Our Voices: Reflections on 2020-2021

THE JOHNS HOPKINS HOSPITAL 2022 NURSING ANNUAL REPORT

JOHNS HOPKINS
NURSING
THE JOHNS HOPKINS HOSPITAL

Table of Contents

THE JOHNS HOPKINS HOSPITAL
NURSING ANNUAL REPORT
OUR VOICES: REFLECTIONS ON 2020–2021
(ISSUED APRIL 2022)

The Johns Hopkins Hospital Department of Nursing
FY21 Strategic Initiatives and Goals 2
Why We Are Here 3

COVID-19

COVID-19 Response: Like Nothing Before 5
Building the Ship 6
The Right Training to Meet the Pandemic 8
'I Wanted to Fight This Pandemic' 10
Curbside Cancer Care 11
Providing Crucial Support During COVID-19 12
1 Year, 1 Month and 28 Days 14

VOICES HEARD

A Formalized Role in Decision-Making 16
Making Their Voices Heard 18
Labor and Delivery: 'No One Feels Forgotten' 20

WHERE WE ARE NEEDED MOST

‘Floating’ to Fill a Vital Need 22

TeleSitter: Keeping an Eye Out 24

INDICATORS OF GREAT CARE

CAUTI-Prevention Champions 26

Crafting a Chain of Fall Prevention. 26

All in the Details: Preventing CLABSI in Kids 28

Pressure Relievers 28

RECOGNITION

A Certification Celebration 29

Daisy Award Winners 30

JHH Nursing Demographics 32

The Johns Hopkins Hospital Department of Nursing FY21 Strategic Initiatives and Goals

Developed in alignment with the Johns Hopkins Medicine Strategic Plan: *Innovation 2023*, and the JHH Nursing Professional Practice Model — the values and goals that define our professional nursing practice.

We Care

Extend the TeleSitter Program across JHH to increase efficiency in monitoring high-risk patients.

We Achieve

Create and operationalize a Supplemental Staffing Unit to maintain full or budgeted census on all units, meet the variable nursing staffing demands at JHH and decrease use of premium staffing.

We Empower

Implement strategies to increase the voice of front-line nurses as measured by 51% of units exceeding nurse engagement score benchmarks.

We Influence

Implement strategies to prevent falls with injuries as measured by moderate or greater injury falls below benchmark.

We Excel

Build capacity to provide nursing care for patients with COVID-19 by cross-training nursing staff to address fluctuations in demand for ICU/IMC trained nursing services.

We Care, We Excel

Build capacity to increase use of palliative care by educating all nursing staff on the structures and processes around consults for ED patients, inpatient hospice referrals, Gyn/oncology patients, and accessing the hospice mobile response team for on-site services.

A Letter from Deborah J. Baker, D.N.P., A.P.R.N., N.E.A.-B.C., F.A.A.N.
Senior Vice President for Nursing, Johns Hopkins Health System
Vice President for Nursing and Patient Care Services, The Johns Hopkins Hospital

Why We Are Here

In March of 2020, when we admitted our first patients with COVID-19 at The Johns Hopkins Hospital, we could not have predicted the enormous impact the pandemic would have on us — as nurses, but also as parents, caregivers, friends and community members, and in just about every aspect of our lives and all that we do.

Since Day One of the pandemic, every nurse at Johns Hopkins has contributed to the complex and multidisciplinary efforts to create a safe environment for COVID-19 and non-COVID-19 care. Throughout it all, Johns Hopkins nurses have continued to do what we do best: innovate, collaborate, and drive change and improvements to patient care and clinical operations.

Nursing staff has taken on new roles; developed new processes; learned new skills, procedures and workflows; designed and run testing tents and mobile testing clinics; deployed with Go Teams to care for underserved and at-risk communities; served as safety officers; and stepped up in countless other ways to respond to the challenges we faced. We have served in roles as the mother, brother, father, sister and friend at the side of a patient's bed when loved ones could not be there.

The speed of change we have experienced, as nurses and across the health care industry, has been nothing short of incredible. And no matter what we encounter, when you look closely, magical moments are revealed — quiet, meaningful interactions with patients, families and care teams, and the times when nurses must lean into their expertise and skill to solve a problem or deliver care. *This* is why we are here.

When clinical excellence meets compassionate care, it has the power to bring light to even the darkest days. I am filled with hope for what our future holds, and confident that as Johns Hopkins nurses, we can achieve anything together.

In May 2020, the Johns Hopkins Hospital dome was lit blue to show support for health care workers and first responders on the front lines of the COVID-19 pandemic.

COVID-19 Response: Like Nothing Before

"We all knew it was coming," says **Norren Cesar**, a lead clinical nurse on Zayed 3, a pre- and post-anesthesia care unit, or prep/PACU, where, in normal times, adult patients are shepherded through preparation for, and recovery from, a variety of medical procedures.

Yet the speed and magnitude of the hospitalwide response to the COVID-19 crisis very quickly turned that well-ordered world upside down. "One Friday in April 2020, we were pulled into a meeting and told, 'This is what we're going to be doing starting Monday,'" she says, "and it wasn't like anything we'd done before."

To care for critically ill patients with COVID-19, the hospital was converting its many specialized intensive care units (ICUs) — cardiac, surgical, neurological — into COVID-19 ICUs. At the same time, elective surgeries were down, reducing the burden on the various PACUs.

"We still needed non-COVID-19 ICU beds, because some surgeries can't be postponed," says **Mary Beth Anderson**, also a lead clinical nurse on Zayed 3. So, half the Zayed 3 staff members were immediately reassigned to a PACU in the neighboring Weinberg building, which normally serves patients with cancer. They were tasked with turning it, virtually overnight, into an overflow ICU for patients who did not have COVID-19.

While Anderson helped lead that conversion, Cesar stayed behind to help run the Zayed 3 PACU, which by that point was absorbing patients from three other PACUs, including Weinberg's. Staff from those units worked together and supported one another in caring for their newly combined patient populations. Staffing and scheduling challenges were enormous. Nurses who'd worked days were working nights and weekends, many learning new skills from new colleagues. Some got sick with COVID-19, and many (including Cesar) were deployed as needed to COVID-19 units.

Anderson is still amazed at how quickly her team was able to create an ICU from scratch. "A PACU is basically a room with stretchers and curtains," she says. "An ICU is filled with monitors and meds and all of the emergency equipment you could ever imagine."

The entire hospital stepped up. "I made lists of stuff we needed, and in no time, it was there," she says. Ten doctors, 20 support staff members and about 60 nurses, some with no ICU experience, learned very quickly to work together with confidence, and all felt lucky to be on a non-COVID-19 unit. "You have to remember how little we knew about COVID, how terrified we were," she says.

Then one day, a patient who'd tested negative turned up positive. Suddenly, the ICU was no longer COVID-free and had to be dismantled. "We'd felt so safe," Anderson says. "We were really shaken."

Yet, Cesar and Anderson emphasize, sometimes struggling to hold back tears, that their efforts were "just what nurses do." They were among the many heroes who served on the front lines of the pandemic.

"Everybody scrambled," says Anderson, "but the ones who walked into those COVID-19 units, especially in the beginning, are the ones to celebrate." ■

"Ten doctors, 20 support staff members and about 60 nurses, some with no ICU experience, **learned very quickly to work together** with confidence, and all felt lucky to be on a non-COVID-19 unit."

MARY BETH ANDERSEN

Carisa Burley (left) and colleagues in the COVID-19 testing tent outside of the Johns Hopkins Outpatient Center.

Building the Ship

When she thinks back to March 2020, **Erica Sauer** marvels at how much of Johns Hopkins' response to the pandemic had to be built — and built instantly — from scratch.

"It was amazing to see the teamwork, the brilliant minds that came together to say, 'OK, here's our problem of the day, let's work through it,'" says Sauer, nurse manager for ambulatory (outpatient) COVID-19 operations. "There were no algorithms for when you needed to be tested, no process to place orders for testing. We were building the ship as we sailed."

At first it was setting up a triage phone line for patients with symptoms. It was responding to cries for help from hard-hit nursing homes, homeless shelters and the Latino community. It was deploying teams of health care workers in vans to triage and test. It was gearing up to switch from using outside labs to processing COVID-19 tests in-house, so patients could get their results in 24–48 hours instead of five or more days.

"A team of at least five of our health care workers went out every day in the beginning," Sauer says. "Can you imagine how challenging it was for them, doing nasal swabs on very fragile patients, many with dementia, in the long-term-care facilities? And I still remember the day they swabbed 400 people at [Baltimore nonprofit] Health Care for the Homeless."

Many others, including the Johns Hopkins Home Care Group and the Johns Hopkins Go Team, stepped up to do outreach, and Johns Hopkins expanded access to testing and care through a new COVID-19 Ambulatory Response Team. And Sauer, normally nurse manager for the cardiology clinic, assisted with COVID-19 screening, testing and, eventually, vaccination.

Everyone entering the Johns Hopkins Outpatient Center had to be screened for COVID-19 symptoms in front of the building, and an outdoor testing site was set up, first under a tent, then in the Caroline Street garage when it became apparent that the tent afforded little protection from the elements.

Carisa Burley, a certified medical assistant (CMA) who expressed her willingness to do whatever was needed, quickly took charge, first of screening and then of testing.

"I was very excited," says Burley, who grew up in Baltimore dreaming of someday working at Johns Hopkins and was hired four years ago as a CMA "floater." "Testing was challenging because I didn't want to hurt my patients, putting that swab so deep into their nose. I learned very quickly how delicate and reassuring we have to be."

But when the vaccine came out, it changed everything, Sauer says. "Until then, there was a lot of sadness. What we were doing was valuable, but it felt like damage control. We started vaccinating in January, and it felt like we'd turned a corner."

Burley, who insisted on working seven days a week at the height of the pandemic, says she was thrilled to be assigned to the vaccination team. "I love, love, love my job," she says.

Sauer calls Burley "an amazing person," adding, "She is the only person I've ever had give me a sad face when I suggested she not work Saturdays. But I truly can't emphasize enough how much of a team effort this has been, from hospital leadership and lab techs to information technology, facilities and maintenance, and security. It was everyone being so willing that made it possible for us to do things we've never done before." ■

Bryan Barshick (right), senior director of nursing for ambulatory services, is joined by two physicians on opening day of The Johns Hopkins Hospital's COVID-19 vaccine clinic.

Members of the Johns Hopkins Go Team, (from left to right) Akeem Predeoux, Scott Ayre, Lisa Puett, Kaity Baker and Ben Bigelow.

The Right Training to Meet the Pandemic

When COVID-19 struck in March 2020, nurse educators at The Johns Hopkins Hospital faced a conundrum: how to immediately train enough nurses to care for the sudden influx of critically ill patients, and how to do it without in-person, hands-on classes.

"We knew we'd have to do our own thing, because it would have to be online and the [internal] multimedia group that normally helps us was under the gun to get as much COVID-19 information out as possible," says veteran critical care nurse educator **Paula Murray**, who with her friend and fellow critical care nurse educator **Nancy Beck** started immediately creating and hosting online classes.

They'd never used Zoom, but they dove right in, educating themselves in its intricacies. They recorded video after video, posting them online with the help of another nurse educator, **Ben Quintanilla**. "He's our tech guru," Murray says. They even hosted a virtual simulation day, broadcasting demonstrations of tasks such as drawing blood for lab work and setting up the hemodynamic monitoring system that keeps track of blood flow, blood pressure and blood oxygen levels.

"We needed training for brand-new nurses who'd never done critical care, and for nurses who'd done it earlier in their careers and were stepping up to meet the need," Murray says. "So, we reached out to our experts, like respiratory therapists, and said, 'Can you give us 30 to 45 minutes to do a video?' And as stressed and over-extended as everyone was, they did it."

Nurses who'd never worked on an intensive care unit (ICU), and even nurses who had, wanted to know how to look after a patient on a ventilator, what buttons to push, what not to touch, what to do when an alarm goes off, how to manage multiple IV drips, and how to administer the pressor drugs that raise an acutely ill patient's blood pressure.

Because Murray and Beck couldn't teach hands-on skills in person, bedside nurses with ICU experience still had to do most of the real-time training. Murray says one of their goals was to take as much pressure as possible off the shoulders of those nurses, "who were orienting new staff while they themselves were seeing a different type of sick patient than they'd ever seen before."

On Nelson 5, the DAISY Award-winning intermediate care unit that became a COVID-19 ICU and continued in that role for more than a year, clinical nurse specialist **Carrie Outten** drew on her ICU experience to help educate her colleagues.

"We had less than a week to give our staff as much ICU training as we could," she says. "We provided written protocols and a PowerPoint to review. But most of it was real-time: 'Here is the patient and here are the procedures that need to happen.'"

"It was pretty intense from the middle of March on," says **Sheila Miranda**, a nurse educator assigned to a number of units, including Nelson 5, who had previously worked with Outten on the medical ICU. "We all just wanted to be out there on the units supporting staff."

"In the beginning, it was an emergency every couple of minutes," Outten says. "By May or June, we'd reached a plateau and we started surveying the staff about their confidence in their new skills. It kept going up, and you could actually see it in their faces. It kind of made you feel like a proud mama bear."

Seeing less experienced nurses begin to work more independently was hugely satisfying, Miranda says. "To me that was huge because it meant the staff was getting the right training, and we were providing the right care." ■

“**We knew we’d have to do our own thing**, because it would have to be online and the [internal] multimedia group that normally helps us was under the gun to get as much COVID-19 information out as possible.”

PAULA MURRAY

Shijie Zhou

'I Wanted to Fight This Pandemic'

She was fresh out of nursing school, new to Johns Hopkins Medicine, new to Baltimore, but **Shijie Zhou** ("Jojo" to her friends and colleagues) was determined to help take care of patients with COVID-19.

"I just feel I'm a nurse and I should be there," she says.

Her father is a doctor in their hometown in China, just a couple of hours from Wuhan, where she earned a degree in business English at Zhongnan University of Economics and Law. Since the beginning of the pandemic, her father has worked on the front lines daily, despite his age (late 60s), his own underlying health issues and a perpetual lack of even basic protective equipment.

"I have been so proud of him and of how doctors and nurses in China coped with this pandemic when nobody else knew what was going on," she says.

When the pandemic hit the U.S., Zhou was in nursing school in Chicago. She was frustrated that as an international student she was not allowed to volunteer on a COVID-19 unit. But after she graduated in May 2020, she obtained her work visa and was thrilled to be hired in August as a registered nurse on the progressive cardiac care unit at The Johns Hopkins Hospital.

"I was so excited," she says. "I wanted to help fight this pandemic."

After she completed her orientation, she started volunteering to work extra shifts on COVID-19 units that were sending out emails asking for help. The first was Nelson 4, a pulmonary medicine unit that had been converted to a high-level isolation unit to care for patients with COVID-19. "I was a little bit nervous because I didn't know how to wear PPE [personal protective equipment]," she says. None of the N95 masks fit her, so a senior nurse helped her order a powered air purifying respirator (PAPR).

"It covers your head like a helmet and you wear a special machine on your back to ventilate the air," she says. "You couldn't take any of it off while you were on the unit, even to drink water." She had been assigned a "buddy" nurse, "and she was always checking in. 'Hey, Jojo, how are you doing? Hey, Jojo, it's been three hours. You have to drink. I'll cover your patients.' And she literally forced me to go outside the unit for a break, which was really, really helpful."

She learned there was a staff shortage because many pregnant nurses and nurses with chronic illnesses had left the unit. She learned how emotionally and physically draining the job could be. Wearing a PAPR for hours caused not only dryness, but severe headaches and pressure sores. She saw patients in great distress, including patients with delirium from being in the intensive care unit, "which is really heartbreaking and challenging for nurses." And all of that protective gear, plus COVID-19 protocols dictating how long nurses could be in patients' rooms, meant little opportunity to bond with and comfort patients.

Zhou spent months floating to various COVID-19 units, and says she is enormously grateful for everything she learned and for the nurses who mentored and supported her. "And I have a deep, deep respect for the nurses who never left those units," she says. "They were truly amazing." ■

Lori Parker

Curbside Cancer Care

When COVID-19 hit and patients with cancer started postponing treatment, oncology and hematology clinical nurse specialist **MiKaela Olsen** and her colleagues at the Johns Hopkins Kimmel Cancer Center were alarmed.

"Patients were afraid and were canceling appointments for important care," Olsen says. "We had to come up with a way to get them the care they needed while also protecting them from becoming infected."

In April 2020, Olsen and her team launched a pioneering curbside injection program in front of the Skip Viragh Outpatient Cancer Building and the Harry and Jeannette Weinberg Building across the street.

At Viragh, patients can pull into the traffic circle at the entrance, have their blood drawn and vitals checked, and receive therapeutic injections, all within 15 minutes, and all without ever having to leave their cars. There is even an enclosed room for the occasional walk-up patient, or patients who need more privacy — for gluteal injections, for instance.

At Weinberg's outdoor clinic, where the focus is more on chemotherapy, normally lengthy appointments for labs and chemotherapy infusions have become a 30-minute, drive-up visit.

At both clinics, common services include flushing central line catheters and performing dressing changes. "We're still thinking of ways to offer more treatments for patients at our curbside clinics," Olsen says.

A former Army nurse and inexhaustible innovator, Olsen drew on her experience with field hospitals to focus on rapidly building an outdoor program that could match the quality of care on the inside — and then recruit nurses best suited to staff it.

At Weinberg, Olsen chose hematologic malignancy RNs **Joanna Bautista** and **Erica Langton** as champions. Oncology RN **Lori Parker** was among those hand-picked to serve at the Viragh building.

Parker says she loves the constant action and the freedom of working outside, no matter the weather. "Except the wind," she says. "That is the worst." Medicines are weather-proofed, with those that require refrigeration kept in "smart" coolers that alert the pharmacy when temperatures rise. A security detail makes sure supplies don't walk away and that nurses work worry-free.

Health care centers nationwide have taken notice, calling Olsen and her team for advice on setting up their own curbside clinics.

"We have treated more than 5,000 patients at our curbside clinics, and our patient volume is increasing," Olsen says. "Patients love this option." ■

Providing Crucial Support During COVID-19

When patients with COVID-19 started pouring in to The Johns Hopkins Hospital in March 2020, **Deborah Sherman** was in the thick of things.

As program director of clinical informatics, the veteran Johns Hopkins nurse works with the team that manages the hospital's electronic medical records system, Epic, to be sure the clinical needs of nurses and patients are well supported. During the pandemic, that meant staying on top of a host of rapidly changing data needs, from tracking COVID-19 test results to ensuring that Pyxis stations (the automated medication dispensers) were appropriately supplied and that Epic could support adult COVID-19 patients being treated in a pediatrics unit.

"There were a zillion details, and it was a huge team effort," says Sherman, who is also operations chief for the JHH emergency management team, which ran the hospital's Emergency Command Center — ground zero for coordinating the pandemic response.

Everyone in the hospital relied on that command center team for updates and answers. Every day it surveyed units to find out what they needed. There were daily meetings and briefings. Sherman was fielding urgent calls for help, including requests for supplies and extra staff.

She coordinated the creation and delivery of fanny packs with protective gear to everyone in the hospital. She helped create a "biomode" toolkit so hospital staff members could click on a link and find everything they needed to know about converting to a high-level isolation unit. She even worked with the hospital's marketing team to map new routes and post signs redirecting emergency crews who were getting lost because their usual routes through hospital corridors had been blocked off as various units went into lockdown.

Sherman's job was "whatever was needed," and she can't emphasize enough how much it depended on teamwork. "Getting everyone vaccinated was a huge team effort," she says.

But her proudest achievement was helping to create a very specialized team — a prone team to train staff members in what was, for many, a vital new skill: turning patients in respiratory distress onto their bellies to help them breathe.

"I was in a meeting, listening to a nurse manager talk about getting eight COVID-19 patients in a row who were so sick they had to be immediately intubated and proned," she says. "I used to work on the MICU [medical intensive care unit] and remember being in one of the first groups proning patients back in the 1990s and I just thought how horrific that shift must have been. Plus, there are plenty of nurses with decades of experience who have never proned a patient. So, it just kind of popped out of my mouth. 'We have a code team to respond to emergencies. Why not a prone team?'"

Everyone loved the idea, and Sherman reached out to the MICU because staff members there have experience in proning. She connected with MICU nurse **Nicole Troiani**, who quickly assumed a leadership role. "I realized there were some simple things that were second nature to me that other people did not know," Troiani says.

Working with nurses, doctors, and physical, occupational and respiratory therapists, Troiani helped spell out those "simple things" in a set of protocols, and made a video demonstrating the process. "I had a lot of experience and had done a lot of research on proning, but we kept learning things from one another. Wound care nurses, for instance, helped me make another video about how to mold the pillow to avoid facial pressure injuries," she says.

But the main task was creating and training a team that would be available 24/7 to respond quickly to units that needed help proning a patient. "We had it up and running within four days of our first meeting," says Troiani, who trained all of the staff members on the team.

The team's job was not only to help prone patients, but to train nurses on other units how to do it, and to eventually work themselves out of a job, which they did in spring 2021.

"Now all of these nurses have a new skill and people are more willing to prone patients early, and we've seen so many benefits of that," says Troiani, who was promoted to nurse practitioner on the MICU in October 2020. "I'm so proud of what we did because it had a real impact."

Sherman concurs. "I really believe we saved lives." ■

“It just kind of popped out of my mouth. ‘We have a code team to respond to emergencies. **Why not a prone team?**’”

DEBORAH SHERMAN

“Now all of these nurses have a new skill and people are more willing to prone patients early, and **we’ve seen so many benefits of that**.”

NICOLE TROIANI

1 Year, 1 Month and 28 Days

It was a bittersweet moment. In December 2020, Nelson 5 won the DAISY Team Award for extraordinary nurses — the first ever bestowed on a team at The Johns Hopkins Hospital. Everyone on the unit was honored for their delivery of care during the pandemic, which the DAISY Foundation described as "the epitome of the art and science of nursing."

"The recognition meant a lot to us," says **Carrie Outten**, clinical nurse specialist on Nelson 5, displaying her enamel DAISY pin with quiet pleasure. "It's been a sad year. We had pretty low mortality rates, but still more deaths than any of our nurses were accustomed to. And it was tough seeing our patients being so sick and away from their families, getting updates over the phone or Zoom. But there is hope going forward."

Nelson 5, which is normally a medical progressive care unit (MPCU) or step-down unit for patients who need special care but don't need to be in the intensive care unit (ICU), went into "biomode" — meaning it was converted into a high-level isolation unit to care for COVID-19 patients — on March 15, 2020. And it didn't go out of biomode until May 26, 2021. At the peak of the pandemic, 11 units at The Johns Hopkins Hospital were in biomode. But Nelson 5 had the distinction of being in biomode the longest of any unit at the hospital — one year, one month and 28 days.

"It all happened very quickly," says **Rachel Hampton**, who was a lead clinical nurse on the unit at the time and is now COVID-19 senior research nurse at the Johns Hopkins University School of Medicine. "We were all wondering how the hospital would deal with the pandemic, then we got word that Nelson 5 would essentially become a COVID-19 ICU. Walls were popped up, a ventilation system was installed to create negative pressure, and we were taking our first patient."

Outten and a few other Nelson 5 nurses had ICU experience, but most did not. Some had been nurses less than a year. All had to learn to sedate and prone patients (turn them onto their stomachs to improve oxygenation), and monitor ventilators and dialysis machines. They had to learn to properly don and doff personal protective equipment (PPE), including the powered air purifying respirators (PAPR) with hoods that often caused pressure sores. And they had to work in the cumbersome gear all day, sometimes for 12- or 16-hour shifts at the height of the pandemic.

At the same time, they acted as surrogate families to their patients, decorating their rooms, learning their likes and dislikes, arranging virtual visits with loved ones, and making sure that no one died alone.

"They certainly weren't the only ones at The Johns Hopkins Hospital taking care of COVID-19 patients," says **Sheila Miranda**, a JHH nurse educator who helped nurses throughout the hospital upgrade their skills to meet the crisis, "but Nelson 5 bore the brunt of the pandemic because they did not get a break from working in biomode for more than a year. No one deserved this recognition more." ■

“**It was tough seeing our patients being so sick** and away from their families, getting updates over the phone or Zoom. But there is hope going forward.”

CARRIE OUTTEN

“[Nelson 5] did not get a break from working in biomode for more than a year. No one deserved this recognition more.”

SHEILA MIRANDA

A Formalized Role in Decision-Making

It's called the "Wheel," and it's one of the most exciting developments over the past two years at The Johns Hopkins Hospital. An ambitious new nursing governance structure, the Wheel not only unifies Johns Hopkins Nursing, it also gives bedside nurses a formalized role at every level of decision-making.

"It's really about nurse empowerment," says **Stephanie Wilmer**, The Johns Hopkins Hospital's coordinator for Magnet, who leads efforts to sustain Magnet status, the coveted designation by the American Nurses Credentialing Center for hospitals that achieve nursing excellence. The Johns Hopkins Hospital has earned Magnet distinction four times since 2003, and Wilmer says one of the things that distinguishes a Magnet hospital is nurses "having a voice at all levels of the organization. So, this is really part of our continuing mission."

The Wheel is also about bringing Johns Hopkins nurses together to work across specialties (and beyond silos) to solve problems. "Our new [Johns Hopkins Health System] president, Kevin Sowers, is a nurse, and he saw a lot of redundancy and not enough standardization in the system," Wilmer says. "We had people doing great things, but they weren't doing it collectively. So, **Deborah Baker**, our senior vice president for nursing and chief nursing officer, charged us with creating a new governance structure that would bring nurses together to benefit the entire hospital."

Wilmer and other nurses in the Office of Nursing Professional Practice collaborated for more than two years to develop and refine the Wheel, determined to make it as simple and effective as possible. A clever YouTube video describes the process, which graphically suggests a wheel, circling to the top of nursing administration and back to the units from which the ideas originate.

Now any nurse or interdisciplinary collaborator can submit a "ticket," briefly describing an issue they've noticed or a suggestion for improvement, on a convenient online submission tool.

Front-line nurses, including new nurses, are encouraged to apply to serve on their specialty coordinating council — pediatrics or emergency medicine, for instance. Those council members can then be selected to serve on the organization-level Professional Practice Coordinating Council (PPCC), which reviews the tickets, as well as a Professional Practice Executive Steering Council (PPESC), which prioritizes issues referred for action by the PPCC. Projects deemed urgent and doable merit creation of a Community — a work group composed of people with the relevant interest and expertise — and the group is given a specific amount of time to study and resolve the issue.

A gratifying number of ideas have already moved through the Wheel to fruition. For the first time ever, night shift nurses have their own advisory group. Advisory groups provide a two-way forum for clinical and other specified nurses to advise the chief nursing officer and directors

of nursing on professional and operational topics.

A ticket suggesting the creation of a night shift advisory group was submitted by neuro critical care nurse **Jess Jenkins**, who works night shift and who applied for and was chosen to serve on both the PPCC and PPESC. Everyone loved the idea, and it moved rapidly through the Wheel, resulting a year ago in the establishment of the new advisory group, which meets every month (virtually because of COVID-19) to share ideas and concerns. The meetings are attended by Deborah Baker, chief nursing officer at The Johns Hopkins Hospital, or a director of nursing, to ensure a two-way communication with leadership.

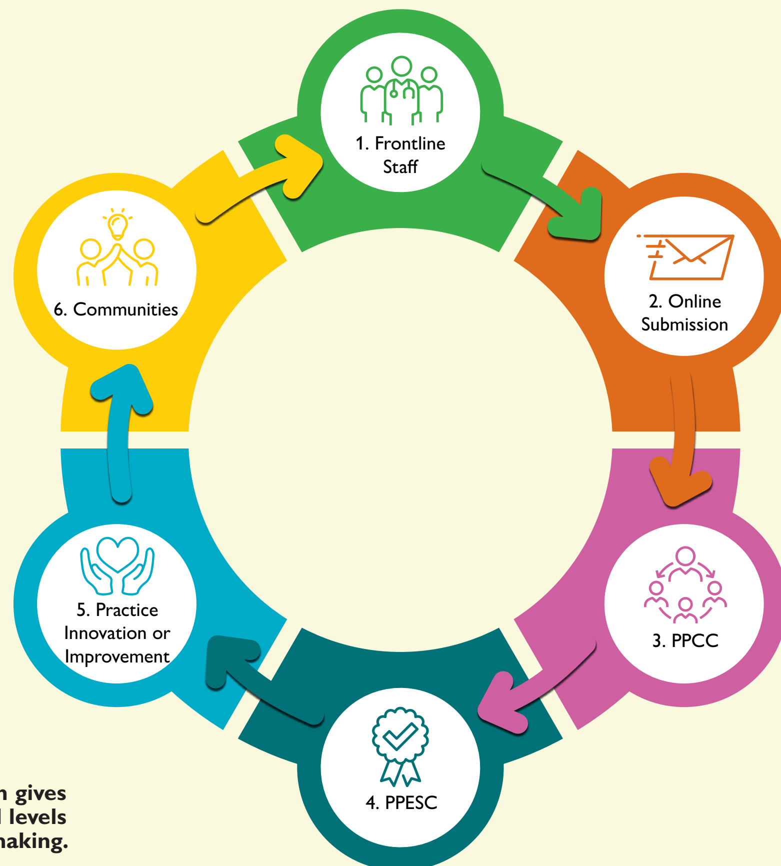
"Deb thinks it's one of the greatest ideas to move through the Wheel," says **Kelley Ennis**, an RNIII in the urology ambulatory clinic who is serving on all three levels of councils and loves the new governance process. "Finally, the night shift nurses have a live forum in which to air their concerns. It's a terrific experience, to be part of making things like that happen."

Ennis says she's talked to nurses from other hospitals who envy the new process. "We have bedside nurses literally at the governance table, both experienced and brand-new nurses. Everyone has a voice," she says. "And another great idea was that we will serve only three-year terms so more nurses have a chance to be involved. It's fun to get together with nurses from other units to advance their ideas. I've learned so much about the wider world of nursing."

Ennis says the reason the Wheel works "is that Hopkins nurses have compassion and vision. And our council members are very dedicated. We get the job done at every meeting."

Yet Wilmer and other nurse leaders are not content to rest on their laurels. "The Wheel is going to continue to evolve with input from staff across JHH." Wilmer says. "It's novel and innovative, something no one else is doing, which is just so Hopkins." ■

The Nursing Governance Structure at The Johns Hopkins Hospital



The "Wheel," which gives nurses a voice in all levels of decision-making.

Making Their Voices Heard

For bedside nurses, a career-ending injury can happen in an instant. You are trying to move or turn a patient, or catch them when they are about to fall. And the patient, who may be delirious and outweigh you by 200–300 pounds, grabs you and wrenches your shoulder or back.

"It's terrifying how quickly it can happen," says **Grace Nayden**, who has been a nurse at The Johns Hopkins Hospital for 31 years, 30 of them on the cardiac care unit, an intensive care unit where she is a lead clinical nurse. Even though the hospital invests in special equipment to help with lifting, when things are happening fast, a nurse might not have time to use it.

Nayden has been out of commission with serious back and shoulder injuries twice, but for her, the last straw was permanently losing two of her best nurses to shoulder injuries just before COVID-19 hit. So, she aired her concerns at a nursing department Solution Session, a bimonthly virtual forum guided by a trained facilitator, in which small groups of nurses brainstorm about problems and possible solutions.

The issue resonated strongly with **Holley Farley**, nursing coordinator for clinical quality, who was told about the discussion at the Solution Session and had her own concerns about a recent patient fall that might have been prevented if the proper lift equipment had been employed. Farley helped shepherd the issue through the new nursing governance system, the Wheel, and now a Community, or work group, is investigating best practices to ensure that the lift equipment is being used, and used correctly, and implementing a hospitalwide solution.

"It's a matter, not only of staff harm, but of patient harm," she says. "But this would never have happened without a bedside nurse like Grace Nayden reporting a problem."

Listening to bedside nurses has long been a priority at The Johns Hopkins Hospital, and there is an ever-growing number of ways nurses can make themselves heard:

- **The Governance Wheel**: This is the big one, the revised nursing governance structure in which bedside nurses have the opportunity to sit on governing councils with nursing leadership at all levels. It starts with simple suggestions — "tickets" — from any staff member and includes three levels of councils: councils representing each unit, a council that triages suggestions, and a council that determines when and how to address significant hospitalwide issues that have made it to them through the Wheel.
- **Solution Sessions:** These intimate virtual meetings are opportunities to air everything from Nayden's nurse injury concerns to how nurses can better care for themselves on the job. And if an issue affects the entire hospital, as did Nayden's, it can be fed directly into the Wheel.
- **Opinion surveys:** Johns Hopkins Medicine is committed to getting feedback from all staff and recently selected an innovative new survey platform that allows for shorter, more frequent surveys on issues ranging from patient care to staff mental health. Results can be more easily consolidated and issues that need to be addressed can be more quickly identified.
- **Virtual forums:** These replace the pre-COVID-19 quarterly in-person Town Halls, and draw hundreds of nurse participants to hear updates and questions answered by leadership, including Deborah Baker, chief nursing officer. Questions are asked by email, and the sessions are recorded so every nurse can watch when it's convenient.
- **Advisory councils:** There are two of these, one representing night shift nurses, and the other the Magnet Advisory Council, which promotes the high nursing standards that earned Johns Hopkins designation as a Magnet hospital. Baker or a director of nursing attends monthly or bimonthly meetings for both.

"One of the things Deb is always listening for is what she calls 'the pebble in the shoe,'" says **Sarah Porter**, director of nursing programs for the vice president's nursing office. "Sometimes it's just little things you think can never be fixed, but they can. At one of the pre-COVID-19 Town Halls, for instance, a night shift nurse asked why we couldn't keep the Metro doors inside the hospital open until midnight so staff wouldn't have to walk outside the hospital late at night, and that got fixed the next day."

Another issue raised by a bedside nurse that led to a hospitalwide reform was how to alert and educate staff members when a patient was in end-of-life palliative care. The result is a bloom of purple butterflies on these patients' doors, coupled with training for staff about how to speak to and around these patients and their loved ones.

"As a nurse at Hopkins, I have always felt empowered, especially at the unit and department levels," says Porter. "And we are continually exploring new platforms and more ways to further empower nurses and close the information loop, so that all nurses know their ideas and concerns are being heard." ■

Grace Nayden

“**We are continually exploring new platforms** and more ways to further empower nurses.”

SARAH PORTER

Labor and Delivery: 'No One Feels Forgotten'

As a staff nurse in the labor and delivery unit on Zayed 8, **Nikki Bellamy** worried that sick moms and babies were sometimes waiting too long to see a nurse or a doctor.

"When we got especially busy, we had patients sitting in the waiting room as long as eight hours without seeing a medical professional," she says. "So we had some near misses, and I just felt we needed a safer practice."

Bellamy shared her concern with obstetrics patient safety nurse **Susan Will**. "And Susan, who is my mentor and hero, said, 'OK, let's get together and brainstorm.'" So, in late 2014 they formed a committee.

"At the time, our triage was first come, first served," says Bellamy. "My idea was to provide rooms and care based on acuity, or the urgency of the case. And we wanted the process to be nursing driven."

It took nearly five years of research, trial runs and data collection, but the new system, which includes use of a well-tested obstetrics triage acuity tool, was fully adopted in 2019. Instead of patients checking in with security and registration while an unseen nurse allocates rooms, there is now a dedicated triage nurse who evaluates each patient before registration. That nurse also reevaluates patients at prescribed intervals. Patient wait time dropped 80%, and high-acuity patients are now assigned a room somewhere on the unit even when triage rooms are full.

"It's been a huge success, and our patients love it because no one feels forgotten," says Bellamy, who was honored this year with the newly created Johns Hopkins Hospital Nurse Professional Practice Model Award. "And I learned that as nurses, we can use our voices, not only to take excellent care of our patients, but to effect broader change." ■

The Language of Good Care

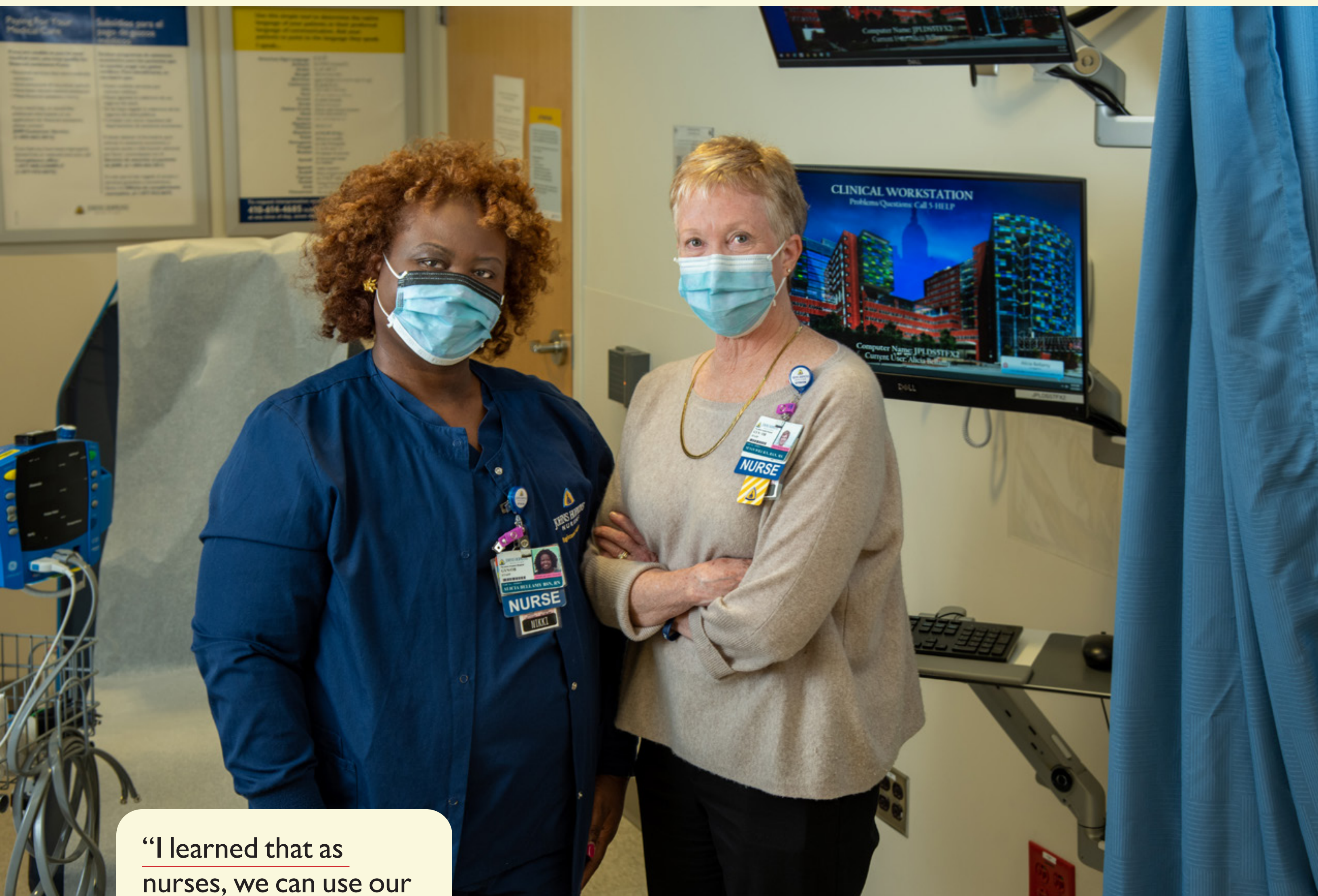
A floor nurse in Labor and Delivery, **Kate Whitney** has a special affinity for immigrants seeking health care. When she was 8, her family moved to Colombia, and she will never forget the terror she felt when she hurt her eye and had to navigate an unfamiliar emergency room in an unfamiliar language.

Now a qualified bilingual staff interpreter, she won a 2019 DAISY Award for Extraordinary Nurses for her exceptional care of a pregnant Spanish-speaking patient with complex medical issues. And her language skills became critically valuable during the pandemic. Labor and Delivery, which had set up its own bio-containment unit for patients with COVID-19, was seeing more and more patients from Baltimore's Latino community.

"Many were scared, having trouble breathing, worried about their babies. We could no longer have in-person interpreters, and the air filtration equipment was so noisy it was almost impossible to use interpreters over the phone," she says.

For months, Whitney worked nearly every shift on the COVID-19 unit helping care for those patients. "One patient Dr. [Andrew] Satin and I took care of in the ICU for many, many months came very close to death. But she finally got well, and when it came time to deliver her baby, they assigned her to me, so that was incredibly meaningful," Whitney says. "I just want all of my patients to know that we understand them and are there to help." ■

Kate Whitney



Susan Will

"I learned that as nurses, we can use our voices, not only to take excellent care of our patients, **but to effect broader change.**"

NIKKI BELLAMY

'Floating' to Fill a Vital Need

In February 2020, The Johns Hopkins Hospital officially launched its brand-new supplemental staffing unit (SSU), an ambitious effort to capitalize on the hospital's increasingly sophisticated data analytics capabilities to deploy "floating" nurses and other staff members precisely where they are needed, and when.

"By March 2020, the pandemic had begun, which propelled us into this much more quickly than we'd imagined," says SSU Program Director **Margie Burnett**. "My initial charge was to hire more intensive care unit nurses to support our ICUs, but we had to set up an office, hire staff and redeploy people from around the hospital."

Burnett, who has worked as a nurse at Johns Hopkins for 37 years, was previously program coordinator for clinical informatics at the hospital, which she defines as "the integration of computer science, nursing science and information science." Using that expertise, she helped plan the unit and was excited to have the chance to run it.

"We've never done something like this on this scale before," she says. "Some people were skeptical about floating nurses because different units have specific ways of doing things. But it is very satisfying when a unit needs additional support and we can help."

A year and a half after its launch, SSU boasts a leadership team, a crew to manage placements and scheduling, and more than 130 floating staff members, from experienced nurses to nursing assistants who function as patient safety attendants. Burnett is especially excited about her most recent SSU expansion — hiring newly graduated nurses. "Some people were leery of new graduates in a float position," she says. "But we've had great feedback, and units are asking to have them back, which is the best compliment we can get."

Emily Longenecker graduated in December 2020 from the nursing program at Harrisburg Area Community College knowing she wanted to work at Johns Hopkins, and knowing she wanted to work for SSU. "My second year of nursing school was in the middle of the pandemic and our clinicals were cut short, so I wanted time to experience all the different specialties in the hospital," she says.

As a new grad, she was nervous about how she would be received, "but every unit is experiencing shortages and has been nothing but welcoming," she says.

Gabrielle Wingett also graduated in December 2020, but from the University of Alabama, where she was permitted as a nursing student to work in a COVID-19 float pool at a local hospital. "I love floating because it keeps me on my toes and I'm always learning something new," she says. "And I think it can be helpful to have a wide range of experiences because patients often have a wide range of problems."

Burnett says one of her new grads even reported recognizing changes in a patient's status that were quickly addressed because she'd seen something similar during a previous assignment. "So, it's exciting because their experience in multiple areas can really help them put the patient picture together." ■

"**We've had great feedback**, and units are asking to have them back, which is the best compliment we can get."

MARGIE BURNETT

The Supplemental Staffing Office leadership team. From left to right: Anna Brompton, Margie Burnett, Christine Orlosky, Sarah Velazquez de Leon, James Gonzales, Kara Sessa, Carrie Long, Scarlette Frazier, Tetyana Mullin.

TeleSitter: Keeping an Eye Out

Multitasking is **Tiarra Waters'** superpower. With almost preternatural calm, the TeleSitter monitor clinical technician keeps an eagle eye on up to 12 at-risk patients, scattered across various Johns Hopkins Hospital units, via a bank of video monitors.

She sees one patient has pulled out an IV line, and immediately notifies his nurse. A moment later, Waters notes that another patient's camera has gone dark, and she makes a quick phone call to find out why and instruct a colleague on how to reestablish the connection.

"It's important to not pay so much attention to one thing that you miss something else," she says matter-of-factly.

At the beginning of the COVID-19 pandemic, Waters and her colleagues monitored some of the sickest patients on Nelson 5, which had been converted into a COVID-19 intensive care unit, because the unit wasn't at first equipped with the see-through sliding glass doors of a standard ICU.

"That was really sad, because we watched some patients for quite a while who didn't make it," Waters says.

Launched at Johns Hopkins in April 2018, the TeleSitter program at first served only a few units within the Department of Medicine, says **Katie Padgett**, lead clinical nurse on Nelson 7, whose supervisor, **Marian Asiedu**, is nurse manager for both Nelson 7 and the hospital's TeleSitter group. Within two years, the program expanded to the entire department, and in February 2021, it went hospitalwide.

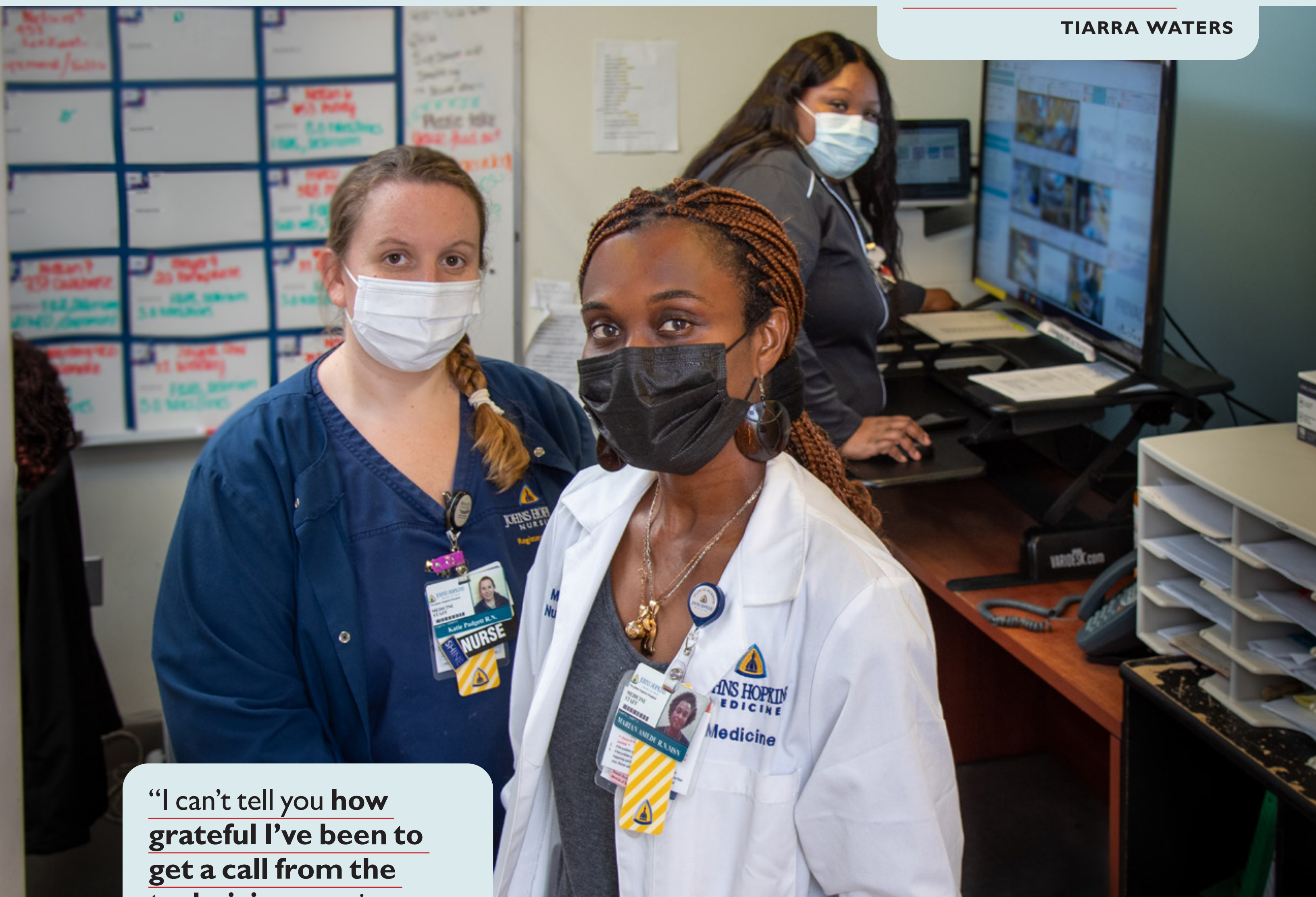
"We've expanded from 12 to 24 cameras, and are planning to acquire more," Padgett says. Patients who need constant supervision to keep them from ripping off dressings, tearing out catheters, or getting out of bed and falling have traditionally been observed by a sitter who simply stays with them in their room. With TeleSitter technology, one person can watch up to 12 patients at a time.

There are three technicians on each shift, two in the TeleSitter command hub watching the monitors and another visiting patients in person and redeploying their fleet of cameras as needed. All are trained in the specific needs of patients in each of the hospital units they serve. To keep themselves fresh and alert, they rotate these tasks every two hours.

"A lot of nurses have been skeptical, but it's just because they're not familiar with it," says Padgett. "I started out as a 'superuser' and got the training to teach other nurses, so I saw the data showing how effectively it reduces falls. Our TeleSitter technicians have alerted us to patients trying to scoot out of bed, a patient going into a seizure, and patients or their visitors bringing drugs or alcohol into the rooms. I can't tell you how grateful I've been to get a call from the technician warning me when a patient needs my attention." ■

At the start of the pandemic, it was really sad, because we watched some patients for quite a while **who didn't make it**."

TIARRA WATERS



"I can't tell you **how grateful I've been to get a call from the technician** warning me when a patient needs my attention."

KATIE PADGETT

Marian Asiedu

When it comes to quality of care, numbers not only tell the story, they also serve as motivators to make things better. Johns Hopkins nurses on these four units succeeded in improving a variety of quality nurse-sensitive indicators, from reducing infections to preventing falls. They all say collaboration was the key.

CAUTI-Prevention Champions

Preventing urinary tract infections in catheterized patients is a top priority for nurses at Johns Hopkins. And nurses on Nelson 5, a medical progressive care unit (MPCU) that normally serves patients who need special care but aren't sick enough for the intensive care unit (ICU), are no exception. In 2019, nurses reported only two cases of catheter-associated urinary tract infection (CAUTI).

But COVID-19 presented troublesome obstacles to CAUTI prevention. Prolonged catheterization is the biggest risk factor, according to the U.S. Centers for Disease Control and Prevention. Critically ill COVID-19 patients are sometimes catheterized for weeks.

CAUTI protocols had to be sacrificed at times to keep gravely ill patients stable. "Our sickest COVID-19 patients were proned [placed face down to improve oxygenation], which makes it hard to clean their catheters," says **Kate Boehner**, R.N. III. "Moving them for any reason could be dangerous."

In late March 2020, Nelson 5 had to be quickly converted into a COVID-19 ICU, and the jump in CAUTI numbers was immediate. By June, there were five new cases on the unit, three in April alone. "We were shocked," says **Carrie Outten**, a clinical nurse specialist who, with her colleagues, launched an extensive analysis, poring over charts, second-guessing procedures, reviewing literature and consulting specialists. They doubled down on prevention and education, instituting a best-practice bundle, including CAUTI audits, and recruiting Boehner to act as the unit's CAUTI champion to help conduct them.

By June 2021, when Nelson 5 finally returned to its normal role as an MPCU, it had been, for nearly nine months, completely CAUTI-free.

Crafting a Chain of Fall Prevention

Falling is a big safety issue for any hospitalized patient. But on an acute rehab unit such as Meyer 7, falls that result in injury are especially devastating. "Everything we do is about helping people recover their independence," says **Erin Hanson**, a lead clinical nurse who has worked on the unit since 2012. "If they fall and hurt themselves, it can be a huge setback."

A campaign to prevent falls with injury, initiated in August 2020 by the unit's nurse manager, **Eric Croucher**, has been highly effective, resulting in fewer falls with injury — including a recent period of three months with no falls with injury at all.

With support from fall prevention experts throughout the hospital, Croucher says the unit focused on its highest-risk patients, particularly patients who are cognitively impaired.

"To reduce anxiety and confusion, we eliminate unnecessary lights and noise in their rooms, for instance, make sure they're on good sleep schedules, and try always to be reassuring and let them know we're there to help," he says.

Other initiatives include staff debriefings after every fall and "green sheets" in each room indicating the assistance that a particular patient needs — perhaps one person and a rolling walker — to move around safely.

But Croucher's favorite innovation is a simple "huddle board" that highlights at-risk patients and lists "pearls" or things to be learned from falls from the previous quarter. It is adorned by a colorful paper chain that gets a new link every day the unit goes without a fall. "Good communication among the staff is a big part of fall prevention," says Hanson. "It really upsets us when a patient falls, so we are all pleased to see that chain getting longer."

"It really upsets us when a patient falls, so **we are all pleased to see that chain getting longer.**"

ERIC CROUCHER

"Everything we do is about **helping people recover their independence.**"

ERIN HANSON

As part of their fall-prevention campaign, the Meyer 7 team adds a link to this colorful paper chain each day that the unit goes without a fall. Pictured from left to right, Eric Croucher, Sharon Sparks, Emily Floyd, and Erin Hanson.

> "I have to hand it to our nurses. Their attitude is 'Yes, it's changing our routine, but **if it's the best thing for our kiddos, we're going to do it**.'"
>
> **OLIVIA SWIFT**

Olivia Swift

Diane Rusnak

All in the Details: Preventing CLABSI in Kids

Infections associated with central lines, the IV lines inserted into a major vein in many hospitalized patients, can be life-threatening, but are preventable. And if anyone understands what it takes to prevent central line-associated bloodstream infections (CLABSI), it's the nurses on Bloomberg 9. This pediatric medical/surgical inpatient and research unit hasn't seen a single case in a year and a half.

Their secret? Constant vigilance, adherence to strict protocols, and great communication and flexibility among staff, says **Olivia Swift**, R.N. III, who serves as the unit's CLABSI champion.

Bloomberg 9's strict schedule of three daily meetings around a huddle board, on which staff pen up-to-the-minute information about patients with central lines, has become a hospital-wide model. Additionally, because daily baths with chlorhexidine wipes are a proven method of infection prevention and have to be done at least an hour apart from soap and water baths, Swift recently initiated a new policy of performing such baths every evening at 8 p.m., when children are already undressed to be weighed.

"It's very simple, and it allows the daytime shift to do the real bath, or 'spa time' as they often refer to it," Swift says. "It does change the workflow, so I have to hand it to our nurses. Their attitude is 'Yes, it's changing our routine, but if it's the best thing for our kiddos, we're going to do it.'"

Pressure Relievers

Preventing pressure injuries, or bedsores, is a huge part of caring for medically fragile patients. Usually caused by prolonged pressure on bony parts of the body, these skin breakdowns can be extremely painful and, if they become infected, life-threatening.

For several years, **Diane Rusnak**, lead clinical nurse on the surgical intensive care unit Zayed 9E, has been involved in a major hospital-wide initiative to reduce unit-acquired pressure injuries (UAPIs). On her own unit, she recently implemented an initiative to eliminate the longstanding use of adult diapers by lining beds to wick away excess fluids, whether from incontinence or weepy wounds.

"We had gotten new airflow beds, which alternate inflated and deflated air cells in order to relieve pressure on the patient's body, and were looking for the best possible linen combination," she says. "So instead of all that impermeable padding, we settled on having only one sheet, with a Dri-Flo pad [which is both absorbent and permeable] underneath, and that allows the patient's skin to breathe."

This initiative and other changes — including ways to more carefully turn patients, which is usually done every two hours to prevent pressure injuries — resulted in a dramatic drop in the number of UAPIs on Zayed 9E, where Rusnak has worked for 38 years.

Some pressure injuries are unavoidable, she says. The unit saw an uptick in UAPIs during the COVID-19 pandemic, for instance, when it went twice into full biomode, from March to June 2020, and again from December 2020 to January 2021. Repositioning critically ill COVID-19 patients to prevent pressure injuries was often too dangerous because these patients had no respiratory reserves.

"There's still a lot of work to be done," Rusnak says. "Even if you can't prevent all UAPIs, there is a lot we can put into play to prevent most of them." ■

Casey Green

A Certification Celebration

Casey Green of the pediatric cardiology intensive care unit at Johns Hopkins Children's Center could make quite an alphabet soup by tossing in a pot the letters from her emergency nursing certifications. But she has something even more important cooking.

In the summer of 2021, Green became just the 85th nurse in the United States ever to hold all five certifications from the Board of Certification for Emergency Nursing:

- Certified Transport Registered Nurse (C.T.R.N.)
- Certified Flight Registered Nurse (C.F.R.N.)
- Certified Emergency Nurse (C.E.N.)
- Trauma Certified Registered Nurse (T.C.R.N.)
- Certified Pediatric Emergency Nurse (C.P.E.N.)

The C.T.R.N. is a rare certification belonging to only a few hundred nurses, and it was Green's motivation to strive for more. Once she obtained the C.T.R.N., she knew nothing was out of the question.

"The C.T.R.N. and the C.E.N. — I'd say they're tied" for the hardest to achieve, Green says.

On top of these, Green also holds — at age 28 — a critical care registered nurse (C.C.R.N.) certification from the American Association of Critical-Care Nurses. Put it all together, and meet Casey Green, R.N., C.C.R.N., C.T.R.N., C.F.R.N., C.EN., T.C.R.N., C.P.E.N. Joining such an elite group of nurses "is still so surreal to me," she says.

Becoming certified is one way for nurses to grow skills and expand expertise throughout their careers. Currently, about 950 Johns Hopkins Hospital nurses have at least one certification.

Obtaining certification is not "just a test anyone can take," Green says, nor is it "just about adding more letters after your name. The knowledge you gain even while studying for certification translates directly into improving your nursing practice, which improves the care you provide to every patient you interact with," she explains.

"As I passed the first emergency certification," Green recalls, "I went on and started scheduling others. I ended up taking six exams in four months!" And she's done it all while working at the hospital and serving as an adjunct faculty member at Howard Community College.

Green hopes her story will influence others who have thought about certification but haven't moved forward. Her next step is "applying for C.R.N.A. [certified registered nurse anesthetist] school … along with continuing to teach and inspire others to surpass me!" ■

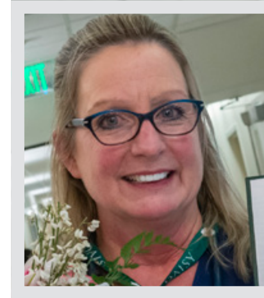
Daisy Award Winners

The 2020–21 Winners of the DAISY Award for Extraordinary Nurses

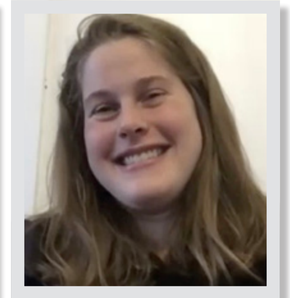
The Johns Hopkins Hospital is proud to honor its outstanding nurses with the DAISY Award — an international recognition program that celebrates the skillful, compassionate care nurses provide to patients and families every day.

Anyone can nominate a nurse by sharing a story of the outstanding care the nurse or nursing team provided. Each month, one extraordinary Johns Hopkins Hospital nurse is selected to receive the DAISY Award by a committee of peers, and one exceptional nursing team is honored annually. During the height of the COVID-19 pandemic, the individual award was presented quarterly.

Nominate an outstanding nurse at hopkinsmedicine.org/nursing/daisy.



Cindy Ryan
January 2020



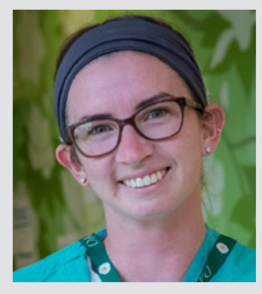
Stefanie Ness
February 2020

Hailey Wildasin
Winter 2020

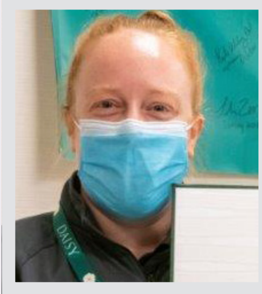
Donatta Opiew
Spring 2021

2020 Team Award Winners: The Nelson 5 Team

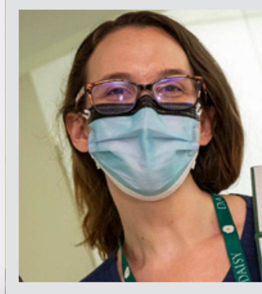
Nelson 5 Nurse Manager, Lara Street



Allison Green
March 2020



Stephanie Zero
Spring 2020

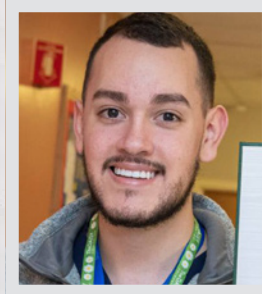


Rachel Anderson
Summer 2020

Tam Warczynski
Fall 2020

Latanya Johnson-Strong
April 2021

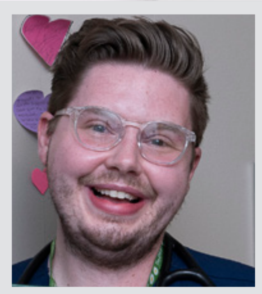
Janet Barnes
May 2021



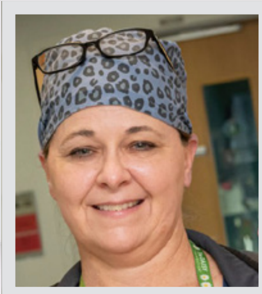
Eric Renteria
June 2021

Sarah MacLean
July 2021

Andrew Driscoll
August 2021



Corey Summers
September 2021



Teresa Kane
October 2021

Anna Lou Paniza
November 2021

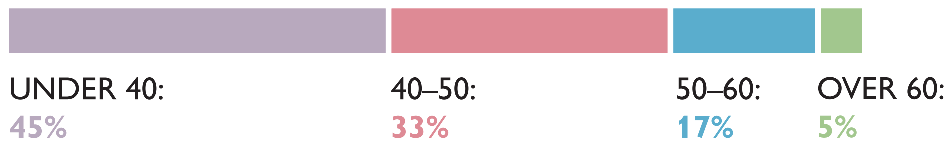
Our Workforce

WOMEN: 89% MEN: 11%

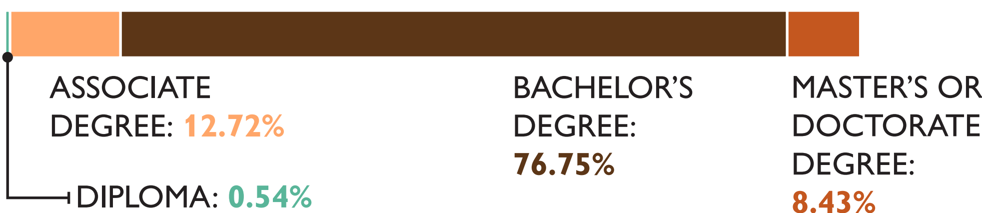
AVERAGE LENGTH OF SERVICE

3,485 REGISTERED NURSES

AGE



EDUCATION



CERTIFICATION

R.N.s CERTIFIED BY A NATIONALLY RECOGNIZED ORGANIZATION: **33%**

The Johns Hopkins Hospital has achieved ANCC Magnet Recognition four times. Magnet status is the gold standard for nursing excellence.

CLINICAL ADVANCEMENT AND PROMOTION

2020–2021:

From **R.N. I** to **R.N. II: 562**

From **R.N. II** to **R.N. III: 341**

From **R.N. II** to **lead clinical nurse: 6**

From **R.N. III** to **lead clinical nurse: 63**

ARTs PROGRAM YEAR 2020–21

Total number of nurses to complete the ARTs program in the 2020–21 program year: **432**

ARTs I: **214**

ARTs II: **218**

ARTs coaches: **175**

PROGRAM YEAR 2021–22 TO DATE

Number of participating nurses: **499**

ARTs coaches: **164**

NUR2107016

Supporting Nursing Excellence
at The Johns Hopkins Hospital

Every day, dedicated Johns Hopkins nurses go above and beyond to provide outstanding, compassionate care to our patients and their loved ones.

To honor their unwavering commitment and expertise as world leaders in nursing care, Johns Hopkins Nursing is working with the Fund for Johns Hopkins Medicine to raise philanthropic contributions from grateful individuals.

Donations to Johns Hopkins Nursing directly support opportunities for professional development, continuing education and well-being initiatives for nursing.

To make a tax-deductible donation, please visit
makeagift.jhu.edu/form/jhhnursing
or contact Adrienne Cappello at arose25@jhmi.edu.

Thank you for your support of Johns Hopkins Hospital nurses.

FLYOVER SALUTE

The iconic Johns Hopkins dome served as a fitting backdrop for a May 2 flyover by the U.S. Air Force Thunderbirds and U.S. Navy Blue Angels — part of a Maryland-wide Healthcare Heroes Day tribute to front-line staff members in response to COVID-19.

Photo by Lorraine Imwold

JOHNS HOPKINS
NURSING
THE JOHNS HOPKINS HOSPITAL