From Shirley Gibson, President

An Open Letter to the Virginia Nurses Association Members on a series of bylaws changes that will have significant impact on the future of our organization.

To become an “Organization of Opportunity.” The 110th House of Delegates representatives voted in Virginia, this was very important in terms of how the association conducts its business.

The second more extensive set of proposed changes dealt with the governance structure of the organization. Over the last several years, based on member feedback, the organization has been exploring ways of simplifying the governance structure of the VNA. Many of you have indicated that “opportunity for you.”

One delegate summed it up as “taking a leap of faith”—we have indeed done so as an organization into compliance with contemporary Virginia corporate law. As the VNA is incorporated, we will be moving forward. It will also allow chapters to form in addition to our traditional geographic districts of the past years.

We are in the process of organizing a transition team to develop the structure and process for the new governance to be established, based on member input. In the coming weeks and months we will keep you informed in ways that you can participate in this important work. In the meantime, please do not hesitate to contact me if you have questions or concerns.

A special thank you to the VNA officers, board, volunteer leadership, delegates and members who came to the meeting prepared, engaged, and ready to do the business of the organization to assure that it continues to move forward to meet the needs of Virginia’s registered professional nurses. One delegate summed it up as “taking a leap of faith”—we have indeed done so as an organization by passing bylaws that will allow us to have a more flexible and dynamic structure for the new governance to be established, based on member input. In the coming weeks and months we will keep you informed in ways that you can participate in this important work. In the meantime, please do not hesitate to contact me if you have questions or concerns.

Best regards,
Shirley Gibson, President

VNA District 12 delegates attend the annual Delegate Assembly in Richmond, on September 17th. (from left to right) President Carolyn Quinn, District 12 Delegate Carolann Stein, President-Elect Marcia Perkins and district delegates: Arlene Gavitt and Gilda Gilbert.
Newly Elected Officers

Here are your newly elected VNA officers: (Left to Right) Linda Dedo, MSN/MHA, RN, Commissioner on Nursing Education; Lauren Goodloe, PhD, RN, Commissioner on Nursing Practice; Denise Hill, BSN, RN, Director at Large; Richarden Benjamin, PhD, RN, and Ronnette Langhorne, members of the Nominating Committee. Not pictured, but newly elected: Chelsea Savage, MSHA, RN, VNA Secretary.

Delegate Roslyn Dance
Delivers Resolution 216

Delegate Roslyn Dance delivers House Joint Resolution No. 216 commemorating VNA’s 25th Annual Nurses Day at the General Assembly. The 25th Nurses Day was celebrated in February and commemorated in the Virginia House of Delegates on February 12, and agreed to by the Virginia Senate on February 18, 2010.

VNA Member of the Year

President Shirley Gibson awards Jennifer Matthews, PhD, RN the VNA Member of the Year Award. Nominated by VNA District 12, Dr. Matthews completed her 2nd term as Commissioner on Nursing Education and was instrumental in the reaccreditation process involving the CE Approver unit within the VNA this past summer.

Delegate Assembly 2010

VNA Mission Statement

The mission of the VNA is to promote education, advocacy and mentoring for registered nurses to advance professional practice and influence the delivery of quality care.

BOARD OF DIRECTORS:

Shirley Gibson, President; Thelma Roach-Serry, Vice President; Chelsea Savage, Secretary; Patti McCue, Treasurer; Lucia Fernandez, CODP Representative; Esther Condon, Committee on Ethics & Human Rights; Lauren Goodloe, Commissioner on Nursing Practice; Linda Ault, Commissioner on Government Relations; Nina Beaman, Commissioner on Resources & Policies; Linda Dedo, Commissioner on Nursing Education; Loressa Cole, Commissioner on Work Force Issues; Denise Hill, Director at Large; Sura Lewis, Director at Large, New Graduate; Janice DeBrueeler-Smith, VNSA Representative; Sallie Ensler, President, Virginia Nurses Foundation.

COUNCIL OF DISTRICT PRESIDENTS:

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Celine Barfoot, Office Assistant

VNT Staff

Susan Motley, Managing Editor

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VNF Gala—An Evening to Honor Nurses

Congratulations To All Who Were Honored at the Virginia Nurses Foundation’s 2010 Gala

Sandra Whitley Ryals  
Friend of Nursing

Carrie Estes  
Honor with the Virginia Magnet Award of Excellence in Clinical Practice

Anne Pollard  
Honor with the Virginia Magnet Award of Excellence in Nursing Leadership

Ann Gillespie  
Honor with the VNF JoAnne Kirk Henry Nurse Leadership Scholarship, 2010

Susan Davenport  
Honor with the VNF Central Virginia Nurse Leadership Scholarship, 2010

Heather Thomas  
Honor with the VNF Central Virginia Nurse Leadership Scholarship, 2010

Ann Parrish  
Honor with the Virginia Council of Nurse Practitioners Scholarship, 2010

Karen Remley, MD, (right) receives heartfelt thanks from VNA President Shirley Gibson for agreeing to serve as this year’s honorary chairman. Dr. Remley’s support helped make the Gala a tremendous success.

VNF 2010 Gala

Thanks to the VNF Supporters  
For helping make this year a Huge Success!

◊◊◊◊◊◊

Presenting  
Bon Secours Virginia  
Centra Health Inc.  
Owens & Minor  
University of Virginia Health System  
Virginia Commonwealth University Health System

Hall of Fame  
INOVA Health System  
HCA-Virginia Health System  
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George Mason University SON  
Martha Jefferson Hospital  
Mary Washington Hospital  
Nurse Leadership Institute  
Sentara  
Virginia Council of Nurse Practitioners  
Virginia Hospital & Healthcare Association

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# 26th Annual Nurses Day at the General Assembly

**Wednesday, February 2, 2011**

*Richmond Marriott Hotel Downtown*

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<th>Time</th>
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<tr>
<td>7-7:30 AM</td>
<td>Registration &amp; Continental Breakfast</td>
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<td>7:30</td>
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<td>Shirley Gibson, MSHA, RN, FACHE, President, Virginia Nurses Association</td>
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<td>8:00 AM</td>
<td>Meet at State Capitol—Taking the Message to the Legislature</td>
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<td>8:30-9:00 AM</td>
<td>Greetings from Governor McDonnell (invited)</td>
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<td>Photo opportunities on the Capitol steps</td>
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<td>9:05-10:30 AM</td>
<td>Individual visits with Legislators</td>
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<td>9:15-10:00 AM</td>
<td>Plenary Session: How to approach and talk to your Legislator—Helpful hints for your visit to the Capitol</td>
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<td>10:00 AM</td>
<td>Break and Exhibitors at the Marriott Hotel</td>
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<td>Lunch and the Annual Emily Couric Address</td>
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<td>with Dr. William Hazel, Secretary of Health and Human Services (invited)</td>
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<td>1 PM</td>
<td>Plenary Session: TBA</td>
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### Registration Form

**THE STATE OF NURSING IN VIRGINIA**  
26th Annual Nurses Day at the General Assembly  
**February 2, 2011; 8:00 am-4:30 pm**  
The Richmond Marriott, 500 E. Broad Street, Richmond, VA

**Name**—Please Type or Print Clearly—this will be printed on your nametag.

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**Registration Fee**

- **Mail To:**  
  Virginia Nurses Association  
  7113 Three Chopt Road, Suite 204  
  Richmond, VA 23226

- **Make checks & money orders payable to VNA Legislative Day**

- Fee includes: materials, legislative packet, coffee and lunch.  
  *does NOT include parking fees—which must be paid separately.*

- **$75**  
  - VNA Member

- **$89.50**  
  - VNA Non-Member

- **$65**  
  - Retiree (Age 62+)

- **$49**  
  - Student

- **Students:**
  - [ ] Will Graduate in May, 2011.
  - [ ] Will Graduate in May, 2012.

We accept **DISCOVER, MASTERCARD** and **VISA**; (Circle One).

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**Signature for credit card authorization**

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**REGISTER EARLY**

**ON-SITE REGISTRATION MAY NOT BE AVAILABLE: LAST YEAR WE REACHED A CAPACITY LEVEL.**

If on-site registration is available, it will NOT include lunch.

- **On-line registration will be cut-off on Monday, January 31, 2011.**
- **Inclement weather will not affect the day’s events.**
- **There are no refunds available due to bad weather.**

**LATE FEE** - After January 18, add **$20.00.** Refund Policy—**NO REFUNDS AFTER JANUARY 29, 2011.**

Full refund minus a 25% administration fee if canceled by Jan. 28, 2010.

Registration forms can also be downloaded from [www.VirginiaNurses.com](http://www.VirginiaNurses.com)

You may fax this form to the VNA or register on-line if you prefer

**VNA Fax number is:** 804-282-4916.
Understanding the Complaint Process

by Michele Satterlund

While it’s an unpleasant experience to learn that a complaint has been filed against you, it’s important to remember that you do have options. The complaint process is not necessarily an attack on you, but it is a process that ensures the protection of both you and the public.

In Virginia, complaints against nurses are submitted to the Virginia Department of Health Professions (DHP) in writing, by telephone, fax, email, or in person. The complaint can be made by anyone who is concerned that a nurse’s practice is in violation of the laws and regulations pertaining to health care practitioners. The person making the complaint (the complainant) could be your employer, a colleague, a patient, a patient’s family member, or even someone who is anonymous. The complaint must be in writing, and the complainant, however, must provide the DHP with the basis for the complaint and provide information detailing the sequence of events surrounding the reason for concern.

Once received, a complaint is referred to a Case Initiation Analyst who determines whether DHP actually has jurisdiction over the person or subject of the complaint. If DHP has authority and there is sufficient information to justify an investigation, an investigator is assigned to the case. The investigator forwards a summary of the findings and evidence related to the case to the appropriate board for a determination. Whenever a complaint is filed, the board is most often the Virginia Board of Nursing.

Once the Virginia Board of Nursing receives the investigator’s report, a preliminary review determines whether there is enough evidence that a violation of a law or regulation occurred. If there is not enough evidence, the Board of Nursing closes the case and no further action is taken.

It’s also important to remember that even if a practitioner’s action may be considered improper, it may not always be in violation of law. The board may find sufficient evidence to violate the laws of Virginia, but there may have been insufficient evidence to have occurred before an informal conference is scheduled.

At an informal conference, the board committee develops a recommendation that includes one of the following: 1) close the case with a finding that no violation of the law has occurred; 2) offer an order in which the licensee consents to be sanctioned; or 3) send the case to the full board for further review.

In making a recommendation for disciplinary action, the committee looks at the severity of the alleged actions, and takes into account factors such as the practitioner’s experience, the practice environment, the practitioner’s understanding of the action, and the action’s effects on patients. The committee will consider the appropriate punishment, which may be a reprimand, corrective action, or suspension or revocation of the practitioner’s license.

Reimbursement of Nurse Practitioners

Reimbursement of nurse practitioners is an important and complex issue. How services are being billed may have a direct effect on access to care. It creates a logical nexus between the billing for nurse practitioners and each company creating different policies for how they will or will not reimburse nurse practitioners. The amount that nurse practitioners are reimbursed for their service is the reason patients often directly impact both salary and bonuses.

When seeing patients in an office setting, a decision needs to be made as to whether you will be billing “incident to,” or billing under your own numbers, when this is possible. What does “incident to” billing mean? “Incident to a physician’s professional service” is a concept that originated in the Medicare system. It requires that the physician be physically present in the office suite, though not in the exam room. It further requires that the physician has established a diagnosis and plan of care for that particular patient and problem. More information about this may be found at the Centers for Medicare and Medicaid Services website at: http://www.cms.gov/TransmittalLetters/ds100500.pdf.

The financial advantage to the practice for billing “incident to” in the case of a Medicare patient is a higher reimbursement. The practitioner will be reimbursed at 100% of the allowable charges when a nurse practitioner bills “incident to,” Medicare reimburses advanced practice nurses at 85% of the physician’s fee schedule if billed under his or her own Medicare number.

There are important aspects of billing “incident to” that you need to be aware of:

- The physician must personally perform an initial service and remain actively involved in the course of treatment.
- Medicaid reimburses nurse practitioners at 100% of the allowable rate in Virginia, with the exception of psychiatric nurse practitioners, who are reimbursed at a lower rate. This is not the case for managed Medicaid.
- Private insurers each have their own policies and fee schedules for how nurse practitioners are reimbursed which vary. Some companies will directly reimburse nurse practitioners and others will not. This further complicates things when a Medicare patient has managed Medicare or a secondary payer.

A good example of the complexity of the payment differences between companies may be found in the state to state reference at the American Academy of Physician Assistants website: http://www.aapa.org/advocacy-and-practice-resources/reimbursement/gran_payers.pdf.

The Institute of Medicine, in a report released in October, 2010 on the Future of Nursing, has just published recommendations that Medicare and Medicaid advance practical nurse practices at the same rate as physicians for performing the same work.

Though the Commonwealth of Virginia clearly states that we may see new patients and current patients with new problems, “incident to” billing adds additional levels of restrictions, as do many private insurers. It is important that nurse practitioners understand the constraints of “incident to” billing, as well as those being placed by private insurers. Reimbursement constraints ultimately affect access to care. Nurse practitioners need to understand these issues and work together to change them.

Michele Satterlund is an attorney with Macaulay & Burtch, P.C. in Richmond, Virginia. She can be reached by telephone at 804-649-8847 or by email at msatterlund@macburch.com.
Lateral violence among nurses has been a topic of ongoing concern for several years. Its lingering influence is reflected in the continuing publication of articles and position statements in nursing journals and professional nursing organizations’ documents. The American Nurses Association (ANA) House of Delegates reaffirmed its position on hostility, abuse and bullying in the workplace. The 2010 House of Delegates resolved that the ANA will fully support the existing principles of the 2006 resolution related to workplace abuse and harassment of nurses and the Texas Nurses Association statements on violence and bullying in the workplace, which state that lateral violence can negatively affect the delivery of healthcare services, have financial and organizational effects on the employer, may affect the efficiency, accuracy, safety and outcomes of care, and hinder recruitment and retention of nurses (ANA, 2010). This article will address the background and current status of lateral violence as a concern for nurses.

Background

Lateral violence is defined as “any inappropriate behavior, confrontation or conflict-ranging from verbal abuse to physical and/or sexual harassment” (Rowell, 2007). Other researchers have labeled it “horizontal hostility” (Thomas, 2003; Bartholomew, 2006) and “horizontal violence” (Farrell, 1997; Hastie, 2002). Lateral violence also encompasses bullying in the workplace, which is repeated inappropriate behavior, direct or indirect, verbal, physical or otherwise, perpetrated by one or more persons against another in the course of employment, which could reasonably undermine an individuals’ right to dignity at work (Task Force on the Prevention of Workplace Bullying, 2001; Murray, 2009). In addition, bullying is differentiated from peer lateral violence by the existence of a real or perceived power differential between perpetrators and victims of bullying (Center for American Nurses, 2007; Vessey, Demarco, Gaffney, Budin, 2009; Murray, 2009).

A theory of oppressed group behavior that describes group self-hatred, low self-esteem, and self-loathing, has been used to explain lateral violence among nurses (Roberts, 1983; Woelfe & McCaffrey, 2007). Longo & Sherman (2007) also cite low self esteem in addition to lack of respect for others as factors in lateral violence among nurses. Environmental factors such as patient and family to nurse violence that is not addressed within practice settings have been identified by the National Advisory Council on Nursing Education and Practice (NACNEP) as influencing the potential for lateral by suggesting to nurses that violence is something to be contend with. (NACNEP, 2007). Stanley Dulaney, & Martin (2007) identified that the “ebb and flow” of lateral violence is associated with reorganization of institutions, the nursing shortage, the pressures associated with producing high quality patient care with minimal staff and budgets.

Organizational Culture and Environmental Impact on Lateral Violence

Organizational culture, defined as commonly held values, beliefs, and attitudes by members of the organization (Boan, 2006) has been linked to lateral violence. If the meanings inherent in the values, beliefs, and attitudes of a culture are strongly held, widely shared, and deeply embedded, they will be strongly influential in either positive or negative ways; meaning within a culture may be taken for granted and thus not easily changed by consensus (Staber, 2003). Therefore, organizational culture or climate can create changes in nurse -to-nurse behaviors simply because the culture supports them whether they are negative or positive. Unless established processes are in place to stop or correct negative behaviors, they may quietly grow until the culture not only supports such behaviors, but expects them. A culture of tolerance for lateral violence may grow until the workplace becomes intolerable. Nurses often practice in environments that are characterized as “toxic” psychologically, emotionally, and spiritually (Alsop, 2007). Issues that create toxic environments may be completely beyond the nurse’s control and frequently represent organizational factors related to economics, competition and management. A “white wall of silence” (Murray, 2009) may surround incidents of lateral violence and provide strong incentives for ignoring or perpetuating violence. Other contributing environmental factors thought to lead to lateral violence are busy, high volume patient areas, institutional policies and rules that are inflexible, and the lack of educational programs and policies to identify and reduce the incidence of lateral violence (Roche, Diers, Duffield, Catling-Paull, 2010). Skill mix of health care providers has been implicated in lateral violence as well with a preponderance of non RN to RN staff as a risk factor (Gilmour & Hamlin, 2003). Hierarchical organizational structures appear to be a factor as well because of their inherent power status differences, often a factor in workplace violence.

Taming the Beast continued on page 8
Impact of Lateral Violence

Lateral violence has far-reaching effects: it impacts individuals, the nursing unit, coworkers, patients, families and the organization. At the individual level, the nurse involved often experiences anger as a first response. This can be followed by anxiety, disbelief, decreased job satisfaction, and decreased job satisfaction, changes in relationships with coworkers, sleep disturbances, headaches, self-blame, helplessness and even Post Traumatic Stress Disorder (Ryan & Poster, 1991; Cooper, 1995; Murray, 2009). The impact on coworkers may be experienced as increased stress, fear of becoming a victim, distrust of colleagues, and increased workload due to individuals involved in the violence missing work or being terminated (NSAHO Task Force Report, 1995). The following have been identified as consequences of workplace violence:

- High stress: post-traumatic stress disorder
- Financial problems due to absence
- Reduced self-esteem
- Musculoskeletal problems
- Phobias
- Sleep disturbances
- Increased depression/self-blame
- Digestive problems

In addition, Hamric, Davis and Childress (2006) identified consequences of moral distress that appear to overlap with the consequences for individuals who have experienced workplace violence:

- Emotional withdrawal from patients and coworkers
- Painful feelings, such as anger, guilt, depression, perhaps physical symptoms
- For nurses, possibly having to leave a position or the profession
- Perpetuation of power imbalances
- Moral residue

For patients and their families:

- Fragmented care, since care providers are frustrated
- Emotionally withdrawn or angry care providers

Lateral violence detracts from the quality of patient care delivered and may contribute to a breakdown in communication between staff, patients and families as a result of the quality of care received. Satisfaction with practice and satisfaction with care are both negatively impacted when the environment lacks supportive colleagues and empowerment of the nurse. (Laschinger, Finegan, & Wilk, 2009). The impact on the organization may be reflected in the increased cost of covering sick leave for victims of lateral violence; the cost of replacement staff; disgruntled employees who are required to service other units; stress among all staff (Ryan & Poster, 1991; NSAHO Task Force Report, 1995; Murray, 2009). Study findings by Laschinger, Finegan & Wilk, (2009) write that emotional burnout occurs among new nurse graduates as a result of meanness and the lack of support for standards of professional practice in the workplace. These factors, in conjunction with the previously cited issues of powerlessness and lack of control of practice, create serious threat to the retention of new nurses and recruitment to the profession.

Lateral violence is not confined to nursing staff members. It occurs among educators and students as well. According to Heinrich (2007) nurse educators reported experiencing interactions with colleagues that were characterized as uncooperative and demoralizing. The term “joy stealing” was used by faculty members to describe such behavior among faculty members. Other faculty to faculty violence can include tactics that undermine, failure to recognize achievements, exclusion of colleagues from opportunities for growth and advancement, taking credit for the work of another faculty member, and using committee meetings to introduce a variety of issues to undermine colleagues' reputation. Students are also vulnerable to violence in their interactions with faculty in classrooms and clinical settings (Sinox & Fitzpatrick, 2009). Clarke (2008) reported that frequently cited faculty behaviors regarded by students as uncivil included making condescending remarks, rude comments or gestures, exerting superiority over others, deviating from the course syllabus and changing assignments, using ineffective teaching methods, and being late for scheduled activities. In the same study, faculty identified uncivil student behaviors that included having distracting conversations, inappropriate use of computers in class, coming to class late or unprepared, and demanding make-up exams and grade changes. There was agreement between faculty and students about which behaviors were uncivil for faculty and which behaviors were uncivil for students.

ANA Code of Ethics for Nurses and Lateral Violence

While lateral violence is often considered a problem that is purely social in nature, a reflection of the larger society, and one that can be addressed by solely social means, there are clear ethical directives that are applicable to this problem when it involves the nurse. The Code of ethics for nurses (ANA, 2001) provides guidelines for nurses concerning relationships with others. First, the Code states that all individuals with whom the nurse comes into contact are to be treated with respect for their inherent worth, dignity, and human rights and that nurses take into account the needs and values of all persons in all professional relationships. Interpersonal relationships are to be conducted with compassion and caring. The nurse is also to be self-respecting and has a responsibility to preserve his or her own moral integrity by practicing within the guidelines of the Code. Participation in lateral violence poses a threat to both perpetrators and victims of lateral violence. Each is diminished by the dehumanization that it represents. Second, the nurse is responsible for collaborating with colleagues for the purpose of providing optimal health care for patients. Participation in acts of lateral violence or failure to intervene disrupts relationships of trust that are required for collaboration among colleagues. Therefore, effective intra and interpersonal relationships are a responsibility for all nurses in all settings and roles. Third, the Code requires that the nurse recognizes, establishes and maintains boundaries that support appropriate limits to relationships and uses them to support professional practice (ANA, 2001). Lateral violence is a breach of professional boundaries and compromises the welfare of nurses and patients. Further, lateral violence compromises the profession as a whole because it is a breach of professional role expectations. Students and nurses are vulnerable to violence in their interactions with faculty in classrooms and clinical settings (Sinox & Fitzpatrick, 2009). Clarke (2008) reported that frequently cited faculty behaviors regarded by students as uncivil included making condescending remarks, rude comments or gestures, exerting superiority over others, deviating from the course syllabus and changing assignments, using ineffective teaching methods, and being late for scheduled activities. In the same study, faculty identified uncivil student behaviors that included having distracting conversations, inappropriate use of computers in class, coming to class late or unprepared, and demanding make-up exams and grade changes. There was agreement between faculty and students about which behaviors were uncivil for faculty and which behaviors were uncivil for students. The Code of ethics for nurses also requires that nurses act on questionable practice. This includes unethical, illegal, or impaired practice that would jeopardize patient well-being and safety. There can be no doubt that relationships that are compromised by lateral violence have negative effects on nursing practice. In addition, lateral violence can lead to impaired practice because it creates a hostile environment that is threatening to colleagues. Nurses who are the targets of violence from colleagues are likely to feel anxious and depressed; such circumstances can disrupt the nurse from patients' needs and result in unsafe practice. As a result, nurses are obliged to report practice that can result in harm to self or others and to use institutional guidelines and practice advocacy in reporting impaired practice (ANA, 2001).

Likewise, nurses should advocate for nurses who...
are victims of lateral violence and use institutional resources to report the problem. This requires moral courage and some risk of becoming a victim of lateral violence. However, when colleagues rise to the defense and support of colleagues experiencing lateral violence, a positive change in nursing culture becomes a reality. Administrators should not ignore reports of lateral violence among nursing staff and should utilize professional resources such as the materials available from the Center for American Nurses (2008) on conflict resolution and workplace advocacy to help nurses to eliminate it. Provision 6 of the Code specifically requires that nurses recognize the need to maintain and improve healthcare environments and conditions of employment (ANA, 2001).

Reducing the Incidence and Consequences of Lateral Violence

When an individual nurse has identified that he/she is the object of lateral violence/bullying in the workplace, he/she can take the following actions:

1. Recognize when bullying exists.
2. Utilize behavioral health services as needed.
3. Be aware of the effect of bullying and look for signs that bullying is affecting you.
4. Know your rights.
5. Be knowledgeable about policies and procedures in your workplace.
6. Document the specifics for all incidents of bullying.
7. Prepare for the possibility that the organization will prioritize their interests.
8. If other measures fail then seek legal counsel. (Murray, 2009).)

Other strategies for nurses who are experiencing workplace violence include utilizing the resources of a union or a professional organization representative to address the problem (Vessey, Demarco, Gaffney, & Buhl, 2009). Professional organizations may provide both formal avenues for assistance with workplace violence and also informal avenues for networking and securing mentors beyond the confines of the workplace. Such networks and mentors may prove to be invaluable sources of support to a nurse experiencing workplace violence (Jackson, Firtko, & Edenborough, 2007). The Center for American Nurses [CAN] offers a tip card with examples of bullying behavior and possible responses for those experiencing bullying. For verbal abuse the tip card suggests that the victim respond with:

I do not appreciate being yelled at in front of others. It sets a bad example for the staff and does not leave a good impression on the patients and family members. If there is something that you need to discuss with me, we can do it in a more private place. (CAN, n.d. p.1).

Institutional Approaches

While individual strategies are useful, it is difficult for nurses to protect themselves from workplace violence without the necessary institutional support (Longo & Sherman, 2007; Murray, 2009). Therefore, institutions should implement the following recommendations to address workplace violence:

1. Institutions should move away from a hierarchical system toward a model of shared governance. More than one study has documented that supervisors, such as managers and charge nurses, may be the initiators of workplace violence (Johnson & Rea, 2009; Vessey et al. 2009). Hierarchical structures limit the reporting of workplace violence particularly violence initiated by a superior (Stevens, 2002). Moreover, hierarchical structures may cultivate a culture of oppression, which others have argued leads to workplace violence (Murray, 2009; Roberts, Demarco, & Griffin, 2009). As institutions move toward a model of shared governance it will become the responsibility of individual nurses, as well as the profession of nursing as a whole, to move away from the behaviors of oppressed groups and embrace the rights and responsibilities that come with this power.

2. Institutions should assess their culture and subsequently communicate expectations.
for how persons are to be treated (Longo & Sherman, 2007). One instrument for assessing culture is the American Association of Critical Care (AACN)’s Nurses Healthy Work Environment Assessment. Expectations should include but not be limited to taking a zero-tolerance stance towards disruptive or violent behavior (Longo, 2010). A link to a sample zero-tolerance policy is provided in the resource table. In addition, AACN (2005) recommends that institutions adopt the following six standards for nurses to promote a healthy work environment:

1. Skilled Communication—Nurses must be proficient in communication skills as they are in skills.
2. True Collaboration—Nurses must be relentless in pursuing and fostering true collaboration
3. Effective Decision Making—Nurses must be valued and committed partners in making policy, directing and evaluating clinical care and leading organizational operations.
4. Appropriate Staffing—Staffing must ensure the effective match between patient needs and nurse competencies.
5. Meaningful Recognitions—Nurses must be recognized and must recognize others for the value each brings to the work of the organization.
6. Authentic Leadership—Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it and encourage others in its achievement (p. 2).

Institutions should provide employees with the necessary training to self-assess their contributions to workplace violence and to appropriately address workplace conflict. Some persons are less familiar with the appropriate boundaries for civility; therefore, they must be educated regarding respectful behaviors (Felbinger, 2008). CAN provides several resources that institutions may use to educate employees including posters, webinars, and videos. Assistance with training in Crucial Conversations is available for eliminating a culture of silence and encouraging appropriate communication.

Institutions should also provide safe mechanisms for the reporting of workplace violence. Nurses who experienced workplace violence report that the human resource department was a preferable avenue for reporting workplace violence (Vessey et al, 2009). Human resource employees should be trained to handle complaints of workplace violence and employees should be notified of this resource. The Occupational Safety & Health Administration (OSHA) provides prevention plans, pre-written policies, assessment checklists and suggestions for post-incident response specific to hospitals (OSHA, 2008).

Several organizational structural factors have been associated with workplace violence. A higher skill mix (percentage of RNs) and percentage of nurses with a bachelors of science in nursing have both been associated with fewer reports of violence in the workplace (Roche, Diers, Duffield, Calling-Paul, 2010). The American Association of Critical Care Nurses (2005) states that appropriate staffing is important for preventing workplace violence. Institutions must become aware of the fact that the structural elements of the healthcare system are related to workplace violence. As evidence of the relationship between structural factors and workplace violence appears, institutions should act to provide structures which support healthy work environments.

Moving Forward

Every nurse is responsible for taming the beast of lateral violence. Both victims and perpetrators must accept responsibility for correcting the problem. Victims should use available resources and decline the role of victim by participating in cultural change that would make workplace violence unacceptable. Perpetrators must accept that their bullying/ violent behavior is unacceptable and will be subject to sanctions. They must also seek appropriate counseling to ascertain the meaning of and reasons for their violent behavior. Both individuals should continue patterns of negative behavior that are “expected” or conditioned. Resolving the problems of lateral violence and workplace bullying presents a challenge to all constituents of the nursing profession.

Although the problem of lateral violence came to light in the clinical practice setting, it can be preceded by cultural factors in educational and institutional environments that provide fertile ground for the development of both positive and negative attitudes and behaviors. Educational institutions must address lateral violence among faculty and students if they are to contribute to cultural change in the practice environment. Recommendations from the Institute of Medicine, [IOM] (2010) include strategies to foster communication and collaboration across disciplinary lines and among nurses in teams. That report also emphasizes educating for problem-solving and quality care improvement. Educators should take the lead in utilizing the IOM recommendations to create learning communities that are responsive to student needs and conducive to student participation and professional socialization.

The topic of lateral violence should be explored within the nursing curriculum and faculty should adopt a pedagogical style that does not promote lateral violence among students and faculty. Students should be introduced early to the Code of Ethics for nurses and its requirement for respectful relationships among nurses. Its role in supporting a culture of caring in nursing should be explored. If cultural change is to occur, educators must make efforts to eliminate lateral violence among colleagues by modeling behavior that reflects the Code and by refusing to tolerate it. Institutional policies and resources should be available to faculty and students as exist in other institutions. Regardless of the setting, nurse leaders should position themselves as collaborators who work with constituents to achieve an environment that does not support lateral violence and bullying. Resources available to structure and implement a safe and non-violent environment include The Joint Commission (JUC) and the American Nurses Association Credentialing Center’s [ANCC] Magnet Hospital Recognition Program. Taming the beast of lateral violence in nursing has challenged us but progress is inevitable if every nurse is committed to the challenge and willing to collaborate in building safer practice environments.

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<th>Table 1: Resource Links</th>
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<tr>
<td>Center for American Nurses</td>
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<td>Resources provided:</td>
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<td>Tip card, guide, poster, fact sheet, 3 webinars, and a video.</td>
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<td>American Association of Critical Care Nurses [AACN]</td>
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<td>Healthy work environment assessment tool</td>
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<td>Webinar for assessing work environment</td>
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<td>Resource provided:</td>
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<td>Sample zero tolerance policy</td>
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<td>Occupational Safety and Health Administration</td>
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<td>Violence Prevention plan</td>
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References


Mason’s School of Nursing Partners
With Free Clinic to Improve
Access to Primary Health Care

FAIRFAX, Va.—Statistics show that nearly 30 percent of residents below age 65 living in the Commonwealth of Virginia lack health care insurance. In addition, studies have shown that uninsured individuals are prone to higher rates of chronic illness and mental health problems.

To help alleviate the growing challenges of receiving adequate health care that the uninsured with chronic illness experience in Northern Virginia, George Mason University’s School of Nursing in the College of Health and Human Services has received a $1.6 million grant (to be funded over five years) from the Health Resources and Services Administration to establish the Mason Partners for Access to Health Care (PATH) program.

Partnering with the Jeanie Schmidt Free Clinic (JSFC) in Herndon, Va., Mason PATH will help improve access to quality primary and behavioral health care for low-income and minority patients in Fairfax County who lack health insurance and suffer from diabetes and hypertension. In addition, JSFC patients will have access to mental health screening for depression and anxiety and management of behavioral health issues.

“The health of an individual and community depend greatly on their access to quality health care and education about self-managing their illnesses,” says Kathy Dickman, director of the PATH program and assistant professor in the School of Nursing. “By expanding health care services at the clinic and offering service learning experiences for students, this grant will pave the way for future models of expansion of improved community-based health care, as well as provide quality care for patients who truly need it.”

Clinical services will be provided by Mason faculty who are trained family nurse practitioners and psychiatric and mental health nurse practitioners. The clinic will also serve as an applied lab for Mason nursing students who will work directly with faculty members to gain experience in areas of nursing administration, clinical specialist and education.

“This grant creates a wonderful partnership between Mason’s School of Nursing and the clinic that will allow our faculty and students to engage in practice with patients in the community,” says Robin Remsburg, director of the School of Nursing. “The faculty can translate their practice into the classroom which contributes to an even richer learning experience for our students.”

The PATH program will also provide individual and group education programs on a variety of topics such as dental care, nutrition, women’s health care and healthy living. These programs are intended to help improve patients’ understanding of their own health conditions and resources available in their community.

The goal of the PATH program faculty in the first year is to expand the clinic’s services by 500 patient encounters, reaching 100 new patients and offer service learning opportunities to more than 40 undergraduate and graduate nursing students. The number of patients and students are expected to increase in the next few years. ♦
Facts about the Shortage of Nurses in Virginia

By 2020, one in three Virginians will not receive the health care needed because of the shortage of registered nurses.

- The demand for full-time equivalent nurses will be 69,600 and the actual number of employed nurses will remain relatively constant at 47,000. This is a 32% shortfall.

Each year, the Virginia Board of Nursing licenses fewer than 2,000 newly graduated RNs from Virginia Schools of Nursing.

- Beginning in 2015, it is forecasted the number of mature and retiring RNs departing the workforce will exceed the number of new RN graduates entering the workforce: shortages exist in nearby states because of similar factors leaving an inadequate supply of new nurses to migrate into Virginia to practice.

- A new RN graduate requires about a year of supervised practice before the RN is able to function autonomously.

Statewide, Schools of Nursing report a total enrollment of about 6,000 students educated in public and private colleges and universities and in hospital settings.

- Nationally, nursing schools report they deny three qualified applicants for every student applicant they accept because of inadequate capacity to accommodate the demand. There is every reason to believe Virginia statistics are comparable.

While Schools have requirements such as securing more classroom and clinical spaces to accommodate increased capacity, the most pressing need is for more academically qualified faculty.

- Currently, faculty salaries for nurse educators are not competitive with salaries of nurses in non-academic positions and settings.
- To attract qualified faculty needed to educate and graduate more nurses, it is imperative that funds be dedicated to increase faculty salaries in for each educational setting.
- New research conducted by the Commonwealth’s Department of Health Professions Healthcare Workforce Data Center shows that one in four RN faculty plans to retire in the next five years.

The current shortage of nurses impacts nurses, patients, the vitality of Virginia’s health care system, and quality of life in the Commonwealth.

- Currently, Virginia ranks 45th in per capita supply of nurses, (down for 40th in 2004) an embarrassing statistic for a State that ranks 9th (up from 11th in 2004) in per capita income. (From 2008 Bureau of Labor statistics)
- Nurses are the intellectual capital at the bedside. Frequently, nurses are the link between positive or negative patient outcomes. We know when spread too thinly or lacking qualified nurses with the appropriate skill sets, there is at risk of missing early signs of a problem, or missing the problem altogether, resulting in adverse outcomes.
- While nursing scholarship and loan repayment programs will increase patient access to nurses in underserved areas and help pay for those applicants who now are in schools, the money will not increase the number of nursing students or graduates, or the number of nurses in the Commonwealth without investment in salaries and capacity.

Safe Staffing Saves Lives

- A recent study on registered nurse staffing finds that “researchers estimated that, for every 1,000 hospital patients, an increase of one full-time RN per day could save five lives in ICUs, five lives on medical floors and six lives in surgical units.
- (Furthermore, the researchers determined that staffing one additional RN per day was associated with lower rates of hospital-acquired pneumonia, respiratory failure and cardiac arrest among ICU patients. Such an increase also could reduce hospital length of stay in ICUs and surgical units by as much as 34 percent and 31 percent, respectively.”

1. SCHEV (State Council of Higher Education in Virginia), (January 2004). The Condition of Nursing and Nursing Education in the Commonwealth. (Author, Richmond, VA).
VNA's Education Day took place on September 18 at the Richmond Marriott Downtown. "Demonstrating Competency" was attended by over 120 nurses from across Virginia.

The day began with an update from the Board of Nursing, Executive Director Jay Douglas, RN, MSN, CSAC, set the tone for the day and Mary Ann Alexander, PhD, RN, the Chief Officer of Nursing Regulation with the National Council of State Boards of Nursing gave an overview on the state of determining competency and regulation which was well received.

There was a panel discussion which included Heather Craven, MS, RN, CMSRN, a Nurse Clinician for Acute Care Medicine, Lauren Goodloe PhD, RN, N EA-BC, Director of Medical Nursing and Geriatric Services, VCU Health System, Marcia Tetterton, MS, CAE, the Executive Director, Virginia Association for Home Care and Hospice and Tia Campbell, RN, BSN, MSN, NCACN, State School Nurse Consultant with the VA Department of Education. The Moderator of the Panel was Linda Ault, BSN, MSN from John Randolph Medical Center.

There were 19 poster presenters from across the Commonwealth.

CONGRATULATIONS TO THE TWO WINNERS:

1. Impact of an Advanced Practice Nurse-Driven Leadership Model as a Compliance Solution Initiative in Quality Management, Pamela Lindsey, MSN, RN; Kristen Jackson, BSN, RN, FNP from Montgomery Regional Hospital, Blacksburg, Va

2. This Will Never Work! Tammy S. Mitchell, RN; Debra Hartman, RN; Sherrri Stanley, RN from Lewis-Gale Medical Center, Salem, Va

Other Posters included the following:

Comparison of Rapid Response Team (RRT) patient outcomes with non RRT unexpected transfers into ICU, Eileen Watkins, RN, BSN, CCRN; Susan Helms, RN, MSN, CCRN; PCCN; Linda Lawson, RN, BSHS, CCRN, Jennifer Brugos, RN, CCRN

• Community Memorial Healthcenter, South Hill, Va

Bedside Reporting: Enhancing Patient Safety, Pamela Lindsey, MSN, RN; Melissa Aaron, BSN, RN; Kenneth Perkins, BSN, RN; Margaret Crigger, RN, OCR

• Montgomery Regional Hospital, Blacksburg, Va

Discharge Process—Acute Care Medicine, Heather Craven, MS, RN, CMSRN; Catherine Neal, BS, RN; Ginger Kouten, BS, RN; Nina Carter, BS, RN

• Virginia Commonwealth University Health System, Richmond, Va

Level of Nursing Care Algorithm, Heather Craven, MS, RN, CMSRN

• Virginia Commonwealth University Health System, Richmond, Va

End-Tidal CO2 Monitoring in the ICU Setting, Emily Ferrera, BSN, RN

• Virginia Commonwealth University Health System, Richmond, Va

Essentials in Critical Care Orientation: Can You Hear Me Now?, Audrey R. Roberson, MS, RN, CEP; Mary P. Linn, MS, RN, CCRN, CCNS

• Virginia Commonwealth University Health System, Richmond, Va

Accuracy of aPTT Samples from Heparin Infusion Lines, Ann M. McGee, ADN, RN

• Virginia Commonwealth University Health System, Richmond, Va

Diabetes Training Project for Nurses at Carilion Clinic, Jane S. Thomas, BSN, RN; Deborah Saure, MSN, RN, CNS, CDE; Jamie Wagner, BSN, RN

• Carilion Clinic, Roanoke, Va

Comparison of Air Insufflation, Tube Marking and X-Ray in Assessment of Gastric Placement of Large Bore Tubes, Lisa Kuppler-Lee, BS, RN; Tina Assenat, RN; Kimberly Furrow, RN; Blair Dodson; RN; Suzanne Hartmann, RN; Tolmie Holcomb, RN; Cindy Rowland, RN; Elizabeth Saum, RN; Terry Tilley, RN; Lisa Zettler, RN; Ellen Harvey, RN

• Carilion Clinic, Roanoke, Va

An Exercise Strategy to Combat Diabetes, 10,000 Steps a Day Through the Family Health Connection, Christine G. Marr, MPH, CHES; Caroline Sparks, PhD, Sallie Eisolder, MSN, RN, CPN

• George School of Health and Health Services, Washington, DC

• Family Health Connection, Woodbridge, Va

Feeding Tube Colonization in NICU Patients: Is This the Next Place for an Infection Control Bundle?, Laura L. Aursy, RN, MSN, NNP

• University of Virginia Health System, Charlottesville, Va

What is the most comfortable (least painful) method of anesthetizing a peripheral I.V. site?, Clara A. Winfield, BSN, RN; Karen Thomas, RN; Susan Taylor, RN; Carol Jensen, RN; Christina Knuclely, RN

• University of Virginia Health System, Charlottesville, Va

Pressure Ulcer Reduction – The Collaborative Skin Investigators Have Arrived!!!, Catherine Ratliff, PhD, APRN-BC, CWOCN; Jennifer Smolz, MSN, ACNP-BC, CWOCN; Carolyn Edmins, RN, FNP-C, CWOCN; Marilyn Dixon, MSN, PCNS-BC, CWOCN; David Mercer, MSN, ACNP-BC, CSOCN

• University of Virginia Health System, Va

Evidence-Based Practice on the Efficacy of Cannabis, Mary Lynn Mathre, MSN, RN

• Patients Out of Time, Howardsville, Va

3.15% Chlorhexidine Gluconate Central Venous Catheter Connection Antibiosis Dramatically Decreases Bloodstream Infections in ELBW Infants, Deborah S. Quast, RN; Gary Karlowicz, MD

• Children's Hospital of the King’s Daughters, Norfolk, Va

• Eastern Virginia Medical School, Norfolk, Va

Nurses’ Perceptions of the Handoff Process Utilizing the ISHAPED Strategy, Mary Ann Friesen, PhD, RN, CPHQ; Robert Watson, MS; Monica Work, MSN, RN, NE-BC; Barbara Harrison, BSN, RN; Patricia Connor-Ballard, PhD, MSR, RN, APRN-BC; Karen Gabel Speroni, PhD, RN, Jeanine Turner, PhD

• Inova Alexandria Hospital, Alexandria, Va

• Inova Health System, Inova Fairfax Hospital, Inova Loudon Hospital, Inova Fair Oaks Hospital and Georgetown University

10 Years of Safety Through Bar Code Medication Administration, Sandy Brew, MSN, RN

• Hunter Holmes McGuire VAMC, Richmond, Va
Leading Change

The Virginia Council of Nurse Practitioners (VCNP) has been active leading change. With passage of the Health Care Reform Bill, we have seen greater opportunities to work in collaboration with our allied health care colleagues to be a part of the solution for improving health care access and delivery in Virginia. We are pleased that nursing has been included on the Virginia Health Reform Initiative Advisory Council formed by Governor Bob McDonnell. The Advisory Council will provide recommendations to the Governor towards a comprehensive strategy for implementing health reform in Virginia. Shirley Gibson, VNA President has been appointed to the Advisory Council and also serves as co-chair of the Capacity Task Force. Mary Duggan, VCNP Government Relations Chair has also been appointed to serve on the Capacity Task Force. Their voices will inform discussions and educate the Administration about the role that nursing and nurse practitioners (NPs) can play to be a part of the solution to health care access and delivery as Virginia is faced with the challenge of increasing demands for health care in the setting of declining numbers of primary care physicians. Nurse practitioners can help fill this gap, especially in primary care, by continuing to focus on health education and counseling, disease prevention and management of chronic conditions.

We have partnered with many state and national nursing organizations to educate legislators about the challenges facing NPs. Supervision is a barrier that limits access to care, prevents NPs from leading many of the community health initiatives being developed in their practice setting that they work in. Virginia is one of 12 states that require supervision, and our laws have not been updated since 1973. Current laws do not reflect the collegial and collaborative relationship between NPs and physicians. During the month of October, legislative receptions occurred throughout the state and provided a forum for NPs to educate their legislators about these barriers. Our public relations efforts have been aligned to support the legislative agenda. News articles, letters to the editor and op/ed articles have been published in local newspapers throughout the state to educate about NPs and our record of providing safe effective high quality care.

We will celebrate National Nurse Practitioner Week, November 7-13, 2010. The theme for the week is “Everyday Heroes—Nurse Practitioners.” VCNP will be conducting a statewide service project with a book drive for Reach Out and Read, a national nonprofit organization that promotes early literacy and school readiness in pediatric exam rooms by giving new books to children and advice to parents about the importance of reading aloud. Reach Out and Read reaches more than 150 participating pediatric offices and clinics in Virginia. For more information about this project, visit the VCNP website www.vcnp.net.

The first $1000 VCNP nurse practitioner scholarship award was presented to Anne Boston Parish, MSN, RN, CS, FNP-BC, to be applied towards her tuition at Marymount University for her Doctor of Nursing Practice (DNP) degree program which she expects to complete by July 2011. Anne is the founder and owner of the Queen Street Clinic in Alexandria, VA, a low-cost family practice clinic for the medically uninsured that provides affordable health care for all ages and illnesses. In April, Anne was also awarded the 2010 Flora Krause Casey Public Health Service Award, which is the highest public health service recognition awarded by the Alexandria Commission of Public Health Services and Alexandria Public Health Department.

The 2011 VCNP Annual Conference will be held March 30th-April 2nd at the Hotel Roanoke, Roanoke VA. The planning committee has developed another excellent curriculum. There will be an opportunity to network with colleagues while earning continuing education. Dr. Dianne Reynolds-Cane, director of the Department of Health Professionals will present the keynote address to inform participants about Health Care Reform in Virginia. Please mark your calendars and plan to attend.

The importance of membership in the professional organization cannot be ignored. To be successful in our efforts to remove supervision barriers and improve access to health care, we need your membership and participation. There is power in numbers. Please consider joining VCNP if you are not currently a member. Applications are available on the website www.vcnp.net.

Cindy Fagan, RN, MS, FNP-BC President, VCNP

Notice of Dues Increase in January, 2011

ANA to increase dues on January 1, 2011

In 2004, the American Nurses Association's (ANA) 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.

Although this computation is made each year, the policy states that the dues increase is only to be implemented every three years.

VNA membership dues have not increased since 2008. ANA’s dues increase becomes effective on January 1, 2011. At that time, the ANA portion of membership dues in Virginia will increase by $4.00. For full-time members, the total dues amount will rise from $244.00 per year to $248.00 per year. That’s $1.47 per day, which is less than the average cup of coffee at your favorite café.

Beginning January 1, 2011 the new Membership Dues breakdown is as follows:

- **Regular Member**: $248.00/year or $21.17 deducted monthly
  - Any RN who is currently employed full or part-time.

- **Reduced Member**: $212.40/year or $18.53 deducted monthly
  - Any RN who is currently unemployed, a full time student or retired and making more than Social Security allows; or
  - Any new graduate who has graduated from school within the last six months.

- **Special Member**: $65.00/year or $5.92 deducted monthly
  - Any RN who is disabled and unemployed or retired and over 62 years of age and making less than Social Security allows.

Members may choose the Electronic Dues Deduction Plan; which deducts 1/12 of the annual dues from your bank account on a monthly basis, To utilize this there is a $6.00 annual billing fee computed in your Membership Dues.
School Nurses Bring Hope To Sweaty Teens:—Virginia School Divisions Kick-off “Know Sweat In School” campaign—

As the hottest summer on record melts into the first days of the new school year, kids across the country begin the oh-so-painful transition from carefree to classroom. But for thousands of Virginia school division students, the school nurse will be ready to help them cope with a more socially difficult transition—excessive sweating.

Sadly, most children who experience excessive sweating symptoms (or hyperhidrosis) aren’t aware they have a treatable condition or are too afraid to talk to anyone—even parents—about the problem. The Know Sweat in School campaign was created specifically to tackle this issue. Thanks to a grant from Secret Clinical Strength® and Gillette Clinical Strength® antiperspirants, the International Hyperhidrosis Society (IHHIS, online at www.SweatHelp.org) has just developed a program kit to bring essential education and support to school children through the familiar face of the school nurse.

During the month of September, a sampling of registered nurses (RNs) and licensed practical nurses (LPNs) throughout Virginia’s 132 school divisions were sent a Know Sweat in School program kit to increase their awareness of the technical information and issues associated with hyperhidrosis. The eventual goal is to provide kits to all 1200 school nurses throughout the state.

“The nurse’s office is a safe haven for most school kids,” said Tia Campbell, school health specialist in the Virginia Department of Education’s Office of Special Education & Student Services. ‘For many children, the school nurse is the only healthcare professional they have, so it’s a good place to begin for a child with excessive sweating symptoms. While we don’t diagnose, we can refer a child with any concerns to the appropriate dermatologist.”

Elements of the Know Sweat in School kit included:

- Nurse Information Sheet describing hyperhidrosis in medical terms
- Several teen-oriented posters for display
- Handouts for students with excessive sweating concerns
- Teen Sweat booklets
- Samples of clinical strength antiperspirants with directions on proper usage

Children with additional questions can access specific information and a list of local doctors trained in hyperhidrosis diagnosis and treatment at the website of the International Hyperhidrosis Society www.SweatHelp.org.

Excessive sweating is a dermatological condition affecting at least 3 percent of the world population. The disorder can cause an otherwise healthy person to produce up to five times more sweat than is normal or necessary. Symptoms usually start in the early to mid-teen years. Already an awkward time of growth and development for most children, the added pressure can be devastating to both self-esteem and grades. Children can end up scared to raise their hands in class for fear of embarrassment from sweat stains; often sitting in the back row under a dark ‘Hoodie’ to keep their condition hidden.

In late September, the Eastern Virginia Medical School and IHHS joined forces to sponsor a CME session for medical practitioners. Area nurses and doctors participated in an accredited hands-on training seminar that taught them how to diagnose and treat excessive sweating symptoms.

“Hyperhidrosis is the number one dermatological disease in terms of negatively affecting a person’s quality of life, yet is also number one in having the most dramatically positive impact on people’s live when treated. Our seminars help us educate our medical professionals on diagnosing symptoms earlier. Caught early, this can literally change the life of a young person with the condition,” said Dr. David Pariser, founding IHHS board member and the 2009 president of the American Academy of Dermatology.

The Know Sweat in School program was made possible with the support of Secret Clinical Strength® and Gillette Clinical Strength® antiperspirants.

About the International Hyperhidrosis Society
The International Hyperhidrosis Society is an independent non-profit organization committed to reducing the symptoms, anxiety and social stigma associated with excessive sweating of an estimated 176 million affected children, teens and adults worldwide. The IHHS supports hyperhidrosis research, educates healthcare professionals in optimal diagnosis and care, raises awareness about the condition’s emotional and economic impacts, and advocates for patient access to effective treatments while increasing public understanding of this debilitating medical condition.

The International Hyperhidrosis Society’s Web site, www.SweatHelp.org, includes a Physician Finder to help anyone with excessive sweating to find medical help, information on additional treatment options, and a comprehensive collection of insurance and reimbursement tools, including downloadable forms, which can help sufferers work with their physicians and health insurance plans to get the correct coverage for necessary treatments. There are practical tips to make the most out of appointments with physicians and information on clinical trials and a free newsletter that will keep everyone current on hyperhidrosis news and medical breakthroughs. And because hyperhidrosis usually starts in the teen years, the IHHS has created an online teen forum to help teenagers learn how to cope with the condition and find effective solutions.

For more information Contact Lisa J. Pieretti, Executive Director, International Hyperhidrosis Society at either 610.346.6008 or via email at LJP@SweatHelp.org. International Hyperhidrosis Society® is a registered trademark of the International Hyperhidrosis Society. Secret Clinical Strength® and Gillette Clinical Strength® are registered trademarks of Procter and Gamble.
VNA District 9

Lucia M. Fernandez RN MSN
VNA President District 9

The summer has flown by and fall is surely upon us. There is something about the crisp cool air and the crunching of leaves when we walk that can both renew and inspire us to great works.

As our tradition in September we kicked it off with the Legislation Dinner. We had Dickie Bell, 20th House District; Ben Cline, 24th House District; Steve Landes, 25th House District, and Ben Cline, 24th House District. Top row, left to right: Linda Ault, VNA House District, and Ben Cline, 24th House District, Tony Wilt, 26th House District; Dickie Bell, 20th House District, Steve Landes, 25th House District; Tony Wilt, 26th House District; Emmett Hanger, 24th Senate District; and Mark Obenshain, 26th Senate District on the panel for discussion. Linda Alt spoke on behalf of the VNA and its mission for shared governance, membership and access to the website for further details virginianurses.com. Many thanks for the great success go to Arlene Weiss the Chair of the committee along the members Jan Botkin and Beth Negron. Our guest moderator was Rebecca Bowers-Lanier. The Legislation dinner spoke on the issues on Health Care in Virginia 2010 and Beyond with our speakers.

We had the Delegation and Education Day in Richmond along with the Gala in September. The vote of voting will be an individual count as opposed to the delegates of each district. This is exciting to have not only a collective voice in nursing but a distinguishing one as well. The outcome regarding shared governance is on everyone’s mind. The details and transitions are still being addressed. I have joined the task force in the effort to facilitate the transition clearly and smoothly. As the committee defines the guidelines I will share this knowledge in the district.

In early November, there was a Career Night for nursing students. This year it was held at Augusta Health Community Center’s Dining Room.

On September 7, District 12 started the Fall meeting with a candle light induction ceremony of the new board in Winchester Medical Center’s new chapel. Outgoing president Carolyn Guinn welcomed guests and members and introduced Rheen Markland RN, Parish Nurse as Master of Ceremonies. Laura Kesner RN, WMC nurse, provided special music during installation which spoke to the special gifts we all have as nurses. Rheen encouraged all members to remember that nurses use our special gifts in various ways while at work or in the community.

Board members are Marcia Perkins, President, Rebecca Myers, Vice-President, Sheryl Crim, Secretary, Susan Clark, Treasurer, Directors Tanya Carrocio and Betty Berry. Delegates are Nancy Luttrell, Carolyn Guinn, Gilda Gilbert, Arlene Gavitt with alternate Cheryl Rakes, Nominations Committee is Arlene Gavitt, Gilda Gilbert, and Carolyn Guinn. During the October 12 meeting 12 district members received an update on the Delegates Assembly in Richmond. This was a historic meeting of delegates since the vote passed to allow each member to have a vote. We discussed the future of the district and what changes we may see. We continued to work on our Strategic Plan and finalized our plans for community service projects, education, meeting with our political representatives, and our holiday meeting in December. We encourage all members to bring a new member to the meeting each month and support the mentor program for new nurses.

District 12

The Northern Virginia Nurses Legislative Reception was held October 6th at George Mason University. This event was jointly sponsored by the Virginia Nurses Association (VNA), Virginia Council of Nurses Practitioners (VCNP) and the Virginia Association of Nurse Anesthetists (VANA). The reception was a remarkable success. Present were Senators George Barker, Dave Marsden, and Mary Margaret Whipple and Delegates David Bulova, Eileen Filler-Corn, Tag Greason, Mark Keam, Ken Plum, Tom Rust, Jim Scott, Scott Surovell, and Vivian Watts.

The reception provided an opportunity for legislators and their respective nursing constituents to connect and exchange ideas, and explore solutions for improving access to healthcare. We were pleased to have Cindy Fagan, President of VCNP, and lobbyists Michelle Satterlund, who lobbies for VCNP and VANA, and James Pickral, who lobbies for VNA, present as well. Also attending were 22 nurse practitioners, 8 certified nurse midwives, 15 VNA members and at least 10 students and faculty.

Sally Bradford, President, VNA District 8, Mary Duggan, Government Relations Chair VCNP, and Louise Hershkowitz, a member of VANA’s Government Relations Committee, gave brief presentations about their respective organizations. Mary included a synopsis of the just released Institute of Medicine report on the Future of Nursing, and discussed how nurses must play a fundamental role in the transformation of the healthcare system.

The presentations were followed by spirited discussions between the legislators and their constituent nurses. Legislators had an opportunity to talk one-on-one with nurses and learn how we are educated and licensed, and what we do in our respective professions. Naturally, discussions related to the supervision barriers imposed on advanced practice nurses, and how these barriers limit access to care, was an important topic.

Each legislator was provided with a handout which provided an overview of advanced practice nursing, and included the contact information for the constituent to complete.

Nurses Legislative Reception

ACDIS

There will be a meeting of the Second Association for Clinical Documentation Improvement Specialist VA (ACDIS) at Lynchburg General Hospital on January 22, 2011. Everyone is invited to attend. For more information, please contact either Martha Dodson at martha.dodson@centrahealth.com or Sennaun Webb at acdis@virginia.edu.
Please Note: $5.42 of the CMA member dues is for subscription to The American Nurse, $16 of dues used for lobbying by the CMA is not deductible as a business expense. However, that percentage of dues is deductible as charitable contributions for state nurses association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. Please check with your CMA for the correct amount.

Membership News

State Nurses Association Membership Application
8815 Georgia Avenue • Silver Spring, MD 20910 • (301) 628-5000

Welcome New & Returning Members

District 1 – Far SouthWest
Christina Hammonds
Dawn Henry
Junior Miller
Claudia Pierce
Serra Spencer-Mitchell
Eileen Watkins

District 2 – New River/ Roanoke
Rebecca Corley
Margaret Cronise
Brittney Dillon
Komal Dobaria
Melva Jeffries
Sarah Morris
Carol Patrick
Melissa Ring
Dawn Smith
Jerusalem Walker
Elizabeth Woodyard

District 3 – Central Virginia
Sherri Andrews

District 4 – Southside
Hampton Roads
Jennifer Bedine
Christina Carter
Rostita Catanaban-Smith
Karen Darden
Vanessa Hadley
Elena Hall
Jacqueline Hunter
Sammie Sabet
Juan Carlos Sanchez-Gil
Kelly Shields
Crystal Wright
Karen Yancey
Donna Zacagnini

District 5 – Richmond Area
Bernhardine Ammons
Lana Brown
Darcie Bowles
Tamelda Bowser
Sandy Brew
Mary Butterworth
Mary Cherry
Angel D’Avilla
Suzette Davis
Jessica Dexter
Jenni Dohalmi
Dhananjayan Anne Dunnington
Marian Hayes
Tracy Higgins
Gina Holt
Denise Johnhally
Angela Joyce
Denise Landers
Angela Lee
Patricia Lewis
Karen Lord-Woo
Tammie Maw
JoAnn Melberg
Stacy Moore
Yvonne Olve
Jonathan Purpura
Jeanne Fondevita
Sherri Rose
Amber Thomas
Jean Whiting
Sheri Zinkos

District 6 – Mid-Southern Area
Peggy Hankins
Karen McTigue

District 7 – Piedmont Area
Amy Black
Kristen Davis
Elizabeth Epstein
Kathleen Fletcher
Jacqueline Griffin
Teresa Harris
Mary Hostetter
Sarah Huffman
Sarah Johnson
Jessica Krum
Nancy Lutz
Neil Peterson
Julie Strunk
Colleen Williams

District 8 – Northern Virginia
Sally Bents-Enchill
Amy Berrigan
Lynette Bracken
Elaine Caswell
Tiffany Carr
Eileen Cassfield
Amanda Costello
Kathy Dougbery
Kelli Frizzell
Sheryl Gary
Masako Griffith
Christine Howey
Patricia Julien-Williams
Theresa Kim
Gloria Ledger-Rose
Shin Lee
Kristin Leonard
Meghan Long Freeman
Katherine Milard
Barbara Moran
Diane Mouton
Lynn Nester
Jill Randazzo
Mary Retino
Kathleen Roman
Denise Settle

District 9 – Mid-Western Area
Natalie Bonilla
Sandra Brown
Amber Bracken
Rebecca Corley
Roanoke

District 10 – Peninsula Area
Judith Bradley
Shantell Cruz
Dorothy Frazier
Ramona Gabriel
Mary Howard
Angela Krone
Eris McCalin
Cynthia Maner

District 11 – Eastern Area
Diana Tutelo
◆
Dorene Scott
Karen McClure
District 6 – Mid-Southern Area
Karen McTigue

Membership Application

State Nurses Association Membership Application

Last Name/First Name/Middle Initial
Credits
Preferred Contact: Home Work
Home Address
Home Address
City/State/Zip County
Employer Name
Employer City/State/Zip Code
Membership Category (check one)
M Full Membership Dues—$244.00
Employee - Full Time
Employee - Part Time
R Reduced Membership Dues—$122.00
Not Employed
Full Time Student
Graduate from basic nursing education program, within six months after graduation (first membership year only)
S Special Membership Dues—$61.00
62 years of age or over and not earning more than Social Security
Totally disabled

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