



THE PARENT CHANNEL®



NEWSLETTER

National in-hospital television networks for patient education

Pain Management • Overcoming Depression • In Production • Women In The Workplace • Cultural Diversity

**From the editor:**

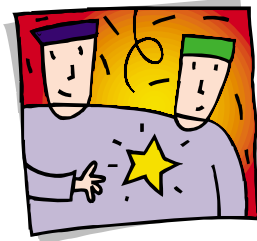
This issue of the Healthtv™ Newsletter we have new initiatives in the works, new segments to announce and new people on our team. We're delighted to have Anne Williams from UMMS as our new chief writer- Anne has been working with us for 2 years on numerous projects - including inservicing. Carole Falletta, RN MBA is our newest educator for the north-east and mid-west. Working with us doesn't stop Carole from continuing to be very active in her role at New York Presbyterian.

Thanks to all the people who've been instrumental in helping us grow and flourish. As always, we welcome comments, input, suggestions for articles and submissions for consideration. Please email these to: healthtv@rogers.com. Check out our website: www.healthtvsystem.com.

Coming Up On**Pain Management**

This has been a long (but extremely rewarding) journey that has included a National Teleconference, a survey, filming at NY Presbyterian Hospital (see Press Release -page10) and - ultimately - a new title for Healthtv™ (see 'In Production' page 4)

This new title couldn't have been developed without the healthcare professionals, associations and consumers who have helped us in the content development process. These efforts were put to use to determine a segment that will (hopefully) encourage better pain management. This education includes helping break down barriers that include the language of pain, cultural perceptions and healthcare misconceptions.



Kudos to Char Hill and Carole Patterson of JCAHO and Joint Commission Resources for giving us assistance and direction. Special appreciation for Anne Rooney, Executive Director, Consulting Services, Joint Commission Resources. As Guest Speaker on HTS' National Pain Management Teleconference, she provided valuable insights. We've received numerous positive comments about her presentation from participating hospitals. Thanks, too, to co-speaker Lenny Duensing, Director of Communication and Outreach, American Pain Foundation. Lenny's continued support and enthusiasm for this project means ever-expanding awareness and distribution of the end product.

Radiation Therapy

Replacing a segment that -- while accurate -- was dated. After informally polling several of our Healthtv' sites, including Shands at University of Florida, invaluable input confirmed the need to continue to provide information on the subject. As always, the productions come with behind-the-scenes stories: the radiation technicians who appear in the segment told us the reason they chose the field was because they each had a personal experience with family members undergoing radiation. The result is a friendly, straightforward explanation of what patients can expect when they're being treated. A 12-year old, who watched the segment and whose mother is undergoing radiation therapy pointed out that it would also be good for families to see this. The new Understanding Radiation segment is entirely underwritten by Healthtv™.

Care for the Caregiver

This emotional and expansive topic is in development. The working group includes Dr. Anthony Perry and his team at Chicago's Rush St. Luke's- Presbyterian.

CDC Public Service Announcements

Our programming has been enhanced by these messages. The Native Diabetes information is well-received in Healthtv™'s New Mexico hospitals. CDC's Kathryn Harben is to thank for facilitating their inclusion. Next program update, we'll have information from the Environmental Protection Agency (EPA) and thanks to Sheila Buchert for getting us messages from the American Cancer Society.

These initiatives would not be successful without the support of the many front-line healthcare professionals who have helped to make sure Healthtv' and The Parent Channel® stay current, useful and utilized to the max!



**Turn to page 5
for Updates.**

Letters to the Editor:



Turned on and tuned in...



SPRING 2001 (Pre-Installation):

I want to thank both of you (Leanne Worsfold and HTS President, Marvin Berns) for all that you have done to make this possible. I know that Healthtv™ is going to be a great success at our hospital and I am personally confident that I know I can count on your company to do you say you are going to do. That is a rare commodity in today's world.

FALL 2001 (Post Installation):

The technical service has been outstanding, as has the educational support. If we have needed anything, we get it, almost on demand. In conclusion, Healthtv™ has been an incredible asset not only to my Dept. but also to every staff person who deals with patients and their educational needs.

Chris Oesterbo, RN, Dir. Pt. Education,
UNMH, Alb. New Mexico,
coesterbo@salud.unm.edu

Hi Leanne - I just want to thank you and Carole (Falletta) for your time and professional, yet friendly and competent approach, to yesterday's new program inservices.

It is always a pleasure to work with you. Your patience with our complex system is always a treat! Your generous lunch for the staff is also always a welcome contribution.

Virginia Forbes, Patient Education
Coordinator, New York Presbyterian

Leanne:

It was a pleasure to meet you today, and to view the Healthtv™ vignettes. This patient education program is well-done, and informative.

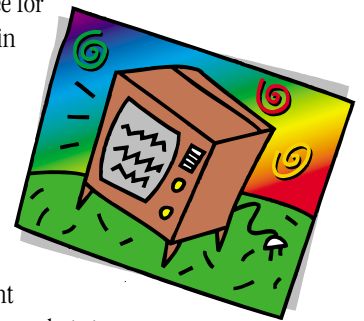
I look forward to Healthtv™ being here at Presbyterian Hospital. It will be a great aid to nurses, as well to chaplains in that we will be able to direct patients to this resource for patient education purposes. Thanks again, and I look forward to further conversation.

Bill Dorman, Chaplain, Director of Pastoral
Services, Board Certified Chaplain, APC,
Certified Clinical Bioethicist

The following are interesting bits of information, which may promote Healthtv™ viewership in your hospital!

Virginia Forbes, from New York Presbyterian Hospital reports that they:

- Created a page on their intranet describing Healthtv™ and its programming.
- Discuss during nursing orientation as part of the available resources.
- Set Healthtv™ as their default channel on the TV system. It then appears when the TV is turned on.
- Post flyers on the units to remind staff/patients to watch it.
- Use Healthtv™ as an example of a resource to document on the patient education record.
- Surveyed staff to find out if they know what types of resources (paper, on line, video (including Healthtv™), groups, etc, are available - This did 2 two things - we found out what they know - and their awareness was increased - if they didn't know about them already.
- Send a global e-mail when programming changes, flyers are distributed, and an announcement is made at the Advisory Committee for Patient and Family Education in order for all departments to inform their staff.



Anne Williams, University of
Maryland Medical Center
reports that they:

- Posted the Healthtv™ and Parent Channel® programming guides on their intranet site so staff can always have the guides available for previewing or printing.
- List channels on their new online patient education form to encourage documentation of patients' and families' viewing.
- Present as a part a comprehensive patient education overview within new nurses' Fellowship Program.
- Sponsor an annual Patient Education Fair where staff can watch programming and learn about other patient education resources within the hospital.

Healthtv™ Welcomes...

Johns Hopkins Medical Centre - Baltimore MD

VA New York Harbor Healthcare - NY, NY

Hospital For Special Surgery - NY, NY

The Jewish Hospital - Cincinnati, OH

Rush-Presbyterian-St. Luke's Medical Center - Chicago, Ill

Rush North Shore - Skokie, Ill

University of Missouri Hospital and Clinic - Columbia, MO

Shands Hospital at the University of Florida - Gainesville, Fl

Good Samaritan Hospital - Los Angeles, CA

UCLA Medical Center - Los Angeles, CA

St. Mary's Hospital - San Francisco, CA



Staff education is perhaps the most important tool to help ensure delivery of safe, efficient, and appropriate care and treatment. Help prevent errors, near misses, and quality deficiencies by providing top-notch education for your staff. This book provides you with advice from experts in the field and examples from organizations breaking new ground in health care staff education.

This book is a collaboration between JCAHO and the Health Care Education Association (HCEA), and begins with a collection of contributed essays from staff education experts on today's key topics in health care. These topics include

- recruiting and retaining employees
- competency assessment
- orientation for new staff
- mentoring, preceptorship, and coaching
- technological advances in learning media
- ensuring administrative support
- budgeting for staff education using consultants versus in-house resources for staff education
- linking staff development to business strategy
- documenting staff education.

This new book offers numerous examples of cutting-edge and exemplary staff education practices in the following areas:

- advance directives
- age- and population-specific competency
- Confidentiality and privacy
- Disaster preparedness
- Equipment management
- Identifying signs of abuse and neglect
- Infection control
- Interdisciplinary team planning
- Medication errors
- Pain management
- Patient safety
- Performance improvement
- Restraint and seclusion

2002. Approx. 200 pages.

Order Code: JCGE-01

ISBN: 0-86688-725-3

Price: \$55

Order information:

Joint Commission Resources

630-792-5800 • www.jcrinc.com

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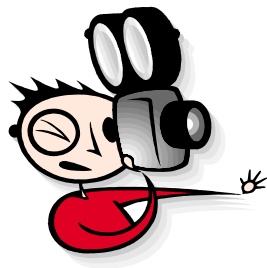
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IN PRODUCTION..

PAIN MANAGEMENT

Spring 2001

As a result of JCAHO's patient education standards, numerous requests from hospitals asking for a pain management segment on Healthv™.

Summer 2001

HTS explores existing material related to patient education and finds hospitals have and use a range of different resources - both print and video. • Through inservices and networking, HTS determines the buzz: How and what are other hospitals doing to meet these standards. • HTS puts forth the question: Was there interest in a collaborative effort toward creating a universally useful basic educational segment on pain management.

September I

In consultation with advisors and key hospital contacts, HTS extends an invitation to participate in a National Teleconference on Pain Management with guest speakers from JCAHO and American Pain Foundation.

September 10

To help determine focus and potential content points, HTS asks hospitals to share their patient education/pain scale-related materials. • JCAHO provides their standards, APF their patients rights materials.

Based on these provided materials, HTS designs a survey to prioritize identified content points, and develops a pre-conference package to help start discussion, and raise awareness of what peers across the country are doing.

JCAHO and APF authorize use of their materials in the packages.

HTS sends out pre-conference materials.

Pain Assessment Scale


0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Imaginable

Pain control is an important part of your care.

This pain scale is designed to help you describe the level of pain you are experiencing.

If you are having pain or your pain medications are not working for you, please tell your nurse.

 SOUTHWEST WASHINGTON MEDICAL CENTER

November 26.

National Teleconference, with guest speakers Anne Rooney and Lennie Duensing. • Results of survey are announced and discussed.

Participants share their 'most important' point.

An advisory group is established to develop a script treatment. • Press release is sent out

announcing the collaboration. • Selected hospitals are interviewed by US News and World and Report.

January 2002

Minutes are approved by the speakers and distributed to participants.

February 2002

A draft script treatment is circulated to and approved by advisors. • Production begins full force with a shoot at New York Presbyterian Hospital (see press release on page 10).

To maximize production capability, while filming other titles we will ask all participants about pain management experiences.

April 5, 2002

Discussions with sponsors continue.

Consensus On Prioritized Content Points (Tabulated by the average and median)

1. Importance of reporting pain
2. Teaching patients to communicate their pain (e.g. location, description)
3. Pain scale (rating pain)
4. Benefits of pain management
5. Goals and expectations of pain management
6. Patients rights

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THE PARENT CHANNEL®

NEWSLETTER

Newborn Infants and Car Safety Seats • Preventing Flat Heads • Beginning Babysitters Manual



From the editor:

We're almost 10 years old and momentum is still going strong. We're still growing (south of the border) and still producing new titles! Our new segment on breastfeeding is the first to educate on babies' cues (with some very cute babies to help us). Also demonstrated are proper latch and positioning. All our moms were happy to participate because of the great breastfeeding assistance they received in hospital.

Thanks to Lactation Consultant/Breastfeeding Resource Nurse, Kim Keizser RN IBCLC, for her lovely on-camera presence.

This issue of The Parent Channel®, we welcome Langley Hospital, from the Simon Fraser Health Region in British Columbia.

Kathy Kasher

A Chat with Grandma

Joan Brooks, President of Grandparents Requesting Access and Dignity, G.R.A.N.D. and founder of Grandparents Raising Grandchildren1, G.R.G. is entering into her retirement years by raising her 12 and 16 year old grandchildren and continues her work as an advocate for grandparents by creating awareness, facilitating support groups and lobbying politicians.

On those frustrating, trying days it has occurred to all of us parents that we can't wait until our children become adults and leave home.

Brooks enlightens us: "Parenting is forever, just when you think you have a handle on it, then you become a grandparent".

There are eight G.R.A.N.D. chapters in Quebec, Manitoba and Ontario with four GRG chapters in Toronto, Peterborough, Niagara-on-the-Lake and Hamilton.

Many grandparents "inherit" grandchildren because of death, illness or divorce of the children's parents.

Brooks says from her experiences many parents are too young to cope and the grandparents takes over. Drug addiction and mental illness also plays a part in many cases.

The only Canadian statistics available, says Brooks, is from the Children's Aid Society where it has been documented in April 1996 that there was a 30% increase in grandparents seeking and gaining custody. In the U.S. 3.4 million grandparents are raising their own grandchildren, 90 per cent of whom will never return home.

Dominic Verticchio, director of services for Hamilton-Wentworth Children's Aid Society, says in every local case grandparents are considered as possible primary caregivers for children whose parents cannot look after them.

Brooks think differently, "Child protection agencies are far too quick to get the child into the "system" thus depriving them of contact with their blood relatives. It's beginning to change, but they don't tend to look within the family unit to place children". She continued to add, that when a parent is okay to cope and can provide a safe environment of the children the grandparent has to step back and let the parent try to be a parent again. The sooner the better.



Sometimes grandparents find the financial burden hard to cope with on a fixed or limited income. Brooks states that some grandparents receive support from Social Service, \$250.00 a month with twice a year clothing allowance but adds this is considerably less than the \$700.00 a month a foster parent receives.

The tough part is coping with an energetic toddler or a rebellious teenager and dealing with senior issues at the same time. It may be overwhelming, sometimes you feel resentful but it is for the children. Brooks describes herself as a white haired old lady running with a hockey stick which also doubles as a cane.

To request the grandparent free information centre's booklet, call: (202) 434-2296 or contact the American Association of Retired Persons Website: www.AARP.org AARP membership line 1-800- 4243410

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RESPIRATORY INSTABILITY OF TERM AND NEAR-TERM HEALTHY NEWBORN INFANTS IN CAR SAFETY SEATS

In a recent article published in *Pediatrics*, researchers at Children's Hospital - St. Paul and the University of Minnesota School of Medicine have discovered that 24 percent of preterm infants and 4 percent of term infants did not fit securely into suitable car seats even with the use of blanket rolls. The same study also concluded that oxygen saturation values declined, in some cases, significantly in both term and preterm infants while in car seats.

Fifty infants were studied for car seat fit, heart rate, respiratory rate, and pulse oximetry. Apneic and bradycardic episodes were also monitored.

Researchers found some surprising results:

- Mean oxygen saturation decreased in all infants from 97% (supine) to 94% after 60 minutes in the car seats
- Seven infants (3 preterm and 4 term) had oxygen saturations of 90% for longer than 20 minutes
- Twelve percent of preterm infants had apneic or bradycardic episodes, but none occurred in the term infants

While infant car seats are an important preventive safety measure, their use with preterm infants or term infants with immature head-righting reflexes should be carefully evaluated prior to discharge from a hospital. This study supports the "American Academy of Pediatrics recommendations that all infants who are born 37 week's gestation, including those who are admitted to Level 1 community hospitals, be observed for respiratory instability and secure fit in their car seats before hospital discharge". Researchers point out that "because lowering oxygen saturation values was seen uniformly in all newborn infants, car seats should be used only for travel, and travel should be minimized during the first months of life".

Merchant, J., Worwa, C., Porter, S., Coleman, J., and deRegnier, A. (2001). *Respiratory Instability of Term and Near-Term Healthy Newborn Infants in Car Safety Seats*, *Pediatrics*, Vol. 108, No. 3 p.647-652.

Preventing **FLAT HEADS** in babies who sleep on their **BACKS**

We are doing a great job educating new parents about the national Back to Sleep SIDS prevention recommendations - revised in 1999.

In a recent survey conducted for Health Canada by Environics, 71% of parents and caregivers reported putting their babies to sleep on their back - a significant rise from the 1989 in which 40% were putting babies on their backs.. This change is reflected by the number of SIDS deaths in Canada - which has fallen steadily, from 385 in 1989 to 269 in 1994 to 138 in 1999.

Along with the success of the campaign, parents and caregivers have voiced concerns over positional plagiocephaly or, "flat heads", which can occur when a baby sleeps with its head always in the same position. Because baby's skull is very soft and the bones can be affected by pressure if they constantly turn their head to the same side, the result is the skull becoming flat. A minor degree of flattening resolves on its own, however more severe flattening may be permanent. Brain function and development are not affected but appearance is. Special clinics to treat this have been established in some children's hospitals in Canada.

In response to public concerns the partners in the Back to Sleep campaign have published an update that addresses plagiocephaly .

Prevention Strategies for Positional Plagiocephally

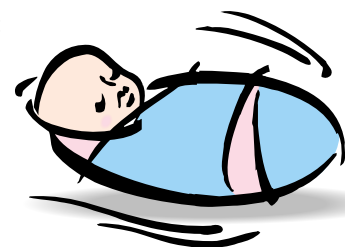
- Ensuring that young infants have supervised tummy time several times a day while awake
- Placing the infants' head in different positions for sleep on alternating days.

One way to ensure changes in head position is to use "counter position". While in their cribs, babies prefer to look out into a room rather than at a wall. Alternating the baby's orientation in the crib allows the baby to have the same view without always lying on the same side of the head. For example, infants can be placed on this/her back with the head at the head of the crib one day, then the next day at the foot of the crib. Attaching a mobile on the side of the crib encourages the baby to look away from the wall.

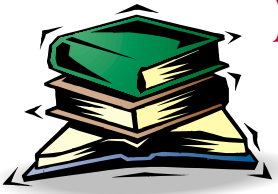
The Canadian Pediatric Society states that, if - despite these strategies - the baby still develops a flat area on the skull, a medical assessment is advised to rule out a more serious condition.

For more information:

www.cps.ca
www.sidscanada.org
www.hc-sc.gc.ca
www.aap.org



NEWSLETTER



BOOK REVIEW

A How-to Workbook For Beginning Babysitters.

This hands-on workbook teaches basic babysitting skills. With language and presentation simplified for readers age nine years and up, children learn necessary babysitting skills through games, story problems, questions and activities. The materials are designed for independent study or in conjunction with a babysitting course. This book is a valuable tool for schools, babysitting courses, youth groups, Girl and Boy Scout programs, teen parenting programs or for parents - to teach their own children responsibility.

Copies of Babysitting Basics \$5.50 US funds
(for orders for 24 copies or less)
Health/Scripts www.babysittingbook.com
Phone: (801) 582-4782

From the Archives...

The following is an excerpt from the July 1943 issue of Transportation Magazine. This was serious and written for male supervisors of women in the workforce during World War II - a mere 58 years ago! Obviously, the intent was not to be "funny," but by today's standards, this is hilarious! For those of you with efficiency issues, pay attention to #8.

Eleven Tips on Getting More Efficiency Out of Women Employees: There's no longer any question whether transit companies should hire women for jobs formerly held by men. The draft and manpower shortage has settled that point. The important things now are to select the most efficient women available and how to use them to the best advantage. Here are eleven helpful tips on the subject from Western Properties:

1. Pick young married women. They usually have more of a sense of responsibility than their unmarried sisters, they're less likely to be flirtatious, they need the work or they wouldn't be doing it, they still have the pep and interest to work hard and to deal with the public efficiently.
2. When you have to use older women, try to get ones who have worked outside the home at some time in their lives. Older women who have never contacted the public have a hard time adapting themselves and are inclined to be cantankerous and fussy. It's always well to impress upon older women the importance of friendliness and courtesy.
3. General experience indicates that "husky" girls - those who are just a little on the heavy side - are more even tempered and efficient than their underweight sisters.
4. Retain a physician to give each woman you hire a special physical examination - one covering female conditions. This step not only protects the property against the possibilities of lawsuit, but reveals whether the employee-to-be has any female weaknesses which would make her mentally or physically unfit for the job.



Conversations On Society & Child Development



A unique web-based forum for health care practitioners to see world-renowned researchers in early child development present their latest findings. Featuring multi-media presentations from medicine and biology to psychology and anthropology, participating thought leaders include Michael Rutter, Charles Nelson, Megan Gunnar and Daniel Keating. Lively roundtable discussions on the potential significance of research to related fields follow presentations.

"I learned more about early brain development in Charles Nelson's presentation that I have in the past five years. Now I know how to talk to parents about this"

Jodi Lee, Understanding Early Years Coordinator,
Winnipeg, Manitoba

- Downloadable text summaries include: presenters, slides incorporating illustrations, graphs and charts.
- Interactivity encourages ongoing dialogue and information exchange.
- Links to other relevant websites.
- Created by the Atkinson Centre for Society and Child Development with the Ontario Institute for Studies in Education at the University of Toronto. For more information and to subscribe www.acscd.ca.

5. Stress at the outset the importance of time; the fact that a minute or two lost here and there makes serious inroads on schedules. Until this point is gotten across, service is likely to be slowed up.
6. Give the female employee a definite day-long schedule of duties so that they'll keep busy without bothering the management for instructions every few minutes. Numerous properties say that women make excellent workers when they have their jobs cut out for them, but that they lack initiative in finding work themselves.
7. Whenever possible, let the inside employee change from one job to another at some time during the day. Women are inclined to be less nervous and happier with change.
8. Give every girl an adequate number of rest periods during the day. You have to make some allowances for feminine psychology. A girl has more confidence and is more efficient if she can keep her hair tidied, apply fresh lipstick and wash her hands several times a day.
9. Be tactful when issuing instructions or in making criticisms. Women are often sensitive; they can't shrug off harsh words the way men do. Never ridicule a woman - it breaks her spirit and cuts off her efficiency.
10. Be reasonably considerate about using strong language around women. Even though a girl's husband or father may swear vociferously, she'll grow to dislike a place of business where she hears too much of this.
11. Get enough size variety in operator's uniforms so that each girl can have a proper fit. This point can't be stressed too much in keeping women happy.



NEWSLETTER



Cultural Diversity



Have you ever wondered why your patient and his family don't seem to care about what you're teaching him? Isn't he paying attention? He's not even looking at me! Maybe he's tired or not ready to learn or maybe he is really listening and showing you respect by not looking at you. A cultural clash might be happening. But how would you know that?

Cultural diversity and cultural sensitivity is far more than an "in" concept for the past decade. Cross-cultural understanding is a timely topic because our neighborhoods and communities are more diverse than ever before. More specifically to healthcare, cultural sensitivity is an awareness of cultural differences among patients and how cultures affect patients' health values and practices. This cultural appreciation supports more effective healthcare to wider populations with complex needs.

Traditionally, healthcare providers have considered familiar barriers like financial differences, transportation issues, lack of childcare, and language barriers. However, there are many other non-traditional barriers and assumptions, which pose an equal challenge to healthcare providers. We tend to assume that people perceive our services in the same way that we do. We also tend to look at life with certain values and beliefs, many of which are western or American in nature. However, we tend to overlook regional differences among like cultures.

So, now that you're hooked into the importance of learning about different cultures, you want a list of ways that certain populations behave, so that you can tailor your care to them. Well, it's not that straightforward. We all have a tendency to categorize things, and people are no exception. From the time we are infants, we categorize objects, toys, food - and then we assign properties (hot/cold, hard/soft) to them. We then move on to people: emotional/stoic, hard-working/lazy and on and on. According to Dr. Cynthia Barnes-Boyd, an expert in cultural diversity in healthcare, we should "understand an individual within the context of culture as well as an individual". In other words, people may behave in expected ways from their ethnic or racial cultures, but they are first and foremost individuals who may express themselves very differently than expected. We frequently become "befuddled" when they don't respond in a way we expect. She adds that the most effective way that healthcare providers can effectively work with patients who may be culturally different from themselves is to first develop a relationship with the individual. Communication is key to advancing relationships of any kind, and in cross-cultural relationships it becomes even more important.

While lists of personality traits among cultures can seem like stereotyping, there are certain values, which are important to recognize among cultures. To name a few:

- Time orientation
- Future orientation
- Communication style
- Openness and directness
- Value of nuclear family structure
- Materialism
- Physical beauty

(Barnes-Boyd, Cultural Diversity: From Philosophy to Practice, 2001)
We should know that areas of sensitivity or differences might most likely be associated with these values.

Perhaps you have truly tried to know your patient as an individual, but you sense that a cultural misunderstanding has occurred. What should you do? Most importantly, Dr. Boyd recommends to "claim it" or own up to it. Acknowledge to the patient or family that you were unaware of this cultural misstep, apologize, then work with the patient to identify changes you can make in your actions.

On a larger scale, hospitals and healthcare agencies can identify many actions to prepare for caring for patients from diverse backgrounds. First, Dr. Boyd again reiterates the importance of improving cross-cultural communication. "You can't begin to understand and appreciate each other if you can't communicate with each other", states Boyd. Sit down with representatives from different populations and discuss their immediate needs and concerns. Dr. Boyd also suggests that you can utilize the diversity in your own staff by creating diversity teams and allow each member equal "air time" to voice their traditions, values, or concerns.

Organizations and individuals can become culturally competent if they honestly identify their own ethnocentrism and develop an action plan to address cross-cultural communication and other important values. Healthcare providers can meet the cultural needs of the individual and the many if we meet them in a way that is comfortable to them.

For more information, please contact:
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Assistant Dean Community Health Initiatives, UIC College of Nursing
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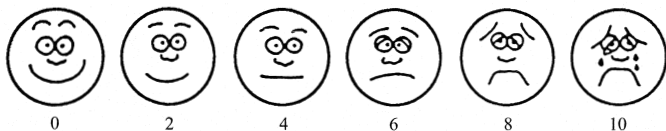
NONPHARMACOLOGICAL PAIN RELIEF KIT



Your patient is in pain, again. . . still. . . , and your manager has asked you to attend a briefing on the new Joint Commission standards on pain. What is a nurse to do?

Identify some new or tried and true strategies to effectively manage the pain and meet the new regulatory requirements by engaging your patient to help manage his own relief.

Pain and pain relief has long been a hot topic in healthcare. Even prior to the Joint Commission for Accreditation of Healthcare Organizations' (JCAHO), new standards on pain management, healthcare professionals have continuously sought new methods to control their patients' pain. At the University of Wisconsin Hospital and Clinics (UWHC), they are successfully piloting an innovative approach to pain management.



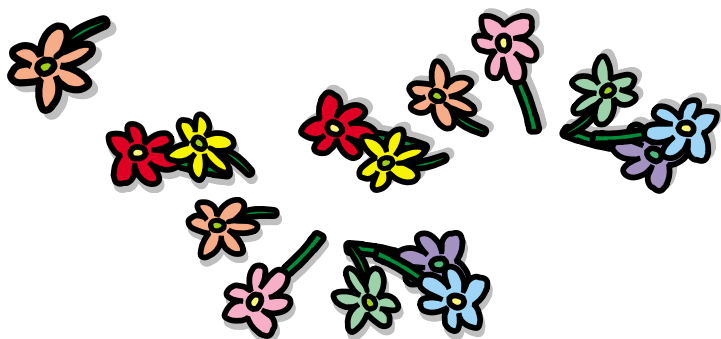
Description



Last fall, UWHC began a nonpharmacological pain management initiative. This initiative was a collaborative partnership between a clinical nurse specialist for pain, the patient education manager, and a nurse researcher. Several underlying assumptions guided the nurses' decision to start the project. First, they recognized that pain is a multidimensional experience. They also realized that patients are often hesitant to take analgesics even if they report high levels of pain. Finally, they knew that nonpharmacologic methods might be more acceptable to patients than increasing their medications.

In addition, the project leaders knew that approximately one third of UWHC patients reported that they used some type of nonpharmacologic strategy to help manage their pain.

With that in mind, the researchers developed a nonpharmacologic pain kit for patient use. The kit, wrapped in an attractive bag, included a relaxation audiotape, a tape player, a stress squeeze ball, plastic massager, and information about relieving pain without medicines.



The purpose of the project was to compare pain and anxiety in orthopedic patients scheduled for surgery. Patients were divided into two groups of approximately 20 each. One group received the trial nonpharmacologic pain relief kit and regularly prescribed analgesics, and the second group received usual pharmacological management alone. Patients' responses were measured with demographic, volume measures, pain scales, and coping and anxiety scales.

Operational Considerations

The pain relief kits were internally produced and were funded by the UWHC's volunteer auxiliary. Because the supplies were purchased in bulk for the projects, costs were minimized. Each kit cost approximately \$25.00 to produce. But the benefits were priceless!

Lessons Learned

Zeena Engelke, MS, RN, the Patient Education Manager and Project Leader, stated that other populations could easily be included in this type of nonpharmacologic pain relief kit study. UWHC chose the orthopedic population, but this could be used with oncology, pediatric, and trauma patients as well. Ms. Engelke added that they learned that the kit seemed to be more effective when given to patients who were already interested in nonpharmacologic strategies for pain relief.

Results

While there was no appreciable decrease in the levels of pain between the two groups, the researchers did find some other interesting differences. The group who received the kit tried a variety of pain relief options and used them more frequently, like deep breathing and walking. While the group who did not receive the kit used no other pain relief strategies beyond traditional medications, family visits, and television.

Added benefits to the patients who received the kit were measured anecdotally and included several unique outgrowths of the research. The pilot created a "sense of adventure" for the patients who received the kit, according to Ms. Engelke. "It had the similar effect as a newborn baby welcome kit frequently has". Additionally, since the pilot group was up walking and deep breathing, their overall recovery was aided.

Conclusion

While these nurses implemented a true research study, you can implement a similar project with your patient population to empower patients through education to help manage their pain. When patients are given permission to be involved and are knowledgeable about their care, patients, families, and staff all reap the rewards.

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P R E S S R E L E A S E



THE HEALTH TELEVISION SYSTEM INC. PRODUCES PAIN MANAGEMENT TV PROGRAM TO HELP HOSPITALS MEET JCAHO STANDARDS

The Health Television System Inc. (Healthtv™), North America's premiere hospital-based patient-education television network has launched production of an innovative pain management TV program. Filming was kicked off last month at NY Presbyterian Hospital. The program is expected to be launched on Healthtv™ Fall 2002.

Recognizing pain as an under-treated, complex major public health problem affecting all types of patients with a number of diseases and injuries, JCAHO has developed standards that create new expectations for the assessment and management of pain in accredited hospitals and other healthcare settings. Studies show that more than 75 million Americans suffer from pain. According to the American Pain Foundation (APF), three quarters of surgical patients say they get poor relief from acute pain.

To develop the content for the pain management program, Healthtv™, in consultation with Joint Commission Resources and in partnership with APF, initiated a national teleconference with leading clinicians from the following hospitals:

University of California Los Angeles (UCLA)
George Washington University Hospital, DC
Rush St. Luke's Presbyterian, Chicago
New York Presbyterian Medical Center
Shands University Hospital, Florida
University of Maryland Medical Society
Kaleida Health System, Buffalo
Presbyterian Hospital, New Mexico
University of New Mexico
University of Missouri Health Care
VA Greater Los Angeles Healthcare System
Medical University of South Carolina

All participants in the teleconference agreed the focus of the video/DVD should be on informing patients about the importance of reporting their pain and their right to receive treatment. It would also help put into perspective the benefits of pain relief.

"The digitally-produced Healthtv™ video/DVD includes experiences of real people, and capitalizes on the passion of specialists committed to pain relief," says Kathy Kastner, CEO, Healthtv™. Featured in the program is Weill Medical College of Cornell University's Director, Division of Pain, Dr. Sunil Panchal.



"Healthtv™ provides high quality programming which is consistently current, accurate and appropriate for the health care consumer," says Virginia Forbes, program director, patient education, New York Presbyterian Hospital. For example, the new pain management segment is of timely importance for the patient, family, and staff. It addresses the most important issues and provides another avenue for learning this important information. Being a part of the production was very exciting for all involved here and we look forward to using the film as a helpful adjunct to our teaching process."

Research has shown that when pain is controlled, people recover from illnesses more quickly and leave the hospital sooner.

According to JCAHO:

- Studies show unrelieved pain can slow recovery, increase healthcare costs
- According to Dennis O'Leary, MD President, Joint Commission, unrelieved pain has enormous physiological and psychological effects on patients and is a crucial component of good care.

The Health Television System, established in major US and Canadian hospitals, is accessible to patients and their families 24/7 via patient's bedside televisions. Launched in 1997, it is the only service providing patient education to heart, cancer and general medical units. Each program is screened by a medical advisory board.

Hospitalized patients get a program guide with a complete listing of topics and times. Surveys show that 85% of patients watch Healthtv™ up to 3 hours a day, over an average four-day length of hospital stay.

"Viewership is high because audiences can watch programs repeatedly which reinforces learning," explains Ms. Kastner.

Currently Healthtv™ is seen in 26 hospitals in 12 states and 45 Canadian hospitals. Growing quickly, the company recently signed on The Jewish Hospital, OH, Good Samaritan, Los Angeles, St. Mary's, San Francisco, and Johns Hopkins Hospital, Baltimore.

Thanks to Virginia Forbes, Manager, Patient Education and Jan Sileo, Media Coordinator at New York Presbyterian Hospital. As a result of your tireless help before and during the shoot, the HTS crew had the best location and the best patients and healthcare professional participation. In spite of the seriousness of the subject matter, everyone found the experience enjoyable.

We Asked, You Told.

The goal of "Overcoming Depression" was to encourage overcoming the stigma of depression, and to seek treatment. As on-camera specialist, Dr. Robin Reesal says, "Just because you have a good reason to be depressed, doesn't mean you don't deserve treatment."

This inservice and segment is designed to educate healthcare professionals on the importance of providing education about depression to patients and family members.

Staff Inservices Program Survey Results "OVERCOMING DEPRESSION"


1. Is the information in this program appropriate for your hospital population?	YES 100%	NO 0%			
2. Will the pacing of this segment hold a viewer's attention?	YES 100%	NO 0%			
3. How would you rate the program length?	Good Length 94%	Too Long 0%		Too Brief 6%	
4. Do you think this program will help you meet JACHO education standards as relates to antidepressant medication?	YES 92%	NO 0%		No Response 6%	
5. Do you think this program is a useful patient education tool and provides good information to share with your patients? On a scale from 1 to 5	MODE 5	1 Not at all 0%	2	3 Neutral 6%	4 Very Much 45%
6. Will you direct your patients and support persons to watch this program on HealthTV™?	YES 99%	NO 1%			
7. Has this inservice and program heightened your awareness and knowledge of this topic? On a scale from 1 to 5	MODE 5	1 Not at all 2%	2 0%	3 Neutral 8%	4 Very Much 41%
		5 49%			

These results are based on 459 responses

Medical Illness Associated with Depression

Depression commonly coexists with certain medical conditions, particularly if hospitalization is involved:

- Myocardial infarction
- Stroke (particularly left frontal lobe)
- Cancer
- Major trauma
- MS



Common Medications That Can Cause or Worsen Depression


- Drug abuse – alcohol, amphetamines, cocaine, marijuana
- Antihypertensive - beta-blockers
- Antihistamines – especially older agents
- Steroid hormones – prednisone, oral contraceptives
- Psychoactive drugs – analgesics (codeine), sedative-hypnotics (diazepam)
- Cancer chemotherapy

PATIENT EDUCATION

There remains a degree of social stigma and resistance to the diagnosis and treatment. Education and support is key.

- Common – is one of the most common illnesses treated
- Responsive – depression is very responsive to treatment
- Full effect takes time – all medications take several weeks to produce their full effects
- Can recur – frequently a recurrent disorder (50% recurrence rate after first episode, 70%

"OVERCOMING DEPRESSION"



- Real people share their experience in over coming depression; including a cancer survivor and her family, as well as a post MI patient.
- This program touches on the importance of diagnosis, treatment and compliance.

For complete results and inservice slides, email healthtv@rogers.com

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incement... Technology Upgrade Announcement... Technolo

HTS is pleased to announce that we've been developing and testing a new delivery system. Delivering a digital MPEG signal, HTS' new DVD playback unit will be more compact. Its increased versatility, may allow for future applications such as: VOD, second language and customized hospital messages.

We're all excited about new programs in the offing:

- Pain Management
- Radiation Therapy
- Medication Safety

As a result of planning for and scheduling this re-tooling, the May 2002 program update will be delayed to coincide with the change-over.



Director of Hospital Services, Leanne Worsfold, and her team will still be conducting site visits to ensure continued momentum and usage. She will keep you posted on timing of the new technology.

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Interested in receiving the The Parent Channel®/Healthtv™ Newsletter? Yes No

Interested in receiving more information on the Parent Channel®? Yes No HealthTV™? Yes No

Please photocopy this form and fax back to 416-654-4068 or 716-662-6759

Name: _____ Title: _____

Hospital/Institution you work at: _____

Address: _____

City: _____ State/Province: _____ Postal/Zip: _____

Phone: _____ Fax: _____ Email: _____

Check out our website: www.healthtvsystem.com

NEXT ISSUE:

Care for Caregiver
 Clinical Trials
 Breaking New Ground



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