

Patient Education Materials From the Layperson's Perspective



The Importance of Readability

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Accessible patient-friendly materials are a useful and cost-effective way of increasing patients' knowledge and allaying their fears. This article describes how nursing leadership at a hospital in Connecticut created a patient education committee to review and help draft materials and developed a Web site to centralize these materials for staff and patients. A patient panel was implemented to test materials; results highlighted the need for planning and testing of materials on target audiences.

According to the Institute of Medicine, there is a higher rate of hospitalizations among people with limited health literacy (Institute of Medicine, 2004). The average layperson does not possess the skills required to understand typical healthcare information (The Joint Commission, 2007). Even those with strong reading and writing skills may not understand medical jargon found in many patient education materials (Institute of Medicine, 2004). A key component of disease self-management for patients is understanding the implications of their diagnoses and the importance of prevention (The Joint Commission, 2007). Few healthcare professionals adequately respond to this health literacy need of patients through providing patient educational materials that are easily understood and geared toward symptom management (Wolf & Bailey, n.d.). In 2007, staff at Danbury Hospital, in Danbury, Connecticut, recognized this gap in health literacy.

Danbury Hospital is a 371-bed regional medical center and community teaching hospital located in northwestern Connecticut. It is the primary provider for a

culturally diverse population of 350,000. Prior to 2007, standardized patient education materials at Danbury Hospital were not easily accessible for staff to use as written reinforcement for the oral education provided in preparation for discharge. Patient education materials prepared in simple, concise language, accompanied with oral education, aid in the retention of knowledge (The Joint Commission, 2007; Wolf & Bailey, n.d.). Patient education materials can be a cost-effective way of increasing a patient's knowledge of a condition and in allaying fears or anxiety about a condition or surgical procedure or hospital stay (Charnock, Shepperd, Needhand, & Gann, 1999; Coudeyre et al., 2002; Kubba, 2000; Singh, 2003). However, many patient education materials are difficult to understand as they are often written at a reading level of 10th grade or higher, whereas the median grade reading level of the U.S. population is estimated as 8th grade (Doak, Doak, & Root, 1996). Patient education materials often include medical terms that are familiar to a health professional but not to patients. One common mistake that health professionals make is not writing to the target audience. Many of the patient education materials at Danbury Hospital were written more for health professionals than for patients.

In 2007, nursing leaders addressed these concerns by forming a patient education committee, chaired by a nursing director. Membership is composed of direct care nursing staff from each of the different service lines within the hospital, in addition to a pharmacist, a dietician, and a librarian with expertise in health literacy. The goal of the committee was to develop patient education materials that are concise, easy to read, and evidence based and that pertain to topics related to the hospital's top diagnostic groups. Staff in the hospital identify gaps in available patient education content and either create a draft handout to submit to the committee for review or submit the topic to the committee to be written by its members. Evidence-based sources such as the National Institutes of Health, the Institute for Medicine, the American Heart Association, the National Institute of Mental Health, and others are consulted to create these materials.

To ensure easy access by staff, a patient education Web site was created through the hospital intranet to

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allow for on-demand printing. All educational materials are prepared in a consistent PDF format and posted to this Web site. The Web site is also made accessible to the community under the Patient Information section of the hospital's Internet site. As yet, there is no information collected on the number of patients accessing this patient education webpage from the outside; however, it has become common practice for staff to use this webpage frequently to print materials for patients. A chief benefit of creating patient education materials rather than relying on Web-based materials is the ability to tailor the information to mirror oral instructions provided by the hospital diagnostic departments and physicians. A further benefit is the ability to create the materials in user-friendly language to ensure understanding and improve adherence.

As new patient education fact sheets are created, they are brought to the patient education committee to approve. This approval process includes evaluating the content for readability, content organization, and overall appearance, as well as the presence of current clinical evidence to support the content. These are all qualities documented in the literature as essential to education materials (Demir, Ozsaker, & Ozcan, 2008; Karten, 2007; The Joint Commission, 2007). The librarian on the committee challenged the members to test the readability of a sample of patient education materials by using a panel of lay people rather than employing readability formulas. Pretesting for readability by lay people is one way to measure the clarity of patient education materials (Karten, 2007).

It was decided to start the panel with a target audience of people with no healthcare training. Approval was received from the hospital institutional review board, and all panel members consented to participate. A minimum convenience sample of 20 panel members, men and women aged 18 years or older, was selected from non-clinical hospital employees and hospital volunteer services, the local senior center, and patients in the Ambulatory Surgery Unit of the hospital. According to Doak et al. (1996), a representative sample of 10–20 readers should be enough to ascertain if there is something wrong with the materials. The response rate was 80% and above, with no fewer than 18 respondents to any piece of material.

Because a number of patient education materials had already been created prior to the implementation of the panel, a decision was made to test two of the handouts that were commonly distributed to patients and a new handout that had just been submitted to the committee. The two commonly distributed handouts were on the topics of healthy heart diet and colonoscopy, and the new handout was a handout for fiberoptic endoscopic evaluation of swallowing. The handouts and feedback forms were mailed or hand delivered to the panel members over

a 3-month period. The panel was given 2 weeks to complete each review and to mail it back. It was estimated that the task would take no longer than 20 minutes for each handout. All responses were confidential, although some respondents chose to write their names on each piece. Permission was granted from Elizabeth Gibbs at Alegent Health, Omaha, Nebraska, to adapt a feedback form that contained eight questions on the presentation of the information, ease of reading, comprehensiveness of the material, use of medical terms, and the benefit of using pictures, diagrams, and checklists. Ample space was provided for comments and suggestions. Respondents were also encouraged to write on the handout itself. The panel was a convenience sample, and the volunteers' reading levels were not tested prior to recruitment; therefore, the panel did not include those with a very low level of literacy. Furthermore, some of the responses indicated that some may have read through the materials in a cursory fashion, as suggested by the lack of comments and uniformity of responses.

The panel provided some very useful feedback, clarifying terms and phrasing along with reordering of checklists, information organization, use of bullets and white space, and the usefulness of pictures. The following comments are examples of feedback from the panel on one of the patient education pieces:

- The heart-healthy diet handout was critiqued by the panel members for the inclusion of such terms as *cholesterol*, *saturated fat*, and *condiments* that were used without further explanation of their meaning. In addition, respondents stated that weights such as 25–30 g of fiber or 6 ounces of chicken were difficult to visualize. The issue of math literacy was raised by several respondents unable to understand mathematical symbols such as \geq (less than or equal to).

The ongoing plan is to submit samples of patient education handouts to the panel members on a quarterly basis to continuously evaluate readability. In evaluating the feedback from the panel, it was decided that having input from a layperson's perspective was an invaluable tool in spotting terminology that may be more challenging to a layperson but could be easily missed by a healthcare professional. The librarian also challenged the committee to invite a layperson from the community to provide an unbiased opinion. The librarian recommended an individual who was a patient advocate and had experience in writing patient materials. The committee believed that this individual would be a good fit for the layperson role and she became a permanent member.

The feedback from the panel serves as a constant reminder that writing patient education materials is no small task and requires careful thought and evaluation.

References

- Charnock, D., Shepperd, S., Needham, G., & Gann, R. (1999). DISCERN: An instrument for judging the quality of written consumer health information on treatment choices. *Journal of Epidemiology and Community Health, 53*, 105–111.
- Coudeyre, E., Poiraudreau, S., Revel, M., Kahan, A., Drape, L. J., & Reavaud, P. (2002). Beneficial effects of information leaflets before spinal steroid injection. *Joint Bone Spine, 69*, 597–603.
- Demir, F., Ozsaker, E., & Ozcan, A. (2008). The quality and suitability of written educational materials for patients. *Journal of Clinical Nursing, 17*(2), 259–265.
- Doak, C., Doak, L., & Root, J. (1996). *Teaching patients with low literacy skills* (2nd ed.). Philadelphia: Lippincott.
- Institute of Medicine. (April 2004). *Health literacy: A prescription to end confusion*. Retrieved September 18, 2009, from www.iom.edu/?id=19723
- Karten, C. (2007). Easy to write? Creating easy-to-read patient education materials. *Clinical Journal of Oncology Nursing, 11*(4), 506–510.
- Kubba, H. (2000). An evidence-based patient information leaflet about otitis media with effusion. *Clinical Performance and Quality Health, 8*(2), 93–99.
- Singh, J. (2003). Reading grade level and readability of printed cancer education materials. *Oncology Nursing Forum, 30*(5), 867–870.
- The Joint Commission. (2007). *What did the doctor say? Improving health literacy to protect patient safety*. Oakbrook Terrace, IL: The Joint Commission.
- Wolf, M. S., & Bailey, S. C. (n.d.). The role of health literacy in patient safety. *Agency for Healthcare Research and Quality Safety Perspectives*. Retrieved September 18, 2009, from www.webmm.ahrq.gov/perspective.aspx?perspectiveID=72

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