

Caring

Headlines

September 18, 2008

Hausman Nursing Fellowship: the future looks bright

(See story on page 4)



2008 Hausman fellows (l-r): Frew Fikru, Alexis Seggalye, and Christopher Uyiguosa Isibor

Excellence in patient care through efficiency and innovation

The active involvement of the entire MGH community will be required as we continue to provide the highest quality care while looking at ways to operate more efficiently.

If necessity is the mother of invention as the old adage asserts, when it comes to health care, a commitment to providing the best care at the lowest cost is the mother of innovation and efficiency. At a time when Medicare and Medicaid reimbursements are declining and healthcare costs exploding, our ability to work smartly and efficiently is more important than ever.

Many hospital-wide, departmental, and unit-based initiatives are under way to help contain costs. I want to thank you all for your support in bringing ideas forward, participating in pilot programs, and engaging in efforts to improve service and reduce unnecessary spending. The active involvement of the entire MGH community will be required as we continue to provide the highest quality care while looking at ways to operate more efficiently.

A number of initiatives are already making a difference. In response to feedback from staff that three-port IV tubing was superfluous and unnecessarily expensive, we made the decision to switch from three- to two-port tubing. We're in the process of implementing this change on all inpatient units, saving the hospital approximately \$200,000 a year without sacrificing quality, safety, or satisfaction.

We know there are opportunities to reduce waste in some of our practices related to clinical supplies. One of our Tiger Teams is looking at bed rentals, vacuum-assisted closure devices ('vac's'), and wound-care products for opportunities to cut costs (see page 9 for more



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

about Tiger Teams). As many of you know, rental beds and vacs sometimes remain on units long after they're no longer needed, which is expensive and wasteful. I'm happy to hear that many units are creating systems for notifying companies to pick up equipment when it's no longer being used eliminating the need to pay late fees and other charges.

In response to feedback from our unit service associates, we're re-examining our practices around linen utilization. We're asking ourselves important questions like what should drive usage—should beds be changed as needed, according to a pre-set time table, by patient request? Should we use disposable versus re-usable washcloths? Each decision is being weighed in terms of its effect on patient care, quality, safety, cost, and efficiency.

This month, as a result of collaboration between many disciplines and departments, the *Who to Call* for

continued on next page

At a recent Staff Nurse Advisory Committee meeting, we had a lively discussion about many of the programs and initiatives being launched to help reduce waste and streamline systems. Talking with those who provide direct care at the bedside is always an effective way to identify unnecessary practices or processes that may no longer add value to our work.

What Clutter Removal List is being distributed to inpatient units. This is an alphabetical list (including photographs) of commonly used items and the telephone numbers for whom to call to have each item removed. This catalogue along with its laminated *Quick Reference Guide* counterpart is intended to help get equipment back in circulation as quickly as possible for utilization by other clinicians—a cost-saving and service-improvement initiative.

With shorter lengths of stay and increased movement of patients throughout the hospital, we're looking at ways to simplify systems while enhancing communication and documentation. A number of technological advances are in the works, including electronic medication administration, automated acute-care documentation in the ICUs, and electronic communication with the labs to reduce the number of requisitions being generated.

Transforming Care at the Bedside (TCAB), the White 9 and White 10 research project sponsored by the Robert Wood Johnson Foundation, the Institute for Healthcare Improvement, and the American Organization of Nurse Executives, is having a positive effect on the way we deliver care. TCAB encourages nurses and other team members to quickly identify, test, and implement new ideas based on observations at the bedside. The TCAB approach allows clinicians to spend more time with their patients and less time doing non-value-added tasks such as retrieving supplies from centrally located storage areas. We're exploring ways to share these ideas with other units and departments throughout the hospital.

At a recent Staff Nurse Advisory Committee meeting, we had a lively discussion about many of the pro-

grams and initiatives being launched to help reduce waste and streamline systems. Talking with those who provide direct care at the bedside is always an effective way to identify practices that may no longer add value to our work. We talked about everything from creative ways to maximize staffing, to cost-cutting ideas for the utilization of elastic stockings, to the advantages of digital versus temple-artery thermometers.

These are the kinds of ideas we're looking for, ideas that originate from our commitment to provide exceptional care and customer service at the lowest cost. Yes, we want to cut expenses, but only in ways that preserve or improve the quality of care we provide. And we need your help. The best systems are those that reflect the wisdom and insight of the people who use them every day.

Send your ideas to me, to your managers and supervisors, or Jennifer Daniel, RN, staff specialist, at 6-6152.

Updates

By now, clinicians throughout Patient Care Services should have received the Staff Perceptions of the Professional Practice Environment Survey. This is your opportunity to offer your opinions, suggestions, or concerns about your practice environment. I hope you'll make it a priority to respond.

I'm pleased to announce that Linda Akuamoah-Boateng has accepted the position of senior project specialist for the PCS Office of Quality & Safety. And John Murphy, nursing director for the Blake 12 Neuroscience ICU, will join the Quality & Safety team as a staff specialist beginning October 13, 2008.

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Hausman Nursing Fellowship: a unique learning opportunity

The Hausman Nursing Fellowship, one branch of the Hausman Fund to Advance Diversity in the Nursing Workforce, was created in 2007 to help promote recruitment of minority nurses to better meet the needs of our diverse patient population. Providing an opportunity for senior nursing students to work in a variety of settings under the mentorship of a minority nurse preceptor, the Hausman fellowship was in-

tended to be a clinical, practical, and social learning experience for future nurses of color. Following are excerpts from the exit essays written by this year's fellows, Frew Fikru, Alexis Seggalye, and Christopher Uyiguosa Isibor. They speak of an environment rich with possibilities and opportunities to learn.

My name is Alexis Seggalye. I am a senior nursing student at the University of Massachusetts, Boston. As a Hausman fellow, I had the opportunity to shadow nurses on different units from the Cardiac ICU

to the Same Day Surgical Unit. You name the unit, and chances are I've been there. All the nurses I worked with had special qualities that made them 'tick' as a nurse—whether it was their good clinical skills, their time management abilities, or just their people skills. I observed these nurses, learned new things from them, and hopefully was able to take some of these skills with me as I begin my nursing career.

As a Hausman fellow, I had the privilege of meeting people in different leadership roles. Each one of these leaders shared at least two hours of their time with me. It's not every day you

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2008 Hausman fellows with fellowship co-chairs, Deborah Washington, RN, director of PCS Diversity Program (center back), and Bernice McField-Avila, MD (right front).

get to sit down and have a conversation with people of this stature. This was one of the highlights of my experience as a Hausman fellow.

My name is Christopher Uyiguosa Isibor. It is with great pride that I introduce myself as a Hausman fellow. I am a student at the University of Massachusetts, Boston, and this was the best summer of my life. I felt like a kid in a candy store. When I'm asked what the Hausman fellowship is all about, I put on my ego cap and describe the impact the Hausman Fellowship has had on me from the mini-leadership conference with my mentor, Deb Washington, to shadowing various nursing leaders at MGH.

Every day I woke up looking forward to another great experience. From one department to another, MGH staff nurses were receptive and showed great interest in teaching. I was impressed with the teamwork and leadership skills of nurses in every department.

Every day I woke up looking forward to another great experience. From one department to another, MGH staff nurses were receptive and showed great interest in teaching. I was impressed with the teamwork and leadership skills of nurses in every department.

One of the best experiences I had was with a resource nurse where I got to view the unit from a different perspective, getting to know a little bit about every patient. The importance of delegating and prioritizing was one of many lessons I learned. I was able to see leadership and compassionate care in action.

The Hausman Fellowship helped energize my future prospects in nursing. The opportunity to see the hospital from a 360° angle was fascinating. I was able to participate in leadership and clinical rotations throughout the hospital and witness the unique contributions of each member of the team.

I started the Hausman Fellowship not knowing what direction my nursing career would take. I can now say that based on my experiences, I have come to a decision. I will pursue my interest in securing a position in nursing leadership. The Hausman Fellowship gave me the opportunity to participate in clinical situa-

tions in outpatient and inpatient settings. I was guided by mentors and had the chance to shadow minority leaders and mentors.

My experience with the Hausman Fellowship has made me a better student nurse, both clinically and intellectually. It taught me to be diligent and proficient and gave me insight into leadership in nursing. I look forward to living up to that expectation and making an impact when I graduate. To the Hausman family and to my mentors, Deborah Washington and Bernice McField-Avila, thanks for giving me this opportunity to prepare for the future. I am ready for my senior year, and it is with great pride that I return to school as a Hausman fellow.

My name is Frew Fikru. I am a senior nursing student at the University of Massachusetts, Boston. This summer I participated in the Hausman Fellowship Program for Diversity in Nursing. The program was an eye-opener for me. Even though my school has its own clinical rotation program, opportunities to observe procedures are limited. The experiences I gained through the Hausman Fellowship were wide and diverse. It helped me decide on the direction I want my nursing career to take.

On day one of the program, Deb Washington explained the organizational structure of the hospital and talked to us about influence and leadership in nursing. In the days that followed, I observed practice in the Wound Care Clinic, Endoscopy, Oncology, the SICU, the Neuro ICU, and I spent time with the IV Nursing Team. The theoretical and conceptual knowledge I had gained through reading is now alive in my mind forever. And the welcoming faces of nurses on every unit was inspirational. All the nurses I met were so passionate and had a strong drive to teach. I could see that nurses at MGH are the best of the best.

My goal is to be a role model and collaborative leader in nursing. Mentoring my fellow students and establishing a diversity network in school is my number one priority. This program will help me be a critical thinker, a leader who builds by confidence and collaboration. I don't have enough words to thank Deb Washington and Bernice McField-Avila for working with us and teaching us on a daily basis.

Last but not least, I would like to thank the MGH Board of Trustees for understanding the need for diversity in nursing. Many thanks to the entire MGH community for allowing us to be involved in this wonderful program.

New nurse learns meaning of ‘personal investment’ in patient care

I wanted to tell him I was sorry he had to go through this. I wanted to cry with him and tell him she would be okay because she had to get back to her daughters. But I had never seen a patient so sick.

My name is Carol Vivaldelli, and I am a new graduate nurse in the Cardiac ICU. Like most new nurses, I find I am very introspective, constantly relating my patients’ situations to my own life experiences.

With less than two months experience and still working under the watchful eye of my preceptor, I can typically be found in a little bubble I’ve made for myself, so focused on caring for my patients I barely know who’s working right next to me. But I always give myself a moment alone with my patients—especially the really sick ones—to give them a little pep talk.

The morning I met Mrs. P started with report, as usual. On that particular morning, I remember understanding only bits and pieces of what was said. What was a ‘pigtail catheter’ and where did it go? Why was Mrs. P on such high doses of Levophed if her fingers were necrotic? While these questions ran through my head, the words, “really sick,” were being uttered by the night shift nurses and my preceptor. That was a phrase I understood.

I began my day as I always did with a checklist of things I needed to do. I introduced myself to Mrs. P and her family. Her husband stood by the door waiting for us. He was a big guy wearing a T-shirt that read “Body by Burger King.” I was so focused, I didn’t even look at his face. He remained in the room for the majority of the day, only leaving when absolutely necessary for procedures. He talked to my preceptor and me



Carol Vivaldelli, RN, staff nurse, Cardiac Intensive Care Unit

about their two daughters, ages 6 and 8. He didn’t want to bring them in, he didn’t want to tell them how sick Mrs. P was. He struggled with the idea of giving them any information about their mother’s critical condition. That’s when my introspective side kicked in.

I thought about my own mom and how she had died of sudden cardiac arrest with no prior symptoms. I remembered the night my dad went to the emergency room and how he sat with my sister and me and told us she was dead. I had refused my dad’s offer to see her in the hospital. I thought about how he must have felt giving us such tragic news. I thought: this man is standing exactly where my own dad had stood 14 years earlier. I wanted to cry. I’m sure the sight of Mr. P—shoulders slumped forward, hands out pleadingly—I’m sure there were tears in my eyes.

I didn’t know what to do, so I completed my hourly tasks. It was all I could handle. I performed my morning assessment, oral care, turning, and suctioning. I felt confident in my ability to do these small things for Mrs. P. I felt Mr. P’s eyes on me. I wanted to tell him

continued on next page

I caught a glimpse of Mr. P. He was pushing a woman in a wheelchair. It took a few seconds to realize it was Mrs. P. She looked beautiful... Mr. P recognized me at the same moment I recognized him. We smiled at each other; then the elevator doors closed. I never got to see Mrs. P greet her daughters after her stay in the ICU. But I can imagine what that reunion must have been like. And that's enough.

I was sorry he had to go through this. I wanted to cry with him and tell him she would be okay because she had to get back to her daughters. But I had never seen a patient so sick.

With my preceptor's confident guidance, we titrated her medication. The cardiac fellow drained her pericardial catheter. Where was all that fluid coming from? I was shocked as he reported the amount of fluid he drained. "Thirty ccs. Next draw at ten o'clock." I held the bag of pericardial fluid, knowing it was the source of her instability. I threw it in the biohazard bag.

Mrs. P's cardiac output measurements improved with each draining. Something was improving. We measured the perfusion to her feet and there was improvement from the previous day. But her fingers and toes were black, like she'd dipped them in ink. They were starting to blister. I was afraid to touch them. The vascular doctor suggested we apply topical nitropaste in hopes it would restore some perfusion. I wanted to squeeze out the entire contents of the tube, anything to help her.

I watched as Mr. P stroked her fingers. He, too, wanted to get rid of the blackness. He asked my preceptor if there was anything else that could be done.

"She makes the important decisions in the family," he said. "She'd kill me if she knew I could have done something and didn't." His desperation was obvious. I wanted to hug him, but I felt as powerless as he did. I thought about his daughters, and how they had no idea how sick their mom was. I thought of myself the night my mom died, having no clue how my life was about to change.

That night, I went to bed anxious to get back to Mrs. P the next morning. I'd never felt that kind of personal investment as a student nurse. The next day, when I headed for Mrs. P's room, my preceptor was already there assessing her. Mrs. P's pressor requirements had increased overnight, and her Levophed dose was as high as it had been the day before. It was shocking to me that after making so much progress, things could slide backward. Just as before, Mr. P stood by his wife's bedside. I think he was wearing the same T-shirt. Had he stayed with Mrs. P all night? Hadn't he gone home to see his daughters or get some sleep? I was suddenly overcome with emotion.

Later that morning, alone in the room with Mrs. P, I gave her my little pep talk. But this one was different from the others. This was a plea from a motherless daughter. I pleaded with Mrs. P on behalf of her own daughters. She was simply not allowed to die. Those girls could not grow up without a mother. Mrs. P was

heavily sedated. She gave no indication she had heard me. But I told myself she knew she had to get better. The ball was in her court.

Later that morning, the respiratory therapist gave Mrs. P a spontaneous breathing trial, which she tolerated well. My words had gotten through to her, I thought. We turned off the sedation, and with the respiratory therapist's instructions, I assisted in extubating her. It was my first extubation.

It's strange when you've only known a patient as intubated, then suddenly she has a voice. Mrs. P's first words were, "My throat hurts." I almost laughed. I was half expecting her to look at me and say, "Thank-you, Carol." Didn't she remember my pep talk? Didn't she want to tell me how right I was about needing to live for her husband and daughters? I pushed the selfish thoughts out of my head and went to get her some ice chips. Mr. P hovered over her.

When I left that afternoon, I felt relieved as if I knew I had done my job. There was nothing else I could offer Mrs. P or her family.

When I returned to work the following week, I learned that Mrs. P had transferred to the step-down unit. I wanted to find her location and talk to her. But I was afraid she wouldn't remember me. Or was I afraid she *would* remember me. Had I spoken too personally to her? Had my feelings toward her been out of place?

About two months later, I was on the elevator. As the doors started to close, I caught a glimpse of Mr. P. He was pushing a woman in a wheelchair. It took a few seconds to realize it was Mrs. P. She looked beautiful. Her hair was curly. Her skin glowed. Mr. P recognized me at the same moment I recognized him. We smiled at each other, then the elevator doors closed. I never got to see Mrs. P greet her daughters after her stay in the ICU. But I can imagine what that reunion must have been like. And that's enough.

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

Carol began by telling us she relates her patients' situations to her own life experiences. I interpreted that to mean that she puts herself in their shoes. And isn't that what you'd want any good caregiver to do? We don't know whether Mrs. P heard Carol when she 'willed' her to get better, but Carol spoke from the heart. This narrative reflects the candor, passion, and sense of discovery felt by so many new clinicians. I think Carol's mom would be proud.

Thank-you, Carol.

Staff Perceptions of the Professional Practice Environment Survey

generating knowledge for the future

—by Susan Lee, RN, nurse scientist, The Yvonne L. Munn Center for Nursing Research

Clinicians
within Patient Care
Services are experts
when it comes
to evaluating our
practice environment.
The Staff Perceptions
of the Professional
Practice Environment
Survey is one way
to make that
expertise
known.

Did you ever think that filling out a survey would help generate knowledge? That's exactly what happens when you complete the Staff Perceptions of the Professional Practice Environment Survey. Clinicians within Patient Care Services are experts when it comes to evaluating our practice environment. The Staff Perceptions of the Professional Practice Environment Survey is one way to make that expertise known. The knowledge captured by the survey influences our strategic direction. Some of the outcomes generated by the survey in past years, include:

- The Clinical Recognition Program was created in response to 1998 survey data that identified a need for recognition of clinical work
- The Center for Clinical & Professional Development expanded in response to 1998 survey data that identified a need for more educational opportunities
- Pagers were assigned to social workers in response to survey data in 2000 that identified a need for improved access to social workers
- The Materials Management Nursing Task Force was created in response to the 2000 survey that identified concerns about supplies and linens
- The Culturally Competent Care Lecture Series was launched in response to the 2001 survey that identified a need to inform clinicians about culturally sensitive care

- Nursing directors' span of control was reduced in response to the 2001 survey that identified a need to improve managers' availability
- An increased use of e-mail and the creation of the "Fielding the Issues" column in *Caring Headlines* came about in response to the 2002 survey that identified a need for improved communication
- The Parking and Commuter Services Task Force was created in response to the 2006 survey that identified parking and transportation issues as an ongoing challenge

These are only some of the changes precipitated by PCS clinicians through the Staff Perceptions of the Professional Practice Environment Survey. The knowledge culled from the survey is used by leaders to build teams, enhance communication, address conflict, and support autonomy and control over practice. This knowledge has guided the advancement of our diversity program, leadership-development curricula, educational programs, strategic planning, and unit-based initiatives.

The Staff Perceptions of the Professional Practice Environment Survey gives staff an opportunity to inform change at MGH. In 2006, 1,837 clinicians responded. We hope to increase the response rate this year. The survey will be available on-line through October. Please share your knowledge and complete your survey as early as possible. For more information, contact Susan Lee at 4-3534.

Tiger Teams roar into action to cut costs and eliminate waste

Over the past two months, Tiger Teams have reviewed data, identified opportunities for savings, implemented pilot programs, and explored opportunities to share best practices with other units and departments throughout the hospital.

Question: We hear a lot about waste and inefficiency in health care. What are we doing in Patient Care Services to help identify opportunities to make our work more efficient?

Jeanette: In looking at ways to cut costs and increase efficiency, we are exploring every opportunity to reduce operating expenses. A comprehensive examination of non-salary expenses (goods and services) has led us to take a closer look at our utilization practices regarding laundry and linens, room stocking, bed and vacuum-assisted closure (VAC) rentals, IV supplies and catheters, lab services, biomedical repairs, forms, and office supplies. These are the areas we're focusing on to eliminate waste.

Question: It seems like an enormous undertaking. How are you going about it?

Jeanette: Earlier in the summer, we formed Tiger Teams to address each of the issues listed above. Tiger Teams are so named because they're empowered to evaluate systems, make decisions, and implement changes quickly. Over the past two months, Tiger Teams have reviewed data, identified opportunities for savings, implemented pilot programs, and explored opportunities to share best practices with other units and departments throughout the hospital.

Question: Has the work of the Tiger Teams resulted in any significant savings?

Jeanette: Early reports are encouraging. One team discovered that by switching from a name-brand to a private-label toothpaste, we could cut our cost in half. Unit service associates pointed out that we re-wash a lot of clean linen resulting in an unnecessary expense. A seven-day survey on a single unit found a significant amount of clean linens being re-washed each week. Extrapolated out, it equals 7,300 pounds of linens per year—the equivalent of three Toyota Corollas. Since we pay for laundry services by the pound, that was an obvious opportunity to eliminate waste while at the same time improve efficiency, and have a positive impact on the environment.

Question: How can we help?

Jeanette: You may be our best source of solutions. As you go about your daily work, you're in a position to see opportunities for improvement. If you have any ideas about how we can eliminate waste, reduce costs, or improve service, contact Jennifer Daniel, RN, staff specialist, at 6-6152.

Announcements

Iftar, the breaking of fast in the month of Ramadan

In the spirit of unity and community-building, Patient Care Services, Human Resources, and the MGH Muslim community invite you to Iftar dinner. All are welcome.

Thier Conference Room
Tuesday, September 16, 2008
6:00pm–8:00pm
(Iftar is at 6:52pm)

RSVP to: fpathan@partners.org

Symposium on geriatric care

65plus and The Norman Knight Nursing Center for Clinical & Professional Development present: the second annual Best Practices in Acute Care for Older Adults

This two-day program brings together experts to discuss patient-centered and evidence-based care of older adults. All clinicians are welcome; recommended for those interested in geriatric certification.

Friday, October 31, 2008, and
Monday, November 17, 2008
8:00am–4:00pm
O'Keefe Auditorium

For more information, call 643-4873.

Work-Life seminar

"Introduction to Home Ownership"

Robert Gray, senior mortgage originator for the Harvard Credit Union will provide an overview of the purchasing process for new home-owners. Tips will be provided on how to make the best decisions in today's uncertain financial market.

Free pre-approval for first-time home buyers. Receive a free *Home Buyers Handbook*.

Wednesday, September 24, 2008
12:00–1:00pm
Thier Conference Room

Feel free to bring lunch

For more information, call the Employee Assistance Program at 726-6976.

RN Residency Program: Transitioning to Geriatric and Palliative Care

The next session of the RN Residency Program begins October 15, 2008, for nurses 45 and older interested in geropalliative care. The program consists of six classroom days, three clinical days, and a nine-month mentorship with a younger nurse on your unit to improve nursing care to older patients and their families.

For more information, contact Ed Cokley, RN, at 6-6152.

Celebrate the Jewish high holy days

Sponsored by the MGH Chaplaincy
Rabbi Ben Lanckton

Monday, September 29, 2008
Erev Rosh Hashanah:
the Eve of the New Year
3:00pm

Hayom Harat Olam: Today the World was and is Created

Services are held in the MGH Chapel and open to all.
For more information, call Rabbi Lanckton at 4-3228.

2008 Robert W. Carey, MD, Lectureship

Sponsored by the nursing staff of the Yawkey 8 Infusion Unit

Speaker: Debra Jarvis, MDiv, oncology chaplain, Seattle Cancer Care Alliance

Topic: "Caring for Our Own in Times of Serious Illness and Stress"

Thursday, September 25, 2008
5:00–7:30pm
O'Keefe Auditorium

All are welcome
No charge for MGH employees
Other fees may apply

For more information or to register, e-mail: cghiloni@partners.org, or call 617-724-5420.

Join Collaborative Governance

The annual application period for Collaborative Governance ends September 30, 2008. Applications are available on-line from the Patient Care Services website. Applications must be submitted electronically.

For more information, call 4-3534.

Staff Perceptions of the Professional Practice Environment Survey

By now, clinicians within Patient Care Services should have received the Staff Perceptions of the Professional Practice Environment Survey.

The survey gives clinicians a chance to voice their support and/or concerns about aspects of the professional practice environment. Every voice is important. All information is reported.

Please make it a priority to respond.

For more information, call Susan Lee, RN, at 4-3534.

Call for Abstracts

Nursing Research Expo 2009

Submit your abstract to display a poster during Nursing Research Expo 2009

Categories:

- Original research
- Research utilization
- Performance improvement

For more information, contact Laura Naismith, RN; Teresa Vanderboom, RN; or your clinical nurse specialist.

To submit an abstract, visit the Nursing Research Committee website at: www.mghnursingresearchcommittee.org

The deadline for abstracts is January 15, 2009.

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Submissions

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

Next Publication

October 2, 2008

Educational Offerings – 2008

September

25

Nursing Grand Rounds

O'Keefe Auditorium
1:30–2:30pm
Contact hours: 1

September

25

Caring for Patients with Heart Failure

Simches Conference Room 3110
8:00am–4:30pm
Contact hours: TBA

September

26

MGH School of Nursing Alumni Program

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

September

26

Ovid/Medline: Searching for Journal Articles

Founders 334
9:00–11:00am
Contact hours: 2

October

1

Simulated Bedside Emergencies for New Nurses

POB 448
7:00am–2:30pm
Contact hours: TBA

October

1

PALS Instructor Class

Founders 325
8:00am–4:30pm
No contact hours

October

3 & 24

End-of-Life Nursing Education Consortium

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

October

6

Building Relationships in the Diverse Hospital Community: Understanding our Patients, Ourselves, and Each Other

Founders 325
8:00am–4:30pm
Contact hours: 6.8

October

6 & 20

ACLS Provider Course

Day 1: 8:00am–4:30pm
O'Keefe Auditorium

Day 2: 8:00am–3:00pm
Thier Conference Room
No contact hours

October

7

BLS/CPR Certification for Healthcare Providers

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

October

8

OA/PCA/USA Connections

Bigelow 4 Amphitheater
1:30–2:30pm
No contact hours

October

10

Basic Respiratory Nursing Care

Bigelow Amphitheater
12:00–4:00pm
No contact hours

October

10

Intermediate Respiratory Care

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

October

14

New Graduate RN Development Program

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

October

14

Chaplaincy Grand Rounds

Yawkey 2-220
11:00am–12:00pm
No contact hours

October

15

Intermediate Arrhythmia

Simches Conference Room 3120
8:00–11:30am
Contact hours: 3.5

October

15

Pacing Concepts

Simches Conference Room 3120
12:15–4:30pm
Contact hours: 3.75

October

15

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

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

October

15

Congenital Heart Disease

Haber Conference Room
7:30am–12:00pm
Contact hours: TBA

October

16

Management of Patients with Complex Renal Dysfunction

Yawkey 4-810
8:00am–4:30pm
Contact hours: TBA

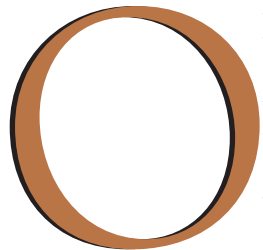
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Barriers to insulin therapy

The July More than Just a Journal Club research presentation

—submitted by the Nursing Research Committee

For more
information
about the
Nursing Research
Committee's More
than Just a Journal
Club, contact
Catherine Griffith,
RN, at 6-3294.



On July 9, 2008, the Nursing Research Committee welcomed Mary Larkin, RN, and Virginia Capasso, RN, to its bi-monthly, More than Just a Journal Club session. Larkin and Capasso presented their recently published research, "Measuring psychological insulin resistance: barriers to insulin use," from the May/June issue of *Diabetes Educator*. Larkin and Capasso used two self-reporting surveys to measure the prevalence of psychological insulin resistance, psycho-social barriers to initiating insulin therapy, in 100 Type II diabetes patients who were not taking insulin. The authors shared that their research question had emerged from their clinical practice; they had recognized that a delay in transitioning patients from oral medication to insulin therapy was adversely affecting patients' health. Of the

100 patients participating in the study, 33% reported they would be unwilling to start insulin therapy if prescribed.

Larkin and Capasso identified several barriers that led participants to delay insulin therapy, including: a sense they had failed to manage their disease; concern that their families would worry; a belief that their lives would be less flexible; and concern that their diabetes was getting worse. They recommend that clinicians identify individual barriers to insulin therapy to help facilitate earlier acceptance and decrease the length of time patients may be exposed to hyperglycemia due to psycho-social barriers.

The presentation was followed by a thoughtful discussion where attendees shared personal and clinical experiences with psychological insulin resistance.

For more information about the Nursing Research Committee's More than Just a Journal Club, contact Catherine Griffith, RN, at 6-3294.

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