Caring Headlines
September 16, 2010

Certified nurse-midwives

Certified nurse-midwife, Dana Cvrk, CNM (right), and labor & delivery nurse, Elizabeth West, RN, support patient, Kerin Mejia, through a labor contraction moments before she gave birth to a beautiful baby girl.
See senior vice president for Patient Care, Jeanette Ives Erickson's, column on page 2.

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Certified nurse-midwives

When choosing a caregiver to guide them through pregnancy and childbirth, women should know they have a choice

Nurse-Midwifery Philosophy of Care

- Focus on prevention and education
- View pregnancy as a normal process
- Provide compassionate, family-centered care
- Encourage women's participation in decision-making
- Use technology and intervention appropriately
- Consult, refer, and collaborate with members of the healthcare team

Nurse-midwifery has been a recognized healthcare profession since the early 20th century, but surprisingly, many people are still unclear about what nurse-midwives do. First established in rural Kentucky in the 1920s, nurse-midwives brought family health services to poor and under-served areas of the Appalachian Mountains. Today, more than 7,000 certified nurse-midwives practice in all 50 states providing individualized, holistic care as integral members of the obstetrical team.

Certified nurse-midwives are registered nurses who've completed graduate-level training in midwifery, passed the national certification exam offered by the American Midwifery Certification Board, and been licensed by the state to practice in birthing centers, clinics, and hospitals. At MGH, nurse-midwives practice within guidelines established in collaboration with the division of Maternal Fetal Medicine and within the scope of practice prescribed for advanced practice nurses. Of the more than 3,500 babies delivered at MGH each year, approximately one third are delivered by nurse-midwives.

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

Nurse-midwives bring a holistic approach to the management of pregnancy, labor, and childbirth. They have their own patients and work collaboratively with obstetricians and maternal fetal medicine physicians within the Vincent multi-disciplinary obstetrical service.

According to Marie Henderson, CNM, director of the Nurse-Midwifery Program, "A nurse-midwife can start to manage the prenatal care of an expectant mother as early as the first positive pregnancy test. If, after a risk assessment, a pregnancy is deemed low-risk (as the vast majority of pregnancies are), a woman can choose to have a nurse-midwife manage her care. The goal of nurse-midwives is to support the choices women make by providing accurate information, encouragement through the discomfort of pregnancy, respect for cultural values, and anticipatory guidance."

continued on next page

For the well-being of both the baby and the mother, nurse-midwives talk to expectant mothers about prenatal testing, smoking, alcohol use, nutrition, weight-control, exercise, flu shots and other vaccines, oral care, breast-feeding, motherhood, home/life balance, even the use of seat belts.

Contrary to popular misconceptions, giving birth with the guidance of a nurse-midwife does not necessarily mean giving birth at home, nor does it mean giving birth without the benefit of pain medication. Natural childbirth (no medication) can be accommodated when it's the mother's choice, but pain medication and/or an epidural are available.

As Henderson is quick to point out, "That's what makes MGH such an incredible place to give birth. Women who choose midwifery care can deliver in a birthing room in the company of their partner or support person, the midwife, and a labor nurse. The entire obstetrical team (obstetricians, pediatricians, anesthesiologists, maternal-fetal medicine specialists, and access to the MGH Blood Bank) is available if the need arises. Nurse-midwives are trusted members of the obstetrical team. Every woman contemplating motherhood should know that nurse-midwifery care is safe for moms and safe for babies."

Nurse-midwives view the onset of pregnancy as an opportunity to provide valuable health education. For the well-being of both the baby and the mother, nurse-midwives talk to expectant mothers about prenatal testing, smoking, alcohol use, nutrition, weight-control, exercise, flu shots and other vaccines, oral care, breast-feeding, motherhood, home/life balance, even the use of seat belts. Moms are given the most up-to-date information to empower them to make the best choices for themselves and their babies.

Midwives encourage a variety of positions for women during labor (as shown in the photo on the front cover). Shifting positions helps women cope with the pain of childbirth more effectively.

MGH serves a global community. Respect for cultural values is an important part of midwifery care. Supporting the choices of women who come to us from other countries means honoring the beliefs and traditions surrounding labor and childbirth in their native countries. A map of the world hangs in the midwifery call room as a way of affirming the local and global practice of MGH midwives.

Midwives are trained to assess complications throughout pregnancy. During the day, the triage area on the Labor & Delivery Unit is run by midwives who assess each woman's concerns and admit, or defer admission, accordingly.

Says Henderson, "It's a privilege to do what I do. As a midwife, I bring a set of skills to women as they give birth. To touch a baby's head as it enters the world and hand that baby to its mother is an incredible moment."

Nurse-midwife, Amy Kogut, CNM, says one of her favorite things about being a nurse-midwife is, "that moment when the mom and family see their baby for the first time—especially when they don't know the gender. They just love it because it's here, it's theirs, and it's amazing. There's just nothing else like it."

For information on becoming a nurse-midwife, e-mail Marie Henderson at: mchenderson@partners.org. To arrange a consult with a nurse-midwife at MGH, call 617-724-2229.

In this Issue

Ramadan at MGH

an opportunity to celebrate and educate

—by Firdosh Pathan, RPh

On August 24, 2010, in the spirit of unity and community-building, Patient Care Services, Human Resources, and the MGH Muslim community held an Iftar (a breaking of the fast during the Holy month of Ramadan). It was the tenth observance of this important Muslim holiday, and heavy rain didn't dampen the spirits of employees, patients, families, and visitors as they came together to enjoy good food and good company. Firdosh Pathan, RPh, who organized the event, and Audrey Jasey, RN, co-chair of the PCS Diversity Committee, offered welcoming remarks. Guest speaker, Abdur-Rahman, provided insight into the meaning and importance of fasting during the month of Ramadan. And Muslim chaplain, Imam Talal Eid, ThD, led the gathering in prayers.

Muslims follow the religion of Islam. Ramadan is a special month for more than 1.2 billion Muslims around the world. It is a time for inner reflection and devotion to God. During Ramadan, the ninth month of the Islamic

Below: event organizer, Firdosh Pathan, RPh, and guest speaker, Abdur-Rahman, welcome guests before (at right): breaking fast

(Photos by Paul Batista)

Good food. Good friends. Evening prayers. And a chat about the benefits

lunar calendar, healthy Muslim adults and many children fast from dawn until sunset. Smoking and marital intimacy are forbidden during fasting, and at the end of the day the fast is broken with prayer and a meal called the Iftar.

During Ramadan, Muslims perform good deeds such as giving more to charity, discontinuing bad habits, visiting one another, or helping the sick and poor. Ramadan is a time for Muslims to be better Muslims. The elderly and expectant mothers may abstain from these practices or choose to observe the fasting tradition at another time of year.

The purpose of Ramadan and the fasting tradition is to acquire self-control, discipline, generosity, and God-consciousness. Because Ramadan is a lunar month, it begins approximately 11 days earlier each year.

At the end of the holy month, Muslims celebrate Eid-ul-Fitr, the festival of fast-breaking, which will take place this year September 10th or 11th (depending on the sighting of the moon).

Typically, Muslims celebrate Iftar with family in their home countries, but many Muslims living in the United States are apart from their families during Ramadan. Having an opportunity to share this celebration with friends and colleagues in the MGH community was a much-appreciated gesture for Muslim staff and patients.

Perhaps Pathan said it best in his prayer prior to breaking fast, "We have one God, one humanity, one world to share. I hope that all the people of the world who pray to this God can one day live together in Peace."

For more information about prayer times or to learn more about the Muslim religion, send e-mail to teid@partners.org or fpathan@partners.org.

Above: Friends of all ages enjoy time together. Below: Muslims pray before breaking fast.

of fasting. What better way to spend a Ramadan evening?

Traditional dance is good medicine for patient on Cardiac Step-Down Unit

She had been at MGH for four months eating unfamiliar food, being cared for by people who spoke a different language, and undergoing procedures that must have seemed as foreign to her as her surroundings... I thought how frustrating it must be for her to be a stranger in this strange land.

My name is Daphne Noyes, and I am a staff chaplain. I work primarily on the Interventional Cardiology Unit, the Cardiac Surgical ICU, and the Cardiac Surgical Step-Down Unit. Like other MGH chaplains, I provide spiritual care to patients and families of all backgrounds, denominations, and faith traditions, and to those who don't subscribe to any particular tradition.

Patients who've been hospitalized for a long time can become withdrawn, listless, or what a chaplain might describe as, dispirited. This was the case with Mrs. A, a 70-year-old Arabic-speaking woman. When I met Mrs. A, she was in the Cardiac Surgical ICU, sedated and intubated. I spoke to her softly, held her hand, said a silent prayer, and left. This became my routine as she remained seriously ill in the ICU for several weeks.

One afternoon I met her sons, who spoke English as well as Arabic. I described the role of the Chaplaincy and told them about my visits with their mother. They seemed vaguely appreciative, but disinterested. The Imam (Muslim chaplain) who had also visited Mrs. A confirmed that the family expressed little interest in chaplaincy support.

Over time, Mrs. A was transferred several times between the ICU and the Step-Down Unit. She had been at MGH for four months eating unfamiliar food, being cared for by people who spoke a different language, and undergoing tests and procedures that must have seemed as foreign to her as her surroundings. Treatment decisions were made by one of her sons. I thought how frustrating it must be for her to be a stranger in this strange land.

Staff nurse, Rachel Spence, RN (left), and staff chaplain, Daphne Noyes

My name is Rachel Spence. I have been a cardiac surgical nurse on the Cardiac Step-Down Unit since 2004. Recently, I had the privilege of taking care of Mrs. A. She had come to Boston to visit family last October when she unexpectedly ended up in a community hospital undergoing major surgery. After several complications from surgery and other chronic health issues, Mrs. A was brought to MGH.

In caring for Mrs. A, I learned a lot about who she was despite the differences in our language and culture. I knew that when I left her room, she liked to have her TV remote and suctioning device (a tip that let her suction her oral secretions) nearby; she liked her blankets pulled up to her neck so only her head peeked out; she liked that I held her hand when she was anxious or not feeling well; and she liked that I helped her understand her dialysis routine. We spent a lot of time together. My desire was to help Mrs. A become physically well and also address her spiritual and emotional

continued on next page

needs. Mrs. A's spiritual and emotional needs became a critical part of her healing process. In thinking about how to encourage Mrs. A's well-being, I knew that all disciplines involved in her care would have to work together.

Daphne: I recalled several studies that spoke to the positive effect music can have on cardiac patients. I thought this might be a way to lift Mrs. A's spirits. I consulted a friend familiar with Middle Eastern arts and culture, and she suggested an Egyptian singer, Um Kalthoum. I brought a CD of Um Kalthoum's recordings to Mrs. A's room. When the music started to play, I saw Mrs. A smile for the first time. I let Mrs. A's nurse, Rachel, know about this intervention so that Mrs. A could enjoy the music as often as she liked.

But I still sensed there was more we could do.

It wasn't a big leap from music to dance. Not that Mrs. A would be able to dance, but she might enjoy seeing some traditional folk dancing from her native country. I ran the idea by Rachel and the nursing director, who both enthusiastically agreed. Mrs. A's son, who was overseas at the time, translated the offer to his mom by phone. Mrs. A welcomed the chance to see a bit of culture from her homeland. I contacted a local dancer and explained the situation. She was happy to comply with our request to provide this unusual form of healing to Mrs. A.

Rachel: One evening after a difficult day of testing and generally not feeling well, Mrs. A got her wish. With the help of the Chaplaincy, we arranged for an Egyptian folk dancer to come to Mrs. A's room. As the music began, Daphne, several unit service associates and critical care technicians, and I watched the 'private' performance along with Mrs. A.

Daphne: The dancer arrived around 6:00pm wearing a deep green, floor-length dress with gold spangles, a headband, and sandals. I escorted her to Mrs. A's room. Introductions were made using a combination of hand gestures and Arabic-English translations (with the help of a unit service associate who spoke Arabic).

When the music started, the dancer began to sway and turn, moving her arms in graceful arcs, smiling at Mrs. A the whole while. With every movement, her dress made a gentle jingling sound. When the rhythm got livelier, Mrs. A began clapping along with the music, smiling broadly. I'd never seen her make voluntary movements like that before. The dancer ended her performance with a deep bow to Mrs. A in a gesture of respect and esteem. Despite her tracheotomy, Mrs. A called out, "Bravo!" several times.

Rachel: We watched Mrs. A smile and clap. You could feel the sense of peace she felt watching this reminder of 'home.' Our focus shifted from the dancer to Mrs. A. The smile stayed on her face long after the dancer was gone. That's when I realized that Mrs. A wasn't 'just' a patient. She was a mother, sister, wife, and friend who had touched our lives as much as we hoped we had touched hers. In my eight years of nursing, Mrs. A was the most challenging patient I ever worked with, but I grew to love her. It was a privilege to be her nurse, advocate, and friend.

Traditional Middle-Eastern folk dancer, Amanda (Hanan) Leone, performs the Baladi, the women's folk dance of Egypt

Daphne: In just five minutes, Mrs. A was transported back to her homeland. The music and dance lifted her (and staff) to a bright, happy place where we were all reminded of the fullness and beauty of humanity.

Rachel: Mrs. A recently transferred to another unit and another MGH 'family.' But I still visit her and tell her (in the broken Arabic I picked up over the past few months) that I miss her and hope some day she'll be able to return to her homeland as a whole, healthy person surrounded by the culture she loves and the people she holds dear.

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

It's not surprising that patients become dispirited after spending a long time in the hospital, especially when they're far from home as Mrs. A was. Daphne and Rachel recognized Mrs. A's need for an emotional 'boost,' and they found that boost in the form of a dancer from Mrs. A's homeland. What better medicine? They allowed Mrs. A to re-connect with her world through the joy of familiar music and dance. This narrative speaks to the power of teamwork, the importance of holistic care, and the indelible impact we have on patients and families.

Thank-you, Daphne and Rachel.

Smoke 'knot' here

reinvigorating our no-smoking policy

—submitted by the MGH No-Smoking Committee

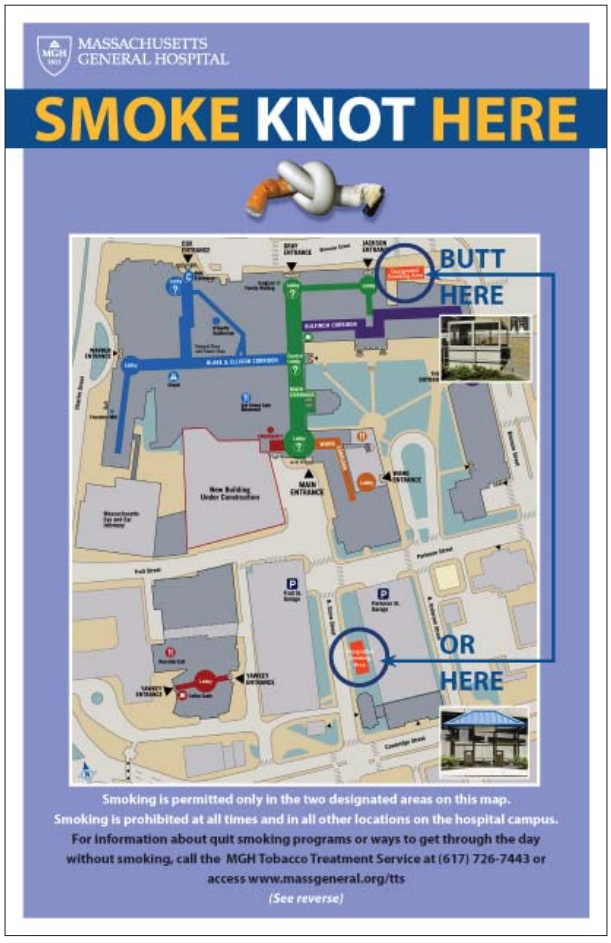
According to Nancy McCleary, RN, of the MGH Tobacco Treatment Service, "Smoking is the single most preventable cause of death and disability in the United States. Research shows that second- and third-hand smoke (the residue left from tobacco smoke) can seriously threaten the health of non-smokers." To promote good health for the entire hospital community, MGH discourages the use of tobacco products and is launching a hospital-wide no-smoking campaign on September 17, 2010.

The campaign, under the auspices of Jean Elrick, MD, senior vice president of Administration, and led by Bonnie Michelman, director of Police, Security & Outdoor Services, focuses on education, enforcement, and enhancement of the MGH no-smoking policy. The policy prohibits smoking in or around buildings owned or occupied by MGH. On the main campus, smoking is permitted *only* in two designated shelters: one on North Grove Street, and one on Blossom Street.

A series of posters and the slogan, "Smoke 'Knot' Here," have been developed to help communicate both the policy and the location of smoking shelters.

Says Michelman, "Our commitment to a smoke-free environment is important not just for the safety of our patients, families, and staff, but also to be compliant with Joint Commission, CMS, and other regulatory standards. We respect everyone's right to enjoy a smoke-free environment."

Several tools are available to help educate staff about the smoke-free policy and how to enforce it. The PCS Excellence Every Day website (http://intranet.massgeneral.org/excellenceeveryday/Toolkit/environmentofcare.asp) offers talking points for managers; handouts showing a map of the campus with the locations of the smoking shelters clearly marked; and a reminder to staff about appropriate use of nicotine-replacement products.



Says Michelman, "Managers and supervisors are expected to hold staff accountable for adhering to the no-smoking policy just as they would for any other policy such as attendance, performance, or dress code." This is a perfect example of, 'It takes a village.' If any MGH employee sees someone smoking in an undesignated area, he or she should let the individual know that MGH is a smoke-free environment and direct them to one of the shelters.

To assist employees who want to quit smoking, the Tobacco Treatment Service offers several options for assistance. For more information, call 6-7443.

2011 annual regulatory compliance education

Some important changes in the coming year

—by Gino Chisari, RN, director,
The Norman Knight Nursing Center for Clinical & Professional Development

HealthStream, the on-line learning-management system that allows us to manage, deliver, and track the learning activities of staff throughout Patient Care Services, has vastly improved our ability to provide and monitor our annual regulatory compliance education. Since 2009, PCS staff have used HealthStream to complete their annual required training. Completion dates for these courses typically coincided with the date of employees' annual performance appraisals. This was an effective system, but it was labor-intensive to track and compile compliance rates. HealthStream's electronic tracking and reporting functions allow us to customize the completion dates of required training to meet the specific requirements of regulatory agencies.

Beginning with the new fiscal year, PCS employees will participate in a pilot program in which 2011 regulatory compliance education will be assigned on October 1, 2010, with a mandatory completion date of December 31, 2010.

Beginning with the new fiscal year, PCS employees will participate in a pilot program in which 2011 regulatory compliance education will be assigned on October 1, 2010, with a mandatory completion date of December 31, 2010. Courses will include the standard fire-safety, infection-control, and HIPPA education, and for those with direct patient contact, there is updated information on restraint use, fall-prevention, and other quality and safety issues.

The new model will allow us to meet, and in some cases, exceed our regulatory requirement to maintain compliance on an annual basis. One benefit of adopting this new process will be having all members of Patient Care Services in compliance at the same time and within a very short time frame. Under the new system, as information changes, it will be easier to communicate those changes directly to those affected, and all clinicians will have the most up-to-date information available. The system will add an extra layer of safety to our efforts to provide high-quality, patient- and family-centered care.

The Knight Nursing Center HealthStream team worked with many content experts throughout the hospital to create a meaningful, comprehensive, and concise program. Annual regulatory compliance education is crucial in ensuring we're all informed and in sync as we work together to provide the safest possible environment for our patients, families, and one another. Staff of The Knight Nursing Center look forward to exploring new and innovative ways to meet and exceed our educational needs.

For more information on HealthStream of the changes in our annual regulatory compliance education, call 6-3111.

An update on the Acute Care Documentation project

Question: What's going on with the Acute Care Documentation project?

Jeanette: As you know, the Acute Care Documentation (ACD) project is a joint MGH-BWH initiative to automate the inpatient medical record. A sophisticated clinical information system called, MetaVision, is being configured to meet the specific needs of our clinicians. The new application will be called "e-chart."

Question: Who will use e-chart?

Jeanette: Everyone who provides documentation in the patient chart will use e-chart. That includes nurses; nurse practitioners; physicians; physician assistants; patient care associates; physical therapists; occupational therapists; pharmacists; respiratory therapists; case managers; social workers; speech pathologist; nutritionists; and chaplains. Initially, e-chart will be rolled out on three pilot units: the Ellison 4 Surgical ICU; the Ellison 9 Cardiac Care Unit; and the White 9 General Medical Unit.

Question: Does that mean MGH will be "paperless" once e-chart is implemented?

Jeanette: While the flowcharts and many notes will be computerized, the gray books will continue to house patient consents and other medical records not yet available electronically. The ACD project builds on the automated systems already in place, including provider order entry (POE) and the electronic medication administration record (EMAR).

Question: How will e-chart impact patient care?

Jeanette: Electronic systems help ensure patient safety and improve care. The goal of e-chart is to improve communication among members of the care team while streamlining the documentation process. With the new system, clinicians from both hospitals will be able to share patient information and develop integrated plans to improve patient care.

Question: How is e-chart being created?

Jeanette: The ACD project team, which includes nurses, physicians, health professionals, and information systems staff, is using an iterative process to ensure that content and design will work for end-users. The clinical content we gathered over the past year is being built into the MetaVision software. A separate usability team is ensuring that information is clear, efficient, and consistent from screen to screen, while a subject-matter team is reviewing content to ensure the design reflects clinician workflow. The ACD joint content committee, comprised of representatives from both hospitals, is reviewing this work and making recommendations for modification. This comprehensive process relies on participation from a multi-disciplinary team and follows sound informatics principles.

Question: Will there be enough computers for all clinicians?

Jeanette: More than 900 computers were installed at the bedside prior to the EMAR roll-out. The ACD project will see installation of new computers in hallways and common areas along with wide-scale distribution of mobile computers to support the work of roving-clinicians.

For more information about the ACD project, contact Sally Millar, RN, director of Informatics, at 6-3104.

Announcements

Eldercare
monthly discussion group

Join facilitators, Janet T. Loughlin, LICSW, Partners EAP, and Barbara Moscowitz, LICSW, geriatric social worker for the Eldercare monthly discussion group, sponsored by the Employee Assistance Program. Come and discuss subjects relevant to eldercare.

Next session:
October 12, 2010
12:00–1:00pm
Doerr Conference Room
Yawkey 10-650

Old friends and new members are welcome
Feel free to bring your lunch
For more information, call 6-6976 or visit www.eap.partners.org.

Save the date
Third annual WorkStrong Fair

The Institute for Patient Care and MGH Physical and Occupational Therapy invite you to attend the third annual WorkStrong Fair, featuring resources to keep our patients and ourselves healthy and safe.

Try out new equipment, learn about work-related injuries and how to prevent them, get your flu vaccine, enter a raffle to win a WiiFit or tickets to sporting events, and enjoy refreshments from Whole Foods, BoYo, and J. Pace & Son.

Thursday, September 30, 2010
11:00am–2:00pm and 3:00–5:00pm
Under the Bulfinch Tent

For more information, call 6-6548

MGH Bicentennial Logo
Submit your ideas

The LVC Retail Shops will help celebrate the hospital's 200th anniversary by carrying items featuring the MGH bicentennial logo. Submit suggestions. The first 25 staff to submit usable ideas will receive a $10 LVC Retail Shop gift card.

E-mail ideas to:
generalstoresurvey@partners.org
("MGH General" in Outlook)

October is Domestic Violence Awareness Month

Information tables will be set up in the Main Corridor to help raise awareness about domestic violence and hospital-wide resources available for patients and employees.

Tuesday, October 5, 2010
7:00–11:00am
Wednesday, October 6, 2010
10:00am–2:00pm
Main Corridor

For more information, contact Liz Speakman, director of HAVEN at MGH at 6-7674.

Nursing History
Call for photos and artifacts

In preparation for the MGH bicentennial, the department of Nursing is creating a book commemorating major nursing milestones.

The Nursing History Committee is looking for photographs, articles, artifacts, and information that would help describe the journey of MGH nurses.

Please send ideas to Georgia Peirce, director, PCS Promotional Communications and Publicity, at 4-9865.

Pathways of Healing

Mind-Body-Spirit
Continuing Education Program
presented by
the MGH Nurses' Alumnae Association

September 24, 2010
8:30am–4:00pm
O'Keeffe Auditorium

Speakers
Dr. Herbert Benson, director, MGH Mind-Body Institute;
Amanda Coakley, RN, staff specialist

$30.00 for MGHNAA members and MGH employees
$40.00 for all others

Register by September 17, 2010 at: www.mghsonalumnae.org or e-mail mghnursealumnae@partners.org

6 Contact Hours

Knight Visiting Scholar

Patricia M. Reilly, RN, program manager for Integrative Care at BWH is the 2010 Knight Visiting Scholar. A recognized expert in complementary therapies, Reilly has lectured extensively on stress-reduction, leadership-development, and caregiver fatigue. Her research focuses on the impact of complementary therapies on patients and clinicians.

Reilly will present, "The Shift is *on*! Are you ready to take the Quantum Leap?"

Thursday September 23, 2010
Grand Rounds: 1:30-2:30pm
O'Keeffe Auditorium

For more information, contact Mary Ellin Smith, RN at 4-5801.

Published by
Caring Headlines is published twice each month by the department of Patient Care Services at Massachusetts General Hospital

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For more information, call: 617-724-1746

Next Publication
October 7, 2010

An update on changes to collaborative governance

—by Mary Ellin Smith, RN, professional development manager

Over the course of the past year, collaborative governance has undergone several changes, and more changes are expected in the near future.

Applications are now being accepted for appointment and re-appointment to collaborative governance committees. Collaborative governance is a critical component of the professional practice model supporting communication and decision-making and placing authority, responsibility, and accountability for patient care with practicing clinicians.

Over the course of the past year, collaborative governance has undergone several changes, and more changes are expected in the near future. Changes made so far include:

- a re-design of the Nursing Practice and Quality committees
- the addition of an Informatics Committee to collaborative governance
- the transition of the Nursing Research committee to an inter-disciplinary research committee

The re-design of the Nursing Practice and Quality committees is occurring so that we're in a better position to address the relationship between quality and practice. Five sub-committees will report to the new Practice and Quality Committee. Sub-committees have been created to reflect the issues of most concern to patients, caregivers, and regulatory agencies. Staff seeking appointment or re-appointment to either the Nursing Practice Committee or Quality Committee will be asked to identify which sub-committee they'd like to be part of. The five sub-committees are: Fall Prevention; Pain Management; Restraint Usage; Skin Care; and Policy, Procedure and Practice.

Responding to technological advances, and in anticipation of electronic acute care documentation, an Informatics Committee has been added. This committee will evaluate and make recommendations related to technology and work closely on the roll-out of Acute Care Documentation.

The transition of the Nursing Research Committee to the Inter-Disciplinary Research Committee will help promote inter-disciplinary collaboration, evidence-based practice, and knowledge-development.

Applications are due by November 1, 2010; applications may be obtained from your directors. For more information, contact Mary Ellin Smith, RN, at 4-5801.

Caring Headlines
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Returns only to:
Bigelow 10 Nursing Office,
MGH, 55 Fruit Street
Boston, MA 02114-2696

First Class
US Postage Paid
Permit #57416
Boston, MA