

January 4, 2007

Caring

HEADLINES

Take Good Care Packs help parents talk to kids about cancer

(See page 4)

Inside:

- Take Good Care Packs 1
- Jeanette Ives Erickson 2
 - It's All About the Patient
- The MGH Tobacco Treatment Service 5
- Clinical Narratives 6
 - Kathie Pazola, RN
 - Geraldine Gardner, RN
- Interdisciplinary Practice 8
 - The MGH Diabetes Center
- Fielding the Issues 9
 - CBEDS
- Spiritual Practices 10
 - Hajj
- Educational Offerings 11



Social worker, Kathy Clair-Hayes, LICSW (center back); Nancy Schaeffer, RN (back right); Ashley Murphy (right); Susan Murphy (second from right); and friends display Take Good Care Packs and first-ever, Caring for Others Award

(Photo by Abram Bekker)

MGH Patient Care Services
Working together to shape the future

Bottom line: it's all about the patient

In a major, world-class, academic medical center like MGH, we are perpetually evolving. Systems change. Buildings change. Protocols change. But one thing remains steadfastly constant, and that's our unwavering commitment to provide the highest quality care to our patients.

As we start this new year, we renew our commitment to provide exemplary care, to bring needed services to the community, and to share our knowledge and passion with the next generation of caregivers.

Our commitment to do right by our patients manifests itself in many ways. Ensuring that care is delivered in a safe, clean, and uncluttered environment is one of our highest priorities. Patient- and staff-safety are at the core of every decision we make. So important is our quality and safety agenda, the hospital recently created a new position: senior vice president for Quality & Patient Safety. After an extensive national search, our own Gregg Meyer, MD, was selected to take on this important role.

Patient Care Services created its own Office of Quality & Safety which is located in the Professional Office Building on Cambridge Street. Employees should avail themselves of these resources (and/or unit-based safety resources) in addressing any quality or safety issue that arises, no matter how small.

I think it's important to remember why we chose careers in health care in the first place. We were called to the caring professions we hold. We were drawn by a desire to help others. We aspire to excellent patient care, not because it's required by regulatory agencies but because it's the right thing to do for our patients.

It's easy to get side-tracked in the fast-paced, rapidly changing world of health care. But as I reflect on the important work we do, it really seems very simple. We

just need to remain true to our basic values. We need to focus on what's best for our patients. And we need to help each other as we go about our daily work.

Caring for patients is by its very nature, collaborative. Teamwork within and among disciplines makes us stronger. Sharing knowledge, information, and decision-making makes us a better, more cohesive team.

It's easy to get side-tracked in the fast-paced, rapidly changing world of health care. But as I reflect on the important work we do, it really seems very simple. We just need to remain true to our basic values. We need to focus on what's best for our patients. And we need to help each other as we go about our daily work.

The most basic element of high-quality care is getting to know our patients—performing assessments that are thorough, considerate, and unhurried. When we know our patients' medical histories, health concerns, and goals for the

future, we can provide care that is sensitive and meaningful. And when we know our patients, we

don't have to keep asking the same questions over and over.

Our patients deserve our best every moment of every day.

That means keeping their well-being first in our thoughts as we go about our daily work.

Practicing good hand hygiene shows our patients and our colleagues we're invested in positive patient outcomes.

Pain assessment, relief, and documentation ensure patients' comfort while they're in our care.

Every patient has the right to a medical interpreter at no charge.

Every observation and intervention should be documented to ensure continuity of care and a seamless transition of services. And all documentation should adhere to the rules of acceptable abbreviations.

From smooth, well-communicated hand-offs, to medication reconciliation, to involving patients in discharge planning, our every action is driven by a solemn commitment to our patients' safety and well-being—a commitment we take very seriously.

When the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) visited our campus a few weeks ago, I was proud of the clinicians and support staff throughout Patient Care Services who represented us so well, making our work and our

continued on next page



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

outcomes visible. You should be proud of the care you provide; the colleagues with whom you practice, teach, and serve; and this hospital and the important work we do.

I want to start the new year by thanking you for immersing yourselves in the professions you've chosen. It's a privilege to work with you. With your talent, vision, insight, and dedication, it's hard to imagine a more impressive health-care team.

Medical Interpreters

Every patient has the right to a medical interpreter at no charge. Medical interpreters help protect patient confidentiality, informed consent, the accuracy and integrity of the patient-caregiver interaction, and the delivery of culturally competent care.

Medical interpreters are available:
 Monday–Friday: 7:00am–midnight
 Saturday and Sunday: 8:00am–10:00pm
 Call: 6-6966

Off hours and holidays:
 Spanish interpreter
 Call: 4-5700, pager #3-0001

Other languages:
 Call: 4-5700, pager #3-0009

Request a medical interpreter when you have a patient who is non-English speaking, deaf, or hard of hearing.

Advance Directives

An advance directive is a document signed by an adult patient providing instructions on how to make healthcare decisions in the event he/she becomes unable to make decisions on his/her own. One type of advance directive is a Massachusetts Health Care Proxy, which names a person to make decisions for the patient. Other types of advance directives describe the kinds of treatment the patient would like to receive or refuse, and are often referred to as living wills. Federal law requires healthcare institutions to put a mechanism in place to ask patients if they have an advance directive. Massachusetts has selected the Health Care Proxy as the preferred form of advance directive.

Unacceptable abbreviations

Unacceptable abbreviations	Intended meaning	Correct entry
Q.D. Q.O.D.	Latin abbreviation for once daily and every other day	Write "daily" and "every other day"
MS MSO ₄ MgSO ₄	morphine morphine sulfate magnesium sulfate	Write "morphine sulfate" or "magnesium sulfate"
H.S.	half strength or hour of sleep (at bedtime)	Write out "half-strength" or "at bedtime"
"0" after a decimal point (1.0 mg)	1 mg	Do not use a zero after a decimal when expressing whole numbers
No "0" before a decimal (.5 mg)	0.5 mg	Always use a "0" before a decimal when the dose is less than a whole unit
ss	sliding scale	Write "sliding scale"
µg	microgram	Write "microgram" or "mcg"
U or u	unit	Write "unit"
IU	international unit	Write "unit"
Apothecary symbols	Dram Minim	Use metric system "ml" "mg" "mcg"
Per os	orally	Write "PO," "by mouth," or "orally"
qn	nightly or at bedtime	Write "nightly"
BT	bedtime	Write "bedtime"

The MGH Tobacco Treatment Service

Under the current standard, all patients should be asked if they've used tobacco products in the past 12 months. If they have, the Tobacco Treatment Service should be notified for a consult (6-7443)

In the smoke-free environment of the hospital, The Tobacco Treatment Service can help patients avoid symptoms of nicotine-withdrawal

Every patient who has smoked in the past 12 months should be given a copy of the *Guide for Hospital Patients Who Smoke* (Standard Register form #84772). A copy of the guide is placed at every patient's bedside when the room is cleaned

Helping patients to quit smoking is part of the excellent care all clinicians provide at MGH

Make your practice visible Document your work

For more information, or to request a quit-smoking consult, call 6-7443

Giving and receiving Take Good Care Packs

—by Kathy Clair-Hayes, LICSW, coordinator, Take Good Care Program

As care providers, we do our best to make a difference in the lives of our patients and their families. Often, families tell us how our care has impacted their lives with cards or gifts. Then, there are those who ask how *they* can make a difference by supporting us in helping other families.

As a 9-year-old, Ashley Murphy received a Take Good Care Pack when her mother was diagnosed with breast cancer. Both Ashley and her mother, Susan, say the pack helped make a scary situation less scary, and helped them talk about the cancer diagnosis in a more meaningful way.

Take Good Care Packs were created by clinical social workers at MGH. We use them as tools in social-work interventions to help parents and children talk about illness or death. Four separate Take Good Care programs focus on: 1) When a parent has cancer, 2) When a child has cancer, 3) When a parent is in the ICU (or involved in a trauma or sudden catastrophic illness), and 4) When a parent dies. Packs are filled with educational, expressive, comforting, and stress-reducing items. Each pack contains items specially selected for one of five age groups: parent, teen, school-age, preschool/kindergarten, and toddler/infant.

Take Good Care Packs are a family-focused intervention used by clinical social workers to support and extend the boundaries of our psychosocial care from the hospital setting to the home setting. We empower parents to build on their family's coping resources since they are the best supporters and teachers of their children.

For her 10th birthday, Ashley Murphy wanted to help other children whose parent(s) had cancer. After talking with her nurse, Nancy Schaeffer, RN, in the Gillette Center for Women's Cancers, Susan Murphy telephoned me. Our discussion first focused on fund-raising ideas, but after hearing about Ashley and her friends, another idea came to mind. Instead of soliciting donations, Ashley and her friends decided to put some time aside at her upcoming birthday party and create Take Good Care Packs for other children.

On November 11, 2006, Ashley and 12 friends gathered to celebrate her birthday. She and her friends donated items and created 40 packs for the Take Good Care Program. On

November 16, 2006, Nancy Schaeffer and I welcomed Ashley, her mother, and a few of her friends to the Cancer Resource Room where we took possession of the packs they had made. To acknowledge this kind gesture, the Take Good Care Program presented Ashley with its first-ever Caring for Others Award. The award recognizes Ashley's efforts to share her gifts and talents to support families living with cancer.

Ashley's mom recalls, "When I was diagnosed, my first worry was my daughter and how I was going to explain it to her. The backpack was such a wonderful way to sit and talk through it. All the items inside helped me get past that dreaded feeling of, 'How am I going to tell my child?'" Ashley told me she

loved the Take Good Care Pack. It made her feel as though people at the hospital cared about her. Some of her favorite things in the pack were the mood-meter magnet and the Teddy bear. When asked what advice she has for other kids, Ashley says, "Don't give up hope."

The packs have helped many families in Schaeffer's practice. "The age-specific contents are so helpful," she says. "Everything in the packs is appropriate for a certain age group, which makes conversations about cancer so much easier. And it gives parents a way to communicate that doesn't feel so much like a lecture."

For more information about the Take Good Care Program, contact your clinical social worker, or e-mail Kathy Clair-Hayes, LICSW.

Talking to children about cancer

Some questions for parents:

- Have you told your children about your illness?
- What words have you used to tell your children about your illness?
- What questions are your children asking?
- Have you noticed any behavioral changes in your children?
- Do you have concerns about your children?
- Would you like some information about how you as a parent can support your children during this time?

If patients express concern about their family's ability to cope, please refer them to a clinical social worker at 6-2643



Ashley and Susan Murphy with Take Good Care Packs and Caring for Others Award

(Photo by Abram Bekker)

Smoking: whether quitting or managing symptoms, TTS can help

—by Georgia Peirce, director, PCS Promotional Communications and Publicity

Recently, 'Mr. B,' a life-long smoker, was admitted to MGH. During his stay, his craving for a cigarette was almost unbearable, but he wasn't strong enough to leave the unit to smoke. Mr. B wasn't ready to quit smoking, so his nurse arranged a consult with the MGH Tobacco Treatment Service where counsellors were able to help Mr. B avoid the discomfort of nicotine-withdrawal during his hospital stay.

Formerly the MGH Quit Smoking Service, the MGH Tobacco Treatment Service offers a variety of nicotine-replacement medications to help keep patients as comfortable as possible while they're in the hospital. If and when patients decide they're ready to quit smoking, the Tobacco Treatment Service provides appropriate counseling and guidance.

Nurses may request a Tobacco Treatment Service consult without a physician's order. A trained counselor will help patients determine their readiness to quit smoking and assist them during the process. For patients who aren't prepared to quit, information and medications are available to help address symptoms of nicotine-withdrawal.

Counselors are available Monday through Friday and make every effort to see patients prior to discharge.

Several measures have been put in place to ensure that tobacco counseling is made available to patients who need or want it. The admission template now allows physicians to order a smoking consult at the time of admission, activating an automatic visit from the Tobacco Treatment Service. House-keeping staff place a copy of the *Guide for Hospital Patients Who Smoke* in every patient's room. The guide provides information on treating nicotine-withdrawal and obtaining assistance with smoking-cessation. Guides may be of help to patients and family members who smoke.

The Post-Hospital Care Plan now includes information on accessing the Tobacco Treatment Service and other state-wide tobacco treatment resources. If patients decide to seek tobacco counseling after they leave the hospital, the Post-Hospital Care Plan can help them find it.

Lung cancer is the leading cause of cancer deaths in the United States among both men and women; 87% of those deaths are attributable to tobacco use. According to the American Cancer Society, lung cancer is the most preventable form of cancer death.

Call for Proposals

**The Yvonne L. Munn, RN,
Nursing Research Awards**

Submit research proposals for the annual Yvonne L. Munn, RN, Nursing Research Awards to be presented during Nurse Recognition Week, May 6-11, 2007
Proposals are due January 16, 2007

Guidelines are available at:
www.mghnursingresearchcommittee.org
For more information, call 617-726-3836

For more information contact the MGH Tobacco Treatment Service at
about smoking-cessation, or to schedule a consult, 617-726-7443.

It's not easy to quit! Why do it alone, when you can get help?

—by Marie Rousseau, RN, Same Day Surgical Unit

Being a non-smoker was something I strived for for years—eight years to be exact. I started smoking as a child of eight. By age 12, I was a real smoker, smoking almost a pack a day.

My mother did everything she could to convince me to stop, but to no avail. By the time I was 30, I knew I needed to quit, but I was physically and emotionally unable. By that time, my smoking had increased to two or three packs a day.

As a nurse, I knew smoking was the enemy. I knew what smoking was doing to me, but I had a physical need. I was being controlled by a substance.

I tried the nicotine patch. I made myself and

everyone around me miserable for weeks. When the patches were gone, I rationalized that it was safe to smoke, and cigarettes soon became the boss again.

I tried again a year later only to fail and resume my pack-a-day habit.

This cycle continued for more than six years. Each time I tried to quit, I let my guard down. I rationalized that personal issues were to blame and always returned to my pack a day.

I hated myself for being so weak. I wanted to be a non-smoker! One day, a friend gave me an audio-tape from The American Lung Association. I bought a supply of nicotine patches, got a list of all the Ni-

cotine Anonymous meetings in my area, and set a date to quit.

A few days before the date, I started listening to the tape before going to bed. On January 5, 1998, I quit smoking. I used all the tools at my disposal and accepted how powerless I was over my addiction to nicotine. I was able to say No when my brain told me I could have just one cigarette. I'm so grateful to finally be free of a habit that was taking so much from me.

As my self-help tape told me to say every time I feel that urge to smoke, "I quit smoking on January 5, 1998, and that's that."

I finally realized my goal... and that is that!

Caring for Thomas Part I: a brief and caring encounter, a lasting and meaningful life lesson

Kathie Pazola is a clinical scholar

My name is Kathie Pazola, and I am a pediatric staff nurse on the Ellison 18 adolescent and school-age pediatric unit.

No one knew it would be his last day. When his mother brought him to the Emergency Department with abdominal pain and dehydration, no one knew he would never go home again.

Diagnosed with hydronephrosis (a serious kidney condition) as an infant, Thomas was 19 and had lived with renal and cardiac disease most of his life. He underwent many interventions and required daily peritoneal dialysis. His physical and emotional growth had been affected by his illness. He was dependent on his single mom for almost everything. He had lived a sheltered life in many ways, and as he grew sicker, his world became even smaller. Thomas spent a lot of time in the hospital for infections, blood clots, heart failure and blood pressure issues. He made many trips to the Pediatric Intensive Care Unit (PICU) in crisis, but always managed to stabilize. When his PICU trips became more frequent, his doctor approached Thomas and his

mom about end-of-life decisions. They decided that if Thomas were to have a cardiac or respiratory arrest, he did not want to be intubated. But he wanted to continue with dialysis and his current battery of medications. He struggled with the ambivalence of hating his illness, but loving his mother and not wanting to leave her.

When they arrived from the Emergency Department that day, Thomas' mother gave his nurse the 'comfort care' order he had needed for the ambulance ride to the hospital. The nurse tried to clarify with Thomas and his mom that comfort care was what they still wanted. Thomas could not answer. His mother wavered in her response. She seemed conflicted. She wanted him to be monitored. She wanted him to start dialysis. When the monitor showed a dangerous arrhythmia, and his blood pressure plummeted, she requested intervention. This set into motion the drama of doctors ordering stat medications, fluids, and treatments. The focus of care shifted rapidly from comfort care to high-tech, fast-paced, active care. We called the nursing super-

visor to inform her and enlist her support. Thomas' nurse and I asked other staff members to cover our assignments while we were involved in Thomas' crisis.

Thomas, over the years, had had a consistent team of nurses, none of who were working that afternoon. His nurse and I had rarely, if ever, cared for Thomas before. Now we were being called upon to give expert clinical care to him and emotional support to his distraught mother.

The doctors felt Thomas needed to be in the PICU to adequately treat his arrhythmias. Mom agreed to this. I was surprised. I felt in my gut that Thomas was not going to live no matter what was done for him. I wanted to say something that would soothe him in the midst of all this drama. If these *were* going to be his last hours, I wanted him to feel gentle caring.

Thomas was alone in the room. I knelt beside him and took his hand. He was semi-conscious. I acknowledged that it was probably scary to have so much happening to him. I assured him that no matter what happened, we wouldn't leave him; he would not be alone. I told

him we'd help his mother. I know from caring for many dying children that they worry about their parents. I wanted him to feel some calmness and peace. That's what *I* could do for him.

I left Thomas in the company of his mother and his doctors and learned he would be taken to the PICU emergently. I helped his nurse transfer him. In the PICU, Thomas received every possible drug to treat his arrhythmia, and he was cardioverted—to no avail. At this point, knowing that all efforts to regulate his heartbeat had been exhausted, his mother agreed to keep him comfortable and prepared to say good-bye.

Thomas' primary nurse came on duty at 7:00pm. We told her what had transpired and covered for her so she could spend time with him in the PICU. She would be a great comfort to him and his mom, for she knew them very well.

She had shared Thomas' hospital history. She had advocated for him over the years. Both Thomas and his mother loved and trusted her. When she returned from visiting, though sad, she was comforted to know they were getting compassionate care from staff in the PICU. In the middle of the night, Thomas died peacefully, with his mom by his side and PICU staff supporting her.

What lessons did I learn in caring for Thomas? What meaning did this experience have for me? I was reminded that the decision to allow a child to die is an excruciating one for a parent, and that parents can waver in their resolve. I learned how necessary it is to 'seize the moment' and say those important words to a patient. And I learned that when nurses support each other and work together, we can ensure a 'good death' for patients, sometimes on very short notice.



Kathie Pazola, RN
pediatric staff nurse

Caring for Thomas Part II: a 13-year journey with a special patient and family

Geraldine Gardner is a clinician in the PCS Clinical Recognition Program

My name is Geraldine Gardner, and I am a pediatric nurse on Ellison 18. I took care of Thomas for 13 years. Our connection was strong, and we shared many difficult and wonderful moments. But the moment that stands out in my mind is the saddest one of all.

Thomas had been diagnosed as an infant with hydronephrosis (a serious kidney condition), and had lived many difficult years before I first cared for him. He had had frequent hospitalizations for dialysis and various procedures. He and his mom were quite a team. Everything I knew about dialysis, I learned from him. He grew sicker over the years and developed severe cardiac disease, but somehow, I never thought he would die. He seemed to have nine lives.

I came to work at 7:00pm one night, and was told that Thomas had been admitted to the Pediatric Intensive Care Unit (PICU) with an erratic heartbeat and blood-pressure issues. I recalled he had requested DNR (Do Not Resuscitate) status during his last admission, but apparently his mother had waver-

ed and asked that he be taken to the PICU. Knowing my relationship with Thomas, my co-workers told me they'd cover for me so I could be with him in the PICU. When I got there, Thomas looked peaceful but was in and out of consciousness. I rubbed his feet and let him know I was there. He opened his eyes and smiled. His mom and I hugged. I somehow felt that Thomas was at peace, despite the IV lines loaded with pressors, the monitor beeping his heart rate above 22, and barely a blood pressure at all.

Beth was his night nurse. This was my first encounter with Beth, and this was Beth's first encounter with Thomas. We stepped aside, and she gave me an update. I shared information with her about Thomas. I told her he had elected to be DNR, and I feared that his mom wouldn't be able to bear seeing him die. I spoke with his doctor who came in that night to see him. Thomas was surrounded by his primary team, and although he said nothing, he appeared to be at peace.

Eventually, I had to return to my patients on Ellison 18, but Beth promised to update me on

any changes, and I promised Thomas' mom that I would be back. I saw the PICU fellow on my way out, and again advocated for Thomas' choice to be DNR. She was grateful for my input.

Two hours later, I got a call that Thomas had died. On my way down to the PICU, I must admit, the vision in my mind was not a serene one. I envisioned all the noise, excitement, and drama that takes place in an ICU. But I was reassured when I got there. His mom was lying with him, stroking his head. She was crying, and I could feel her anguish. I looked at Thomas, and he looked serene, almost happy. Beth was quietly removing the lines and traces of PICU equipment. The room was softly lit. Thomas' DNR wish had been honored; he had died peacefully and with dignity. The PICU staff were professionals in every sense of the word. They had given Thomas everything he needed so he could die gently. His mom later told me she was glad he didn't die at home or on Ellison 18, for that was their 'second home.' Their needs had been met by a staff she didn't know,



Geraldine Gardner, RN
pediatric staff nurse

coupled with support from those she had known throughout their entire hospital history—a true partnership.

Later, I spent some quiet time processing the night. I came away from this experience with a greater understanding that nursing is a calling. We are invited into people's lives at a time when they're most vulnerable. How we respond to that invitation is a matter of our own personal practice. To witness the birth or death of a patient is a gift, and I will forever be changed by the interactions I have with my patients.

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

These two compelling narratives were written by two nurses who had very different relationships and experiences with Thomas and his mother. Geraldine had been Thomas' nurse for

many years. Kathie met them on the last day of Thomas' life. But there are similarities in the stories they tell. There are similarities in the care they provided.

Both were guided by nursing intuition—Kathie as she comforted Thomas and helped prepare him to face death, and Geraldine as she advocated for Thomas' last wishes to be respected.

They both recognized and understood Thomas' mother's ambivalence in keeping the DNR order in place.

This is a difficult narrative to read. Thomas' death was a tragedy neither Kathie nor Geraldine could control. But they gave Thomas and his mother excellent, compassionate, end-of-life care and, working together, allowed Thomas to have a peaceful death.

Thank-you both, Kathie and Geraldine.

Diabetes Center introduces Interdisciplinary Research Rounds to promote evidence-based practice

—by Mary Larkin, RN; Ellen Anderson, RD; Tiffany Soper, RN; and David M. Nathan, MD

The MGH Diabetes Center is comprised of the closely integrated Diabetes Treatment Center, established as the Diabetes Clinic in 1919, and the Clinical Research Center now in its 23rd year. Together, these centers develop new treatments and provide the highest quality care for people with diabetes. Having both centers under one roof fosters interdisciplinary collaboration between clinical providers and researchers, creating a fertile ground for clinical inquiry, research-development, and translating the latest findings into practice.

Over the past few years, staff of the treatment and research centers have met regularly to develop research projects. Meetings are multidisciplinary with representatives from Medicine, Nursing, Nutrition, Physical Therapy, Social Services, Psychology, as well as research coordinators and support staff. Meeting regularly to share ideas, discuss challenges, and develop research questions into clinical studies, this multi-disciplinary team has

successfully developed and secured funding for studies initiated by nurses, dietitians, and endocrine fellows.

The group comes together to discuss the feasibility of conducting clinical research, specific aims, design, and plans for data-analysis. One person takes the lead in developing the research protocol with input from research mentors and the team. This model gives less experienced researchers an opportunity to develop ideas with the guidance of senior investigators.

The multi-disciplinary collaboration of staff from clinical and research settings allows clinicians knowledgeable in the challenges experienced by patients to discuss the development of new treatments with skilled researchers. Our research efforts are clinically based with a focus on im-

proving care for patients with diabetes. The goal is ultimately to cure diabetes; but until a cure is found, we provide the most advanced, comprehensive therapy available.

The medical issues associated with obesity, dyslipidemia, hypertension, eye, kidney, nerve, and cardiovascular disease are also addressed by the clinical staff of the treatment center in collaboration with other MGH experts in various specialties.

The Diabetes Research Center has led several important clinical studies over the past two decades. Many of the current therapies for diabetes were developed at the MGH Diabetes Research Center. Patients from the treatment center often participate in research studies and benefit from new therapies developed and tested by the research center.

The work of the Diabetes Research Center focuses on developing and evaluating innovative, preventive, and treatment interventions for Type 1 and Type 2 diabetes and their complications, and on the psychosocial adaptation to living with diabetes. Current studies include the Diabetes Control and Complications Trial; the Epidemiology of Diabetes Interventions and Complications, which demonstrates the importance of intensive metabolic control in preventing complications of Type 1 diabetes; and the Diabetes Prevention Program, which demonstrates the effective use of lifestyle and medications in the prevention of Type 2 diabetes. The Diabetes Control and Complications Trial and the Diabetes Prevention Program are considered the most important studies in diabetes since the discovery of insulin.

Other clinical studies include: the Look AHEAD study, which examines the prevention of heart disease in Type 2 dia-

betes; the Immune Tolerance Network Study, which investigates islet transplantation as a treatment of Type 1 diabetes; the TODAY study, which explores treatment options for adolescents with Type 2 diabetes; and many other cutting-edge projects.

The Research Center has collaborated extensively with epidemiological researchers to explore risk factors for diabetes and its complications. Ideas for interventional studies often arise from the epidemiologic observations of these studies.

The Diabetes Center is dedicated to providing the best comprehensive care for people with diabetes. Staff focus on preventing complications and strategies to promote diabetes self-management. The Diabetes Self-Management Education Program uses an interdisciplinary approach to give patients the latest information and tools to manage diabetes. A team of nurses, dietitians, and psychologists leads four two-hours sessions for patients with Type 1 and Type 2 diabetes. The collaboration of this interdisciplinary team has proven to be a successful model in which diabetes care and clinical research work hand-in-hand to improve the lives of our patients.



Interdisciplinary staff of the MGH Diabetes Center

CBEDS: improving our ability to manage capacity and communicate effectively about patient-placement

Question: I've been hearing about a new system called, 'CBEDS.' Can you tell me what it is?

Jeanette: CBEDS, which stands for Coordinated Bed Efficiency Dashboard System, is a bed-management-information system. It is a key initiative aimed at improving capacity-management by using electronic technology to enhance patient placement, communication, and support for room turn-over. CBEDS offers enhanced search and patient-placement capabilities; efficient, real-time communication about bed status; and automated support for room-cleaning. CBEDS is being used on inpatient units for patient placement, admissions, transfers, pending discharges and discharges. The system automatically notifies unit service associates when a room needs to be cleaned for a new patient.

Question: Will all inpatient units eventually use CBEDS?

Jeanette: Yes. As of December 12, 2006, CBEDS was operational on 33 inpatient units. By January 16, 2007, the final inpatient units will go live, including: Obstetrics, the Neonatal Intensive Care Unit (NICU), Psychiatry, and Research.

Question: Who else uses CBEDS at MGH?

Jeanette: The Admitting Department uses CBEDS as a tool to search for inpatient beds and communicate with inpatient units about patient-placement recommendations. Admitting receives information from in-

patient units about pending discharges and transfers. It's extremely important to enter pending discharge information into CBEDS as soon as possible to ensure the best possible patient-placement decisions.

The Post Anesthesia Care Unit (PACU) uses CBEDS to view bed-reservation and bed-status information for their patients. On December 19th, the Emergency Department began receiving similar bed-reservation and bed-status information automatically from CBEDS to the EDIS system. Linking these critical areas to inpatient units through CBEDS improves our ability to manage capacity and reduces the number of phone calls about patient placement and bed availability.

Question: You said unit service associates are automatically notified by CBEDS. How does that happen?

Jeanette: Unit service associates now carry pagers while working on inpatient units. When a dis-

charge or transfer is entered into CBEDS, the unit service associate is automatically paged and notified which bed needs to be cleaned. Using the phone in the room, the unit service associate calls into CBEDS and indicates when he/she began cleaning and when cleaning is complete. This information is automatically fed into the CBEDS system so everyone involved has up-to-date information on the status of the next available beds. During off-shifts on units that don't have unit-based service associates, CBEDS pages a unit service associate through the Central Resource Team (CRT) alerting them of the need to clean a bed.

Question: CBEDS indicates a bed is closed by showing a black box on the screen. Is it possible to indicate *why* the bed is closed?

Jeanette: Great question. Aggressively managing beds and, more importantly, keeping as many beds open as possible, is critical given our high volume of patients. There are limited opportunities to increase the number of beds we have until the new building is completed in 2011. Currently, CBEDS cannot display the reason for a closed bed, but it will be able to in the near future. The next iteration of CBEDS will have the ability to attach a code to every closed bed, explaining why it isn't available. We expect to see this change early in 2007.

For more information about the CBEDS initiative, contact George Reardon, director, PCS Systems Improvement, at 4-5952.

Call for Abstracts Nursing Research Day 2007

Categories:

- Encore presentations
- Original research
- Research utilization
- Performance improvement

Abstracts must be received by January 31, 2007

www.mghnursingresearchcommittee.org

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Please contact Ursula Hoehl at 726-9057 for questions related to distribution

Submission of Articles

Written contributions should be submitted directly to Susan Sabia **as far in advance as possible**. *Caring Headlines* cannot guarantee the inclusion of any article.

Articles/ideas should be submitted by e-mail: ssabia@partners.org
For more information, call: 617-724-1746.

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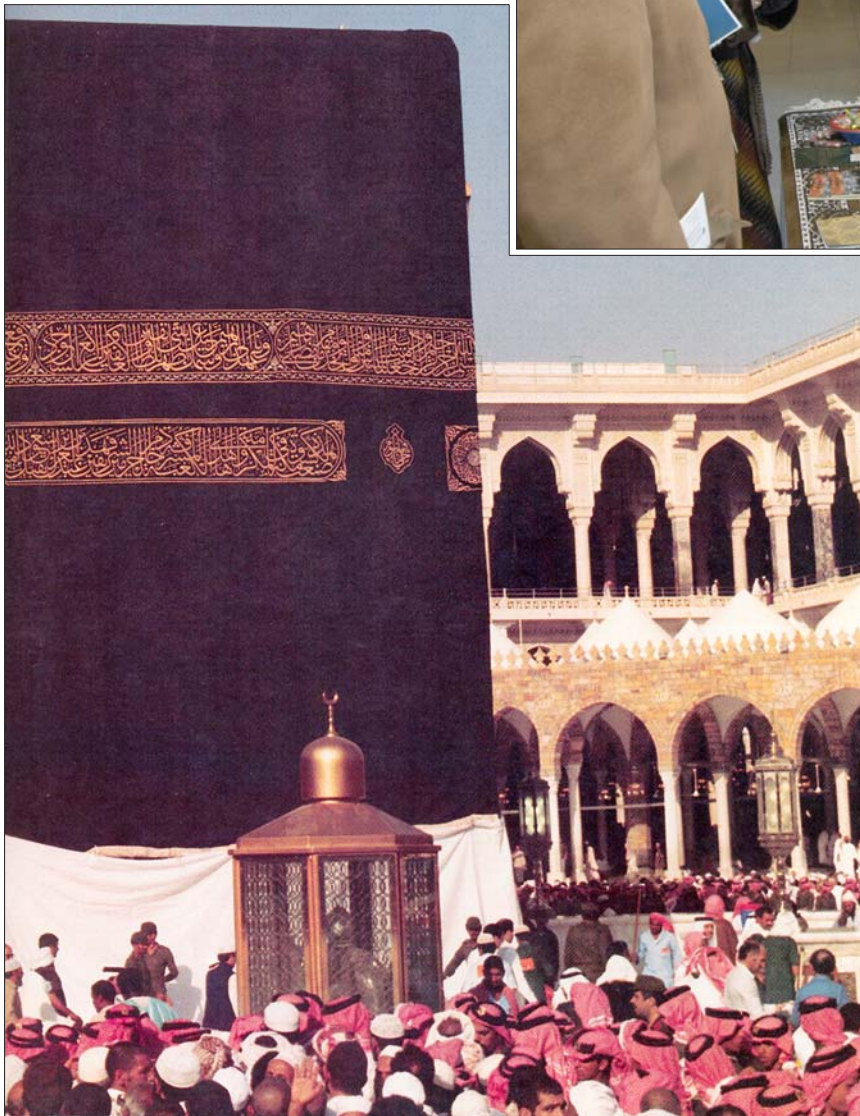


Hajj: the annual Muslim pilgrimage to the sacred city of Makkah (Mecca)

—submitted by the PCS Diversity Committee

On Wednesday, December 20, 2006, the Patient Care Services Diversity Committee sponsored an educational booth in the Main Corridor in observance of the Hajj, the annual pilgrimage by Muslims to the sacred city of Makkah (Mecca). One of the Five Pillars of the Islamic religion calls for Muslims to make the pilgrimage to Makkah at least once in their lives if they are physically and financially able to do so. More than two million people make the journey every year from all over the world.

The Hajj always begins in the twelfth month of



the Islamic year (on the lunar calendar) so sometimes the Hajj and Ramadan occur in summer months and sometimes in winter months. For the journey, Muslims wear simple garments to eliminate any distinction of class and culture, so all stand equal before God.

The end of the Hajj is marked by a festival, the Eid al Adha, which is celebrated with prayers and the exchange of gifts in Muslim communities. This and the Eid al Fitr, the festival celebrating the end of Ramadan, are the two major holidays of the Islamic calendar.

At MGH, the Muslim prayer room is located in Founders 109. For more information about the Hajj, Ramadan, or the Islamic religion, send e-mail to teid@partners.org or fpathan@partners.org.

At left: the Ka'bah in Mecca, built by Abraham, is the sanctuary to which Muslims from all over the world pray and to which they make pilgrimage every year
Above: PCS Diversity Committee members, Deborah Washington, RN, and Firdosh Pathan, RPh (both on the right), provide information about the Islamic religion, the Hajj, Ramadan, and other Muslim traditions

Educational Offerings

January 4, 2007

<i>When</i>	<i>Description</i>	<i>Contact Hours</i>
January 16 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification FND325	---
January 17 8:00–4:00pm	Oncology Nursing Concepts: Advancing Clinical Practice Yawkey 2200	TBA
January 24 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
January 24 and 31 8:00am–4:30pm	Phase II: Wound Care Education Training Department, Charles River Plaza	TBA
January 25 8:00am–12:30pm	Pediatric Advanced Life Support (PALS) Re-Certification Program Training Department, Charles River Plaza	---
January 25 1:30–2:30pm	Nursing Grand Rounds O'Keeffe Auditorium	1.2
January 25 12:00–4:00pm	Basic Respiratory Nursing Care Bigelow Amphitheatre	---
January 29 and 30 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: NEMC; Day 2: FND325	14.4 for completing both days
January 31 8:00am–12:00pm	BLS Certification—Heartsaver FND325	---
February 2 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification FND325	---
February 3 (Saturday) 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills FND325 (No BLS card given)	---
February 5 8:00am–2:00pm	BLS Certification for Healthcare Providers FND325	---
February 6 and 7 8:00am–4:00pm	Oncology Nursing Society Chemotherapy-Biotherapy Course Yawkey 2220	16.8 for completing both days
February 6 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification FND325	---
February 8 8:00am–4:30pm	Workforce Dynamics: Skills for Success Training Department, Charles River Plaza	TBA
February 8 2:00–3:00pm	Ovid-Medline: Searching for Journal Articles FND334	TBA
February 12 and 26 8:00am–3:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room	---
February 14 8:00am–2:00pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
February 14 8:00–11:30am	Intermediate Arrhythmias Yawkey 10-660	3.9
February 14 12:15–4:30pm	Pacing Concepts Yawkey 10-660	4.5
February 14 11:00am–12:00pm	Nursing Grand Rounds Haber Conference Room	1.2
February 14 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---

For detailed information about educational offerings, visit our web calendar at <http://pcs.mgh.harvard.edu>. To register, call (617)726-3111.
For information about Risk Management Foundation programs, check the Internet at <http://www.hrm.harvard.edu>.

MGH is committed to improving hand hygiene

Don't contaminate the environment with used gloves

- Gloves should not be worn in public areas (main hallways, elevators, stairs, cafeteria) unless you are:
 - actively transporting a patient, specimen, or used piece of equipment which requires the use of gloves
 - performing cleaning or maintenance work that requires gloves
- When gloves must be worn in public areas, use a clean, un-gloved hand (or ask someone else) to open doors, push elevator buttons, etc.
- Do not discard used gloves on floors, stretchers, lunch trays, stairs, public hallways, etc. where others may come into accidental contact with them. Use the nearest appropriate waste container



Stop the Transmission
of Pathogens
Infection Control Unit
Clinics 131
726-2036

Never wash gloves

- Washing gloves can weaken the glove material and enable germs to be spread more readily
- There can be a greater risk of infection if gloves are used improperly or if they are worn as a substitute for hand hygiene

Gloves do not provide a perfect barrier

- Gloves often have microscopic holes or tears that are invisible to the naked eye, and holes can develop with wear and use
- Germs can pass through holes—just as air can pass through the tiny holes of a blown-up balloon
- The good news is, gloves are 70-80% effective
- The bad news is, gloves are only 70-80% effective
- Gloves do not protect you from germs already present on your skin
- Gloves provide a protective covering for your skin, but they also create a warm, moist environment where bacteria from your skin can multiply, especially when gloves are worn for extended periods of time

Use Cal Stat *before and after* glove use



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