I had the pleasure of teaching a health policy class this past year that yielded a stimulating group of well thought out policy papers. Each student chose a subject that they could develop a policy statement around and then researched the evidence that supported or negated its merit. They were asked to list the stakeholders, develop criteria by which to evaluate the policy, discuss alternatives, and lastly, make an attempt to discuss how this might be financed. One paper in particular caught my attention, not because the subject was particularly exciting, in fact, it was disheartening, but because the student was so passionate about it. She chose lateral/horizontal violence in nursing as her subject. It seemed appropriate to address this subject as the continuing education offering in this issue of the ISNA Bulletin focuses on horizontal violence.

Lateral or horizontal violence is described as the aggressive and destructive behavior against each other. It is the demeaning and downgrading of others through unkind words and cruel acts that gradually undermine confidence and self-esteem (Woelfle & McCaffrey, 2007). Lateral violence threatens the health and well being of nurses and staff and has become a patient safety issue. The incidence of lateral violence has increased and has become a national issue not only for our professional nursing organization, ANA, but also for other specialty nursing organizations, accrediting agencies, and health care institutions to address. Many health care institutions have initiated zero tolerance policies, but the problem still exists. Some of the strategies institutions have initiated zero tolerance policies, organizations, accrediting agencies, and health care aggressors and external forces must to be built on trust and respect. Without this foundation any strategy will be short lived. I cannot recall being bullied by another nurse, however I have had a few unfortunate experiences from other healthcare providers. From an institutional standpoint, I have been blessed with wonderful nurse peers who have supported me and the staff when I worked in Indianapolis for Saint Francis, Winona and Wishard Hospitals. We had management that fully supported a respectful, trusting culture and had no tolerance for petty disagreements or lack of restraint from the nursing or medical staff. It has probably helped that I grew up with six brothers and three sisters. We lived in a small house with lots of bunk beds and shared chores. We had a common goal: family preservation and harmony. As I think back, I would define my mom and dad as, benevolent dictators, whose job was to support an environment in which each child could learn to trust and respect those with whom they lived and eventually translate this wisdom to the world outside their home. They required us to work outside their home. They required us to work and respect others if there was a problem. They helped us through the process and supported our efforts in working through those problems. We were accountable for our actions and there were consequences. We were responsible for loving each other, and ultimately respect and trust grew. It wasn’t easy, but it worked.

I believe there is a common theme with nursing management and my family experience. I know that learning to be a good manager began with my family. Similarly, managers must provide a supportive environment in which each staff nurse can thrive and learn to trust and respect their peers and management. They must be models for their staff. It is not easy. It takes commitment, passion and lots of focused work. Respect and trust must be nurtured through a commitment to the patients we serve and to be competent, caring and loving people, who treat others as we want to be treated. For me, the New Year begins, to recommit to respecting and trusting yourself and those with whom you work.

ISNA Board of Directors Meeting Summary

November 19, 2010

Present: Barbara Kelly, President; Diana K. Sullivan, Secretary; Directors Mary Cisco, Angela Heckman, Vicki Johnson; Ernest Klein, Executive Director. Absent: Paula McAfee, Vice President; Michael Fights, Treasurer. Guests: Kathy Weaver, Public Health Nurse Chapter

REVIEWED


ISNA's Strategic Plan: October 2010 Financial Statement

APPROVED

Minutes: August 13, 2010 Board conference call as amended; September 29, 2010 Annual Meeting of the Members; September 29, 2010 Executive Committee Conference Call; and September 30, 2010 Board of Directors Conference Call.

2011 ISNA Budget with $21,000 income over expenses. Transfer of income over expenses from the ISNAP CE Conference to the ISNAP Needs Assistance Fund. Proposal from EntImler CPA for audit, monthly financial statements and tax forms.

OTHER

Set Date/Location of 2011 Annual Meeting: Friday, September 30, 2011 Primo Banquet Center South Indianapolis.

Appointed Rose Marie Pennell, Ft. Wayne to the Committee on Approval vacancy. Brenda Lammert, Vinceannes, will serve as an alternate.

REPORTS

Verbal report from President Barbara Kelly on the Midwest Regional meeting and the ANA Constituent Assembly “virtual” meeting in Chicago, November 6 and 7, 2010. Reviewed the written staff report.

Safety Task Force–Cynthia Stone, Chairperson reported. Board agreed to move forward with the grassroots coalition building.

2011 Legislative Conferences, Diana Sullivan Reported. Adding an additional basic and a new advanced sessions.


ANA Assessment Increase

In 2004, the American Nurses Association House of Delegates passed an automatic dues escalator that increases the ANA Assessment Factor based on the Consumer Price Index for Urban Consumers (CPI-U). The rate change is computed using the 12 months percentage change from June to June each year. It stipulates that the change for any year cannot go below 0% and there is a 2% cap on any increase. In addition, the change in the Assessment Factor is to be rounded to the nearest dollar. Although this computation is made each year, the policy states that the dues increase is only to be implemented every three years.

In 2010, the ANA House of Delegates removed the sunset clause from the escalator policy allowing these changes in the ANA Assessment Factor to continue.

The increase was effective on January 1, 2011. At that time, the ANA Assessment Factor increased by $4.00, rising from $134 to $138.00. The ISNA portion of the dues will not change. The total annual ISNA/ANA Assessment is $273.00 for a full ISNA/ANA member. The monthly electronic payment will increase to $23.45/month.

BN969A - 2011 ISNA Budget with $21,000 income over expenses. Transfer of income over expenses from the ISNAP CE Conference to the ISNAP Needs Assistance Fund. Proposal from EntImler CPA for audit, monthly financial statements and tax forms.

BN970A - 2011 ISNA Budget with $21,000 income over expenses. Transfer of income over expenses from the ISNAP CE Conference to the ISNAP Needs Assistance Fund. Proposal from EntImler CPA for audit, monthly financial statements and tax forms.
### Welcome to New and Reinstated ISNA Members

<table>
<thead>
<tr>
<th>Name</th>
<th>City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judith Abell</td>
<td>Bloomington, IN</td>
</tr>
<tr>
<td>Donetta Alkazmari</td>
<td>Worthington, IN</td>
</tr>
<tr>
<td>Amy Bedan Poff</td>
<td>Borden, IN</td>
</tr>
<tr>
<td>Donna Blake</td>
<td>Carmel, IN</td>
</tr>
<tr>
<td>Beth Blevins</td>
<td>Fishers, IN</td>
</tr>
<tr>
<td>Beverly Bowling</td>
<td>Scottsburg, IN</td>
</tr>
<tr>
<td>Susie Brishaber</td>
<td>Sellersburg, IN</td>
</tr>
<tr>
<td>Leigh Brown</td>
<td>South Whitley, IN</td>
</tr>
<tr>
<td>Heather Coil</td>
<td>Colorado Springs, CO</td>
</tr>
<tr>
<td>Lisa Costlow</td>
<td>Centerville, IN</td>
</tr>
<tr>
<td>Penny Culp</td>
<td>Decker, IN</td>
</tr>
<tr>
<td>Carrie Darr</td>
<td>Sullivan, IN</td>
</tr>
<tr>
<td>Jodi DelHaven</td>
<td>Memphis, IN</td>
</tr>
<tr>
<td>Catherine Delnat</td>
<td>West Terre Haute, IN</td>
</tr>
<tr>
<td>Gloria Dillman</td>
<td>Munster, IN</td>
</tr>
<tr>
<td>Linda Dolan</td>
<td>Monrovia, IN</td>
</tr>
<tr>
<td>Karen Dunning</td>
<td>Hebron, IN</td>
</tr>
<tr>
<td>Denise Fullmer</td>
<td>New Carlisle, IN</td>
</tr>
<tr>
<td>Susan Gerhart</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Erika Gorslene</td>
<td>Portage, IN</td>
</tr>
<tr>
<td>Melissa Grcich</td>
<td>Knox, IN</td>
</tr>
<tr>
<td>Heather Hardin</td>
<td>Salem, IN</td>
</tr>
<tr>
<td>Kristin Hastings</td>
<td>Evansville, IN</td>
</tr>
<tr>
<td>Tamara Hawn</td>
<td>Bloomington, IN</td>
</tr>
<tr>
<td>Therese Hayes</td>
<td>Huntington, IN</td>
</tr>
<tr>
<td>Ronda Hendricks</td>
<td>Bloomington, IN</td>
</tr>
<tr>
<td>Monica Herning</td>
<td>Greenfield, IN</td>
</tr>
<tr>
<td>Nisa Hogle</td>
<td>APO AE</td>
</tr>
<tr>
<td>Rachel Holcomb</td>
<td>Batesville, IN</td>
</tr>
<tr>
<td>Julie Jones</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Marla Kantz</td>
<td>Lafayette, IN</td>
</tr>
<tr>
<td>Carolyn Kirkendall</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Denise Lakin</td>
<td>Brazil, IN</td>
</tr>
<tr>
<td>Sue Lasiter</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Karma Lee</td>
<td>Brownsburg, IN</td>
</tr>
<tr>
<td>Pamela MacLaughlin</td>
<td>Bloomington, IN</td>
</tr>
<tr>
<td>Caron MacPherson</td>
<td>Greenfield, IN</td>
</tr>
<tr>
<td>Megan Magee</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Noishah Malott</td>
<td>Fishers, IN</td>
</tr>
<tr>
<td>Katherine Maximena</td>
<td>Jasper, IN</td>
</tr>
<tr>
<td>Deborah May</td>
<td>Carmel, IN</td>
</tr>
<tr>
<td>Angela McNels</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Patricia McQuade</td>
<td>South Bend, IN</td>
</tr>
<tr>
<td>Franda Miller</td>
<td>Rochester, IN</td>
</tr>
<tr>
<td>Marnita Mills</td>
<td>Beech Grove, IN</td>
</tr>
<tr>
<td>Kathleen Morrison</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Charlene Myers</td>
<td>Delphi, IN</td>
</tr>
<tr>
<td>Jamie Napier</td>
<td>Seymour, IN</td>
</tr>
<tr>
<td>Beverly Richards</td>
<td>Fishers, IN</td>
</tr>
<tr>
<td>Kathryn Rickson</td>
<td>LaGrange, KY</td>
</tr>
<tr>
<td>Joyce Sines</td>
<td>Ft Wayne, IN</td>
</tr>
<tr>
<td>Svetlana Sparber</td>
<td>Munster, IN</td>
</tr>
<tr>
<td>Ruth Syron</td>
<td>Columbus, IN</td>
</tr>
<tr>
<td>Annie Trapp</td>
<td>Valparaiso, IN</td>
</tr>
<tr>
<td>Patricia Vassell</td>
<td>Miramar, FL</td>
</tr>
<tr>
<td>Penny Wagner</td>
<td>Moores Hill, IN</td>
</tr>
<tr>
<td>Christina Wheeler</td>
<td>Kokomo, IN</td>
</tr>
<tr>
<td>Rebekah Wood</td>
<td>Westville, IN</td>
</tr>
</tbody>
</table>
The Indiana State Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

The ISNA Committee on Approval approves continuing nursing education providers to award nursing contact hours to the individual activities they develop and present. Any individual, institution, organization, or agency in Indiana responsible for the overall development, implementation, evaluation, and quality assurance of continuing nursing education is eligible to seek approval as a provider. Information must be submitted describing three different educational activities planned, presented, and approved by the Indiana State Nurses Association in the two years preceding the application and should be representative of the types of educational activities usually provided. Applications are reviewed by the Committee on Approval at their meetings in May and November.

For information, contact the ISNA office, e-mail ce@IndianaNurses.org or visit the ISNA web site www.IndianaNurses.org/education. The following are continuing nursing education providers approved by the ISNA Committee on Approval:

For complete contact information go to: www.indiananurses.org/providers.php

Ball Memorial Hospital, Muncie, IN
Bloomington Hosp & Healthcare System, Bloomington, IN
Clarian Health Partners, Inc., Indianapolis, IN
Clarian North Medical Center, Carmel, IN
Clarian West Medical Center, Avon, IN
Columbus Regional Hospital, Columbus, IN
Community Health Network, Indianapolis, IN
Deaconess Hospital, Evansville, IN
Good Samaritan Hospital, Vincennes, IN
Health Care Education & Training, Inc., Carmel, IN
Health Care Excel, Inc., Terre Haute, IN
Hendricks County Regional Health, Danville, IN
Indiana Wesleyan University School of Nursing, Marion, IN
King's Daughters' Hospital & Health Services, Madison, IN
LaPorte Regional Health System, LaPorte, IN
Lutheran Health Network, Fort Wayne, IN
Major Hospital, Shelbyville, IN
Marion General Hospital, Marion, IN
MCV & Associates Healthcare Inc., Indianapolis, IN
Memorial Hospital & Health Care Center, Jasper, IN
Memorial Hospital of South Bend, South Bend, IN
Methodist Hospitals, Gary, IN
Parkview Health System, Fort Wayne, IN
Porter Education and Rehabilitation Center, Valparaiso IN
Purdue University Continuing Nursing Education, West Lafayette, IN
R.L. Roudebush VA Medical Center, Indianapolis, IN
Reid Hospital & Health Care Services, Richmond, IN
Schneck Medical Center, Seymour, IN
Scott Memorial Hospital, Scottsburg, IN
St. Francis Hospital & Health Centers, Beech Grove, IN
St. Joseph Regional Medical Center, South Bend, IN
St. Margaret Mercy, Hammond, IN
St. Mary’s Medical Center, Evansville, IN
St. Vincent Hospital & Health Care Center, Indianapolis, IN
The Community Hospital, Munster, IN
Valparaiso University College of Nursing, Valparaiso, IN
Wishard Health Services, Indianapolis, IN

I always enjoy sharing certification stories with you in this column. This time, I want you to meet seven nurses who have accepted the challenge of certification and achieved their goal. Here’s their story.

“About two years ago, I decided to organize a group of nurses to study for certification in OR nursing (CNOR). As the unit educator at Dupont Hospital, I knew implementing recommended practices in the OR would be easier if the unit’s nurses were aware and understood recommendations and standards of practice as endorsed by AORN. After doing some recruiting, I had 11 nurses express interest in forming a study group.

Our plan was simple. Following the recommended study guide offered by CCI, we planned to meet for 20 weeks, for one hour, to study. Since there were 20 areas of OR nursing to explore, we divided the topics among the group with every member of the group being responsible for creating handouts and teaching the topics selected. The hospital purchased books and study guides for the group and the department.

Our first meeting had 10 RNs attending. For the next 20 weeks we met for one hour after work and learned from our fellow team members. Almost every week had all 10 members attending.

Over the next several testing windows, we had 7 members of the group sit for the exam and pass! This makes our department have a about a 35% rate of Certified Operating Room Nurses (CNOR) working.”

—Liane Ammerman, RN, BSN, CNOR
Dupont Hospital Surgical Services Team Educator

Do you want to share your story with your colleagues? It may encourage them to join you! When you are successful, I'd love to share your story in this column too! It's time to get started! Please contact me at Sue.Johnson@parkview.com to share your experiences.
<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Event/Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 9, 2011 9:00 A.M.</td>
<td>Indiana State Nurses Association “Public Policy 101” Conference at Indiana State Teachers Association, 150 W. Market Street, Indianapolis, IN (4:15 contact hours)</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.IndianaNurses.org">www.IndianaNurses.org</a> Email: <a href="mailto:info@indiananurses.org">info@indiananurses.org</a></td>
</tr>
<tr>
<td>February 16, 2011 9:00 A.M.</td>
<td>Indiana State Nurses Association Legislative Conference “Advanced” at Indiana State Teachers Association, 150 W. Market Street, Indianapolis, IN</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.IndianaNurses.org">www.IndianaNurses.org</a> Email: <a href="mailto:info@indiananurses.org">info@indiananurses.org</a></td>
</tr>
<tr>
<td>February 17, 2011</td>
<td>Indiana State Board of Nursing Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN</td>
<td>Phone 317/234-2043 Email: <a href="mailto:pla2@pla.IN.gov">pla2@pla.IN.gov</a> Web: <a href="http://www.in.gov/pla/nursing.htm">www.in.gov/pla/nursing.htm</a></td>
</tr>
<tr>
<td>March 3, 2011 10:00 A.M.</td>
<td>Indiana Organization of Nursing Executives (IONE) Board Meeting/Hendricks Regional Health Bldg., 1100 Southfield, Plainfield, IN 46168 2nd floor conference room. Phone 317/839-7200</td>
<td>IONE, Phone 317/423-7731 Web: <a href="http://www.indianaone.org/ide3/html">www.indianaone.org/ide3/html</a> Email: <a href="mailto:mbisesi@johnsonmemorial.org">mbisesi@johnsonmemorial.org</a></td>
</tr>
<tr>
<td>March 4, 2011 10:00 A.M.</td>
<td>Indiana Organization of Nursing Executives (IONE) Spring Conference at Primo West</td>
<td>IONE, Phone 317/423-7731 Web: <a href="http://www.indianaone.org/ide3/html">www.indianaone.org/ide3/html</a> Email: <a href="mailto:mbisesi@johnsonmemorial.org">mbisesi@johnsonmemorial.org</a></td>
</tr>
<tr>
<td>March 4, 2011 9:30 A.M.</td>
<td>Indiana State Nurses Association Board of Directors Meeting 2915 N. High School Road, Indianapolis, IN</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.IndianaNurses.org">www.IndianaNurses.org</a> Email: <a href="mailto:info@indiananurses.org">info@indiananurses.org</a></td>
</tr>
<tr>
<td>March 8, 2011 9:00 A.M.</td>
<td>Indiana State Nurses Association “Public Policy 101” Conference at Indiana State Teachers Association, 150 W. Market Street, Indianapolis, IN (4:15 contact hours)</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.IndianaNurses.org">www.IndianaNurses.org</a> Email: <a href="mailto:info@indiananurses.org">info@indiananurses.org</a></td>
</tr>
<tr>
<td>March 17, 2011</td>
<td>Indiana State Board of Nursing Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN</td>
<td>Phone 317/234-2043 Email: <a href="mailto:pla2@pla.IN.gov">pla2@pla.IN.gov</a> Web: <a href="http://www.in.gov/pla/nursing.htm">www.in.gov/pla/nursing.htm</a></td>
</tr>
<tr>
<td>April 15, 2011 DEADLINE!</td>
<td>Indiana State Nurses Association Deadline for Consent to Serve Forms</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.IndianaNurses.org">www.IndianaNurses.org</a> Email: <a href="mailto:info@indiananurses.org">info@indiananurses.org</a></td>
</tr>
<tr>
<td>April 21, 2011</td>
<td>Indiana State Board of Nursing Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN</td>
<td>Phone 317/234-2043 Email: <a href="mailto:pla2@pla.IN.gov">pla2@pla.IN.gov</a> Web: <a href="http://www.in.gov/pla/nursing.htm">www.in.gov/pla/nursing.htm</a></td>
</tr>
<tr>
<td>May 3, 2011 10:00 A.M.</td>
<td>Indiana Organization of Nursing Executives (IONE) Board Meeting/Hendricks Regional Health Bldg., 1100 Southfield, Plainfield, IN 46168</td>
<td>IONE, Phone 317/423-7731 Web: <a href="http://www.indianaone.org/ide3/html">www.indianaone.org/ide3/html</a> Email: <a href="mailto:mbisesi@johnsonmemorial.org">mbisesi@johnsonmemorial.org</a></td>
</tr>
<tr>
<td>May 19, 2011</td>
<td>Indiana State Board of Nursing Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN</td>
<td>Phone 317/234-2043 Email: <a href="mailto:pla2@pla.IN.gov">pla2@pla.IN.gov</a> Web: <a href="http://www.in.gov/pla/nursing.htm">www.in.gov/pla/nursing.htm</a></td>
</tr>
<tr>
<td>June 3, 2011 9:30 A.M.</td>
<td>Indiana State Nurses Association Board of Directors Meeting 2915 N. High School Road, Indianapolis, IN</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.IndianaNurses.org">www.IndianaNurses.org</a> Email: <a href="mailto:info@indiananurses.org">info@indiananurses.org</a></td>
</tr>
<tr>
<td>June 16, 2011</td>
<td>Indiana State Board of Nursing Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN</td>
<td>Phone 317/234-2043 Email: <a href="mailto:pla2@pla.IN.gov">pla2@pla.IN.gov</a> Web: <a href="http://www.in.gov/pla/nursing.htm">www.in.gov/pla/nursing.htm</a></td>
</tr>
<tr>
<td>July 21, 2011</td>
<td>Indiana State Board of Nursing Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN</td>
<td>Phone 317/234-2043 Email: <a href="mailto:pla2@pla.IN.gov">pla2@pla.IN.gov</a> Web: <a href="http://www.in.gov/pla/nursing.htm">www.in.gov/pla/nursing.htm</a></td>
</tr>
<tr>
<td>August 12, 2011 10:00 A.M.</td>
<td>Indiana Organization of Nursing Executives (IONE) Board Meeting/Hendricks Regional Health Bldg., 1100 Southfield, Plainfield, IN 46168 2nd floor conference room. Phone 317/839-7200</td>
<td>IONE, Phone 317/423-7731 Web: <a href="http://www.indianaone.org/ide3/html">www.indianaone.org/ide3/html</a> Email: <a href="mailto:mbisesi@johnsonmemorial.org">mbisesi@johnsonmemorial.org</a></td>
</tr>
<tr>
<td>August 18, 2011</td>
<td>Indiana State Board of Nursing Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN</td>
<td>Phone 317/234-2043 Email: <a href="mailto:pla2@pla.IN.gov">pla2@pla.IN.gov</a> Web: <a href="http://www.in.gov/pla/nursing.htm">www.in.gov/pla/nursing.htm</a></td>
</tr>
<tr>
<td>September 9, 2011 9:30 A.M.</td>
<td>Indiana State Nurses Association Board of Directors Meeting 2915 N. High School Road, Indianapolis, IN</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.IndianaNurses.org">www.IndianaNurses.org</a> Email: <a href="mailto:info@indiananurses.org">info@indiananurses.org</a></td>
</tr>
<tr>
<td>September 9, 2011 DEADLINE!</td>
<td>Deadline Pre-Registration ISNA Annual Meeting of the Members September 30, 2011</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.IndianaNurses.org">www.IndianaNurses.org</a> Email: <a href="mailto:info@indiananurses.org">info@indiananurses.org</a></td>
</tr>
<tr>
<td>September 15, 2011</td>
<td>Indiana State Board of Nursing Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN</td>
<td>Phone 317/234-2043 Email: <a href="mailto:pla2@pla.IN.gov">pla2@pla.IN.gov</a> Web: <a href="http://www.in.gov/pla/nursing.htm">www.in.gov/pla/nursing.htm</a></td>
</tr>
<tr>
<td>September 30, 2011</td>
<td>ISNA Annual Meeting of the Members Primo Banquet Center South, 2615 E. National Ave., Indianapolis, IN</td>
<td>Indiana State Nurses Association, Phone: 317/299-4575 <a href="http://www.IndianaNurses.org">www.IndianaNurses.org</a> Email: <a href="mailto:info@indiananurses.org">info@indiananurses.org</a></td>
</tr>
<tr>
<td>October 18, 2011 1:00 P.M.</td>
<td>Indiana Organization of Nursing Executives (IONE) Board Meeting/Brown County Inn</td>
<td>IONE, Phone 317/423-7731 Web: <a href="http://www.indianaone.org/ide3/html">www.indianaone.org/ide3/html</a> Email: <a href="mailto:mbisesi@johnsonmemorial.org">mbisesi@johnsonmemorial.org</a></td>
</tr>
<tr>
<td>October 19-21, 2011</td>
<td>Indiana Organization of Nursing Executives (IONE) Fall Conference/Brown County Inn</td>
<td>IONE, Phone 317/423-7731 Web: <a href="http://www.indianaone.org/ide3/html">www.indianaone.org/ide3/html</a> Email: <a href="mailto:mbisesi@johnsonmemorial.org">mbisesi@johnsonmemorial.org</a></td>
</tr>
<tr>
<td>October 20, 2011</td>
<td>Indiana State Board of Nursing Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN</td>
<td>Phone 317/234-2043 Email: <a href="mailto:pla2@pla.IN.gov">pla2@pla.IN.gov</a> Web: <a href="http://www.in.gov/pla/nursing.htm">www.in.gov/pla/nursing.htm</a></td>
</tr>
<tr>
<td>November 11, 2011 10:00 A.M. (Transition Meeting)</td>
<td>Indiana Organization of Nursing Executives (IONE) Board Meeting/Hendricks Regional Health Bldg., 1100 Southfield, Plainfield, IN 46168</td>
<td>IONE, Phone 317/423-7731 Web: <a href="http://www.indianaone.org/ide3/html">www.indianaone.org/ide3/html</a> Email: <a href="mailto:mbisesi@johnsonmemorial.org">mbisesi@johnsonmemorial.org</a> 2nd floor conference room. Phone 317/839-7200</td>
</tr>
<tr>
<td>November 17, 2011</td>
<td>Indiana State Board of Nursing Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN</td>
<td>Phone 317/234-2043 Email: <a href="mailto:pla2@pla.IN.gov">pla2@pla.IN.gov</a> Web: <a href="http://www.in.gov/pla/nursing.htm">www.in.gov/pla/nursing.htm</a></td>
</tr>
<tr>
<td>December 15, 2011</td>
<td>Indiana State Board of Nursing Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN</td>
<td>Phone 317/234-2043 Email: <a href="mailto:pla2@pla.IN.gov">pla2@pla.IN.gov</a> Web: <a href="http://www.in.gov/pla/nursing.htm">www.in.gov/pla/nursing.htm</a></td>
</tr>
</tbody>
</table>
Horizontal violence and bullying has been extensively reported and documented in healthcare, with serious negative outcomes for registered nurses, their patients, and health care employers. In this article horizontal violence (HV) will be defined and some of the theories behind it will be introduced. Bullying and horizontal violence will be discussed and various strategies to deal with it will be described. There has been quite a bit of research done on this topic and several studies will be highlighted. The Joint Commission (JCI) standards on maintaining a culture of safety will also be reviewed.

On the international level, one out of every three nurses plan to leave his or her position due to HV. In the United States, 97% of nurses report experiencing HV (Bartholomew, 2006). The effects of HV are reflected in poor patient and employee satisfaction scores and ultimately in the reputation of the hospital or setting (Hutchinson, Vickers, Jackson, and Wilkes (2006) suggested that violent behavior among nurses is “accepted” within the profession, and a nurse who is bullying is considered an under-reported phenomenon.

There are several terms used to describe this phenomenon: bullying, horizontal violence, and lateral violence. Bullying is an “offensive, abusive, intimidating, malicious or insulting behavior, or abuse of power conducted by an individual or group against another, which is offensive, abusive, intimidating, malicious or insulting to the recipient .” (Bartholomew, 2006) Bullying has been described as “overt and covert non-physical hostility, such as criticism, sabotage, undermining, inconsiderate actions, and work impeding” (Jackson, Clare, & Mannix, 2002).

Definitions of bullying share three elements that come from social and sexual harassment law: 1. 1. The behavior is intimidating or insulting. 2. 2. The behavior is repeated. 3. The behavior is directed at the recipient, not the intention of the bully.

Horizontal violence and bullying are terms used to describe the physical, verbal, or emotional abuse of an employee by a member of any form of bullying. Other terms have been described as “overt and covert non-physical hostility, such as criticism, sabotage, undermining, inconsiderate actions, and work impeding” (Jackson, Clare, & Mannix, 2002).

Disenfranchising work practices can also contribute to HV. This would include task and time imperatives, where patients are seen as tasks rather than people. Generational and hierarchical abuse is often exhibited when nurses eat their young because they were treated badly when they started. Other factors are clique formation and low self-esteem. Nurses who are the most vulnerable to HV are newly hired nurses, temporally assigned nurses as floats, newly licensed nurses, and nurses from a different group or culture, such as male nurses (Griffin, 2006).

Education and increased awareness is the key to dealing with HV. To eliminate the problem of HV, Gasparis Vonfrolio (2005) indicated we must address the problem of HV and its impact on health professionals and patients.

Workplace violence is only physical (a lot of HV is psychological).

All workplace violence is reported by the victims (in 1996 the US Dept of Justice found that more than 50% of acts of violence in the workplace go unreported).

Victims of workplace violence have only themselves to blame. (In general 50% of individuals blame themselves for their mishap).

Violence is not destructive.

Prevention is more expensive than repairing the damage.

Victims of workplace violence believe in justice and its support.

The ten most frequent forms of HV as described by Boulton (2000) include the following behaviors, listed in order from the most to the least frequently encountered. Nonverbal (loudness, raising of eyebrows, making faces) verbal affronts (snide remarks, lack of openness, and abrupt responses) and undermining behaviors (turning away or not being helpful). Withholding information (deliberately setting up a negative situation), inflicting (bickering) and “scapegoating” (attributing HV to others). All these behaviors are other forms of HV. Backstabbing (complaining to others about an individual and not speaking directly to that individual), failure to respect boundaries, discerning confidences are the last three forms of HV identified.

Impact of Horizontal Violence

HV has individual, organizational, and financial impacts. Individual impact includes health problems due to chronic anger, decreased self-esteem and lack of motivation. Social impact includes strained relationships and low interpersonal support. Depression, stress and burnout are indicators of this impact, which can result in physical manifestations of illness (Bartholomew, 2006). Patient safety is also at risk. "The consequences of HV are detrimental to patient safety, and may cause the patient serious emotional and physical injuries. Nurses who perceive that their clinical questions or concerns would not be viewed in a positive manner from their experienced colleagues are less likely to seek a second opinion from a fellow nurse or seek advice from an experienced colleague. This may result in the number of days lost from bullying by comparing absenteeism figures, they found that more than 50% of acts of violence in the workplace go unreported."

Victims of workplace violence have only themselves to blame. (In general 50% of individuals blame themselves for their mishap).

Violence is not destructive.

Prevention is more expensive than repairing the damage.

Victims of workplace violence believe in justice and its support.

The ten most frequent forms of HV as described by Boulton (2000) include the following behaviors, listed in order from the most to the least frequently encountered. Nonverbal (loudness, raising of eyebrows, making faces) verbal affronts (snide remarks, lack of openness, and abrupt responses) and undermining behaviors (turning away or not being helpful). Withholding information (deliberately setting up a negative situation), inflicting (bickering) and “scapegoating” (attributing HV to others). All these behaviors are other forms of HV. Backstabbing (complaining to others about an individual and not speaking directly to that individual), failure to respect boundaries, discerning confidences are the last three forms of HV identified.

Impact of Horizontal Violence

HV has individual, organizational, and financial impacts. Individual impact includes health problems due to chronic anger, decreased self-esteem and lack of motivation. Social impact includes strained relationships and low interpersonal support. Depression, stress and burnout are indicators of this impact, which can result in physical manifestations of illness (Bartholomew, 2006). Patient safety is also at risk. "The consequences of HV are detrimental to patient safety, and may cause the patient serious emotional and physical injuries. Nurses who perceive that their clinical questions or concerns would not be viewed in a positive manner from their experienced colleagues are less likely to seek a second opinion from a fellow nurse or seek advice from an experienced colleague. This may result in the number of days lost from bullying by comparing absenteeism figures, they found that more than 50% of acts of violence in the workplace go unreported."

Victims of workplace violence have only themselves to blame. (In general 50% of individuals blame themselves for their mishap).

Violence is not destructive.

Prevention is more expensive than repairing the damage.

Victims of workplace violence believe in justice and its support.
In addition to the institution adopting a zero tolerance policy for HV, other strategies identified by CAN (2008) included promoting a culture of safety, providing leadership training for managers and educational staff about the effects of HV, providing support for anyone impacted by HV, and creating a system for reporting and monitoring. It is suggested individuals participate with other hospitals to pass state legislation. Employers should have an appropriate anti-bullying policy both to prevent bullying and to deal with cases speedily should they arise. Not dealing with cases speedily will give rise to worsening of the situation and may increase the psychological damage involved. The matter of bullying should be addressed in the safety statement (Prevention, 2001).

**Individual Strategies**

Individual strategies include accepting one’s fair share of the workload, respecting other’s privacy, being cooperative with regard to the shared working conditions (e.g., light, noise), being willing to help when requested, and keeping confidences. Working cooperatively despite feelings of dislike, not speaking negatively about superiors, addressing co-workers by the first name, being calm before approaching them, and communicating respectfully, not engaging in a conversation about a co-worker with another co-worker, standing up for the “absent member” in a conversation where they are not present, and not criticizing publicly are other effective strategies (Bartholomew, 2006).

**Strategies to stop the cycle at the individual level include:**

- Gain control and recognize that the behavior is offensive and must stop - using “I” messages and describing the behavior is offensive and must stop.
- Confront the aggressor – make it clear that the behavior is offensive and must stop and that you will report it.
- Implement the plan.
- Confront the aggressor – make it clear that the behavior is offensive and must stop - using “I” messages and describing the behavior and how it made you feel.
- Make a formal written complaint, following the grievance policy.
- As a last resort, seek out legal advice if the situation warrants (Leiper, 2005).

**Thomas (2003) identified some additional strategies**

- Take time before you respond to a situation that makes you angry – use relaxation techniques or meditation or wait until you are calm before approaching them.
- Consult an expert if conflict is festering in the workplace.
- Let your colleagues know that you care about them and what they are going through.

**Breaking the Cycle continued on page 8**
Compliment rather than complain.

✓ Cultivate team spirit by recognizing high achievers, anniversaries, and other special events.

Additional suggestions offered by Bartholomew (2009b) when confronting a bully, include:

✓ Don’t wait—the sooner you confront the behavior, the better.

✓ Seek the support of a trusted person in private.

✓ Take a few deep, centering breaths before you begin the conversation.

✓ If you remember, when looking at the person in front of you, instead of across from each other.

✓ Remember: the goal: speak your truth.

✓ Remember, when someone is loud, aggressive, or mean, try to have your voice be something you wanted to say to them. It’s OK to speak directly to me.

✓ Vent, but don’t confront—The individuals I learn the most from are clearer in their directions and feedback. Is there some way we can structure this type of situation?

✓ Beating around the bushes—When something happens that is “different” or “contrary” to what I understood, it leaves me with questions. Help me understand how this situation may have happened.

Withholding information—It is my understanding that there was (is) more information available regarding the situation, and I believe if I had known that (more), it would (will) affect how I learn.

✓ Sabotage—There is more to this situation than meets the eye. Could you and I (whatever, whoever) meet in private and explore what happens?

✓ Infighting—Always avoid unprofessional discussion in nonprivate places. This is not the time or place. Please stop (physically walk away or metaphorically take a step back). This is not the time to do this.

✓ Scapegoating—I don’t think that is the right connection.

✓ Back-bashing—I don’t feel right talking about him/her/the situation when I wasn’t there or don’t know the facts. Have you spoken to him/her?

✓ Failure to respect privacy—it bothers me to talk about what you said to the 25 individuals or I only heard overheard that—it shouldn’t be repeated.

✓ Broken confidence—Wasn’t that said in confidence? Or that sounds like information that should remain confidential (Griffin, 2004, p. 260).

One year later Griffin asked participants open ended questions about their experience with HV, use of cognitive interventions as a strategy to deal with HV, and the overall socialization process. She found that the nurses who reported that they experienced HV confronted the perpetrators using techniques learned in class, and in every situation, the negative behavior stopped. However, four nurses were reluctant to talk about others in private.

Dunn (2003) used Briles’ Sabotage Savvy questionnaire and the Index of Work Satisfaction (IWS) to determine whether nurses who felt HV was compromising patient safety, while others felt compromising patient safety, while others felt disillusioned with the nursing profession. One-third of the respondents indicated that they had considered leaving nursing as a consequence of the incident. Many of these nurses did not report the incident because of the lack of support systems available for new graduates who experience HV.

Barrett, Platek, Korber, and Padula (2009) completed a study that included both quantitative and qualitative components. A pre-post design study was used with a control group. The majority of nurses were female, and the majority of the nurses were nurses as well as novice and veteran nurses. There should be policies in organizations relating to HV, protecting staff from and holding staff accountable for workplace bullying. This environment includes creating a culture of high-quality patient care when staff members work in an atmosphere of fear and intimidation. Management must take action to fight HV.

Establishing a culture that fosters a sense of cohesiveness among staff is a critical link in improving patient satisfaction and decreasing HV. Barrett, Platek, Korber, and Padula (2009) completed a study that included both qualitative and quantitative components. A pre-post design study was used with a control group. The majority of nurses were female, and the majority of the nurses were nurses as well as novice and veteran nurses. There should be policies in organizations relating to HV, protecting staff from and holding staff accountable for workplace bullying. This environment includes creating a culture of high-quality patient care when staff members work in an atmosphere of fear and intimidation. Management must take action to fight HV.

Barrett, Platek, Korber, and Padula (2009) completed a study that included both qualitative and quantitative components. A pre-post design study was used with a control group. The majority of nurses were female, and the majority of the nurses were nurses as well as novice and veteran nurses. There should be policies in organizations relating to HV, protecting staff from and holding staff accountable for workplace bullying. This environment includes creating a culture of high-quality patient care when staff members work in an atmosphere of fear and intimidation. Management must take action to fight HV.

Barrett, Platek, Korber, and Padula (2009) completed a study that included both qualitative and quantitative components. A pre-post design study was used with a control group. The majority of nurses were female, and the majority of the nurses were nurses as well as novice and veteran nurses. There should be policies in organizations relating to HV, protecting staff from and holding staff accountable for workplace bullying. This environment includes creating a culture of high-quality patient care when staff members work in an atmosphere of fear and intimidation. Management must take action to fight HV.

By the end of the hospital session on giving and receiving feedback and managing conflict, the nurses reported that the intervention focused on the impact of the intervention of overall group dynamics and processes. RN scores on the Conflict Management Scale (p=.037) and the NCLNP interaction scores improved post-intervention. Bally (2007) described the role of nursing leadership in creating a mentoring culture in the workplace. A mentoring culture among older nurses and HV among younger nurses heightened the importance of mentoring in the context of overall organizational stability and performance. If this is a long-term commitment and solution, it will lead to improve staff retention, satisfaction and better patient outcomes. Mentoring cultures depend upon elements of a stable infrastructure such as managerial and executive support, scheduling flexibility, incentives, and recognition opportunities. Effective mentoring programs are critical to achieving the sustainable effect of mentoring programs that are rooted deeply in organizational culture.

The Joint Commission Culture of Safety

The Joint Commission [TJC] (2008) recognized the need to “shift the culture” of the institution from one focused on patient safety and quality and created several standards relating to this:

✓ A culture characterized by open and respectful communication among all members of the healthcare team in order to provide patient safe care. It is a culture that supports openness, honest, and effective communication by using professional language.

✓ A culture characterized by open and respectful communication among all members of the healthcare team in order to provide patient safe care. It is a culture that supports openness, honest, and effective communication by using professional language.

✓ A culture characterized by open and respectful communication among all members of the healthcare team in order to provide patient safe care. It is a culture that supports openness, honest, and effective communication by using professional language.

✓ A culture characterized by open and respectful communication among all members of the healthcare team in order to provide patient safe care. It is a culture that supports openness, honest, and effective communication by using professional language.

✓ A culture characterized by open and respectful communication among all members of the healthcare team in order to provide patient safe care. It is a culture that supports openness, honest, and effective communication by using professional language.

✓ A culture characterized by open and respectful communication among all members of the healthcare team in order to provide patient safe care. It is a culture that supports openness, honest, and effective communication by using professional language.

✓ A culture characterized by open and respectful communication among all members of the healthcare team in order to provide patient safe care. It is a culture that supports openness, honest, and effective communication by using professional language.
zero tolerance, initiating disciplinary action, and reducing fear of intimidation or retribution. Developing and implementing a reporting/surveillance system was also suggested.

Ignoring bad behavior has potentially serious consequences for patients. Aleccia (2008) stated about 70 percent of nurses studied believe there's a link between disruptive behavior and adverse outcomes, and nearly 25 percent said there was a direct tie between the bad acts and patient mortality. In an Institute for Safe Medication Practices study of about 2,000 clinicians more than 90 percent said they’d experienced condescending language or voice intonation; nearly 60 percent had experienced strong verbal abuse and nearly half had encountered negative or threatening body language (Institute of Medicine, 2007).

Bartholomew (2009) discussed how nurse managers can create collaborative relationships on their unit with physicians. Research shows that 1-3% of physicians are disruptive, yet this group causes exponentially devastating effects on morale, retention, and patient safety. Managers must take the necessary actions to demonstrate to nurses and physicians the standard of acceptable behavior and set the tone for collegiality on the unit. Nothing is more powerful than staff witnessing a manager approaching a disruptive physician and saying, “Can I speak to you for a minute in my office?”

Suggestions given by Lindeke (2008) to develop collaborative relationships grouped strategies into three categories: self-development, team development, and communication development. Self-development strategies included developing emotional maturity, understanding the perspectives of others, and avoiding compassion fatigue. Team development strategies included building the team, negotiating respectfully, managing conflict wisely, and designing facilities for collaboration. Communication development strategies included communicating effectively in collaboration. Communication development strategies included building the team, negotiating respectfully, managing conflict wisely, and designing facilities for collaboration.

Horizontal violence is a phenomenon that is detrimental to patient safety and should not be allowed to continue. This is a serious problem and it is imperative that the profession addresses this problem. Various organizational and individual strategies were outlined to combat HV and minimize its impact on staff. Organizations need to create a culture where HV is not tolerated.

Nurses and students need to be given tools that provide information on how to address conflicts and change disruptive behavior in the workplace. Nurses, individually and collectively, must enhance their knowledge and skills in managing conflicts and promote workplace policies to eliminate HV.

References


Breaking the Cycle continued on page 10


Thomas, S. F. (2003). Horizontal hostility: Nurses against themselves: How to resolve this threat to retention. *AJN, 103*(10), 87-91.


H:\bb\articles\Breaking the Cycle of Horizontal Violence

---

**INDEPENDENT STUDY**

This independent study has been developed to enable nurses to recognize and deal with horizontal violence. 1.06 contact hours will be awarded for successful completion of this independent study. Ohio Nurses Foundation, Copyright © 2010, Ohio Nurses Foundation.

The Ohio Nurses Foundation (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation. Expires 12/2012

**DIRECTIONS**

1. Please read carefully the enclosed article “Breaking the Cycle of Horizontal Violence.”
2. Complete the post-test, evaluation form and the registration form.
3. When you have completed all of the information, return the following to the Indiana State Nurses Association, 2015 North High School Rd, Indianapolis, IN 46224:
   A. The post-test;
   B. The completed registration form;
   C. The evaluation form; and
   D. The fee: ISNA Member/LPN ($15)–NON ISNA Member ($25)

The post-test will be reviewed. If a score of 70 percent or better is achieved, a certificate will be sent to you. If a score of 70 percent is not achieved, a letter of notification of the final score and a second post-test will be sent to you. We recommend that this independent study be reviewed prior to taking the second post-test. If a score of 70 percent is achieved on the second post-test, a certificate will be issued.

If you have any questions, please feel free to call Sandra Ohri, MA, MS, RN, Director, Nursing Education, zohri@ohnurses.org, 614-448-1027, or Sandy Swearingen, sawrearingen@ohnurses.org, 614-448-1030, Ohio Nurses Foundation at (614) 437-5414.

**OBJECTIVES**

Upon completion of this independent study, the learner will be able to:

1. Describe horizontal violence in healthcare.
2. Describe strategies to deal with horizontal violence.

This independent study was developed by: Barbara Brun, MA, MN, RN-BC, NE- BC, Director, Nursing Education and Staff Development, Summa Health System. The author and planning committee members have declared no conflict of interest.

There is no commercial support or sponsorship for this independent study.

Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice.
DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name: ______________________________

Final Score: ________________________

Please circle one answer.

1. Bullying is behavior which is generally persistent, systematic, and ongoing.
   a. True
   b. False

2. Name-calling, backstabbing, and gossip are three examples of what type of hostility?
   a. Overt
   b. Covert
   c. Severe
   d. Illegal

3. Which of the following is an example of covert behavior?
   a. Fault-finding
   b. Criticism
   c. Sabotage
   d. Shouting

4. Associations that have issued statements regarding horizontal violence include all of the following EXCEPT:
   a. Center for American Nurses
   b. American Nurses Credentialing Center
   c. American Association of Critical Care Nurses
   d. International Council of Nurses

5. Characteristics of an oppressed group include:
   a. High self-esteem
   b. Self-hatred
   c. Heightened sense of identity
   d. Sense of power and control

6. Nurses who are most vulnerable to horizontal violence are newly hired or licensed nurses, float nurses, and male nurses.
   a. True
   b. False

7. There are numerous myths about horizontal violence. Which of the following statements is true and is not a myth?
   a. Workplace violence is only physical
   b. Workplace violence is inevitable
   c. Prevenion is more expensive than repairing the damage
   d. The level of physical violence at work has changed

8. According to Bartholomew, the most frequent form of horizontal violence is:
   a. Backbiting
   b. Broken confidences
   c. Non-verbal innuendos
   d. Withholding information

9. The number one strategy to deal with horizontal violence is to:
   a. Increase awareness of the problem
   b. Report incidences to management
   c. Monitor employee satisfaction scores
   d. Maintain culture of blame

10. Individual impacts of horizontal violence include:
    a. Increased self-esteem
    b. Increased motivation
    c. Anger
    d. Decreased absenteeism

11. Organizational strategies to deal with horizontal violence include all of the following EXCEPT:
    a. Adopting a zero tolerance policy
    b. Embracing transformational leadership
    c. Promoting a culture of safety
    d. Developing reactive institutional policies

12. Individual strategies to deal with horizontal violence, as identified by the Center for American Nurses, include:
    a. Keeping a journal
    b. Adopting and modeling professional ethical behavior
    c. Accepting a fair share of the workload
    d. Reflecting on the behavior of others

13. In the study by Dunn, the highest ranking items reported by the victims were:
    a. Ceasing to talk when others enter
    b. Complaining about others
    c. Being expected to do others’ work
    d. Sharing false information with others

14. The organization that recognized the impact of poor interpersonal relationships on patient safety and quality and created several standards relating to this was:
    a. The American Hospital Association
    b. The Occupational Safety and Health Administration
    c. The Joint Commission
    d. The American Medical Association

15. Suggestions given by Lindeke to develop collaborative relationships included all of the following EXCEPT:
    a. Self-development
    b. Team development
    c. Communication development
    d. Organizational development

Evaluation:

1. Were the following objectives met? Yes No
   a. Describe horizontal violence in healthcare. □ □
   b. Describe strategies to deal with horizontal violence. □ □

2. Was this independent study an effective method of learning? If no, please comment: □ □

3. What one idea will you take from this study and apply to your setting? ________________________________

4. How long did it take you to complete the study, the post-test, and the evaluation form? ________________________________

5. What other topics would you like to see addressed in an independent study ________________________________

The Ohio Nurses Association (DBN:001-91) is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

________________________________________
______________________________
______________________________
February, March, April 2011 ISNA Bulletin • Page 11

Breaking the Cycle of Horizontal Violence

Post Test and Evaluation Form

Name: ____________________________

(Please print clearly)

Address: ____________________________ ____________________________________________

City/State/Zip: ____________________________ ____________________________________________

Daytime phone number: ____________________________ ____________________________________________

Fee: __________ ISNA Member/LPN ($15) __________ Non-ISNA Member ($25)

Please email my certificate to: ____________________________ ____________________________________________

Email Address (please print clearly)

MAKE CHECK PAYABLE TO THE INDIANA STATE NURSES ASSOCIATION.

Enclose this form with the post-test, your check, and the evaluation and send to:

ISNA, 2915 North High School Road, Indianapolis, IN 46224.

ISNA OFFICE USE ONLY

Date Received: ____________________________ Amount: ____________________________

Check No: ____________________________

Registration Form

Name: ____________________________

(Please print clearly)

Address: ____________________________

City/State/Zip: ____________________________

Daytime phone number: ____________________________

Fee: __________ ISNA Member/LPN ($15) __________ Non-ISNA Member ($25)

Please email my certificate to: ____________________________

Email Address (please print clearly)

Breaking the Cycle of Horizontal Violence

ONF-10-51-1

Registration Form
Public reporting on quality of care has definite, if modest, effects on nursing home care improvement

Public reporting of information about the quality of care delivered by health care providers is thought to improve quality in two ways: (1) consumers will be more likely to choose high quality providers, and (2) providers will have an incentive to invest in and improve the quality of care. A new study found that public reporting drove modest gains in nursing home care quality. A team of researchers headed by Rachel Werner, M.D., Ph.D., of the University of Pennsylvania, studied 6,137 nursing homes and 1,843,377 post-acute stays for the 12 months before and after the Nursing Home Compare public reporting requirements went into effect. The nursing homes were measured on three post-acute care quality measures: the percentages of short-stay patients who did not have moderate or severe pain, who were without delirium, and whose walking improved. The percentage of patients who were without moderate or severe pain increased from 73.8 percent to 77.3 percent with public reporting.

Nursing home-specific improvements in quality accounted for 2.4 percent of the increase, and an increased number of patients choosing high-quality nursing homes (increased market share) accounted for 1.6 percent. Residual changes in quality reduced the total by 0.5 percentage points. The percentage of patients without delirium increased only slightly from 96.2 to 96.5 percent since a 2.9 percent increase in market share was almost canceled out by residual changes of 2.7 percent. There were no overall changes in the percentage of patients with improved walking, since, once again, gains in quality and market share were canceled out by residual changes. This study was supported by the Agency for Healthcare Research and Quality (HS16478).

See “Public reporting drove quality gains at nursing homes,” by Dr. Werner, Elizabeth Stuart, Ph.D., and Daniel Polsky, M.D., in the September 2010 Health Affairs 29(9), pp. 1706-1713.

Nationwide survey shows free clinics provide care to nearly 2 million patients

The first survey in 40 years of all known U.S. free clinics shows that free clinics contribute substantially to the ambulatory care safety-net system (community health centers, emergency departments, public clinics, and hospital outpatient departments), even though they operate outside of it. Every State (with the exception of Alaska) and the District of Columbia has one or more free clinics.

Julie S. Darnell, Ph.D., M.H.S.A., currently of

the University of Illinois at Chicago, surveyed all known free clinics in the United States, with 764 out of the total 1,007 clinics responding to the survey. In any given year, these clinics provide care to 1.8 million patients, most of whom are uninsured. This amounts to 3.1 million medical and 300,000 dental visits. They provide these services at no cost or for a very low fee, and the majority of patients treat at free clinics are age 18 to 64. Half are white, 25.1 percent are Hispanic, and 21.2 percent are black. These clinics are also important sources of health care for the homeless.

The main services include physical examinations, medication dispensing, chronic disease management, and urgent/acute care. While more than half (54.1 percent) of all free clinics charge nothing for their services, 45.9 percent request an average fee or donation of $9.30 from the patient. If patients require x-rays or lab tests, most of these are free from other facilities when necessary. The study was supported in part by the Agency for Healthcare Research and Quality (HS15535).


Hospital charges for 1 in 20 hospital stays average $18,000 per day, according to the Agency for Healthcare Research and Quality (AHRQ). These patients were most likely to be in the hospital for treatment of septicemia (blood infection), hardening of the arteries, and heart attacks. According to AHRQ’s analysis, the average was based on the top 5 percent most expensive hospitalizations, or about 2 million patient stays. These stays lasted an average of 19 days. In contrast, daily hospital bills for the remaining 95 percent of patient stays in 2008 averaged just $18,000 per day, according to the Agency for Healthcare Research and Quality (AHRQ). These patients were most likely to be in the hospital for childbirth, pneumonia, and heart failure. Compared with the less expensive stays, patients with more expensive hospital stays also were:

• More severely ill—about 10 times more likely to experience extreme length of stay (39 percent vs. 4 percent).

• At greater risk of dying in the hospital—nine times more likely to be in the highest category for risk of death in the hospital (28 percent vs. 3 percent).

• Older—average age of 59 vs. 48 years.

This AHRQ News and Numbers is based on data in Most Expensive Hospitalizations, 2008 http://www.hcup-us.ahrq.hhs.gov/reports/statbriefs/sb99.jsp. The report uses data from the 2008 Nationwide Inpatient Sample, a database of hospital inpatient stays in all short-term, non-Federal hospitals. The data are drawn from hospitals that comprise 90 percent of all discharges in the United States and include patients, regardless of insurance type, as well as the uninsured. For more information, contact Bob Isquith at Bob.Isquith@ahrq.hhs.gov (301-427-1538).

Four million hospital admissions potentially unnecessary

About one in 10 of the nearly 40 million hospitalizations in 2008 were potentially avoidable, according to the latest News and Numbers from the Agency for Healthcare Research and Quality (AHRQ). The admissions were for conditions such as diabetes, dehydration, and certain heart conditions and infections for which hospitalization can be avoided if treated with appropriate outpatient care.

AHRQ data also found that:

• Rural hospitals had nearly twice as many potentially preventable admissions as urban hospitals (16 percent vs. 9 percent).

• People from lower-income communities accounted for nearly one-third more potentially preventable hospital admissions than patients from higher-income communities (12 percent vs. 8 percent).

• Hospitals in the West had the fewest potentially preventable admissions (8 percent) while those in the South had the most (11 percent).

• Patients aged 65 and older accounted for 60 percent of the potentially preventable hospitalizations.

This AHRQ News and Numbers is based on data in Potentially Preventable Hospitalizations for Acute and Chronic Conditions, 2008 http://www.hcup-us.ahrq.hhs.gov/reports/statbriefs/sb99.jsp. The report uses data from the 2008 Nationwide Inpatient Sample, a database of hospital inpatient stays in all short-term, non-Federal hospitals. The data are drawn from hospitals that comprise 90 percent of all discharges in the United States and include both insured and uninsured patients.

AHRQ Research Notes continued on page 13
For other information, or to speak with an AHRQ data expert, please contact Bob Isquith at Bob.Isquith@ahrq.hhs.gov or call (301) 427-1539.

**Premiums for some family plans cost $20,000 or more**

One in 10 enrolled workers in Alaska, Indiana, and Minnesota were in health insurance plans costing $20,000 or more—at least $7,000 more than the national average—for employer-based health insurance premiums that covered their families in 2008, according to the latest *News and Numbers* from the Agency for Healthcare Research and Quality (AHRQ). The Agency’s analysis of annual employer-based health insurance premiums also found that, for the nation as a whole, 10 percent of enrolled workers—about 2 million—had a family plan that cost $17,000 or more. The average annual premium for family plans in 2008 was $12,298.

In addition, AHRQ’s analysis of employer-based health insurance premiums in 2008 for private industry found that:

- The portion of family plan premiums paid by the employee for 1 in 10 workers nationwide was $6,700 or more, compared with the national average of $3,394.
- However, 10 percent of workers in Arizona, Colorado, New Mexico, and Washington spent at least $8,100 to get family coverage.
- Some 3.1 million workers nationwide with single coverage were in plans with annual premiums totaling $6,200 or more, or at least 41 percent higher than the national average of $4,306.
- For workers who were enrolled in single-coverage plans, 1 in 10 paid at least $1,900—more than double the national average of $882.

Health insurance premiums vary within and between the States. The survey provides estimates of the range of premium costs within each State and across the nation, in addition to average premiums.

The data in this AHRQ *News and Numbers* summary are taken from the Insurance Component of the Medical Expenditure Panel Survey [http://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp](http://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp), a source of detailed information on employer-sponsored health insurance coverage and costs at the national, State, and metropolitan area levels.

For MEPS summary data on employer-based health insurance premiums, go to [http://www.meps.ahrq.gov](http://www.meps.ahrq.gov).

---

**Pay-for-performance does not improve care quality in the short term in safety-net settings**

A new study questions the effectiveness of pay-for-performance (P4P) programs in improving the quality of care in safety-net settings that predominantly serve Medicaid and uninsured patients. The researchers found no evidence that P4P, financial incentives to providers to improve care quality, led to substantial quality improvements in the short term in two safety-net settings they examined. For example, incentives for well-child visits led to a significant increase in well-child visits at one of the safety-net sites studied. However, a comparable increase was also noted for nephrology visits, which had not received incentives. Conversely, the lack of incentives did not cause physicians to pay less attention to non-incentivized quality measures, which also increased during the study period.

The physicians surveyed from the two safety-net settings were generally comfortable with P4P as a concept, but less certain about its role in directly motivating quality improvement, the researchers...
found. Also, the safety-net providers generally agreed that the challenges of meeting the needs of their underserved, complex patients competed for clinicians’ time and energy to devote to P4P quality goals.

The study was conducted with two safety-net providers in the northeastern United States. At site A, a teaching hospital’s Medicaid managed care plan provided services through a network of community health centers and provided incentives for reaching four quality targets: annual retinal eye exams; annual glycosylated hemoglobin (HbA1c) measurement for patients with diabetes; prescription of controller medications for patients with asthma; and six well-child visits. Site B provided safety-net care through primary care physicians in medical groups owned by the hospital, including three groups that primarily served Medicaid and uninsured patients. The incentive program focused on three quality measures related to diabetes; an annual HbA1c test; an annual low-density lipoprotein check; and an annual foot exam. Data included a survey of provider attitudes among 256 site A physicians and 156 employed by site B, interviews with key leaders at sites A and B, and clinical information on the established quality measures for each site.

The study was funded in part by the Agency for Healthcare Research and Quality (Contract No. 290-02-0006). More details are in “Pay-for-performance in safety net settings: Issues, opportunities, and challenges for the future,” by Gary Young, J.D., Ph.D., Mark Meterko, Ph.D., Bert White, D.Min., and others in the March/April 2010 Journal of Healthcare Management 59(2), pp.132-141.

Acceptance of “smart” intravenous infusion pumps is growing among nurses, but challenges remain

Over the years, intravenous (IV) infusion pumps have undergone technological refinement in an attempt to reduce medication administration errors. Today, more and more hospitals are using what are known as “smart” IV pumps. These are designed to double-check the programmed dose of medication and identify other errors before and during medication or fluid infusion. A new study of nurses’ experiences with these pumps finds that their acceptance is growing. However, challenges remain with regard to implementing these pumps in the health care setting and dealing with technical performance issues. The researchers surveyed nurses attending training sessions on smart IV pumps prior to their implementation at a large medical center.

Nurses were surveyed again via e-mail at 6 weeks after the pumps were actively in use and then every year. The researchers expressed positive perceptions of the smart IV pumps on the pre-implementation and 6-week post-implementation surveys. These positive perceptions increased significantly after 1 year of use. This was particularly true when it came to the perceived efficiency of these pumps. Such improvements were not observed, however, regarding nurses’ experiences with the pump’s implementation process and technical performance. Nurses cited problems with the usefulness of information received about the pump’s implementation as well as clarity of the training materials. Even after 1 year, perceptions regarding the pump’s noise and reliability did not improve.

Factors that influenced a nurse’s acceptance of the pump included reliability, programming speed, efficiency, error recovery, alarm messages, and interface satisfaction. Technology refinement by smart pump vendors will be needed to overcome problems such as air-in-line alarms and delay-related beeps. Better training materials, particularly ones that can serve as ready references, will also help with the acceptance of these pumps, note the researchers. Their study was supported in part by the Agency for Healthcare Research and Quality (HS14253).


Surgical infection prevention measures reduce postoperative infections when used together, but not singly

A new study finds that compliance with several infection-prevention measures from the Surgical Care Improvement Project (SCIP) predicts a decreased likelihood of postoperative infections. The SCIP, a national effort to reduce the rate of surgical complications, has developed 20 quality measures, including 9 (6 of which focus on postoperative infection prevention) that are publically reported on the Hospital Compare Web site of the Centers for Medicare & Medicaid Services (http://www.hospitalcompare.hhs.gov). Reporting to Hospital Compare is voluntary, but failure to do so results in a decrease in Medicare or Medicaid payments.

The researchers found that patients who received proper treatment that included at least two SCIP infection-prevention measures every time indicated (S-INF compliant) had a significantly 15 percent reduced probability of postsurgical infection. Patients whose treatment complied with the original three SCIP infection-related measures (S-INF-Core) involving proper use and timing of antibiotics also had a 16 percent reduction in risk of postoperative infection, but this finding narrowly missed statistical significance. In contrast, no individual SCIP infection-related measure was individually associated with reduced risk of postoperative infection. The data were from a retrospective study of 405,720 patients discharged between the beginning of July 2006 and the end of March 2008 from 398 hospitals who filed Hospital Compare reports. Among these patients, there were 3,996 documented postoperative infections. The researchers analyzed the rates of infection for discharged patients who did or did not adhere to the S-INF and S-INF-Core composite measures and the six individual SCIP measures. The study was funded in part by the Agency for Healthcare Research and Quality (T12 HS00059).

More details are in “Adherence to Surgical Care Improvement Project measures and the association with postoperative infections,” by Jonah J. Stulberg, M.D., Ph.D., M.P.H., Conor P. Delaney, M.D., Ph.D., Duncan V. Neuhouser, Ph.D., and others in the June 2010 Journal of the American Medical Association 303(24), p. 2479-2485.