Caring Headlines
January 7, 2010

MGH gets into the holiday spirit with charitable giving, seasonal singing, and some really cool *hats!*

The newsletter for Patient Care Services
Massachusetts General Hospital

Members of the Chaplaincy, together with MGH staff and visitors, hold holiday songfest in the Main Corridor (back), while members of the PCS Diversity Committee collect gifts for their annual initiative to support the HAVEN Program and families affected by domestic violence.

2010 strategic plan

building on a solid foundation of excellence and a commitment to patient- and family-centered care

MGH Mission: Guided by the needs of our patients and their families, we strive to deliver the very best health care in a safe, compassionate environment; to advance that care through innovative research and education; and to improve the health and well-being of the diverse communities we serve.

As we embark on a new year, I'm thrilled to share Patient Care Services' strategic plan for 2010. In articulating our goals for the future, and on the heels of one of the most successful Joint Commission visits ever, we're building on that momentum and focusing our efforts on quality, safety, and service. Our strategic goal for 2010 is to improve the patient, family and employee experience by:

- improving clinician and support staff communication with patients and families
- improving responsiveness
- improving the cleanliness of the hospital
- eliminating patient falls
- eliminating hospital-acquired pressure ulcers
- enhancing utilization of evidence-based practice to promote safety

Our tactics in achieving these goals will be multi-faceted, multi-disciplinary, and require the support and participation of every member of Patient Care Services. A significant number of initiatives are already in place to advance this work, and more will be rolled out as we fine-tune our objectives.

Improving communication with patients and families is paramount. We want to ensure that all patients and family members are treated with courtesy and respect. Hourly rounding, which has already been adopted on some units, is one way to enhance both communication and responsiveness. We're seeing that the un-scripted, 7-P approach (rounding regularly to assess Person, Plan, Priorities, Personal hygiene, Pain-management, Position, and Presence) helps build rapport, has a reassuring effect on patients, and contributes to patient safety. We're convening an inter-disciplinary

Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse

team to look at ways to roll this approach out to the wider hospital community.

Our patient and family advisory councils are en excellent source of feedback in helping us understand how to better communicate with patients and be more responsive to their needs. Our Greeter Program is a wonderful vehicle for interacting with patients and families, making them feel welcome, and getting a first-hand sense of their experience in the hospital. Social Services is developing a program to speed access to mental-health services for patients referred to MGH; Physical and Occupational Therapy has created a call center to improve responsiveness and access to outpatient services.

Eliminating (not just reducing) patient falls and hospital-acquired pressure ulcers is an ambitious goal. We wanted to be bold. Many units are having great success in this area, and we'll be sharing best practices to take full advantage of this evidence-based learning. In collaboration with Nursing, Occupational Therapy is exploring sensory modalities to help prevent falls among patients experiencing confusion or dementia. Physical Therapy has amended its documentation to include information on mobility so that appropriate in-

continued on next page

terventions can be employed to prevent falls. Physical therapists have presented fall-prevention seminars to elders in the community and through our own Senior HealthWise lecture series. Our 65-*plus* program has implemented unit-based, geriatric, educational programs to help promote optimal care for older patients, including fall- and pressure ulcer-prevention.

When we talk about improving the cleanliness of the hospital, I want to be clear that this is not solely the responsibility of our unit service associates. This is a Patient Care Services goal, and we all share responsibility. We've already made great progress in this area. The recent re-design of the operations manager role brought more focused attention to the environment of care. We developed and implemented a new training program to augment that re-design. We're providing better tools (mop heads, micro-fiber cleaning cloths, re-configured cleaning carts, etc.) to ensure our efforts are producing optimal results. We're re-visiting some of the tasks once assigned to unit service associates to limit the time they spend away from the unit and make better use of time spent on the unit. And we're piloting an electronic tool—a small, hand-held device (similar to a PDA) that will automate the process of evaluating room-cleanliness.

One tactic that addresses cleanliness, communication, *and* responsiveness, is a practice we're implementing where unit service associates will introduce themselves and ask whether it's a good time to clean when they enter a patient's room. They'll leave signed and dated cards in bathrooms noting each time the room is cleaned, and in the patient's absence, they'll leave tent cards letting them know their room has been cleaned.

As Richard Bluni of the Studor Group reminded us during a recent visit, quality and safety *is* the patient experience. By vigilantly attending to quality and safety, we can't help but improve clinical and operational outcomes, and by extension, the patient experience. We will continue our on-going efforts to promote safety through proven, effective methods and evidence-based practice.

All of our tactics and strategies are intrinsically linked to ensure that patients and families experience the best possible care. I look forward to working with you as we execute our 2010 strategic plan, and I welcome your feedback and suggestions as we move forward.

As Richard Bluni of the Studor Group reminded us during a recent visit, quality and safety is the patient experience. By vigilantly attending to quality and safety, we can't help but improve clinical and operational outcomes, and by extension, the patient experience. We will continue our on-going efforts to promote safety through proven, effective methods and evidence-based practice.

Updates

I am happy to announce that Meghan Fitzgibbons has assumed the role of volunteer coordinator, replacing Kathy Clair Hayes, LICSW, who left in November to work with the newMGH-Boston Red Sox Home Base Program.

Cathie Harris, RN, has accepted the position of Pediatric clinical nurse specialist in the Emergency Department.

Tom Blanchard, RN, has accepted the position of clinical nurse specialist for the Blake 9 Cardiac Catheterization Lab.

And Barbara Cashavelly, RN, has accepted the nursing director position for the Phillips 21 General Medical Unit, effective January 25, 2010.

Welcome all.

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Celebrating MGH volunteers

—by Meghan Fitzgibbons, volunteer coordinator

In December, the MGH community celebrates Volunteer Pin Week, a time to recognize the efforts of our many volunteers and honor specific milestones in their careers. Think: 'Ether Day' for volunteers.

Of the 1,200 volunteers who donate their time to MGH, more than 150 celebrated milestones this year with more than 97,000 hours of service. One volunteer, Jim Gillespie, received his 9,000-hour pin. Gillespie volunteers on the Yawkey 8 Infusion Unit where he visits with, and delivers lunches to, chemotherapy patients. Says Gillespie, "I love the people I work with. Patients appreciate the littlest things we do for them. It gives me great pleasure to know I'm helping someone. I got so much in life. It's nice to be able to give a little back."

MGH volunteers (back row, l-r): Anissa Bernardo (100 hours), Derek London (100 hours), Claudine Kouegbe (100 hours), Kathy Rehm (5,000 hours), Peggy Scott (2,000 hours), and Jim Gillespie (9,000 hours) (Seated): Karen Lambert (500 hours), Charlie McCarthy (5,000 hours), Michael Kemper (100 hours), and Carla Trodella (100 hours).

Sheena Smead, administrative operations manager says, "Jim is a fixture on our unit, so kind and focused on patients. He really listens."

Staff nurse, Stefanie Walsh, RN, adds, "Jim is an invaluable asset. He is compassionate and caring to all patients; he never fails to have a smile or a kind word."

Says nursing director, Joanne Lafrancesca, RN, "Jim is loved by patients and staff. He has a special gift for caring complemented by the best sense of humor ever."

Volunteer, Kathy Rehm, a liaison in the Gray Family Waiting Area, received her 5,000-hour pin this year. Says Rehm, "The best part of volunteering at MGH and what keeps me coming back are the people—patients from around the world and the amazing caregivers, support staff, and volunteers. It truly is a privilege to be a part of this organization."

More than 650 volunteers serve on a weekly basis. They serve in a number of ways throughout the hospital: as patient escorts, as pet-therapy handlers, or supporting staff in the Same Day Surgical Unit, Emergency Department, Cancer Center, pediatric units, and patient education centers. They visit patients with book carts or just provide a smile or some welcome company. Still others serve as Eucharistic ministers via a collaborative relationship with the Chaplaincy.

Volunteers (high-school students, college students, working adults, and retirees) selflessly contribute their time, motivated by nothing more than a desire to make a difference.

Says Paul Bartush, director of the MGH Volunteer Department, "As we work to enhance the patient and visitor experience at MGH, we know it requires the investment of individuals in all role groups. Volunteers contribute in a very meaningful way."

For information about volunteering, please contact volunteer coordinator, Meghan Fitzgibbons at 3-4344.

SICU hosts very special ethics rounds

—by Sharon Brackett, RN, Surgical Intensive Care Unit

Caring for acutely ill patients and their families can present ethical and emotional challenges. For this reason, the PCS Ethics in Clinical Practice Committee has initiated a program of unit-based ethics rounds with the support and guidance of Ellen Robinson, RN, clinical nurse specialist in ethics. Ethics rounds offer facilitated discussion of ethical issues and an opportunity for clinicians of all disciplines to share their concerns in a supportive environment. Some rounds feature guest speakers who offer insight or expertise on a particular topic.

Recently, organ donation was the topic of ethics rounds in the Ellison 4 Surgical Intensive Care Unit. Staff nurse, Sharon Brackett, RN, and New England Organ Bank (NEOB) coordinator, Wendy Valerius, presented a rare panel of guests that included Frank and Johanne Bent, whose son Josh suffered a traumatic brain injury and eventually became an organ donor; and Mike and Nancy Slama. Mike received one of Josh's organs.

Frank and Johanne Bent (left) and Mike and Nancy Slama display blanket/ memory quilt honoring organ donor, Josh Bent.

(Photo provided by staff)

The Bents shared their first-hand experience of being supported through Josh's injury and their decision to honor his wish to be an organ donor. They described their journey as one nobody would choose to take, but one that ultimately had a positive outcome. It was helpful that Josh had made his wish to be an organ donor known, saving his parents that agonizing decision in the midst of their grief.

The Slamas shared their experience as Mike's illness worsened. He had been diagnosed as a teen-ager, and his illness had led to increased disability, frequent hospitalizations, and near-death. Following the transplant, Mike returned to good health and an active life.

For some time, the SICU has offered critically ill young patients fleece blankets that families are free to take when their loved one is discharged or in the event they don't recover. The hope is that blankets will give families comfort and a tangible memory of their child. The Bents were given such a blanket by SICU staff nurse, Ginny Jordan-Hoar, RN. In a poignant moment during ethics rounds, the Bents displayed the blanket, which they had turned into a memory quilt with photos and mementos from Josh's life.

Says Brackett, "There wasn't a dry eye in the house. Seeing these two families together provided an enduring narrative of the positive outcomes that can come from organ donation. Stories like this can bolster staff through the emotional challenges of caring for families facing sudden traumatic injury and contemplating organ donation."

For more information on organ donation, visit the NEOB website at www.neob.org. For information about unit-based ethics rounds or the blanket program, call Sharon Bracket, RN, at 4-5100.

Sometimes nursing means being a trusted confidant

honesty and advocacy go hand-in-hand for radiation oncology nurse

Dr. C is a 62-year-old, neurologist from a neighboring state. He is married and a father of five children. He had come to MGH to discuss options related to a brain tumor.

My name is Jayne Hill, and I am a staff nurse in Radiation Oncology. I've worked at MGH for 26 years and practiced in both inpatient and outpatient settings. In providing comprehensive, holistic care to my patients and their families, every day brings new challenges.

Dr. C is a 62-year-old, prominent neurologist from a neighboring state. He is married and a father of five children. A non-smoker, he was recently diagnosed with stage-IV lung cancer with brain metastasis. He had come to MGH to discuss options related to a brain tumor.

After our initial consultation, it was clear that Dr. C wanted to be intimately involved in his treatment plan. He had extensive knowledge of brain function and was very familiar with the side-effects of whole-brain radiation. As a neurologist, he was extremely concerned about preserving his cognitive abilities.

Traditionally, whole-brain radiation consists of low-dose, fractionated radiation applied to the whole brain to eradicate any outlying microscopic cancer cells. But because Dr. C wanted to do everything possible to minimize damage to the area of his brain that con-

Jayne Hill, RN, staff nurse
Radiation Oncology

trolled cognitive function, he insisted on partial-brain radiation. I knew that radiating only part of the brain, would put Dr. C at risk for allowing the cancer to spread in areas of the brain not radiated. I was sympathetic to his situation, but I also knew this was a significant risk. And so did he.

After extensive discussions with his radiation oncologist, the decision was made to proceed with partial-brain radiation. I was ready to provide support and education regardless of how Dr. C chose to proceed.

I sat with Dr. and Mrs. C and explained the plan of care. Treatments would last three weeks and consist of daily radiation therapy. I gave them information on possible side-effects such as, fatigue, nausea, vomiting, and skin reactions. I assured them that during Dr. C's treatment, they would meet with me and their oncologist every week, and I would assess Dr. C's pain, fatigue, and skin to see how he was tolerating treatment. I ad-

continued on next page

vised them on proper skin care and other relevant issues.

I could see this was going to be a difficult road for them. I let them know they could contact me any time if they had concerns. I wanted to help them through this difficult and frightening time. Knowing that they came from out of state, I arranged for them to meet with a social worker who could provide them with options for temporary housing and help with emotional support.

Dr. C completed his radiation treatment without incident and returned to his practice in his home state. He continued to receive outpatient chemotherapy. Unfortunately, he returned to MGH several months later in very poor condition. His cancer had spread. Mrs. C reported that he was withdrawn and not eating or drinking. Dr. C, usually well-dressed and impeccably groomed, was unshaven and incontinent. His eyes were dull.

I told her if it were my father, I would want to know. I wouldn't want to be planning a honeymoon if my father was dying... Ultimately, Dr. C made it to the wedding, and his son deferred his honeymoon so he could spend more time with his father.

As a nurse, I had to intervene. Mrs. C was frustrated that he wouldn't let her help. I spoke with Dr. C. He confided that, "It's not the cancer that gets me down. It's the sense of emotional weakness and loss of control." I assured him it was okay to feel all those emotions. It was okay to feel sad and helpless—he was dealing with a lot. I asked if he'd like to see our staff psychologist, but he declined.

Dr. C became wheelchair-bound and increasingly dependent on others for assistance with his activities of daily living. He refused any kind of support, and his demeanor remained stoic. I continued to offer outside services such as visiting nurses, social services, and spiritual support, but he continued to insist he didn't need help.

I discussed his situation with his oncologist and we arranged a family meeting. We broached the subject of hospice care, but Dr. C was adamant that his family could give him everything he needed—he didn't need care from 'outsiders.' Mrs. C became overwhelmed and had to be taken to the Emergency Department with chest pains.

Adding to the complexity of the situation, Dr. C's youngest son was planning to get married in two weeks. Mrs. C asked if I thought she should tell her children about the gravity of Dr. C's prognosis. Apparently, they didn't know. I advised her that it would be better for everyone if she didn't have to carry this burden alone. I thought she should be open with her children, that they had a right to know about his deteriorating condition. I told her if it were my father, I would want to know. I wouldn't want to be planning a honeymoon if my father was dying.

I could tell she felt trapped. Mrs. C didn't want to cast a pall over the wedding and what she thought should be a happy occasion. I reminded her that their son was a grown man and capable of making that decision. Ultimately, Dr. C made it to the wedding, and his son deferred his honeymoon so he could spend more time with his father.

As a nurse, I felt I helped this family make some difficult decisions during a devastating time in their lives. Dr. C was able to retain his dignity and attend his son's wedding, and Mrs. C was very appreciative of my support in helping her cope with these life-and-death decisions.

Comments by Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse

Dr. C's decision to receive partial-brain radiation gave Jayne insight into who he was and what was important to him. It informed her care as Dr. C's disease progressed. Jayne recognized that his diminishing independence put a strain on his wife. She took a risk in guiding Mrs. C to talk openly with her children about the severity of Dr. C's illness. Jayne's honesty empowered this family to make informed decisions and gave them some control over a sadly uncontrollable situation.

Thank-you, Jayne.

Evidence-based practice initiative to launch in January

—by Lynda Brandt, RN, project coordinator

The Yvonne L. Munn Center for Nursing Research provides a formal infrastructure to support nursing research from the earliest conceptualization of a research project through grant-submission. The Center boasts a strong foundation of research conducted by staff nurses, clinical nurse specialists, nurse practitioners, and nurse scientists.

MGH nurses have engaged in evidence-based practice for many years, both here at the hospital and through professional organizations. That experience is now laying the foundation for a more widespread initiative in evidence-based practice. Earlier this year, the Division of Nursing in the Bureau of Health Professions awarded a $900,000 grant to advance evidence-based practice among nurses at MGH.

Standing (l-r): Diane Carroll, RN; Liz Johnson, RN; and Lynda Brandt, RN. Seated: Susan Lee, RN; and Carole Foxman.

(Photo provided by staff)

Says, Susan Lee, RN, project director, "This grant will help us teach nurses about evidence-based practice so we can answer those important clinical questions that arise at the bedside." The grant will go toward building an infrastructure to help nurses answer questions like, "What's the best way to prevent falls?" and then synthesize that knowledge into practice.

Lee, a nurse practitioner, was driven to this idea when preparing a recent lecture. "When I went to the literature to find the correct way to take orthostatic signs, I was unable to find consensus. There were as many methods as texts consulted." Lee recognized a need for resources and experts in evidence-based practice to help nurses find and use best evidence. Her hope is that this grant will help fill that need.

For the next three years, Lee and her team—Lynda Brandt, RN, project coordinator; Liz Johnson RN, clincial nurse specialist; Carole Foxman, medical librarian; and Diane Carroll, RN, project evaluator—will offer classes to nurses in all role groups and support nurses who want to adopt new practices on their units.

Starting in January, evidence-based practice 'lunch-and-learns' will be offered every Wednesday from 11:00am–12:00pm on Founders 3.

- EBP 100: Achieving excellence through evidence-based practice
- EBP 101 A nursing director's guide to evidence-based practice
- EBP 102 Starting a Journal Club on your unit to promote evidence-based practice

To register for a course, call The Knight Center at 6-3111. For more information, contact Lynda Brandt, RN, at 3-6671.

CarePages, communication, and the flu

With flu season upon us, MGH is taking every precaution to minimize the spread of the virus. In an effort to limit exposure on patient care units, friends and family members 18 years old and younger are being asked to refrain from visiting. We understand this can be stressful for patients and families, but CarePages can help relieve some of the anxiety.

Questions: What are CarePages?

Jeanette: CarePages is a free, on-line service that helps patients and families stay in touch when a loved one is in the hospital. Patients or family members can post messages, updates, and photographs to keep loved ones abreast of the patient's condition. To view a sample page, visit www.carepages.com/mgh. On the right, click on "become a member" to register. Then log on and visit the CarePage called "AmysNews."

Questions: How does it work?

Jeanette: Every CarePage is a private website that can be viewed or updated by patients and/or family members any time of the day or night, anywhere in the world. CarePages is sponsored by Patient Care Services, so it's free to all users. CarePage visitors need to complete a simple registration process to gain access, then they can post messages as often as they'd like.

Patients and families tell us that CarePages is a great convenience. All their loved ones can be updated simultaneously, and they're thrilled not to have to repeat the same details over and over.

Questions: How can I set up a CarePage?

Jeanette: It's very easy. On any computer, go to: massgeneral.org/carepages, and follow the on-screen instructions. You'll be prompted on how to create a CarePage using a simple, fill-in-the-blank process.

Questions: How do family and friends find a CarePage once it's been created?

Jeanette: The patient or family extends an e-mail invitation to their network of contacts. The e-mail is sent via CarePages and includes all the necessary information, including a link to the CarePage site (and a toll-free number in case they need help).

Question: How long does a CarePage remain active?

Jeanette: CarePages can be used before, during, or after hospitalization; there is no expiration date. After several months of inactivity, CarePages will contact the family to determine whether the page should be deleted or not. A CarePage can remain active for as long as a patient or family wants.

Questions: So this is a way to keep in touch while visiting restrictions are in place during the flu season?

Jeanette: Absolutely. To create a CarePage, visit massgeneral.org/carepage. For more information, contact Georgia Peirce at 617-724-9865.

Invitation to registered nurses

The RN Residency: Transitioning to Geriatrics and Palliative Care Program is now accepting applications for the winter/spring 2010 sessions.

The RN Residency Program provides registered nurses an opportunity to learn and apply current, evidence-based geriatric and palliative nursing knowledge and innovative patient-care delivery models. A combination of didactic teaching and clinical experience, the program aims to strengthen the nursing workforce and improve the quality of nursing care to older adults and their families.

All registered nurses interested in geriatrics and palliative care are invited to apply.

January 19–21, 2010
(plus one day per month through June, 2010)
Classes held at
Simches Research Center

For more information,
call Ed Coakley, RN, at 4-7677

Call for Abstracts
Nursing Research Expo 2010

Do you have data that could be presented via a poster? The PCS Nursing Research Committee will be offering classes in abstract-writing. Look for information in future issues of *Caring Headlines*.

Prepare now to submit your abstract to display a poster during the 2010 Nursing Research Expo

Categories:

- Original Research
- Research Utilization
- Performance Improvement

For ideas on getting started, contact your clinical nurse specialist. Co-chairs of the Nursing Research Expo Sub-Committee (Laura Naismith, RN, or Teresa Vanderboom, RN) can also offer assistance.

For abstract templates and exemplars, visit the Nursing Research Committee website at:

www2.massgeneral.org/pcs/The_Institute_for_Patient_Care/NR/abt_research.asp

(Note corrected website)

The deadline for submission of abstracts is January 15, 2010.

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday, 7:30am – 5:30pm

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday, Thursday,
7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

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All stories should be submitted to: ssabia@partners.org
For more information, call: 617-724-1746

Next Publication

January 21, 2010

Educational Offerings – 2010

January
14
BLS/CPR Re-Certification

Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

January
15
Management of Patients with Complex Renal Dysfunction

Founders 311
8:00am–4:30pm
Contact hours: TBA

January
20
BLS/CPR Re-Certification

Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

January
20
Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

POB 448
7:00–11:00am
Contact hours: TBA

January
21
BLS/CPR Certification for Healthcare Providers

Founders 325
8:00am–12:30pm
No contact hours

January
22
PALS Re-Certification

Simches Conference Room 3-110
7:45am–4:00pm
No contact hours

January
22
PCA Educational Series

Founders 325
1:30–2:30pm
No contact hours

January
25
Assessment and Management of Psychiatric Problems in Patients at Risk

O'Keeffe Auditorium
8:00am–4:30pm
Contact hours: TBA

January
25 & 26
Intra-Aortic Balloon Pump

Day 1: BMC
Day 2: Founders 311
8:00am–4:30pm
Contact hours: TBA

January
29
Heart Failure: Guidelines for General Care Nurses

O'Keeffe Auditorium
8:00am–4:30pm
Contact hours: TBA

February
1
BLS Heartsaver Certification

Founders 325
8:00am–12:30pm
No contact hours

February
1 & 8
ACLS Provider Course

Day 1: 8:00am–3:00pm
O'Keeffe Auditorium
Day 2: 8:00am–3:00pm
Thier Conference Room
No contact hours

February
1
Pediatric Simulation Program

Founders 325
12:30–2:30pm
Contact hours: 2

February
3
BLS/CPR Re-Certification

Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

February
3
Simulated Critical-Care Emergencies

POB 445
7:00–11:00am
Contact hours: TBA

February
4
BLS/CPR Certification for Healthcare Providers

Founders 325
8:00am–12:30pm
No contact hours

February
4 & 5
Oncology Nursing Society Chemotherapy Biotherapy Course

Day 1 and 2: Yawkey 2-220
8:00am–4:30pm
Contact hours: TBA

February
8
BLS/CPR Re-Certification

Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

February
9
New Graduate RN Development Program

Founders 311
8:00am–4:30pm
No contact hours

February
9
Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

POB 448
7:00–11:00am
Contact hours: TBA

For more information about educational offerings, go to: http//mghnursing.org, or call 6-3111

November Journal Club

a special Veterans Day presentation

—submitted by the Nursing Research Committee Journal Club

On November 11, 2009, Veteran's Day, Janice Bell Meisenhelder, RN, presented her original research on, "Terrorism, Post-Traumatic Stress, Coping Strategies, and Spiritual Outcomes," at the Nursing Research Committee's Journal Club. Her article, published in the July, 2008, *Journal of Religious Health*, dealt with the psychological aftermath of the events of September 11, 2001. Bell Meisenhelder surveyed Presbyterian Church members and elders from all over the country by mail from 2000–2002. Congregations were randomly selected. The survey garnered a total of 1,056 respondents—a 55% response rate.

Janice Bell Meisenhelder, RN

(Photos by Paul Batista)

Questions addressed topics such as post-traumatic stress, degree of perceived threat, coping strategies (spiritual and non-spiritual), and the relationship between stress to coping strategies. Bell Meisenhelder and co-author, John P. Marcum, predicted that people with higher positive spiritual coping would experience more positive spiritual outcomes. Researchers focused on post-traumatic stress symptoms such as, re-experiencing, hyper-arousal, avoidance, and numbness. Bell Meisenhelder pointed out that many people who experience mild symptoms don't seek medical help but have found nurses helpful, whether as neighbors, family members, friends, or acquaintances.

In comparing a subset of respondents in states close to New York and Washington, DC, with the rest of the country, researchers found that national responses were similar to regional responses. They surmised that this was due to the extensive television coverage immediately after the attacks. The study revealed a small to moderate degree of post-traumatic stress in the majority of the national sample, with most feeling personally threatened two months after the attacks. People with more stress used more coping mechanisms such as looking to God for strength, praying, displaying a flag, seeking time with friends and family, and contributing money to help victims. Positive spiritual coping strategies were strongly related to positive spiritual outcomes.

On January 13, 2010, Ann Marie Barron, RN, will present her research on, "Integrating Therapeutic Touch into nursing practice." The Journal Club meets from 4:00–5:00pm in Bullfinch 222. For more information, call Martha Root, RN, at 4-9110.

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January 7, 2010

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