokers stating that it would be difficult for family members to simply give up cigarettes when they were already under a great deal of stress. While the council agreed with the pulmonary department and the campus will be completely nonsmoking, the needs of family members were addressed and

SOURCES

For more information on what partnerships are like with patients and families, contact:

- **Barb Precht**, community development director, Arthritis Foundation, Ohio River Valley Chapter, 7124 Miami Ave., Cincinnati, OH 45243. Phone: (513) 271-4545, ext. 112. E-mail: bprecht@arthritis.org.
- **Juliette Schlucter**, project consultant, advancing family-centered care, The Children's Hospital of Philadelphia. Phone: (610) 407-7030. E-mail: schlucter@emial.chop.edu.

they will be able to receive help for their addiction. For example, they will be given nicotine gum. Staff members will take those who must smoke to a place off campus as well.

Diversity is what makes the council successful, says Precht. She is halfway through a second two-year term on the family advisory council at Cincinnati Children's Hospital. Although most serve only one term, Precht was asked to stay on to complete work on special projects in which she was involved.

To find council members, applications are taken and then each candidate, whether staff or family member, goes through an interview process. Two council members conduct each interview and then answers to the questions posed are discussed by the entire council.

Precht says potential council members who don't seem to see any flaws with the hospital aren't good candidates, but neither are those who are too negative. In addition, people who have received health care from a variety of departments are sought.

There is no formal orientation; council members simply receive a binder that has information on the hospital, the advisory council, and projects the council has completed and is working on.

"It also has information on what to look for as far as family-centered care, such as respect, information sharing, and support, so they always have that in the back of their mind," explains Precht.

To work in partnership, it isn't just patients and families that must understand the concept of family-centered care, but staff as well. Often staff members see it as another initiative such as patient safety, cultural competency, and literacy, says Schlucter.

She says the consulting project, Advancing Family-Centered Care, seeks to unify the message, helping all staff members understand family-centered care is the way a health care institution operates and is not just another initiative. ■

PEM advises 'focus daily on greatest impact'

Never enough hours in day to accomplish all tasks

Annette Mercurio, MPH, CHES, manager of patient, family, and community education at City of Hope National Medical Center in Duarte, CA, has been in her position for 13 years. However, her job duties have changed quite a bit since she started.

"When I first started, it was primarily a community focus and now it is primarily a patient education focus," says Mercurio.

Currently, her job description is to plan, develop, direct, and evaluate patient and community education programs. She also is responsible for managing the institution's community benefit programs. California requires nonprofit, private hospitals to report the benefits they provide to their community and conduct needs assessments.

City of Hope is one of 40 comprehensive cancer centers in the United States designated by the National Cancer Institute. It has 160 inpatient beds and more than 100,000 outpatient visits a year.

To meet the educational needs of this number of patients, Mercurio is assisted by a staff of five people. She supervises the patient and family education coordinator, coordinator of the patient and family learning center, coordinator of the patient and family resource desk, oncology resource nurse for the telephone information service, and senior secretary. In addition to staff members, Mercurio often oversees interns from either undergraduate or graduate programs in health sciences. She reports to the vice president for patient care services and chief nurse executive.

Mercurio has a master's of public health and has been in hospital-based health education for about 24 years. Before her move to Southern California, she directed patient and community education at the University of Virginia Health Sciences Center in Charlottesville.

In a recent interview, Mercurio, who also sits on the editorial board of *Patient Education Management*, discussed her job, her philosophy on patient education, the challenges she has met, and the skills she has developed that help her do her job well.

Q: What is your best success story?

A: "When we had to bounce back from downsizing and a lot of community functions were trimmed. I think the greatest part of that success was finding really outstanding people to help develop services we deliver to patients and families directly such as the patient and family resource desk and learning center.

"Initially, when I came here we had a stronger community focus. We had a mobile screening program with a nurse, nurse educator, nurse practitioner, and clinic assistant that traveled to underserved communities, and that program was

cut. Also, we had a telephone information service with three nurses and that program was cut except for one nurse. The institution felt we needed to focus more internally, and it has made for stronger patient and family education services."

Q: What is your area of strength?

A: "To collaborate across disciplines and departments and with other organizations in the community to stretch resources. For example, the education department works with the social work, clinical nutrition services, and other departments to offer the 'I Can Cope' workshop to patients and families. Either social work or education takes the lead in organizing the sessions depending on which department has an intern.

"I am working on a performance improvement team right now called Patient and Family Partnership and Safety. We have representatives from many disciplines working on that team. So much of coordinating patient and family education across the institution is about being able to build and facilitate interdisciplinary teams."

Day-by-day accomplishments

Q: What lesson did you learn the hard way?

A: "Each day you must focus on achieving the greatest impact you can. Certainly we all experience change. We might lose funding or staffing, but knowing you have personal integrity and that you worked your hardest to make a difference endures no matter. It's important to look at what you have accomplished and what you can impact."

Q: What is your weakest link or greatest challenge?

A: "Balancing work and personal time. I definitely blur the boundaries by staying late and taking work home with me. It is really a challenge to make sure I am creating some space for other needs in my life, too, such as exercise. I wouldn't have been in this field for as many years as I have if I wasn't passionate about it, wanting to do better and better. You can't accomplish everything you want to in a 24-hour day so it is hard to stop finally and say 'I need to have a little time for me' so that is what I work on."

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

A: "When I first started in patient and family education, there was a lot of defining the learning needs of individual patients and the educational needs of groups of patients from the standpoint of health care professionals. I think we have gotten more and more to the point where we really do want to have patient and families involved in shaping the programs.

"The Patient and Family Partnership and Safety team has patients helping us look at what we can do across our patient populations to involve patients and families more in advancing safety. That is just one example. In the future we are going to see more and more of the partnerships between hospitals, patients and families, and health care providers in shaping services."

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

A: "Our last Joint Commission survey was in September 2005. The greatest difference has been to involve the frontline staff in looking at the whole auditing process of medical records within patient care services. We are really trying to do more to involve frontline staff in those reviews and implement more of a peer review process, instead of a department outside the immediate area being the one to audit the records and give feedback. In this way, the bedside nurses have more of a chance to see what the strengths and deficits might be in patient and family education documentation."

Q: When trying to create and implement a new form, patient education materials, or program where do you go to get information and ideas from which to work?

A: "If it is a form I tend to go to frontline staff within City of Hope or other colleagues outside the system depending on the subject matter. For example, if I felt the patient education documentation form was not working, I might go to a listserv I belong to or informally talk with some of the nursing staff and other professionals.

"For programs and materials usually we have patients and families working with us. Also we

SOURCES

For more information about patient education management at City of Hope National Medical Center, contact:

• **Annette Mercurio**, MPH, CHES, manager, patient, family and community education, City of Hope National Medical Center, 1500 East Duarte Rd, Duarte, CA 91010-0269. Phone: (626) 301-8926. E-mail: amercurio@coh.org.

go to staff meetings to identify nurses that will work with us in developing a program. The experts are the frontline care providers and patients and families." ■

JCAHO pushing new age of patient empowerment

'Speak up' changes, new patient safety goal

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is emphasizing that knowledge is power when it comes to patients. Recent Joint Commission initiatives indicate a growing trend toward patient education and empowerment to enhance a culture of safety and prevent infections.

"It is very clear that issues of infection are rising high on the agenda, "says **Robert Wise**, MD, vice president of the division of standards and survey methods at JCAHO. "This issue of patients taking greater responsibility for themselves is clearly a push, not only for patient safety, but also the expectation that health care workers understand that they are going to be meeting more and more informed consumers. That is something that should be embraced as a positive thing."

In the effort, the Joint Commission joins myriad cultural forces that are driving a transformation in the way the patient is viewed in the health care system. The patient safety movement has given rise to consumer advocacy groups that are demanding more transparency in health care. As a result, there is an increasing pressure to bring patients into the process and educate them about preventing infections and other adverse outcomes. Indeed, there is the perception that patients — with growing knowledge about the risk of infections and patient safety hazards, such as medication errors — could become health care's much-needed new partners in prevention.

But what about liability concerns? Does informing and educating patients somehow make hospitals more liable if treatment fails, for whatever reason? "There is that added awareness of the risk, which could lead to some additional litigation by the mere fact that there is an increased [knowledge]," says **Julie Savoy**, BSN, RN, JD, an attorney at Gachassin Law Firm in Lafayette, LA.

"But the trade-off is very beneficial in that if it gets more people to wash their hands, that's a good thing. The more the consumer knows, the better partner they are going to be in their own health care and the better advocate they are going to be for themselves and the better outcomes they will have."

Time to 'Speak Up'

Indeed, the Joint Commission is urging patients to "Speak Up" in a campaign that emphasizes the importance of taking care of your own health and avoiding transmission of infections to others. The brochure highlights four easy things everyone can do to prevent infection and help avoid contagious diseases such as the common cold, strep throat, and the flu.

"One [emphasis] is keeping yourself healthy and the other one is making sure other people are healthy," Wise says. "So it's making sure you don't get sick but also not spreading it. It's respectful of family members, colleagues; so that if there is an infectious illness, there is a greater chance of containing it."

Moving from public health to hospitals, the brochure was recently updated to include a recommendation that patients "gently remind" health care workers to clean their hands and wear gloves. The Speak Up brochure states: "Doctors, nurses, dentists and other health care providers come into contact with lots of bacteria and viruses. So before they treat you, ask them if they've cleaned their hands. Health care providers should wear clean gloves when they perform tasks such as taking throat cultures, pulling teeth, taking blood, touching wounds or body fluids, and examining your private parts. Don't be afraid to gently remind them to wear gloves."

In issuing such warnings, the Joint Commission wants to alert patients without alarming them, Wise explains.

"Patients need to be involved with their care, but it is not a statement that hospitals are unsafe," he explains. "Hospitals are extremely busy places and we know that a health care worker can forget something. It can have something to do with infection control, like washing hands, moving quickly, and [the health care worker] not realizing they should be putting gloves on. As the informed consumer, these are two important things that a patient can take responsibility for; it could have a significant impact on their health getting better."

The Joint Commission reports that heath care organizations are printing out the Speak Up materials for patient rooms, sponsoring local public ser-

vice announcements using their own physicians and nurses, and including the brochure content in patient information materials, web sites, and community newsletters. **(See editor's note at the end of the article.)**

New goal calls for 'active involvement'

Moreover, the Joint Commission has announced a major change for its 2007 Patient Safety Goals. A new goal for hospitals is a requirement that accredited organizations encourage patients' active involvement in their own care as a patient safety strategy. The requirement — first applied to the home care, laboratory, assisted living, and disease-specific care programs in 2006 — will apply to all hospitals in 2007. The complete goal reads: "Encourage patients' active involvement in their own care as a patient safety strategy. Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so."

The accompanying rationale reads: "Communication with patients and families about all aspects of their care, treatment or services is an important characteristic of a culture of safety. When patients know what to expect, they are more aware of possible errors and choices. Patients can be an important source of information about potential adverse events and hazardous conditions." The implementation expectation for the goal is that "Patients and families are educated on methods available to report concerns related to care, treatment, services, and patient safety issues."

That development follows publication this year of the book, *You: The Smart Patient,* which calls for consumers to become informed about infections and other risks they face in the hospitals. The Joint Commission is listed as a co-authoring agency on the book, which urges that patients demand that health care workers wash their hands. "The importance of hand washing to prevent infection is such a big deal that the Joint Commission came up with buttons for nurses, doctors, and other health care staff to wear that read 'Ask Me If I've Washed My Hands,'" the book states. "So, if you see those on your health caregivers' lab coats (or even if you don't), ask away. Don't be shy about it."[1]

The Joint Commission is not acting unilaterally here, but joins a variety of organizations urging similar measures. For example, the Association for Professionals in Infection Control and Epidemiology (APIC) has launched a web site designed as an educational source for consumers and health care professionals (www.preventinfection.org). APIC bills the web site as a one-stop educational source that provides information on infectious diseases and prevention measures from leading experts in the field. "When it comes to infection, the old adage, 'An ounce of prevention is worth a pound of cure' is more appropriate now than ever," says **Kathleen Meehan Arias**, MS, CIC, 2006 APIC president "This site is designed to convert consumers to informed patients."

(*Editor's note: All materials for Speak Up initiatives do not require reprint permission and are available on the Joint Commission web site at* www.jointcommission.org.)

Reference

1. Roizen MF, Oz MC, with the Joint Commission and Joint Commission Resources. *You: The Smart Patient.* New York City: Free Press; 2006. ■

Hand washing: You must measure compliance

Best practices will be identified

Lack of consensus on how to measure hand hygiene compliance has made this a daunting challenge for quality professionals. To address this, the Joint Commission has partnered with infection control organizations to identify how to measure compliance with hand hygiene guidelines. The final product of the 18-month project will be an educational monograph that recommends best practices for measuring hand hygiene compliance.

Effective measurement will help health care organizations target interventions, which in turn should improve hand hygiene practices by health care workers and ultimately result in fewer health care-associated infections, says **Jerod M. Loeb**, PhD, executive vice president of the Joint Commission's division of research.

Measuring compliance with hand hygiene practices during the delivery of care is difficult, mainly because of the resources needed to monitor the practices of many different care providers in numerous locations for meaningful periods of time. Since there is no unified approach to measuring hand hygiene performance, it's impossi-

ble to determine whether overall performance is improving, deteriorating, or staying unchanged as new strategic interventions are introduced.

The Joint Commission's National Patient Safety Goals require accredited organizations to follow the Centers for Disease Control and Prevention's hand hygiene guidelines, but many studies have shown poor compliance. In addition, the Joint Commission's infection control standards require continuous strategic surveillance for infection and infection-related risks, and this is a key focus during surveys.

Hospitals using observation, patient education

At Covenant HealthCare in Saginaw, MI, a hospitalwide hand hygiene committee has improved compliance by using daily rounding by infection control nurses to observe compliance, using a unit-based data retrieval form to monitor universal precautions. "We will be using a tracking monitor that can be installed on a soap or alcohol dispenser," says **BJ Helton**, MPH, CIC, infection prevention and control program administrator.

The nurse manager or a designee from each nursing unit is required to monitor at least 30 staff members every year, and the completed observation is sent to infection control. The information is shared at individual unit conferences and also will be presented at quarterly outcomes report meetings.

At these meetings, all of the clinical nurse specialists report what accomplishments have taken place, and the nursing dashboard and regulatory dashboard are presented. "By presenting the hand washing and universal precautions data, there will be more room for housewide discussion," says **Ann D. Law**, RN, Covenant's outcomes specialist.

In addition, a patient education brochure on hand hygiene is placed on patient tray place mats. "A collaborative effort with organizational development led to a computer program with our new infection prevention logo, SqWash Leo the Bug," adds Helton. "The VP of nursing made it a mandatory requirement for everyone to participate in seeing this program."

At OSF St. Joseph Medical Center in Bloomington, IL, patients are educated about hand hygiene via the hospital's Get Well Network, which is accessible on every TV. The program includes a segment on hand hygiene and how it can reduce the spread of infection. The hospital's patient satisfaction survey includes a question to get the patient's viewpoint on whether hospital staff and physicians are practicing good hand hygiene.

To obtain additional data, an observation program is being implemented. "Of course, this brings about its own measurement problems," says **Kathy Haig**, director of quality resource management. "Human resources in most health care settings is a limited and valuable commodity, so is it the best use of our resources to have them observe?"

Without observing, though, there is no valid way to determine compliance, says Haig. Another concern with the observation methodology is the validity of the data, since they can be very subjective. "For example, if the door to the patient's room is closed, how do you know if the staff member practiced hand hygiene?" she says.

The observer must be kept secret to prevent a "Hawthorne effect," people doing what they are supposed to because they know they are being watched, says Haig. "It is also important to prevent the observer from being perceived negatively by peers," she adds.

The aggregate data will be shared with the various unit managers as improvement opportunities. "I expect that we will, at some point, compare our results to the infection rate, although our infection rate currently is very low," says Haig.

The fact that different departments in the hospital have different opportunities for hand washing presents another challenge. "When you measure by observation, how do you watch for all of the opportunities specific to the area?" she asks. "Admittedly, our process is not perfect, as we cannot measure all the times when hand hygiene should be done, but we feel it is a start." ■

Hospitals telling smokers that 'it's time to quit'

Smoke-free hospitalizations

Patients hospitalized at University of Rochester (NY) Medical Center might not be able to kick the habit during their hospitalization, but staff will no longer be aiding their addiction.

The hospital recently joined many others in becoming an entirely smoke-free campus, so that medical staff "can get out of the mode of helping people to the front door so they can have a

smoke," says **Robert J. Panzer**, MD, FACP, chief quality officer for the medical center.

Hospitalized patients who are smokers present a number of practical challenges, from merely being ill tempered and nervous to unhooking themselves from monitors and making their way outside to smoke, heedless of their recovery and the smoke-free campus the hospital might have created.

Do most cardiac patients who smoke know, deep down, that they should quit? Do their doctors and nurses urge them to stop smoking, and does the hospital make it abundantly clear that smoking is not permitted in the building and, in more and more cases, anywhere on hospital property?

The answer to all those questions is, of course, "yes," but while a health crisis and hospital stay might be a wake-up call to some smokers, many others are not able to make the break. Coming down hard on the patient in that situation, a patient educator says, is unlikely to accomplish anything.

So what can health care providers do to prevent their patients from smoking while in the hospital? According to some smoking cessation educators, the answer sometimes is nothing.

"Patients are not allowed to smoke in our hospital," points out **Rafael Maldonado**, health educator for University Hospital in San Antonio. "But they do."

That's the reality, Maldonado says — even thought they know they should not smoke, and everyone around them and treating them tells them to stop, the simple fact of being hospitalized does not mean the end of smoking for some patients.

In those cases, Maldonado says, the most ethical approach is the connection with the patient at the point where he or she is on the "change scale," the spectrum that ranges from complete unwillingness to change all the way to absolute readiness and motivation to change.

"I strongly believe it's far more important to just say, 'If you're ready to quit, I can coach you through it,' as opposed to saying, 'You have to quit' and trying to kind of slap them on the hand," he explains.

Health crisis might not be enough to quit

For many patients, particularly cardiac or cancer patients, hospitalization is a wakeup call, alerting them to the need to make serious lifestyle changes. Those patients, Maldonado says, are ready to begin the process of quitting. For others, the lifelong habit might be shaken by a health crisis, but not enough to prepare them to quit.

"We have a few patients who, even if they are on monitors, and even though we do not have any smoking areas on the hospital grounds, will unhook themselves from the monitors, and go outside to the farthest point they can — which might be 3 feet from the door — and they will smoke," Maldonado says. "They have been smoking so many years, and now they're confronted with physicians telling them they can't smoke. They're going through withdrawals, and on top of everything else they're coping with [during their hospitalization], they can't cope with the withdrawal."

Hospitals across the United States address smoking with their patients, typically at admission. In some cases, there is continued contact with patient educators throughout the stay; in others, the patient receives printed materials and initiating contact with smoking cessation advisors is left to the patient.

Panzer says University of Rochester Medical Center chose the date of the Great American Smokeout to implement its campus-wide no smoking policy.

"We are not going to permit patients to smoke while they're inpatients, period," he says. "We can't control what they do when they leave, but we're not going to give them leave to go out there [and smoke] while they are inpatients."

University Hospital-San Antonio is trying a new initiative, funded by a Robert Wood Johnson Foundation grant. Maldonado and other educators in the four-hospital system are trying to identify as many smokers as possible, and maintain direct contact with them throughout their hospi-

SOURCE

For more information, contact:

- **Robert J. Panzer**, MD, FACP, chief quality officer, professor of medicine and community & preventive medicine, Strong Memorial Hospital, University of Rochester Medical Center, Rochester, NY. Phone: (585) 273-4438.
- **Rafael Maldonado**, health educator, University Health System, 4502 Medical Drive, San Antonio, TX 78229. E-mail: rafael.maldonado@uhs-sa.com.

talization.

The health educators rely heavily on the medical and nursing staff — particularly nurses — to work with each patient who smokes, at whatever point on the change continuum he or she might be.

Every contact can be an opportunity for teaching, Maldonado explains.

"We identify smokers when they are admitted, and begin treatment and a quit plan for them while they are in the hospital," he says.

Under the grant, the educators are targeting heart patients. The first step — identifying smokers — is deceptively difficult, he points out.

Many smokers will answer "no" when asked if they use tobacco products — some to avoid saying "yes," and some because, at that particular moment of a health crisis, consider that they have stopped.

"When they arrive at the hospital, we get patients from all levels of the stages of change, from ready to not ready, to those who aren't sure," Maldonado continues. A large number of patients consider themselves as having quit at the point of admission, but realistically and statistically, their percentage of relapse is very high.

University of Rochester Medical Center's program screens patients for tobacco use within the year prior to admission, and then steers them to a nicotine replacement therapy pathway.

"The best way to handle cigarette addiction is to move [the smoker] toward cessation with nicotine replacement, if suitable," Panzer says.

Take advantage of all teachable moments

No matter where the patient is in willingness to quit, Maldonado and the hospital education staff address that person's individual needs.

If a patient is ready to quit, he or she begins cessation therapy in the hospital. (Patients or their insurers pay for the smoking cessation therapy, and grant monies cover those who can't pay.)

"Those who aren't ready, we still address them," Maldonado says. "We give them information and educate them as much as possible. We can start getting them to at least think about why they should quit."

A study published in 2000 in *Preventive Medicine* examined patient compliance with hospital smoking policies and the effects of hospitalization on patients' subsequent smoking.[1] Hospitalization can precipitate nicotine withdrawal, the authors noted, but also offers willing quitters an opportunity to stop smoking.

In that study, the authors found that one-quarter of smokers admitted to smoke-free hospitals said they smoked during their hospital stay; 55%

CNE 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 credit letter. When your evaluation is received, a credit letter 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

- ■ A look at family advisory councils
- ■ Educational needs of families coping with autism
- ■ Family-centered patient education
- ■ Effective pain control education
- ■ Strategies for improving pre-surgery teaching

CNE Questions

1. Which of the following ways to incorporate family members into the medical system when implementing patient- and family-centered care might be used?
A. family consultant;
B. member of family advisory council;
C. member of improvement team;
D. all of the above.

2. Patient outcomes are usually improved with the family-centered care model because enhanced, routine communication is encouraged with health care providers and patients and families are more informed.
A. True
B. False

3. The Joint Commission's "Speak Up" campaign tells patients that health care providers should wear clean gloves during which of the following procedures?
A. taking throat cultures;
B. pulling teeth;
C. taking blood;
D. all of the above.

4. What is the most ethical approach for health care providers to discourage patients from smoking while in the hospital, according to **Rafael Maldonado**, health educator for the University Hospital in San Antonio?
A. tell them to quit;
B. give them a patch;
C. gauge where they are on the change scale;
D. tell them smoking kills.

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

reported nicotine cravings within 48 hours of admission. Abstaining from tobacco during the hospital stay was a strong indication that abstinence would continue after discharge, the authors added.

Patients wrestling with nicotine withdrawal are very vulnerable to relapse, so it is important to help them understand what is happening and why their bodies are reacting in that way.

"We try to help them understand, too, where the physician is coming from, that he or she is not just this person ordering you to stop smoking," Maldonado explains. "Most doctors want patients to have stopped smoking two weeks before an incision is made, because they want the patient to be at their healthiest status ever."

An inpatient smoking cessation program, such as the one at University Health, starts with educating the clinical and support staff, with an eye toward making whatever the method be easy and efficient.

"We understand that nurses are overloaded with work, so all we ask is that they help us identify patients who smoke, and then turn them over to me," Maldonado explains. "Then, we take every opportunity to educate the patients as much as possible.

"Every moment is a teachable moment, regardless of what stage of change they are." ■

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Reference

1. Rigotti NA, Arnsten JH, McKool KM, et al. Smoking by patients in a smoke-free hospital: Prevalence, predictors, and implications. *Prevent Med* 2000; 31:159-166.

AHC Media LLC

Dear *Patient Education Management* Subscriber:

This issue of your newsletter marks the start of a new continuing nursing education (CNE) semester and provides us with an opportunity to review the procedures.

Patient Education Management, sponsored by AHC Media LLC, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options and physician office practices. Our intent is the same as yours - the best possible patient care.

The objectives of *Patient Education Management* are 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; and
- develop patient education programs based on existing programs from other facilities.

Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You can then compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form we will mail you a letter of credit. This activity is valid 24 months from the date of publication. The target audience for this activity is nurse managers, education directors, case managers, discharge planners, hospital clinicians, management, and other health care professionals involved in designing and/or using patient education/staff education programs.

Those participants who earn nursing contact hours through this activity will note that the number of contact hours is decreasing to 15 annually. This change is due to the mandatory implementation of a 60-minute contact hour as dictated by the American Nurses Credentialing Center. Previously, a 50-minute contact hour was used. AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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On behalf of AHC Media, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,

Brenda Mooney
Vice-President/Group Publisher
AHC Media LLC

3525 Piedmont Road NE
Building Six, Suite 400
Atlanta, Georgia 30305-1515
Tel (404) 262-7436
Fax (404) 262-7837
www.ahcmedia.com