Coming Full Circle

Fifteen years after Peace Corps, Nicole Warren ’98 remains committed to Mali’s matrones

I was sworn in as a Peace Corps volunteer in May 1994, after three months of crash courses in local language and maternal and child health, and deposited rather unceremoniously in a village about eight miles off a paved road in southeast Mali, West Africa. By default, I began working with Sali, a matrone, or auxiliary midwife. She was the only female health care worker available in her community.

When I met her, Sali could not believe I had never seen a child born. Hadn’t everyone? She laughed, shaking her head in amazement as she put my inexperience with birth in the same category as not being able to pound millet or carry water on my head. Despite our vast differences, Sali took it upon herself to introduce me to working with childbearing women.

In Mali, matrones are formally trained health care workers, providing the majority of reproductive health services in a country where one in 15 women die from a childbearing related cause. Though they are uniquely situated to help reduce maternal mortality in their communities, matrones fall at the bottom of the medical hierarchy. Because of their rural location and relatively low status, most matrones are inadequately trained, poorly supervised, lack basic equipment, and receive little continuing education.

Despite these challenges, matrones are committed, determined health care workers who provide the best care they can with little respite or support. It was Sali who introduced me to the realities these women face as wife, mother, farmer, and matrone. Sali’s family and clients needed her attention at all hours. Clients came to her on the backs of bikes, mopeds, and donkey carts. She never turned them away. She couldn’t have if she wanted to: They literally trailed her as she made the well-worn trip from her home to the village maternity throughout the day.

On market days when I helped her with prenatal consultations, Sali’s multitasking was at its peak. I remember watching her assess one client’s abdomen, explain how to take an antibiotic to another confused client, and breastfeed the youngest of her eight children—all at once. When the last client was taken care of, Sali would sigh and complain that her busy morning prevented her from getting the best produce at the market.

I returned to the U.S. in 1996 and pursued training in nursing, midwifery, and public health, traveling to Mali as often as I could. In 2002, I became a nurse-midwife and began to appreciate the magnitude of the matrones’ responsibilities through my own professional lens.

As I struggled to balance my own personal and professional responsibilities, I thought about the matrones, who were doing the same thing, only under much harsher conditions and with far fewer resources. In the midst of my busy clinic day, I could call up an electronic version of evidence-based guidelines to help guide my practice. A well-rested, competent colleague would reliably relieve me at the end of a 24-hour shift. If a client I had been laboring with suddenly developed a complication, I could call on a nearby expert to provide needed care. Matrones have no such resources.

I was fascinated by the matrones’ experiences and admired the way they managed with so few resources—and so the matrones became the focus of my doctoral
research. I traveled to Mali in 2003-2004 to conduct my field work, interviewing matrones in the district of Koutiala, where I had served as a volunteer.

The matrones were natural collaborators, eager to tell their stories and proud of the contributions they make to their communities. They described the way they link traditional and biomedical models of care and provide access to higher levels of care when needed. Many expressed frustration that they could not do their job as well as they would like, struggling to meet their responsibilities with few supplies, little supervision, and little continuing education. In a place like Mali, where the health care system is severely under-resourced, I knew that these front-line matrones would struggle to find that support.

Back at home, the matrones’ stories stayed with me. They had told me about women bleeding to death because they did not have the drugs they need. They grew tired of delivering stillborns caused by malaria. Like so much of maternal and newborn mortality, most of these tragedies were preventable.

So, in 2006, I formed an organization called “Mali Midwives” to support continuing education for matrones. With enormous support from other returned Peace Corps volunteers, U.S.-based nurse midwives, family, and friends, Mali Midwives raised enough funds by 2009 to sponsor a pilot project: a continuing education event for matrones in Koutiala.

The medical director and the midwifery supervisor I had known in Koutiala in 2004 had both been replaced in the intervening years, so the first Mali Midwives event was organized with nothing more than a few phone conversations and a couple of awkward e-mails. The day before the event, three of the region’s top clinical staff—two sage-femmes, the most highly trained midwives in Mali, and a physician specializing in reproductive health—sat down to adapt the training materials to fit the matrone’s education, skill level, and preferred language (Bambara, not French).

The matrones were scheduled to arrive the next morning. I woke up feeling anxious and hurried down to the medical center, trying to keep my expectations low. But as I turned the corner to the health center’s courtyard, I was greeted by dozens of matrones chatting with old colleagues and friends. Sali flashed her broad smile at me from the back of the crowd. I had not seen her in four years.

Over the next six days, 82 matrones participated in the continuing education event, focusing on “essential newborn care.” At the end of each session, matrones were initially hesitant to ask questions. The first few shy inquiries gave way to a barrage of questions well beyond the session materials. They did their best to take advantage of having three supervisors at their disposal.
One matrone asked, “If I hear heart tones at the first prenatal visit but not at the second, what should I do?” Another asked, “How many pills of iron should the woman take?” A third tried to clarify when and how much malaria prophylaxis should be given. These discussions had the others on the edge of their seats. The matrones had been waiting for an opportunity to ask these questions, to have an audience with more highly skilled colleagues, and to discuss common problems with peers. When the matrones were satisfied, the session broke up and matrones lingered, exchanging stories and ideas about caring for women and newborns.

This was by far the shortest trip I have ever taken to Mali—barely two weeks. But as I said goodbye to Sali and watched her start her journey back to the village where we had first met 15 years earlier, I felt like I had come full circle.

In September, Nicole Warren will again come full circle, returning to Hopkins (where she earned her baccalaureate nursing degree in 1998) as Assistant Professor in the Department of Community Public Health. Warren is Director of Mali Midwives, a non-profit organization dedicated to helping auxiliary midwives in Mali get continuing education. To lend your support, visit www.malimatrones.org, become a fan of the Mali Midwives Facebook page, or contact Dr. Warren at malimidwives@gmail.com.

—Nicole Warren ’98, PhD, MPH, CNM

Nicole Warren ’98 visits her mentor, Sali, during her honeymoon to Mali in 1999.
Pigs for Peace

How can one person give the gift of hope, economic empowerment, and improved health to a woman who has suffered and survived warfare, rape, and displacement from her home, family, and community? The answer, according to Associate Professor Nancy E. Glass, PhD, MPH ’96, RN ’94, may be as simple as purchasing a pig.

In 1990-1991, Glass was a young Peace Corps volunteer, serving in the country of Zaire. Now, after nearly 20 years—including a decade of bloody civil war—she is finding new ways to help families in the Democratic Republic of the Congo (formerly Zaire) who suffer from malnutrition, disease, and a severely damaged economic and social infrastructure.

For rural women serving as head of their households, says Glass, the challenges posed by the country’s gender roles and norms make health and economic stability seem impossible to secure. In 2008, she helped launch Pigs for Peace through the nonprofit organization, Great Lakes Restoration, in an effort to help such women.

“In other countries, microfinance has done wonders for improving the lives of poor, rural women,” notes Glass. “Empowering women economically leads to increased gender equity in the society, and that means improved health for women and their children.”

In the Congo, where annual income averages $89 per year, potential borrowers may be daunted by traditional microfinance lending models, so lenders are turning to livestock rather than cash to provide economic opportunities. But why pigs in particular?

“Pigs are common farm animals in the Congo,” says Glass. “They don’t need much space to live and forage, and they’ll eat just about anything. This, combined with the social prohibition against women making decisions about selling or killing a cow or goat, makes pigs the right solution for this kind of lending program.”

Here’s how it works:
Make a $50 donation, and Pigs for Peace will loan a pig to a Congolese family and provide a pen, veterinary support, mating opportunities, and education about pig farming. Rather than repaying principal and interest monetarily, the family gives two piglets back to the organization—one from each of the first two litters. Other piglets can be kept as meat or sold for an average price of $40 per animal.

“At first, Pigs for Peace sounds like simply economic outreach, but it’s so much more,” says Glass. “We provide education and support to the families regarding health, rape prevention, and gender equity. The women use the money from the pigs to plant new crops, raise chickens, access clean water, purchase mosquito nets, start businesses, and send their children to school. I really believe a pig can save a family.”

To learn more about Pigs for Peace, or to make a donation, visit www.glrbtp.org, become a fan of the Pigs for Peace Facebook page, or contact Dr. Glass at 410-614-2849 or nglass1@son.jhmi.edu.

—Kelly Brooks-Staub

Nancy Glass with survivors in the Democratic Republic of the Congo.
Our Nurse in Uganda

In Uganda, where life expectancy is only 52 years, the health problems are overwhelming. HIV/AIDS and malaria are the leading causes of death, the maternal mortality rate is among the highest in the world, and infectious diseases are a constant threat.

In an unprecedented international role for a nursing school, the Johns Hopkins University School of Nursing (JHUSON) is helping to lead a two-year needs assessment and strategic planning with Makerere University, the largest university in Uganda.

“The question we’re asking is ‘How can Makerere University—with its enormous 35,000 student population—better serve the Ugandan population in educating future health care providers?’” says assistant professor Sara Groves, DrPH, APRN, BC, who is coordinating the assessment, aimed at improving health outcomes in Uganda and East Africa. “We want to collect data that is beneficial to Makerere, to find the right resources to grow the university, and to create the best education possible.”

The multi-tiered program will determine methods to best serve Uganda in terms of the health care curricula, research, and administrative structure. Groves notes she is also facilitating the assessment of the health care delivery system in hospitals and clinics to ensure “the grant is implemented to teach students to deliver health care in the best possible way.”

As part of the grant, she is also working with four pilot projects to improve health care education and delivery: a community-based education program for health care students; an exploration of incentives for women to deliver their babies in hospitals or community centers to decrease maternal mortality; an attempt to improve the translation of health care research to impact public policy; and an experiment to translate successful models of HIV treatment in urban environments for use in rural community clinics.

The job includes coordination between faculty at Makerere and Hopkins, within the disciplines of nursing, medicine, and public health, to assess the health care education and delivery in the country. The group will collect data through the end of the year and in 2010 will work to synthesize the information and write a strategic plan.

“It’s a well-organized effort, considering its scope,” says Groves. “Everyone is really involved. The program has been embraced throughout both Hopkins and Makerere.”

In addition to managing the health care and educational needs assessments, Groves is also teaching a Public Health Nursing course, which includes taking Makerere students to work at remote sites in rural Uganda.

For nursing students at Hopkins, the collaboration will provide international opportunities as well. This year, four MSN/MPH students will travel to Uganda to work on the community health needs assessment and program evaluations.

“Our work in Makerere is just one example of what is possible for Hopkins Nursing internationally,” says Dean Martha N. Hill, PhD, RN, FAAN. “We’re collaborating in so many areas—curriculum development, teaching, mentoring, modeling, and data collection.”

A joint effort of nursing, medicine, and public health at both universities, the collaboration is funded by the Bill & Melinda Gates Foundation and being facilitated by the Johns Hopkins Center for Global Health.

Says Groves, “It’s been great fun to get students and faculty on two continents working together. In 10 years, I hope to see that the Hopkins-Makerere collaboration has made a significant impact on the health of Ugandans.”

—Kelly Brooks-Staub
Sometimes, the most intriguing career path is off the beaten one.

You may have read that Johns Hopkins Medicine is becoming ever more global. Over the last ten years, we have engaged in dynamic knowledge-exchange partnerships with institutions abroad to help them raise the standard of health care in those regions.

Today, we manage five facilities abroad: three hospitals in the forward-thinking United Arab Emirates, one in the ever-changing isthmus of Panama and an oncology unit in Singapore. We also manage long-term affiliate relationships with hospitals in Turkey, Chile, Japan and Lebanon. And there are more to come.

We’ve found that with Hopkins-trained nursing directors on the ground, working with local partners to adapt best practices to the culture, we’re able to push the boundaries of health care and clinical discovery in ways none of us ever dreamed possible.

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Halting the Hurt: Research to End Intimate Partner Violence

Anya was 15 and pregnant when her mother threw her out. The 28-year-old father of her child took her in. Soon, his verbal abuse became physical and sexual abuse. Anya visited the ER regularly, but never pressed charges. Six years, a miscarriage, and two more children later, she finally summoned the courage to flee the relationship. That courage came in the form of an emergency department nurse, who, Anya says, saved her life.

No one is immune from intimate partner violence (IPV). Annually, as many as eight million people are known IPV victims in the U.S.; the actual number is probably much higher. For decades, the silence about IPV was deafening. Victims felt too much shame and fear to speak out. Health care professionals and first-responders didn’t know how to ask about IPV. Today, the situation is changing. JHU-SON leaders in IPV research have advanced new tools and knowledge to give IPV victims a voice and a renewed sense of safety and self-worth.

IPV researchers at home and abroad look to Chair and Professor Jacquelyn C. Campbell, PhD, RN, FAAN as a mentor and to her work as a model and springboard for their own inquiry. Her passion and leadership in IPV research, education, and advocacy have not flagged for more than 25 years. She recently conducted a review of international research examining the potential relationship between IPV and HIV/AIDS infection among women (International Journal of Injury Control and Safety Promotion, December 2008). The study yielded as many new questions as it did answers, such as why victimization of HIV-positive women differs between the U.S. and Africa and whether IPV may lower resistance to infections such as HIV.

Campbell is best known as the creator of the Danger Assessment, an instrument to assess the risk for lethal IPV violence. Since its 1981 introduction, the instrument’s validity has been tested continuously across a broad range of communities, ages, races, and ethnic groups. Its questions have been refined to reflect the most salient risk factors for lethal violence. This spring, Campbell and JHUSON Associate Professor Nancy E. Glass, PhD, MPH ’96, RN ’94, in one of many collaborations, reported on the significant predictive accuracy of the current version of the Danger Assessment in the Journal of Interpersonal Violence (April 2009). An adaptation is being used by Maryland first responders as a short IPV danger screen; a separate tool has been introduced for use with same-sex partners.

Glass, whose sense of social justice was honed as a Peace Corps volunteer, has sought to identify and
respond to the factors that keep some female IPV victims from seeking help and safety. She recently examined differences in the types of IPV experienced by Latinas and non-Latinas. Reporting in the Journal of Community Psychology (March 2009), she found that, in contrast to the diverse types of IPV found among other populations, among young rural Mexican immigrants, forced sex is the form of IPV most commonly reported, a finding that may have important implications for IPV prevention.

In other work in the Latina community, Glass describes the elements of a successful, culturally appropriate, IPV intervention for Latinas. [Hispanic Journal of Behavioral Sciences, March 2009]. Foremost is the ability to establish and nurture relationships with Latina-serving, local organizations that can open the door to Latina IPV victims. Glass notes, “Partnerships are at the heart of community-based participatory research. Our research and the IPV support services we left behind were possible and sustainable only because community organizations were active, engaged partners.”

Men are not the only perpetrators of intimate partner violence. According to JHUSON Associate Professor Joan E. Kub, PhD, APHN, BC and alumna Jessica R. Williams, PhD ’08, MPH, RN, women in heterosexual relationships also commit IPV, and in greater number than once believed. Their review of female-to-male IPV studies (Trauma, Violence and Abuse, October 2008) confirmed that female-perpetrated IPV is common among adolescents, college students, and adults. Emotional violence is most prevalent, followed by physical violence and sexual violence. While some IPV may arise in response to victimization by a male partner, date, or friend, more study is needed to delineate the range of factors implicated in female-initiated IPV.

Without intervention, IPV can pass from one generation to the next, a growing concern since, each year, as many as 10 million children witness IPV. To help break the cycle, Professor Phyllis Sharps, PhD, RN, CNE, FAAN, is assessing the effectiveness of the Domestic Violence Enhanced Visitation Program (DOVE), a community-based, nurse-led IPV prevention initiative. While outcome findings are months away, Sharps is hopeful, since the program enables IPV victims to mobilize resources to escape, stay safe, and keep their babies safe.

According to Glass, the IPV research by JHUSON faculty shows “nurses can make a difference in the lives of IPV victims. Community systems can be created; health care providers can learn the right questions to ask and the right resources for their patients. So many of the changes we’ve seen in IPV-related policy and programs, education, and health care have happened because a nurse cared and took action.”

1 Anya’s story is a fictional case example based on the lives of real women with whom JHUSON IPV researchers have worked and aided over the years. —Teddi Fine

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### Above All, Ask the Hard Questions

**How to ask**

To identify and assist victims of intimate partner violence (IPV), nurses need to ask difficult questions. Creating a nonjudgmental, compassionate environment helps, as does a good sense of timing. Privacy—particularly from the domestic partner—is crucial to a safe environment in which a patient is best able to disclose difficult information.

**What to ask**

- Do you feel safe in your current relationship?
- Within the last year, have you been hit, slapped, kicked, pushed, shoved, or otherwise physically hurt by your partner or ex-partner? If yes, by whom? Do you currently have contact with him?
- Has anyone ever forced you to have sex when you didn’t want to? If yes, who? Do you currently have contact with him?

**How to Help Victims of IPV**

- Use the Danger Assessment (www.dangerassessment.org) to assess level of physical risk— including homicide.
- Help the victim develop a safety plan. Provide information about hotlines and shelters.
- Carefully, completely, and objectively document the IPV in the woman’s own words, in clinical assessment, and in pictures.

**Helpful Information**

- **IPV Danger Assessment Tool**
  - [www.dangerassessment.org](http://www.dangerassessment.org)

- **Maryland Network Against Domestic Violence**
  - [www.mnadv.org/links.html](http://www.mnadv.org/links.html)

- **National Domestic Violence Hotline**
  - 1-800-799-SAFE (7233)
  - 1-800-787-3224 (TTY)
  - [www.ndvh.org](http://www.ndvh.org)

- **National Sexual Assault Hotline**
  - 1-800-656-4673
  - [www.rainn.org/counseling.html](http://www.rainn.org/counseling.html)

- **The Domestic Abuse Helpline for Men (DAHM)**
  - 1-877-643-1120, access code 0757
  - [www.noexcuse4abuse.org](http://www.noexcuse4abuse.org)

- **Centers for Disease Control and Prevention**
A Foot in the Door

In times of economic crisis and low vacancy rates, Hopkins is reaching out to new nurses

The recession won’t last forever, nor will the hospital’s nonexistent vacancy rate, says Karen Haller, PhD, RN, vice president for nursing and patient care services. Even in the current downturn jobs exist, Haller says, but nurses won’t have their pick. Her mantra for one and all: “Get your foot in the door.”

For new nursing graduates, the recession means that they are going to have to look harder, longer, and maybe cast their nets wider when hunting for a job, says Haller.

Throughout the hospital, important allies are finding ways to employ as many new nurses as possible. Nursing leadership, for example, revised a rule to allow grads with Certified Nursing Assistant (CNA) credentials to keep the clinical associate jobs they held as students while waiting for RN jobs to open up.

Karen Davis, MSN ’94, nursing director for the Department of Medicine, took advantage of the rule change to hire several new grads in CNA positions so they held as students while waiting for RN jobs to open up.

The revised policy allowed Allison Murter, MSN ’04, RN, nurse manager for the bone marrow transplant unit on Weinberg 5B, to offer a CNA job to Pete Meagher, an eager new nursing graduate. She reached him in Boston where he was interviewing at another hospital. Pete said, “I’m coming back; I’ll take it,” Murter recalls.

Meagher has already passed the nursing board exams, but started work as a CNA on June 1. “He was holding out for this unit which was phenomenal and makes me very proud,” Murter says. She has also hired another grad in a CNA position who is preparing for her boards.

The new Oncology Functional Unit Nurse Team, established by Suzanne Cowperthwaite, MSN ’08, RN, is a flexible team willing to cover weekend shifts as well as for sick calls and medical leaves of absence on oncology inpatient and outpatient units. The team frees up other nursing staff to precept novices, says the assistant director of nursing in the department of oncology.

“We love to hire nursing students we know and have been on our units,” Cowperthwaite says.

“You know what they’re capable of, and they can have an easier transition into the role.”

Another job creation strategy requires a “divide and multiply” approach. “Every time I get a resignation now, I take that position and cut it in half and make it into two part-time positions,” says Joan Diamond, MSN, RN, a nurse manager in obstetrics. That way, “the nurses get their foot in the door and there are always opportunities for overtime,” Diamond says. “I want to support as many new grads as I can.”

Sherri Jones, MSN ’09, RN, coordinator of nursing programs for the department of surgery, and nurse managers remained committed to new grads although all positions were filled throughout the department. “We decided, ‘Let’s continue to finish interviewing and ask grads if they’d like to be a part of a waitlist.’” Jones and her colleagues drafted a letter to the select few who made the waitlist promising to stay in touch.

The waitlist has been a good confidence builder, Jones says. “We built a lot of trust, and the interviewees felt wanted.”

And sooner than Jones anticipated, the waitlist came in handy: “Come to find out, about four units have had openings.”

—Stephanie Shapiro
Lifting the Haze

When Karin Taylor, a clinical nurse specialist in Child and Adolescent Psychiatric and Mental Health, came to work in the Department of Psychiatry in the mid-1980s, she remembers walking off the elevator and into “a haze of smoke.”

The patients smoked everywhere except in bed. The nurses, including Taylor, a clinical specialist on Meyer 3, also smoked.

Over the decades, the air has cleared on Meyer units as cigarette breaks were gradually restricted. And in February of this year, all of Meyer went smoke-free, courtesy of a campaign spearheaded by Taylor.

“We are doing the patients a horrible disservice by not educating them about the damage caused by tobacco,” says Taylor, who kicked the habit 20 years ago. “For too long in psychiatry, there was the thought, ‘Oh, gosh, these people have lost so much in their lives; we don’t want to take this away from them.’”

But permitting patients momentary relief has long-term disadvantages. Psychiatric patients die 25 years earlier than the general population as a result of medical complications, many of them related to smoking, Taylor says. While primarily a health measure, the ban also eliminated the possibility of violent responses from patients denied daily cigarette breaks granted to others.

Before the smoking ban took effect, Taylor and colleagues led education efforts for staff and patients. Concerns expressed in focus groups that the tobacco prohibition would be unfair or incite violence were allayed. The department’s patient education committee and smoking task force also made sure that admission order sets would provide patients with adequate nicotine patches and gum. Nurses were also encouraged to provide plenty of hard candy, fruit, music, stress balls, and fresh air breaks to help patients cope with withdrawal.

With the imminent smoking ban in the Meyer 1 courtyard and pending legislation to ban smoking on sidewalks around hospitals in Baltimore City, the hospital can look to Psychiatry’s example, says Judith Rohde, ScD, RN, Director of Nursing for Neurosciences and Psychiatry.

—Stephanie Shapiro

Stable Staffing in an Unstable Economy

When this year’s graduating class first entered nursing school, confidence was high. The chronic global nursing shortage promised jobs, flexibility, competitive salaries, and benefits to newly minted RNs. Then the recession hit.

In my 21 years at The Johns Hopkins Hospital, I have never seen turnover as low as it has been this year: less than seven percent in the first nine months of fiscal year 2009, compared to 12 percent the previous year. For the month of May alone, the turnover was less than one percent.

Though the numbers are stunning, they illustrate a familiar pattern: When the economy contracts, nurses stay put to offset household income losses. When the economy is flush, nurses are apt to work fewer hours, accept promotions, or relocate when a spouse takes a new job.

Faced with these new economic challenges, nursing leadership and nurse managers throughout the hospital are devising thrifty and creative ways to avert layoffs and employ as many new nurses as possible.

We have curtailed several premium-pay programs for a savings of $6 million—that translates to 60 nurses who were able to keep their jobs this year. A similar program at the Johns Hopkins Bayview Medical Center saved $3 million and 30 nursing jobs. Neither I nor the nursing directors will receive pay raises this year. The goal, of course, is to hit that balance between saving money right now and preserving what programs we need when the economy improves.

This period of recession and retrenchment offers us opportunities. We’re fully staffed, and can now re-direct the energy we’ve been pouring into recruitment these past years. We can shift our resources into stabilizing programs, making quality improvements, and developing new leadership among our ranks. It’s a welcome time of stable staffing.
The Patient Comes First

New programs empower clinical associates, improve collaboration with nurses

Over the years, Osler 8 nurse manager Sandra Garlic, BSN, grew weary of losing reliable clinical associates because they felt undervalued and overworked. “I’ve seen some excellent CAs come and go on my unit because of their frustrations and not having enough of a voice in decisions,” Garlic says.

As Johns Hopkins nurses increasingly manage computerized records and medication administration, clinical associates have taken on more responsibility at the bedside. It is the CAs who place and remove straight catheters, change dressings, draw blood, take vital signs, administer EKGs and glucometer finger sticks, and frequently are the first to note changes in a patient’s baseline status.

What’s more, experienced CAs stand ready to help new nurses. “I may not be an RN, but I’ve been in codes,” says Theresa Toppin, a CA in Weinberg. “I will be at your back when a code happens, even if you don’t know what’s going on or this is the first code you participate in. I’m strong enough to be behind you so that your patient won’t know that this is the first code you ever participated in.”

Despite the wealth of experience and support Toppin and other clinical associates contributed to a unit, they were often left out of daily reports and their opinions were frequently ignored. Nor were CAs equipped to lobby on their own behalf.

Through a host of initiatives, nurse managers and their colleagues throughout Johns Hopkins have enlisted the clinical associates in a campaign to boost their confidence and stature in the workplace. It is a continuing effort that demands new protocols, as well as mutual respect, essential to teamwork. The solution is not “just putting tools in place that mandate what’s going to happen,” stresses Pat Sullivan, MS, RN ’77, a nurse manager on Meyer 3. “It’s changing the culture.”

When CAs from Osler 8, Meyer 8, and Nelson 7 gather for meetings of the SOARING program, the proceedings begin with I Believe I Can Fly, the group’s theme song. In 2002, Garlic established SOARING, based on the principles of Success, Ownership, Accountability, Respect/Responsibility, Independence, iNtegrity, and Growth. At these meetings, Garlic and hospital nurse educator Margo Preston Scott, MSN, RN, cover the basics of conflict resolution, communication strategies, prioritizing, how to avoid chronic absenteeism, and other skills. Once SOARING launched, Scott took the lead, preparing lesson plans, giving presentations and inviting guest speakers. Increasingly, Garlic and Scott have given CAs the floor to make presentations as well. “Sandra and I want this to be their meeting and to feel good they’ve been at SOARING even if there’s tough stuff to talk about,” Scott says.

Garlic, who will receive her MSN from Johns Hopkins University School of Nursing in December, and Scott advocate on the behalf of CAs with nursing staff, while also urging them to solve problems on their own. Program participants recognize that “they’re the best advocates for themselves,” Garlic says. “Now, nurses respect their opinions, because they’ve learned what a CA can do and listen to them.”

Motivated by new-found confidence, Christine Wilson and April Rufus, both CAs on Osler 8, developed a protocol and visual aid for novices learning how to suction patients. After approval by Garlic, the protocol was introduced to the unit during an in-service training by Wilson and Rufus. Without SOARING, “We probably would have discussed the suction protocol among ourselves [and left it at that],” says Wilson, who is enrolled in an RN program at the Community College of Baltimore County.

Though skeptical at first, Phyllis Oseni, another CA on Osler 8, found that participation in SOARING paid off in very practical ways. “We did a skit one time about how your

It is the CAs who place and remove straight catheters, change dressings, draw blood, take vital signs, administer EKGs and glucometer finger sticks, and frequently are the first to note changes in a patient’s baseline status.

Meanwhile, a systems analysis told Sullivan, Meyer 3 nurse manager, that poor communication between nurses and CAs assigned to observe high-risk patients
jeopardized everyone’s safety. Clinical associates on Meyer 3 often spend most of their shift observing and interacting with patients at risk for suicide. And yet, Sullivan says, “They’re not used to contributing in rounds, because they have felt like nobody’s listening to them. Some of it is self-perception, not believing they’re important. We try to bring them in and support their efforts.”

Sheila T. Johnson, a CA for 21 years, helped to revise a patient report sheet to ensure critical information is updated shift to shift based on behavioral observations made by CAs. Johnson contributed to the effort as a member of a multidisciplinary task force that included Sullivan, nurse clinicians Karin Taylor, PMHCNS-BC and Elizabeth Scala, IIE- PACE, as well as a PI team leader and attending physician.

Designated by her peers as one of the unit’s “lead CAs,” Johnson now works hand in hand with the charge nurse, participating in daily milieu rounds and reports. “To know you’re being heard and something’s being done about what you’re saying makes you feel like you’re really part of the team,” she says.

Marian Richardson, MSN, RN, AOCN, a nurse manager in the Department of Radiation Oncology, has always valued the role played by the CAs throughout Weinberg and sought ways to build upon their enthusiasm.

When communication faltered between nurses and clinical associates in various Weinberg departments, experienced CA Roslyn Watson approached Richardson with a plan to hold educational seminars for her peers.

“I just saw what was needed on the floors,” Watson says. “Talking to Marian, I knew the nurses and CAs needed to be a team and that’s my goal, to make all of us a team.”

Richardson readily agreed to support Watson’s efforts, which began with building morale among her peers. “The CAs play a vital role in the functioning of our clinics,” Richardson says. “We wanted to recognize their contribution and provide educational meetings to enhance their skills.”

In less than a year, Watson and a committee of other experienced clinical associates have established a monthly series of seminars where CAs learn communication and coping skills, participate in training programs and receive information about educational opportunities. Last October, Weinberg clinician associates also held the first “CA Week,” complete with health screenings, massages, and guest speakers.

“Basically, our whole idea for this program is that the patient comes first,” Watson says. “No matter how hard the job is, the patient comes first. And everyone’s going to be a patient one day.”

—Stephanie Shapiro

April Rufus, a clinical associate on Osler 8, helped develop a protocol and visual aid for novices learning how to suction patients.
Staying Motivated Beyond the First Step

The nurses who lead the First Step Day Program on Meyer 2 understand that treating a patient’s addiction is only part of the journey toward recovery. The 12-year-old program also provides comprehensive health care and psychiatric treatment—a multi-pronged approach rarely found in other day hospital programs.

What sets First Step apart even further is the attention the staff—nurses, therapist, and outreach workers—pays to the needs of patients as they complete the program and transition back into the community. By helping clients procure birth certificates Medicare, food stamps, and other necessities, the nurses go beyond the call of duty to make sure that each patient is discharged with a social safety net.

The team of six has also built a strong relationship with the housing facilities where First Step patients live, often advising dorm supervisors on medical concerns. “It’s not just a 12-hour a day program,” says Debbie Ekonomides, RN, who often takes those late-night calls from dorm supervisors seeking guidance. “We work around the clock.”

To be admitted to First Step, patients, referred by consultation services on all medical floors, must demonstrate motivation for recovery. They typically remain in the program for up to 28 days, but First Step nurses follow up as patients graduate to the Program for Alcoholism and Other Drug Dependencies.

When alumni return for Monday meetings, still clean 18 months out, the First Step team’s 24/7 effort is rewarded. Those visits, says program coordinator Patti Burgee, RNC, CARN, “keep us motivated.”

—Stephanie Shapiro

Gatorade, Free of Charge

When Renay Tyler, MSN ’05, ACNP, CNSN, RN, and her husband John got out a map and drew a circle through all points within a two-hour radius of Towson, they were contemplating convenient locations for a weekend retreat.

“If we’re going to buy another property, it should be something that we can enjoy and afford,” said Tyler to her husband. She wasn’t exactly looking for a second job.

Within that circle, though, was a charming variety store on milepost 76.5 of the C&O Canal National Historical Park. The store, attached to an old cabin, was for sale. Both Renay, an assistant director of nursing for advanced practice in the Department of Surgery, and John, an administrator with the Veteran’s Administration, were plenty busy during the week. Still, the shop, for 40 years a popular stop for towpath travelers and boaters, beckoned.

In 2006, the Tylers bought Barron’s Store at Snyder’s Landing, near Sharpsburg, MD. The couple’s decision to keep the store open and fix the property pleased original proprietor Lee Barron who was nearing 80 and ready to retire.

Now, on weekends from spring through fall, the Tylers continue the Barron’s tradition. “We sell cold drinks, granola bars, penny candy, and we have ice cream,” says Renay Tyler. Enrolled in the new doctor of nursing practice (DNP) program at the Johns Hopkins University School of Nursing, she does homework and works on performance appraisals during lulls in business.

And in some ways, Tyler’s weekend job is not unlike her weekday job. In both, “I’m engaged in meeting people and finding some common ground, whether it’s a customer or a colleague,” she says. “It’s more than just selling a soda and more than just giving a performance appraisal.”

Occasionally, Tyler’s nursing skills come to the rescue. “We’ve had a few kids who spin out over their handlebars and cases of dehydration when it’s unseasonably warm,” Tyler says. Those patients get a Gatorade, free of charge.

—Stephanie Shapiro
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Noted With Pride

Mary Ellen Wilson was awarded the “Maryland ACEP Emergency Nurse of the Year Award.”

Margo Preston Scott, MSN, RN, Nurse Educator (GRAD YEAR) was nominated for recognition as a “Trailblazer” by the Associated Black Charities. She was nominated by Morton M. Lapides, Jr., School President of the iWORKS Learning Center, Inc.

Jaimie Stafford, RN, represented Johns Hopkins Nursing in the Hugh O’Brien Youth Leadership Program (HOBY), where she discussed the rewards of a nursing career with sophomore high-school students. The event was held at St. Mary’s College over Memorial Day Weekend.

Aiko Kodaira, RN, MS, OCN; Mikaela Olsen, RN, MS, OCN; Judith Karp, MD; Rajashree Pakala, RD; Kathy Piercy, RD; Karen Mackey, BSN, RN; Kelsey Oveson, BA; Frances Chandler, MSN, RN; and Meghan Lopez, MSN; RN received the The Shirley Sohmer Research Award for their study, “The Determination of the Most Appropriate Diet in Leukemia Patients Receiving AcD-Ac Consolidation Chemotherapy” in which they evaluated the diet protocol that has been used for 20 years at the Kimmel Cancer Center at Johns Hopkins.

Dawn Luzetsky, MSN, RN; Nancy Stanley, RN; Annette Perschke, MSN, RN, CRRN; E. Robert Feroli, PharmD, FASHP; and Peter Doyle, PhD also received the The Shirley Sohmer Research Award for “Examining and Reducing Distractions and Interruptions During Medication Administration: A Translation Study.”

The Nursing Publication Award was given to Sandi Dearholt, MS, RN; Kathleen White, PhD, RN, NEA-BC; Robin Newhouse, PhD, RN, NEA-BC, CNOR; and Linda Pugh, PhD, RNC, FAAN; Stephanie Poe, MSN, RN for the publication, “Educational Strategies to Develop Evidence-Based Practice Mentors.”

The Pediatric IV Response Team of Radiology Nurses received the The Shirley Sohmer Research Award for their study, “The Determination of the Most Appropriate Diet in Leukemia Patients Receiving AcD-Ac Consolidation Chemotherapy” in which they evaluated the diet protocol that has been used for 20 years at the Kimmel Cancer Center at Johns Hopkins.

Nurses Week Awards

Kelly Caslin, BSN, RN and Neysa Ernst BSN, RN of Osler 4 received The Linda Arenth Award for Innovation in Service Excellence for initiating “Frequent Vitals” at the weekly staff meetings to review their patient satisfaction scores and target areas for improvement.

Journal Articles

American Society for Peri-Anesthesia Nurses (ASPAN) Safety Tool Kit, 2009
Dina A. Krenzischek, Pamela Windle, Maureen Iacono, Jennifer Allen, Tanya Spiering, Theresa Clifford, Becki Hoyle, Chris Price, Cindy Ladner

Breast Cancer Research and Treatment

“Promoter Hypermethylation in Sentinel Lymph Nodes as a Marker for Breast Cancer Recurrence”
Hetry Carraway, Shelun Wang, Amanda Blackford, Minghao Guo, Penny Powers, Stacie Jeter, Nancy Davidson, Pedram Argani, Kyle Terrell, James Herman, Julie Lange [March 2009]

Breast Care

“Invasive Lobular Carcinoma of the Male Breast: A Rare Histology in an Uncommon Disease”
Susanne Briest, Russell Vang, Kyle Terrell, Leisha Emens, Julie Lange [February 2009]

Frontiers of Health Services Management

“No Falling Through: Using Handoffs to Improve Patient Care”
Paine, L and Millman, A. [Spring 2009]

Gastroenterology Nursing

“Confocal Laser Endomicroscopy: in Vivo Endoscopic Tissue Analysis”
Christine Smith, Jeanette Ogilvie, Laurie McClelland [September 2008]

Issues in Mental Health Nursing

“Crisis Prevention Management: A Program to Reduce the Use of Seclusion and Restraint in an Inpatient Mental Health Setting”
Maureen Lewis, Karin Taylor, Joyce Parks [March 2009]

Journal of Nursing Care Quality

“Evaluation of Quality Improvement Initiative in Pediatric...”
Oncology: Implementation of Aggressive Hydration Protocol
Lisa Fratino, Denise Daniel, Kenneth Cohen, Allen Chen [April-June, 2009]

Journal of PeriAnesthesia Nursing
“Pharmacotherapy for Acute Pain: Implications for Practice”
Dina Krenzischek, Colleen Dunwoody, Rosemary Polomano, James Ruthwell [February 2008]

Journal of PeriAnesthesia Nursing
“ASPAN’s Delphi Study on National Research: Priorities for PeriAnesthesia Nurses in the United States”
Myrna Mamaril, Jacqueline Ross, Ellen L Poole, Joni M Brady, Theresa Clifford [February 2009]

OR Nurse
“The SGAP flap for the Post-mastectomy Patient”
Frances Bayne, Courtney Edwards, Svetlana Filer [May 2009]

Patient Safety
“A Novel Process for Introducing a New Intraoperative Paradigm for Mitigating Hazards and Improving Patient Safety”
Jose Rodriguez-Paz, Lynette Mark, Kurt Herzer, James Michelson, Kelly Grogan, Joseph Herman, David Hunt, Linda Wardlow, Elwood Armour, Peter Pronovost [January 2009]

Book Publications
Chemotherapy and Biotherapy Guidelines and Recommendations for Practice, 3rd Ed.
Polovich, M, Whitford, JM, Olsen, M (Eds.). Pittsburgh: Oncology Nursing Society [2009]

Hopkins Nursing Contributors: Joanne Finley, MiKaela Olsen, Janet R. Walczak [2009]

PeriAnesthesia Nursing Core Curriculum
Chapter 8
Elsevier Health Sciences, 2009
Dina A. Krenzischek

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Teaming Up
New OB Stat Team Responds to L&D Emergencies

A new, interdisciplinary OB Stat Team at Howard County General Hospital is engaging in intensive drills to help avert and respond to issues that may arise during pregnancy, childbirth, and puerperium.

“The biggest benefit of having such a team is the comfort level of the staff and physicians,” said Digna Wheatley, MHA, RN, Risk Manager at Howard County. Introduced in January 2009, the OB Stat Team went live after conducting a series of four drills over the course of three months. “By practicing the skills necessary for difficult situations early on, they can truly be ready in an emergency.”

The OB Stat Team provides early intervention and stabilization for obstetrical emergencies throughout the hospital. Subdivided into teams Alpha and Bravo, the Team responds quickly, arriving on location in five minutes or less when an emergency situation arises.

Team Alpha, paged for most OB emergencies, is comprised of a labor and delivery charge nurse, anesthesiologist, obstetrician, obstetrical technician, pharmacist, unit secretary, respiratory therapist, lab personnel, and security. A chaplain is also part of the team, acting as a liaison between the patient’s family and the team itself.

For life-threatening emergencies involving antepartum/postpartum hemorrhaging, the Bravo Team is called. The group includes members of the Alpha Team plus eight additional staff, including a second anesthesiologist, neonatologist, pathologist, and Gyn/Oncologist.

Since going live, the team has answered six calls, and each emergency is another learning experience. For example, when the team recently received a call that a woman was going into labor in the lobby, they raced down the stairs to meet her—only to discover that the mother had been placed on an elevator going the opposite direction.

Such instances are documented by the primary staff nurse in both the medical record and OB Stat Team record. The charge nurse then completes a summary report to be reviewed in a later debriefing session.

“How could we improve communication?” By reassessing past situations and holding followup drills every six months, the team constantly strives for improvement and preparedness for the next obstacle ahead.

“Through the collaboration efforts of various disciplines, the team will have the resources necessary to overcome numerous obstacles,” said Judy Brown, MAS, RN, Senior Vice President of Outcomes Management at Howard County. “Every group has a role and we all move in concert.”

—David Biglari
Maintaining a consistent nursing staff is essential to providing high quality patient care. But in recent years, Maryland hospital units suffered from high nursing turnover rates. At the Johns Hopkins Bayview Medical Center’s Surgical Intensive Care Unit (SICU), the turnover rate reached 35 percent in 2005.

In January 2008, the Maryland Hospital Association (MHA) responded with the creation of the Nursing Retention Collaborative, an 18-month project spanning 26 hospitals, designed to help reduce voluntary turnover to five percent or less on an ongoing basis.

Carol Miller, RN, BSN, CCRN, patient care manager of the Bayview SICU, had just started her new position when she was asked to manage and organize her unit’s participation in this new collaborative.

“It was a lot of work,” Miller recalls, “and a lot of data collecting.”

Miller distributed surveys to the nurses in SICU to help assess qualitative performance. Unlike previous surveys, which ranked satisfaction on a “1–5” scale, nurses were asked to write narratives describing the nursing environment on their unit—what worked, what didn’t work, what they liked, and what needed improvement.

It didn’t take long for Miller to see a common thread in the survey responses: SICU nurses needed to improve their communication with one another.

“We started off putting an easel in the break room, where people could leave positive comments at the end of their shift,” Miller said. “Unfortunately, people were writing comments about the messes people were leaving behind, and so on.”

To better communicate about staff responsibilities, one of the charge nurses developed a room check sheet that covered the bare essentials of what needed to be done at the end of each shift. The checklist worked so well, it was shared with other units in the hospital.

In light of the success of the checklist, a daily goal sheet was developed and filled out by the charge nurse as a way of measuring whether the unit was meeting its goals. It too was adopted by other units.

The room checklist and daily goal sheets were a good first step. But another reason staff turnover was high, according to Advanced Clinical Nurse (ACN) for Education Lynda Hodges, RN, BSN, CCRN, was personality conflicts.

“There were a lot of assumptions being made due to a lack of communication,” Hodges said. “Everyone seemed to be on the defensive because of a look, or something that was said and taken the wrong way.”

Communication sessions, led by human resource representatives, offered insight into effective communication methods and conflict management.

“We learned about constructive feedback, and that it’s okay to disagree, but more importantly, how to come to a resolution,” Miller said. “It was well-received.”

The result? Fewer complaints about communication styles, high SICU scores on the Safety Attitude Questionnaire (SAQ), and zero catheter associated bloodstream infections for the past 16 months. To date, the SICU turnover rate has dropped from 27 percent in 2008 to 18.4 percent.

—Jonathan Eichberger
Brutal Cold, Warm Care
Annie Lee, MSN/MPH ’09

Growing up, Annie Lee, MSN/MPH ’09 thought that 55 degrees was cold. But this winter, when she arrived in Unalakleet, Alaska for a clinical rotation as part of her MSN-FNP/MPH program, the temperature was –30 and falling. “It’s freezing cold,” wrote Lee in an e-mail to her family. “Alaska is where I discovered that people keep their cars plugged in at night to keep the engine warm, leave the car running when they run into the store, and wear snow cleats to prevent falls.” It is also the place where she reached patients by trudging through snow drifts in a fur parka, ogled the Northern Lights from a medevac flight, and mourned the death of a woman on a tiny island in the Bering Sea.

Friday, January 16, 2009
My day today was pretty random and funny. It ranks up there with the time I took Kapwera lessons and made a complete idiot out of myself. Things I did today:

1. Saw a patient (since that is why I am in Alaska). That’s right, a 9.5 hour day at the clinic and I saw one patient. I guess when the weather gets bad, no one goes outside...
2. Tried reindeer sausage (leaner than pork, but isn’t everything?)
3. Was told stories about “the time I shot a bear” or “the time I had to medevac” by the 60+ year old women who work at the clinic.
4. Practiced excising moles and suturing on thawed out chicken (because no one came in with a laceration or volunteered to lacerate him or herself for the sake of my learning).
5. Practiced reading various x-rays.
6. Ate muktuck (whale blubber). I had the blubber of a Bowhead whale. Very “chewy” and rubbery. I can’t say that I would eat it again. Definitely not lean.
7. Went to a “restaurant,” Peace on Earth. It looks like someone’s garage with folding chairs and tables with plastic tablecloths on top. Not only is it a pizza place, it also sells instruments, sunglasses, and wetsuits, and is also a beauty salon (now offering piercings and acrylic nails).
8. Went to a Tae Kwon-Do exhibition by some Korean college students. Afterwards, the Koreans (all of whom were male) scrimmaged against the local high school girls’ basketball team.
9. Responded to an on-call! Luckily, my preceptor and I stayed at the game because there was an injury—a girl came down and rolled her ankle with impressive swelling. After an initial assessment and splint at the school gym, my preceptor and I raced back to the clinic on his snowmobile to warm up the x-ray machine while the patient and health aides followed by the school van.

“I find myself forlorn,” Lee wrote at the end of her trip. “I am coming to know and love people and places and then I leave. This makes me wonder if it is us, the ones who ‘serve’ the community, that benefit more than those being ‘served.’”

View more photos and read the complete collection of Lee’s correspondence from the Arctic Circle at www.nursing.jhu.edu/lee.
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