



## Months of planning for a major tribute

**I**T SEEMS LIKE A SIMPLE THING: TAKE THE pictures, frame the pictures and then hang the pictures along the yellow walls of the Adelaide Nutting Corridor. But for those charged with coordinating this biennial tribute to nurses, designing that hallway takes months of careful planning.

So, on a cold February day, directors from each nursing department gathered around a conference table to discuss the details of replacing the last display—which focused on nurses’ interests outside the hospital—with this year’s theme: “Discovery through Collaboration and Innovation.”

Now they must decide which nurses will represent that theme in photographs—one for each of the department’s 13 divisions—to be presented during Nurses’ Week in May and displayed for the next two years. “This is about celebrating and recognizing nurses,” says Karen Haller, vice president of nursing, during the meeting. “It’s about these people as representatives of what nursing is.”

First unveiled on June 5, 2003, the hallway commemorates the work of Adelaide Nutting, the Hospital’s first nursing superintendent, whose picture hangs at the end of the corridor, with a plaque celebrating her dedication to nursing. With its close proximity to the Hospital’s main entrance, food establishments, waiting areas and ATMs, the Nutting Corridor generates hundreds of passersby daily. Such a public tribute to nurses—and on such prized Hospital real estate—is impressive, says Lisa Phifer, director of nursing for pediatrics.

“It’s wonderful that the hospital has devoted such a popular corridor in the main part of the



From left, nurses Laurie Turner and Sheila Whitt and physician Nasir Bhatti, all of Otolaryngology, pose for photographer William Gray.

Hospital to Adelaide Nutting,” Phifer says. “We’re so proud that there will always be a tribute to nurses in such a public place.”

With so many onlookers, there’s a lot to consider. The photos should show the department’s diversity—men and minorities included. They should show an array of nursing roles, from nurse practitioners to RNs. And, keeping with this year’s theme, the chosen subjects should demonstrate leadership and collabora-

tion with other departments, such as Ophthalmology’s new instrument cleaning process, coordinated between nurses and infection control specialists.

Aesthetics also generate a lot of discussion around the table. They want it to look like an art gallery and eventually decide on black and white photographs, mounted on white mats and black frames. And, please, Haller interjects, no giant group shots of nameless faces standing in front of a building. Instead, the pictures should show nurses in their own environments, whether in an operating room or at a patient’s bedside. “After all, this isn’t a historical record or an archive,” she says. “It’s an artistic display.”

When they unveil the redesigned hallway, it will be to a crowd that includes nurses and physicians alike, says Judy Rohde, director of nursing for psychiatry and neuroscience. “This hallway speaks volumes about the work nurses do,” she says. “We all get so excited when this time comes around.” ■



### CATCH US AT THE NURSES’ WEEK 2007 BULLPEN PARTY

**Friday May 4**  
Oriole Park at  
Camden Yards  
5 p.m.

**We’re headed back to the  
Bullpen to celebrate  
Nurses’ Week, so mark  
your calendars.**



#### ON THE INSIDE

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## VITAL LINES



Last year I wrote to you about how important it is that Nursing keep pace with the Hospital's determination to boost discharge volume. It's a hefty goal: from 49,477 in FY06 to 55,211 during FY12—an 11.6 percent increase.

Taking into account our annual turnover, we'd need at least 800 new nurses within the next 10 years just to keep up. So we hired an outside consultant to examine our recruitment outlook. With so much recent concern about a nationwide nurse shortage—at one point projected to reach 760,000 by 2020—their forecast surprised us.

The future, they say, looks bright. In fact, very bright.

More people are interested in nursing. Nursing school enrollment has increased enough to cut the predicted shortage in half. And, at the rate we're hiring, we should have all the nurses we need.

But don't get too confident. It's not enough just to hire nurses. We also need to retain them.

To that end, we must create a work environment that encourages long-term careers. We're constantly seeking new ways to help our nurses, whether through our SPRING training program or by installing new lift-assist devices in hospital rooms to help nurses move heavier patients without as much physical strain.

Most important, we cannot become complacent just because our outlook is good. Instead, we must remain vigilant about recruiting and retaining talented, dedicated nurses so that as Johns Hopkins grows, so do we.

**Karen Haller**  
Vice President for Nursing

# Making Fall Stats Plummet

**S**OMETIMES A WATCHFUL nurse is all that stands between a patient and a dangerous tumble to the floor. But, until two years ago, nurses here were equipped with only an unreliable fall assessment tool that lacked any evidence to back it up. Even worse, it offered little guidance for reducing risk.

Falls are the sixth leading cause of serious injury and death throughout U.S. hospitals. Since 2005, the Joint Commission has placed fall reduction on its annual list of national patient safety goals. And, as of January 2006, hospitals must have effective fall reduction programs in order to receive accreditation.

"With safety standards rising, we knew we had to improve," says Maria Cvach assistant director of nursing for clinical standards. "Most importantly, we wanted to do something to significantly affect patient safety."

Like many nurses, Cvach has seen how a single fall can unleash a chain of events that causes a patient to deteriorate. All it takes, she says, is one broken bone that ultimately contributes to a fatal infection: "Then family members are left wondering if the hospital had prevented the fall, would their mom still be alive?"

Three years ago, Cvach joined a team of Hopkins bedside nurses charged with developing a new fall-prevention protocol.

Launched by the Nursing Standards of Care and Clinical Performance Improvement Committees, the team was led by Stephanie Poe, assistant director of nursing for clinical quality, whose job often involves investigating patient falls.

For six months the team examined fall research and tools from other hospitals, hoping to find a better risk-assessment protocol. They wanted something that



Team members **Stephanie Poe** and **Maria Cvach** designed a tool to help nurses decrease fall rates throughout the Hospital.

would fit on one page and that could be completed by hand in less than five minutes. When none of the tools they found worked, they embarked on the time-consuming process of designing their own.

Over the next year, the nurses read more than 100 articles on fall prevention and examined protocols from 15 other hospitals to determine which risk factors were backed by scientific evidence—mobility, for instance—and which were not, such as gender.

The result is a one-page checklist that takes less than a minute to complete and grades an assortment of risk factors, including medication use and impaired vision, on a numeric scale. Once

the points are totaled, nurses have a compact but thorough assessment for predicting a patient's risk of falling.

Since the tool's introduction in 2004, falls at Hopkins Hospital have decreased substantially, says quality outcomes coordinator Patty Dawson. Between 2004 and 2006, the number dropped from 2.6 falls per 1,000 patient days to 2.2. Meanwhile, after the team published an article about the tool in the *Journal of Nursing Quality* in April 2005, an estimated 20 hospitals asked to use it.

"We knew it was an effective tool," Poe says. "But we never dreamed that so many other organizations would want to use it too." ■

## Noted with Pride

**Deborah Hobson**, surgical intensive care unit, will receive the 2007 Circle of Excellence Award from the American Association of Clinical Care Nurses.

**Katie Dickinson**, pediatric intensive care unit, received an

honorable mention in the *New York Times Magazine's* fourth annual "Tribute to Nurses."

In April, helicopter flight nurse **Cathleen Vandenbraak** received the 2007 Distinguished Certified Flight Nurse Award from the As-

sociation of Air Medical Services.

**Loretta Clark**, pediatrics, received an endowment for her position as pediatric diabetes nurse educator. It is the first endowed clinical nursing position at Hopkins. ■

# More Food, Fewer Crises

**I**T'S LUNCHTIME ON MEYER 3, and patients head over to a small cafeteria in the unit's lobby, where a steam table offers sloppy Joes, soup, green beans and fresh fruit. Nearby, a staff member stands behind a Formica countertop, organizing small bags of chips and pouring beverages. Once their plates are full, the patients take a seat at a nearby table and two nurses join them. Slowly, they begin to eat and talk.

Few people outside the psychiatric realm would have any idea that new ground is being laid every time a meal such as this one rolls around. But the introduction of family-style dining last year has changed the atmosphere across Meyer 3, a locked unit that accommodates up to 22 patients, many of them diagnosed with schizophrenia or affective illnesses, such as bipolar disorder. Initiated by the Hospital's department of Food and Nutrition, the meals have been so successful that other psychiatric units in the departments of Psychiatry and Neurosciences are considering similar dining plans.

Until last year, the unit's patient satisfaction scores regarding food service were abysmal, says Nurse Manager Patricia Sullivan. "There was this perception among the pa-

tients that the food wasn't going to be good, that it was going to be cold, that people weren't going to get what they ordered," she says. "Something had to change."

Before the switch, Meyer 3 patients selected from a menu provided a day in advance, just like most patients in the Hospital. Once they made their choices, there was no switching and no changing their minds. By the time the next day's breakfast, lunch or dinner rolled around, however, many patients wanted something completely different. "Tastes change," says Helen Mullan, the clinical nutrition manager for all of the Hospital's adult units. "Patients may be in the mood for meatloaf today, but tomorrow they may not feel like eating a heavy meal."

An unsavory or unsatisfying dinner may be no big deal for patients with a normal, healthy mindset. Indeed, most may forget their disappointment by the time their trays are cleared. But for patients with aggressive or violent tendencies, food service can be difficult, particularly when those patients become disgruntled. And the pre-ordered trays added another layer of complexity.

Disorganized patients, dissatis-



A Meyers 3 patient enjoys lunch with nurse Claudia Kwakye-Ackah.

fied with the contents of their own trays, would take food from other patients' plates when they thought no one was looking. Some would grab the wrong tray entirely. Consequently, arguments broke out during what should otherwise be one of the pleasanter parts of the day. "We were actually seeing the most aggression by our patients during mealtimes," says Amy Hardin, an NC-III on the unit.

The meal plan's rigidity was only one problem. Illiterate patients couldn't read the menus; others forgot what they ordered. Then there were the patients with paranoia, who insisted on prepackaged meals. Meanwhile, some patients failed to order large enough portions and would still be hungry after they'd finished eating. And in a unit where many patients are admitted against their will—

## A STEP AHEAD OF CRISIS

Sedating, secluding or even physically restraining a patient is sometimes unavoidable. But nurses in the departments of Psychiatry and Neurosciences are making such measures a last line of defense.

When the Joint Commission first announced stricter standards for using seclusion and restraints, psychiatric units across the country began rethinking their crisis management plans. On Meyer 3, nurses decided that the best way to meet the heightened standards was to prevent the situations—such as fights and

flaring tempers—that require defensive action in the first place. Soon, other psychiatry floors in the Hospital joined in, forming a multi-unit crisis management committee.

"Compared to other hospitals, we never had a high rate of seclusion or restraint in our unit or throughout the department," says committee member Maureen Arthur, an NC-II on Meyer 3. "Still, we decided to challenge ourselves further, because we knew we could do something better."

So far they've succeeded. Since the project began in 2004, seclu-

sion and restraint rates on Meyer 3 have dropped by more than half.

The program they devised begins the day a patient is admitted. Within 24 hours, a nurse meets with each patient to discuss what might set off unstable behaviors and how to prevent a situation from escalating. From then on, Arthur explains, staff members work with patients to eliminate potential triggers, such as loud noise or stress, before it's too late and a full-fledged crisis ensues that could put both the nurses and other patients at risk.

To further promote the pa-

tients' comfort, nurses have created a soothing, homey environment throughout the unit. Music plays in the lobby, where activity tables offer books, games or arts and crafts. A small cafeteria offers family-style meals, and patients and nurses eat together. Nurses also make a concerted effort to talk to patients outside of the treatment setting.

"We want to create collaborative relationships with our patients and get them back to their highest level of functioning," Arthur says. "It shows them that we truly care." ■



often brought in by family members or police—a bad meal makes an already difficult situation worse.

“When you’re in a hospital, you already feel like you have little control over your life,” says Karin Taylor, an advanced practice psychiatric nurse on Meyer 3. “Then, when a mealtime goes wrong, you think, great, now I don’t even have anything to eat. Family-style meals totally eliminate that, because patients can have what they want.”

Introducing that concept was Mullan’s brainchild. Last summer, concerned that food was creating too much strife, she and the rest of the dietary staff began contemplating how to make mealtimes less stressful. They found only two alternatives, however, that would work for their floor. One was individual room service, an option typically reserved for contagiously ill, bedridden or unstable patients. But room service was a bad idea on Meyer 3, where nurses say group settings help their patients develop some desperately needed social skills before they return to their communities.

While Mullan pondered family-style dining—their only other possibility—another group of nurses was formulating a new crisis-prevention program for the unit. They had heard about other hospitals’

success with family-style meals, so when Mullan presented the idea, they responded eagerly. The team hoped that by creating a more comfortable, trustworthy environment, they could prevent chaos before it struck. And, they thought, there was a good chance that offering flexible, choice-based mealtimes could eliminate much of the food-related dissension.

“Food is the one thing patients feel like they know the most about,” Mullan says. “That’s why, in a hospital setting, patients are more likely to voice their opinions about food than anything else.”

So, in September 2006, the kitchen staff and nurses gradually began incorporating the change by rolling in the steam table for one or two meals a week, then for one meal a day, and finally for breakfast, lunch and dinner. Patient complaints decreased almost instantly. “By the time we introduced the third meal, 91 percent of patients on the unit were saying they were satisfied with the food service,” Mullan says. “They even said the food tasted better, even though it’s the same food. Just the presentation seems to make a difference to them.”

The meals provide patients with a more normal, real-world experience, similar to a regular cafeteria line. There is plenty of food to go around, and patients can select their meals at a moment’s notice, without any anxiety or fears of going hungry later.

“It’s more like what you would see on the outside,” she explains. “They don’t need to decide today what they’re going to be in the mood for tomorrow, or how hungry they will be.”

A dietary staff member is present at each meal to make sure patients don’t take more than they need or select items they shouldn’t have for medical reasons like diabetes.

Meanwhile, to increase goodwill and communication between the care staff and patients, at least two nurses sit down in the cafeteria and eat with patients.

“To prevent crises, you have to create a trusting environment that makes patients feel like people are there to help them,” Taylor says. “Now, not

only are they getting what they want, but the nurses are also eating with them. They realize we’re in this boat together.”

With today’s short hospital stays, eating together also allows nurses a rare opportunity to talk with patients about something other than illness, Hardin says. “We might not get to know that much about them personally,” she observes. “But at mealtimes they talk to each other and you get included in the conversation.”

Though there’s no research available to measure the benefits of family-style dining in psychiatric settings, there’s still good reason to believe it improves patient experiences. A recent study of nursing-home patients in the Netherlands concluded that family-style meals improved quality of life and promoted a healthier body weight. The study also concluded that eating together allowed patients more time to interact with staff members and one another.

The results are similar on Meyer 3. Satisfaction scores have risen, and patients praise the family-style meals in surveys distributed at the end of their hospital stays. Arguments and physical fights over food now happen rarely, if ever. Violence across the floor has decreased by 58 percent, something the nurses attribute at least partially to the family-style meals. Even paranoid patients, relieved to see staff members eating from the same serving dishes, rarely demand prepackaged meals.

“If people are satisfied with the food, they take that satisfaction and look at other things differently,” Taylor says. “It’s like in any situation: If you really like one part of something, it’s going to color how you look at the rest of the situation, whether you’re in a department store, a restaurant or a psychiatric hospital.” ■



## MAGNETIC PRACTICES

### Peer Review

Receiving a performance review from fellow nurses is a delicate and time-intensive endeavor. An objective and well-defined peer review process, however, plays a vital role in promoting professional growth and development. It’s also a key element in achieving and maintaining Magnet designation.

“Peer review can be a very anxiety-ridden process,” says Tenise Shakes, an NC-III on Meyer 9. “For some people it can be really hard to take that kind of feedback.”

That’s why, during last January’s Ambassador Workshop—the second in a series of seminars about maintaining Magnet status—57 nurses gathered to discuss peer review and compare notes.

Because every division is so different, peer review processes need to be customized to fit each specific unit, says workshop attendee Didi Missler, an NC-III in the medical intensive care unit on Osler 7 and chair of her unit’s peer review committee. Some units have one individual reviewing another, while others employ a group critique. Some conduct reviews more often than others. Still, she explains, nurses can learn much from other units’ methods.

Working long hours in a team atmosphere often results in close friendships, making peer review even more difficult, says Christine Gonzalez, an NC-III in the Weinberg ICU. But, she continues, personal loyalties take a back seat to the job at hand.

“The overall culture in our unit and throughout Hopkins is one of high standards,” she says. “We know we’re here to deliver quality care to our patients, and we can’t do that if we don’t hold each other accountable.” ■



## MEDICATION DISTRIBUTION

Distributing medication to hospital patients is a complicated and sometimes error-prone process. Nurses at Hopkins administer medication in 81 different patient care units, with prescription orders changing as fast and often as patients' conditions. Out of the estimated 3 billion prescriptions filled annually by U.S. hospital pharmacists, one in five doses contains a mistake. Of those mistakes, 7 percent turn harmful. Redesigning medication use systems (MUS) is a starting point for preventing harmful medication errors. To that end, an interdisciplinary team examined the MUS and gathered feedback on a better design, concluding that an ideal MUS would be simple, reliable and evidence-based, and require good communication among caregivers. A plan for implementing the ideal system and studying the impact was established, and the results are being monitored.

**Deborah Dang**, nursing; **E. Robert Feroli**, **Carla Gill**, **Kenneth Shermock**, **Lori Paine**, Center for Innovation; **Jeannette Sufliita**, nursing, and **Jo M. Walrath**. Quest for the Ideal, A Redesign of the Medication Use System. (2006). *Journal of Nursing Care Quality* (22) 11—17.

## DECREASING NEW GRADUATE TURNOVER

Health care organizations invest significant amounts of time and resources into recruiting and training new graduates to fill nursing positions. Yet new nurse graduates experience a stressful transition into health care environments, and 30 percent of these recruits leave their first job within one year. Another 57 percent quit after two. This study showed that participants in a nursing internship program called Social and Professional Reality Integration for Nursing Graduates (SPRING) had higher retention rates and an increased sense of belonging and commitment. A review of actual retention rates proved this even further. Internship programs for nurse graduates support the socialization of nurses and their transition into professional roles, while improving their competence. This study supports the ability of such a program to improve nurse retention and decrease new nurses' intent to leave the organization after six months.

**Robin P. Newhouse**, nursing; **Jeannette Sufliita**, nursing; **Janice J. Hoffman**, neurosciences, **Dorna P. Hairston**, surgery. (2007). Evaluating an Innovative Program to Improve New Nurse Graduate Socialization into the Acute Healthcare Setting. *Nursing Administration Quarterly* (31) 50—60.

## ADVERSE DRUG EVENTS IN ICUs

Adverse drug events (ADEs) are often the result of poor continuity of medication during a patient's hospitalization, particularly in intensive care units. New medications are frequently being ordered, requiring that concurrent medications also be changed. Patients' home medications, supplements, drug allergies or sensitivities must also be taken into account. To avoid dangerous drug interactions or errors, a formal medication reconciliation (i.e., med rec) process is vital, the authors found. One of the most important aspects of the med rec process is having several people check for errors and problems, instead of only one person. As a result, medication-related complications are reduced and continuity of care is enhanced.

**Mandalyn Schwarz** and **Rhonda Wyskiel**, Weinberg intensive care unit. (2006). Medication Reconciliation: Developing and Implementing a Program. *Critical Care Nursing Clinics* (18) 503—507.

## ASTHMA IN INNER-CITY CHILDREN

During a year-long study, scientists interviewed the parents and studied the pharmacy records of 180 asthmatic Baltimore inner-city children, ages 2 to 9, trying to determine whether they received the proper amounts of medication to control their illness. Any child whose asthma causes wheezing, coughing and shortness of breath two or more times every week is supposed to take inhaled corticosteroids to curb inflammation and prevent attacks. Throughout the year, only 20 percent of the children sought the six or more refills of daily medications needed to control asthma symptoms and prevent outbreaks from occurring. Another 60 percent received too little medication to fully prevent flare-ups, while 20 percent got no medication at all or relied solely on quick-relief rescue drugs, which stop attacks from progressing but do not prevent them from happening again. Inner-city children face a greater risk because their living conditions often include asthma triggers such as secondhand smoke, mice and cockroach allergens. The study also showed that children cared for by asthma specialists were more likely to follow a proper drug regimen.

**Kim Mudd**, pediatrics, **Arlene M. Butz**, **Mona Tsoukleris**, **Michele Donithan**, **Van Doren Hsu**, **Ilene H. Zuckerman** and **Mary Bollinger**. (2006). Patterns of Inhaled Anti-inflammatory Medication Use in Young Underserved Children with Asthma. *Pediatrics* (118) 2504—2513.

## ACADEMIC SCHOLARSHIP

Maintaining some clinical practice is promoted among nursing school faculty to strengthen clinical expertise, maintain relevant curricula and generate revenue. Also, for some clinical faculty, this kind of practice can provide a foundation for academic scholarship. Yet tension exists between the demands of faculty practice and the academic mission of nursing schools. In 2003, the dean of the Johns Hopkins School of Nursing convened a task force to assess the state of faculty practice within the school and provide recommendations for strengthening and aligning faculty practice to the school's scholarly mission. Most of those interviewed agreed that faculty practice was not only valued, but consistent and beneficial to the school's mission. The task force concluded that faculty members must carefully balance the amount of time spent in clinical practice versus their scholarly work, and they offered 10 recommendations on how the nursing school can best maintain, utilize and strengthen faculty practice.

**Kathleen Lent Becker**, **Deborah Dang**, nursing, **Elizabeth Jordan**, **Joan Kub**, **Alison Welch**, **Carol Smith** and **Kathleen White**. (2006). An Evaluation Framework for Faculty Practice. *Nursing Outlook* (55) 44—54.

## BETTER ANEMIA MANAGEMENT

Anemia is a common problem among cancer patients, often caused by treatment-related factors. This condition adversely affects their quality of life and increases morbidity and mortality. Managing and preventing anemia requires careful assessment of risk factors, etiologic factors and analysis of clinical findings, as well as prompt intervention before the symptoms influence the patient's overall health. Clinical trials show the success and safety of epoetin alfa and darbepoetin alfa for reducing RBC transfusions and increasing Hgb values in anemic cancer patients. Furthermore, there is significant evidence that normalized Hgb levels affect survival and quality of life. Despite advances in anemia management and the development of clinical practice guidelines recommending early intervention, practice does not currently reflect consistent application of this evidence.

**Brenda K. Shelton**, oncology. (2006). Therapeutic options for patients with cancer and treatment-related anemia. *Advanced Studies in Nursing* (4) 109—114.

# She Traded Horses for Humans

**D**RIVING AWAY FROM THE INTENSE and emotionally draining environment of the Hospital's oncology unit, Alice Pons has one thing on her mind—getting home to the comfort and serenity of Country Life Farms. “As soon as I drive out of the parking garage,” she says, “I’m like a homing pigeon.”

Pons' grandfather purchased the Harford County property in 1933 and turned it into a horse-breeding farm that spans 117 acres. Five years ago, the family purchased an additional 150 acres a few miles away and built a training facility. Over the years, Country Life has produced several award-winning horses, including 17-year-old Cigar, a member of the Racing Hall of Fame whose winnings included the coveted U.S. Breeders' Cup Classic.

For Pons, though, Country Life offers more than horse racing and awards. It provides a refuge from the clamor and hustle of the Hospital.

Sitting in the den of her family's turn-of-the-century farmhouse, a fire gleaming in the pellet stove and a golden retriever sitting at her feet, Pons is clearly in her element. Outside, snow falls on the ground, and a mare and her foal meander through a fenced-in pasture.

“This place is therapeutic,” says Pons, an NC-III on Weinberg 5. “The city is so noisy and dirty. The farm is the antithesis of that.”

She loves the farm so deeply that it's hard



Oncology nurse Alice Pons at Country Life Farms.

to envision her leaving it four days a week to work 12-hour shifts as an oncology nurse. But even harder to imagine is the willpower she gathered in 1999, when she sacrificed her job as the farm's manager to become a nurse.

Back then, Pons supervised everything from the breeding process to the budget. By 1998, however, she had started considering other career possibilities, including veterinary school. Then, in 1999, a close friend was diagnosed with breast cancer.

Soon, Pons was driving her friend back and forth for treatment. “I was just amazed by what the nurses did,” she says. “They're right there in the trenches. Then, my friend told me that I should be working with humans.”

Pons took her friend's advice, and that year, she enrolled in the Johns Hopkins School of Nursing. She hasn't completely given up farm work, though.

Even after a long day's work, Pons still checks in on the horses when she returns home, particularly during foaling season, when mares can give birth at any time. She spends many weekends at regional horse races, and she can recite a complete background of the 50 or so horses in their stables, from their ages to their weights to the probability of their siring another foal. “I don't have a definitive role here any more,” she says. “I'm just an extra set of eyes and ears.”

Leaving the farm behind was hard.

The rewards of her work as a nurse, however, make the change worthwhile. “The beauty of it,” she explains, “is that many of the same ailments that befall animals also affect humans. Before, I was basically a nurse for animals.” ■

## Nurse

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