The Future of Nursing

Hopkins Reacts to New RWJF/IOM Report

Inside:
26 Hopkins Celebrates 50 Years of Peace Corps
40 Continuing Education in Acute Hypersensitivity Reactions
Features

24 The Future of Nursing
by Kelly Brooks
Nursing in America is facing unprecedented challenges. At Johns Hopkins, Dean Martha N. Hill, PhD, RN, and university and hospital leaders are discussing the major role that nurses must play in meeting them. What is it going to take—from nurses, hospitals, administrators, government, and other members of the healthcare team—to satisfy future demands for care? The Hopkins team analyzes the recommendations outlined in the new report, The Future of Nursing: Leading Change, Advancing Health, from the Institute of Medicine and Robert Wood Johnson Foundation.

28 Spirit of Service
by Jennifer Walker
As the Peace Corps celebrates its 50th anniversary this year, the Johns Hopkins School of Nursing celebrates the 20th anniversary of the Peace Corps Fellows program. In this issue, meet four Peace Corps Fellows alumni who have dedicated their careers to community and global health. Learn how the life and death of R. Sargent Shriver, the first director of the Peace Corps, inspired student Kari Hatfield. And use your smartphone to scan our QR code, which takes you to five podcasts by current Peace Corps Fellows.

Departments

3 Insights
Donna Shalala believes we have the power to transform the nursing profession.

6 On the Pulse
Students sleep on Baltimore streets, researchers go to spit camp, and more.

18 Bench to Bedside
Nursing the wounds of war, making the call on an endangered child, and more.

20 Global Nursing
Cyber-education for Uganda, a Tanzanian nurse overcomes the odds, and more.

23 Live from 525
In Peace Corps, nursing student Mandy Chavez learned the importance of a name.

34 Continuing Education
Acute Hypersensitivity Reactions: earn one contact hour.

38 Hopkins Nurse
The benefits of palliative care, an outstanding ICU, and other news from the Johns Hopkins Hospitals.

52 Vigilando
News from the Johns Hopkins Nurses’ Alumni Association.

Nursing students Sarah Schoen and Nora Jens wore colorful garb from Guatemala and Lesotho on March 2 to celebrate the 50th Anniversary of the Peace Corps. Dean Martha N. Hill joined 36 Peace Corps Fellows who wore outfits from their countries of service for the day’s festivities. [Photo by Howard Korn]
Contributors

A recovering health-policy wonk turned freelance science and medical writer, **Teddi Fine** will harness a childhood dream to be a simultaneous translator. But today, instead of studying Urdu or Karen, she’s opted instead to be a not-very-simultaneous translator of science, as seen in “Bench to Bedside” (page 18). When she’s not poring over nursing research (as some read a good mystery novel) or crafting press releases about Hopkins nurses, she keeps her creative engine humming by designing and fabricating fanciful art jewelry.

**Rebecca Poch** has always believed Muriel Rukeyser’s quote, “The universe is made of stories, not of atoms.” “However, my interview subjects for John Hopkins Nurses might beg to differ,” she says. Her favorite thing about writing for “Hospkins Nurse” (page 38) has been hearing and re-telling the stories shared by fascinating people. Rebecca is a freelance writer based in Northern Virginia who also manages technology and multimedia-resource projects for the arts-education programs at the Wolf Trap Foundation for the Performing Arts.

**Rich Shea** is a freelancer who has written and edited award-winning articles and publications throughout his 20-year career as a journalist. He’s written about everything from politics to pop singers to public health and managed the publication of New Times, Brouard-Poisach, an alternative newspaper, and Teacher Magazine, among others. As the son of a retired RN, he has great respect and admiration for the nurses that he wrote about in “Hospkins Nurse” (page 46).

**Jennifer Walker** was all too happy to talk to Returned Peace Corps Volunteers for this month’s story on the program’s 50th anniversary (“Spirit of Service,” page 28). “They have such interesting—and often heartbreaking—stories to tell about their host communities and the people and healthcare systems there,” she says. “It’s clear that their time in the Peace Corps has profoundly impacted their careers as nurses and their lives.” Walker is a freelance writer specializing in stories about social and community issues, arts and culture, and food. She also writes development and communications materials for nonprofits. www.jennflwalker.com

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**Insights**

**Nursing’s Rich, Satisfying Future**

*It won’t be easy, but we can transform the nursing profession by Donna Shalala*

When President Kennedy established the Peace Corps 50 years ago this March, he called upon Americans skilled in teaching, agriculture, and health to lend their talents overseas. It will not be easy, he warned, but it will be rich and satisfying.

Today, the same words that, against my family’s wishes, prompted me to head to a tiny Iranian village after earning a bachelor’s degree in 1962, could be applied to the challenges we face in transforming the nursing profession. It will not be easy, but it will be rich and satisfying.

As the largest segment of the healthcare workforce, nurses hold the key to creating the kind of patient-centered, evidence-based healthcare system we envision for all our citizens. That system will remain more dream than reality until nurses assume their proper leadership and partnership roles outlined in the Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health.*

Serving as a blueprint for improving our healthcare system, the report contains five key messages the profession should embrace as guidelines:

First, nurses, nursing education programs, and professional associations should prepare the nursing workforce to assume leadership positions across all levels. At the same time, nurses need to take steps to build their leadership skills and knowledge, and they must seek opportunities to use those skills in partnerships on healthcare teams and in efforts that improve the delivery of care. We need more nurses influencing major healthcare decisions.

Second, we need to improve the way nurses are educated to meet the complex needs of patient care in the 21st century, which will include enabling and encouraging nurses to achieve higher levels of education and training. This will require an improved education system that promotes lifelong learning and addresses shortages of nursing faculty and researchers. Healthcare organizations and nursing schools should implement residency programs to facilitate the transition from classroom to bedside. The IOM calls for more nurses to pursue higher degrees, increasing the number with BSNS to 80 percent and doubling the number with doctorates by 2020.

Third, nurses should practice to the full extent of their education and training. It’s about empowering all nurses, doctors, and other health professionals to practice to the best of their abilities—to do what they were educated and trained to do.

Fourth, the healthcare system needs better information about its existing workforce to properly shape its future workforce. To accomplish that, the report recommends building an improved infrastructure to collect and analyze healthcare workforce data.

And last, but in my opinion most important, nurses should be full partners with physicians and other healthcare professionals in redesigning the healthcare system we envision for all our citizens. As the largest segment of the healthcare workforce, nurses hold the key to creating a system that promotes lifelong learning and addresses shortages of nursing faculty and researchers. Healthcare organizations and nursing schools should implement residency programs to facilitate the transition from classroom to bedside. The IOM calls for more nurses to pursue higher degrees, increasing the number with BSNS to 80 percent and doubling the number with doctorates by 2020.

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**Eco Box**

**Paper Requirements:** 54,039 pounds

**Wood Use:** 6 tons

**Total Energy:** 21 million BTUs

**Greenhouse Gases:** 7,215 lbs

**Wastewater:** 17,225 gallons

**Solid Waste:** 1,915 pounds

**Greenhouse Gases:** 21 million BTUs

**Wood Use:** 54,039 pounds

**Paper Requirements:** 54,039 pounds

**Environmental impact estimates were made using the Environmental Defense Paper Calculator at www.papercalculator.org.**

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**Author:** Rich Shea
Letters to the Editor

House Calls

Last issue’s cover story, “House Calls,” highlighted a program to help aging, impoverished Baltimore residents gain independence at home. The key is an unlikely trio—a nurse, an occupational therapist, and a handyman—teamwork to help each resident.

A representative from Fancy Scrubs wrote: “This is so refreshing to read—we hope to see many more seniors in the future years being able to live at home on their own through programs like these.”

While Nancy Brown, a self-described “aged care nurse,” writes that, “the aged care industry is letting our elderly people down, and the system is also letting our Assistants in Nursing (AINs) burn out.”

Nursing Shortage is a Sore Spot

We’re still getting comments on “The Global Nursing Shortage” from our summer 2010 issue. Some readers expressed concern that international nurses working in the U.S. might prevent American nurses from finding jobs.

A reader named Sheila commented online that, “American healthcare executives try to hire international nurses so they can pay them less. They are fully aware that there are U.S. graduates needing jobs. American hospitals should not be allowed to hire foreigners unless there are no qualified Americans for the job! That’s how they do it in England and Ireland.”

Kudos and Comments

I have just had a chance to peruse the Fall/Winter issue of your Nursing magazine; and it is excellent! So many different articles, and I enjoyed each of them. The magazine just keeps getting better and better.

I am off to Tokyo and Singapore and then S. Korea for a couple of surveys. As you can imagine, I am especially interested in the Global Health articles.

One small comment from page 18: my aging eyes struggled with the white print on the pale greenish background. Thanks for listening.

Best regards,
Robbie Heath

Letters to Johns Hopkins Nursing

We welcome all letters regarding the magazine or issues relating to Hopkins Nurses. Email 200 words or less to editor@son.jhmi.edu or send to:

Editor, Johns Hopkins Nursing
The House, Room 107
Baltimore, MD 21205

Letters will be edited for length or clarity.

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Students Spearhead LGBT Cultural Curriculum Change

“Of all disciplines, healthcare professionals should be most accepting of all people and aware of the potential issues that arise from sexual diversity,” notes Marcella Leath, classmate Joanne Arellano agrees. She self-identifies as “queer,” an umbrella term for a myriad of minority sexual orientations and gender identities. “My gender presentation is on the feminine side, so people don’t see me as part of the LGBT community until I say something,” says Arellano. When she goes to the gynecologist, for example, they take for granted that “someone like me should be on birth control pills. They make assumptions about me and my body, and they’re resistant when I tell them I don’t need that.” She wants to learn—and wants her classmates to learn—a better way to care for LGBT patients.

When Leath, along with senior Amy Hofmann and juniors Danielle Miller and Bethany Roth, completed her health assessment class, she noticed the lack of LGBT topics and information, and had some specific ideas about how such information could improve patient care. As a first step, the students brought a resolution to this year’s National Student Nurses Association (NSNA) Annual Convention in April, proposing that the NSNA support LGBT education in nursing school curricula as a means to improve health disparities and the cultural competence of professional nurses. The resolution was passed with 66 percent of the vote. Then in the fall, as the news media were reporting on “Don’t Ask, Don’t Tell” and the suicide of Tyler Clementi, a gay student at Rutgers University, the students brought some specific recommendations to the Hopkins nursing baccalaureate curriculum committee. They suggested that nursing students learn about the gender spectrum, the need to ask how a patient identifies their gender, the barriers to care affecting LGBT individuals, and the needs of same-sex couples and families navigating the legal problems affecting their access to supportive healthcare. Their proposal was adopted with a unanimous vote, and the Hopkins nursing curriculum was modified.

“Nurses can be in a pivotal position to improve care for LGBT patients, especially in school and college settings,” notes Sarah (Jodi) Shaefer, PhD, RN, who heads the baccalaureate curriculum committee.

“We want to produce nurses that will be effective with patients from all types of populations.”

Teaching with the Best of Them

Hopkins Named “Center of Excellence” in Nursing Education

It’s official: Johns Hopkins is among the best places in the world to get a nursing education. The National League for Nursing (NLN) has named the Johns Hopkins University School of Nursing as a Center of Excellence in Nursing Education, bestowing an additional honor on a 120-year legacy of outstanding nursing education and practice.

“All of our creative teaching ideas, support, and best practices paid off for us to gain this recognition,” says Pamela R. Jeffries, PhD, RN, Associate Dean for Academic Affairs. “Our real success, though, is educating skilled, thoughtful nurses—and fostering a curiosity that they will carry throughout their careers.”

According to the NLN, schools designated as a Center of Excellence “demonstrate sustained, evidence-based, and substantive innovation in the selected area; conduct ongoing research to document the effectiveness of such innovation; set high standards for themselves; and are committed to continuous quality improvement.”

Johns Hopkins earned recognition in “Creating Environments that Enhance Student Learning and Professional Development,” one of three designated areas of excellence.

“Each and every one of our faculty colleagues helped to make this happen,” says Associate Professor Anne Belcher, PhD, RN, who directs the Office for Teaching Excellence. “We’re constantly evaluating our teaching strategies and looking for new, innovative ways to help our students learn and excel.”

The Center of Excellence award was given at the National League for Nursing Education Summit on Friday, October 1 in Las Vegas. Dedicated to excellence in nursing education, the National League for Nursing includes nurse educators, education agencies, healthcare agencies, and interested members of the public.
A Bench is Not A Bed
“Sleeping Out” Brings Awareness of Homelessness

On a cold night in November, Hopkins nursing students were sleeping on Baltimore’s city streets. “We are bringing the reality of homelessness and hunger out in the open,” says Kirsten Blomberg, ’11. She points out that although an estimated 1,419 men, women, and children are homeless in Baltimore on any given night, homelessness “is not something that is obvious to us in our day-to-day lives; it’s hidden.”

Blomberg and 200 others—fellow nursing students, local college students, and homeless people—hit the streets to commemorate National Hunger and Homelessness Awareness Week. The event kicked off with a panel discussion and a concert, after which the Hopkins nursing students gave out free blood pressure screenings. They handed out socks and blankets, played cards, and then hunkered down to see what life is like sleeping on the streets.

“It was chilly for sure, but we wore layers and had enough blankets,” says Blomberg. And what did Baltimore’s homeless citizens think of the event? “It really meant a lot to them,” she says. “I remember waking up in the early morning, maybe around 4:00 a.m. I looked around and saw that a couple of the homeless people were staying up, watching out for us. They just wanted to make sure we were safe throughout the night.”

Smarter Nursing with High-Tech Dummies
National Study to Determine Effectiveness of Simulations

How can patient simulators—high-tech manikins that respond to a nurse’s care—help prepare the nurses of tomorrow? The Johns Hopkins University School of Nursing is among 10 nursing schools nationwide collaborating on a landmark study to find out just how smart this “dummy” education can be.

“Nursing students have been learning their clinical skills the same way for more than 40 years, but the healthcare environment has changed,” says Pamela Jeffries, DNS, RN, Associate Dean for Academic Affairs. “The patients have changed, their acuity has changed, the knowledge required of our nurses has changed, so the way we educate nurses has to change too.”

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Schools have been experimenting with patient simulations for several years, but their effectiveness has only been evaluated with a handful of small studies. This Simulation Study, conducted by the National Council of State Boards of Nursing, seeks to change that. Researchers at 10 nursing schools will follow more than 1,000 students throughout their education and into the first year of their careers to discover how using simulations in learning affects performance in the workplace after graduation. Incoming students at the study schools, including Hopkins, may choose to begin participating in the study starting this fall.

Learn more about the Simulation Study at www.ncsbn.org.

Learning from Leaders
Top Nurses Share Knowledge with Hopkins Students

Top-notch U.S. nurses are sharing their knowledge, insights, and wisdom with the nurses of tomorrow through a speaker series for students in the New Careers in Nursing leadership program. The program, funded by the Robert Wood Johnson Foundation, benefits students from groups underrepresented in nursing who demonstrate significant financial need.

Presenters include:
- Patricia Grady, PhD, RN, Director of the National Institute of Nursing Research. “Think about where you can put your intellect, your experience, and your leadership to work. Start early; it increases your options.”
- Karen Haller, PhD, RN, Vice President for Nursing and Patient Care at The Johns Hopkins Hospital
- Leslie Mancuso, PhD, RN, President of the National Council of State Boards of Nursing Research
- Ellen Marie Whelan, PhD, NP, Senior Health Policy Analyst and Associate Director of Health Policy at the Center for American Progress
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- Ellen Marie Whelan, PhD, NP, Senior Health Policy Analyst and Associate Director of Health Policy at the Center for American Progress
Living Legacy
Fellowship Recipients Are a Tribute to the Life of Ellen Zamoiski
by Sara Michael

Johns Hopkins University School of Nursing lost a great friend when Ellen Levi Zamoiski died on October 19, 2010. Over the years, Zamoiski’s daughter and son-in-law, Clair Zamoiski Segal and Thomas (Tommy) H. Segal, have given generously to the school in her honor, and in 2005 established the Ellen Levi Zamoiski Doctoral Fellowship. Her legacy lives on in these Hopkins-trained nurse researchers, who benefited from the Zamoiski Fellowship.

The first recipient of the fellowship, Jessica Roberts Williams, PhD ’08, MSN ’05, applies her interest in mental health and her skills of translating research findings in practical applications as a research analyst with a consulting firm outside Washington, DC.

The fellowship is particularly meaningful, Williams says, because it recognizes “the importance of doctoral education in nursing and the contribution it makes to the field.”

As a critical care nurse and tracheostomy nurse practitioner, Vineiya Pandian, MSN ’04, dedicated her career to mechanical ventilation and its effect on quality of life. With the fellowship, Pandian could take classes full-time and receive the support and guidance needed for conducting research. Without it, “I would not have come this far,” she said, adding she plans to become an international expert on the management of adult patients with tracheostomy.

For Sara Rosenthal, MSN ’08, BS ’04, her diagnosis of Type 1 diabetes in college and the impact providers had on her then set the stage for her nursing career. Her work in a neonatal intensive care unit inspired her doctoral research on treatment decision-making, work made possible through the fellowship. “This really allowed me to dedicate myself full-time to my coursework.”

Mary Paterno’s interest in healthcare was awakened when she witnessed intense poverty during a trip to China as a professional pianist. Paterno, MSN ’10, BS ’06, who pursued nurse-midwifery and is working on her PhD, relied on the funding at a critical time during her ambitious combined master’s and PhD program. “It allowed me to focus on my role as an advanced practice nurse and as a researcher.”

Hopkins Nursing Dean Receives Leadership in Research Award

Dean Martha N. Hill, PhD, RN, has received the 2011 Leadership in Research Award from the Southern Nursing Research Society (SNRS).

“Your outstanding contributions to research in nursing, healthcare, and interdisciplinary work exemplify excellence in nursing research,” wrote SNRS President Marti Rice, PhD, RN, in Hill’s award notification letter. Excellence in Nursing Research was the theme of the 25th annual SNRS conference in Jacksonville, FL, where Hill was presented with the award.

Internationally known for her research in preventing and treating hypertension and its complications, particularly among young, urban African-American men, Hill is an expert in integrating patient-, provider-, and system-level interventions to improve care and outcomes for vulnerable and underserved populations. For more than 25 years Dr. Hill has made sustained contributions to cardiovascular nursing science, with 40 years of experience as an administrator, educator, and clinician providing support and practical perspective to her scholarly work.

“Dr. Hill has provided extraordinary contributions to nursing research through her scholarship, student mentorship, and program development,” wrote Jerilyn Allen, ScD, RN, associate dean for research at JHUSON, in her letter nominating Dean Hill for the award. “The local and global impact of [Hill’s] research and scholarship has changed the thinking in the field of cardiovascular prevention science in vulnerable populations.”

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New Associate Dean to Lead Community and Global Programs
by Jon Eichberger

Professor Phyllis Sharps, PhD, RN, FAAN, chair of the Department of Community and Public Health, has been appointed the Associate Dean for Community and Global Programs, beginning January 1.

“Collaborations within our community are just as vital as our partnerships globally, and Phyllis has a demonstrated, successful track record for both,” said JHUSON Dean Martha N. Hill, PhD, RN. “We now have a position that will oversee the School’s outreach at home and abroad while constantly exploring innovative ways to strengthen our existing partnerships.”

Sharps will oversee the School of Nursing’s community programs, wellness center, and the newly created Center for Global Nursing, which is responsible for the PAHO/WHO (Pan American Health Organization/World Health Organization) Collaborating Center, student study-abroad programs, school-school collaborations, and special academic consulting and advising initiatives, such as those with NEWCIZA University and Malaysia.

As an expert in maternal and child health nursing, a researcher, and a mentor to the next generations of Johns Hopkins nurses, Dr. Phyllis Sharps works at the forefront of community and public health nursing and at the interface of mental and physical health. In addition to serving as the department chair, she is also the director of three health and wellness centers operated by the School.

Simulation Coordinator Jessica Ockimey received a Staff Performing Over the Top (SPOT) award in December for her initiative in finding a replacement (from the University of Maryland) for the School’s non-working Sim Baby. Her effort ensured that a pediatric course ran smoothly and started on time. Diane Aschenbrenner, the faculty member who nominated Ockimey for the award, said that “Jessica doesn’t have a cape, but I think she was truly a hero that day for all of those students and faculty.”

Jessica Ockimey: Performing Over the Top

New Camp Makes Mouths Water
Hopkins Trains Researchers in Saliva Analysis

Each year more than 11 million children and adults go to camp—horseback-riding camp, weight-loss camp, band camp, even technology camp. The latest trend? Spit Camp, where researchers are trained in saliva analysis.

“Spit campers get right to it,” says Douglas A. Granger, PhD, creator and director of the Johns Hopkins University School of Nursing Center for Interdisciplinary Salivary Bioscience Research (CISBR). “Under careful supervision, they put on lab coats, collect specimens, and learn the assay procedures, and practice the interpretation of saliva results.”

In bimonthly two-day workshops, Granger and CISBR staff teach about saliva as a biological specimen, saliva collection, the basics of saliva assay, and tips for writing grant proposals, designing studies, and analyzing data. The workshop is designed for graduate students, post-doctoral scholars and fellows, and faculty without biology training.

For more information, visit www.nursing.jhu.edu/spitcamp.

Recognition for High-Tech Teaching

Pamela Jeffries, Associate Dean for Academic Affairs, has been recognized for her role in developing and advancing the field of simulation in nursing with a Presidential Citation from the International Society for Simulation in Healthcare (SSH).

“Pam has made an enormous contribution to the educational foundation, the science, and the momentum behind simulation,” says Dr. Michael Seropian, President of SSH, who presented the award at the society’s annual meeting in New Orleans in January. “She has really had a substantive impact on simulation across disciplines. It’s a well-deserved award.”

Only eight presidential citations have been awarded in the history of the society. With more than a decade of teaching, research, publications, and advocacy for simulation, Jeffries, DNS, RN, has proven herself a leader in the field. “I want to be one of today’s nurses who revolutionize tomorrow’s nursing education,” she says.
In the News
Margaret Adams, traditional ‘12, chronicled her experience shadowing a nurse practitioner visiting migrant worker camps in the September issue of Urbanite. “These workers, many brought here on H2B visas, reveal their ailments: a twisted shoulder, pesticide rashes, feet swollen from long hours standing in water,” she writes. “I do my best to translate their words, my tongue twisting on the rural accents of counties far from here.”

Phyllis Sharps, PhD, RN, writes a regular column entitled “Hopkins Health Check Up” for Heart & Soul magazine. In October 2010, Sharps answered a question about oral health and pregnancy. “Oral health is an essential part of overall health for adults, especially pregnant women,” she wrote. “Dental care is not only safe, it’s necessary during pregnancy.”

Faculty—Health Systems & Outcomes
Patricia Abbott, PhD, RN, presented on healthcare reform and health information technology at the Yura Petra Research Lectureship at Old Dominion University in Norfolk, VA in November 2010. Maryann Flaherty, DrPH, RN, traveled to London this fall to address top nurse executives from the United Kingdom about the rapidly changing role of nurse leaders within a “new normal” healthcare environment.

Laura Gittin, PhD, appeared before the Senate Special Committee on Aging in December. Testifying on behalf of the American Occupational Therapy Association, she described how occupational therapy improves functional dependence of dementia patients.

Martha Hill, PhD, RN, was the keynote speaker for the Institute of Science 10th Anniversary Celebration, held in Basel, Switzerland in November 2010.

Faculty—Acute & Chronic Care
Anne Belcher, PhD, RN, presented and consulted on peer evaluation of classroom teaching at the University of Pennsylvania School of Nursing in December 2010.

Fannie Gaston-Johansson, PhD, RN, FAAN, was featured in the inaugural Who’s Who in Black Baltimore, a publication highlighting more than 200 influential African-Americans who have made an impact on Baltimore.

Doug Granger, PhD, has been invited to serve as a scientific advisor for the Alberta Pregnancy Outcomes and Nutrition study in Canada.

Faculty—Student, and Staff News
Professor Susan Immelt, PhD, RN, was invited to consult with the University of Maryland School of Nursing building a primary healthcare nursing curriculum in Nigeria.

Dan Sheridan, PhD, RN, has been awarded grants from the Maryland Governor’s Office of Crime Control and Prevention: one to coordinate two 45-hour, sexual assault forensic nurse examiner trainings, and the other to begin to move one day of the traditional classroom training to an online format.

ibby Tanner, PhD, RN, has been inducted as a National Gerontological Nursing Association Fellow. She also presented on recruiting through gospel radio at the American Public Health Association Annual Meeting in November 2010.

Students
UNP student Barbara Buczkak received funding from the South Central Organization of Nurse Leaders to complete her capstone project on improving the quality of postpartum education during hospitalization. She also traveled to Nairobi, Kenya in the fall to help improve evidence-based nursing practice at Aga Khan University Hospital.

PhD student Katherine Scafide presented at the International Association of Forensic Nurses conference last fall in Philadelphia, PA. Scafide discussed improving forensic bruise assessment, and Draugton presented on the use of prophylaxis following sexual assault.

Faculty—Community—Public Health
Professor Martha Hill, PhD, RN, was invited to be an awards judge in the Sigma Theta Tau 2011 International Awards for Nursing Excellence competition. She will be judging the category of “Nursing Media Award”—a category which Johns Hopkins Nursing magazine won last year.

Research Coordinator Nasreen Bahrameh was recognized as a Shining Star recognition from one of her patients at the Johns Hopkins Hospital. The patient’s wife described her as “very caring” and “genuinely concerned” for her patients.

Team Efforts
Faculty members Pamela Jeffries, DNS, RN, and Rosemary Mortimer, MED, RN, gave a presentation about their online Politics course—developed with staff members Emily Jones and Jennifer Fischer Larkin—at the Global Alliance for Leadership in Nursing Education and Science in Pentagon City, VA, in December 2010.

Faculty members Sarah Santon, PhD, CRNP; Cheryl Dennison, PhD, RN; and ibby Banner, PhD, MS, RN, presented a symposium on threats to independence and aging-in-place at the Gerontological Society of America Annual Meeting in New Orleans in November 2010.

Scholarship Success!
Senior Sarah Hobongwana is one of the 89% of Hopkins baccalaureate nursing students who receive some form of financial aid. She receives a stipend through the school’s Leadership, Excellence, Achievement, Diversity, and Success program, earned a nursing scholarship from the Health Resources and Services Administration, and received funds from the Congressional Black Caucus Spouses Cherteous Brand Health Initiative.

Matthew Hayat, PhD, MS, is the first recipient of the Scholarship of Teaching and Learning Award presented by the Office for Teaching Excellence. He received a grant to support a study assessing graduate nursing students’ knowledge and attitude about statistics.

Susan Immelt, PhD, RN, was present on using simulations to teach both medical and nursing students at the National Forum on Quality Improvement in Health Care in December 2010.

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Matthew Hayat, PhD, MS, is the first recipient of the Scholarship of Teaching and Learning Award presented by the Office for Teaching Excellence. He received a grant to support a study assessing graduate nursing students’ knowledge and attitude about statistics.

Susan Immelt, PhD, RN, was present on using simulations to teach both medical and nursing students at the National Forum on Quality Improvement in Health Care in December 2010.

Faculty—Community—Public Health
Jason Farley, PhD, MPH, CRNP, has been asked to consult with the University of Maryland School of Nursing building a primary healthcare nursing curriculum in Nigeria.

Dan Sheridan, PhD, RN, has been awarded grants from the Maryland Governor’s Office of Crime Control and Prevention: one to coordinate two 45-hour, sexual assault forensic nurse examiner trainings, and the other to begin to move one day of the traditional classroom training to an online format.

ibby Tanner, PhD, RN, has been inducted as a National Gerontological Nursing Association Fellow. She also presented on recruiting through gospel radio at the American Public Health Association Annual Meeting in November 2010.

Students
UNP student Barbara Buczkak received funding from the South Central Organization of Nurse Leaders to complete her capstone project on improving the quality of postpartum education during hospitalization. She also traveled to Nairobi, Kenya in the fall to help improve evidence-based nursing practice at Aga Khan University Hospital.

PhD student Katherine Scafide and Jessica Draugton presented at the International Association of Forensic Nurses conference last fall in Philadelphia, PA. Scafide discussed improving forensic bruise assessment, and Draugton presented on the use of prophylaxis following sexual assault.
In a Veterans Day ceremony befitting a day when the United States remembers all who have served in the armed forces, PhD student Major Kristal Melvin, NP, U.S. Army Nurse Corps, was promoted to Lieutenant Colonel (LTC). Melvin’s doctoral dissertation explores post-traumatic symptoms (with or without PTSD diagnosis) and their impact on relationships among Army combat-veteran couples. After she earns her PhD, Melvin will be assigned to one of five nursing research cells in the Army Medical Department.

Marie Nolan Promoted to Professor
by Sara Michael

Marie Nolan, PhD, MPH, RN, faculty member and chairperson of the Department of Acute and Chronic Care, has been promoted to the rank of Professor.

Her research focuses on patient and family healthcare decision-making at the end of life and on decisions regarding living organ donation, key issues in both clinical care and bioethics. Nolan’s pioneering end-of-life research has advanced the understanding of patients’ preferences for shared decision-making with family and physician and has called into question the autonomous decision-making model on which advance-care-planning health policy is based.

Nolan was previously director of the PhD program and currently serves as the director of the China Doctoral Program Partnership, a collaboration between Hopkins and Peking Union Medical College, funded by the China Medical Board of Boston. Nolan holds a joint faculty appointment in the Johns Hopkins Berman Institute of Bioethics and has served on advisory panels of the National Institutes of Health regarding end-of-life care research.

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Seek advice from a tax professional before entering into a gift annuity agreement.

Johns Hopkins gift annuities are not available in all states.
The Cost of Cancer
Financial Concerns Plague Even Insured Women with Breast Cancer
by Teddi Fine

For many women, the challenges of breast cancer treatment are heightened further by today’s difficult economic and employment climate. While healthcare costs have long been known to increase stress and deter treatment for uninsured women with breast cancer, PhD candidate Rachel Klimmek, BSN, RN, and assistant professor Jennifer Wenzel, PhD, RN, have found economics also affect women with breast cancer who are insured by managed-care organizations.

Many women find managed-care processes dehumanizing, time-consuming, and demoralizing…some patients report financial uncertainties can be harder to manage than the disease itself.

In “Insurance-related and financial challenges reported by managed care enrollees with breast cancer,” [Clinical Journal of Oncology Nursing, October 2010], women reported considerable stress related to the loss of personal control over treatment, care, and cost decisions; and to the dearth of speed and transparency in managed-care decisions, resulting in delayed treatment and unanticipated, patient-borne costs.

According to Klimmek, “Many women find managed-care processes dehumanizing, time-consuming, and demoralizing; in the very time they may be struggling with body image, the impact of cancer on work and family, and survival itself.” Wenzel adds, “At unthinkable as it might seem, some patients report financial uncertainties can be harder to manage than the disease itself.”

Bound by Law
Making the Call on an Endangered Child
by Teddi Fine

When it comes to detecting child abuse in preschool children, nurses are on the front lines. Yet, just over eight percent of reports to child protective services are from nurses.

According to post-doctoral fellow and clinical mental health nurse Shelly S. Eisbach, PhD, RN, most nurses say making the required call is a “no brainer” when a child has obvious signs of abuse. But when the signs are more subtle, the decision becomes more difficult and more critical.

In a descriptive exploration, “I Am I Sure I Want To Go Down This Road? Hesitations in the Reporting of Child Maltreatment by Nurses,” [Journal for Specialists in Pediatric Nursing, October 2010], Eisbach and a colleague asked how nurses handle these less definitive cases of child abuse. Do they report it, hesitate, or seek additional information before contacting protective services? Do they engage the families immediately or watch the situation over time?

Based on their interviews with pediatric nurses and nurse practitioners, Eisbach found no one path is always the right one for detecting and reporting child abuse. Sometimes, when a nurse engages a family, they reach out for help; other times, delay can result in heartbreak.

She advised nurses to “follow their knowledge, experience, and ‘gut feeling’ to save a child from harm.” Further, Eisbach called upon everyone “to be as public and outspoken about child maltreatment in this country as we are about animal abuse.”

In the Field
Nursing the Wounds of War
by Teddi Fine

When a suicide bomb detonates or an improvised explosive device blows up at a roadside or in a car, the damage can be both vast and shattering for those nearby, whether the victims are soldiers or innocent bystanders. These explosions send shrapnel—sharp bits of metal—into everything and everyone near them. As seen in far too many news accounts of the combat in Iraq and Afghanistan, lives and limbs can be lost or shattered.

In many cases, shrapnel wounds are small, superficial, soft-tissue injuries that combat nurses and doctors call “peppering wounds.” They literally “pepper” a portion of the body—too often the face and neck—with these tiny wounds, frequently with bits of embedded metal.

While not among the life-threatening injuries seen in combat-zone medicine, these potentially disfiguring wounds are among the most common, and the most susceptible to independent management by nursing staff. But, as Air Force Major and JHUSON graduate Jennifer J. Hatzfeld, PhD, RN, realized during her deployment to a military hospital in Kandahar, Afghanistan, no established guideline existed to support nursing assessment and treatment of these superficial shrapnel wounds.

Training varied markedly among the U.S. Navy-managed hospital’s intercollegues at the Kandahar hospital took action.

The team mapped out a best-practice protocol for patients with peppering shrapnel wounds. They approached the issue from a common nursing perspective: focusing holistically on the needs of the individual patient and combining immediate and specific treatment protocols with attention to longer-term needs related to pain management, nutrition, and emotional support.

And all this despite responding to mass casualties in an environment of escalating operations and limited access to research resources and a dearth of research on the topic. The work was done between shifts, on precious days off, and in moments between patient care and the next crisis, but the work was done.

The very process of creating the protocol had a tangible benefit by bringing together a diverse group of clinicians from different countries with different nursing experiences, all of whom were far from home and working under extreme circumstances.

Their accomplishment, observes Hatzfeld, is “a great example of what nursing teamwork is all about.” Today, as director of nursing research at Travis Air Force Base in California, Hatzfeld notes, “This was a very small project dealing with an unfortunately common battlefield injury. Our work certainly does not revolutionize the already great care that’s being provided to our injured service members in the field, but it does have the potential to make caring for these wounds a bit easier, with more successful outcomes.”

The work she humbly describes as small may in fact have big applications closer to home. In the event of a disaster, the guidelines she helped craft could well give nurses the guidance they need to better care for patients with wounds they previously had never seen or treated.
Continuing Education in Uganda—from Cyberspace

Nurses Share Hypertension Knowledge

A full room of nurses in Kampala, Uganda, fell silent as Dean Martha N. Hill, PhD, RN, spoke into the microphone. “We’re very happy to be here talking with you about hypertension,” she said. “Welcome to cyberspace.”

At the first-ever continuing nursing education program in Uganda, nurses from both Johns Hopkins and Makerere University presented hypertension case studies and led a dialog about standards of care in the two countries. Questions from Makerere ranged from best practices (Why is it important to reduce alcohol when the patient is hypertensive?) to healthcare economics (How much does medication cost in the hypertensive?) to healthcare economics of care in the two countries.

“Tanzania Needs You!”

An Overseas Friendship Develops From a Passion for Nursing

by Karen Gibbs

Patricia Abbott, PhD, RN.

In Tanzania, the needs are vast; there is a real need for medical professionals, and nurses are key to the healthcare system. When Patricia Abbott first heard about the need for nurses in Tanzania, she was inspired to help. She reached out to the Tanzanian Ministry of Health and was able to secure a position for herself and a few other nurses in the country’s first medical school with a four-year medical education program. Abbott spent several months in Tanzania, working with nurses and nursing students, and helping them to develop their skills.

In Tanzania, the needs are vast; there is a real need for medical professionals, and nurses are key to the healthcare system. When Patricia Abbott first heard about the need for nurses in Tanzania, she was inspired to help. She reached out to the Tanzanian Ministry of Health and was able to secure a position for herself and a few other nurses in the country’s first medical school with a four-year medical education program. Abbott spent several months in Tanzania, working with nurses and nursing students, and helping them to develop their skills.

Tanzanian Clementina Tirani (left) is earning her bachelor’s in nursing, thanks (in part) to mentorship from faculty member Patricia Abbott.

Doctoral Partnerships Go Global

International Students Present Dissertation Presentations at Hopkins

by Jon Eichberger

Nursing collaborations, sexual trauma, schizophrenia, and women’s health: these are all prominent topics in today’s healthcare system, and they will need a new generation of nursing professionals to address them. That’s why these topics are the focus of dissertation presentations by doctoral nursing students at Hopkins in December. But their studies aren’t based in Baltimore—these students are earning their doctoral degrees in China and South Africa.

Huang Baoyan, Kang Xiaofeng, Zou Haixu, Fan Yanyan, and Sun Ning are members of the fourth cohort of doctoral nursing students from China’s Feking Union Medical College (PUMC). The PUMC/HUSON doctoral program partnership, funded by the China Medical Board of Boston, Inc., has resulted in the first nurse PhD graduates from a Chinese university. Mahalsela Annah Rakhudu, Gabisengle朔e Margaret Manalk, and Kathleen Khomotso Diriko were the first to be invited as part of an informal collaboration with North-West University in South Africa. “These students have seen first-hand how American nursing compares to their native nursing program in South Africa, and have applied that experience to their doctoral studies,” says professor Phyllis Sharps, PhD, RN, who also served as faculty mentor to the South African students.
patients have can be our exclusive focus. We can forget that under lists of past medical histories and medications, a mother, father, brother, sister, daughter, or son lies on that hospital bed. But we treat and care for patients—not the medical diagnoses.

I remember Angela when I am with a patient, and I consider how nice it was to be called Mandy and not vazaha. As I make my way through clinical rotations and meet patients hooked up to machines or unable to communicate with words, I will always think back to that day with Angela.

When I walk into a room to administer medications or do an assessment, I will look them in the eye and say “hello” to them before I check their I.D. band. I will remember how we all can appreciate being involved in the care and treatment in our lives and how a simple gesture, such as calling someone by their name, can make all the difference in the world.

The Foreigner
Calling Someone By Name Makes All the Difference
by Mandy Chavez, Accelerated '11

Four-year-old Angela taught American Peace Corps volunteer Mandy Chavez the importance of a name.

A ngela and I were sitting on a bench outside my house, gently swinging our legs, as we did most days. She normally didn’t have any shoes on, but this day she was wearing purple sandals—worn and tattered with a faded picture of Barbie on them.

“I like your shoes,” I said.

“Thanks,” she replied. “Look, there is a vazaha on them.” Vazaha is the Malagasy word for “foreigner.” It’s a word that I heard over and over in Madagascar.

At some point, I had given up trying to explain to people my name was Mandy and not vazaha.

“Okay, like Miss Mandy, huh?” I said, positive she would agree.

But she stopped, looked at me with confusion and replied, “You’re not a vazaha. You’re Miss Mandy,” and then continued swinging her feet.

Angela, a four-year-old girl, was able to teach me something that I have been able to bring with me into practice since starting the nursing program at Johns Hopkins. It’s important to see people. It’s important to remember that each one of our patients has a name and deserves to be treated as an individual.

Oftentimes, the medical problems...
Nursing in America is changing. Bigtime. While the healthcare industry is simultaneously coping with the aging-patient “silver tsunami,” increasingly complex insurance procedures and loopholes, and implementation of healthcare reform, one thing is clear: healthcare is facing unprecedented challenges, and nurses must play a major role in meeting them.

In a new report, The Future of Nursing: Leading Change, Advancing Health, the Institute of Medicine and the Robert Wood Johnson Foundation examine what it’s going to take—from nurses, hospitals, administrators, government, and other members of the healthcare team—to satisfy future demands for care. Chaired by Donna Shalala, the former Secretary of the U.S. Department of Health and Human Services (see page 3), the report committee offers specific recommendations for the future of the nursing profession.

At Johns Hopkins, Dean Martha N. Hill, PhD, RN, thought “it would be valuable to look at the report recommendations and ask: How do we measure up? What is special about academic health centers in general and about Hopkins in particular? And, what might we do as a step forward?” She invited an interdisciplinary group of university and hospital leaders to do just that.

Growing Our Knowledge

The report’s recommendations center around four themes: improving and increasing nursing education, supporting nurses in practicing to the fullest extent of their education and training, creating a culture and systems in which nurses act as full partners with other healthcare professionals, and collecting better nursing workforce data.

The Future of Nursing recommendations are “not surprising,” said Steven Wartman, MD, PhD, a Hopkins alumnus and President and CEO of the Association of Academic Health Centers. In a boardroom full of Hopkins VIPs, Wartman’s voice brought a wider perspective to the conversation. “What concerns me is the bigger picture or the context in which these...
recommendations might or might not be implemented on a national scale."

Take, for example, the suggestion to increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020. Today, only 50 percent of U.S. nurses meet this criterion. And while it may make sense to increase nurses’ education, say Wartman, “nursing has been described as a fractured profession. If that is still true, the fracture, the fault line, is between the two-year programs and the baccalaureate programs.” In this light, he wondered whether this educational goal is attainable.

Karen Haller, PhD, RN, believes it is—and that the nursing profession is divided no longer. “We’ve well earned our reputation as a fragmented profession, but I don’t want the myth to outlive the reality,” pointed out Haller, who serves as Vice President of Nursing and Patient Care Services at Johns Hopkins Hospital. “One of the appendices in this report is the consensus model, a model about licensure, accreditation, certification, and education requirements. All of the nursing organizations have signed on to it in addition to the 50 state boards of nursing,” she noted. The support of baccalaureate-level education, she said, is unanimous.

So how does Hopkins measure up? At the Hospital, “we’re at 78 percent of nurses with a bachelors,” said Haller. “I’ve got to step that up two percentage points over the next few years.”

And at the School of Nursing, “the vast majority of our students, more than 80 percent, already have a college degree when they come to us,” added Hill. The report also recommends doubling the number of nurses with a doctorate degree by 2020 and ensuring that nurses engage in lifelong learning through continuing education and training.

Fulfilling Our Potential

The recommendation will only be useful, however, if nurses can fully use their knowledge to improve practice. But nurses often confront government regulations and institutional policies that prohibit them from performing at the top of their ability.

“State regulations that support advanced practice nursing are very uneven across the United States,” explained Hill. The laws permitting (or forbidding) advanced practice nurses to independently examine patients, order and interpret lab tests, prescribe drugs, admit patients in a hospital, or provide other such services vary widely from state to state. Wartman pointed out that, “dealing with a complex regulatory environment at a time when states’ rights are becoming very powerful and very important presents a serious challenge. How do you move to a more national framework?”

As we look toward the future, the need for consistent advanced practice nursing laws will be even greater. Hill noted that “as increasing numbers of people have insurance or require primary care, we’re going to need more providers who are qualified in skill that can lead it in practice.”

But not everyone agrees that advanced practice nurses should step up to the role of primary-care providers. Edward Miller, MD, Dean of the School of Medicine, said that the report’s recommendations, taken “to the ultimate,” would be for nurses to conduct independent practice. He asked, “Is that the way the right way to go? I’m more partial to the team concept. I think the recommendation goes a little too far, to tell you the truth.”

His concern echoes that of other physicians, some of whom wrote to the editor of the New England Journal of Medicine in December. They emphasized that nurses are not interchangeable with physicians and advocated for keeping the traditional, physician-led healthcare team.

Deborah Trautman, PhD, RN, Executive Director of the Johns Hopkins Center for Health Policy, spoke to the issue of whether nurses want to step into leadership roles. “Leadership doesn’t mean they step away from the bedside, necessarily, but in some nurses’ minds that’s what they think. But having nurses continue to do what we support at Hopkins—be involved and participate beyond traditional boundaries—serves not only nursing well but serves some of our other areas equally as well.”

The advanced practice nurse needs to have more recognition in the Hopkins Health System, offered Margaret Garrett, Senior Counsel and Director of Risk Management for the Johns Hopkins Health System. “In community positions, we’re getting advanced practice nurses to do more of the primary care, which is excellent because we need that particular level.”

The recommendation to remove scope-of-practice barriers doesn’t just apply to advanced practice nurses, pointed out Haller. The idea is to allow all nurses, and all levels, to perform to the fullest extent of their training. This would enable nurses to maximize their value to the healthcare team—and it can even help lower the cost of healthcare overall.

“The notion I find very attractive in this report is putting the work at the lowest-paid level that is trained to handle it. This means having our aides or our technicians doing certain work rather than our RNs. The report would take that idea all the way up, through every level of healthcare, including advanced practice nurses and our physicians,” said Haller.

Ronald R. Peterson, President of the Johns Hopkins Health System, noted that, “In most compensation models, as long as someone is qualified to do the job, people who are doing the same job should be compensated equally. But if we go the next step of saying that a baccalaureate-trained nurse should be differentiated in terms of scope of work versus someone who has AA, then we have a basis in my opinion for differentiating in terms of compensation.” Hopkins currently gives baccalaureate-prepared RNs more tasks, responsibilities, and compensation at the top tiers of the clinical ladder.

“We need to deliver our services in the most cost-effective way. We have to figure out a way to pay attention to the total cost given the rendering the services,” Peterson added.

Working with Our Colleagues

These kinds of changes—that reach across disciplines and affect the entire healthcare team—require an enormous amount of respect, collaboration, and communication. The challenge, Wartman pointed out, is “that all the health professions practice within the framework of a guild, and this mentality to a large extent prohibits these kinds of changes that we’d like to see happen. Maybe there are steps within the Hopkins environment that can be taken to reduce that.”

According to Hill, Hopkins is well on the path. “The guild is gone in research. It has become very collegial, very collaborative. I think faculty move that way because they understand that’s going to be the best science,” she said.

The question is how to move that interdisciplinary environment out of the research lab and into the hospital and the classroom. One major obstacle? “We have three schools [nursing, medicine, and public health] with three calendars,” said Hill. Planning interdisciplinary lectures, joint classes, or multi-school student organizations while on different schedules “presents a huge problem and we’ve got challenges there.”

Who’s Talking about the Future of Nursing?

1. Margaret Garrett
   Senior Counsel, Johns Hopkins Health System

2. Ronald Peterson
   President, Johns Hopkins Health System

3. Deborah Trautman, PhD, RN
   Executive Director, Johns Hopkins Center for Health Policy

4. James Yager, PhD
   Senior Associate Dean for Academic Affairs, Bloomberg School of Public Health

5. Edward Miller, MD
   Dean, Johns Hopkins School of Medicine

6. Karen Haller, PhD, RN
   Vice President of Nursing and Patient Care Services, Johns Hopkins Hospital

7. Deborah Dang, PhD, RN
   Director of Nursing Practice, Education, and Research, Johns Hopkins Hospital

8. Martha Hill, PhD, RN
   Dean, Johns Hopkins School of Nursing

9. Steven Wartman, MD, PhD
   President and CEO, Association of Academic Health Centers

“I think we work pretty well together between the schools of public health and nursing,” added Jim Yager, PhD, Senior Associate Dean for Academic Affairs at the Bloomberg School of Public Health. “But perhaps we could have a bit more sharing of some best practices. But our different academic calendars do create difficulties. I don’t know if Hopkins will ever address that issue. I mean, for us to change our calendar would be revolutionary, but not necessarily bad.”

“I think if we want to do some real good, we need a single schedule among the three schools. That would knock down a couple of barriers,” agreed Miller, speaking for the School of Medicine.

“This is a sword that no one’s been willing to fall on. And who has the authority to make it different?” asked Hill.

The group paused, imagining the possibilities.

“Generally, what’s remarkable about this place is when you get people to come together, anything can happen,” said Hill. “These walls are extremely permeable.”
Peace and friendship. Service to others. Helping your neighbor. It’s the spirit of the Peace Corps—and the spirit of nursing—that we hear in R. Sargent Shriver’s call to look “more at each other.”

This year the Peace Corps celebrates its 50th anniversary. Since 1961 more than 200,000 men and women have traveled to 139 countries, helping their neighbors and promoting peace and understanding between nations.

But 2011 marks another milestone: the 20th anniversary of the Peace Corps Fellows program at the Johns Hopkins School of Nursing. The program was established in 1991 (see page 61) to provide community-outreach opportunities and financial assistance to Returned Peace Corps Volunteers (RPCVs). More than 300 RPCVs have become Hopkins nurses through this program.

“I hadn’t considered nursing until I served in the Peace Corps. I realized the power that nurses have, particularly in the developing world, and how much I enjoy working at the community level to help people to help themselves,” says Devon Gershaneck, accelerated BS ’06. Today she is a nurse in the Emergency Department at the Johns Hopkins Hospital and will graduate from the MSN-FNP/MPH program this August.

Want to listen to our Peace Corps Fellows share their stories from the field? Check out their podcasts online at www.nursing.jhu.edu/peacecorpsstories, or scan this barcode with your smartphone.

“Break your mirrors!!! Yes indeed—shatter the glass. In our society that is so self-absorbed, begin to look less at yourself and more at each other. Learn more about the face of your neighbor and less about your own.”

—R. Sargent Shriver, First Director of the Peace Corps (1961-1966)
Judith Harkins
The girls in her summer-camp class had lots of questions. They had reproductive questions; they had nutrition questions.
Judith Harkins, MSN/MPH ’03, BS ’01, RN, was leading English-language lessons during her Peace Corps service in Albania (1994–1996), so she worked the girls’ questions into her curriculum. Soon, she says, “I started realizing that if I had the technical training, I could do a whole lot more.”
Harkins came to Hopkins to study nursing and public health, and then interned at Family Health International (FHI), a nonprofit that helps HIV populations in developing countries. FHI hired her as a technical officer, and today she works as a contractor with various agencies on HIV prevention and treatment.

After spending time overseas in the Peace Corps, nursing was an obvious career choice for Harkins. “For me, it was hard to think about doing anything else,” she says.

Kimberly Connolly
“When I graduated college, I really had no idea what I wanted to do with my life, but I knew I wanted to do the Peace Corps,” says Kimberly Connolly, MPH, MSN ’03, BS ’00, RN.
During her Peace Corps service in Niger (1995–1997), Connolly taught women about hygiene, breastfeeding, vaccinations, and nutrition at a clinic with no running water or electricity. She taught mothers how to make porridge from peanut powder, oil, and millet—“a grain that grew all over the place”—to help their children gain weight.
“I loved the health-education portion of my work,” she says. “But I wanted more of a clinical background.”
Connolly came to Johns Hopkins to study nursing and public health, but knew she wanted to go back overseas. Her work has since taken her to China, Ethiopia, Liberia, Indonesia, and the Democratic Republic of the Congo, where she spent three years rebuilding health centers and training nurses and physicians with the International Rescue Committee and the Ministry of Health.

Today Connolly is the first director of the Villanova University College of Nursing’s new Center for Global and Public Health.

Remembering Sarge
by Kari Hatfield, Traditional ’12
Sargent Shrivers, founder of the Peace Corps, had a tremendous impact on my life. When he answered President Kennedy’s call to form the Peace Corps in 1961, he succeeded in creating a program that young college graduates could utilize to change and shape the world in which we live. In 2006, I was one of those graduates, fresh out of college, naive and not quite sure what was next in life, but eager and ready to serve.
And off I went to China, where I spent two years serving, growing, changing, and pursuing my idealism.
Mr. Shriver, the Peace Corps patriarch, died on January 18. I never had the pleasure of meeting him, but as I spent time reading about him and his inspiring legacy of selflessness and philanthropy, my heart was heavy as I thought about the loss of such a strong pillar of service. Everything that I read spoke beautifully about his dedication to fighting inequality and injustice, and I feel honored to have worked as a part of one of his programs.
My roommates, Jackie, a fellow RPCV, and I went to pay our respects to Mr. Shriver and his family at a public wake in D.C. I was expecting the atmosphere to be somber and

Continued on page 32
Rachel Breman
Rachel Breman, MPH, MSN ’04, BS ’02, RN, traveled to Niger’s remote villages with a generator and television. From 1997 to 1999, she taught seminars on nutrition, HIV, and breastfeeding. Along the way she realized how helpful a clinical background would be to the people she met, like a woman who had terrible mastitis.

“I’ll never forget looking at her breast,” she says. “And she was asking me what she should do. I didn’t know what to tell her.” But Breman wanted to help. When her Peace Corps nurse told her about the Johns Hopkins University School of Nursing, “I wasn’t confident that I could get through nursing school,” she says. She went on to receive her BS and MSN degrees, and this year she came back to the school as an instructor in public health nursing.

“Peace Corps made me realize that some people have no opportunities in their lives, but I have all the opportunity in my life,” says Breman. Whatever challenges she may face, “I know I could actually do it.”

Richard Kimball
In the late 1990s, Richard Kimball, PhD, MSN/MPH ’01, BS ’99, APRN-BC, cut his hand on a door knob in Kazakhstan. As a Returned Peace Corps Volunteer (he’d served in Moldova the prior two years), he was used to this kind of inconvenience and injury, and he didn’t think much of it. But the next day he had a red hand and a red streak shooting up his arm. He had phlebitis.

At the local hospital he suffered through harsh conditions and a treatment that didn’t work. He eventually got IV antibiotics from a Kazakh physician the U.S. Embassy. His phlebitis healed, and his interest in nursing had been sparked by seeing the good work of the nurses he met.

In the next few years, Kimball earned his BS and MSN at Johns Hopkins, and went on to receive his PhD in Health Policy. Today, he is an assistant professor at the Johns Hopkins University School of Medicine. Peace Corps, he says, “taught me how to listen to people and their stories, to listen to see what’s going on and not just notice a broken arm.”
ACUTE HYPERSENSITIVITY REACTIONS: WHAT NURSES NEED TO KNOW

Earn 1 Contact Hour—Free of Charge

The goal of this CE activity is to provide nurses and nurse practitioners with knowledge and skills to recognize and manage acute hypersensitivity reactions (HSRs) occurring as a result of medication administration. After reading this article, you will be able to:

- Recognize early signs and symptoms of acute HSRs
- Describe evidence-based nursing and medical management of HSRs
- Discuss prevention of HSRs

A n acute hypersensitivity reaction is a rare but serious complication of exposure to foods, natural rubber latex, medications, and other antigens. Patient allergies are not always clearly defined in the medical record, and severe reactions may not be anticipated. Nurses and nurse practitioners must recognize HSR risk factors, read early signs and symptoms, and intervene to protect the patient from further harm.

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<td>Delayed cytotoxic</td>
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Common antigens eliciting HSRs include foods such as peanuts and shellfish, environmental antigens such as natural rubber latex, venoms such as those from bee stings and fire ants, and medications such as antibiotics, monoclonal antibodies and chemotherapy. Although acute HSRs generally occur within minutes of antigen exposure, there is a wide spectrum of HSR presentations—including biphasic and delayed reactions—that may occur hours to days after antigen exposure. The type of reaction is determined by the primary immunologic mechanism as outlined in Table 1, although it is important to be aware that HSRs in clinical practice often involve multiple immune pathways and may be difficult to categorize.

For the purposes of this CE activity, we will limit our discussion to acute HSRs resulting from exposure to medications and biologic agents. Most of these are categorized as Type I or anaphylactic HSRs. Type I reactions manifest almost immediately upon antigen exposure. The primary mediator of Type I Reactions is immunoglobulin E (IgE). Anaphylactoid or pseudoanaphylactic reactions produce identical symptoms, but are not characterized by progressive symptoms with each exposure or the presence of IgE antibody. All HSRs are complex immune responses of mast cell degranulation activating histamine release, complement system, prostaglandins, and inflammatory leukotrienes. The effects of these immune response mediators are responsible for most of the symptoms seen in HSRs, whether they are cutaneous reaction characterized by itching and hives (histamine) or bronchospasm and tachypnea (leukotrienes and prostaglandins).

When are acute HSRs likely to occur? Acute HSRs are rare, with 1% of Americans considered at risk of exposure to known allergens. Of those who experience anaphylaxis, approximately 1% will die from anaphylaxis. In hospitalized patients, anaphylactic reactions account for about 6% of reported adverse drug reactions.1 HSRs are more likely to occur with intravenous administration. Complex, protein-based molecules are more likely to elicit the immune-mediated response of an acute HSR, which accounts for the increased incidence of acute HSRs with infusions of biological agents such as antisera or monoclonal antibodies. These agents are often administered in ambulatory settings to patients with diseases such as Crohn’s disease, multiple sclerosis, autoimmune disorders, and cancers. Some smaller molecules, like the penicillins, bind to circulating serum proteins, resulting in increased size and antigenic potential in susceptible patients. Some drugs used in medication admixture contribute to the risk for HSR.1 Cremophor, for example, is a diluent for paclitaxel, cyclosporin, and tenoposide. The most likely acute HSR medication categories are described in Table 2. Cremophor is a diluent for paclitaxel, cyclosporin, and tenoposide. The most likely acute HSR medication categories are described in Table 2.

<table>
<thead>
<tr>
<th>Table 2: Definition of Anaphylaxis</th>
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<tr>
<td><strong>Type</strong></td>
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<tr>
<td>Anaphylaxis</td>
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<td>Cytotoxic</td>
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<td>Serum sickness</td>
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<td>Delayed cytotoxic</td>
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<th>Table 3: Acute HSRs</th>
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<td><strong>HSR</strong></td>
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<tr>
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<td>Delayed cytotoxic</td>
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Diagnostic Criteria for Anaphylaxis

Table 4: Table of Anaphylaxis

| **Type** | **Mechanism** | **Signs and Symptoms** |
|--------------------------------|
| Anaphylaxis | Immediate immunoglobulin E-mediated reaction | Fever, nausea, vomiting, flushing, back pain, angioedema, rash, dyspnea, bronchospasm, feelings of impending doom, circulatory collapse |
| Cytotoxic | Antigen–antibody complexes activate inflammatory pathways | Viscosities, nephritis, arthritis |
| Serum sickness | Immune complex form and deposit in various tissues | Graft rejection, contact dermatitis, granuloma formation, Gruh-Venus-Host Disease |
| Delayed cytotoxic | Activated T-cells destroy targeted cells | |

<table>
<thead>
<tr>
<th>Table 5: Table of Acute HSRs</th>
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<tbody>
<tr>
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The most likely acute HSR medication categories are described in Table 2. Cremophor is a diluent for paclitaxel, cyclosporin, and tenoposide. The most likely acute HSR medication categories are described in Table 2.

How should acute HSRs be managed?

Stop, Call, Assess, Prepare.

If you suspect your patient is experiencing early signs of an acute HSR, don’t hesitate to implement your emergency interventions. STOP the infusion but maintain IV access. CALL the provider. ASSESS your patient further: collect vital signs, use a pulse oximeter to obtain oxygen saturation, listen to breath sounds, and check for symptom progression. Finally, PREPARE for emergency treatment, including the potential need to administer IV fluids, oxygen, and resuscitative medications.

Serious systemic effects include dyspnea, bronchospasm, cyanosis, tachycardia, and hypotension or hypertension. Hypotension in the lower back may indicate visceral smooth muscle contraction. The patient may also experience a sense of impending doom, loss of consciousness, and may suffer a circulatory collapse. A uniquely life-threatening event in an acute anaphylactic HSR is angioedema, a rapid swelling of tongue and throat tissues that can obstruct the patient’s airway. Life-threatening HSRs are more likely to occur with intravenous administration, which places the antigen into the bloodstream, with milder response.

Nurses should be alert to possible symptoms during and immediately after administration of the at-risk agent. Initial sublethal symptoms may progress to life-threatening complications within minutes. Anaphylactic diagnostic criteria are described in Table 2. Clinical suspicion is augmented with diagnostic tests to validate HSRs, so that future antigen exposure can be controlled. Allergen-specific IgE levels are available for some drug allergens, but can be complemented with nonspecific tests of immunologic activity such as eosinophilia, serum total tryptase, or flow-cytometry basophil activation assays on CD3 and CD63.5,6,8

How should acute HSRs be managed?

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(0.3-0.5 mL of a 1:1000 solution as intramuscular or subcutaneous injection, repeated every five to fifteen minutes), albuterol (two puffs from a multi-dose inhaler), a rapid-acting corticosteroid such as hydrocortisone 100 mg, and an antihistamine such as diphenhydramine 50 mg. For pediatric patients, epinephrine 0.01 mg/kg is repeated every five minutes as necessary. IV fluids, vasopressors such as norepinephrine, and histamine 1 receptor blockers such as ranitidine may also be ordered. Oxygen therapy is appropriate for most patients, but is only effective if bronchospasm is effectively controlled.

Your organization may have developed a protocol for managing severe anaphylactic reactions. These treatment algorithms are generally based on expert opinion and consensus; there is limited published evidence due to the rarity of HSRs and the urgency of management.2 Some controversial components of therapy include the best route for epinephrine administration and preferred vasopressor agents. Intravenous epinephrine administration is associated with extreme tachycardia and myocardial ischemia. Intramuscular and subcutaneous administration may be equivalent if there is not excess edema or obesity. Dopamine is associated with enhanced tachycardia, but higher efficacy of norepinephrine has not been established. The administration of histamine 2 receptor blockers such as ranitidine (50 mg IV) is a common practice, but is not based upon clinical evidence of efficacy.

If your patient is experiencing angioedema, be aware that an emergency cytochrome oxidase or tracheotomy may be needed. Availability of emergency surgical airway supplies and expert clinicians is recommended when administering agents with high risk for HSRs.

An acute HSR is a frightening experience. After the initial event, supportive care and close monitoring will be needed for several hours to ensure that symptoms do not recur. Immediate-acting medications treating the reaction may dissipate before the agent that triggered it does, and residual antigens can cause a recurrence of symptoms 4–6 hours after the initial event.3 The patient and family members will need explanations of treatments and reassurance that close monitoring and proactive strategies can prevent harm. For some patients who experience mild HSRs, it may be appropriate to consider readministration of the agent in spite of the reaction. This should only be attempted under carefully controlled and monitored conditions, with premedications and a slower infusion rate. Published desensitization protocols exist for some medications and may be useful in these situations.

An acute HSR is also an adverse drug reaction (ADR) and should be reported according to your organization’s policies. The World Health Organization defines an ADR as “any response to a drug which is noxious and unintended, and which occurs at doses normally used in humans for prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function.” Enhanced reporting of ADRs will assist in defining true incidences of drug reactions.

Can acute HSRs be prevented?

Recognizing high-risk patients and situations is an essential first step in reducing HSR morbidity and mortality. Clinical variables known to increase risk for HSRs include personal history of drug allergy, multiple allergy syndrome, presence of Epstein-Barr or HIV infection, or concurrent asthma. For high-risk medications, premedications with antihistamines and corticosteroids are widely used. Skin testing may be performed before administration of medications with high incidence of HSRs. Desensitization protocols may also be useful in preventing IgE-mediated HSRs. Most involve administering a greatly diluted amount of the antigenic agent (usually a dose in micromgrams, rather than milligrams) and then gradually increasing the dose every 15 to 30 minutes to induce tolerance.3 The patient must be closely monitored by experienced healthcare personnel, as reactions are still possible.

Key Points

In summary, hypersensitivity reactions to food, medications and biological agents are uncommon but potentially serious reactions that require acute nursing assessment and critical thinking skills. Paramount to this proactive approach is recognition of allergenic risk factors and significant signs or symptoms before they become life-threatening. Readily available emergency supplies and medications can minimize the adverse outcomes of severe HSRs.

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References


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Filling the Well
Palliative Care Offers Benefits for Patients, Families, and Healthcare Professionals Alike
by Rebecca Poch

When the physician called Robin Lewis-Cherry, BSN, to ask her to approve dosages of Azava for her chronically ill mother, Robin realized her mother was dying. She approved the treatment and hung up, and her eyes fell on her binder of material from the End of Life Nursing Education Consortium (ELNEC) certification course she was in the midst of completing. “Literally the first thing I did,” she recalls, “was to reach for that binder and thumb through it.”

They had just covered in class the signs of physical deterioration that signal the end of life. Robin, a nurse in Nelson 3, was seeing her mother pass through this process even as her instructors presented it, the maturing setting home in a deeply personal way. The course had started out as something that all members of Johns Hopkins’ cross-departmental Nurse Palliative Care Committee were taking, but it had become a guide, walking her through the unexplored territory of her own grief. She found herself running again and again to the resources of this training not only for her work, but also for her own support. “I was grateful to have it,” she says. “I was able to understand how my mother’s condition was progressing, and I was better prepared to make the decisions about her care that would make her more comfortable.”

Enriching Patient Care
Rita Moldovan, DNP, RN, a Clinical Nurse Specialist who works in Palliative Care in Johns Hopkins’ Department of Medicine Nursing, was the one who had invited Lewis-Cherry to join that committee. She herself was drawn to palliative care before there were any formal programs in place at Johns Hopkins. She recalls working on the night shift early on in her three decades of nursing, when she would have more time to sit with patients who couldn’t sleep and to talk with them about their fears and the things they struggled with.

“We can help patients and their entire team look beyond the immediate moment and make decisions about the big picture, whatever that looks like for them.”

She saw a need. Over the past eleven years, her work has focused on making palliative care an integral part of the patient experience at Johns Hopkins, not only for terminal patients but also for those whose conditions are curable. Although it includes hospice and end-of-life care, Moldovan emphasizes its benefits for all patients, especially at this point in time. “Healthcare has become so complex,” she says. “There are so many options and factors to consider. Patients are at their most vulnerable, and making decisions can feel confusing and overwhelming.”

Lynn Billing, RN, CHPN, B-C, agrees. As Nurse Coordinator with the Duffy Pain and Palliative Care Service in the Sidney Kimmel Comprehensive Cancer Center, she is face-to-face with these realities every day. Duffy’s interdisciplinary team—which includes a nurse, a physician, a pharmacist, a social worker, a chaplain, and others—receives new referrals almost daily. “Our job is to take as much time as needed to make sure the patient really understands everything about their situation. We need to be sure we’ve helped them frame and determine their goals in a realistic way while honoring their hopes and dreams.”

“We can help patients and their entire team look beyond the immediate moment and make decisions about the big picture, whatever that looks like for them,” says Moldovan, adding that her first questions in a palliative care situation are always, “What do you know? What do you hope for?”

Family Matters
Palliative care always involves the patient’s family, whether that’s discussing with a patient their anxiety about being a burden on their loved ones, or providing support directly to family members who may experience burnout and fatigue in their roles as caregivers.

Lewis-Cherry recalls how glad she was that she accepted the offer of palliative care from the team at the University of Maryland Medical Center during her mother’s final weeks. The team’s physician talked with her and her brother about their mother’s wishes and helped them sort through the options for interventions with that in mind. “I felt validated in my choices,” she says. “It helped to hear him say that he agreed with what we wanted to do.”

Moldovan finds it very useful to seek out one family member who really “gets it” and to allow them to be a liaison between hospital staff and the rest of the family. Billing adds that different members of the Duffy team tend to have their specialty when it comes to families—one may excel at talking with young children, while another may relate best to grandparents. It can be essential to draw on the strengths of the whole team to talk to family members, sometimes separately, and discover what’s at the root of their beliefs.

Palliative Care vs. Hospice Care: What’s the Difference?

Lynn Billing describes palliative care as an umbrella term under which fall relief of suffering, patient-family well-being, and promoting the best possible life. Its goal is to address the care of the patient-family unit as a whole, whether that means re-evaluating pain medicine, taking the time to explain confusing options and help the patient choose what’s best for them, or helping family members address their own anxiety and exhaustion. Palliative care is available to any patient or family faced with a life-threatening illness.

Hospice care, on the other hand, is something that comes under the umbrella of palliative care but is much more situation-specific. Patients referred for hospice care generally have been given a prognosis of six months or less to live and who are no longer seeking curative treatment. Its philosophy, Rita Moldovan points out, is the same as palliative care—the alleviation of patient suffering. However, she adds, palliative care is appropriate for any stage of chronic, serious, or life-threatening illness, whether or not it’s curable, and in fact is recommended to begin as early as possible in the treatment process.

Palliative Care
- Includes, but is not limited to, hospice care
- Recommended for any condition, whether terminal or curable
- Begun as early as possible in the treatment process
- Employed even if curative treatment is under way
- Most often refers to specific in-hospital programs, but also includes outpatient, home, and nursing-facility care
- When appropriate, considers extending life of the patient as a factor in decisions about care and treatment

Hospice Care
- Specific form of care that falls within palliative care
- Recommended only for terminal conditions
- Begun when the patient has a prognosis of six months or less
- Employed when the patient is no longer seeking curative treatment
- Most often provided as home care or within designated nursing home facilities (Johns Hopkins does not have a hospice program within the hospital facility)
- Does not seek to extend the life of the patient, while not hastening death
No matter what, there is always something we can do to help.

Team Effort
When a palliative care team is called into a situation, they may find that they need to mediate disagreements among the patient's care providers about the best course of action. Says Moldovan, “We try to work with the patient’s team to get everyone to a point of agreement, and one of the things we’re constantly educating about is how to weigh the burden of a particular intervention against its benefits.”

The team always strives to form an alliance with the patient’s care providers, not to supplant them. They are able to take the time with the patient-family unit that the staff’s workload may not permit. They can bring perspective and offer validation for providers’ decisions or bridge communication between the providers and the family.

Moldovan based her doctoral work on her observations of the need for more widespread and structured implementation of palliative care within Johns Hopkins. Out of that work emerged her current project, the establishment in 2010 of the Nursing Palliative Care Committee. Formed in collaboration with Deborah Dang, PhD, RN, the Director of Nursing Practice, Education and Research at Hopkins to examine the issues around palliative care, their chief goal is to develop and implement a framework that will educate and empower all nursing staff to better provide this care.

The committee, made up of nurses from all departments within Johns Hopkins, meets once a month for two hours. Their first two years’ priorities are to ensure that all members take the ELNEC certification course and to create protocols and nurse competencies that will be shared with all nursing staff. Moldovan believes the certification and protocols will give bedside nurses the tools they need to more confidently identify and serve the best interests of the patient in all situations.

Addressing Nurse Suffering
One of the issues that Moldovan believes the committee will tackle down the line is that of nurse suffering and resiliency. She would like to see outcomes, evaluations and studies that result in recommendations for support resources on an organization-wide basis. The emotional and spiritual impact of the work on nurses, particularly in end-of-life situations, is something that she does not feel is fully understood or consistently addressed across the organization.

It was a topic that the committee discussed on the day Robin Lewis-Cherry’s mother was buried. At the next meeting, they asked Lewis-Cherry if she would like some time to talk with them about her experiences and her grief, and they invited her to read the poems she had written for each of her parents’ memorials.

From that point on, the committee decided to designate the first fifteen minutes of every meeting to a debrief session. Every member has the opportunity to share their thoughts and experiences, to talk about their sorrow when they’ve lost a patient, and to recount the stories they might otherwise have no place to tell. “We need to make time to support each other,” says Moldovan. “If the well is dry, we have nothing left to give.”

“What you’ve been through,” she says. Lewis-Cherry is glad to draw on her experiences and training to support her colleagues. “A lot of nurses don’t have an outlet at work because there’s so much to do,” she points out. When a fellow nurse came to her seeking guidance about dealing with the death of a close family member, Lewis-Cherry was able to give her concrete advice to help her manage the specifics of the situation.

This is, Moldovan says, at the heart of palliative care—a focus on tangible, practical, everyday actions that a patient, their family, and their care providers alike can take to improve quality of life. The essence of her philosophy is simple: “No matter what, there is always something we can do to help.”

Lynn Billing coordinates palliative care for cancer patients and facilitates courses on end-of-life care for nurses.

“It helps to know that you’re not alone in what you’ve been through,” she says. Billing sees this healing emerge organically every time she facilitates the ELNEC course. The nurses who participate have often dealt with end-of-life situations, and the interactive nature of the course gives them the opportunity to talk with each other about their experiences and to share their feelings.

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EOE. Suburban Hospital has a smoke free environment.
Guatemala Esperanza was born, as so many ideas are, out of a spontaneous moment in a casual conversation. Radiation oncology nurse Ron Noecker, RN, who had lived in Guatemala for a time, returned in March 2010 from one of his regular trips and mentioned to Marian Richardson his desire to return and help with the ongoing work in impoverished areas.

“So let’s go,” replied Richardson, RN, a nurse manager in Radiation Oncology. Just seven months later, a team of thirteen Johns Hopkins oncology nurses and radiation therapists were en route to the tiny mountain village of Pacoj. There they would spend two days working alongside the residents and the team’s partners from Hombres y Mujeres en Accion to build much-needed homes.

To join the trip, participants had to pay their own travel expenses and help with fundraising efforts. The group’s goal was to raise $4,400 to build two homes in the region; thanks to a matching gift from Chairman of the Board of Johns Hopkins Medicine C. Michael Armstrong, they raised enough to build four.

Suzanne Cowperthwaite, MSN, RN, NEA-BC, Assistant Director of Nursing at the Sidney Kimmel Comprehensive Cancer Center and one of the first to sign up, notes that the bulk of Guatemala Esperanza’s work happened before they ever boarded a plane. The team raised money and collected items like socks, vitamins, and school supplies from Hombres y Mujeres en Accion’s wish list. Every member of the team limited their own belongings to carry-on and used their 50-pound luggage allowance to bring as many donated supplies as they could fit. Team member Andrea Cox’s mother rallied her quilting group to make baby quilts to send along.

Although the focus of the team’s work was not medical, the construction of new homes improves health in the village. Existing housing often lacks ventilation, has poor flooring or none at all, and leaks when it rains, making illness and health issues worse.

“In our work, we often get isolated in academics,” says Marian, who coordinated the project with Ron. “This seemed like a great opportunity to get out into the world and do something concrete.”

Ron recalls that his family and friends used to react to his trips to Guatemala as if he were going to the other side of the world. “But it’s not that far away. We’re just going to help out our neighbors.”

For more information about the Guatemala Esperanza project, visit www.guatemalaesperanza.org.
“I Am a Nurse; This is What I Do”

Even During Vacation, a Nurse Is Still on the Job

by Lynn Richards-McDonald, MSN, RN

SPRING Nurse Educator and Cervical Cancer Screening Coordinator

In Lynn’s own words, she tells us how our profession calls us when we least expect it—and we act.

This began as a lovely trip with my family to Sedona, where we planned to head to the Grand Canyon to see one of the Seven Wonders of the World. On this day, however, we boarded a train to the Verde Canyon Valley.

Lynn Richards saved the day for a fellow tourist in the Verde Canyon Valley.

Not long into the trip, I heard a message from the train staff, “Is there a doctor or nurse on board?” My husband tapped me on the shoulder and said, “I think they need your help.”

Meeting Agnes
I gathered my things and headed to the air-conditioned cabin in the back. There sat an elderly woman. Near her was another woman who stated she was a school nurse, the tour-bus guide, and several staff members from the train. They all looked frightened.

The first question I asked was, “Who is this woman?” It seems they only knew her first name; for this story, we will call her “Agnes.”

Apparently, Agnes had paid for a bus tour and train ride. She was traveling alone. One of the train staff informed me she had vomited eight times in her hot cabin. It was 105 degrees outside that day. I approached Agnes, thinking, I need to do that either.

I quickly figured out that Agnes was probably hard of hearing. I asked her several questions in each ear, “Is there anyone here you can call for help?” She attempted to move but could not do that either.

Turning Back
The train team asked me what I wanted to do. Realizing we were two hours into our four-hour train ride, I asked where the nearest medical facility was. They stated that it was at the Clarksdale depot, where the train had departed. I asked if an emergency vehicle or helicopter could come to the train.

They said no, the ground was too hot for a helicopter to land.

I told them, “This woman is ill and needs to go to the nearest medical facility. If the nearest medical facility is Clarksdale where we came from, then we need to turn around and go back.”

That’s exactly what they did.

Getting Help
The train team brought me a defibrillator “just in case.” I was able to get ice chips down Agnes, which she tolerated.

We needed to know more about her. We found Agnes’s physician’s phone number in her purse and gave her a call. I give an assessment and asked for any information to establish a baseline and help stabilize her patient. She was able to tell me the patient’s medical history and encourage us to get to a medical facility as soon as possible.

After about 45 minutes, the train came to a complete stop to allow two paramedics aboard who had traveled down the tracks to meet us. They asked me, “What do we got?” and I gave them my assessment of the patient. We began by taking her blood pressure (220/130) and other vital stats. We started an IV and placed a pacing EKG. We worked on Agnes as a team.

Why Did I Help Her?
We rode together for another 50 minutes, and were greeted by eight paramedics and two ambulances at Clarksdale. I carried the IV bag while the paramedics transported her off the train and onto a gurney.

I went back to my seat where my family was sitting only to be greeted by passengers standing and clapping. I exited the train and received hugs from several passengers.

One retired nurse stated that she never felt safer to be on a train knowing what I was doing for this woman. Another woman asked, “Why did you help her?” My response was, “I am a nurse; this is what I do.”

Realizing we were two hours into our four-hour train ride, I asked where the nearest medical facility was. They stated that it was in the Cardiac Surgical ICU, she has offered to sing for patients. She notes, “It’s a way to bring comfort to someone who’s hurting and alone.”

Jones especially cherishes opportunities to offer singing as a gift to people she knows and cares about.

In recent years, she’s sung at memorial services for two colleagues who died. “That was so meaningful to me,” she says. “I was honored to be able to use my voice to show respect for them and all they shared with patients and colleagues.”

Natural Nightingale
A Nurse’s Voice Brings Healing and Comfort

by Rebecca Proch

For Sherri Jones, MSN, RN, singing is very much like nursing. “They’re both ways to help make someone’s life better for a little while. You use your talent, and you serve others well.”

The daughter of a musician and a minister, Jones’ mother had her learning to harmonize almost before she could talk, and her father showcased her and her brother in duets at church services. Before long, her father began offering the siblings’ talent at the weddings he performed, and an avocation was born.

Lynn, now the Coordinator of Nursing Programs at Johns Hopkins Department of Surgical Nursing, studied music all her life and performed in musicals and church choirs throughout high school and college. She finally returned to her wedding singer roots as a way to support herself through nursing school.

The weekend schedule allowed her to focus on her coursework during the week, and she loved the work so much that she began singing for other kinds of ceremonies in a wide variety of faiths as well.

Between working full-time and raising three children, Jones eventually gave up singing as a side job, but music remains central to her life—and it has continued to cross paths with her nursing career. During her time as a nurse in the Cardiac Surgical ICU, she has offered to sing for patients. She notes, “It’s a way to bring comfort to someone who’s hurting and alone.”

Jones especially cherishes opportunities to offer singing as a gift to people she knows and cares about.

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A Learning Profession
Bayview Nurses are Going for Advanced Degrees
by Rich Shea

growing up in Gary, Indiana, the daughter of a steel-mill worker and a stay-at-home mom, Rona Corral knew she’d eventually be a nurse. She candy-striped in high school, and through a mentorship program she teamed up with an RN to prepare for enrollment in Purdue University’s BS track, which, after her graduation in 2000, landed her a job in a Gary community hospital. But after a year, she recalls, “I wanted to see a job in a Gary community hospital. But after her graduation in 2000, landed her in Purdue University’s BS track, which, with an RN to prepare for enrollment in the hospital’s Bridgeview. Rona Corral, MSN, BS, RN is one of 50 nurses who have earned academic degrees while working at Bayview. What Corral and Wallace have in common is the means by which they got their degrees while working full-time: a combination of the hospital’s $5,000 stipend for any employee pursuing a nursing degree and its tuition-forgiveness program, with an application process that includes recommendations and explanations to a selection committee how you intend to use your degree. “Not everyone’s accepted,” says Wallace. “But if you are, every dollar you spend after your $5,000 benefit is exhausted, they’ll reimburse you. The nice thing about that program is that it also covers books, which are extremely expensive.” Even more valuable than money is time, says Wallace. And with Greene’s help, she was able to flex her hours, working weekends so she could attend weekday classes. Studying for the certificates, she tried yet another route: online courses. Bayview accepts those approved by the American Association of Colleges of Nursing. As for Corral, the tuition-forgiveness program allowed for one paid day off each week, meaning that she worked two 12-hour shifts and studied during the third. “That was critical,” she says. A scheduling accommodation is also made for nurses pursuing a BS via the nearby College of Notre Dame. Grouped as a “cohort” for two-and-a-half years, the nurses studied evenings on-hand “sterile procedure” training, which Corral conducted with nurses and tech staff. “Evidence shows that collecting blood cultures using this technique decreases the chances of contamination,” says Corral, who credits her master’s training. “That was the message in every class at Hopkins—look at why we’re doing things, and not just do them because they’ve always been done that way,” she explains. “The question was, ‘How can we improve the practice?’”

Paths To an Advanced Degree

The 750 full-time and 250 part-time nurses at Bayview are all encouraged to attain advanced degrees, so Bayview offers help in many ways:

- Sollers Point Initiative Program—Named for the Baltimore high school with which Bayview has a partnership, it enables senior-year students to train on-site as patient-care technicians, with the possibility of one to two students continuing their education at the Johns Hopkins University School of Nursing.
- College of Notre Dame cohort—RN seeking to earn a BS spend two-and-a-half years as members of a cohort that, one night a week, attends classes taught by the nearby college’s instructors in the hospital.
- $5,000-a-year stipend—given, with approval, to nurses pursuing an advanced nursing degree.
- Tuition-forgiveness program—This competitive program is open to all degree-pursuing nurses, who must complete an application that includes recommendations and explaining to a selection committee what they plan to do with their degrees. Those accepted have tuition and textbook expenses covered by Bayview.
- Online study—with any institution accredited by the American Association of Colleges of Nursing.
- Johns Hopkins University School of Nursing—offers a variety of degree-attaining routes, including bachelor’s, master’s, doctoral, and online options.
- Clinical Academic Practice Partnership (CAPP)—Experienced nurses who serve as preceptors earn college credits, the number dependent on the hours spent precepting.
A Quick Clinical Update
New Training Models Save Time, Money, and Headaches
by Rich Shea

When Debbie Fleischmann, MFA, BS, RN, NEA-BC, became Director of Clinical Education at Howard County General Hospital two years ago, the hospital, she recalls, was “not immune to budget difficulties." But having worked at Howard for 20 years, she knew where to scale back. The nurses’ eight-hour clinical updates, for instance, bore overtime and replacement costs and were “dissatisfying” for many. “They provided general-education needs, but specific needs for specialty units were not being met. So we decided to go with a different model.”

The shorter sessions are focused on specific skills, and, since the groups are smaller, it’s more efficient. Everybody got more out of them.

Two, actually—and they were tested, with positive results, on nurses and patient-care technicians this past fall. “With eight-hour days, you had tons of subjects in that period. It was just too much information and really draining,” says Kim Moore, an obstetrics RN specializing in labor-and-delivery. “The shorter sessions are focused on specific skills, and, since the groups are smaller, it’s more efficient. Everybody got more out of them.”

During the OB sessions, which took place in October, three stations—for mock codes, safe-body mechanics, and post-partum hemorrhaging—were set up in the hospital’s OB area. Five-and-a-half-hour sessions, each of the hospital’s 175 techs was given 30 minutes to demonstrate competency, after having been provided preparation materials via the hospital intranet, according to Fleischmann. This meant the techs were only off the floor for 30 minutes at a time, whereas the 100 OB nurses either had to be covered for two hours or come in on call, and thus get paid for, days off. Ironically, the biggest challenge was ensuring the techs could squeeze in the 30 minutes. In early 2011 hospital administrators will evaluate the results, then decide whether the OB or tech model will work best for other units. “We may even use a combination of both,” says Fleischmann.

Regardless, nurses like Moore, who enjoyed working with a small team that received useful feedback from instructors, found much to praise. “What we really liked,” she says, “is that the stations were run by co-workers. They’re-actual nurses practicing with us, as opposed to outsiders coming in. So it meant more to us, that they knew where we’re coming from.”

Beacon of Excellence
Suburban’s ICU Wins National Award
by Rich Shea

In 2008, Kimberley Kelly and several of her staff at Suburban Hospital’s ICU attended a dinner hosted by the American Association of Critical-Care Nurses (AACN), which was honoring regional recipients of its Beacon Award, given to units meeting a rigorous set of safety, organizational and leadership standards. Beacon winners, as the award’s name implies, serve as models nationwide. And Kelly, who had signed on as nursing director in 2005, when morale in the ICU was low due to staff and management turnover, realized something.

“I felt like, ‘We can do this,’” Kelly, MBA, RN, CCRN, recalls. “‘We can check off 75 percent of these standards we’re already meeting.’ We had lots of energy, and the unit had stabilized at that point.”

Two years later, after undergoing an 18-month application process, Suburban’s ICU—along with Johns Hopkins Hospital’s ICU—was indeed awarded a Beacon, which, as AACN’s president, Kristine Peterson, states, “represents extraordinary commitment to high-quality critical care standards.” So, what did Kelly and her crew of 75 nurses do to clinch the award?

“Our biggest challenge was critical-care certification of staff,” says Kelly. The Beacon standard is 65 percent, and at the time only four nurses on the 24-bed unit, which serves 2,000 patients a year, were certified. But the AACN also credits other units actively seeking improvement. And in two years Suburban’s ICU upped its certification number to 23 by having in-house experts teach nurses, who also listened to test-prep CDs during their commutes. “It’s a lot of work,” Kelly concedes, “but now the expectation is to get your certification.”

Suburban’s 67-page Beacon application lists many other reasons for award qualification. The turnover problem Kelly once faced, for example, was resolved by having senior nurses help prepare student nurses and travelers to become permanent staff members. The result: the staff vacancy rate, at 40 percent in 2005, is now 9 percent, and the once 27-percent turnover rate is 8 percent.

Collaboration also extends to education, for which several employees—intensivists and the ICU educator, among them—determine staff needs and follow up with semi-monthly in-services. This has engendered the “healthy work environment” the AACN aimed to model when it created the Beacon in 2003. As evidenced in its application, the Suburban ICU reported high scores in its most recent employee- and patient-satisfaction surveys—95 and 81 percent, respectively.

The latter is no surprise, considering that the unit’s daily-rounds routine includes patient-family participation. Kelly says that Suburban’s set-up—in which intensivists work closely with nurses—is “atypical.” “Our nurses,” she explains, “are empowered and expected to present the patient’s history, physical review of systems, and problem list. Our power is in our mutual respect and collaborative approach.”

Suburban’s ICU team is nationally recognized for their commitment to high-quality critical care standards.
Crucial Conversations
Nurses Learn Communications Strategies That Improve Patient Safety
by Jennifer Walker

A nurse sees her co-worker walk into a patient’s room without washing his hands or pulling on gloves and a gown. Root-cause analysis results show that 99 percent of patient errors occur because healthcare staff don’t effectively communicate in these situations. But what is the best way for the nurse to bring the issue to her co-worker’s attention?

Since January 2009, Sibley Memorial Hospital has trained approximately 300 RNs to answer this question. In its Seven Crucial Conversations for the Healthcare Professional workshop, staff learn how to feel safe and respond appropriately when crucial conversations—with high stakes, high emotions, and/or differences in opinion—are necessary.

“[Staff] need to advocate for patients,” says Joan Vincent, RN, MSN, MS, MEA-BC, Vice President for Patient Care Services and Chief Nursing Officer. “If we don’t feel safe in the conversation, then sometimes I feel we don’t advocate as hard as we can.”

Through the generosity of Prince Charitable Trusts, the one-day workshop is led by seven nurse facilitators—a combination of managers, researchers, staff nurses, and education and training specialists—who were trained by the communications company VitalSmarts. Lead nurse trainer Patty Haresign, RN, B-C, MS, an education and training specialist with the hospital, says that the first step is teaching staff to be aware of crucial conversations. “[We] have to be able to recognize [them] and sort of step back and really look at the content of what we’re saying,” she says.

Staff also learn to recognize the feelings they bring to the conversation and to listen to other sides of the story, all while staying focused on—and quickly resolving—the central issue at hand.

“In healthcare you have to be able to speak to somebody spontaneously,” says Haresign. “If you can state facts and not worry about the emotions, you can really get to the point of what you need.”

On surveys distributed after the workshop, staff members said they feel more comfortable having crucial conversations with their colleagues. They’ve also learned to think before they react.

But Haresign points out that it’s difficult to follow all of the workshop’s communications strategies at once. “We tell [attendees], ‘Go out and begin with one or two skills,’” she says. “These skills only really become part of you with practice.”

To learn more about the Crucial Conversations program at Sibley Memorial Hospital, contact Sandra Lukis, RN, or Patricia Haresign, RN, at educationandtraining@sibley.org.

Learning Into Action

Laura Butler knew from an early age that she wanted to be a nurse, inspired by the nurses who helped care for her father as he had multiple knee surgeries.

“When I was little, I wanted to take care of my dad the same way they did,” says Butler, a student in the traditional class of 2012.

But before diving into her nursing curriculum, Butler pursued a liberal arts background with a major in bio-nursing. “I like to learn,” she says. “It interests me to gain more knowledge. You can always bring that to nursing.”

When she’s not hitting the books, the Maryland native likes to run and spend time with her friends and family. As she has turned her focus to her nursing studies, with the support of the Mary Dent Scholarship, Butler says she’s challenged, but adds, “I am having a lot of fun.”

As for her future, Butler wants to pursue surgical nursing and is enjoying sharing her studies with her father, who just underwent a knee replacement.

“I’m putting what I learn into action when I am at home.”

Mary Dent Scholarship Fund
Long-time Baltimore resident Daniel Dent established this fund—named for his wife, Mary Dent, who is a former nurse—to help nursing students who plan to practice in Baltimore after graduation.

The scholarship provides full tuition and clinical supplies for an outstanding student pursuing a baccalaureate degree.
At our networking panel events, alumni are featured in an informal panel discussion to speak about their professional experiences, offer advice, and answer questions for undergraduate and graduate students. The students are able to enjoy an evening with alumni and food and interaction along with alumni mentors. Let us know if you are interested in participating in future panels. The Alumni Association also co-hosted a celebration ceremony and reception for master’s program graduates in December. This event was wonderful, moving, and made special through the personal remarks of Anthony Pho, accelerated ’28, the president of the Graduate Student Nurses Association. Congratulations graduates and keep in touch! The Nurses’ Alumni Board thought it would be a great idea to share some Hopkins history in this and future issues (see sidebar on page 55).}

CLASS News

46 Class Reporter—Laura Brautgang, June, (410) 328-8617, LRJnna@son.jhmi.edu. Georgia Rauch Ahlten and her husband are proud parents of their four children. Georgia has been in rehab since August; she became a great grandmother for the second time recently. Mary Bailey Camp has a picture of Eleanor Roosevelt speaking to the class in 1945 at Hampton House, she had 28 family members living around. Mona Staska Riley is very active in Senior Club at her church and antique club. We were told to send that Phyllis Conner passed away in December. We have 29 of the original 100 left from us.

50 Class Reporter—Betty Borenstein Scher, (440) 449-5934, borerbcomcast.net. After all the news gathered for our 50th reunion, there is still news from holiday card. Cara Lawrence remains as active as always doing original writing started in a class at University of Washington reading her non-fiction books; singing in a choir; planning a trip by ferry to Alaska. Greetings from Marion Bonn, who sent some graduate caps to our Archives. She is “enjoying retirement, reading, Scrabble, crossword puzzles, beautiful flower garden in the spring, and... busy as I want to be!” Card from Jo McDaniel Hubbard with no “new news.” Anna Clair Junkin wrote: Although. Mary Agnes Hull Stewart is unable to communicate with her, her son, Tim, and his wife, with whom she lives much of the year, sent us greetings and brought us up to date with our classmate. With the arrival of Beth and Tim’s first grandchild, Anna Clair Junkin’s great-granddaughter Erin Delingshow hopes that he will be well to get to our next reunion. Charlie Royer sent her summary of the year: too many hospitalizations for him, all of his family doing well. Ruth Stila Whitman, who has a picture of Eleanor Roosevelt holding the Board of Directors, is involved with community disabled population and is caretaker for her disabled cousin since 1979. Bettie Lou Herig Webster hopes to come to the reunion. She has 15 grandchildren, one name in the offing! Rose Mary Burroughs Schultz and Joe love children in DE, NJ and FL, and have 17 grandchildren. Rose Mary volunteers a couple days a week or whenever she is in a vertical position. Jacqueline Fosdick Bronson has nine grandchildren. She is involved with P.E.O. Philanthropic Education Organizations that promotes and fosters education for women. Our sympathy goes out to Esther Moore Clement on the death of her husband, a classmate. Lawrence Everett will be headed to the Iberian Coast this winter. Their son John is a top sporting goods executive and has a picture of Eleanor Roosevelt holding the Board of Directors, is involved with community disabled population and is caretaker for her disabled cousin since 1979. We were happy to learn that Betty Scher ’50 was a great suggestion that DNP students be encouraged to sign up. We hope we can count on you to assist the next class of Hopkins nurses!

51 Class Reporter—Rose Mary Burroughs Schultz, (410) 826-0235, trashmail.com. Pris Gray Teeter lives at a retirement community near all her children. She is busy, traveling, volunteering at church, local hospital and art centers, and being mom, grandmother and great grandmother. Fran Signorelli Paeler lives in Annapolis with her husband of 49 years, close to their children and 11 grandchildren. Their neighbors are George and Gerry Waybright. Scottie Lea Riggs-Gallagher hopes to come to the reunion. She became a great grandmother this past summer. Anne Moroney lives near one of her sons. Her other four grandchildren live in PA. Rosie Ghyysels is making plans for a move to a retirement community. She had a mini- Michigan reunion with Cathy Morton Bork and Jane Boice (’54) who are both nurses, plus a classmate together with alumni in Seattle occasionally. She is involved with community disabled population and is caretaker for her disabled cousin since 1979.

52 Class Reporter—Nina Cafaro, June, (217) 528-8001, jrknna@tinaco.com. Georgia Rauch Ahlten and her husband are proud parents of their four children. Georgia has been in rehab since August; she became a great grandmother for the second time recently. Mary Bailey Camp has a picture of Eleanor Roosevelt speaking to the class in 1945 at Hampton House, she had 28 family members living around. Mona Staska Riley is very active in Senior Club at her church and antique club. We were told to send that Phyllis Conner passed away in December. We have 29 of the original 100 left from us.

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Her family, including six granddaughters, are all well. Kathy Downs Coveny is having some health problems but is looking forward to seeing everyone in September. Nan Wheeler Matais hopes to see everyone in September! You will soon be receiving information about our 50th reunion. Hope to see you there.

‘64 Class Reporter—Gerry Pignato Peterson, (812) 224-1108, gpmatthew@bells
nets. Most of this report thanks is to Eileen Sweetland Leinweber, who continues to be involved in Learning in Retirement and the local ARC BOD. She has four granddaughters. Number five is due in July. So will be number five granddaughter or number one grandson? Kathie Johnson is retired from nursing and has started her own business in the sale of antiques and consignment items. She has two grandsons. Beth Bernard Phillips works four days a week as a staff nurse in the OR at Zale Lipsey Hospital. She has five grandsons (as six baby due 1/11). Helene Botta Williams works a four-day week in her retirement job. She is enjoying the newest granddaughter. I’m proud and happy to be on the Board of the JH Nurse Alumni Association and eager to hear your thoughts and ideas for the Association. Did you know that Martha Norton Hill will receive the 2011 Leadership in Research Award from the Southern Nursing Research Society?

‘71 Class Reporter—Joan Mondahl Lorentz, jannlorentz@bells.net, (813) 874-2387. I have been living in WY for a bit over a year, working as a NM of an acute psychiatric unit. I resigned as of 3/2111. What’s next? Not sure. Marcia Wilson Baistiy writes that following the death of her mother, they moved to CO to be closer to two of their children. Marcia says that “after my second stint in management, I am now happily back at the bedside, working in the ED taking care of patients.” She is keeping her options open for other job opportunities that will allow her to gracefully slide into retirement! Marcia says that their house is a two-story house with access across three acres in the foothills of the Rockies. She says she is enjoying the cold and snow and mountains. Kristine Miller Liptak is happy being called Grammy, as her son and his granddaughter are due March 2011. I’m proud and happy to be on the Board of the JH Nurse Alumni Association and eager to hear your thoughts and ideas for the Association. Did you know that Martha Norton Hill will receive the 2011 Leadership in Research Award from the Southern Nursing Research Society?

‘72 Debra Case was recently promoted to the newly created position of director of clinical education at The Johns Hopkins Hospital. She is enjoying the newest granddaughter. I’m proud and happy to be on

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Waterloo Place Apartments is YOUR new home away from home!

By Betty Borenstein Schoer ‘50

Nancy P. Ellick, Class of 1923, was the first woman in Baltimore to own and operate a car. She did most of her own repairs to the car as well. But Ellick did so much more, both as a person and as a nurse! A member of the illustrious and hard-working Ellick family of Maryland, she graduated from the Johns Hopkins Hospital Training School for Nurses in 1923 and was appointed a head nurse at the hospital. In 1905 she served as Superintendent of Nurses at Church Home and Infirmary and two years later became acting Superintendent of that hospital. The following year she was appointed Superintendent of the newly opened Rockefeller Institute Hospital in New York, a hospital established as a research institution that investigated several diseases at a time, and admitted only patients with one of those selected diseases. Ellick served in that position until she retired in 1938. Ellick was a real innovator in nursing. As a student nurse she created a worksheet to be followed in the care of typhoid patients. After graduation, she created a back rest for patients before discharge, as she was concerned that hospital laundry room, one batch at a time. She was always an active member of the Alumnae Association, chairing committees and writing many articles for the Alumnae Magazine. At least one of these emphasized the unique position of nurses for innovation and invention. Even more, she was decorated by the French government for her outstanding contributions to healthcare during World War I. Nancy Ellick was the epitome of the good nurse: a great nurse and a great human being!

For more information, visit www.

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Who is this Hopkins Nurse?

What alumna was the first woman in Baltimore to own and operate a car?

By Betty Borenstein Schoer ‘50

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Stay Connected in your Region
Lisa Kowal '06
Regional Connection Chair
From the east coast to the west coast, our alumni are giving their time to keep us connected through the Regional Connection program. The program gives alumni the opportunity to assist with recruiting students, welcoming new alumni to their area, networking with local alumni, and connecting to what's happening at Johns Hopkins. Currently we have Regional Connection groups in Boston, Atlanta, San Diego, Maine, Wisconsin, and Texas. We want to expand our Regional Connection groups to more cities and states. Please contact the JH Nursing Alumni Office (jhnaa@son.jhmi.edu or 410-955-4285) or visit www.nursing.jhu.edu/alumni/regional for more information about how you can 'connect' with your Hopkins colleagues.

We're also updating the Alumni website (www.nursing.jhu.edu/alumni) and plan to have presentations of interest to our alumni. Please check in regularly to see what’s new and send suggestions of what you’d like to see on the page (jhnaa@son.jhmi.edu).

Philadelphia alumni gathered last fall to discuss a pilot project called Art and Healing: using visual art to decrease nursing stress and to help nurses reconnect with their nursing spirit. Present were (from left) Lisa Russell O’Shea, Alumni Office; Eileen MacMurtrie ’00; Alice M. Hart ’65; Evie Karlsson Merritt ’66; Claire Whitfield Barnash ’05; Jodi Shaefer, Faculty; Yvonne M. Beckman ’54.

Johns Hopkins and Church Home Alumni
2011 Alumni Weekend September 23 and 24
Whether you graduated 50 years or five years ago, from Hopkins or Church Home, come join your nursing colleagues
Sponsored by the Johns Hopkins Nurses’ Alumni Robb Society Leadership Dinner September 22
sponsored by the Johns Hopkins University School of Nursing for donors of $1,000 or more

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■ Car Rental discounts—from Avis and Budget
And more—check the website www.alumni.jhu.edu

Become an active member of the Nurses’ Alumni Association by sending your check to JHNA Alumni at the San Martin Center, 3400 N. Charles Street, Baltimore, MD 21218 or go online to www.alumni.jhu.edu/jhna/membership. We receive 50% of all dues paid by our alumni.

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$1,000 Lifetime Membership (pay four annual payments of $250 each)

Thanks for your support!

In Memoriam
Malda F. LaRochelle ’38
Frances Davs Crocker ’40
Martha Jane Bergold ’46
Phyllis Conner ’46
Margaret Allan Reep ’47
Thomas Clement, husband of Esther Moore Clement ’51
Mary Jo Schmidt ’57
Violet Hall Hembrow-Gay ’59
Robert Donald, husband of Kay Knapp Donald ’60
Ralph W. Boyd, father of Maria Boyd Fazio ’86
Shawnee Mitchell-Wright, accelerated 2002

Tea Annual Spring Thursday, May 5, 2011 2 - 4 pm Carpenter Room Johns Hopkins University School of Nursing $25.00 RSVP by April 29, 2011

Please join us as we renew the tradition of nurses enjoying afternoon tea and sharing special memories.

Make Checks payable to
Johns Hopkins Nurses’ Alumni Association
Mail Checks to:
Deb Kennedy, 1990 Gulfstream Court, Forest Hill, MD 21050

Questions? Call Deb Kennedy, 410-893-2421
Way to Go, Mary Ellen!

As always, the November issue of Baltimore Magazine featured the region’s top doctors. In “The Tale of My Most Mysterious Case,” Dr. Melissa Sparrow, Chief of Pediatrics at Greater Baltimore Medical Center, gave well-deserved credit and praise to nurse Mary Ellen Zachweia Helton, CHH ’75 for her astute ears.

Mary Ellen was caring for a two-month-old child and noticed that the child’s cry had changed. She immediately got the doctor to listen and re-examine the patient, ultimately leading to a diagnosis of Infant Botulism. The child was immediately transferred to another facility where she could receive a life-saving antidote.

In Memoriam

Hester DeHaven, CHH ’31

Vatana Sadarananda, husband of Dorthea “Dee” Stough Sadarananda, CHH ’53

For alumni of the Church Home and Hospital School of Nursing

Cinco de Mayo Alumni Tea

The second annual Alumni Tea will be held on Cinco de Mayo! Yes, save May 5, 2011 to attend this lovely event that will be held at the School of Nursing from 2-4 pm. See page 57 for the invitation and details on how to register. The tea will be catered by The Casual Cup, Phoenix, Maryland. Be festive and wear a hat as several ladies did last year!

In Memory Of

Our oldest living graduate, Hester Martin DeHaven, CHH ’31, died on January 19 at Gilcrest Hospice. She was 100 years young!

Nurses’ Health Study

Can you imagine completing one or two surveys every year for 35 years? That is exactly what Lois Laumann Phillips, CHH ’55, has done since she agreed to be part of the Nurses’ Health Study. In 1976, Lois, a public health nurse in Baltimore County, was among 170,000 nurses selected to be part of this ongoing study, which Donna Shalala called “one of the most significant studies ever conducted on the health of women.” In the name of research, thank you to Lois for her dedication and commitment.

Archive Donations

Thank you to Dorothy Habicht Siegert, CHH ’47 for her donation of a class picture and a group photo of all of that year’s head nurses taken on the lawn of Church Home. Also appreciated is the generous donation of a navy wool Church Home Cape from Sis Hopkins Uniform Company from Lois Laumann Phillips, CHH ’55!

Keepspakes:

CHH Cap: Kay’s Caps (516-791-8500 or PO Box 818, Valley Stream, NY 11582). Request School #31.

CHH Pins and Rings: Vince Fino (410-256-9555 or 9650 Belair Road, Perry Hall, MD 21236)

CHH Cap Charm: Tilghman Jewelers (410-268-7855). Comes in silver or gold.

Transcripts: Quinlan Storage (888-416-5353, ext. 7550 or 3907). Contact Aniese Gentry.

Archive Donations Always Appreciated

Thank you to Dorothy Habicht Siegert, CHH ’47 for her donation of a class picture and a group photo of all of that year’s head nurses taken on the lawn of Church Home. Also appreciated is the generous donation of a navy wool Church Home Cape from Sis Hopkins Uniform Company from Lois Laumann Phillips, CHH ’55!

Keepspakes:

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May 21, 1991: Paul Coverdell (left), director of the Peace Corps; M. Gordon Wolman, Johns Hopkins University Interim Provost; and Carol Gray, Dean of the Johns Hopkins University School of Nursing, signed an agreement creating the Peace Corps Fellows Program at Johns Hopkins. It was the first such program at a U.S. nursing school, and has since graduated 387 Returned Peace Corps Volunteers.

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