

JOHNS HOPKINS NURSING

Playing a Bigger Part

Through simulation, educators learn to teach around the difficulty in finding clinical placements

15-Year Journey

The School of Nursing has left its mark on Haiti, and vice versa

Student Profile

Helping out after his father's back injury set Patrick Bartels on the path to nursing

ETHICAL MAZE

As Ebola raises hard questions, trailblazers answer with a roadmap for 21st-century nursing



JOHNS HOPKINS NURSING

A publication of the Johns Hopkins School of Nursing, the Johns Hopkins Nurses' Alumni Association, and the nursing departments of the Johns Hopkins-affiliated hospitals



Milestone: For 15 years, Hopkins Nursing faculty members, particularly Elizabeth Sloand, PhD, RN, PNP-BC, have led groups of students to Haiti, where they have witnessed unimaginable poverty and tragedy (a devastating 2010 earthquake) but also beauty and inspiration. Sloand, pictured above at a Haiti health screening, says students gain an experience that will serve them well throughout their careers. (Article on Page 34) PHOTO COURTESY OF ELIZABETH SLOAND

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OUT FRONT ON ETHICS

BY STEVE ST. ANGELO

How to deal with the fear, finger-pointing, and rush to judgment that all featured so prominently in the Texas Ebola outbreak had already been put on the discussion table as Cynda Rushton, PhD, RN, gathered a team of national healthcare leaders in Baltimore in August to debate these and other aspects of nursing ethics. A report from that National Nursing Ethics Summit would prove prescient.



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BY JENNIFER L.W. FINK

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THOUGH FIRST LOVE IS STAGE, NURSING IS NEVER SECOND FIDDLE

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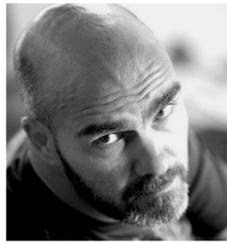
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Harry Campbell is a Baltimore illustrator whose work has appeared in the *New York Times*, *Time* magazine, the *Wall Street Journal*, *Hopkins Magazine*, and many other national and international publications. His vividly realized works in this issue deal with topics including nursing ethics (P. 22), simulations (P. 28), and a scoreboard that tells who's who on a hospital unit (P. 40).



Photographer **Chris Hartlove** is a fixture around Baltimore and Johns Hopkins, shooting across the school's various campuses, all while documenting the restoration of the Washington Monument in Mount Vernon. He's known for catching folks at their best, putting them at ease when they are visibly not. Here, he captures the many faces of an Evening with the Stars (P. 8), including Patrick Bartels, the focus of our Student Profile (P. 18).



Media Relations Coordinator/Writer **Danielle Kress** is editor of the *DailySON*, the School of Nursing's newsletter, as well as *On the Pulse*, a roundup of student, faculty and staff news, and *Cells to Society*, which showcases research publications from faculty and students. To this issue she contributes a feature on the 15th anniversary of the school's work in Haiti (P. 34), plus a look at that electronic board on a labor and delivery unit (P. 40).



Freelance writer **Joan Davila** is fairly new to *Johns Hopkins Nursing*, though not to the school, where she leads a popular Tuesday night Zumba class. Her three articles for this issue include "A Serious Role" (P. 38), "A Time to Refocus" (P. 42), and "Suddenly in Harmony" (P. 47). In addition to being a health and fitness guru, Joan has more than 10 years' experience in marketing.



Johns Hopkins-trained freelance writer **Kim Polyniak** is making her magazine debut, having previously worked in healthcare communications and as a producer for Maryland Public Television and WBFF-TV (Fox 45 News). Here she tackles a complicated merger of two very different units at Johns Hopkins Bayview Medical Center in "One and the Same," (P. 48).

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Johns Hopkins Nursing is a publication of the Johns Hopkins School of Nursing, the Johns Hopkins Nurses' Alumni Association, and the nursing departments of the Johns Hopkins-affiliated hospitals. The magazine tracks Johns Hopkins nurses and tells the story of their endeavors in the areas of education, practice, scholarship, research, and national leadership.

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LETTER FROM THE EDITOR:

WHEN ONE DOOR
(OR WINDOW)
CLOSES...



After quite a bit of thought about threads that tie the themes and articles of this issue together ... it hit me. I mean the top glass panel of an ancient storm window at the back of my 1860s rowhouse. There was, for instance, the idea of teamwork raised by my furious wife, who reminded me that when working with heavy and notoriously balky objects above one's head, it is good to have a backup.

A more worthy example might be the teamwork displayed during a first-of-its-kind Nursing Ethics Summit led by Cynda Rushton, PhD, RN, fast becoming a national figure on matters crucial to nursing and healthcare ("Ethics in the Time of Ebola," P. 22). Or the school simulations team that teaches student nurses the footwork and the teamwork they'll need in real life ("Playing a Bigger Part," P. 28). It is in Howard County General Hospital bidding farewell to Kathy Herman, part of the surgical team's "ballet" for so many years ("Operation Last Dance," P. 45).

We could also talk about hope: There's the effort at JHH to help terminal patients embrace the time left ("A Time to Refocus," P. 42); nurses who have served as living organ donors to strangers ("To Give and to Receive," P. 36); or a tireless effort to gather supplies for nurses fighting Ebola in Sierra Leone ("A Package Deal," P. 50).

With a clear head and conscience—my wife held the homicidal frame aloft while I inserted the screw and the storm is no longer a danger to those below—I can tell you that this is a rich issue of *Johns Hopkins Nursing*, so much so that we've had to hold a few articles back for Spring 2015. They'll serve as a head start ... or a starting place for the next person, should your friendly neighborhood editor get any more smart ideas about hanging out windows.

Steve St. Angelo



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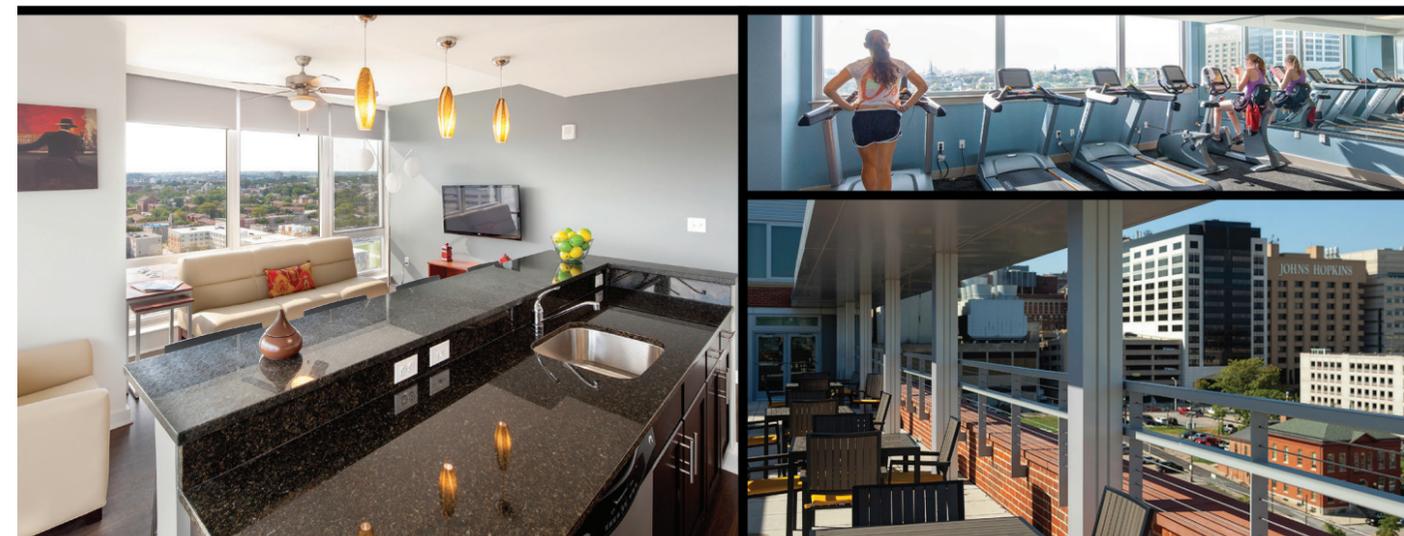
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NOTES FROM THE DEAN:

The Courage to Safeguard the World



“Our faculty, students, and alumni are healthcare heroes, and time and time again their work abroad intersects and advances our school’s work in East Baltimore and nationwide.”

I often say that the world is now “one big backyard,” and this was brought home again recently when Ebola reached the United States. An event ravaging West Africa was suddenly at our own doorstep, presenting complex healthcare challenges in practice, education, and policy. The media coverage of Ebola in the United States cast a light on polarities of views and opinions but also the importance of nursing.

Our faculty, students, and alumni know this all too well. This issue features their travels and work in Haiti, St. Croix, the Congo, China, South Africa, and Sierra Leone. Our faculty and students have a long history of packing their bags with medicine and supplies to conduct health screenings, vaccinations, and provide basic education and healthcare in some of the most challenging areas of the world. They are healthcare heroes, and time and time again their work abroad intersects and advances our school’s work in East Baltimore and nationwide. We’ve seen this in the areas of HIV/AIDS, tuberculosis, and domestic and intimate partner violence, just to name a few.

When Ebola knocked at our door, our faculty and clinical staff were able to respond quickly and provide expertise to the Centers for Disease Control (CDC), United Nations (UN), and national media by parlaying their international experience to impact national needs. **Jason Farley**, PhD, MPH, CRNP, is a global expert in infectious diseases; **Tener Goodwin Veenema**, PhD, MPH, RN, an international expert on disaster preparedness/response and containment of outbreaks such as Ebola, was instrumental in developing the CDC’s Ebola training modules for healthcare workers; and **Nancy Glass**, PhD, MPH, RN, associate dean for research and associate director of the Johns Hopkins Center for Global Health, was appointed to a UN delegation to study containment efforts in the Democratic Republic of Congo and ensure that Ebola protocols include community engagement there and in the U.S.

Perhaps the most interesting intersection with Ebola has to do with our cover story about nursing ethics. This past

summer, **Cynda Hylton Rushton**, PhD, RN, a national leader on the role of ethics in nursing and medicine, led a summit of national nursing leaders to address many of the same issues raised by the Ebola crisis, such as weighing personal risk against professional responsibilities, ethical obligations of hospitals and healthcare providers, and moral courage to expose deficiencies in care.

Little did we know how “ethics” would become an emotionally charged sidebar during the Ebola crisis, with nurses leading the call for thoughtful decision making regarding the care of patients and healthcare workers here and abroad. It was primarily nurses who were infected, raised containment and procedural concerns, and put their lives at risk to save others, regardless of the dangers. This is what nursing is all about. It’s looking at the world as one backyard, developing and sharing data and best practices, having the moral courage to speak out and, most importantly, taking care of the sick and protecting the vulnerable.

We hope you enjoy this issue and we applaud and salute all our faculty, students, and alumni—and nurses worldwide—who work so very hard to make our backyard a safe and healthy place for all.

Patricia M. Davidson
PhD, MEd, RN
Dean, Johns Hopkins School of Nursing



ON THE PULSE

News from **Around the School**

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AN EVENING WITH THE STARS

Shining Star winners light up the night at the third-annual Evening With the Stars gala. View a galaxy of images from the event.

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CHINESE DOCUMENTARY CELEBRATES TIES

P. 14

LAURA GITLIN EARNS GSA LAWTON AWARD



Assistant Professor Jennifer Wenzel welcomes Rachel Klimmek, PhD '13.

Progress for PhD Program

An expanded class of PhD candidates enrolled at the Hopkins School of Nursing (JHSON) this fall brings diverse perspectives from the United States and five other nations, and broad interests as well.

The 15-member class that welcomes Sarah L. Szanton, PhD, ANP, as program director features stated interests ranging from cardiovascular, HIV/AIDS, tuberculosis, and diabetes care to intimate partner violence, pain and palliative care, the effects of stress, and ergonomics and engineering in patient safety and mobile technology.

The number of candidates more than doubles that of the previous class (seven), continuing a surge by the PhD program at JHSON.

Szanton, herself a 2007 product of the PhD Program, is the driving force behind the CAPABLE Project, which inexpensively helps elderly residents remain safely in their own homes longer. Szanton says she’s excited about the PhD program’s direction, makeup, and focus.

Non-U.S. PhD candidates hail from Cameroon, China, England, South Korea, and Thailand. ■



Find additional news and notes about students, faculty, and staff in the new digital *On the Pulse* newsletter. Watch for it in your “in” basket every other month. If you’re not on the school’s internal system and would like to receive a copy by email, or if we’ve somehow overlooked you, send a note to son-editor@jhu.edu. A link also appears on the school’s homepage: nursing.jhu.edu. ■

An EVENING with the STARS

With 125 years of history already in the air, five people joined the galaxy of Hopkins Nursing at An Evening With the Stars, a third-annual fall gala at the school. Surrounded by alumni, students, staff, faculty, and friends of the school as well as nurses from across the medical system, four Shining Star Award winners were chosen from the Johns Hopkins-affiliated hospitals and the School of Nursing. There was a separate winner of the second-annual Rosenwald Star Nurse of the Year Award. Emcee Candace Dold of Fox 45 in Baltimore, whose brother is a nurse at The Johns Hopkins Hospital, announced the winners (quotes, except for Rosenwald Star, from nomination forms):

PHOTOGRAPHY CHRIS HARTLOVE

Looks Like a Winner: Clockwise from top, Shining Stars (from left) Genjevee Cline, Morning Gutierrez, Tener Goodwin Veenema, and Clifton Thornton; Walter D. "Wally" Pinkard Jr., chairman of the School of Nursing Advisory Board, gets a festive touch; Allison Pyles with Peter Rosenwald, who handed her the second-annual Cynthia and Peter Rosenwald Star Nurse of the Year Award; Dean Patricia M. Davidson mingles with students Xin Li, left, and Jing Zheng.





HOPKINS NURSE STAR

Genieveve Cline, DNP, RN, advanced education specialist, All Children's Hospital in St. Petersburg, FL: "Her enthusiasm and passion are evident in all her endeavors."

Morning Gutierrez, RN, senior clinical permanent charge nurse, Johns Hopkins Bayview Medical Center: "Morning has a customer service approach to patient care that is exceptional." She is "an awesome role model to her colleagues."

ROSENWALD STAR NURSE

Recognizes a nurse working in The Johns Hopkins Hospital's intensive care units who goes above and beyond the call of duty.

Allison Pyles, RN, nurse clinician, Neuroscience Critical Care Unit: "I have always felt that I am the lucky one. I have the opportunity to be in a job that I love and I get to work with patients and families at such a critical time in their lives."

SHINING STAR RUNNERS-UP

Cheryl Dennison Himmelfarb, PhD, RN, ANP
Associate Professor, Department of Acute and Chronic Care

Kelly Hann
BSN Candidate 2014, Hopkins School of Nursing

Doris Cybert Wilcher, RN, IBCLC
Lactation Consultant, Howard County General Hospital

Lynn McDonald, DNP, RN
Cervical Cancer Screening Program Coordinator, The Johns Hopkins Hospital

LeighAnn Sidone, MSN, RN
Director of Professional Practice and Nursing Quality, Suburban Hospital

Mary "Katie" Sisk, RN, CIC
Certified Infection Preventionist, Sibley Memorial Hospital

JHSON STUDENT NURSE

Clifton Thornton, MSNC, RN, CNMT (will graduate from the pediatric nurse practitioner program in December): "An outstanding student, a talented and capable research assistant, and a skilled tutor." (Read a Q&A with Cliff on Page 12.)

JHSON FACULTY NURSE

Tener Goodwin Veenema, PhD, MPH, RN, associate professor, pediatric emergency nurse practitioner: Has "excelled in her roles as a researcher, professor, and mentor."



PHOTO BY NICK YOUNG

Student Q&A

Cliff Thornton, MSN '14

Cliff Thornton is a big kid. It isn't just that he's a very tall guy, with hair and beard just this side of unruly and a complexion flushed from a morning bike ride to school. It's that he feels he's still the child who grew up on a Michigan farm and got into pharmacy but, seeking more direct patient contact, found nursing instead. Thornton can relate to young patients ... way, way down to their level. He spoke recently about the journey to Johns Hopkins Nursing.

WHEN DID YOU KNOW THAT NURSING WAS IT FOR YOU?

I got a job at a pharmacy and realized that the information was really interesting but the job itself really wasn't a good match for me. I really liked the nurse practitioners because they knew their patients so well. They would walk into the room and immediately know about the patient's family and, "Oh, you went to Disney. And how awesome was that?" And then I talked to them about the stuff I wanted to do as a provider—work with underserved populations, work with children, and try to have sort of a global aspect—and they were telling me how that's really the role of the NP.

WHAT'S SO REWARDING ABOUT PEDIATRICS?

We can have a bigger impact on a population level of health if we start with the children and work our way up. With children, you can tell a parent, "They should exercise more," and they're like, "Soccer camp right now! We start today!"

BUT ADULTS WON'T ALWAYS LISTEN TO ADVICE FOR THEMSELVES?

Frankly, I got annoyed with adults when I worked with them. ... Kids are hilarious. I found an eraser in a girl's ear once on an exam. I asked her, "Did you put something in your ear?" and she was, like, "Yeah, a few months ago."

WHY HOPKINS?

I applied to schools that have a reputation for producing science, that were changing the field themselves, so I would hopefully come out a bit ahead.

YOU GREW UP ON A FARM IN MICHIGAN. HOW BIG A CULTURE SHOCK HAS BALTIMORE BEEN?

My house touches both of my neighbors' houses, and it took me, like, months to get over that.

HOW IS THE EXPERIENCE DIFFERENT FOR A MALE NURSING STUDENT?

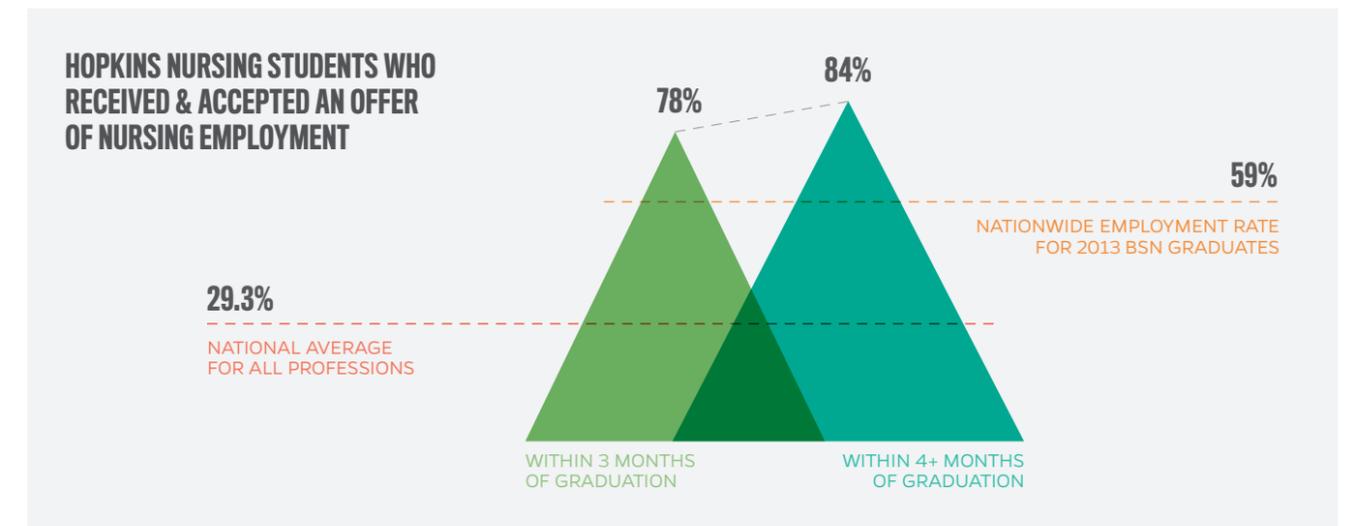
The T-shirts ... if they bring T-shirts to school, they're all designed for "nursing students." They're all small, medium ladies' shirts.

ANYTHING ELSE?

I was extremely nervous about the labor and delivery rotation, because I thought I was going to go into a room and it was going to be like Hollywood and there was going to be a sweaty pregnant woman screaming in pain: "You're my nurse? Get out!" But it actually turned out to be one of my favorite rotations. They called me "Captain Contraction" on the floor because I had more births than anyone else in my rotation. I think I had 12, and other people had maybe two or three during the half semester we were on the unit. ■

Grads Getting Jobs

Group builds community a step at a time



Most students completing a bachelor of science in nursing (BSN) degree in 2013 at Hopkins report they quickly found the jobs they wanted, where they wanted them—and with little difficulty.

Seventy-eight percent of respondents

to the annual survey conducted by the School of Nursing reported they had received and accepted an offer of nursing employment within three months of starting their job searches (most indicating that they had a job in hand at graduation). At four months and beyond,

the Johns Hopkins employment rate grew to 84 percent.

The nationwide employment rate for 2013 BSN graduates, determined through an American Academy of Colleges of Nursing survey of all nursing schools, was 59 percent at graduation—compared to a 29.3 percent national average for all professions.

A majority of the Johns Hopkins nursing job seekers found employment in their first choice of position (71 percent) and 77 percent reported that position was in their preferred geographic location. Nearly one-third (32 percent) received two or more job offers—with 3 percent receiving four or more offers. Forty-five percent reported very little or no difficulty in finding a job, while 25 percent encountered only moderate difficulty.

Dean Patricia M. Davidson, PhD, MEd, RN, noted, "These results are positive and reassuring, but not surprising. These new nurses are exemplary products of their education and carry the unique Hopkins 'brand' wherever they go." ■



Chinese Documentary Celebrates Ties

Film studies cooperation between JHSON, Medical College

Hopkins Nursing has long historical ties to China, in large part due to Anna D. Wolf, who left Hopkins in 1919 to organize the school of nursing at Peking Union Medical College (PUMC). And in 2008, five nurses graduated from the first full-time doctoral program for Chinese nurses at PUMC, part of a partnership with the Hopkins School of Nursing.

The relationship is celebrated in the Chinese documentary *The Other Shore: A Century of Better Health in China and American Philanthropic Medical Capacity Building*, parts of which were filmed at the Hopkins schools of Nursing, Medicine, and Public Health in East

Baltimore earlier this year.

Marie Nolan, PhD, MPH, RN, associate dean for academic affairs, was interviewed for the documentary, which aired this fall in America on the Phoenix Chinese Channel. In the film (in Chinese with English voices interspersed), Nolan discusses nursing and the role of women in the 1920s. The episode also discusses the rise of the Communists and the impact of nationalization on PUMC.

The episode that features Nolan can be viewed at the Web address nursing.jhu.edu/PUMCChronicle (she appears just after the 12:30 mark). ■

Gitlin Earns Award Named for Mentor



Laura N. Gitlin, PhD, has received the 2014 M. Powell Lawton Award from the Gerontological Society of America (GSA).

The Lawton Award recognizes a contribution in gerontology that has led to an innovation in treatment, practice or service, prevention, amelioration of symptoms or barriers, or a public policy change that has led to some practical application that improves the lives of older persons. Gitlin got the award at the GSA's Annual Scientific Meeting in early November in Washington, DC.

Gitlin, founding director of the Center for Innovative Care in Aging, is a professor in the Department of Community-Public Health with joint appointments in the Department of Psychiatry and Division of Geriatrics and Gerontology in the School of Medicine.

"Dr. Gitlin has made a fabulous contribution to growing gerontology since she has been at Johns Hopkins," says Dean Patricia M. Davidson, PhD, MEd, RN. "We are very proud of her."

Gitlin is nationally and internationally recognized in the areas of non-pharmacologic approaches in dementia care, family caregiving, functional disability, and aging in place.

The award is named in memory of M. Powell Lawton, PhD. "I am deeply honored and humbled," Gitlin says of the award. "My first research position was with Dr. Lawton at the Philadelphia Geriatric Center, and his light still guides me." ■

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To Sleep, Perchance to Dream of a Cure

By Steve St. Angelo

Rest-deprived rats on chemotherapy drug had worse side effects

Society in general is experiencing a sleep deficit, whether through work obligations or lifestyle choices that may limit time spent snoozing. And that could mean more than droopy eyelids. It could bring more intense side effects during treatment for the more than 1.7 million people diagnosed each year with cancer, suggests a study by Sharon Kozachik, PhD, RN, Gayle Page, DNSc, RN, and a colleague. They found that rats experienced worse side effects when treated with Paclitaxel (PAC), a common chemotherapy drug, and denied proper sleep.

And once the sleep was lost, there was no getting its positive effect back by allowing extra rest later.

In "Recovery Sleep Does Not Mitigate the Effects of Prior Sleep Loss on Paclitaxel-Induced Mechanical Hypersensitivity in Sprague-Dawley Rats," a preclinical study published in *Biological Research for Nursing*, restricted sleep among rats led to worse reactions to PAC, associated with painful, debilitating peripheral neuropathy of the hands and feet that may persist long after therapy is completed.

According to the study, "How poor sleep sets the stage for adverse outcomes among people diagnosed with cancer is not entirely understood. The aims of this preclinical study were to determine the accumulative and sustained effects of sleep restriction on Paclitaxel-induced mechanical sensitivity in animals. If these relationships hold in humans, targeted sleep interventions employed during a PAC protocol may improve pain outcomes." ■

ILLUSTRATION BY AARON MOORE



Faith in Cancer Care

By Steve St. Angelo

Belief in providers as agents of God's will can increase chance of seeking treatment

If African-American cancer patients believe that God works through their care providers, their trust and willingness to undergo treatment increases, according to Jill Hamilton and colleagues in "African-American Cancer Survivors' Use of Religious Beliefs to Positively Influence the Utilization of Cancer Care," published in the *Journal of Religion and Health*.

African-Americans diagnosed with cancer are more likely to die than whites, with a 33 percent higher death rate for black men than white men and 16 percent higher death rate for black women than white women, according to the American Cancer Society. The disparity can be blamed, in some cases, on an unwillingness to seek care, fatalism, and a lack of faith in healthcare providers.

"Probably, the most profound takeaway message from this report is the way in which a strong faith in God motivated these participants to overcome challenges to accessing cancer care, traveling back and forth to cancer centers, struggling with a lack of finances, and in spite of the expressed views of others that death was imminent," the study says. "These participants sought out cancer care and completed the treatments prescribed in part to their belief that it was God who determined their fate from cancer."

A better understanding of how religion can overcome barriers to accessing cancer care can be used to develop interventions tailored to the needs of African-American cancer patients, it suggests. ■

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The Bright Side

Don't tell Dad, but the scary injury that laid his father up for five months in a Chicago hospital was one of the best things ever to happen (at least professionally) for Patrick Bartels, Accel. '15.

"I'm not sure how to put this, because my dad was in so much pain ... but I was having a blast hanging out with the staff there," says Bartels, a community account manager for United Way in Portland, OR when he got the call in 2012 that Dad had suffered a seizure, fallen, and broken his back. Bartels began flying back and forth to spend time with him at Northwestern Memorial. "The nursing staff especially just blew me away. The work just seemed so fulfilling and interesting."

When Dad went home, so did Bartels. A long-term relationship on the West Coast had ended, and now he'd fallen for nursing. A teacher in Portland suggested he give the Johns Hopkins School of Nursing a look, but Bartels wasn't so convinced that Hopkins would look back.

He got in, and received a Louise G. Thomas Cooley Scholarship to boot. "I found out about it at 3 a.m., when my roommates were all sleeping," Bartels says. "I was silently jumping around, screaming at the top of my silent lungs."

Bartels would like to become a family nurse practitioner, and he feels Baltimore and Hopkins are as good a place as any to start down that path. "This place is just too cool not to take advantage of," he says. "You've got the best people in every field connected to healthcare. I'm pumped every time I get to go across the street and work in the hospital." ■

Louise G. Cooley Scholarship

The Louise G. Thomas Cooley Scholarship Fund was established in 2004 by friends of Mrs. Cooley, a 1949 graduate of the Johns Hopkins Hospital Training School for Nurses.

Learn more at nursing.jhu.edu/financialaid

PHOTO BY CHRIS HARTLOVE

"They saved my kids' lives. I'm forever grateful to both of them."



Born at 23 weeks' gestation, Mark and Isabella Stewart weighed less than two pounds each and were diagnosed with pediatric pulmonary hypertension—a complex condition with a 20 percent mortality rate.

Today, the twins are active two-year-olds. An innovative multidisciplinary approach to their care, involving Drs. Michael Collaco and John Coulson and supported by the Eudowood Board and others, has given real hope to their parents. It also suggests a reduction in the condition's mortality rate to 12-15 percent.

Courtney Stewart believes her children's progress is a direct result of the doctors' close cooperation. "They saved my kids' lives," she says. "I'm forever grateful to both of them."

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ALL THAT AND MORE

By Jessica Lucas, Accel. '14

Honeymoon destination, resorts, idyllic beaches, frozen frilly drinks, steel drum musi—these are things one might think of when you mention St. Croix in the U.S. Virgin Islands.

To be honest, it is what I imagined when I first became aware of a public health clinical opportunity there: do some good, have a little fun in the sun.



Here's what you don't think of: nurses at impoverished schools making do with just a single box of band-aids; a department of health starting from scratch to collect cancer prevalence data on the island; a lack of disaster preparedness; a hospital in

danger of losing its CMS certification; and a gap in healthcare education for many chronic disease patients. One team of Hopkins Nursing students was about to have an eye-opening experience.

Our brains felt like mush before we even left the States. There is so little information about healthcare in St. Croix, the culture, the demographics, everything. So we tried to prepare for everything. And that's just what we got over the course of 10 days on the island.

On the morning of our departure, we arrived bright-eyed and bushy-tailed with three stuffed-to-the-brim suitcases of medical supplies, donated items, and presentation supplies. Waiting for us on St. Croix were patients of all types, ages 0-107. So we hit the ground running, giving presentations on healthcare and chronic diseases, observing at social services agencies, conducting vision and general health screenings, and even teaching elementary to high school students about puberty and sexual health. It was the best experience I could have asked for in a public health nursing clinical. We saw everything, and perhaps moved a few people's situations a little bit closer from underserved to what we used to think everybody lived like in paradise. We continued to put the footprints of Hopkins Nursing in the sands of St. Croix and can only encourage the groups that follow in them to continue with these efforts to truly make a lasting impact on the island.



After so after many days of 4 a.m. wakeups and 11 p.m. bedtimes, we were still only half-ready to leave this lovely tropical getaway as we boarded our plane back to the States with yawns and a few more circles under our eyes, ready for a vacation. ■

📄 READ MORE ABOUT JHSON LIFE AT [BLOGS.NURSING.JHU.EDU](https://blogs.nursing.jhu.edu)

STORY STEVE ST. ANGELO | ILLUSTRATION HARRY CAMPBELL

ETHICS IN THE TIME OF EBOLA

A 21ST-CENTURY GUIDE FOR NURSES

On October 16, when a nurse from a Texas hospital took to the national media to decry unsafe conditions for workers exposed to the Ebola virus, the echoes carried all the way to Baltimore, to ethics Professor Cynda Hylton Rushton, PhD, RN, and, she hopes, to the student nurses making their way toward tomorrow's front lines.

There was what Dallas nurse Briana Aguirre asserted: that nurses had been left unprotected and unprepared to fulfill an ethical mandate to treat any patient, no matter the diagnosis. But perhaps most important was that Aguirre had the courage to "speak up and speak out," says Rushton, Anne and George L. Bunting Professor of Clinical Ethics. While patient respect and safety are paramount, this is an obligation that nurses need to embrace more often since medical systems "don't always support them to do the right thing" amid a swirl of technological demands, understaffing, an aging population with more complex chronic conditions, and pressures to make care more efficient and less costly.

That it took Ebola's arrival in the United States to trigger such a moment is not lost on Rushton, founding member and core faculty of the Johns Hopkins Berman Institute of Bioethics. Nor was it a big surprise.

How to deal with the fear, finger-pointing, and rush to judgment that all featured so prominently in Texas had already been put forward for discussion as Rushton gathered a team of national nurse leaders in Baltimore in August to debate these and other aspects of nursing ethics ahead of a push by the American Nurses Association (ANA) to revisit and clarify its own Code of Ethics, a framework for the conscientious caregiver.

A report from that National Nursing Ethics Summit, the first of its kind, was released in November, but its diagnosis rang clear from the start. “We need to strengthen a culture that genuinely supports doing the right thing, at the right time, for the right reason,” Rushton explains. The resulting *Blueprint for 21st Century Nursing Ethics* takes a hard look at how society and medical care have changed, and how front-line nurses, educators, researchers, policymakers, and hospital leaders must adapt “to support nurses to perform their roles in an ethical way.”

Take patient involvement as one simple example, Rushton says. Nowadays, “we want patients to be heavily involved in their care, but the healthcare system simply wasn’t built for that.” Hopkins nurses have “cultivated the capacities for such give-and-take bedside care,” she says, but it can be a challenge to find an environment ready to embrace their skills.

“For many reasons, the environments in which nurses work are changing rapidly, yet one core principle holds constant: nurses’ desire to serve their patients, families, and communities while fulfilling nursing values,” says the *Blueprint for 21st Century Nursing Ethics*. It seeks “organizational arrangements and work designs that enhance the practice of nursing and create for the next generation the chance to fulfill their desire to have meaningful careers in service to others.”



The report is a roadmap, and Rushton admits that there are miles to go before healthcare systems (and nurses) can sleep.

WHAT KEEPS NURSES UP AT NIGHT

Without fail, nurses join the profession to help heal the sick or injured. But ethical dilemmas on the job can create a chasm between nurse and patient, affect the level of care, and even drive frustrated caregivers from the field or to throw up their hands and “go along to get along.” These dilemmas can be as seemingly mundane as bean counting and as fraught as risking peer scorn and employment status by speaking up when patient care doesn’t measure up.

There are disagreements with the course of care, measures that can cause patients to suffer even while ultimately healing them, pain management, a sharp increase in dementia cases, patients and families not fully informed of medical options, decisions to end life, respectfully caring for those with diverse backgrounds and rituals, workplace hierarchies or red tape, worker shortages, legal uncertainty, privacy rules, and fatigue.

Or perhaps, in the case of Ebola, there is the notion of performing herculean tasks—at the risk of personal health—to resuscitate patients or to save their failing kidneys when death appears likely anyway.

THE EBOLA EFFECT

“Ever since Florence Nightingale took it upon herself to care for the sick and the wounded in the Crimean War in the 1850s, nurses have proven their value and their valor where care is most daunting and risky,” Dean Patricia M. Davidson, PhD, MEd, RN, wrote in an op-ed for the *Baltimore Sun* as first reports of nurse deaths from Ebola in West Africa reached the U.S. “We were never promised it would be easy, or safe. They didn’t tell us that because nurses don’t wait to be told. We are called, we act, and we save lives.”

Nevertheless, tacit in that caregiving pact is the understanding that such brave souls will be protected at all costs. “That nurses are infected as a result of an epidemic is not without historical precedent,” says Associate Professor Tener Goodwin Veenema, PhD, MPH, RN, pointing as just one instance to a SARS outbreak in 2003 in Canada that killed 44, with nurses among the victims. “That nurses are infected in 2014 due to this epidemic is

completely unacceptable.”

Veenema, an international expert on disaster preparedness and response, insists that Ebola should not have caught the U.S. off guard, and called the sudden

“We were never promised it would be easy, or safe. They didn’t tell us that because nurses don’t wait to be told. We are called, we act, and we save lives.”

— Dean Patricia M. Davidson, PhD, MEd, RN

rush to get hospitals across the U.S. ready too little too late, and predictably so. “It is completely unrealistic and unethical at this point in the outbreak to believe that all of our nation’s hospitals and 2.9 million nurses can instantaneously become prepared to handle this level of complex disease containment,” Veenema said after the Texas Ebola case was confirmed and health workers had been sickened. “Lofty and important as this goal may be, that ship sailed a long time ago when Congress cut funding to hospital and public health preparedness programs.”

Veenema, a 2013 Florence Nightingale Medal of Honor winner, says she favors elite teams of nurses and a limited number of hospitals to serve as outbreak centers. “Sadly, a cadre of properly educated nurses wearing appropriate-level personal protective equipment [PPE] could have established screening clinics, implemented a population-based triage model, rapid isolation of the sick, and quarantine of the exposed, and could have contributed to the early containment of this epidemic while it remained in Africa.”



A TRUSTWORTHY SYSTEM

Ebola is spread through contact with bodily fluids, the flows of which increase as a patient nears death. Droplets of saliva, vomit, diarrhea, and blood are bursting with the lethal virus, and one unsafe touch can mean infection. There is currently no known cure.

Care provided by nurses requires education and training not just in the specificity of treatment, says Veenema, but in the crucial steps of “donning and doffing” PPE. Improper handling of the cumbersome gear after being in contact with Ebola patients or contaminated areas can lead to self-infection and death.

Given the uncertainty, “nurses are understandably concerned about how to weigh their personal risks with their professional responsibilities,” says Rushton. “Embedded in these decisions are vexing ethical questions. What are the consequences if a staff member refuses [to treat a patient] infected with Ebola?” And despite the serve-any-and-all underpinnings of the profession, Rushton suggests that perhaps there are classes of nurses who, ethically, should be excused from treating Ebola patients: the pregnant, the inexperienced, and those with medical conditions that might leave them more susceptible.

“Nurses are understandably concerned about how to weigh their personal risks with their professional responsibilities. Embedded in these decisions are vexing ethical questions.”

— Cynda Hylton Rushton, PhD, RN

“How can we reassure front-line clinicians that the personal protection devices we have are adequate to protect their health? Is it justified to perform CPR on patients known to be carrying the Ebola virus? These are some of the ethical challenges that we must engage in to create a trustworthy system for both patients and clinicians,” Rushton explains. “While nurses must protect the welfare of their patients, they also have an obligation to identify unsafe working conditions that include insufficient training and equipment.”

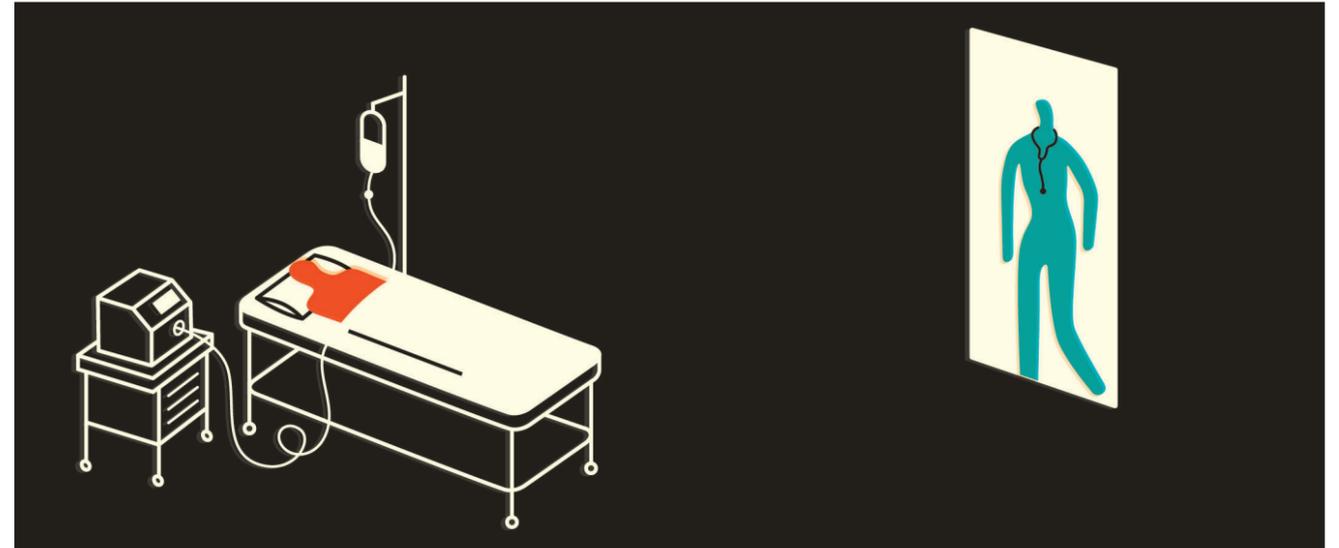
She adds, “Nurses do not have an ethical responsibility to be martyrs.”

FEAR AND LOATHING

In late October, Kaci Hickox, ’11, landed at a New Jersey airport, offered that she had been working with Doctors Without Borders to treat Ebola victims in Sierra Leone, and was immediately whisked against her will to quarantine though she had no Ebola symptoms and tested negative for the virus. Like Aguirre, Hickox spoke out from her isolation tent in New Jersey against an unfair quarantine policy built on ignorance and fear. She was released after public outcry against her treatment for service the White House called “deserving of praise and respect.”

“This is not a situation I would wish on anyone, and I am scared for those who will follow me,” Hickox wrote in an essay she emailed from the quarantine tent to the *Dallas Morning News*. “I am scared that, like me, they will arrive and see a frenzy of disorganization, fear and, most frightening, quarantine.”

Davidson applauded Hickox. “She epitomizes a Hopkins nurse. Kaci upheld the first provision of the American Nurses Association Code of Ethics by offering her services to those in need and delivered care with compassion and competence.” And she spoke



up. Of the quarantine policy, Davidson said, “Fear has a way of constraining our capacity for respect and empathy. This should not be an excuse for disrespectful attitudes, procedures, or policies.”

AN ETHICAL ENVIRONMENT

As this magazine’s deadline passed, the world was still awaiting the containment of Ebola, at least for now, and waiting for the clock to start ticking toward the next big outbreak, or natural or manmade disaster. And Rushton and her fellow nursing ethics leaders were embracing a golden opportunity.

Ebola has raised with force many of the issues that Rushton works daily to address as the co-chair of the Johns Hopkins Hospital Ethics Committee and Consultation Service, a teacher at the School of Nursing, and a leader of the Berman Institute of Bioethics. Through the *Blueprint for 21st Century Nursing Ethics*, the ANA’s retooled ethics code, and continued interprofessional cooperation, Rushton hopes a truly ethical healthcare culture can be achieved. Here, Rushton says, ethical issues could be addressed openly, with courage and integrity. But how do you build a system that recognizes and overcomes the human tendency toward blame, shame, and a rush to

judgment? “Self-awareness would be a good first step,” she says, adding that ethics must become a foundational element of all nursing curricula as they are at Hopkins.

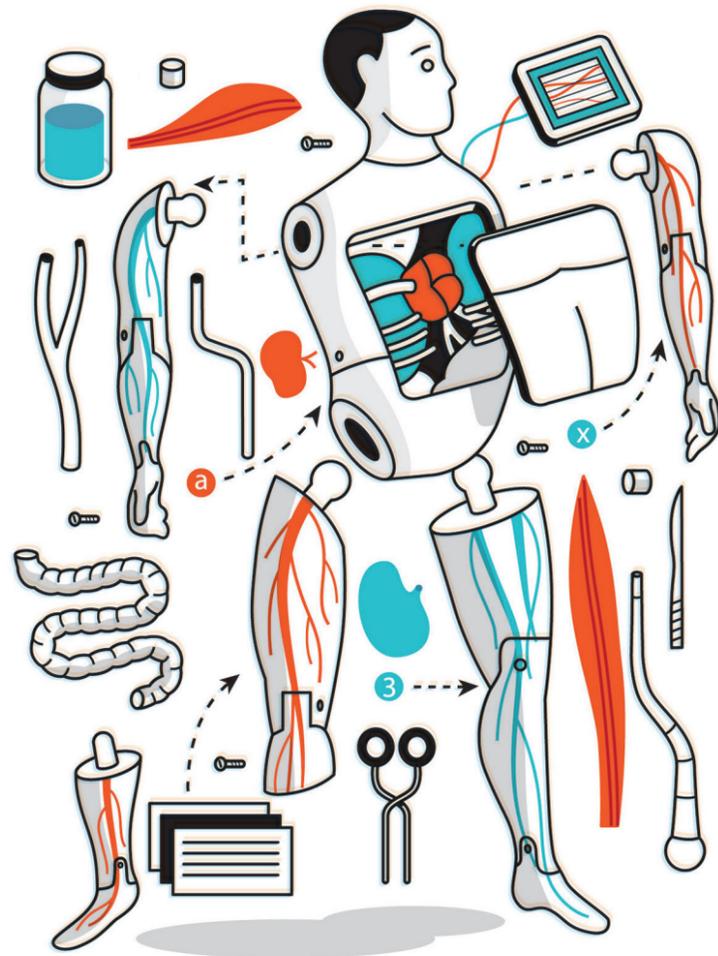
As the *Blueprint* explains, “At this time of rapid evolution, the need for action tempered with thoughtful discussion and analysis is urgent. Nursing needs to be effectively engaged, in order to assure that the solutions to our healthcare dilemmas represent the values of the profession and sustain nursing’s place in the interprofessional and public dialogue.”

For today, the U.S. healthcare industry and the world will have learned much from their handling of a frightening disease. By the time the next outbreak comes, of Ebola or something else, new policies for care of the stricken and the safety of the caregiver will very likely be in place.

If not, Hopkins nurses still have their voices, and they won’t be afraid to use them—if Rushton, Veenema, and Davidson have anything to say about it. ■

TO VIEW THE FULL *BLUEPRINT FOR 21ST CENTURY NURSING ETHICS* VISIT NURSING.JHU.EDU/ETHICSREPORT

TO WATCH THE VIDEO *WHAT KEEPS NURSES UP AT NIGHT?* VISIT NURSING.JHU.EDU/UPATNIGHT



PLAYING A BIGGER PART

‘Game changer’: National curriculum survey validates value in simulation

STORY JENNIFER L.W. FINK | ILLUSTRATION HARRY CAMPBELL | PHOTOGRAPHY JIM BURGER

The patient, a middle-aged male, complains of severe chest pain. His mouth is drawn into a grimace; his skin is pale and clammy. A quick check of his vital signs reveals an elevated pulse, and the medical team strongly suspects a heart attack.

The student nurse:

- Is asked to leave the room
- Observes the action from the corner
- Helps under the direction of her clinical advisor
- Takes control of the situation

The correct answer? D, at least it is in the Johns Hopkins School of Nursing (JHSON) simulation lab. There’s no penalty, though, for answering A, B, or C; after all, those answers reflect the clinical experience of most nurses currently in practice. If a patient develops an acute complication during a clinical rotation—and that’s a pretty big if, as complications are by definition unpredictable—students are likely asked to leave the room, limited to the role of a bystander, or allowed to help in a very small, very supervised way.

In the JHSON sims lab, though, students guide a patient’s care. They obtain an EKG, get a “pulse ox” (a noninvasive reading of blood oxygen level), assess the patient’s pain, and notify the doctor. They keep an eye on the patient’s condition and

respond appropriately when, say, atrial fibrillation occurs. They then stabilize and prepare the patient for transfer to a higher acuity setting.

They get to do those things because the “patient” is actually a high-fidelity manikin, capable of sweating, speaking, and responding to student interventions. The use of manikins (and, occasionally, actors) allows student nurses to safely perfect their skills in low-risk simulations before being called upon to respond in high-intensity, high-risk, real-life situations.

“In simulation, we put students in the role of the nurse,” says Sandy Swoboda, MS, RN, FCCM, a simulation education and senior clinical research coordinator with the Johns Hopkins schools of Medicine and Nursing. “They think as the nurse. They are making decisions independently with the knowledge they have, and if they go down the wrong pathway, that’s OK, because it’s a safe learning environment. If they make a mistake, they’re not going to harm a patient.”



Emily Vaughn (left) and Alexandra Valencik treat a “patient” in the simulation lab.

The Rise of Simulation

JHSON has long believed in sims. Now there’s proof that it works. The National Council of State Boards of Nursing (NCSBN) National Simulation Study recently reported that students who receive as many as half of their clinical hours via simulation do as well on their nursing boards and in practice as peers who complete a traditional clinical experience.

Traditionally, nursing students have learned at patient bedsides. But in recent years, obtaining such high-quality clinical experiences has become increasingly difficult. “Clinical sites are getting harder and harder to find,” says Pamela Jeffries, PhD, RN, ANEF, professor of nursing and vice provost for digital initiatives at Johns Hopkins University. In some urban areas, competition for clinical sites is fierce, and some rural areas don’t have enough healthcare facilities to accommodate students. Furthermore, rules designed to protect patient safety (and hospitals from liability) have limited what students can and cannot do in clinical environments. Some healthcare facilities no longer allow students to give medications.

Nurse educators also recognized the need to provide students with a broad array of experiences, one that can be difficult to meet in clinical settings where student experiences are limited by patient care needs. Most students, for instance, never get the chance to witness or assist in a birth, much less care for a woman who is hemorrhaging post-partum.

Before the advent of high-fidelity manikins, it was difficult (if not impossible) to simulate such dynamic healthcare scenarios. Simulation, if it was used at all, primarily allowed students to practice skills in a static environment. In the 1990s and 2000s, though, increasingly sophisticated, computer-controlled manikins made their way into nursing simulation labs, and students and instructors quickly realized that these devices could be used to simulate actual patient encounters.

Simulation, says Cynthia Foronda, PhD, RN, CNE, assistant professor of nursing, is “a guaranteed way to give students many experiences. The sky is really the limit in terms of what can be taught and learned.” Instead of worrying about clinical availability, nursing instructors can create

simulation experiences that put students in an active vs. a passive role.

Simulation as a Substitute

Perhaps not surprisingly, given the difficulty of securing clinical sites and experiences for students, the number of schools of nursing using simulation to teach students has increased dramatically. And as schools began to realize the utility of simulation, some began petitioning their state boards of nursing, asking to substitute simulation time for a portion of students’ clinical time.

While the anecdotal evidence seemed solid, there was little concrete evidence—and much skepticism—that simulation experiences could replace real-life clinical encounters. The NCSBN study was designed to carefully analyze the effectiveness of simulation in nursing education. It is the first large, randomized controlled study to compare the education and preparation of students who complete their clinical experiences in traditional settings to students whose clinical experience includes a combination of simulated and traditional clinical encounters.

The study followed more than 600 nursing students from 10 different institutions over two years. One-third of the students received 25 percent of their clinical education in a simulated environment. One-third received 50 percent of the clinical education via simulation. The remaining third, the control group, had traditional clinical experiences; no more than 10 percent of their clinical time was spent in simulation.

JHSON participated in the study, and educators and researchers Swoboda and Maggie Neal, PhD, RN, served as co-coordinators of the study at Hopkins, as well as skeptics.

“We both went in saying, ‘We don’t believe that simulations can possibly replace the clinical environment,’ ” Neal recalls, yet the study

ultimately proved them wrong. The NCSBN study shows that students who receive up to half of their clinical experience in simulated environments are as knowledgeable and competent as students who complete their clinical experience in the traditional manner.

Jeffries, a co-author of the study, calls it “a game changer.”

“There was not a lot of evidence out there looking at the science and pedagogy of learning through this kind of experiential learning,” Jeffries says. “Now, though, we have this huge evidence base to show that students do learn in simulation.”

Simulation at JHSON

The study results are welcome news to students and staff at JHSON, many of whom realized the value of simulation through the school’s participation in the NCSBN study. Despite her initial doubts, Neal now considers simulation an effective and efficient way to teach students clinical skills and critical thinking.

“In a clinical practice setting, faculty usually have somewhere from six to eight students to supervise, and you can’t begin to see what’s going on with each of those students in a clinical environment on a daily basis,” Neal says.

“What’s great about a simulation is that it flows based on the students’ interventions. If a student forgets to apply oxygen, the patient’s O₂ saturation will drop until the student notices and intervenes.”

— Cynthia Foronda, PhD, RN, CNE

“In a simulated environment, I can guarantee that students are competent because I can make everybody do a simulation scenario and can see each of them.”

Nursing students and staff have access to four fully outfitted simulation rooms, and students begin participating in simulated scenarios during their first nursing class. Some, such as the heart attack scenario described at the beginning of this article, use manikins. Others, such as a psychiatric interview with a patient with schizophrenia, use actors. In all cases, students have the opportunity to take on and inhabit the role of the nurse.

“What’s great about a simulation is that it flows based on the students’ interventions,” Foronda says. “If a student forgets to apply oxygen, the patient’s O₂ saturation will drop until the student notices and intervenes; we can make those changes to the manikin’s vital signs.”

And because the experience is simulated, staff can allow students to progress through

an experience without stopping to protect patient safety. Later, students and staff discuss the experience in a debriefing session, with each person called on to respectfully share observations.

The debriefing session, often twice as long as the simulated encounter, is an essential part of the success of simulation learning, Swoboda says. “We go through a very structured debriefing process. We engage students in a discussion; we give them a little information and then draw out from them what they’ve learned. We help them make connections between what they’ve learned in class, what they learned in simulation, and what they learn in clinical.”

Simulation days are intense. Currently, eight hours of simulation are considered equivalent to eight hours of traditional clinical, but whereas students typically care for one patient (and spend lots of time reading charts and observing) during clinicals, sims students participate in two or three scenarios in the course of an eight-hour day. “With sims, they’re working the whole time they’re here,” says Nancy Sullivan, DNP, RN, JHSON sim lab director.

The Future of Sims

At present, JHSON students receive about 18 percent of their clinical education in a simulated environment, and that percentage is unlikely to change in the near future—despite the NCBSN study—because of logistical challenges. “Simulation is resource-intensive,” Swoboda says. High-fidelity manikins cost more than \$70,000 apiece, and the amount of simulation education an institution can provide is limited by the number of manikins, faculty, and simulation suites available.

Still, nursing educators expect simulation to play an ever-larger role.

“I personally think simulation is going to get bigger and bigger and bigger,” Sullivan says, calling it an ideal way for healthcare personnel to practice low-occurrence, high-risk scenarios, such as an Ebola outbreak. She expects simulation to play a larger role in the education of graduate-level nursing students as well.

Simulation may also pave the way for interprofessional learning. Foronda hopes to eventually use virtual simulations to “span traditional boundaries and foster interprofessional communication.”

“Right now,” she says, “it’s very challenging to find space to facilitate interprofessional simulation. I’d like to foster virtual simulations that have physician students, pharmacy students, and nursing students interacting in a virtual world.”

Meanwhile, educators with experience in simulation are sharing insights and best practices with other nursing faculty. Neal coordinates the Maryland Faculty Academy of Simulation Training (MFAST), a group that’s teaching faculty how to write, facilitate, and debrief simulation scenarios. Jeffries serves as president of the Society of Simulation in Healthcare, a group that shares information and conducts research regarding simulation.

Jeffries and Sullivan predict that future nursing students may eventually be required to participate in standardized simulation scenarios deemed an essential part of nursing education. Some schools, Sullivan says, are even moving toward requiring students to demonstrate proficiency in simulation before allowing them to handle certain patient scenarios in real-life clinical settings.

“In simulation, we give our students experience that leads to increased comfort when they encounter scenarios in the real world,” Sullivan says. “They can build on their experience much more readily as a real nurse if they’ve already seen that situation in a simulated scenario.” ■



REAL-LIFE EXPERIENCE BEHIND THE SIMS

Nancy Sullivan’s mother was no dummy.

“I always wanted to do what my mother did,” says Sullivan, daughter of a nurse and herself a 2013 graduate of the Hopkins DNP program.

“I thought it would be really cool to go to a nursing diploma program, so I could live in a dorm with other nursing students, right on the hospital grounds,” Sullivan recalls. “But I was very lucky because my mother was insistent and said, ‘No, you need to get your degree.’ Of course, that turned out to be a very good idea.”

Having a degree in nursing—at a time when few others did—ultimately allowed Sullivan to serve as a clinical instructor, lecturer, and clinical coordinator. She brings that experience, and 30-plus years as an emergency/trauma/critical care nurse, to her new role as simulation lab director.

“My role is to take our simulation lab into the future,” Sullivan says. “Our students love to learn, and it’s fun to watch them make connections and get more comfortable with what they’re doing. It’s a privilege to be able to support them throughout their education.” ■



Nancy Sullivan, left, and Cynthia Foronda observe student responses to situations the instructors create.



A Heart For Haiti



HAITI PHOTOS COURTESY OF ELIZABETH SLOAND AND NICOLE WARREN, INCLUDING IMAGES BY STUDENTS FIDELA CHIANG, REBECCA BACKER, AND MARGARET MILLS.

HAITI'S LESSONS OF HEALTH AND HOPE

15 YEARS INTO THE MISSION, HIGHS, LOWS, AND ALWAYS AN EAGERNESS TO RETURN

STORY DANIELLE KRESS

The School of Nursing has left its mark by bringing hope and healthcare to Haiti, and as Beth Sloand, PhD, RN, PNP-BC, pioneer of the school's efforts, would tell you, it's worked both ways. "Haiti doesn't leave you. It has a way of clinging to your heart."

It's been 15 years since Sloand and the school first went to the Caribbean nation, and in a look back through the years, one can see the rollercoaster ride of highs and lows that has encompassed the work in Haiti.

"You really don't know until you've been there," says Sloand. "But after my first trip, I was convinced that I would be back." Since 2000, approximately 75 students and 40 faculty have participated in the trips. Three times a year, baccalaureate, master's, and doctoral students go to Haiti to screen, treat, vaccinate, and educate local groups about clean water and sanitation. It's through the school's long-standing engagement with the community that sustainable change and a trusting relationship have been established. The theme of providing hope for the residents and sustainability for the future lives on, and Sloand says many of the students "develop a heart for Haiti"—one that not only strives to help the Haitians, but that changes nurses as well.

Amid the excitement of the journey, there have been times when the work is heartbreaking and hard to swallow. "The earthquake in 2010 was so devastating to the health and infrastructure of the community, you almost couldn't see the light at the end of the tunnel," Sloand recalls. "We cared for hundreds of people, but there would still be children crying for shelter or medical care. It was painful, but in the end it brought more motivation to keep moving forward."

Almost five years since the earthquake, restoration has become visible, but MSN-FNP/MPH candidate Fidela Chiang, part of a recent trip to the village of Leon, confesses it's no quick fix. "We cannot solve all the problems of Haiti, but we can cast a boy's broken arm, give a man a pair of shoes, or treat pneumonia. You have to think quickly and creatively in a low-resource setting, and you learn the importance of teamwork." Graduate student Diana Chia agreed, noting the intensity of the work and its test of leadership ability reinforced her desire to work with underserved populations. "I felt incredibly lucky to be able to empower the locals to manage their conditions. I learned how to provide patient care in an amazing and challenging environment, and it's something I will carry into my clinical practice."

During the latest mission to Haiti, Nicole Warren, PhD, MPH, CNM, and retired faculty member Sara Groves, DrPH, APRN, BC, led students in addressing a crippling cholera epidemic. "We looked at the effectiveness of some of our community health promoter programs and provided education on community mobilization," says Warren. Their assessment showed that "tippy taps"—a simple hand washing technique—was being widely adopted and used. "Students were awed by the impact of this simple prevention intervention, and our discussions gave students the opportunity to learn about a step-wise approach to addressing complex infrastructure problems common in rural, poor communities."

While the needs may seem obvious, Warren acknowledges the next steps will be pursuing what the residents identify as important to them. "The Haitians have become like teachers to us, and we will follow the communities' lead to provide support where needed." ■

Three times a year, students from Hopkins Nursing bring care to Haiti, getting as much from the experience, their faculty leaders say, as they give.

HOPKINS NURSE

News from **The Johns Hopkins Hospital & Affiliates**

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OTHER LIVES: A SERIOUS ROLE

Steve Sawicki is all business when it comes to nursing at The Johns Hopkins Hospital. But mention acting, his first love and first career, and the caregiver offers a little peek behind the curtain at what makes him tick.

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KATHY HERMAN DANCES INTO THE SUNSET

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COMPLEX INTEGRATION WITHOUT A HITCH

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EBOLA SUPPLIES FOR SIERRA LEONE;
NURSES SPREAD WORD IN LIBERIA

To Give and to Receive

By Jennifer Walker

New life for those with transplants and for nurses who couldn't bear to stand by

As a clinical nurse specialist with the Incompatible Kidney Transplant Program at The Johns Hopkins Hospital, Janet Hiller, MSN, RN, often hears about patients who are getting sicker while waiting to find donors. Wanting to help, Hiller decided to run her name through the tissue typing database in late 2009. "It only takes one new donor to stimulate a lot of matches," she says. Out of a pool of 100 recipients, she was a match for one, a young woman in her 20s, whose name was surprisingly familiar to her.

Earlier that year, the same young woman was scheduled to be part of a national kidney exchange at Hopkins. A program like this often begins with



It has been four years since [my donation], and I feel absolutely no different. There aren't even any scars."

— Janet Hiller, MSN, RN

an altruistic donor who offers his kidney to Patient 1. A friend or relative of Patient 1 donates a kidney to Patient 2, whose friend or relative donates to Patient 3, and so on. But one donor had to drop out of the exchange for medical reasons. That left the young woman without a donor. Two months later, in early 2010, Hiller donated her kidney.

"It's easier than a lot of people think it is," says Hiller, who has never met the recipient. Hopkins employees who become living donors get an additional four weeks of leave to recover from surgery. As for long-term complications, "It has been four years since [my donation], and I feel absolutely no different. There aren't even any scars."

Since 1954, when the first such donation took place, there have been more than 50,000 living kidney donors, according to the National Kidney Registry. Most donors at Hopkins give a kidney directly to a loved one or participate in a paired exchange. But there are also a few Good Samaritan donors like Hiller who donate a kidney to anyone in need.

For Susan Humphreys, PhD, RN, kidney donation was the second item on her bucket list. (The first was to complete her doctoral dissertation.) The Johns Hopkins Hospital nurse manager became interested in donating when she started taking yoga lessons



and reading Eastern philosophy three years ago. Realizing that she was a healthy 64-year-old woman who had never had surgery, "I wanted to do something with my good health," she says.

Humphreys donated her kidney in early 2014. A week later, her recipient, a woman in her 20s, wanted to meet her at the hospital. There, Humphreys found out that the woman had been on dialysis after losing the kidney her mother gave her when she was a child. "It's very special to get to know your recipient and to incorporate them into your close relationships," Humphreys says. They continue to keep in touch through Facebook.

No matter how committed they are, Good Samaritan donors naturally have doubts at some point during the process, especially if loved ones aren't completely supportive of the decision. Hiller's youngest daughter, 15 at the time, was concerned about complications.

"Her dad said, 'There is a 1 in 10,000 chance that mom could die,' " Hiller says. "All she could hear is, 'Mom could die.' She didn't hear [the odds]." Because of her reaction, "I thought seriously about it in relation to her and the family. If my family wasn't OK with it, then I wouldn't do it." After they talked more about the surgery, Hiller's daughter eventually agreed she should go through with it.

Humphreys—who also has a daughter who was initially upset about her decision—was anxious about the surgery herself. Having once worked in the kidney program, "I know that things can go wrong, and I know no one is immune to [that]," she says. Humphreys also worried whether her kidney would work with the recipient, considered a "high-risk" patient because of her history.

Humphreys shared her concerns with Hiller. "She was reinforcing to me that at some point you decide [to donate] regardless of the risks," Humphreys says.

And on surgery day, Humphreys had a "wonderful experience."

"[Donating] gave me joy and that very deep feeling of being interconnected with people in the world," she says. "If I had two kidneys [to spare], I'd do it again." ■

Transplant Group's Guiding Hands

"You have to jump a really high bar to clear being a [kidney] donor," says living donor and Nurse Manager Susan Humphreys, PhD, RN. Medical conditions, lack of family support, and work constraints are reasons that a potential donor may drop out of the program or be ruled out by the transplant team. Every week, the team discusses whether donors can continue with the screening process, which can take three to six months.

Potential donors fill out a basic questionnaire that covers health and family history and then go through lab testing. At this point, people with certain medical conditions may be informed they cannot continue the process, says Pam Walker, RN, living donor nurse coordinator. These include diabetes, heart or kidney disease, and infectious diseases.

Donors who pass the medical screening have a full-day evaluation at the hospital. Along with undergoing a CAT scan and an EKG, donors meet the surgeons, psychologists, and nurse coordinators on the transplant team. They also meet with a donor advocate and a social worker.

After surgery, living donors meet with transplant nurse practitioner Kate Knott, MSN, CRNP, who explains short- and long-term restrictions, such as the need to avoid non-steroidal anti-inflammatory drugs like ibuprofen. She follows up after six months and every year thereafter.

Throughout the process, donors who have doubts or anxiety have "plenty of time to ask questions," says Sherrie Klunk, RN, living donor nurse coordinator. "We educate them so they have all the information they need to make informed decisions."

What about donors who change their minds late in the game?

That's fine, says Mary Kaiser, clinical social worker and living donor advocate. "Up until the very last second, if they want to change their minds, they can," she explains. "It's very special that they are [considering] having a surgery just to help another person. We support any decision they make." ■



PHOTO BY STAN BAROUH/EVERYMAN THEATRE

Other Lives: A Serious Role

By Joan Davila

Steve Sawicki hears the curtain call but puts his all into bedside care

Steve Sawicki, RN, isn't big on soliloquys, at least not when it comes to his regular nursing job. There, he's strictly business. But mention acting to the caregiver who joined The Johns Hopkins Hospital in 2006 and he offers just a little peek behind the curtain.

"My true love, what really drives me creatively and feeds my soul, is the theater," says Sawicki, a nurse clinician on Meyer 6 providing bedside care to geriatric patients with psychiatric concerns and adults living with persistent pain. "Spending time with my outside interests recharges my batteries."

These include playing the viola, bass guitar, tuba, and accordion, and Sawicki's been known to cantor for Saints Philip and James Church in Charles Village. It's a work-life balance that Sawicki has for now intentionally tilted toward his role at the bedside. "These outside interests remain just that. ... I take pride in my work as an RN, and I enjoy it."

But he's not against a little improv on the unit: "I follow hospital protocols, but every now and then I may have to rely on storytelling skills to distract a patient with dementia while a phlebotomist is attempting to draw blood."

After earning a degree in theater from St. Michael's College in Winooski Park, VT in 1989, Sawicki went on a whirlwind U.S. tour from 1989-90 and again from 1996-97 with the National Players (from Olney, MD) performing in *A Midsummer Night's Dream*, *The Life and Adventures of Nicholas Nickleby*, and *The Importance of Being Earnest*. He's also acted at the Olney Theatre Center for the Arts, Baltimore Shakespeare Festival, CenterStage, and Everyman, Iron Crow, and AXIS theaters.

Has nursing influenced his acting? "Well, there was one play that featured a character in a hospital bed, and I provided a little guidance for the actor playing a nursing role."

While he's all caregiver all the time right now, there's no rush to bring down the final curtain. Smiling, Sawicki shares what's on the back burner: "One of my theater friends and I are putting our heads together to create a two (or more) person show. We are in the very beginning stages of that, and it's so exciting!"

For now, his first love (and first career) waits, performing an important role of its own. "After the grueling schedule we had to keep [on two theater tours] I find that I'm pretty much prepared for any circumstance that comes my way." ■

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Care Team Knows the Score

By Danielle Kress

Electronic board keeps staff (and patients) in the loop with who's on duty

When it comes to the nurse or doctor on duty, “Guess Who” is about the last game a provider or a patient wants to play. And on the JHH Zayed 8E Labor and Delivery unit, where nurses, doctors, residents, and clinicians are constantly in and out of rooms, knowing the name of every staff member could be a great challenge. That was before the Electronic Team Board—a big-screen monitor that displays the name, face, and title of every health worker on the floor. With it, staff members now know the “who’s who” in just a glance.

Centered in the hallway in front of the main nursing desk on the east side of the unit, the screen waits. As staff members begin their shifts, they touch their badges to a sensor underneath the screen, and their photos and color-coded job titles appear, making it easy to quickly identify the triage nurse, the physician, or the obstetrics nurse on duty. Mary Evans, RN, NCII, nurse clinician and champion of the board project, says it's a small extra step

“As health professionals, we need to know who we are working with. If I know who is on duty, I know who to call, and I can minimize patient harm by providing quicker and more accurate care.”

— Mary Evans, RN, NCII

each morning that makes a big difference throughout the day. “It’s no longer a guessing game,” she says. “I can look up at the board, see who is on duty, and put a name with a face. The results have been enormous.”

The issue of “internal communication” among staff members surfaced at a Comprehensive Unit-based Safety Program (CUSP) meeting, where a team of staff members addressed the unit’s processes and procedures to see where improvements could be made. The group asked, “What might happen today that could harm a patient?” Discussions around staff communication emerged and it wasn’t long before the group had a simple yet effective solution—the electronic team board.

“We work on a big floor where you might only see the doctor one time during the day,” says Evans. “But as health professionals, we need to know who we are working with. If I know who is on duty, I know who to call, and I can minimize patient harm by providing quicker and more accurate care. The board is the tool for facilitating that.”



ILLUSTRATION BY HARRY CAMPBELL

Susan Will, MS, RN, the unit’s obstetrics patient safety nurse, believes the board has made significant improvements to team cohesiveness. “If people know your name and call you by name, you feel more a part of the team,” she comments. “There’s more knowledge now of the individuals you’re working with, and I think people feel vested in the process.”

Presented by Will, Program Coordinator in Clinical Informatics Rhonda Johnson, MSN, RN, and Senior Software Engineer Kirby Smith (the lead designer behind the board’s technical preparation), the electronic team board was showcased at the annual Johns Hopkins Armstrong Institute for Patient Safety and Quality Patient Safety Summit, and it was well received among colleagues. Other departments throughout the hospital are now

considering installing the same type of system. “When doctors and nurses from other units come to visit, they see our board and say, ‘Wow, how can we get one of these?’ It will be really neat to see how far this new idea can go.” Evans states.

With improvements still to be made, the unit is considering putting the same type of screens on the west wing of the unit and in patient rooms so that it’s easy for patients to remember the names of those directly providing their care. “We need to make sure that our patients are comfortable with the quality of care we give them,” stresses Evans. “When patients and their families feel they are receiving the best care and that we are really advocating for them, bonds begin to form, and the once-scary hospital quickly begins to turn into being a much happier place.” ■



This Way Forward: Nancy Poultney Ellicott (1872-1944)

Nancy Poultney Ellicott graduated The Johns Hopkins Hospital Training School for Nurses in 1903 ready to roll, in every sense of the word. Born to a wealthy Maryland family, Ellicott enjoyed the benefits of her financial and social standing (she was the first woman in Baltimore to own and drive a car), but she embraced the privilege of nursing even more tightly.

Ellicott quickly became head nurse at The Johns Hopkins Hospital, then superintendent of nurses in the Church Home and Infirmary. Immediately recognized for her innovative thinking, she was hired in 1910 by the brand-new Rockefeller Institute Hospital in New York City, serving as its superintendent of nursing and housekeeping for 28 years and revolutionizing patient care and hospital hygiene. Her back rest for patients inspired beds with hinged

frames; the hamper on wheels she invented made safer and easier the chore of hauling away soiled sheets (and made the Rockefeller Institute a lot of money); she proposed ceiling-mounted, sliding curtains between beds; and she pushed the use of beds on wheels to move patients more quickly and comfortably.

John D. Rockefeller himself noted, “Miss Ellicott was a woman of extraordinary ability and outstanding in her chosen profession. ... The service which she rendered the Rockefeller Institute Hospital cannot be overestimated.”

Ellicott advocated tirelessly for better pay and retirement benefits for nurses. ■

Sources: Alan Mason Chesney Medical Archives; Rockefeller University Hospital; The Johns Hopkins Hospital Department of Nursing

A Time to Refocus

By Joan Davila

Hope Project helps make final months, weeks, days, or hours worth living

To Anna Ferguson, RN, hopelessness is one of the cruelest symptoms of a terminal illness.

Unsettled at hearing patients facing difficult prognoses remark grimly that “you have left me with no hope,” the hematologic malignancies research nurse began thinking of ways to change a mindset that can cost gravely ill patients any good months, weeks, days, or even moments that might be left. The Hope Project is a product of her determination to offer the dying a reason to keep living.

“I was left wondering what ‘hope’ really is,” says Ferguson of a word often avoided in medical settings for fear of creating false hope in patients very likely beyond a cure. “I realized it has to mean something more, and it can’t be reserved for just the curable. It occurred to me that we had a real opportunity to help patients maintain hope, even [during] failed therapies,” adds Ferguson, who works in the Johns Hopkins Sidney Kimmel Comprehensive Cancer Center.

What she realized was that asking the question “What are you hoping for?”—for today, for tomorrow, for next week—can be an incredible door opener.

“The process of flushing out what hope means to each individual patient eventually becomes a natural portal into the essential conversations we’re already having about their illnesses, treatments, side effects, and therapies, and it’s extremely therapeutic,” she explains. By focusing on “small, everyday hopes,” the now two-year-old Hope Project, which Ferguson

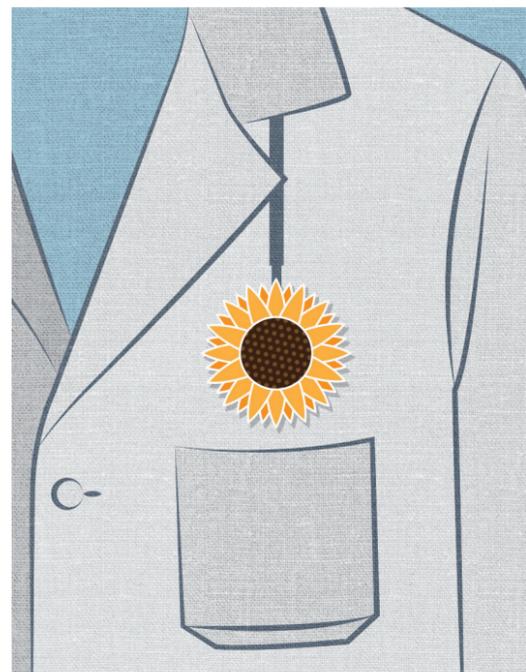


ILLUSTRATION BY ANDY BONNER

leads, “lets patients know that hope is about them, not their medical outcome.”

“We see patients get knocked down time and again, get back up, and keep fighting thanks to hope. And when there’s no longer medical hope, we can help people refocus their hopes for the remainder of their lives.”

At a November 2012 kickoff event for the project, three patients in their 30s, all with incurable cancers, took part in a discussion that Ferguson says she’ll never forget. “They shared that hope for a cure is not what kept them going. Hope to attend family weddings and kids’ soccer games is what inspired them, got them out of bed, and ultimately gave them quality of life.”

Hope Project materials bear a simple symbol, the sunflower, to represent the power of hope and how living things twist and turn toward the sun to get the nourishment, light, and energy they need to thrive. And patients and families aren’t the only ones who benefit from the project’s efforts.

“We get a front-row seat to the best of humanity,” Ferguson explains of nurses at the cancer center. “Patients give us hope. That’s what completes the circle.” ■



We see patients get knocked down time and again, get back up, and keep fighting thanks to hope. And when there’s no longer medical hope, we can help people refocus their hopes for the remainder of their lives.”

— Anna Ferguson, RN

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HOWARD COUNTY GENERAL HOSPITAL

Operation Last Dance

By Steve St. Angelo

Nurse manager Kathy Herman steps away from key role in the surgical ‘ballet’

So much has changed in the practice of surgical nursing since Kathy Herman, RN, walked through the front door of Howard County General Hospital in 1978, including her feelings for the profession. A love of nursing simply wasn’t there from the beginning. But over time, “just a job” turned into so much more, an exemplary career in nursing that concluded in November as Herman bid a fond farewell to HCGH and a hello to the idea of being a full-time grandmother.

That’s a long way from her original work plans, which ended at her own introduction to motherhood. “I had a baby, and that was going to be it for nursing,” says Herman, who closes her career instead as nurse manager of the main operating room. “But five months later, I was tired of baby talk.” The hospital

welcomed her back happily, and though things have changed exponentially in 37 years on the job, one thing never did:

“I have never known Kathy to dial it in on any day,” says her (former) boss, Sharon Rossi, MS, RN, senior director of perioperative services. “She does the right thing, not the easy thing. That can be tough in an OR setting. Above all else she is an awesome teacher, whether

with patients, or nurses, or families. And she does it without them feeling threatened or minimized in any manner.”

As for changes, Herman mentions the technological advances in surgery as the most mind-boggling. “Things I couldn’t even imagine,” she says. “You no sooner buy it than it’s outdated.”

Herman kept current over the years through affiliations with professional programs, by reading every journal she could lay her hands on, and “keeping abreast of what’s going on at places like

Johns Hopkins.” She says her advice to nurses at any point in their careers would be to do the same, because more change is inevitable: “Be a lifelong learner.”

Herman, a Pennsylvania native, moved to Columbia, MD when her husband was transferred by his company to Baltimore. Her next stop, she says, is California to be near her one child and, hopefully, to be a grandmother one day.

Asked her favorite memory from her time at HCGH, Herman says it’s watching her surgical team treat a seriously ill patient as a seamless unit: “It’s almost like a ballet.” ■

“I have never known Kathy to dial it in on any day. She does the right thing, not the easy thing. That can be tough in an OR setting.”

— Sharon Rossi, MS, RN



ALL CHILDREN'S HOSPITAL

Making Time to Make It Clear

By All Children's Staff

PICU checklist preps bedside nurses to keep families in the loop

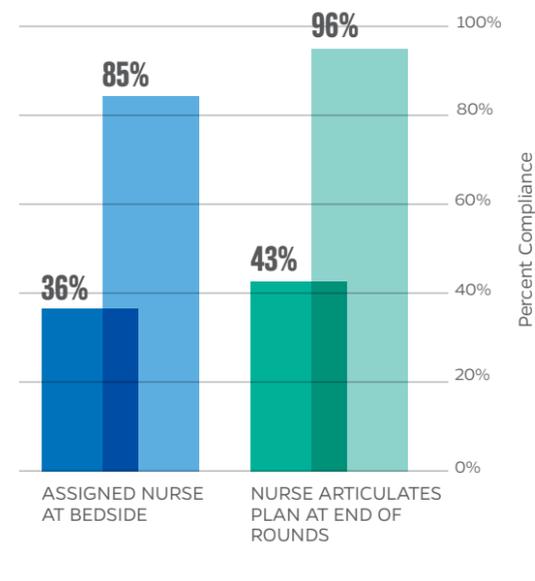
Interdisciplinary teamwork, advanced technical skills, and a mastery of a range of life-support technologies are essential to patient care on the pediatric intensive care unit, or PICU.

But nurses in All Children's 28-bed PICU must be as ready to help families understand a young patient's potentially complex course of treatment as to quickly respond to a medical emergency. So when a number of families reported that they were often unsure of their child's plan of care, the unit's clinical leaders launched a multidisciplinary quality improvement project designed to enhance bedside nurses' ability to articulate it.

A key factor is the nature of an ICU. Baseline data showed that the assigned RN, a critical member of the interdisciplinary team, was present at the bedside at the start of multidisciplinary rounds only 36 percent of the time due to competing needs on the unit. Consequently, the bedside nurse was able to articulate a patient's plan of care to a family just 43 percent of the time.

So a standardized approach was added to daily rounding in the PICU that uses a "Time Out" in order for nurses to give full focus to a 19-point safety checklist. The plan is verbalized aloud, with a charge nurse prompting a bedside nurse through each item on the list.

Improvement has been dramatic. Three months after introduction of the checklist, the bedside nurse was present at the beginning of rounds 85 percent of the time, and the percentage of nurses able to successfully articulate a patient's plan of



care increased to 96 percent. The satisfaction score also improved as families felt more confident in their understanding of a loved one's plan of care.

"We continued to refine the process for several months, creating a drop-down menu to ensure the use of standard language for questions and answers and to capture data on changes made as a result of the safety checklist," explains PICU Director Melissa Macogay, RN. "Our project illustrates that ACH nurses have a direct influence on patient outcomes by contributing to interprofessional decision-making through structural empowerment." ■



Our project illustrates that ACH nurses have a direct influence on patient outcomes by contributing to interprofessional decision-making through structural empowerment." — PICU Director Melissa Macogay, RN

SIBLEY MEMORIAL HOSPITAL

Suddenly in Harmony

By Joan Davila

Sibley Hospital fine tunes pediatric code blue emergency response through monthly simulations

There's little time for staff to prepare and even less time to think when code blue is called due to pediatric cardiac arrest. Teamwork can mean the difference between life and death. And teamwork takes practice.

"Although things are done correctly [most of the time] during code blue situations, the process often seems 'clunky.' There is room for improvement when it comes to code blue preparedness in all hospitals," explains Jennifer Abele, MD, Sibley's Emergency Department medical director, who spearheads the simulations at the DC hospital.

Therese Pearrell, MSN, RN, couldn't agree more. "Pediatric code blue emergencies are low-volume, high-risk situations, and there's a lot of low-hanging fruit when it comes to pediatric emergencies and code competency. Working together repeatedly is what enables us to quickly remedy code blue situations with precision in a way that no self-learning packet could ever teach."

Sibley began code blue simulations—designed to (without notice) quickly summon all staff and emergency equipment—in May 2013. From nurses and respiratory therapists to anesthesiologists and even hospital chaplains, all available medical professionals are called upon once a month to perform back-to-back simulations on a manikin displaying symptoms of cardiac arrest. Meanwhile, participating nurses (three per simulation) have their shifts covered, so human patients aren't left unattended.

"A simulation is performed just like an actual emergency situation," says Abele. "The element of surprise is what keeps us on our toes. ... Everyone responds quickly and willingly."

"As medical professionals, we're used to studying and preparing for what's ahead," Pearrell adds. With these exercises, "The lack of advance notice is the key ingredient. The simulations are the time to make errors. Making the wrong moves [when there is no danger to an actual patient] makes for better recall" during an actual emergency.

"We have learned so much about working together," Abele says. "Learning to work as a team has helped this transcend beyond peds to adult cardiac arrest patients. It's truly the best practice out there."

Abele puts it in perspective: "We're like an orchestra that needs to practice regularly for the big performance, so everyone can play their part in harmony."

She recalls a note from the grateful parents of an infant saved during in actual code blue in August, an inspiring reminder that code blue simulations do more than save the life of the victim. They affirm the reality of what hard work can mean.

"Thank you ... and thank you a thousand times again." ■



PHOTO BY JIM BURGER

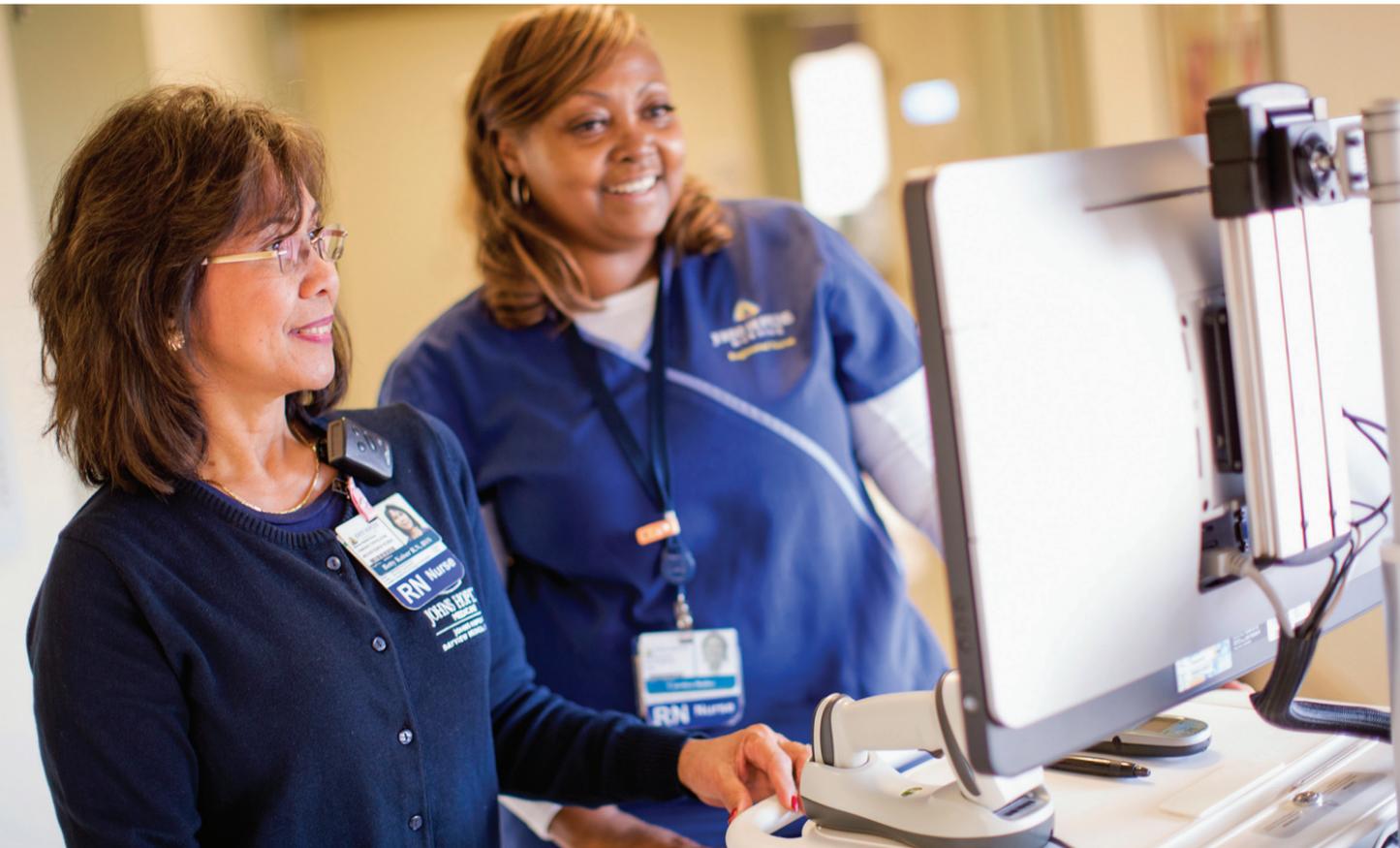
All available Sibley medical professionals are called upon once a month to perform back-to-back simulations on a manikin displaying symptoms of cardiac arrest. The code blue simulations may have already saved one baby's life.

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

One and the Same

By Kim Polyniak

Integration of acute care and specialty programs goes off without a hitch



PHOTOS BY CHRIS HARTLOVE

It's a Tuesday in early September at the Johns Hopkins Bayview Medical Center specialty hospital programs. At 7:59 a.m., Betty Kaiser, RN, a nurse on the ventilator/complex medical unit, sees patients on the floor, awaiting the change to come. "You anticipate something new," she says. "That's always exciting." In 60 seconds, a new technology will launch, ushering in a modern era in patient care for the three-unit facility. The switch is just one phase of the integration of the specialty hospital programs and the nearby acute care hospital on the same campus.

After the closing of the skilled nursing facility program last year, the name Johns Hopkins Bayview

Care Center was changed to specialty hospital programs. The move left 80 patient beds in the facility's rehabilitation, ventilator/complex medical, and behavioral medical programs. It was then that the idea of integration took shape.

The first step was restructuring eight departments at the specialty hospital, including nursing administration and nursing/clinical units, into the acute hospital organizational structure. "All of these people who have done things a certain way for so many years had to get used to new bosses, and new bosses had to get used to them and how they were operating," says Barbara Feege, MBA, director of finance, of the four-month process.

The decision was also made to introduce MEDITECH, the electronic medical record (EMR) system at Johns Hopkins Bayview. Previously, the specialty hospital programs employed a paper-and-pencil method. The transition to MEDITECH was seen as "the better quality, the better safety, the better communication," says John M. Preto, MS, RN, director of nursing for Medicine. Physicians, nurses, and medical staff could share patient information and coordinate care with the acute hospital. Staff members would also become familiar with an electronic system before a planned shift to Epic, the EMR for the Johns Hopkins Health System, in December 2015.

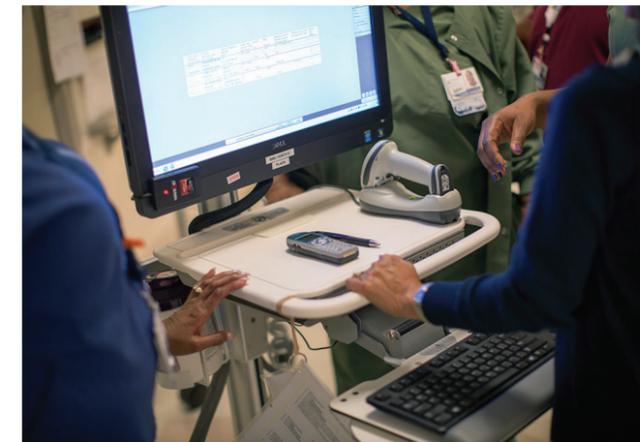
With MEDITECH, the specialty hospital programs could also now go through the acute hospital's pharmacy. PYXIS machines (automatic medication dispensers) and work stations on wheels, or WOWs (a computer with a wand to scan barcodes on patients' bracelets for medication verification), were added to units. Teams from departments at both locations deciphered workflows to ensure no issues arose—in some cases untangling conflicting methods. Says Peg Richards, MSN, RN, NEA-BC, director of nursing, specialty hospital programs, "We had to sit down and say, 'Was there a good reason why we were doing it differently?' And if there wasn't—which in most cases, that's what it was—then we just adopted the hospital's methodology."

“We had to sit down and say, ‘Was there a good reason why we were doing it differently?’ And if there wasn’t—which in most cases, that’s what it was—then we just adopted the hospital’s methodology.”

— Peg Richards, MSN, RN, NEA-BC



Clockwise from top: Betty Kaiser, Peg Richards, and a WOW cart, which allows nurses to verify medications as they make their rounds.



Facing page: Kaiser and fellow RN Carolyn Bailey on the unit.

After months of planning and preparation, including staff training and \$650,000 in capital costs, MEDITECH officially launched at 8 a.m. on September 9. "We had no major problems," Richards says. "Nothing broke down. Everybody worked together."

Staff members quickly discovered the benefits of the merger. "I'd say the biggest thing is the safety, having the MEDITECH and the bedside medication verification and the PYXIS machines cut down on medication errors," Richards says.

In January, the next phase of the integration takes place. Patient care coordinators, or nursing supervisors, and the float pool at both locations will combine to increase efficiency. Nurses will "have a larger pool, more options to meet staffing needs, because now they're integrated," explains Andrew Magalee, MS, RN, director of nursing for staffing and resource management.

For now, Betty Kaiser says she, like other nurses, is becoming familiar with the new technology. She also feels the integration has created a deeper connection with the acute hospital. "We feel like we are just one family," she says. ■

SUBURBAN HOSPITAL

A Package Deal

By Steve St. Angelo

Emergency team member Bobby Smith races to save lives at home and in Ebola-torn Sierra Leone

These days, if he's not on duty with the emergency shock trauma team at Suburban Hospital, Thomas "Bobby" Smith is headed to or from one of several storage facilities. There, critical nursing supplies he has gathered wait for a trip to areas of Sierra Leone ravaged by Ebola. It's an exhausting effort, but Smith sees it as the least he can do for nurses, his native country, and the world.

"We need to stop this Ebola, whatever it takes," Smith says on the road from his Germantown home.

A patient care tech who has worked in Suburban Hospital's Emergency Department for more than two decades, Smith is the founder of Hope for Lives in Sierra Leone. His mom died when Smith was young, and he emigrated to the U.S. in 1989 to live with a sister. He started the nonprofit in 2011 after a trip home to bury his father (and two relatives who died the same week) revealed a country he scarcely recognized. This Sierra Leone featured a populace devastated by years of civil war and poverty.

He began collecting all the shoes and school and medical supplies he could get his hands on, from friends, co-workers, and local hospitals and

businesses, organizing stops at Connaught Hospital and his old elementary school, St. Anthony's, both in Freetown, the nation's capital. Smith knows education is the key to health and sustainable lives in Sierra Leone. The organization plans to give St. Anthony's a computer lab alongside the library it already

built, and has also provided several fishing boats and a refrigeration unit to help nearby villagers feed themselves.

The current effort seeks footwear, scrubs, stethoscopes, gloves, and masks, plus cash for nurses sometimes forced to go weeks or months between paychecks.

Smith's own journey to healthcare came at the urging of his sister, a teacher who once worked as a nursing aide. Pretty quickly, he realized, "You know what? I think I'll continue doing this. ... It's a no-brainer. All we do is helping people and saving lives."

And he'll keep doing Hope for Lives even when Ebola subsides. Through the organization, more than 30 clinicians will travel to Connaught Hospital in 2015 to perform surgical procedures and train hospital staff. If Smith has his way, the team will be much larger by the time it embarks.

"Ebola changes things so much," explains Smith, who before the outbreak visited Sierra Leone a few times a year to lend his medical skills. (A planned trip was recently canceled for safety reasons.) "Right now everybody is focused on Ebola and they're forgetting about everything else. But what about the people who have appendicitis, or who have an infection? If I can bring 200 people, I will, if finances allow. They will spread out all over the country taking care of all the basics."

Meanwhile, it's time to meet friends who are helping him at a storage facility. Another shipment will soon be bound for Sierra Leone. There's a container to fill and money to raise (transporting the supplies will cost about \$10,000). So Smith will keep running "until God tells me it is my time to slow down." ■

JHPIEGO

Spreading the Word

By Ann LoLordo

For Liberian nurses, Ebola prevention becomes part of every discussion

As the Ebola crisis overwhelmed their native Liberia, nurses Comfort Gebeh, Nyapu Taylor, and Varwo Sirtor-Gbassie responded to repeated calls to update infection prevention and control practices in health facilities. The trio traveled throughout the capital of Monrovia and neighboring districts, training health providers on approaches and skills that could save lives: hand hygiene, instrument cleaning and sterilization, proper disposal of waste materials, and other infection prevention measures.

The nurses are expert trainers who had spent the better part of the past five years helping strengthen the delivery of maternal and newborn health services in Liberia as part of Jhpiego's team in country. They also educated nurses and midwives on the latest in maternal health and family planning measures, teaching them how to properly counsel women on the impact of healthy birth spacing.

But since the Ebola virus swept through their country, devastating the health system and killing more than 1,000, the nurses have incorporated information on the disease into their routine trainings and adapted their infection prevention and control materials for the Ebola context.

"If we are talking about family planning, we have to talk about Ebola too," said Marion Subah, a former Hopkins nurse and Jhpiego's country representative. "This is what we do, now that we have the outbreak."

The Jhpiego nurses have worked overtime to share the latest information in infection prevention, providing the tools needed for front-line health workers to protect themselves and patients.



If we are talking about family planning, we have to talk about Ebola too."

— Marion Subah



PHOTO BY KAREN KASMAUSKI/MCHIP

It has been a humbling and rewarding experience, says Taylor, "especially when participants show that they fully understand the importance of practicing infection prevention and control (IPC) at all times and when they identify how IPC helps protect them from infecting patients or themselves."

The Jhpiego team was so well-known for the quality of its training that community groups reached out as well. More than 100 members of the Muslim community from Monrovia attended one such training session. "We talk about washing hands, fixing the right concentration of chlorine solution [to clean and disinfect surfaces]," says Subah, a native Liberian. "We tell people, 'Do not touch anybody with Ebola symptoms unprotected. And if you are called on to help someone, you must put on the double black plastic bags, and call the hotline if someone is sick.'"

Muslim leaders identified with the step-by-step process of properly washing hands because of their practice of ritual washing. When the nurses explained the need to forgo the traditional washing of the dead to prevent possible transmission of the Ebola virus through body fluids, Muslim leaders agreed.

"At the end of the day, each [group] came up with action plans for infection prevention at their different mosques, including sharing the message in communities, with women's groups, market merchants, youth, motorcyclists, and others," says Taylor.

The selflessness of her Jhpiego colleagues has been inspiring, says Subah. "Everybody would do what had to get done. They put other people first. They are very understanding. People have been through some pretty difficult times. They are very resilient." ■



VIGILANDO

News from **the Johns Hopkins Nurses' Alumni Association**

Inside this section:

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ALUMNI WEEKEND

Sunny days and starry nights (and plenty of cameras) greeted alumni, who laughed, reminisced, and toasted friendships old and new.

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Updates from the alumni of 1952 through 2010

P. 59 CHURCH NOTES

Anniversary year; Creutzburg Scholarship grows; plaque unveiled at last

Alumni Update

Susan Kulik, BSN '86, MSN/MBA '06, DNP '12

This is my first letter as president of the JHNAA. I am thrilled about this honor, and looking forward to continuing many of the projects and programs I have been working on over the past two years as vice president of the Board. I have big shoes to fill, since Paula Kent did such a terrific job leading the JHNAA over the past two years. We are very grateful for her leadership! In the coming months, the Board plans to focus on student engagement and think about creative ways to support our students. We also want to look at the ways we can bridge the gap between our long-standing and newer alumni. I hope to meet as many alums as possible in this new role, and want to hear your questions, concerns, and ideas.

Alumni Weekend 2014 was a terrific success. We had many of the same events that had been so popular in the past, including the cocktail party at Bond Street Social, tours of the hospital, and Saturday's lunch; and new ones such as poster presentations and cocktails with alumni, Johns Hopkins Hospital staff, and students. In the Class News section, you will be able to read

firsthand accounts of the Weekend from our class ambassadors. I hope you will join us for next year's Alumni Weekend, which will take place September 24-26.

At the business meeting during Alumni Weekend, we discussed the JHNAA Task Force's recommendation to dissolve the 501(c)(3) status of the JHNAA while retaining its incorporated status. In September, the JHNAA Board voted to accept these changes. The JHNAA's funds will now live in a protected endowed fund, and the interest will be used for the JHNAA's operating expenses. As a result of these changes, the Bylaws Committee made a series of recommendations. These were distributed to alumni in October, and a special meeting was held on November 3 to vote on the changes. If anyone has questions about changes to the JHNAA, please let me know. I think it was a smart move and will ensure our growth moving forward.

Have a wonderful holiday season with your family and friends! ■

Finance Committee Report

Gerry Peterson

September 2014

The Alumni Association remains financially sound. The JHNAA Fund portfolio value as of September 16 was \$791,873. As reported last year, the Board approved an investment policy that reinforces the objectives of the funds asset allocation to provide the highest return consistent with a moderate level of risk with a long-term horizon. The University Development fund awarded us \$6,009.65

to replace funds previously received from dues as the University Alumni Association no longer requires dues paying memberships. This was a reduction from the previous year, when we received \$20,000. The JHSON Development Office also subsidized the JHNAA's budget for Alumni Weekend activities.

The Alumni Association continues to sponsor pins for graduating classes and we continue to support alumni programs such as Alumni Weekend, networking events, and student activities. The Alumni Association's budget is on target, especially considering expenses for next year will be reduced with the shift of funds to Johns Hopkins. ■

CLASS NEWS

1952 Jean Ross Neuman is retired from nursing after many years. Her family continues to appreciate her training as she still provides insights to their medical needs. Her loving family includes six great-grandchildren. In October, Jean and her husband, **Edward**, celebrated their 60th wedding anniversary.

1954 Alumni Weekend was an experience which I truly hope to repeat. Somehow, some way we plan to attend in 2019. Seeing classmates was a real pleasure, but even more I enjoyed hearing about how well the school is responding to needs of the future—both the students and those whom they will serve.

Class Reporter: Arianne Register

1959 Twelve members of the Class of 1959 gathered during the 2014 Alumni Weekend to celebrate its 55-year reunion. Those attending one or more events included **Evelyn Gant Chesney, Mary Sue Clark Spahr, Jill Derstine, Trudy Jones Hodges, Jean Hummer Hamlin, Mary Keener Warfield, Meredith Fawcett Kooyman, Peg**

Royer Kostopoulous, Rachel Meyers Seitz, June Persson, Pat Vreeland Bredenberg, and Ruth Worthington Yurchuck. We enjoyed all the weekend activities, from the Bond Street Social on Thursday night, tours of the hospital or medical archives on Friday, our class dinner at the Hopkins Club, and the JHNAA business meeting on Saturday, which was followed by lunch. Dean Davidson's gala, An Evening with the Stars: Celebrating 125 Years of Hopkins Nursing, was a great way to end this wonderful weekend!



Peg Kostopoulos distributed a reunion booklet that summarized responses to our class information survey, with pictures of us as new grads and current information of where we are now. Of course the highlight of this reunion was getting reacquainted with classmates. It was great to reconnect, and to share memories, laugh, and talk about the many changes we saw on the medical campus. The new buildings are awesome, Hampton House is an office building, and the old tunnel from Hampton House to the hospital has not changed much at all. We are already looking forward to our 60th reunion!

Class Reporter: Ruth Worthington Yurchuck



The Alan Mason Chesney Medical Archives Annual Report

Phoebe Evans Letocha

September 2014

Student assistant Emelynn Abreu completed the index of all the names in the post-graduate student records and part of the withdrawn student records for the Johns Hopkins Hospital School of Nursing, and also catalogued photographs received from Marketing and Communications at the School of Nursing.

Archival Projects:

Personal Paper Collections: *Individual web pages include brief biography, collection description and portrait photograph when available.*

Johns Hopkins Hospital School of Nursing and the Johns Hopkins University School of Nursing

medicalarchives.jhmi.edu/papernursing.html

Church Home and Hospital School of Nursing

medicalarchives.jhmi.edu/paperchurch.html

New finding aids: Carolyn Conant Van Blarcom Collection:

medicalarchives.jhmi.edu/finding_aids/carolyn_vanblarcom/carolyn_vanblarcomd.html

Anna Wolf Collection:

medicalarchives.jhmi.edu/finding_aids/anna_wolf/anna_wolfd.html

Index to the Johns Hopkins Nurses Alumnae Magazine/Vigilando—Betty Scher completed the index of articles from 1901 to 2003, and the finding aid is now available:

medicalarchives.jhmi.edu/finding_aids/nurses_magazine/nurses_magazined.html

Betty also completed an Index to the Nursing News from 1985-2002 and started the index to the Hopkins Nurse publication before her death on November 13, 2013. ■

ALUMNI WEEK



END

From traditional tours of the campus and hospital and through the tunnel from the old Hampton House, to a mixer at Bond Street Social, to Saturday lunch and an Evening With the Stars, Alumni Weekend 2014 was once again a highlight of the year. Alumni laughed, reminisced, and toasted 125 years of Hopkins Nursing, then began looking forward to the next big reunion, September 24-26, 2015. ■





1963 **M. Louise Fitzpatrick**, EdD, RN, FAAN, Connelly Endowed Dean and Professor at the College of Nursing, Villanova University, was recently re-elected to the Board of Trustees for the Commission on Graduates of Foreign Nursing Schools. Dr. Fitzpatrick

has also been invited to be a member of the External Advisory Board of the Rafic Hariri School of Nursing at the American University of Beirut. She was selected "based on her prominent and valuable contributions to the discipline and profession of nursing at the national and global levels." She was recognized in May with the prestigious Legion of Honor Gold Medallion of the Philadelphia-based Chapel of Four Chaplains, the organization's highest award and one that has also been given to U. S. presidents. According to her nominating statement, Dr. Fitzpatrick was honored as a "living legend of the profession of Nursing and a national and international icon in the fields of Nursing education and history ... she has devoted her life to education, service to others and caregiving in the highest sense." The organization also acknowledged her global impact on service to the underserved.

we raised nearly \$220,000 for the Martha N. Hill PhD Endowment Fund. We had an elegant Class Dinner at the Hopkins Club and lots of opportunities to reminisce in our hospitality suite at the hotel (thanks **Mary Jo Kubeluis** and **Sue Gormley Buchanan**). At Saturday's luncheon, the class received Johns Hopkins Alumni Association 50 Year Medallions and **Alice Kiger** received a Johns Hopkins Alumni Association Global Achievement Award. Then **Eileen Sweetland Leinweber** presented a moving salute to the class followed by a fantastic slide show of the class as we were then and are now prepared by **Diane Demarest Becker**. Diane also made wonderful memory books for the class. We are looking forward to as much fun for our 55th reunion.

Class Reporter: Gerry Pignato Peterson

1969 The Class of '69 participated in reunion activities celebrating 45 years since graduation. Impossible!



Can it be true?! Yes! We had an enthusiastic group who appeared in person while others were present in spirit. On Friday, class members toured the old turf, including highlights like Hampton House, the tunnel, and, of course, the statue of Christ that we passed so many times. We visited older, familiar parts of the hospital and were astounded by all the new buildings at Hopkins.

We had our largest Class of '69 showing on Friday evening for our dinner at the Hopkins Club on the Homewood campus. Spouses captured our group on film (see photo). A smaller group appeared in our official class photo, which was taken on Saturday after the business meeting. The weather was perfect and we vowed to rally our class to come to Baltimore for our 50th reunion ... in 2019. Mark your calendars now! We collected updates from our classmates that will be included in the next few issues of *Vigilando*.

Class Reporter: Maureen Dodd

1970 **Judith Day McLeod** (also DNP '12), Program Director of the RN-BSN and MSN Programs at Stanbridge College, was named the 2014 Professional Woman of the Year by the National Association of Professional Women.

1971 **Pamela Magnuson** celebrated the 11th anniversary of her heart transplant on October 23. She is working as a school nurse and loving it.



1979 The Class of 1979 gathered in presence and spirit for the 35th reunion celebration of our graduation from the SON. **Jane Houck, Kitti Watts, Carol Kalfon, and Susan Balfour** enjoyed a wonderful evening of sharing and catching up since we were last together many years ago. We were also able to share in our fellow classmates' life adventures through Jane Houck's diligent emails and letters that have kept us all informed of where our fellow classmates' professional paths have led, as well as personal family celebrations and sorrows many have experienced along the way. While we were a small group in actual numbers for the weekend reunion celebration, we were a complete class in spirit just as we were during the years that shaped the beginning of our nursing adventure in East Baltimore 37 years ago.

Class Reporter: Susan Balfour

1994 **ACCELERATED Lois Wessel** is a Family Nurse Practitioner at Celebremos La Vida and Community Clinic Inc., as well as a faculty member in the NP program at the School of Nursing and Health Studies at Georgetown University. She has published and lectured widely on care for the underserved, immigrant health, and health literacy.

1997 **ACCELERATED Michael Frakes** married Malisa Iannino on June 14th in Boston (see photo). Michael directs clinical services and organizational quality for Boston MedFlight and sits on the ANCC Commission on Magnet. Malisa is a nurse in the newborn intensive care unit at the University of Massachusetts Medical Center.

2000 **Marian Grant** (also MSN '05) was one of seven health professionals from across the country selected to participate in the prestigious Robert Wood Johnson Foundation Health Policy fellows program for 2014-2015. The program provides exceptional midcareer health professionals the opportunity to actively participate in health policy at the federal level. Marian is currently an assistant professor in the Department of Family and Community Health at the University of Maryland School of Nursing.

2004 **Tresa Dusaj** graduated with a PhD from Rutgers, the State University of New Jersey. She welcomed a daughter, Saachi Kaur, on March 27.

Since 2004, **Lai Wong** graduated from the MSN-FNP/MPH program, stayed in the Baltimore area, got married and had a son, Lucas (now 2 years old), while working in vascular surgery for a while. Currently she is taking a break and will start a new

JOHNS HOPKINS
IN MEMORIAM

- Margaret Walker Hamsher '40
- Stella B. Simpson '42
- Virginia M. Smith '42
- Frances L. Elder '44
- Margery S. Loiselle '46
- Gertrude Sargent Taber '47
- Elizabeth G. Baker '48
- Lillian Chang Soo-Hoo '53
- Mary Elizabeth McGeady '55
- Anna Jean Altman McQueen '55
- Madeline M. Massengale Beall '56
- Anne Greer Witte '59
- Carolyn Lawrence Marlin '66
- Emily Pollock Hill '71
- Peter C. Lasher Accel. '00



position in orthopedics soon. She is sorry to miss everyone at the reunion, but is definitely proud of the Class of 2004! She included a photo from her family's trip to Hong Kong in May.

2004 ACCELERATED Jan Kaminsky (also PhD '13) was named Executive Director of the School of Nursing at Kean University in New Jersey as of September 2014. She looks forward to the growth opportunities ahead, including a brand-new facility for next September and the first cohort of PhD students moving through the program.

2009 ACCELERATED Julia Tracey worked after graduation for three

years as an RN at JHH on Meyer 3 Adult Psychiatry and then CMSC 9 (10 North) Adolescent Med/Surg. Julia completed the Pediatric NP program at the University of Pennsylvania in 2013 and accepted a position as a Nurse Practitioner Fellow in Adolescent Medicine & Behavioral Health at The Children's Hospital of Philadelphia.

2010 Dedra Danielle Sally spent the first four years of her nursing career working on a high-risk labor and delivery unit in Philadelphia, Pa. In 2013, she completed an MSN in Nurse-Midwifery and Women's Health Nurse Practitioner at the University of Pennsylvania. Dedra is relocating to New Jersey to work for a private practice as a Certified Nurse-Midwife. ■



Church Notes

By Deb Corteggiano Kennedy, '73



Donations

Thank you to the many alumni who took time to bring items for the Archives. It is exciting that we received a copy of "Probie" and a CHH Volunteer badge and silver pin from **Gert Armstrong**, '49; the flag that flew over Church Home before it closed from maintenance worker **Tony Kondratenko**; a Pinkie Cap from **Diane Dekowski Kittok**, '72; and numerous items from **Yevette Hull Habicht**, '66, including a yearbook, newsletters, programs, and logo buttons. **Bonnie Kleinschmidt**, '64 brought Christmas programs from the past and **Linda Clarke**, '64 a CHH ashtray! Nurses today would be shocked to learn that patients were allowed to smoke in their rooms and doctors and nurses smoked openly at the Nurses' Station! The item that really gave us all a good laugh was a porcelain mini bedpan donated by **Condict Martak**, '64! ■

An Anniversary Year

The Homecoming Reunion Weekend was especially important this year as it marked both the 110th anniversary of the Church Home & Hospital Alumni Association formation and the 10th anniversary of our merger with the Johns Hopkins Nurses' Alumni Association. Throughout the weekend, over 30 CHH alumni attended the various events, including alumni from '42 to '76 and eight members of 1964 celebrating their 50th! Thank you to Hopkins for providing transportation for the alumni who live at Oakcrest so that they could be a part of the celebration. The raffle and jewelry sale raised \$250 and the basket of wine was won by **Nancy Waters**, CHH, '47.

Freda Creutzburg Scholarship Continues to Grow

As we approached this anniversary year, fundraising efforts were in full swing. I am proud to announce that \$25,871 was added to the scholarship, which included \$10,000 each from MedStar and **Patricia Kniffin Roberts**, '65. Thank you all for your very generous contributions. No amount is too big or small and we continue to make a difference in the lives of people working to become nurses just as we did.



Plaque Unveiled

The long-awaited, beautiful plaque that signifies the relationship between the two alumni associations was unveiled on September 25 by Dean-emerita **Martha Hill**, Dean **Patricia Davidson**, and myself. For all she has done to "Secure a Future for Our Past," Dean Hill was presented with a silver key pin from Tiffany's as a sincere thank you for all she has done in her vision and wisdom for her "cousins," the CHH alumni. The plaque is hanging on the wall overlooking the garden staircase in the SON.

CHURCH HOME IN MEMORIAM

- Norma I. Bugbee '40
- Virgie Keefer Stratmann '47
- Genevia B. Ewald '48
- Ruth Fowler '48
- Charlotte Gebb Dietz '55
- Darla Lemon Whisler '57
- Barbara Warfield '59

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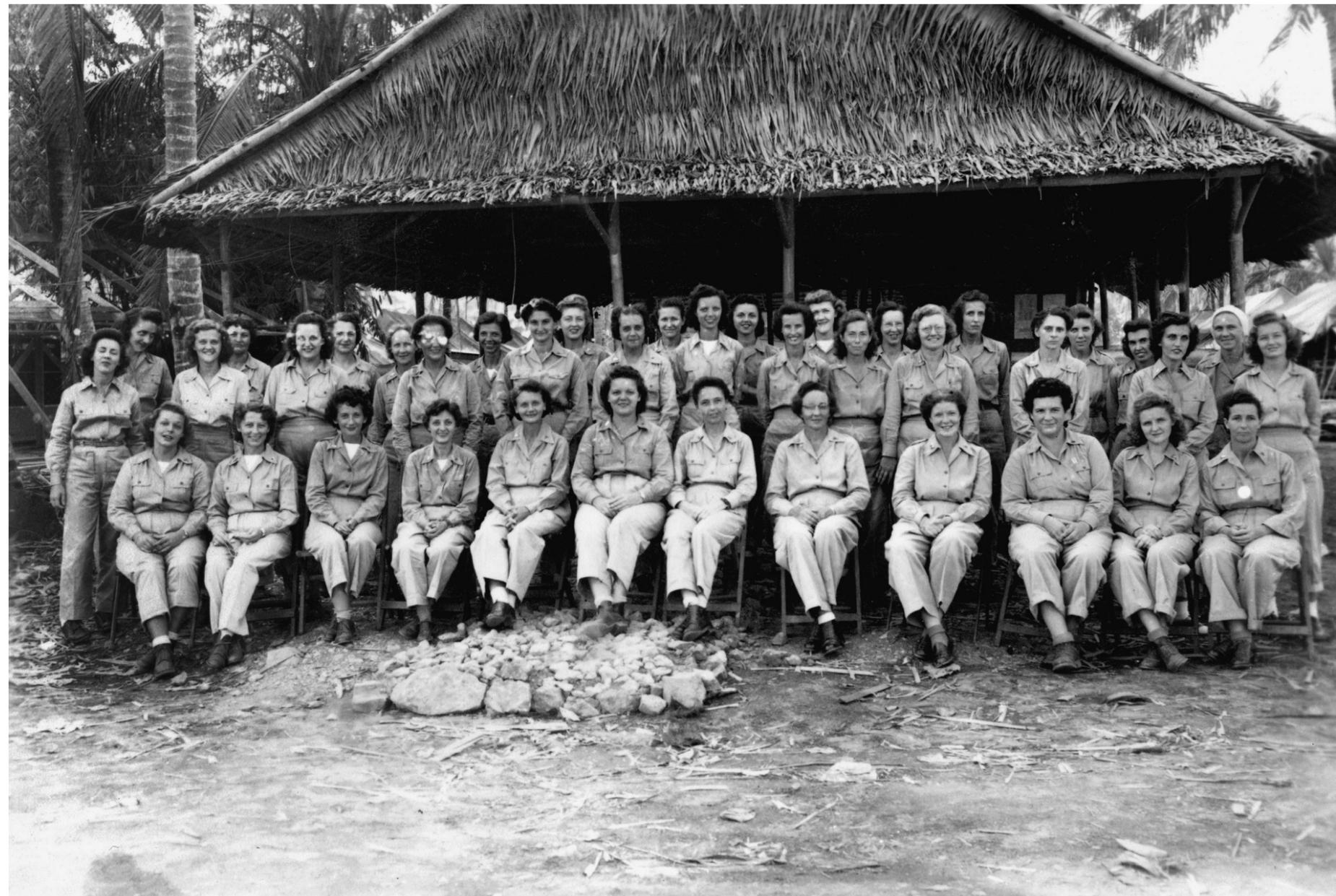
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Past President
JHU Alumni Association

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Over There: Members of the 118th Unit, a group of Hopkins Nursing graduates who, during World War II, enlisted to support the effort. From *Our Shared Legacy*: "From 1942 through much of 1944, the 118th was ensconced in Australia, where they treated cases of malaria more often than battle wounds. ... Their work became less comfortable and more complex when they moved on to Leyte Island in the Philippines." Here, the nurses share a moment of calm on Leyte. PHOTO FROM THE ALAN MASON CHESNEY MEDICAL ARCHIVES

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