Combating workplace viol

By Christine L. Latham, DNSc, RN;
Karen Ringl, MSN, RN; and
Mikel Hogan, PhD

Hospitals are complex organizations with hierarchical structures that can be breeding grounds for miscommunication and maladaptive behavior, which can lead to workforce violence. Reports of these negative workplace activities include gossiping, criticism, innuendo, scapegoating, intimidation, passive aggression, withholding information, insubordination, bullying, pranks, and verbal and physical aggression.[1] Workforce violence can include any behavior that causes the victim to believe that he or she's been

ence with peer mentoring

harmed.[2] Examples of violent workplace activities in healthcare settings have been researched and reported internationally.[3-5]

Countless nurses have been victims of these behaviors, which have had a significant impact on their careers.[2] Novice nurses are especially vulnerable to workplace violence and are typically unprepared to deal with it.[6] The commonly heard phrase "nurses eat their young" reflects the negative relational culture that exists in many healthcare settings, which is especially detrimental to new nurse employees.[1,7-9] These nurses are more likely to resign from their positions and may even leave the profession.[6]

We share data about negative encounters in the workplace that could adversely influence newly employed nurses' impressions of

healthcare employment and discuss ways that peer mentoring can attenuate negative perceptions, facilitate proactive workplace problem solving, and create a more supportive culture.

Exploring workplace violence
Previous qualitative research lends additional contextual evidence of ongoing transitional issues for new direct care RNs. One study concluded that a 6-month role transition experience in acute care can be a traumatic period for early RN employment. The author also determined that there are eight major themes to describe nurse perceptions of that experience:[10]
1. Change as a constant: The difficult shift from being a student (a known experience) to embracing the new responsibilities of being a nurse in the practice world of the hospital.
2. Stress: Caused by a lack of experience and organization skills, new clinical situations and procedures, frequent interruptions, relying on others while strongly feeling they should do it themselves, lack of support from other RNs, and feeling overwhelmed by the scope of new responsibilities.
3. Lack of self-confidence: New employees expressed high levels of anxiety during the initial 5 months of their nursing practice. The study underscored that the ability to think critically can be diminished by high levels of anxiety. It also cited research that suggests self-doubt and diminished self-confidence significantly and negatively reduce general reasoning ability.
4. Emotions: The initial exhilaration and eagerness of entering the nursing practice was replaced by fear, apprehension, and intimidation.
5. No preceptor support: New nurses perceived that they lacked

necessary guidance, and felt validated (or not validated) by responses of senior nurses regarding decisions or clinical judgments.
6. The experience of loss: New nurses had feelings of aloneness and vulnerability due to the loss of their "ideal world," innocence, familiarity of academia, clinical supervision, externally set boundaries of care and safety, collegiality, and grounding feedback. The losses were never acknowledged by the new nurses or their colleagues in the hospital, nor was there support to guide them through the process of adjusting to the losses.
7. Disillusionment, disappointment, and detachment: New nurses believed that there was inconsistency between education and the real world; practice didn't meet the standards they learned in academia. They felt inadequately prepared and that education in the new setting was fragmented.
8. Dichotomies: The new nurses claimed they were caught in the middle of polar perspectives on many issues, such as caring, quality, dependency, practice, focus, and experiential opportunities.

Nurses supporting nurses
In response to evidence of the potential for negative experiences during early employment, a grant-supported mentoring program for direct care RNs was initiated between a university and two hospitals to enhance peer nurse support, team performance, and communication between nurses and managers.[11,12] The Nurses Supporting Nurses mentoring program instructed volunteer RN staff on how to become a mentor and how to support mentor-mentee relationships with newly hired RNs, including new graduate RN mentees. The program included

ongoing support and education for mentors and regularly scheduled governance board meetings with managers, which helped teach mentors how to use more proactive methods to deal with negative healthcare team encounters.[11,12]

Previously published reports on the outcomes of this program provided evidence that mentoring enhances RN work relationships with healthcare team members and assists mentors to become supportive informal leaders, which may lead to formal leadership roles on the hospital units.[12] Our study builds on previously published articles about this mentoring program by sharing evidence of ongoing horizontal hostility and negative behaviors between RNs and between RN staff and other disciplines, as well as the value of peer mentoring to attenuate new RN employee perceptions of these experiences.

Building a supportive framework
A 5-year intensive study was conducted to create a more supportive work environment for RNs by establishing a formal mentor program and a Workforce Environment (WE) Governance Board. This established a shared governance model by allowing mentors to share work environment issues with managers at formal and mentor-management meetings.

The mentoring program was established by a university faculty team who partnered with management and the RNs from two hospitals. Following marketing of the new mentoring program, mentor applications were accepted and reviewed by managers, who decided on the nurses who would become part of the RN peer mentoring program. Mentees volunteered or were asked to be part of the mentoring program

as a "rising star." Initially, mentors agreed to have one mentee, but later the mentors were able to accept multiple mentees. Both mentors and mentees attended classes on mentoring, other professional communication, and team-building strategies.

The mentors used semistructured online journals to record mentee meeting content and outcomes, and mentors attended regular support meetings with the university faculty team. There were three sets of qualitative data accrued from years of mentor journaling, mentor support meetings, and mentor-manager WE Governance Board meetings.

The formal mentoring program consisted of two 8-hour interactive classes taught by partnering university faculty on the mentoring program team. Class content included professional behavior related to culturally sensitive communication, conflict resolution, shared decision making, time management, team building, and healthcare system financial and regulatory challenges. The classes also had typical mentor information on facilitation of mentee growth and problem solving, use of reflection and feedback, mentor-mentee relationship phases, how to write mentee agreements to actively participate in the mentor-mentee relationship, and strategies for completing the mentoring relationship.[11,13]

Self-awareness was enhanced by sharing personality and learning style data with each individual mentee and mentor to encourage reflection on communication style and preferred learning methods. These two personal attributes weren't correlated with mentee choice of mentor or participation in the program. Both mentors and mentees attended the two 8-hour formal class sessions.

Following these classes, mentors were taught how to journal by entering regular monthly information in password-protected, online, structured journals that included guided questions for mentor entries. Mentor journaling included mentor-mentee experiences, such as building relationships, identifying mentee issues, facilitating problem solving, and mentee outcomes of peer mentor support activities. Journaling completed by mentors included the type of mentoring that was delivered, as well as mentee outcomes, and it also provided a means of determining mentor engagement for later recognition of their work.

In addition to the classes, mentors met together each month as a support group with the university program team to share mentoring experiences. Discussions included relationship building, mentee issues (such as taking breaks, time management, delegating, and working as a team), and other ways to enhance the supportive culture of the hospital.

Mentors learned how to interact with the hospital and nursing management teams by attending semiannual WE Governance Board meetings that focused on the progress of the mentoring program. These board meetings were held with nursing administrators and direct care RN mentors to identify workforce issues and recommend potential solutions in a proactive and nonhostile manner. For example, agendas included discussions of incident reports and the "just environment," how various nursing units enforce lunch breaks for nurses, and methods to recognize outstanding nursing work. Over time, the mentors were recognized by the nursing staff for their supportive roles and reported having up to eight mentees beyond the one or two mentees that they agreed to work with as part of the formal university-hospital mentoring program.

Volunteering to end violence

Following a university-approved Institutional Review Board written consent process, there were 89 frontline direct care RN mentors and 109 RN mentees who volunteered to participate in a formal mentoring program for at least 1 year, resulting in 105 formal mentor-mentee teams that were followed over 5 years. The mentor-mentee group included 4 male mentors (4%) and 10 male mentees (9%), and the mean age of RN mentors was 41 years (range 26 to 65), whereas mentees' mean age was 33 years (range 23 to 57). Over 47% (n = 42) of the mentors reported an ethnicity other than White. Over the 5 years, mentors reported longer RN staff employment (x = 7.5 years; range 2 to 40 years) than mentees (x = 2.1 years; range 1.57 to 3.39 years). The mentees were new direct care nurses, and the majority were newly licensed nurses. Most mentees with previous employment indicated interdepartmental transfer to a new specialty area within the same facility.

The mentoring program was conducted in two self-selected hospitals that had administrators who were interested in enhancing RN support. Both hospitals are not-for-profit and similar in size, but one is a teaching medical center with an affiliation to a major university and the other is a large community hospital. Both hospitals have a decentralized management hierarchy and value advanced practice nursing. Each hospital has established career ladders for professional advancement. In addition, the university program team assessed each

hospital's organizational chart, line authority, job descriptions, professional advancement and performance appraisal processes, committee structure and operations, unit structure, and major service and product lines. Over 5 years, both hospitals either obtained or maintained Magnet® recognition, and there was extensive expansion of facilities and service lines that necessitated a need to orient large numbers of new RNs.

A content analysis coding approach was used with the mentor journals, the minutes of the mentor support meetings, and WE Governance Board meetings with mentors.[14,15] The merged data from these three qualitative components of the formal mentoring program revealed that mentoring not only mitigated negative perceptions of coworkers, but also provided new strategies to address horizontal hostility and negative workforce behaviors. All meetings were audiotaped and professionally transcribed by an assistant and reviewed by the university mentoring program team. Content analysis was then used to analyze the three qualitative components.

The content analysis was subjected to validity and reliability processes that included gathering data over a 5-year time period to establish transferability, using peer examination of data to establish credibility and dependability, and confirming

some of the findings with a multi-method approach by simultaneously examining quantitative findings reported by participants about the professional practice environment.[12,16] Data analysis validated that there are still early employment encounters that impede new nurses' positive feelings about their work environment. The data also delineated the effect of mentoring on negative perceptions and experiences of new nurses.

"Nurses eat their young"

The content analysis revealed that obstacles to improving the workforce environment still exist for newly employed RNs. The data gathered from this study are similar to previous healthcare employment research findings, lending additional evidence of ongoing transitional issues for new direct care RNs.[10]

The data from the current mentoring program indicated that new graduates' perceptions within the previously identified themes included a variable amount of negativity that ranged from lack of support to intimidation, bullying, and outright aggression. The university team developed a violence continuum to address the range of perceptions and emotions experienced by new nurses. (See *Figure 1.*) Poor support levels were defined as a lack of assistance and encouragement, whereas intimidation meant that the
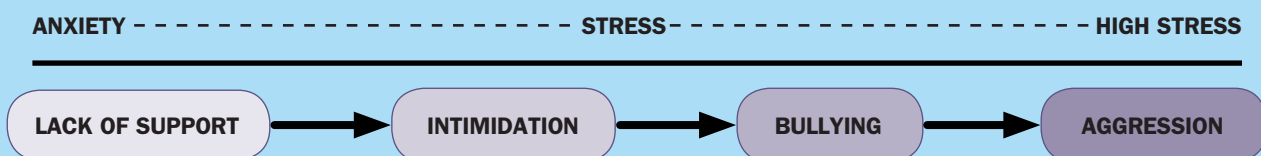
new RN perceived that he or she was threatened, coerced, or singled out. Bullying involved harassment or maltreatment, and the highest level of violence or aggression involved new nurses' perceptions of behavior that was hostile, angry, or assaultive in nature.

The mentoring data from the current study is depicted in *Table 1*. The quotes in *Table 1* depict the type and level of the negativity encountered by new nurses as they transitioned into their new employment roles, validating previous findings that nurses continue to have difficulty with the transition period of their employment.[10] For example, the "change as a constant" theme reflects mostly intimidation; however, "stress," "feelings of fear and rejection," and "lack of preceptor support" include fairly high levels of incivility and horizontal violence, such as bullying and aggression. *Table 1* also provides quotes from mentors and mentees regarding how the mentoring program helped to mitigate the negativity and provide support for nurses through the transition process.

The successes of mentoring

Working RNs, and especially newly licensed RNs, continue to experience violence in the workplace. Based on the categorization of the mentee data into varying levels of violence, direct care RN participants reported a fairly low level of

Figure 1: Violence continuum

ANXIETY - - - - - - - - - - - - - - - - - - - STRESS - - - - - - - - - - - - - - - - - HIGH STRESS

LACK OF SUPPORT → INTIMIDATION → BULLYING → AGGRESSION

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violence when they experienced change, loss, or dichotomies between what was learned (ideal) and the real world. However, they reported higher levels of violence in relation to stress, self-confidence, emotions/fear, and the perceived lack of support. RN mentees reported a wide variance of horizontal violence for disillusionment that ranged from perceiving a basic lack of support for patient/family care to outright aggression when describing negative professional interactions. From the nursing staff perspective, negative peer interactions reflected the highest level of perceived violence.

Furthermore, pre- and post-mentoring data indicate that a peer mentoring support system helps to allay negative perceptions and instill new ways to address negative situations experienced by new nurses. The data in *Table 1* support the larger study that indicated other positive results of the mentoring program. For example, as a result of the 5-year mentoring program, hospital one met recruitment needs with a documented 80% decrease in vacancy rates ($P = .03$), and hospital two improved retention by 21% ($P = .03$). Mentors reported that they personally prevented 68 RNs from leaving the two hospitals, resulting in cost savings comparable to 134 full-time, annual salaries.[12] These costs include advertising, interviewing, hiring, and orientating new employees, as well as staffing with overtime or registry RNs until the new hire is ready to function independently.

This mentoring program addressed issues raised by the Institute of Medicine's *Future of Nursing* report and numerous other professional nursing organization nurse advocacy reports.[17] These reports suggest that new nurse residency programs

must continue to support nurses in transition after graduation. These nurses need additional support to meet lifelong learning goals and be more involved in collaborative efforts to redesign practice environments along with physicians and other members of the healthcare team. Mentoring helps nurses meet these employment goals and enhance their perspectives about professional growth.[11,12]

A unique aspect of this mentoring program was the incorporation of formal WE Governance Board meetings between administrators and mentors, which provided valuable feedback and support, functioning as a forum to proactively address work environment issues. This type of forum proved to be very valuable to mentors, who indicated that they liked the shared governance approach of these meetings because it allowed them to actively participate, helped them understand the "bigger picture" from administrators, and assisted them to learn how other departments implemented various strategies to address conflict and other workplace issues.

This formal meeting approach not only included ways to resolve issues, but also methods to measure the outcomes of the new approaches.[18] Managers were also able to get a bird's eye view of frontline perspectives, clinical leadership, and future growth needs. This shared governance forum, along with ongoing mentor support group meetings, mentor education, and new methods of mentor recognition, augmented the importance of the mentor role.[12]

Expanding the mentor role

Given the ongoing perceptions and data indicating that "nurses eat their young," mentoring programs are needed to enhance new nurse orientation and nurse graduate

residency programs to empower RNs to address negative workforce behaviors and hostile workplace environments. Additionally, mentoring programs give practicing nurses an opportunity to continue learning about professional approaches to resolving patient care problems, as well as broader healthcare delivery issues. The data from our study suggest that academic educational programs may need to introduce student peer mentoring so that after new graduates are employed, they're able to seek out and use their workplace mentors appropriately.

The transferability of data from this mentoring program is limited as it was conducted in two hospitals within one geographical region. It's recommended that future multisite studies be conducted and include broader measures of hospital/healthcare culture and other characteristics that affect individual RN and healthcare team outcomes. Furthermore, future research with mentoring work needs to move beyond retention and vacancy rate data and nurse self-report of team performance to include patient and family perspectives of the quality of their care and contributions of specific nurses to patients' healthcare outcomes.

Uniting nurses for the future

The findings of our study suggest that the work environment perceptions of newly hired RNs are similar to those reported by other studies.[10] Transitioning to a new role within nursing continues to include negative workforce behaviors along a continuum, illustrating the degree of violence experienced by the RNs. Content analysis of the data determined that mentoring had a role in mitigating new direct care nurses' negative perceptions of workforce violence. These findings

Table 1: Workplace violence and effect of mentoring

New RN transition themes	Nurse participant quotes (Violence continuum ranking)	Effect of mentoring quotes
Change as a constant	*Nurse to nurse:* "Nurses…find new people as threats…nurses pick on each other; maybe this is because the new grads are not properly oriented." (Intimidation)	"This [mentoring] program made us realize that we could be mentors and better nurses…it will help nurses stay. It creates enthusiasm for my job."
	Nurse to patient or family: "They [administrators] should treat the nurses the way we treat our patients." (Intimidation)	"[Mentors help mentees] to fit in…survive the day…how to get along and learning good patient care."
Stress	*Nurse to nurse:* "Doctors eat their young AND our young (RNs)." (Aggression)	"Kill negative people with kindness. Take the time to show new nurses around. If you give you will get a lot back…. Asking 'what can I do for you?' and more established nurses [physicians] will accept you."
	Nurse to patient or family: "Some nurses feel they are held hostage on their unit (not allowed to transfer)." (Bullying)	"Newer nurses do not want to leave the unit [to take breaks] because of concern for their patient. Mentors reinforce the need for breaks… [and the importance of taking breaks to reduce stress]."
Lack of confidence	*Nurse to nurse:* "Some nurses do not defend their positions at all; how do you report lack of respect?" (Bullying)	"How do you get the confidence to speak out, especially by those who lack experience? This is why mentors are so valuable."
	Nurse to patient or family: "Inexperienced nurses struggle with dealing with patients and families…calling the doctor is another thing that new nurses struggle with…fake it till you make it." (Intimidation)	"It is important to give new nurses the skills to handle things with physicians. We don't fix their problems, but we help them come up with solutions (for patient care)."
		"Communication is a major issue. The doctors need to be a part of the relationship-based care. The doctors need to know who they are working with."
Emotions of fear and rejection	*Nurse to nurse:* "Nurses get the blunt of doctor's wrath….no matter what the facts are." (Aggression)	"Open meetings [governance boards] like this are helpful…it provides a chance to share with others and have your opinion valued."
	Nurse to patient or family: "… nurses are fearful of retaliatory actions. Mutual respect is needed. Some MDs leave nurses out of the loop with regard to patient care." (Aggression)	"Trust factors are recommended and mentors should be on the same floors as their mentees [to assist with conflict]."
Lack of preceptor support	*Nurse to nurse:* "A new nurse had a horrible experience and almost left nursing. She didn't get feedback from her preceptor…was made fun of and not supported." (Bullying)	"There is a lack of feedback after you complete your preceptorship. Nurses really want support, encouragement, and feedback. Mentors provide that."
	Nurse to patient or family: "…a patient coded, everyone pitched in to help the nurse, but the family was very abusive to the nurse…and the preceptor did not intervene." (Aggression)	"Feelings of inadequacy when a patient and family [went] to another nurse instead of [assigned new RN]….suggestion [from mentor] to ask the patient/family if there is something she [mentee] can get them?"
		(Continued…)

Table 1: Workplace violence and effect of mentoring (Continued...)

New RN transition themes	Nurse participant quotes (Violence continuum ranking)	Effect of mentoring quotes
Experience of loss	*Nurse to nurse:* "People seem to leave this hospital because of staff relationship issues. They do not feel supported." (Lack of support) *Nurse to patient or family:* "There is no debriefing after a death or similar event. There is no place to cry, unload, or find out how they (the RN) can improve….no accommodation for grieving." (Lack of support)	"Mentees don't know how to seek support. In our profession, we have not done a good job of conveying that you should seek support…mentees don't know how and they are overwhelmed [such as experiences with death]."
Disillusionment, disappointment, detachment	*Nurse to nurse:* "One nurse worked (a lot) of overtime, and needed a favor. She was denied by the charge nurse and the supervisor. Staff does not feel comfortable talking to management; they are vindictive." (Aggression) *Nurse to patient or family:* Patient refused to be cared for by a nonEuropean nurse, and "management did nothing to make the nurse feel better or even acknowledge that what the patient did was wrong…" (Lack of support)	"There are some great programs here [like mentoring], we value the mentors….[they are] the ones who keep nurses here…they [administration] need to make this a part of the fabric of this organization."
Dichotomies between ideal and real world	*Nurse to nurse:* "Generally a charge nurse is promoted who is familiar with the unit. There is no formal leadership training or people skills." (Lack of support) *Nurse to patient or family:* "We [staff RNs] have to go through the charge nurse and get permission to contact the doctor, and we find this very insulting." (Lack of support)	"They [the mentees] need to know how they can help the informal leaders…mentees can come up with goals to improve patient care and work relations on the unit." "Mentors want to work on [having a greater] social impact…we need to address the issues, not just the result….patients leave the hospital… and then bounce back."

are particularly important in light of the *Future of Nursing* report that challenges nurses to be full partners with physicians and other healthcare providers in redesigning healthcare.[17]

It will be difficult for full RN participation in future healthcare redesign if hostility and violence continue to exist among professional colleagues in the workplace. Our study suggests that improving the positive culture of the workplace environment is facilitated by classes on professional issues and mentoring, support of mentors, and formalized mentor-nurse manager shared governance meetings that create mentor-administrative alliances. These activities improve communication with and support of fellow nurses to address maladaptive behaviors and decrease the potential for workplace violence. **NM**

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At the University of California School of Nursing, Fullerton, Christine Latham and Karen K. Ringl are professors. Mikel Hogan is an applied anthropologist, professor, and department chair of the Human Services department for the College of Health and Human Development at California State University, Fullerton.

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