Removing Barriers to Patient Education

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What are the most frequent barriers that nurses encounter when teaching patients about their medications?

More than 250 nurses answered this question in a survey that was distributed with a nursing newsletter, Nurse Advisor, published by the Institute for Safe Medication Practices (ISMP). The nurses’ responses tell a story of successes and challenges as they assume this considerable responsibility—one that nurses clearly share with other health care providers, including physicians, pharmacists, and health care managers. The survey also revealed distinct areas in which various health care providers can offer support to nurses who educate patients about their medications.

Printed Materials for Patients

ProBLEM: Although most nurses responded that they consistently provided verbal information to patients about their medications, few nurses offered written information to patients; 25% of the nurses never provided it. One in four nurses said that written materials were not available or that they were scarce, especially for patients who did not read English. This situation was more common in teaching hospitals, perhaps because of the cultural diversity of the patient population. When written material was available, one-fourth of the nurses said that it was often unsuitable in terms of patients’ health literacy or reading level. One-third responded that the material did not cover important information clearly.

SOLUTION: Pharmacists and physicians should work with nurses to explore ways to make suitable written materials more easily available for patients. If computer terminals and a printer are located in patient-care units, electronic databases might be able to provide one solution. A few systems offer patient leaflets that are suited for various reading levels and that are available in several languages.

To ensure that these systems meet everyone’s needs, managers should determine the average reading level in the community and which spoken languages are predominant. This information is sometimes available from local government resources.

Management’s support for widespread education must be paramount, so that nurses, pharmacists, and physicians can effectively use electronic resources to educate patients. If electronic databases are not feasible in all patient-care units, the pharmacy department should provide paper leaflets, which can be updated annually, for the most commonly used medications.

Organizations should seek feedback from patients (e.g., in focus groups or through satisfaction survey questions) and from health care providers (e.g., primary care physicians) to ensure that the written materials effectively communicate the most important information.

Written Information for Preventing Errors

ProBLEM: Half of the nurses who responded to the survey mentioned that they had no written information to give to patients about preventing medication errors, thus making this gap one of the frequently reported barriers.

SOLUTION: The Agency for Healthcare Research and Quality (AHRQ) has made several publications available.1 ISMP also offers an informative pamphlet on the patient’s role in preventing medication errors; Web-based resources; and a consumer newsletter, Safe Medicine.5 Pharmacists can assist in developing materials for specific areas. To start, physicians (especially those on the emergency staff), other prescribers, and nurses should be asked to suggest medications, therapeutic categories of drugs, or systems of drug administration that they believe might be vulnerable to error—such as metered-dose inhalers, low-molecular-weight heparin, and acetaminophen dosing for children.

Problems can also be uncovered if the reason for patient readmissions is reviewed. Managers or other leaders should determine whether confusion about a medication, such as warfarin or digoxin, played a role.

The materials must focus on the ways that errors might occur and how patients can protect themselves. For instance, was there a delay in restarting warfarin therapy after a “hold” order? Was the patient taking both a generic brand and a proprietary brand of the same medication?

Pharmacists and physicians should also determine whether special patient education is required for a new drug on the formulary, and they should seek out or develop any necessary patient materials before the product is added to the formulary.

Time Constraints

ProBLEM: Lack of time was a common barrier for patient education for almost 50% of the nurses, especially in inpatient settings.

SOLUTION: Similar time constraints for pharmacists suggest that patient consultations with a pharmacist may prove to be the most effective educational support, especially when errors are likely, such as when patients are discharged with prescriptions for several medications.

Physicians can help by identifying patients who require in-depth education and by ordering pharmacy consultations for them. Physicians should also list the medications that are anticipated upon discharge in the progress notes so that nurses can begin instructing patients before the day of discharge.

REFERENCES

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The reports described in this column were received through the USP–ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the ISMP (www.ismp.org) or the USP (www.usp.org) Web site or communicated directly to ISMP by calling 1-800-FAIL SAFE or via e-mail at ismpinfo@ismp.org. ■