



How New Grads SPRING Forward

WHEN IT COMES TO nursing, it's personal for Caroline Umana. She chose the profession because her father had a massive heart attack and was saved by a Hopkins cardiologist and excellent nurses. When she landed her first job on Nelson 3, she was, by her own admission, "pretty naive" and, also, a nervous wreck. On her first night at work, she got physically ill and experienced her first code. Within the first month, she had a new nurse manager, and three months later she was one of three nurses for two dozen patients during a blizzard. She seriously began rethinking her decision to become a nurse. "The staff on my unit wasn't sure, nor was I, that I would be able to handle it all," says Umana.

Ten months later, Umana was telling her story to an audience of her peers, her unit preceptor and nurse manager at her graduation from Hopkins' SPRING program, the year-long internship that helps new grads transition into their first professional role as a nurse.

The formal part of SPRING (Social and Professional Reality Integration for Nurse Graduates) consists of a series of classes held throughout 12 months. They cover topics that most new nurses are eager to learn more about, from "Code 101" to end-of-life issues. But groups also talk about "the problems that can arise around scheduling, delegating, assertiveness, even balancing home and work," says Jeannette Sufлита, director of the program.



On Oct. 17, Caroline Umana, second from left, and her fellow interns celebrated the conclusion of their year-long orientation.

Those are also the sorts of issues that occupy SPRING's nurse educators, who have specialized expertise in mentoring new grads during their first-year transition. They spend a quarter of their time rounding and checking with preceptors and other unit leaders on the interns' progress.

As anyone who's done it knows, the first year of nursing is "really, really tough," says Barbara McGuinness, the nurse educator for

the Department of Medicine. Particularly at Hopkins, "you have a lot of people who come from other places, small towns or other communities, to a big, urban inner-city hospital." Plus, the amount of knowledge interns need to gain in the beginning is "huge."

The nurse educators report that they help many interns to balance work and personal life. "They may have children, and they didn't realize their work schedule was going to take time to adjust to," explains Susan Sartorius-Mergenthaler, nurse educator for oncology. "We tell them, Pull in your resources; don't think you can do this alone."

Still, Sufлита says, the nurse educators don't solve interns' problems for them. They "talk it out, give them some ideas, role-play with them and serve as personal coaches."

That kind of encouragement is important to retain new nurses. From 2002, when SPRING began, 757 interns have joined the program, 457 have completed it and 201 are still participating.

"That," says Sufлита, "is a great return on investment." ■

SPRING Stats

- From 2002 to 2005, only 35—out of nearly 500—interns transferred to other units; only 10 of the 35 have left the organization.
- The largest group to date—63—was hired in July.
- SPRING is supported by a grant from the Health Services Cost Review Commission.
- Designed for Hopkins by the Department of Nursing's Staff Education Committee, SPRING was cited by the American Hospital Association in 2003 as a Health

Care Workforce case example of Ideas in Action on hospitalconnect.com, which features examples of innovation that are already working across the nation and that could make a real difference in an organization.

- The one-year retention rate for the program as a whole is nearly 90 percent (compared to 40 percent to 65 percent as cited nationally in the literature). ■



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VITAL LINES



I finally did it. I am now certified in advanced nursing administration. After months of practicing, I conquered my nerves, took the American Nursing Credentialing Center's certification exam and passed.

This test was not easy. But if it were, it wouldn't mean anything. Nursing certification recognizes professional achievement in a specialty practice. It signifies attainment of a high level of knowledge and skills. It reassures our patients, improves quality of care and reminds us of the foundations of our practice.

It's also the one area where we're lagging behind our Magnet colleagues. The ANCC notes that the average number of certified direct-care nurses among Magnet hospitals is nearly 22 percent. Only about 8 percent of our eligible nurses are.

But getting certified is not just about institutional excellence. It's about personal and professional excellence. It's an opportunity to increase your credibility among peers, to validate your expertise and solidify your professional confidence. Nurse managers say they would hire a certified nurse over one who was not certified if all else were equal.

Professional organizations such as the Oncology Nursing Society and the ANCC offer certification exams. Details about how to apply, how to prepare and even sample tests are posted on each organization's Web site. I encourage you to join me!

Karen Haller
Vice President for Nursing

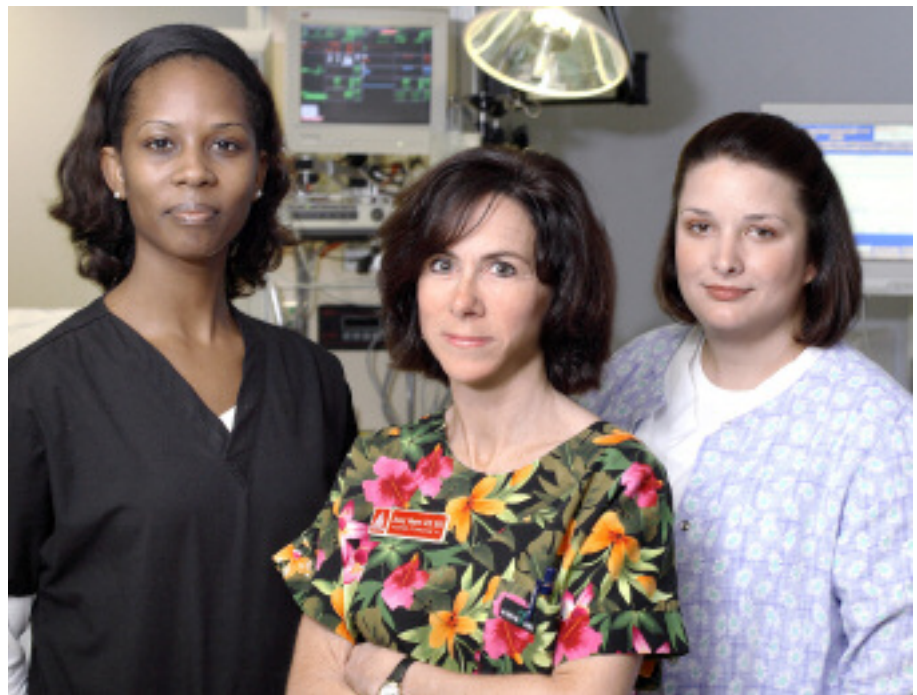
At the Fulcrum of Care

JENNY MOYER remembers well the elderly gentleman's dedication to his critically ill wife. Every day for two months, he came to his wife's room on the cardiac surgery intensive care unit to sit by her side. Gradually, Moyer and other caregivers noticed that he was wearing the same clothes every day and that he never ate. Slowly, his vigilance turned to weariness.

Then the care team learned that he was uncomfortable eating a meal in the room while his wife was being fed through a tube. "So we ordered an extra meal, and the nurses took turns eating with him," recalls Moyer, a nurse clinician III on the CSICU.

This small, poignant interaction illustrates the "total care management" model that Hopkins Hospital has employed for nearly eight years. Its premise is to make everyone who touches patients and their families a vital link in delivering efficient medical treatment, relying on nurses to provide the care coordination.

That multidisciplinary approach to patients has lowered such hospital indicators as length of stay and cost per case. As a result, the University HealthSystem Consortium recently recognized



Multidisciplinary care coordination here has been cited as a national model thanks to the work of nurses throughout the Hospital, including, from left, the CSICU's Shanta Robinson, Jenny Moyer and Christina Savage.

the Hopkins model as one of the top three in the country.

The Hospital consistently exceeded national standards, according to the UHC's care coordination benchmarking project. For example, Hopkins (and the other top performers, Harvard's Brigham and Women's Hospital and Toledo's Medical University of Ohio) exceeded length of stay expectations (0.97 compared to the target of 1.0 and the national average, 1.03), meetings with spouse, family or significant other within seven days of admission (93.4 percent compared to target of 94 percent and national average of 53.2 percent), and detailed discharge instructions (97.4 percent compared to target of 100 percent and national average of 61.6 percent).

The Hopkins model came out of a need to improve the quality and cost efficiency of caring for patients, from admission to discharge. The prevailing opinion was that everyone, from attending physicians to residents and from respiratory therapists to social workers, had to work as a team in treating patients.

But these caregivers rotate in and out during a patient's hospital stay, so the responsibility of coordinating care and constantly screening for changing patient needs rests with the bedside nurse. On some units, this pivotal role falls to the nurse clinician III; on others it might be the nurse practitioner. But whatever the title, as Assistant Nursing Director Terry Nelson puts it, "the nurse is the one constant presence." ■

Noted with Pride

The 2006 annual Nursing Awards were presented in May during Nurses Week to Elizabeth Zink and Karen McQuillan, neurosciences (*Nursing Publication Award*); and Karin Taylor, Kristine Mammen, Joyce Parks, Maureen Arthur Lewis, Ann Murdock, Karen Abernathy, Bernard Vincent Keenan, Katherine Collins and Tina Cubeta, psychi-

atry (*Shirley Sohmer Research Award*).

Elizabeth Berg, pediatrics, has been named Ground Transportation Nurse of the Year by the Air & Surface Transport Nurses Association.

Dina Krenzischek, anesthesiology, has received the 2006 Presidential Award, the American Society of PeriAnesthesia Nurses'

highest honor.

Janet Orlin, oncology, was named the 2006 top national winner of the Student Nurse Cherokee Inspired Comfort Award.

Lisa Rowen, surgery, is editor in chief of the new journal *Bariatric Nursing and Surgical Patient Care*. Renay Tyler, surgery, is associate editor. ■

Indispensable Partners

IT'S MONDAY MORNING on the medical intensive care unit, and here comes an unneeded bag of amiodarone. Nurse clinician II-M Leah Dickerson, who's already given her patient the prescribed bolus of the antiarrhythmic, marks the medication for return to the pharmacy. But, unwilling to simply let it go at that, Dickerson takes an extra few seconds and walks to a computer work station near the back of the MICU.

"Just FYI," she begins. No rancor. No attitude.

Leah Trimble, the unit's point of care pharmacist, is in the thick of double-checking the morning's medication orders and ensuring that they're entered correctly in the pharmacy computer, but she immediately turns her attention to Dickerson. Then, toggling to a different view on her monitor, Trimble nails the amiodarone problem and calls the Carnegie 6 pharmacy one floor below. Matter of factly, she points out the importance of checking an order's date, a reminder that the rookie pharmacist there is now unlikely to ever forget.

On a 16-bed unit where 90 percent of the patients are intubated,

where medication orders average nearly 100 per day and using every central line port is routine, this nearly invisible incident might seem to be the nth degree of trivial. And that, says nine-year veteran MICU nurse Shilta Subhas, is exactly the point: "I remember what it was like not to have a point of care pharmacist here—I would have to talk to five people to get the same result Leah Trimble gets with one quick call."

BY 1999, THE SAME YEAR THE Institute of Medicine issued its report on the high incidence of medical errors and cited better communication among caregivers as a prime remedy, Hopkins was already moving away from the old "pharmacist-in-the-basement" model that had prevailed as long as anyone could remember. Adopting instead a decentralized approach, the Hospital, medical staff, and departments of Pharmacy and Nursing joined forces to redesign pharmacists' roles in the highly complex medication use system and bring their knowledge directly to the bedside. Nurses "got it" instantly.



For the Hospital's tiniest patients, Carol Wesolowski and Schelly Webber say sharing their knowledge has become second nature.

"We embraced our point of care pharmacist with open arms," says Subhas. "Getting the drugs we need here used to be a huge issue, and every time you don't have a drug for your patient, it's extremely frustrating. Now, the right drug gets to the right patient much faster."

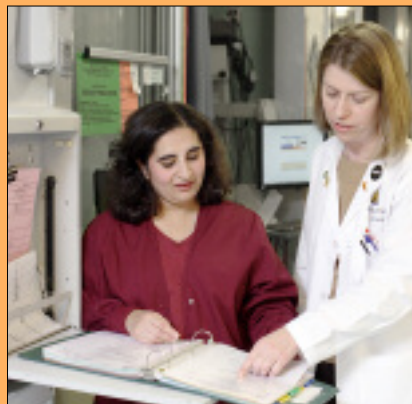
One reason Leah Trimble and

Hopkins' 22 other point of care pharmacists are so adept at smoothing drug-delivery glitches is that, in addition to their roles covering one to three units during the week, they also work every third weekend and some nights in one of the Hospital's eight inpatient pharmacies. And with a foot in each

LET'S TALK ABOUT IT

When clinical pharmacy specialist Annette Rowden joined the medical intensive care unit in spring 2000, her deep knowledge of drug actions and interactions quickly earned the respect of the physicians she began rounding with every morning. No question they put to her was too tough. "What they didn't expect," she says, "was that I had questions for them. I think they were a little surprised."

The Hospital's determination to provide safer care, coming as it does amid a nationwide shortage of both nurses and pharmacists, has prompted increasing recognition that the old, separate silos of medicine, nursing and pharmacy aren't in patients' best interests.



Shilta Subhas and Annette Rowden confer on the MICU.

Rowden is one of about 18 clinical pharmacy specialists at Hopkins—some working exclusively on a single unit, as she does; oth-

ers covering an area such as pediatric oncology—who've completed specialized pharmacy residencies and are experts in the therapeutic use of medications. Her daily presence, says Shilta Subhas, MICU clinical nurse specialist and facilitator of the unit's Clinical Practice Committee, brings an invaluable dimension to even the thorniest of medication use issues. Working with physician members of the committee, for example, Subhas and Rowden have helped create or revise protocols for administering heparin, insulin drips, activated protein C for sepsis, and sedation, which is ordered

for some 90 percent of MICU patients.

"Annette's input is tremendous," Subhas says. "She also helps us figure out the best way to get the drugs here, which ones we should stock. We've learned a lot about how Pharmacy works."

And Rowden, who championed the practice of the MICU's nurses presenting during multidisciplinary patient rounds, is quick to point out that the learning is mutual. "Pharmacy will never know as much about the actual status of the patients as the physicians and the nurses," she says. "The nurses are the ones who can give an up-to-the-minute summary. Everything they say is important." ■



handwritten orders and the slow-downs they can cause for Pharmacy, also has quirks. One, says Trimble, is that it defaults to certain times, and if prescribers aren't specific, it could be six hours before the drug arrives. To prevent these and other delays from interfering with patient care, Trimble has been known to sprint to the pharmacy and retrieve the needed medication herself.

Yet her trouble-shooting to keep nurses off the phone is only part of the benefit. "There's a subset of medications that MICU nurses use all the time," says Subhas, "but many of our patients not only have the acute medical problem that brought them here but ongoing diseases such as diabetes or congestive heart failure as well. So we do take care of patients who would more typically belong on the cardiac unit or neuro ICU. That's when we really rely heavily on the pharmacist."

Questions span the expected gamut—dosing, side effects, compatibility, monitoring—but also go to tough administration issues: Can we switch from IV to oral? Can this be crushed and given through a nasogastric tube? Being on hand to actually see the patients and talk to the nurses face to face means that Trimble can tailor her answers on the spot. Her proximity also builds trust. "The nurses use me a lot," Trimble says. "We have a good rapport. They know they can ask me anything."

PERHAPS NOWHERE IN THE Hospital is hand-in-glove collaboration between Nursing and Pharmacy more evident than on the 45-bed neonatal intensive care unit.

domain, they know firsthand the issues facing both nurses and pharmacists.

"Missing doses are a standard problem," says Trimble, "and there isn't one, easy solution." The pneumatic tube used for speeding stat deliveries from pharmacy to unit, for example, seems on occasion to have a mind of its own. "Pharmacy sends the order," Trimble says, "but it doesn't show up, and no one knows where it went."

The new Eclipsys provider order entry system, which eliminates



MICU point of care pharmacist Leah Trimble helps nurses provide safer, quicker care.

MAGNETIC PRACTICES

Survey Stars

Of the 70 Department of Nursing units that participated in the 2005 National Database for Nursing Quality Indicators survey, 12 scored in the top quartile for more than five subscales. In August, their nurse managers met to discuss the secrets behind those scores. Led by Patty Dawson, the Hospital's Magnet and quality outcomes coordinator, the group uncovered several common themes:

- Strong unit identities and clear unit visions
- Staff ownership of and investment in the vision
- Closely knit teams who work and play together
- Managers who make personal connections with staff, while supporting professional development and autonomy

Many said they based their strong identities around their specialty function or patient populations, such as Osler 8, which cares for HIV/AIDS patients. But Dawson points out that even the units without a clear-cut niche proved they could still build strong work-groups—by celebrating both professional and personal contributions, aspirations and achievements. "Several units focus on the benefits of a diverse staff," she says. "And many mentioned that their teams socialized together frequently, whether it was for a holiday, a birthday or a book club."

Kudos to the top-scoring units: CMSC 4, Harriet Lane Primary Clinic, PICU and Peds RR (pediatrics); Meyer 3, 4 and 6 (psychiatry); Osler 4, 5 and 8 (medicine); Weinberg 5A (oncology), and JHOC procedures (outpatient). ■

Patients here can weigh as little as 500 grams; their conditions range from the lung disease and gastrointestinal problems typical of prematurity to cardiac and surgical issues, GI anomalies, sepsis and hypoxic ischemic injury. Their medication requirements are unique, even for the Children's Center.

"Our doses are so small, so different from everywhere else," says nurse clinician III Schelly Webber. "We have to be meticulous in checking and double-checking everything, no matter what the computer says."

Because the pediatrics pharmacy sits right around the corner and was Carol Wesolowski's home base for most of her 16 years at Hopkins, she began functioning as the NICU's point of care pharmacist even before the role was formalized. "There's always been a close relationship," says Webber, herself on the job for 19 years. "Carol is a tremendous resource. She's very familiar with what we need and she makes sure that we get it. If I had to start a dopamine drip right now, I could speak to Carol and know it would be taken care of instantly."

Wesolowski spends most of her time on the unit, processing medication orders and fielding questions from nurses and physicians that range from simple missing-dose requests to complex inquiries concerning IV compatibility, dosing and metabolism. Yet policies

and procedures, which she reviews with Nursing to assure accuracy and improve the safety of drug administration, are also among her prime responsibilities. "I'm always looking for ways to improve things," she says, "and make it safer for the babies. The unit joined with Pharmacy to put together a handy reference on drug compatibilities, for example, and in a three-way team effort involving physicians, nurses and pharmacists came up with a solution for working with a morphine drip calculator program that was geared toward doses more typically used in older children.

"In nursing school, pharmacology was part of what I learned," says Webber. "So I really rely on Carol to help make the system work the way it needs to—it's a very collaborative process."

Still, the benefit to patients doesn't come only from the knowledge that pharmacists bring to the equation. Decisions that Wesolowski makes every day in the NICU, she says, are informed by the insights the nurses readily share: "It's seeing the set-up of that particular baby and talking face to face that helps me make better pharmacologic decisions. I could give an answer from a book without getting feedback from the nurse, but it might not be the best answer for that particular baby. NICU nurses help me know the patients, and that helps me do my job better." ■



Journal

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TEAM TRAINING

The health care environment presents significant risk of errors leading to patient injury and harm. One method to promote patient safety involves improving team coordination. The MedTeams training program, a nationally funded research project, provided the framework for team training in several labor and delivery units in the United States. Changing a culture and integrating team training skills take significant commitment and patience, and many challenges were confronted when team training was implemented. Strategies to ensure success are discussed.

Karen T. Harris, Catharine M. Treanor, gyn/ob, and Mary L. Salisbury. (2006). Improving Patient Safety with Team Coordination: Challenges and Strategies of Implementation. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35 (4), 557–566.

HYPERTENSIVE CRISIS

Severe, abrupt blood pressure elevation accompanied by progressive or impending organ damage leaves many patients with irreversible injury to the brain, heart or kidneys. The threat of stroke has underpinned traditional strategies for managing hypertensive crisis, with the goal being to knock down the elevated blood pressure (BP) fast. We now know that reducing BP too rapidly or drastically in a patient whose body is used to chronically high blood pressure can lead to organ hypoperfusion and potentially irreversible ischemic damage. Many clinicians today recognize that preventing or minimizing organ damage is a more important goal than simply lowering BP. They now are asking, How low, and how fast, do I go? In addition to monitoring the effects of antihypertensive drugs, nurses now must observe for signs of organ damage caused by hypoperfusion and ensure that BP isn't lowered too aggressively.

Siew Lee Cheng, neurosciences. (2005). Treating HTN Crisis: How Low? How Fast? *RN*, 68 (6), 37–41.

PERINATAL SAFETY

With medical malpractice premiums and costs of obstetric claims, settlements and jury awards at an all-time high, MCIC Vermont Inc., which underwrites medical liability insurance for five academic medical centers, decided to promote safer perinatal care, including the development of a new role: the perinatal patient safety nurse. The perinatal patient safety nurse is an advanced-practice nurse whose primary responsibility is to keep patient safety as a focus of all unit operations and clinical practices. The PSN's role is to make sure that patient safety is considered the number-one priority—above costs, production and perceived inconvenience—in all decisions that affect patients. PSNs participate in

patient rounds, outcome data collection, medical record and electronic fetal monitor strip review, and case reviews with care providers. A main focus of their work is to increase health care professionals' attention to performance improvement. The initiative has highlighted the need for interdisciplinary education for team members.

Susan Brown Will, gyn/ob, Kyle P. Hennessee, Loretta S. Jacobs, Loraine M. O'Neill and Cheryl A. Raab. (2006). The Perinatal Patient Safety Nurse: A New Role to Promote Safe Care for Mothers and Babies. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, (35), 417–423.

LEARNING FROM DEFECTS

In September 2004, a team of quality and safety researchers at Johns Hopkins developed a practical tool to investigate defects in patient care. The Learning From Defects tool is a "lighter" version of root-cause analysis that provides a structured approach to help caregivers and administrators identify systems that contribute to defects and includes a follow-up mechanism to ensure that safety improvements are achieved. It supports the staff's ability to investigate more incidents closer to the time of the incident and to identify and mitigate a larger number of contributory factors. The tool is divided into three sections. The first asks the investigator to explain what happened. The second directs investigators to review and check all factors that caused or increased risk of patient harm and all factors that reduced or eliminated harm. The last section asks the investigator to list specific actions to reduce the likelihood that the defect will happen again, to assign a project leader and follow-up date, and to consider how to evaluate if the risk is reduced.

Peter J. Pronovost, Christine G. Holzmüller, Elizabeth Martinez, Christina L. Cafeo, surgery, David Hunt, surgery, Conan Dickson, Michael Awad, Martin A. Makary. A Practical Tool to Learn from Defects in Patient Care. (2006). *Joint Commission Journal on Quality and Patient Safety*, (32), 102–108.

EXTREMITY FRACTURE

To document the health-related quality of life (HRQOL) of children with an extremity fracture and to determine whether it varies significantly by fracture region and site, children hospitalized for an extremity fracture at four pediatric trauma centers were studied. The Pediatric Quality of Life Inventory was used to measure HRQOL at baseline and at three and 12 months. Of the 100 children enrolled, 52 sustained a lower extremity fracture and 48 an upper extremity fracture. Postinjury scores were significantly poorer than preinjury scores for all subjects. In addition, a significant proportion of subjects reported impaired physical

and psychosocial HRQOL at three and 12 months. At three months postinjury, children with a lower extremity fracture had significantly poorer outcomes compared to children with an upper extremity fracture. By 12 months postinjury, the physical function of children with a tibia and/or fibula fracture remained significantly lower than that of children with an upper extremity fracture. By one year postinjury, most children recovered, but those with a tibia and/or fibula fracture still reported significantly poorer physical functioning.

Ru Ding, Melissa L. McCarthy, Eileen Houseknecht, Susan Ziegfeld, pediatrics, Vinita Misra Knight, Patricia Korehbandi, Donna Parnell, Patricia Klotz, CHAT Study Group. (2006). The Health-Related Quality of Life of Children with an Extremity Fracture: A One-Year Follow-up Study. *Journal of Pediatric Orthopaedics*, (26), 157–163.

XTREME NURSING

The stark realities of today's nursing shortage have cast a shadow of concern on our profession's ability to provide quality nursing care for patients in the future. Despite extensive local and federal efforts to increase the supply of nurses, improve working conditions for nurses and facilitate nurse retention, forecasts suggest that we are entering a period of Xtreme nursing, a state of serious imbalance between the demand for and the supply of nurses. This article reviews the shortage and explores scenario planning as a process that can offer the nursing profession and the American health care industry a means of identifying new, bold and more realistic approaches for delivering patient care in the future.

Joyce E. Johnson, Molly C. Billingsley, Linda L. Costa, administration. (2006). Xtreme Nursing and the Nursing Shortage. *Nursing Outlook*, (54), 294–299.

QUALITY MEASURES

Nurses are central to quality improvement initiatives and are critical in identifying, measuring and improving processes in quality and safety measures. As experts in processes of care within health care organizations, nurses have the opportunity to, and should, use strong measures in quality initiatives to promote evidence-based decisions. This approach to measuring safety will result in more interpretable results that measure the problem of interest and allow comparison of results across time and between organizations. These results will promote evidence-based management decisions, required to lead improvements in health care quality and safety.

Robin P. Newhouse, administration. (2006). Selecting Measures for Safety and Quality Improvement Initiatives. *Journal of Nursing, Administration*, (36), 109–113.

From Hopkins to Hopkinton

AT HIGH NOON ON APRIL 17, 2006, in rural Hopkinton, Mass., about 20,000 runners assumed their positions for the 110th Boston Marathon. For the next few hours they'd focus on one thing: reaching the finish line as fast as humanly possible. Half a million well-wishers cheered them every step of the way during the second largest single-day sporting event in the nation, ranking behind only the Super Bowl in media attention.

Among those attuned to the race were several nurses at Hopkins Hospital's pediatric clinical research unit. Between tasks, via computer, they tracked runner 9566—PCRU nurse Tiffany Hevner—and cheered with patients watching TV updates. Hevner was in the race for the long haul, except that it didn't take her terribly long. She finished the 26.2-mile jaunt in 3 hours and 24 minutes, scoring in the top 6 percent of all women and top 22 percent of all entries.

"It was so exciting," says Hevner of the race. "Olympic runners participated, and hordes of people yelled and high-fived us." To even qualify for the Boston Marathon, one must have completed another marathon within the times set by the Boston Athletic Association. Between alternating 12-hour day and night shifts, Hevner spent four months training, every day—rain or shine—increasing her mileage every weekend.



At the finish, Tiffany Hevner makes 26.2 miles look so easy.

With the same drive, Hevner, 26, takes care of children who have cancer or metabolic disorders and those enrolled in research studies. "We bond with those kids," she says, "and when they're not doing well, it can take its toll." Running, she observes, relieves the stress and helps her focus.

Sometimes the impetus to run comes from patients. Two years ago, a 14-year-old girl on her unit whose father was part of the Leukemia and Lymphoma Society's Team in Training encouraged Hevner to sign up. She raised \$4,000 for cancer research to compete in the San Francisco Women's Marathon to benefit LLS.

A self-proclaimed overachiever ("My mom inspired me to set high goals"), Hevner took up running at 14 and joined her Frederick, Md., high school track team, where she met the young man she'd marry nine years later. He's run alongside her ever since, though she claims to be more competitive.

In September, Hevner was promoted to nurse clinician III, another goal she had set for herself. She has no plans for another major race. "I just wanted to be able to say that I ran the Boston Marathon." Hevner plans to soon pursue another lifetime goal—raising a family. No training is required, but she's hoping her day job will give her some insight. ■

Nurse

Johns Hopkins Hospital
Administration 220
600 North Wolfe Street
Baltimore, Maryland 21287-1720

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Karen Haller, Ph.D., R.N., vice president for nursing and patient care services

Mary Ann Ayd, editor

Maxwell Boam, designer

Keith Weller, photographer

Contributing Writers: Patrick Gilbert, Mary Ellen Miller, Judith Minkove, Lindsay Roylance

Advisory Board: Karen Benton, Jakarta Blakeney, Joseph Capozzoli, Deborah Dang, Joan Diamond, Sondra Garlic, Paula Kent, Robin Newhouse, Jane Sharrocks, Patricia Sullivan.

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