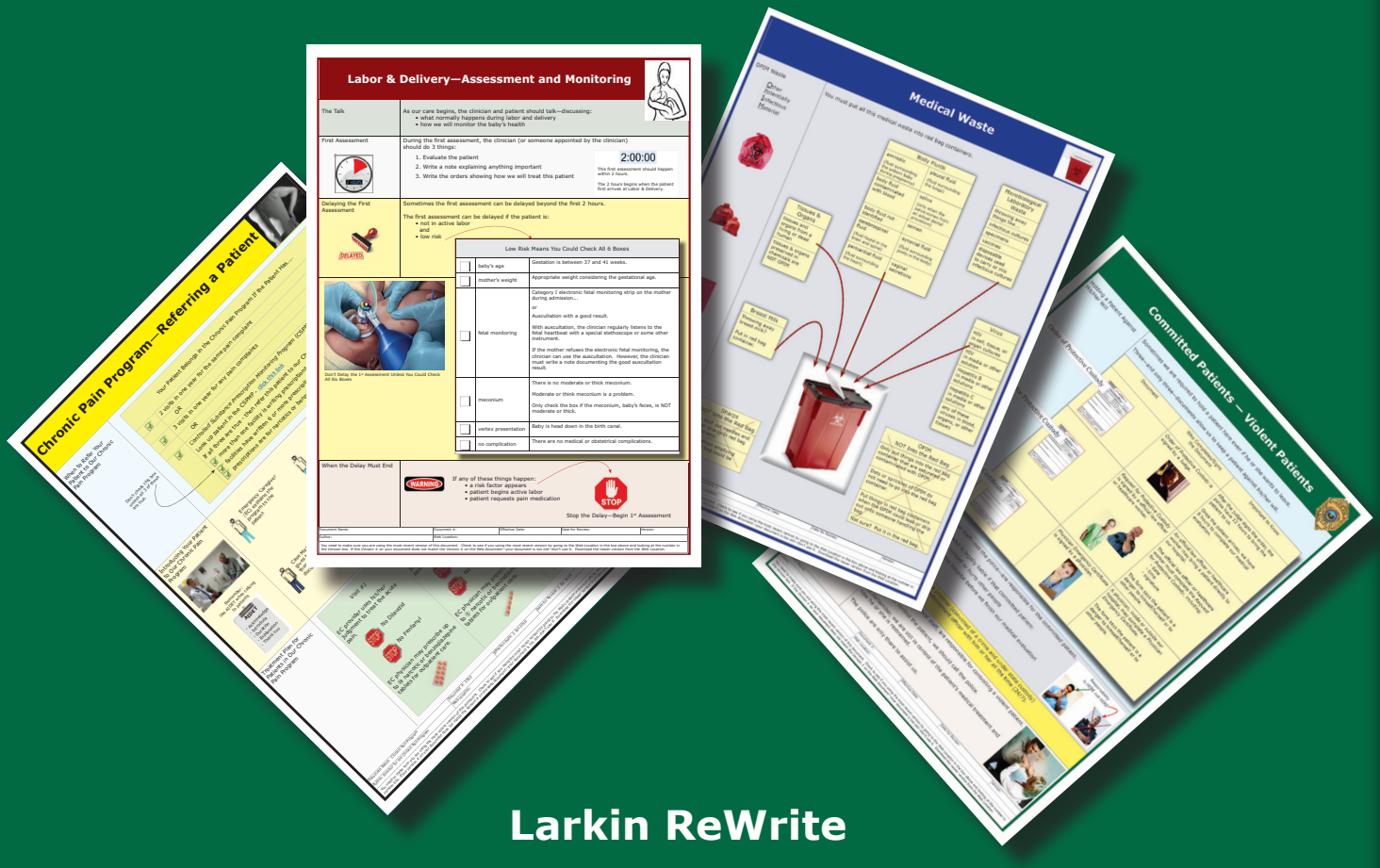
Communication Best Practice

Healthcare

Full Brochure

Samples
Research
Pricing

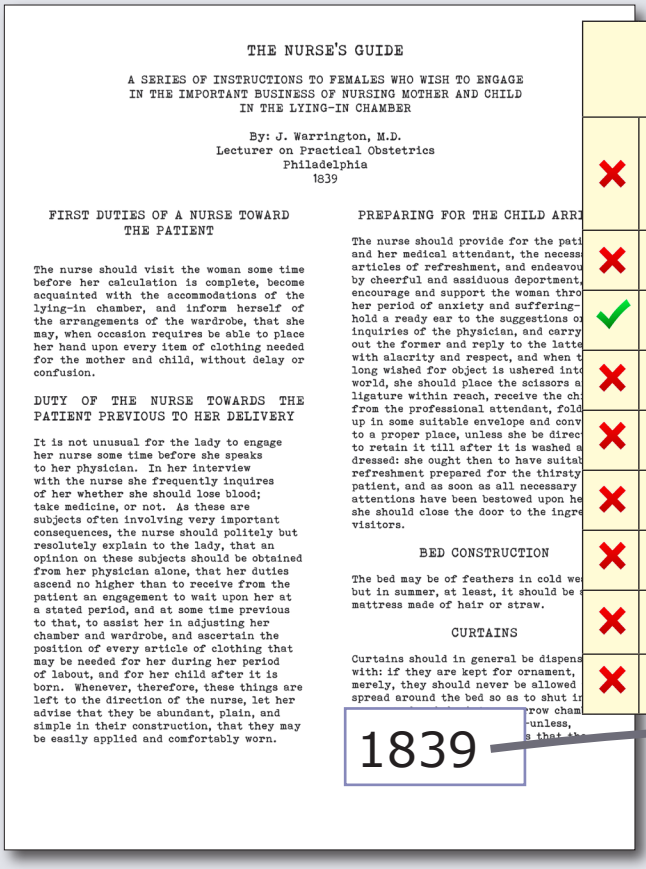


Larkin ReWrite

Dr TJ Larkin & Sandar Larkin

Larkin Communication Consulting

Communication Best Practice - 175 Years No Progress



THE NURSE'S GUIDE

A SERIES OF INSTRUCTIONS TO FEMALES WHO WISH TO ENGAGE IN THE IMPORTANT BUSINESS OF NURSING MOTHER AND CHILD IN THE LYING-IN CHAMBER

By: J. Warrington, M.D.
Lecturer on Practical Obstetrics
Philadelphia
1839

FIRST DUTIES OF A NURSE TOWARD THE PATIENT

The nurse should visit the woman some time before her calculation is complete, become acquainted with the accommodations of the lying-in chamber, and inform herself of the arrangements of the wardrobe, that she may, when occasion requires be able to place her hand upon every item of clothing needed for the mother and child, without delay or confusion.

DUTY OF THE NURSE TOWARDS THE PATIENT PREVIOUS TO HER DELIVERY

It is not unusual for the lady to engage her nurse some time before she speaks to her physician. In her interview with the nurse she frequently inquires of her whether she should lose blood; take medicine, or not. As these are subjects often involving very important consequences, the nurse should politely but resolutely explain to the lady, that an opinion on these subjects should be obtained from her physician alone, that her duties ascend no higher than to receive from the patient an engagement to wait upon her at a stated period, and at some time previous to that, to assist her in adjusting her chamber and wardrobe, and ascertain the position of every article of clothing that may be needed for her during her period of labout, and for her child after it is born. Whenever, therefore, these things are left to the direction of the nurse, let her advise that they be abundant, plain, and simple in their construction, that they may be easily applied and comfortably worn.

PREPARING FOR THE CHILD ARRI

The nurse should provide for the pati and her medical attendant, the necess articles of refreshment, and endeavou by cheerful and assiduous deportment, encourage and support the woman thro her period of anxiety and suffering- hold a ready ear to the suggestions o inquiries of the physician, and carry out the former and reply to the latte with alacrity and respect, and when t long wished for object is ushered int world, she should place the scissors a ligature within reach, receive the ch from the professional attendant, fold up in some suitable envelope and conv to a proper place, unless she be direc to retain it till after it is washed a dressed: she ought then to have suitab refreshment prepared for the thirsty patient, and as soon as all necessary attentions have been bestowed upon he she should close the door to the ingre visitors.

BED CONSTRUCTION

The bed may be of feathers in cold we but in summer, at least, it should be mattress made of hair or straw.

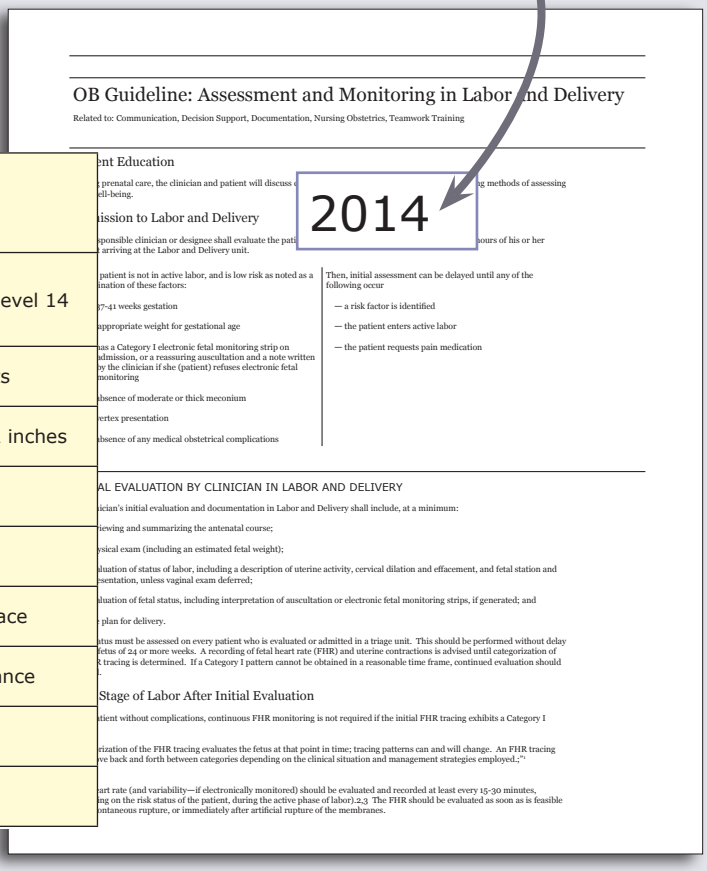
CURTAINS

Curtains should in general be dispens with: if they are kept for ornament, merely, they should never be allowed spread around the bed so as to shut in row cham unless,

1839

One Successful Communication Best Practice In This 1839 OB Hospital Policy		
✗	writing complexity	this document is grade level 22 less than 1% of adults can read at level 22 best practice is grade level 8
✗	dot points	replace paragraphs with dot points/lists
✓	best line length	best line length for reading ease is 3½ inches
✗	color	no color blocking to separate topics
✗	graphics	no objects representing major topics
✗	empty space	text boxes not separated by empty space
✗	fear appeal	no disturbing photo increasing compliance
✗	font	serif font not easiest to read
✗	document control	no document control footer

175 Years No Progress



OB Guideline: Assessment and Monitoring in Labor nd Delivery

Related to: Communication, Decision Support, Documentation, Nursing Obstetrics, Teamwork Training

ent Education

prenatal care, the clinician and patient will discuss ng methods of assessing ell-being.

ission to Labor and Delivery

sponsible clinician or designee shall evaluate the pati ours of his or her arriving at the Labor and Delivery unit.

patient is not in active labor, and is low risk as noted as a ination of these factors:

7-41 weeks gestation

appropriate weight for gestational age

as a Category I electronic fetal monitoring strip on admission, or a reassuring auscultation and a note written by the clinician if she (patient) refuses electronic fetal monitoring

bsence of moderate or thick meconium

ertex presentation

bsence of any medical obstetrical complications

Then, initial assessment can be delayed until any of the following occur

— a risk factor is identified

— the patient enters active labor

— the patient requests pain medication

AL EVALUATION BY CLINICIAN IN LABOR AND DELIVERY

ician's initial evaluation and documentation in Labor and Delivery shall include, at a minimum:

iewing and summarizing the antenatal course;

ysical exam (including an estimated fetal weight);

luation of status of labor, including a description of uterine activity, cervical dilation and effacement, and fetal station and sentation, unless vaginal exam deferred;

luation of fetal status, including interpretation of auscultation or electronic fetal monitoring strips, if generated; and

plan for delivery.

tus must be assessed on every patient who is evaluated or admitted in a triage unit. This should be performed without delay etus of 24 or more weeks. A recording of fetal heart rate (FHR) and uterine contractions is advised until categorization of tracing is determined. If a Category I pattern cannot be obtained in a reasonable time frame, continued evaluation should

Stage of Labor After Initial Evaluation

tient without complications, continuous FHR monitoring is not required if the initial FHR tracing exhibits a Category I

rization of the FHR tracing evaluates the fetus at that point in time; tracing patterns can and will change. An FHR tracing ve back and forth between categories depending on the clinical situation and management strategies employed.;"

art rate (and variability—if electronically monitored) should be evaluated and recorded at least every 15-30 minutes, ng on the risk status of the patient, during the active phase of labor).2,3 The FHR should be evaluated as soon as is feasible ontaneous rupture, or immediately after artificial rupture of the membranes.

2014

One Successful Communication Best Practice In This 2014 OB Hospital Policy		
✗	writing complexity	this document is grade level 14 only 17% of adults can read at grade level 14 best practice is grade level 8
✓	dot points	replace paragraphs with dot points/lists
✗	line length	best line length for reading ease is 3½ inches
✗	color	no color blocking to separate topics
✗	graphics	no objects representing major topics
✗	empty space	text boxes not separated by empty space
✗	fear appeal	no disturbing photo increasing compliance
✗	font	serif font not easiest to read
✗	document control	no document control footer

Communication Best Practice

Lists/Dot Points

more than twice as many people will read a paragraph if sentences are replaced with a list or dot points

Writing Complexity

grade level 8; 50% of adults can read at this level

Graphics

increases recall up to 800%

Labor & Delivery—Assessment and Monitoring

The Talk	As our care begins, the clinician and patient should talk—discussing: • what normally happens during labor and delivery • how we will monitor the baby's health
First Assessment	During the first assessment, the clinician (or someone appointed by the clinician) should do 3 things: 1. Evaluate the patient 2. Write a note explaining anything important 3. Write the orders showing how we will treat this patient 2:00:00 This first assessment should happen within 2 hours. The 2 hours begins when the patient first arrives at Labor & Delivery.
ying the First essment	Sometimes the first assessment can be delayed beyond the first 2 hours. The first assessment can be delayed if the patient is: • not in active labor and • low risk

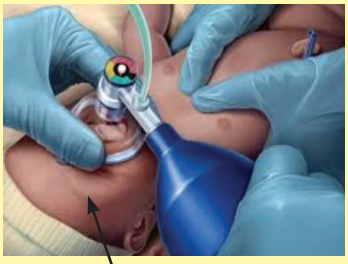
Line Length

3½ inches best length for accurate reading

Perseverance

after the grade level is reduced, 82% more people will finish reading the entire document

Low Risk Means You Could Check All 6 Boxes		
☐	baby's age	Gestation is between 37 and 41 weeks.
☐	mother's weight	Appropriate weight considering the gestational age.
☐	fetal monitoring	Category I electronic fetal monitoring strip on the mother during admission... or Auscultation with a good result. With auscultation, the clinician regularly listens to fetal heartbeat with a special stethoscope or some other instrument. If the mother refuses the electronic fetal monitoring, the clinician can use the auscultation. However, the clinician must write a note documenting the good auscultation result.
☐	meconium	There is no moderate or thick meconium. Moderate or think meconium is a problem. Only check the box if the meconium, baby's feces, is NOT moderate or thick.
☐	vertex presentation	Baby is head down in the birth canal.
☐	no complication	There are no medical or obstetrical complica



Don't Delay the 1st Assessment Unless You Could Check

Verdana Font

easiest font to read online

Disturbing Photo

fear-appeal photo makes it 50% more likely employees will follow the policy

Color

increases time spent looking at page by 21%

When the Delay Must End	
WARNING	If any of these things happen: • a risk factor appears • patient begins active labor • patient requests pain medication STOP Stop the Delay—Begin 1st Assessment

Comprehension

(r = –0.75) correlation between grade level and correct answers to a test

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Author:	Web Location:		

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Empty Space

adding even small amounts of empty space around text increases comprehension by 20%

Document Control

conforms to most international standards (e.g. OHSAS 18001)

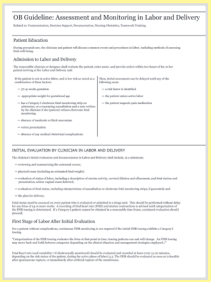
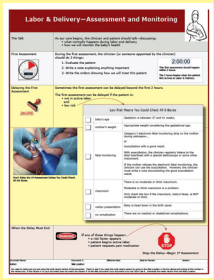
Legal Implications

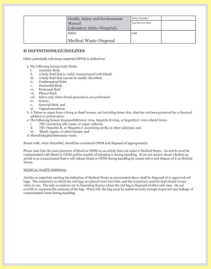
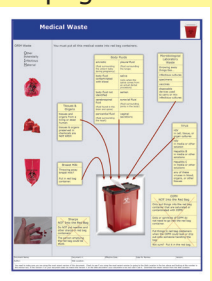
organizations sued for difficult-to-read documents:

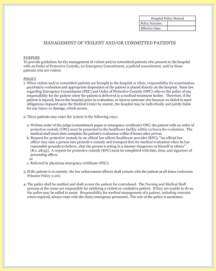
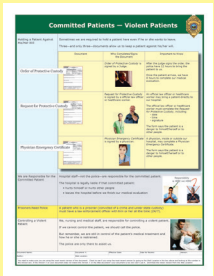
- insurance (policies)
- government (ballots)
- hospitals (HIPAA)
- cable TV (contracts)
- government (benefits)

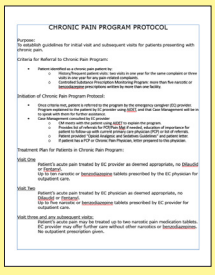
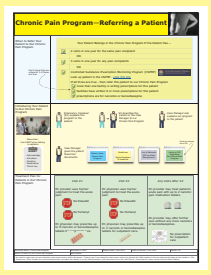
Four Samples

Larkin Rewrite: Applying Communication Best Practices to Hospital Policies

	Policy	Original	Larkin ReWrite
Sample #1	OB Guideline - Assessment and Monitoring in Labor and Delivery	page #5 	page #6 

	Policy	Original	Larkin ReWrite
Sample #2	Medical Waste Disposal	page #7 	page #8 

	Policy	Original	Larkin ReWrite
Sample #3	Management of Violent and/or Committed Patients	page #9 	page #10 

	Policy	Original	Larkin ReWrite
Sample #4	Chronic Pain	page #11 	page #12 

OB Guideline: Assessment and Monitoring in Labor and Delivery

Related to: Communication, Decision Support, Documentation, Nursing Obstetrics, Teamwork Training

Patient Education

During prenatal care, the clinician and patient will discuss common events and procedures in labor, including methods of assessing fetal well-being.

Admission to Labor and Delivery

The responsible clinician or designee shall evaluate the patient, enter anote, and provide orders within two hours of his or her patient arriving at the Labor and Delivery unit.

If the patient is not in active labor, and is low risk as noted as a combination of these factors:

— 37-41 weeks gestation

— appropriate weight for gestational age

— has a Category I electronic fetal monitoring strip on admission, or a reassuring auscultation and a note written by the clinician if she (patient) refuses electronic fetal monitoring

— absence of moderate or thick meconium

— vertex presentation

— absence of any medical obstetrical complications

Then, initial assessment can be delayed until any of the following occur

— a risk factor is identified

— the patient enters active labor

— the patient requests pain medication

Larkin ReWrite for this OB Policy is on the next page

Labor & Delivery—Assessment and Monitoring

The Talk

As our care begins, the clinician and patient should talk—discussing:

- what normally happens during labor and delivery
- how we will monitor the baby's health

First Assessment

During the first assessment, the clinician (or someone appointed by the clinician) should do 3 things:

1. Evaluate the patient
2. Write a note explaining anything important
3. Write the orders showing how we will treat this patient

2:00:00

This first assessment should happen within 2 hours.

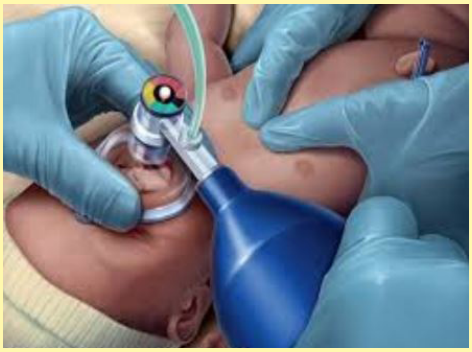
The 2 hours begins when the patient first arrives at Labor & Delivery.

Delaying the First Assessment

Sometimes the first assessment can be delayed beyond the first 2 hours.

The first assessment can be delayed if the patient is:

- not in active labor
  and
- low risk



Don't Delay the 1st Assessment Unless You Could Check All Six Boxes

Low Risk Means You Could Check All 6 Boxes

☐	baby's age	Gestation is between 37 and 41 weeks.
☐	mother's weight	Appropriate weight considering the gestational age.
☐	fetal monitoring	Category I electronic fetal monitoring strip on the mother during admission... or Auscultation with a good result. With auscultation, the clinician regularly listens to the fetal heartbeat with a special stethoscope or some other instrument. If the mother refuses the electronic fetal monitoring, the clinician can use the auscultation. However, the clinician must write a note documenting the good auscultation result.
☐	meconium	There is no moderate or thick meconium. Moderate or think meconium is a problem. Only check the box if the meconium, baby's feces, is NOT moderate or thick.
☐	vertex presentation	Baby is head down in the birth canal.
☐	no complication	There are no medical or obstetrical complications.

When the Delay Must End

If any of these things happen:

- a risk factor appears
- patient begins active labor
- patient requests pain medication

Stop the Delay—Begin 1st Assessment

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Author:	Web Location:			

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	Health, Safety and Environment Manual Laboratory Safety (Hospital):	Policy Number	
		Last Review Date	
	Subject Medical Waste Disposal	page	

II DEFINITIONS/GUIDELINES

Other potentially infectious material (OPIM) is defined as:

a. The following human body fluids:
   i. Amniotic fluid;
   ii. A body fluid that is visibly contaminated with blood;
   iii. A body fluid that cannot be readily identified;
   iv. Cerebrospinal fluid;
   v. Pericardial fluid;
   vi. Peritoneal fluid
   vii Pleural fluid;
   viii. Saliva only when dental procedures are performed;
   ix. Semen;
   x. Synovial fluid, and
   xi. Vaginal secretions;
b. A Tissue or organ from a living or dead human, not incluidng intact skin, that has not been preserved by a chemical additive or preservative;
c. The following human immunodeficiency virus. hepatitis B virus, or hepatitis C virus related items:
   i. HIV containing cell, tissue, or organ cultures;
   ii. HIV Hepatitis B, or Hepatitis C containing media or other solutions; and
   iii. Blood, organs, or other tissues; and
d. Microbiological laboratory waste.

Breast milk, when discarded, should be considered OPIM and disposed of approproately.

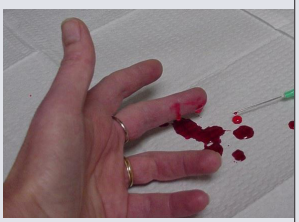
Please note that the mere presence of blood or OPIM on an article does not make it Medical Waste. An article must be contaminated with blood or OPIM and be capable of releasing it during handling. If you are unsure about whether an article is so contaminated that it will release blood or OPIM during handling be conservative and dispose of it as Medical Waste.

Larkin ReWrite for this Medical Waste Policy is on the next page

Medical Waste

OPIM Waste

Other
Potentially
Infectious
Material



You must put all this medical waste into red bag containers.

Body Fluids	
amniotic (fluid surrounding the unborn baby during pregnancy)	pleural fluid (fluid surrounding the lungs)
body fluid contaminated with blood	saliva (only when the saliva comes from an actual dental procedure)
body fluid not identified	semen
cerebrospinal fluid (fluid found in the brain and spine)	synovial fluid (fluid surrounding joints in the body)
pericardial fluid (fluid surrounding the heart)	vaginal secretions

Microbiological Laboratory Waste
throwing away things like...
infectious cultures
specimens
vaccines
disposable devices used to carry or mix infectious cultures

Tissues & Organs
tissues and organs from a living or dead human
tissues & organs preserved in chemicals are NOT OPIM

Virus
HIV in cell, tissue, or organ cultures
HIV in media or other solution
Hepatitis B in media or other solutions
Hepatitis C in media or other solutions
any of these viruses in blood, organs, or other tissues

Breast Milk
Throwing away breast milk? Put in red bag container.

~~Sharps~~ NOT Into the Red Bag
~~Do NOT put needles and other sharps in red bag containers.~~
~~The person emptying the red bag could be stuck.~~

~~OPIM~~ NOT Into the Red Bag
~~Only put things into the red bag container that are saturated or contaminated with OPIM.~~
~~Dots or sprinkles of OPIM do not need to go into the red bag container.~~
~~Put things in red bag containers when the OPIM could leak or drip out onto someone handling the bag.~~
Not sure? Put it in the red bag.

Hospital Policy Manual	
Policy Number:	
Effective Date:	

MANAGEMENT OF VIOLENT AND/OR COMMITTED PATIENTS

PURPOSE

To provide guidelines for the management of violent and/or committed patients who present to the hospital with an Order of Protective Custody, an Emergency Commitment, a judicial commitment, and/or those patients who are violent.

POLICY

1. When violent and/or committed patients are brought to the hospital or clinic, responsibility for examination, psychiatric evaluation and appropriate disposition of the patient is placed directly on the hospital. State law regarding Emergency Commitment (PEC) and Order of Protective Custody (OPC) relieves the police of any responsibility for the patient when the patient is delivered to a medical treatment facility. Therefore, if the patient is injured, leaves the hospital prior to evaluation, or injures someone else because we failed to meet obligations imposed upon the Medical Center by statute, the hospital may be individually and jointly liable for any injury or damage, which occurs.

2. These patients may enter the system in the following ways:

   a. Written order of the judge (commitment paper or emergency certificate) OPC; the patient with an order of protective custody (OPC) must be presented to the healthcare facility within 12 hours for evaluation. The medical staff must then complete the patient's evaluation within 8 hours after arrival.
   b. Request for protective custody by an official law officer/healthcare provider (RPC); "An official law officer may take a person into protective custody and transport him for medical evaluation when he has reasonable grounds to believe...that the person is acting in a manner dangerous to himself or others" (R.s. 28:53). A request for protective custody (RPC) must be completed with date, time, and signature of presenting officer.
   or
   c. Referred by physician emergency certificate (PEC);

3. If the patient is in custody, the law enforcement officers shall remain with the patient at all times (reference Prisoner Policy 2.20).

4. The police shall be notified and shall screen the patient for contraband. The Nursing and Medical Staff persons at the scene are responsible for subduing a violent or combative patient. If they are unable to do so, the police may be called to assist. Responsibility for medical management of a patient, including restraint when required, always rests with the clinic/emergency personnel.. The role of the police is assistance.

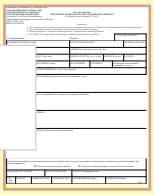
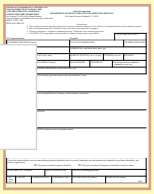
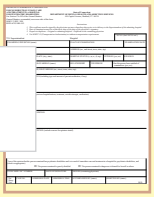
Larkin ReWrite for this Committed Patient Policy is on the next page

Committed Patients — Violent Patients

Holding a Patient Against His/Her Will

Sometimes we are required to hold a patient here even if he or she wants to leave.

Three—and only three—documents allow us to keep a patient against his/her will.

Document	Who Completes/Signs the Document	Important to Know
 Order of Protective Custody	*Order of Protective Custody* is signed by a Judge. 	After the judge signs the order, the police have 12 hours to bring the patient to us. Once the patient arrives, we have 8 hours to complete our medical evaluation.
 Request for Protective Custody	*Request for Protective Custody* is signed by a official law officer or healthcare worker. 	An official law officer or healthcare worker may bring a patient directly to our hospital. The official law officer or healthcare worker must complete the *Request for Protective Custody*, including: • date • time • signature The form says the patient is a danger to himself/herself or to other people.
 Physician Emergency Certificate	*Physician Emergency Certificate* is signed by a physician. 	A physician, inside or outside our hospital, may complete a *Physician Emergency Certificate.* The form says the patient is a danger to himself/herself or to other people.

We are Responsible for the Patient

Hospital staff—not the police—are responsible for the committed patient.

The hospital is legally liable if that committed patient:

- hurts himself or hurts other people
- leaves the hospital before we finish our medical evaluation

Prisoners Need Police

A patient who is a prisoner (convicted of a crime and under state custody) must have a law enforcement officer with him or her all the time (24/7).

Controlling a Violent Patient

We, nursing and medical staff, are responsible for controlling a violent patient.

If we cannot control the patient, we should call the police. Police will search the patient to see if he or she is carrying anything illegal.

But remember, we are still in control of the patient's medical treatment and how he or she is restrained.

The police are only there to assist us.

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Author:	Web Location:			

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CHRONIC PAIN PROGRAM PROTOCOL

Purpose:
To establish guidelines for initial visit and subsequent visits for patients presenting with chronic pain.

Criteria for Referral to Chronic Pain Program:

- Patient identified as a chronic pain patient by:
  - History/frequent patient visits: two visits in one year for the same complaint or three visits in one year for any pain-related complaints.
  - Controlled Substance Prescription Monitoring Program: more than five narcotic or benzodiazepine prescriptions written by more than one facility.

Initiation of Chronic Pain Program Protocol:

- Once criteria met, patient is referred to the program by the emergency caregiver (EC) provider. Program explained to the patient by EC provider using AIDET, and that Case Management will be in to speak with them for further assistance.
- Case Management consulted by EC provider
  - CM meets with the patient using AIDET to explain the program.
  - Provides list of referrals for PCP/Pain Mgt if needed, education of importance for patient to follow-up with current primary care physician (PCP) or list of referrals.
  - Patient provided "Opioid Analgesic and Sedatives Guidelines" and patient letter.
  - If patient has a PCP or Chronic Pain Physician, letter prepared to this physician.

Treatment Plan for Patients in Chronic Pain Program:

Visit One

Patient's acute pain treated by EC provider as deemed appropriate, no Dilaudid or Fentanyl.
Up to ten narcotic or benzodiazepine tablets prescribed by the EC physician for outpatient care.

Visit Two

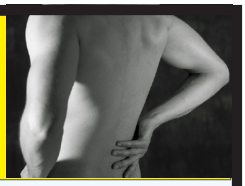
Patient's acute pain treated by EC physician as deemed appropriate, no Dilaudid or Fentanyl.
Up to five narcotic or benzodiazepine tablets prescribed by EC provider for outpatient care.

Visit three and any subsequent visits:

Patient's acute pain may be treated up to two narcotic pain medication tablets.
EC provider may offer further care without other narcotics or benzodiazepines.
No outpatient prescription given.

Larkin ReWrite for this Chronic Pain Policy is on the next page

Chronic Pain Program—Referring a Patient



When to Refer Your Patient to Our Chronic Pain Program

Your Patient Belongs in the Chronic Pain Program If the Patient Has....	
☑	2 visits in one year for the same pain complaint
	OR
☑	3 visits in one year for any pain complaints
	OR
☑	*Controlled Substance Prescription Monitoring Program* (CSPMP) — Arizona State Board of Pharmacy, Controlled Substances Prescription Monitoring Program Look up patient in the CSPMP - click this link If all three are true - then refer this patient to our Chronic Pain Program ☑ more than one facility is writing prescriptions for this patient ☑ facilities have written 6 or more prescriptions for this patient ☑ prescriptions are for narcotics or benzodiazepine

Don't check this box unless all 3 of these are true.

Introducing Your Patient to Our Chronic Pain Program

Remember:
Use AIDET when talking to patients

AIDET
- Acknowledge
- Introduce
- Duration
- Explanation
- Thank You

Emergency Caregiver (EC) explains the program to the patient

EC describes the patient to the Case Manager at our Chronic Pain Program

Case Manager also explains our program to the patient

Case Manager gives the patient these four documents:

- Patient Letter Chronic Pain Program
- Guidelines Opioid Analgesic & Sedatives
- List of Referrals (PCP and Pain Management)
- Letter to PCP Explaining Our Chronic Pain Program

If patient already has a PCP

Treatment Plan for Patients in Our Chronic Pain Program

Visit #1

EC provider uses his/her judgment to treat the acute pain.

STOP No Dilaudid

STOP No Fentanyl

EC physician may prescribe up to ⑩ narcotic or benzodiazepine tablets for outpatient care.

Visit #2

EC physician uses his/her judgment to treat the acute pain.

STOP No Dilaudid

STOP No Fentanyl

EC physician may prescribe up to ⑤ narcotic or benzodiazepine tablets for outpatient care.

Any Visits After #2

EC provider may treat patient's acute pain with up to 2 narcotic pain medication tablets.

EC provider may offer further care without any more narcotics or benzodiazepines.

No prescription for outpatient care

Document Name: Chronic Pain Program	Document #: 2302	Effective Date: 2 Jan 2016	Date for Review: 2 Jan 2019	Version: #3
Author: Director for the Chronic Pain Program	Web Location:			

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Why Larkin ReWrite is Easier to Understand

Our Writing is Simpler

Lower Grade Level Complexity

The average hospital policy is written at grade level 14 — only 17% of adults can read at grade level 14.

The average *Larkin ReWrite* is written at grade level 8 — 50% of adults can read at grade level 8.

How We Lower the Grade Level

The more frequently a word is used in a language, the easier it is to understand.

"Tell" is the 103rd most frequently used word in the English language.

"Instruct" is the 4,286th most frequently used word in the English language.

"Tell" is understood more quickly than "Instruct".

We lower the grade level by using:
- words with higher frequency of use
- shorter sentences with fewer words
- shorter paragraphs with fewer sentences

We Do Not "Dumb Down" Documents

We do not make a document easier to understand by removing difficult content.

We do not:
- remove any content from the document or
- add any content to the document

We only say it more simply.

Topics are Represented as Objects

Objects are Easier to Understand

Concepts are difficult to understand—objects are easier.

A good explanation takes an abstract concept and re-describes the concept as a real thing.

This is why good teachers rely so heavily on:
- examples
- metaphors
- stories
- models
- illustrations

All these try to "objectify" the conceptual.

Our graphic design looks at the document content and then represents the major topics as objects.

Text giving details is then boxed and integrated (often with arrows) into the object.

This emphasis on objects makes the document much easier to understand, remember, and follow.

source: Douglas Hofstadter "Analogy as the Core of Cognition"
https://www.youtube.com/watch?v=n8m7lFQ3njk

Laboratory Research: How Objects Improve Memory

People find it much easier remembering objects than remembering concepts.

In the morning, people were shown hundreds of index cards. Later in the day, these people were shown cards and asked if they saw this card in the morning.

Cards with *Names of Objects* (e.g. "Dog") were correctly remembered as much as 200% better than *Concept* cards (e.g. "Animal").

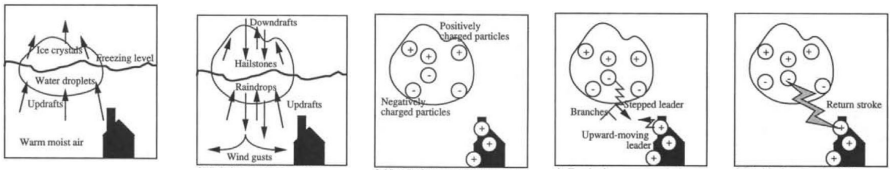
Cards with *Pictures of Objects* (e.g. ) were correctly remembered as much as 800% better than Concept cards (e.g. "Animal").

source: Alan Pavio, "Dual Coding Theory and Education".
http://moodle.up.pt/pluginfile.php/147313/mod_book/intro/paivio.pdf

Student Research: How Objects Improve Understanding

College students took an exam on lightening.

The students given a 48-word description of lightening with 5 crude illustrations (shown below) scored 100% better on the exam than the students given a 600-word description without the illustrations.



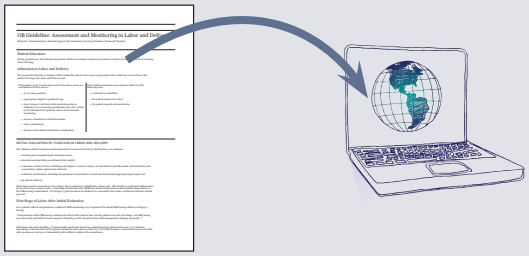
1. Warm moist air rises, water vapor condenses and forms clouds.
2. Raindrops and ice crystals drag air downward.
3. Negatively charged particles fall to bottom of cloud.
4. Two leaders meet, negatively charged particles rush from cloud to ground.
5. Positively charged particles from the ground rush upward along the same path.

source: Richard Mayer, University of California at Santa Barbara
http://webcache.googleusercontent.com/search?q=cache:z7d1dPbvTGMJ:visuallearningresearch.wiki.educ.msu.edu/file/view/mayer,%2520et%2520al%2520%281996%29.pdf+&cd=1&hl=en&ct=clnk&gl=us

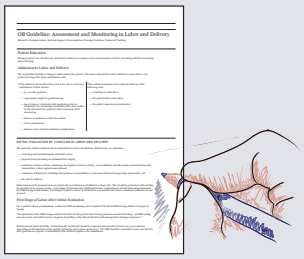
Larkin ReWrite combines simpler writing with major topics represented as objects.
The typical increase in comprehension is between 100% and 600%.

Overview - Larkin ReWrite - How It Works

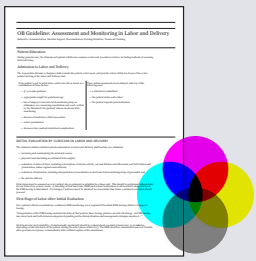
1. You upload your document from our website (see pg. 13)



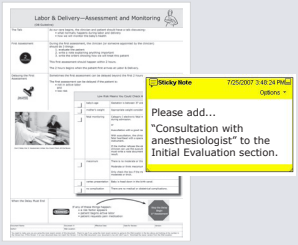
2. We rewrite your document (see pg. 14)



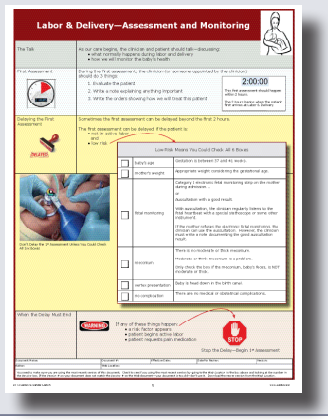
3. We add graphic design to your document (see pg. 15)



4. We return the document to you for any changes (see pg. 16)

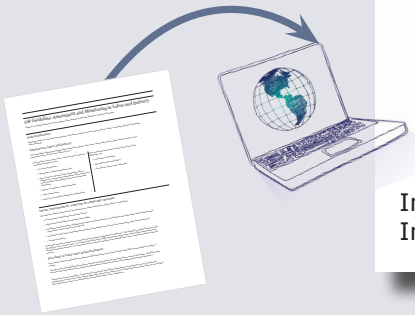


5. We insert your changes and return the easier-to-read document (see pg. 17)



1. Uploading Your Document

Upload your document



- Go to our website www.Larkin.Biz
- Go to our Larkin ReWrite Page
- Click button at bottom of page "Upload"
- Complete the form
- Hit "submit"

Immediately you will receive a message saying we got your document. In 24 hours, you will receive an email with invoice.

Or, send us an email.

Attach your document to the email.

In 24 hours, you will receive a return email with an invoice attached.

No commitment

Uploading or emailing a document to us does not imply any commitment on your part.

We do not start rewriting your document until you agree to pay the invoice amount and ask us to begin rewriting.

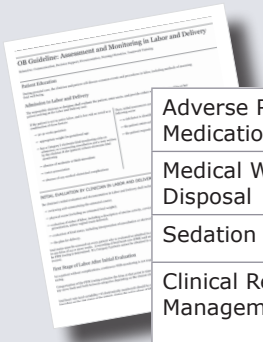
Confidentiality

We will return your original document to you at any time.

We will not release your original document or our rewrite of your document to anyone but you (or someone you authorize to receive the document).

If others, inside or outside your company, ask to see your original or our rewrite, the answer is no, unless we receive permission from you.

Typical healthcare policies we rewrite:



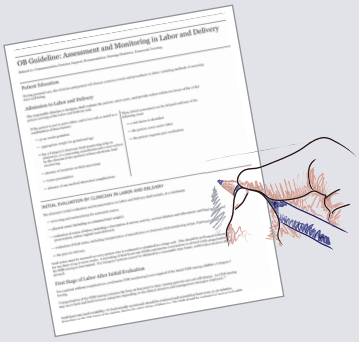
Adverse Reaction to Medication	MRSA Policy	Patient Restraint	Bloodborne Pathogen Exposure
Medical Waste Disposal	Patient Fall Management	Hand Hygiene	Cryogenic Liquids
Sedation	Radiation Safety	Infection Control	Patient Death
Clinical Records Management	Tissue Procurement, Storage, and Disposition	Laser Safety	Return/Disposal of Human Body Parts
Patient/Visitor Complaint	Laboratory Safety	Resuscitation/Not for Resuscitation	Medicine Management

2. We ReWrite Your Document

We Do Not Remove Any Content

We Do Not Add Any Content

We Just Say It More Simply



Original Document

3.0 Radiographic Shielding

3.11 Gonadal shielding of not less than 0.25 mm lead equivalent shall be used for patients who have not passed the reproductive age during radiographic procedures in which the gonads are in the direct (useful) beam, except for cases in which this would interfere with the diagnostic procedures.

Grade level 23
less than 1% of adults can read at that grade level

Larkin ReWrite

Radiographic Shielding

Is your patient young enough to have children (still in childbearing years)?

Are the patient's reproductive organs in the direct (useful) radiographic beam?

If you answer "yes" to both questions—you must put a gonadal shield on the patient.

The thickness of the gonadal shield must be at least 0.25 mm (lead equivalent).

A gonadal shield is not necessary if the patient's reproductive organs are part of the diagnostic procedure.

Grade level 9
43% of adults can read at that grade level

Original Document

Fetal Monitoring Apparatus

1.2. Each hospital shall provide and maintain appropriate fetal monitoring apparatus to meet the needs of its patients. Accommodations for preserving all electronic fetal monitoring tracings is also the responsibility of the institution, with special consideration and allocation of resources to assure permanent and secure preservation of fetal monitoring tracings (antenatal and intrapartum) for all babies born with five minute Apgar scores of 4 or less. If copies of electronic fetal monitor strips are kept, then preservation and storage of paper fetal monitoring strips is not necessary

Grade level 19
2% of adults can read at that grade level

Larkin ReWrite

Fetal Monitoring Equipment

Your patients need fetal monitoring equipment and your hospital must have it. Also, your hospital must keep all fetal monitoring tracings.

BE CAREFUL...

Does the newborn have a 5-minute Apgar score of 4 or less?

If yes, you need to be especially careful to keep the baby's fetal monitoring tracings. You must keep the tracings before birth (antenatal) and the tracings during birth (intrapartum).

If you keep the electronic tracings, you may throw away the paper ones.

Grade level 9
43% of adults can read at that grade level

3. We Add Graphic Design

OB Guideline: Assessment and Monitoring in Labor and Delivery

Related to: Communication, Decision Support, Documentation, Nursing Obstetrics, Teamwork Training

Patient Education

During prenatal care, the clinician and patient will discuss common events and procedures in labor, including methods of assessing fetal well-being.

Admission to Labor and Delivery

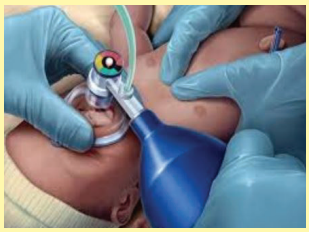
The responsible clinician or designee sh
patient arriving at the Labor and Delive

If the patient is not in active labor, and
combination of these factors:

- 37-41 weeks gestation
- appropriate weight for gestationa
- has a Category I electronic fetal n
  admission, or a reassuring auscul
  by the clinician if she (patient) re
  monitoring
- absence of moderate or thick mec
- vertex presentation
- absence of any medical obstetrica

Labor & Delivery—Assessment and Monitoring

The Talk	As our care begins, the clinician and patient should talk—discussing: • what normally happens during labor and delivery • how we will monitor the baby's health
First Assessment 	During the first assessment, the clinician (or someone appointed by the clinician) should do 3 things: 1. Evaluate the patient 2. Write a note explaining anything important 3. Write the orders showing how we will treat this patient 2:00:00 This first assessment should happen within 2 hours. The 2 hours begins when the patient first arrives at Labor & Delivery.
Delaying the First Assessment 	Sometimes the first assessment can be delayed beyond the first 2 hours. The first assessment can be delayed if the patient is: • not in active labor and • low risk



Don't Delay the 1st Assessment Unless You Could Check All Six Boxes

Low Risk Means You Could Check All 6 Boxes		
☐	baby's age	Gestation is between 37 and 41 weeks.
☐	mother's weight	Appropriate weight considering the gestational age.
☐	fetal monitoring	Category I electronic fetal monitoring strip on the mother during admission... or Auscultation with a good result. With auscultation, the clinician regularly listens to the fetal heartbeat with a special stethoscope or some other instrument. If the mother refuses the electronic fetal monitoring, the clinician can use the auscultation. However, the clinician must write a note documenting the good auscultation result.
☐	meconium	There is no moderate or thick meconium. Moderate or think meconium is a problem. Only check the box if the meconium, baby's feces, is NOT moderate or thick.
☐	vertex presentation	Baby is head down in the birth canal.
☐	no complication	There are no medical or obstetrical complications.

When the Delay Must End	 If any of these things happen: • a risk factor appears • patient begins active labor • patient requests pain medication  Stop the Delay—Begin 1st Assessment

Document Name:	Document #:	Effective Date:	Date for Review:	Version:
Author:	Web Location:			

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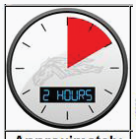
4. We Return The Document To You For Any Changes

Labor & Delivery—Assessment and Monitoring

The Talk	As our care begins, the clinician and patient should talk—discussing: • what normally happens during labor and delivery • how we will monitor
First Assessment	During the first assessment should do 3 things: 1. Evaluate the patient 2. Write a note explaining 3. Write the orders sh (ed by the clinician)
Delaying the First Assessment	Sometime The first a • not and • low ed beyond the first 2 hours. ient is:



Sticky Note 7/25/2007 3:48:24 PM Options
Please change this time to:
"approximately two hours"

2:00:00

This first assessment should happen within approximately 2 hours.

The 2 hours begins when the patient first arrives at Labor & Delivery.

Sticky Note 7/25/2007 3:48:24 PM Options
Would you replace this infant photo with the new one attached to the PDF.

Don't Delay the 1st Assessment Unless You Could Check All Six Boxes

		Means You Could Check All 6 Boxes
☐	baby's age	Gestation is between 37 and 41 weeks.
☐	mother's weight	Appropriate weight considering the gestational age.
☐	fetal monitoring	Category I electronic fetal monitoring strip on the mother during admission... or Auscultation with a good result. With auscultation, the clinician regularly listens to the fetal heartbeat with a special stethoscope or some other instrument. If the mother refuses the electronic fetal monitoring, the clinician can use the auscultation. However, the clinician must write a note documenting the good auscultation result.
☐	meconium	There is no moderate or thick meconium. Moderate or think meconium is a problem. Only check the box if the meconium, baby's feces, is NOT moderate or thick.
☐	vertex presentation	Baby is head down in the birth canal.
☐	no complication	There are no medical or obstetrical complications.

Sticky Note 7/25/2007 3:48:24 PM Options
Please add "nulliparity" to list immediately after "a risk factor appears".

When the Delay Must End	 If any of these things happen: • a risk factor appears • nulliparity (the woman's first delivery) • patient begins active labor • patient requests pain medication  Stop the Delay—Begin 1st Assessment

Document Name:	Document #:	Effective Date:	Date for Review:	Version:
Author:	Web Location:			

You need to make sure you are using the most recent version of this document. Check to see if you using the most recent version by going to the *Web Location* in the box above and looking at the number in the *Version* box. If the *Version* # on your document does not match the *Version* # on the Web document—your document is too old—don't use it. Download the newer version from the *Web Location*.

Labor & Delivery—Assessment and Monitoring

The Talk

As our care beg… REQUESTED CHANGE INSERTED HERE …ould talk—discussing:
- what norr…
- how we w… delivery

First Assessment

During the first assessment, the clinician (or someone appointed by the clinician) should do 3 things:

1. Evaluate the patient
2. Write a note explaining anything important
3. Write the orders showing how we will treat this patient

2:00:00

This first assessment should happen within approximately 2 hours.

The 2 hours begins when the patient first arrives at Labor & Delivery.

Delaying the First Assessment

Sometimes the first assessment can be delayed beyond the first 2 hours.

REQUESTED PHOTO INSERTED HERE

…t can be delayed if the patient is:
…labor

Don't Delay the 1st Assessment Unless You Could Check All Six Boxes

Low Risk Means You Could Check All 6 Boxes		
☐	baby's age	Gestation is between 37 and 41 weeks.
☐	mother's weight	Appropriate weight considering the gestational age.
☐	fetal monitoring	Category I electronic fetal monitoring strip on the mother during admission... or Auscultation with a good result. With auscultation, the clinician regularly listens to the fetal heartbeat with a special stethoscope or some other instrument. If the mother refuses the electronic fetal monitoring, the clinician can use the auscultation. However, the clinician must write a note documenting the good auscultation result.
☐	meconium	There is no moderate or thick meconium. Moderate or think meconium is a problem. Only check the box if the meconium, baby's feces, is NOT moderate or thick.
☐	vertex presentation	Baby is head down in the birth canal.
☐	no complication	There are no medical or obstetrical complications.

REQUESTED CHANGE INSERTED HERE

When the Delay Must End

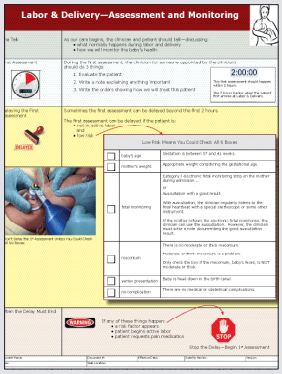
If any of these things happen:
- a risk factor appears
- nulliparity (the woman's first delivery)
- patient begins active labor
- patient requests pain medication

Stop the Delay—Begin 1st Assessment

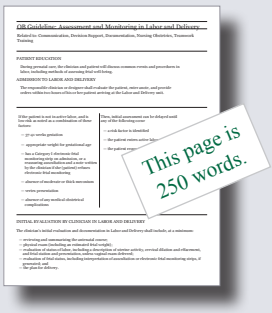
Document Name:	Document #:	Effective Date:	Date for Review:	Version:
Author:	Web Location:			

You need to make sure you are using the most recent version of this document. Check to see if you using the most recent version by going to the *Web Location* in the box above and looking at the number in the *Version* box. If the *Version* # on your document does not match the *Version* # on the Web document—your document is too old—don't use it. Download the newer version from the *Web Location*.

Prices



Price Per Page				
Complexity	*Typical Grade Level*	*Typical Examples**	*Price*	Price Includes: ✔ rewrite the page ✔ add graphic design
High	15 and above	Radiation Safety Cryogenic Liquids Laser Safety	US$360 each page	
Medium	12-14	Sedation PAPR Respiratory Devices Withholding Life-Sustaining Treatment	US$270 each page	
Low	11 and below	Prisoner Patients Emergency Evacuation Stuck or Splashed Reporting	US$180 each page	
*Examples show typical complexity for those topics. The examples are only a guide. Sometimes relatively simple topics are written with very high complexity. More rarely, difficult topics are written simply. Your invoice will show the complexity rating of your document and the price per page.				

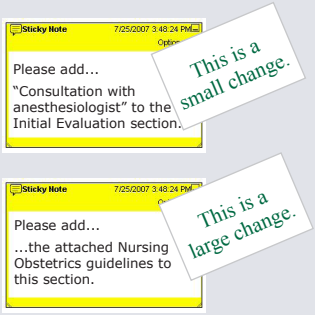


What is a Page?

A page is 250 words.

After you give us your document (uploaded from our website or attached to an email), we will email you an invoice:

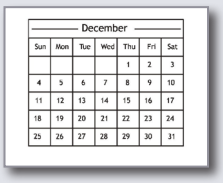
- we count all the words in your document
- we divide the total number of words by 250 (to get the number of pages)
- we determine the document's complexity (high, medium, or low)
- invoice amount is:
  - number of pages x document complexity (US$360, US$270, or US$180)



Price for Changes

Correcting a mistake that we make is no cost.
If you request a small change, cost is US$9.00 each small change.
If you request a large change, cost is US$25.00 to US$50.00 each large change.

What is the difference between a "large" change and a "small" change?
A "small" change means we can make the change without reformatting the page.
A "large" change means we need to reformat one or more pages to make the change.



Turnaround Time

Average turnaround time is 10 business days.

What does "turnaround" mean?
10 business days after we receive payment—we return the document to you for any changes.

Payment Methods

- online using credit card (pay on our website: www.Larkin.biz)
- check sent in the mail (details in our invoice)
- electronic direct deposit into our bank account (details in our invoice)
- our rewrite will not be released until the payment is complete

What To Do Next

Call Us

Since 1985, we have been helping large companies improve communication with employees.

We can talk about any of your employee communication needs.

You may schedule a telephone call or conference call for no charge.

Our phone number is: 1-212-860-2939

Email Us

You may send us an email at: Larkin@Larkin.Biz

Learn More

Our Website has information about our:

- papers (free downloads)
- book: *Communicating Change* (McGraw-Hill)
- video clips: TJ's presentations
- biography: Dr TJ Larkin & Sandar Larkin

Visit: www.Larkin.Biz

Our Services

Presentation	1-3 hours	TJ shows communication best practice: • theory • research • examples TJ shows how to use communication to create employee behavior change. See video samples on our website.
Workshop	6 hours	More hands on, TJ and a small group practice applying communication best practices to your documents.
Implementation	2 weeks	TJ moves in-house, joins a project team, and together they work on a major communication campaign.

Email us for fees (Larkin@Larkin.Biz)

Dr TJ Larkin & Sandar Larkin

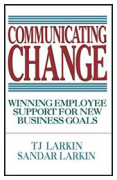
Dr TJ Larkin and Sandar Larkin began Larkin Communication Consulting in 1985.

The Larkins help large companies improve communication with employees.

Two specialties

Communicating Safety	*Communicating Major Change*
Healthcare Oil & Gas Mining Chemicals	new technology mergers outsourcing benefit changes restructuring

Larkin's publications include

Book 	*Communicating Change*, McGraw-Hill, New York.
Harvard Business Review 	"Reaching and Changing Frontline Employees," *Harvard Business Review*.

TJ's background

Ph.D. Communication (Michigan State University)
M.A. Sociology (University of Oxford)

Sandar's background

Before starting Larkin Communication Consulting in 1985, Sandar worked for the Long Term Credit Bank of Japan.

Contact information:

Larkin Communication Consulting
230 Park Avenue, Suite #1000
New York, New York 10169
USA

phone 1-212-860-2939
email Larkin@Larkin.Biz
web www.Larkin.Biz