

# Caring

Headlines

October 7, 2010

## New Graduate in Critical Care Nursing Program



Under the watchful eye of preceptor, Robert Bergman, RN, new graduate nurse, Kathryn Bunt, RN, performs oral care on an intubated, post-operative patient in the Surgical ICU. Bunt is a recent graduate of the 2010 New Graduate in Critical Care Nursing Program (see story on page 4).

# Healthcare reform

## *What is it, and what does it mean for Patient Care Services?*

What didn't receive quite as much attention back then, was the part of the new law that focuses on reducing healthcare costs, increasing the effectiveness of treatments, and improving the efficiency of care delivery.

**W**hen President Obama signed healthcare reform legislation into law last spring, the media focused primarily on expanding health-insurance coverage to include the more than 50 million Americans then un-insured. Public debate centered on how best to accomplish this—how quickly to require insurance, how comprehensive it should be, and what penalties should be imposed for those who chose not to participate. These were important questions, but for those of us in Massachusetts, it seemed like old news.

In 2006, Massachusetts had adopted near universal health insurance, mandated roles for individuals and employers in buying health insurance, taken steps to make it easier to purchase insurance, and expanded both access to primary care and Medicaid eligibility for low-income families. By 2009, 97% of Massachusetts residents had health insurance, and our state law had become the model for the healthcare reform bill that was ultimately signed by the President.

What didn't receive quite as much attention back then, was the part of the new law that focuses on reducing healthcare costs, increasing the effectiveness of treatments, and improving the efficiency of care delivery. And that's the part that's going to significantly change the way we do business for years to come.

Cost-reduction, or slowing the rate of cost growth, is central to this new law, which makes cost-reduction



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

an important issue for MGH. Rising healthcare costs is not a new problem. National healthcare costs have grown steadily for 40 years driven primarily by the cost of new technology and chronic diseases. And expanding health-insurance coverage is only going to exacerbate the problem.

Over the next ten years, reimbursement payments from Medicare will be smaller, and other payers are likely to follow suit. We can also expect smaller payments if, for example, we experience an increase in potentially avoidable hospital re-admissions or hospital-acquired conditions. There will be no payments for cases that involve 'serious reportable events' and lower payments if certain quality standards aren't met. These changes are part of a trend called 'value-based purchasing,' in which payment is based on how *well* services are delivered rather than the *volume* of services provided.

I have no doubt that we will meet this challenge, but it will mean changing the way we design and deliver patient care.

*continued on next page*

The pressure to do more with less is a reality. And it's not somewhere off in the future, it's now. To succeed over the next decade, we need to be creative, accountable, and focused. We need to look carefully for ways to identify gaps and waste. And we need to put systems in place to eliminate that waste.

The new law encourages innovation to reduce costs and improve care. We're already learning to provide better care for sicker patients through the MGH/MGPO Care Management Demonstration Project. Now in its third year (and expanding to include BWH and North Shore Medical Center), the project shows that investing in care-management in tandem with a well coordinated clinical team can minimize hospital admissions, reduce costs, and improve care for patients with chronic conditions.

In the past, the way hospitals and physicians are paid has proven an impediment to care re-design. Under the 'fee-for-service' method, hospitals and physicians are paid separately, which limits a hospital's ability to reduce costs or re-invest savings in systems-improvement. But that may be changing. The new law encourages some new strategies:

- *Bundled payments*: all costs associated with an episode of care (such as caring for a diabetic patient for one year, or caring for a hip-replacement patient before, during and after surgery) are combined. Caregivers work together to decide on the right services for each patient, sharing the savings that accrue when effective care is delivered at lower cost
- *Global payments and Medicare accountable care organizations (ACOs)*: a group of healthcare providers (hospitals, physicians, and others) band together to accept payment and responsibility for all the healthcare needs of a large group of patients (5,000 patients for a Medicare ACO) with a goal of reducing costs and improving quality. These 'global payments' are similar to the capitation contracts of the 1990s,

though some believe our ability to predict care needs has improved, making it less risky

- *Health care innovation zones*: an academic medical center (or group of AMCs) focuses on improving patient care and teaching while also reducing costs
- *Comparative effectiveness*: therapies available to treat the same illness are reviewed, and the most cost-effective, evidence-based treatment becomes the standard for care and reimbursement

These are just some of the terms we'll be hearing over the next few years. The pressure to do more with less is a reality. And it's not somewhere off in the future, it's now. To succeed over the next decade, we need to be creative, accountable, and focused. We need to look carefully for ways to identify waste and gaps in service. And we need to put systems in place to eliminate that waste.

Every decision we make should come from our commitment to improve care and eliminate non-value-added costs. That means tapping deeper into our ability to be resourceful and efficient. It may not be easy, but I know we are up to the challenge. We are accomplished collaborators, researchers, educators, and caregivers. These skills will serve us well in the months to come. Just as we have always been leaders in health care, let us also be leaders in healthcare reform.

#### Update

I'm happy to announce that Christina Stone, RN, most recently psychiatric clinical nurse specialist, has accepted the position of nursing director for the Blake 11 inpatient Psychiatry Unit.

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# New Graduate in Critical Care Nursing Program

—by Gail Alexander, RN, professional development manager

Standing (l-r): coordinator of the New Graduate in Critical Care Nursing Program, Gail Alexander, RN; Kathryn Bunt, RN; Amy Simpson, RN; Lara Jenkins, RN; and Jennifer Ashley, RN. Seated: Megan Cole, RN; Jessica Hancock, RN; and Sarah Abbott, RN. Leah Leonard, RN, is not pictured.

**O**n September 10, 2010, eight new graduate nurses from MGH and North Shore Medical Center joined the ranks of the 155 alumni of the New Graduate in Critical Care Nursing Program when they received certificates of completion at a ceremony in the Knight Nursing Center. Brian French, RN, Simulation Program manager and interim director of The Blum Patient & Fam-

ily Learning Center, congratulated participants for completing the rigorous six-month program. He recognized the commitment of the preceptors who assist new nurses to transition into clinical practice. Said French, “Through the power of example you allow graduates to grow, discover, and fulfill their passion for nursing.”

Nursing director, Colleen Snyderman, RN, described some of the strategies used to promote professional development in the Cardiac ICU. “Time is built into the schedule for new nurses and preceptors to step away from the clinical setting and reflect on their experiences. This gives novice nurses an opportunity to consider what they’ve observed, assessed, or accomplished in a quiet, non-stressful setting. We call this reflective practice. Clinical narratives help illustrate the experiences, decision-making, learning, and concerns of the developing nurse.”

Snyderman introduced new graduate nurse, Jessica Hancock, RN, who read her narrative (see page 6), and her preceptor, staff nurse, Sharon Nadworny, RN, who engaged in a dialogue about the experience described in the narrative.

Program coordinator, Gail Alexander, RN, reinforced the theme of emerging knowledge and skill by sharing quotes from other narratives written by participants in the program.

Surgical ICU nurse, Kathryn Bunt, RN, felt rewarded when she established a rapport with a patient’s wife who had been struggling with her role as proxy and decision-maker for her husband. Said Bunt, “As nurses, we’re obligated to put our feelings aside and make every attempt to do precisely what the patient would want. Through honest communication and



## Education/Support (continued)

heartfelt support, we're meeting the needs, not only of the patient, but also the family."

Leah Leonard, RN, of the North Shore Medical Center, described her interactions with a family who was so appreciative of her attentive care, they changed their minds about staying overnight and returned home to get some much-needed rest. Said Leonard, "One thing I learned from my short time in this profession is that people change each other's lives each and every day without even knowing it."

Megan Cole, RN, also of the North Shore Medical Center, came to understand the importance of good communication skills when interacting with anxious family members. Said Cole, "I was nervous every time I spoke to families, or when they asked questions. I felt as if I were testing my words in my head before I said anything." She knew she was becoming more skilled when she began to gain confidence in her ability to, "speak both intelligently and empathetically with family members."

Feeling near tears on a particularly demanding day, Jennifer Ashley, RN, Cardiac ICU, described how a family member had searched the unit to personally thank her for the care she provided to them and their loved one. It completely changed her outlook. All she had been focusing on was her inability to 'catch up,'

Preceptor, Sharon Nadworny, RN (right) helps new graduate nurse, Jessica Hancock, RN, unbundle her narrative.



when she realized she had provided great care for this patient and his family. Said Ashley, "It meant a lot to hear that they felt their loved one had received good care. It made me feel as if all my hard work was worth it."

As they begin their practice, new nurses often struggle to meet the competing demands of patients and families. Lara Jenkins, RN, Neuroscience ICU, described that struggle this way: "I found it challenging to balance my need to become more efficient with the need to spend time with family members, to reassure them and include them in the care process. I realize now how important it is to step out, even for a brief time, to update the family and alleviate their concerns."

Narratives tell of powerful interactions between nurses and patients. The calming presence of one new nurse was recognized by her patient, a man with severe lung disease who was facing difficult decisions about his treatment plan. He was dangerously desaturating and needed a breathing tube to save his life. Amy Sinclair, RN, of the North Shore Medical Center, wrote "I held his hand as my preceptor drew the meds. During intubation, I gave the meds. After I gave him the first dose, I told him: 'Don't worry, I'll be here the entire time.' He looked me in the eye and said, "Amy, before you put the tube in my throat, I want you to know you've been absolutely amazing. I hope you have the wonderful life you deserve. Make sure I'm knocked out so I don't feel a thing."

Some compelling stories from some amazing nurses, describing the work they do every day.

Certificates of completion were given to:

- Sarah Abbott, RN, Neuroscience ICU
- Jennifer Ashley, RN, Cardiac ICU
- Kathryn Bunt, RN, Surgical ICU
- Megan Cole, RN, Cardiac Surgical Unit, North Shore Medical Center, Salem
- Jessica Hancock, RN, Cardiac ICU
- Lara Jenkins, RN, Neuroscience ICU
- Leah Leonard, RN, Intensive Care Unit, North Shore Medical Center, Lynn
- Amy Simpson, RN, Intensive Care Unit, North Shore Medical Center, Salem

For more information about the New Graduate in Critical Care Nursing Program, visit: [www.mghnursing.org](http://www.mghnursing.org), or contact Gail Alexander, RN, at 6-0359. For application information, contact David Pattison in Human Resources at 6-5593.

# New-found confidence and a 'caring heart' comfort patient in Cardiac ICU

*a clinical narrative by a recent member of the New Graduate in Critical Care Nursing Program*

But it's during those hurried 'normal' days that I'm able to positively affect the lives of my patients in small ways. I'd like to share one of those stories with you.

**M**y name is Jessica Hancock, and I have been a nurse in the Cardiac ICU for four months and nine days. The learning curve has been steep, and the emotions have cycled from frustration to pride and back again. I still get butterflies when I read my new title, "cardiac intensive care unit nurse." Butterflies from the awesome responsibility I now own and butterflies from the honor I feel to be part of such an esteemed profession.

I knew that writing a narrative was a prerequisite of the New Graduate in Critical Care Nursing Program, so I waited for 'just the right narrative patient.' I envisioned myself saving an arresting patient on an elevator, single-handedly ambuing and doing chest compressions—an A-B-C machine! Or maybe I would help a patient I'd grown close to die with dignity and peace. But neither of those things happened. My days are filled with rushing around, caring for not one, but *two*, cardiac patients and their families. My head spins thinking about it. But it's during those hurried 'normal' days that I'm able to positively affect the lives of my patients in small ways. I'd like to share one of those stories with you.



Jessica Hancock, RN,  
new graduate nurse in the Cardiac ICU

Mr. T had been at home with his wife washing dishes when he lost consciousness and fell to the floor. Mr. and Mrs. T are in their 70s, they are pillars of their Boston Cambodian community. Mrs. T called 911 and while waiting for an ambulance, performed the ancient Cambodian practice of Kos Khyol or 'coining' on Mr. T. This is where hot coins are rubbed across infirmed bodies to 'balance the wind.' Mr. T was intubated en route to the Emergency Department, and it was determined that he was having a STEMI, ST elevation myocardial infarction. He was rushed to the Cardiac Cath Lab where two metal stents were placed in his left anterior descending coronary artery. He was brought to the Cardiac ICU for further management, and I started caring for him on his second day on the unit. When I met Mr. T, he was intubated and sedated.

*continued on next page*

I flipped the paper over, replaced the marker in his hand, and he wrote again. This time, I was able to make out what he wrote. It said: "Thank-you for your caring heart." Mr.T brought his hands into prayer position over his heart and bowed his head slightly. No, Mr.T, thank-you for allowing me the honor of taking care of you and your wife.

He was on low-level pressors to maintain a mean arterial pressure of 65. My plan for the day was to try to wean the pressors and sedation to enable a spontaneous breathing trial later in the day. Throughout my shift as Mr. T woke up, I re-oriented him to his environment, reminded him what had happened, and assured him he was safe and that we were taking good care of him.

Mrs. T came for a visit that afternoon while I was at lunch, and when I returned I found her sitting in a chair against the wall. Her English was limited, but I explained that her husband could hear her and that it was okay to touch him and talk to him. I told her the tube in Mr. T's mouth was connected to the machine by his bed and that it was helping him breath. I pulled the covers back revealing Mr. T's hand. Placing my hand on his, I showed her it was okay to touch him. She smiled and began to talk quietly to him. He opened his eyes and looked at her. His expression was peaceful; he knew she was there.

As Mr. T's sedation lifted, he was able to nod appropriately to questions, and slowly I got to know the man I was caring for. He had been a pilot for the Cambodian army and had moved with his wife to the United States decades earlier. They had children who no longer lived in Boston. He was a practicing Buddhist—a fact that was reinforced by a visit from two robe-clad monks. I had studied Theravada Buddhist Meditation in college in Southeast Asia, so the familiar sound of their chanting was as calming to me as it was to Mr. T.

As the day progressed, I was able to wean Mr. T completely off his pressors and reduce his sedation to a point of relaxed sleep. Mr. T was one of the first patients I cared for where my preceptor wasn't in the room during the whole shift. I was nervous I might turn his Levophed down too quickly and his blood pressure would bottom out. My preceptor reminded me, "You can always just increase it again." I found solace in this fairly obvious reminder.

I soon found myself feeling more comfortable making those decisions on my own, trusting my ability to keep his blood pressure within set parameters. At one point when my preceptor was in another room helping another patient, Mr. T came close to finishing his Levophed. I started to go looking for my preceptor to help me shut off the pump. But instead, I decided to try it myself. And I did. I stared at the monitor. His blood pressure was fine. And I've been comfortable weaning pressors ever since.

Before Mr. T's spontaneous breathing trial, I explained the procedure and what would happen. He raised his hand as if to write something in the air. I found a marker and clipboard and helped Mr. T curl his hand around the marker. I held the clipboard in front of him, and he began to write. His eyes drooped; he continued writing long after the marker left the page. In scribbled, loopy handwriting it looked as though he had written something, shall we say, not suitable for publication. I stopped myself from smiling. I knew that couldn't be right.

"Are you in pain Mr. T?" I asked. "Are you cold? Would you like to try that again?"

I flipped the paper over, replaced the marker in his hand, and he wrote again. This time, I was able to make out what he wrote. It said: "Thank-you for your caring heart." Mr. T brought his hands into prayer position over his heart and bowed his head slightly.

No, Mr. T, thank-you for allowing me the honor of taking care of you and your wife. It was truly my pleasure.

Every day when I walk from the Charles T Stop to the Cardiac ICU, I repeat the same mantra in my head: "What would Flo do?" I know it's cliché. But it's true. Florence Nightingale was an innovator, a nursing pioneer, and a patient advocate long before women had the right to vote. She took the time to stop and truly care for each of her patients. I want to be her one day. My hope is that as I become more competent in nursing skills and tasks, I'll have more time to do what I love most about nursing—be available to my patients and families and offer them solace in what is often a terrifying time. I am humbled by their trust in me.

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

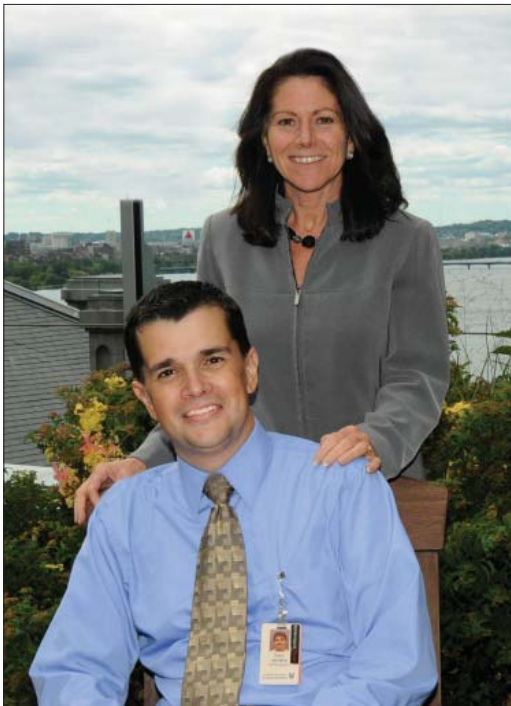
Even as a new nurse, Jessica's narrative reflects a depth of life experience—experience she brought to the bedside as she cared for Mr. T. Comfort with the many tasks associated with critical-care nursing will come in time. Jessica's instincts and compassionate nature are already a driving force in her practice. Even in his diminished state, Mr. T was able to see her 'caring heart.' I feel sure that if Ms. Nightingale read this narrative, she would be happy to see that her vision to combine the art and science of nursing is alive and well in Jessica's practice.

Thank-you, Jessica.

# Pediatric nurse makes lasting impression

*Patient and caregiver reunited after 30 years*

MGH photographer, Paul Batista, and nurse practitioner, Anne Fiore, in the Yawkey Building's Healing Garden overlooking the Charles River.



Many of us know Paul Batista, MGH photographer, who covers hospital events with his trusty camera and trademark good nature. Many of us know Anne Fiore, NP, orthopaedic oncology nurse practitioner, from her years of compassionate service to MGH. But it wasn't until recently that Batista and Fiore realized they knew each other.

Recalls Batista, "Back in 1980, I was hospitalized at MGH for a fast-growing brain tumor. I was 15 years old, scared, confused, and angry. I had a great team of

caregivers who took great care of me and were able to contain the tumor. All these years, I remembered one nurse who went above and beyond with her exceptional care, understanding, and support."

Batista's mother didn't speak English, so Fiore would explain all the medical jargon, make him laugh, and help take his mind off his circumstances. Says Batista, "She brought my mother snacks and drinks. When I learned I was going to have to stay in the hospital longer than expected, I was very upset. Anne was right there, comforting me, calming me down. I didn't know what radiation was. She explained it. When I had a spinal, she was

right there with me. She was my source of strength. At fifteen, I was lost, and Anne helped me find my way."

As Batista grew into adulthood, he never forgot the kindness and support Fiore had shown him. He wanted to thank her for the difference she had made in his life, but he didn't know her last name. When he himself came to work at MGH, he asked colleagues if they knew a pediatric nurse named Anne hoping it would lead him to her. But it never did. Until August 27, 2010.

Says Fiore, "I'd seen Paul around when he would come and take pictures for the Orthopaedic Service, Grand Rounds, and the Advanced Practitioner group. He was always polite and efficient. A great photographer. But this one time, we were waiting for someone to arrive, and I noticed him looking at me—really looking at me. Finally, he said, 'Did you ever work in Pediatrics?' I told him I did. I still do.

"He asked if I knew Dr. Truman. And, of course, I did—we had worked together for many years.

"The next thing I knew, the hair on the back of my neck stood up as he said, 'It's you. You're Anne. My nurse. I've been looking for you for thirty years. I wanted to thank you.'"

As they talked and Batista reminded her of his story, Fiore was humbled.

"To think that my care had made *such an impact* on this young man. Words can't describe how I felt. It just reinforces my belief that we still need the human touch in this fast-paced world."

Talk about happy endings—Batista was finally able to say thank-you, and Fiore learned of the incredible impact her interventions had had on an impressionable young man facing a daunting cancer treatment.

Says Fiore, "Our words and actions make a difference. What an honor to be part of a patient's life—to guide, teach, care, and allay fears. That's why I wake up every day and, for thirty-three years, have loved what I do."



# Clinical Recognition Program Survey

*Some positive perceptions and some recommendations for change*

*Question:* I understand a survey was conducted recently to assess the Clinical Recognition program?

*Jeanette:* Yes, the Clinical Recognition Program was implemented in 2002, introducing four levels of practice: entry-level, clinician, advanced clinician, and clinical scholar. We felt it was time to ask clinicians and leaders within Patient Care Services their thoughts on the program. Surveys were sent to PCS clinicians and leadership at the end of 2009. The return rate for leadership was 65% and over 30% for clinicians.

*Question:* What did the survey show?

*Jeanette:* The survey showed that more than 50% of clinicians who responded had a positive perception of the Clinical Recognition Program and almost 40% said they would seek recognition at the advanced clinician or clinical scholar level in the next two years.

They described the program as an opportunity for self-reflection, professional development, and recognition, and appreciated the financial compensation for advanced clinicians and clinical scholars. The survey showed that clinicians who seek recognition at the advanced clinician and clinical scholar level feel very supported by leadership and their colleagues as they develop their portfolio and prepare for the interview.

The survey also showed some areas we need to focus on in the future.

*Question:* What areas?

*Jeanette:* Clinicians and leadership both reported that when a clinician perceived to be ready for recognition at a certain level is denied, it negatively affects perception of the program. There was a feeling that advanced clinicians and clinical scholars whose day-to-day practice doesn't reflect the higher standards of recognition should be held accountable to practice at the recognized level. We heard that many clinicians find the prospect of developing a portfolio and preparing for an interview with the Review Board challenging. We also heard that we need to provide more opportunities for clinicians to learn about the program and be supported as they develop their portfolios.

*Question:* What will you do with this feedback?

*Jeanette:* The survey results have been reviewed by the Clinical Recognition Program Review Board and Steering Committee, PCS leadership, at staff meetings, and at the Staff Nurse Advisory Committee. Based on the survey results and this feedback, we plan to:

- promote the program emphasizing that it is a four-level program
- explore ways to better integrate the themes and criteria of the Clinical Recognition Program into performance reviews and clinical practice
- convene a task force to review the application process
- identify ways to better support clinicians developing their portfolios (writing, interview skills, etc.)
- host a forum highlighting the accomplishments of advanced clinicians and clinical scholars

For information on the Clinical Recognition Program, visit: <http://www.mghpcs.org/IPC/Programs/Recognition/Index.asp>.

# Roll-out of the Inpatient Evacuation Plan

*After many months of planning and testing, MGH has created a detailed emergency evacuation plan for patients and staff. Evacuation Toolkits will be distributed to inpatient units during the month of October to ensure all employees are aware of the plan.*

Evacuation is always a last resort; only units in imminent danger would ever be evacuated... Staff and patients will be asked to go to a designated 'assembly point' until it's safe to re-enter the hospital, or until arrangements can be made to transfer patients to another location.

**Question:** What's the most important thing to know about evacuation?

**Jeanette:** Evacuation is always a last resort; only units in imminent danger would ever be evacuated. Unit or department leadership will advise staff as to what steps to take. Staff and patients will be asked to go to a designated 'assembly point' until it's safe to re-enter the hospital, or until arrangements can be made to transfer patients to another location. Nurses should bring any critical medications with them as they evacuate patients. The assembly point will have basic medications, equipment, and supplies, and if there's time, specialized equipment or supplies needed for patient care may be brought from units.

**Question:** How can I learn about the specific plan for my unit?

**Jeanette:** Each inpatient unit will receive an Evacuation Toolkit with detailed instructions. Staff should review the toolkit, and information will also be available through HealthStream.

**Question:** If the elevators aren't working, how would patients be transported?

**Jeanette:** Patients who can walk would be assisted down the stairways. Med Sleds are also available. Med Sleds are portable devices designed to safely transport non-ambulatory patients down stairwells using a 'drag and roll' technique. An entire section of the evacuation plan is devoted to transporting patients, both with and without elevators.

**Question:** What about procedure areas and ambulatory practices?

**Jeanette:** Planning for those areas is under way. The principles and processes developed for inpatient units will be adapted to meet the needs of procedure and ambulatory care settings.

**Question:** Where can I get more information?

**Jeanette:** The full plan contains information about all aspects of evacuation including how to handle visitors, find beds at other facilities, create a discharge site, set up the assembly point, and much more. The plan is available on Sharepoint under Emergency Preparedness. For more information, contact: Tony Digiiovine, RN; Maryfran Hughes, RN; Bessie Manley, RN; Lori Pugsley, RN; Maureen Schneider, RN; or Susan Tully, RN.

# Announcements

## MGH mourns the loss of former director of PT

It is with great sadness that the MGH community learns of the passing of Pauline "Polly" Cerasoli on September 11, 2010, at the age of 71.

Cerasoli was director of Physical Therapy from 1981–1987 and taught at the MGH Institute of Health Professions. A warm and caring leader who impacted a generation of therapists, her tenure at MGH saw the initial outreach of physical therapy to the health care centers where it still plays a vital role today.

It is fitting that the theme of this year's PT Annual Report is service to the community.

During October, National Physical Therapy Month, we celebrate the contributions Polly Cerasoli made to our patients and to the physical therapy profession.

## Help for Parents of Children with Autism Spectrum Disorders

### Strategies for Building Stronger Family Relationships

Discussion will focus on strategies for managing behavioral issues related to family and school, including how to cope with the challenges of living with a child with ASD.

Led by Leigh Horne-Mebel, LICSW, social worker and certified child and adolescent therapist.

(First of a two-part series)

Thursday, October 7, 2010  
12:00–1:00pm  
175 Cambridge Street, 3rd floor, suite 320

For more information, call 6-6976 or visit [www.eap.partners.org](http://www.eap.partners.org).

## 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](http://www.eap.partners.org).

## October is Domestic Violence Awareness Month

Representatives from Jane Doe, Inc. and the Victim's Rights Law Center speak about the new Massachusetts legislation 258E, that offers protective orders for victims of harassment and stalking. Light lunch served. Social Work CEUs pending.

Wednesday, October 13, 2010  
11:30am – 1:00pm  
Thier Conference Room

Panel Presentation: Teens Taking Action Against Domestic Violence:

Wednesday, October 20th  
3:00–5:00pm  
Thier Conference Room

Panelists from: Boston Public Health Commission Start Strong Program, DOVE, Inc. Youthspeak, Gay Men's Domestic Violence Project and others. Light refreshments served. Social Work CEUs pending.

Presented by the MGH Domestic Violence Working Group: HAVEN; Police & Security; and Partners Employee Assistance Program.

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

## 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.

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

## October is Health Literacy Month

The Patient Education Committee is hosting an educational display

Wednesday, October 13, 2010  
9:00am–3:00pm  
Main Corridor

A webinar, entitled, "Health Literacy and Patient Education in Primary Care: Improving Communication with your Patients" will be hosted by Taryn Bailey, RN.

October 14, 2010  
12:15–1:00pm

For more information, contact Judy Gullage, RN, at 6-1409.

## 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.

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Next Publication  
October 21, 2010

# Governor proclaims September Pain Awareness Month



Paul Arnstein RN, clinical nurse specialist for Pain Relief, Jennifer Searl, health educator in the Blum Patient & Family Learning Center, and Annett Franke, RN (right), a graduate nursing student from Germany, staff Pain Awareness booth in the Main Corridor.

**P**ain is colorless, odorless, and tasteless. Despite many advances in assessing and managing pain, many people still suffer because they fear treatment or think expressing pain is a sign of weakness. With complex patients, it can be difficult to evaluate pain in a simple and meaningful way. Governor Patrick recently proclaimed September Pain Awareness Month. On September 15, 2010, to help raise awareness about options available for evaluating and treating pain in a safe, effective way, Paul Arnstein, RN, clinical nurse specialist for Pain Relief, and Jennifer Searl, health educator in the Blum Patient & Family Learning Center, hosted a Pain Awareness Day. Staffing a booth in the Main Corridor, they provided information to help inform the public and health professionals about pain, pain-management, and treatments available. Visitors were treated to a prize if they could correctly answer true or false to questions on the 'Wheel of Pain.'

For more information about pain-management, call Paul Arnstein, RN, at 4-8517.

**Caring**  
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