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ISMP An ECRI Affiliate

Nurse AdviseERR®

Educating the Healthcare Community About Safe Medication Practices

Survey suggests disrespectful behaviors persist in healthcare

Practitioners speak up (yet again)—Part I

In our October 2021 newsletter (www.ismp.org/node/27774), we discussed the topic of disrespectful behaviors, which have persisted in healthcare for years. Unfortunately, too many practitioners remain silent or make excuses in an attempt to minimize the profound devastation caused by disrespectful behaviors. Disrespectful behaviors encompass a broad array of conduct, from aggressive outbursts to subtle patterns of disruptive behavior so embedded in our culture that they seem normal. Any behavior that discourages the willingness of staff or patients to speak up or interact with an individual because they expect the encounter will be unpleasant or uncomfortable, fits the definition of disrespectful behavior. In our 2021 article, we examined the adverse effects of disrespectful behaviors and why they arise and persist in healthcare.

In 2003 (www.ismp.org/node/976) and 2013 (www.ismp.org/node/615), ISMP conducted national surveys via our newsletters about workplace intimidation and/or disrespectful behaviors in healthcare. More recently, from September through November 2021, ISMP conducted another survey to measure the progress (or lack thereof) with reducing disrespectful behaviors in healthcare. Although the 2021 survey was conducted amid a worldwide pandemic, more than 1,000 practitioners spoke up and clearly exposed the continued tolerance of disrespectful behaviors in healthcare. In **Part I** of our report, we present what the 2021 respondents had to say about disrespectful behaviors in the workplace and compare these results to our 2003 and 2013 survey results. In **Part II** of our report, which will appear in a future newsletter, we will explore how to address disrespectful behaviors in healthcare.

Respondent Profile

Our 2021 survey was completed by 1,047 respondents—995 who worked in an acute care setting and 52 who worked in a long-term care (LTC) setting. More than half of the respondents worked facility wide (28%) or in the pharmacy (26%); however, respondents from critical care (9%), general units (9%), perioperative locations (5%), emergency departments (4%), behavioral health (4%), and ambulatory or other special care units (15%) also participated in the survey. The respondents were mostly nurses (42%) and pharmacists (37%); however, we also received survey responses from pharmacy technicians (6%), quality/risk/safety practitioners (5%), physicians (3%), and others (7%, therapists, administrators, nursing assistants, education specialists). Sixty percent of the respondents were staff-level practitioners, and more than one-quarter were managers, directors, or administrators (28%). Examples of other types of practitioners (12%) who participated in the survey included medication safety officers, faculty, clinical specialists, residents/fellows, and consultants. The vast majority (96%) of respondents had 2 or more years of experience in healthcare, with 68% reporting more than 10 years of experience; only 4% of respondents had less than 2 years of experience.

Frequency and Types of Disrespectful Behavior

Almost everyone who works in healthcare today has a story to tell about disrespectful behavior, as healthcare organizations have fueled the problem for years by implicitly accepting and/or tolerating disrespectful behaviors. Furthermore, the healthcare culture historically has accepted a certain degree of disrespect and normalized this style of

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SAFETY wires

Avoid using TB syringes with orange caps. A pharmacy recently purchased Monoject 1 mL tuberculin (TB) syringes from Cardinal Health that have an orange cap over the ⅝ inch 25-gauge needle. The TB syringes used previously had a red cap. Cap colors are based on the International Organization for Standardization (ISO) standards 7864 and 6009 that recommend an orange hub or needle cap (if they are pigmented) for a 25-gauge needle. (An unpigmented hub or needle cap is also acceptable.) The orange-capped TB syringes were distributed to patient care areas, and staff immediately identified the potential for confusion with insulin syringes with a 25-gauge needle attached, which also have an orange cap (**Figure 1**). Using the wrong syringe type is bound to cause confusion when measuring doses and may lead to potential dosing errors. The orange-capped TB syringes were removed from general circulation and will only be available when administering a PPD (purified protein derivative) test.

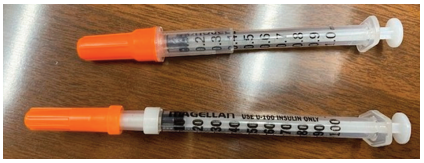

Figure 1. Cardinal Health tuberculin syringe (top) looks similar to the U-100 insulin syringe (bottom).

We shared this information with Cardinal Health and asked the company to rethink the use of an orange-capped 25-gauge needle on their TB syringes, which they agreed to discuss internally. Intradermal TB syringes with an attached needle generally provide a 26-gauge (brown hub or cap), 27-gauge (gray hub or cap), 28-gauge (green hub or cap), or a 29-gauge (red hub or cap) needle. We were able to identify other TB syringe brands that do not use an orange-capped 25-gauge needle on their TB

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communication. Also, according to three-quarters (75%) of the 2021 respondents, the coronavirus disease 2019 (COVID-19) pandemic has contributed to an increase in disrespectful behaviors among coworkers. Thus, it is no surprise that most of the survey respondents have personally experienced (79%), witnessed (60%), or are otherwise aware of disrespectful behaviors (23%) during the past year. In fact, only 5% of the respondents reported that they have not experienced, witnessed, or are not aware of disrespectful behaviors in the workplace.

The 2021 survey respondents reported a wide variety of disrespectful behaviors that they had personally experienced or witnessed during the past year (**Table 1**). The offenders who engaged in disrespectful behaviors included all genders; however, female offenders were reported most frequently for all types of disrespectful behaviors except physical abuse/assault and throwing objects, for which males were the most frequently reported offenders. Forty percent of respondents reported that three to five different individuals had engaged in disrespectful behaviors during the past year, and another 35% reported that such events involved more than five different offenders. Only 25% of respondents reported that repeated occurrences of disrespectful behaviors arose from just one or two individuals. Surprisingly, respondents reported that individuals who engaged in disrespectful behaviors (offenders) were frequently equal or subordinate in position (rank) to the intended target(s) of the behaviors for certain types of disrespectful behaviors:

- Physical abuse/assault
- Shaming, spreading malicious rumors
- No teamwork/reluctant to follow safety practices
- Negative comments about colleagues/leaders
- Insulted due to race/religion/gender/appearance

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Table 1. Frequency of disrespectful behaviors experienced/witnessed in the past year; gender and rank of offender(s), 2021

Key: (O) Often=more than 10 times; (S) Sometimes=3-10 times; (R) Rarely=1-2 times; (N) Never=no occurrences
Gender: (M) Male, (F) Female, (NB) Nonbinary Rank: Higher or equal/lower than the intended target(s) of the behaviors

Disrespectful Behaviors	Experienced (%)				Witnessed (%)				Offender(s) Gender (%)			Offender(s) Rank (%)	
	O	S	R	N	O	S	R	N	M	F	NB	Higher	Equal/ Lower
Negative comments about colleagues/leaders	44	30	15	11	52	31	12	5	63	91	8	60	89
Impatience with questions, interruptions	38	36	19	7	39	39	17	5	62	77	6	77	55
Condescending/demeaning comments, insults	32	33	22	13	36	37	20	7	59	82	5	71	64
Constant nitpicking/faultfinding	34	27	20	19	38	32	18	12	46	89	5	66	69
Reluctant/refuse to answer questions, return calls	29	38	22	11	33	39	19	9	62	75	6	75	51
No teamwork/reluctant to follow safety practices	26	30	23	21	31	31	21	17	66	86	8	56	87
Shaming, spreading malicious rumors	18	20	22	40	22	24	22	32	42	92	6	50	82
Yelling, cursing, outbursts, threats	12	20	31	37	14	25	31	30	65	69	5	67	60
Disrespect during virtual meetings, email, online	11	17	22	50	13	18	23	46	59	85	7	63	76
Report you to your manager (threat/actual)	8	15	27	50	10	20	29	41	52	81	7	58	69
Insulted due to race/religion/ gender/appearance	5	10	18	67	7	13	22	58	62	79	8	56	79
Throwing objects	2	3	11	84	2	4	16	78	69	60	8	50	69
Physical abuse/assault	2	3	7	88	2	4	9	85	80	58	11	37	77
Other*	52	25	9	14	52	27	7	14	55	82	5	71	56

*Examples of other behaviors (n=209) fell into broad categories of incivility and lack of respect, or specific behaviors such as lying, threatening false accusations, shunning, withholding information, or political-based disrespect.

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syringes. So, we encourage you to work with your supply chain staff to avoid the risk of stocking TB syringes with orange caps alongside insulin syringes with orange caps.

Tubing spikes drop from IV bags in use. QuVa, a sterile compounding company that provides ready made products to hospital pharmacies and outpatient healthcare centers, has been using Douglas Medical Products (DMP) intravenous (IV) bags to prepare medications as a replacement for other IV bags that are in short supply due to supply chain issues. ISMP and ECRI recently investigated a report about IV tubing spikes falling out of these bags (product code: DMP0150) or the bags leaking during infusions. The reporting facility revealed that this has happened on five occasions. In addition, a letter shared with QuVa customers reported that this has also occurred in other facilities. The problem appears to happen with a Baxter administration set (product code: 2C8541). Some of the QuVa bags impacted contained fentanyl. This could lead to patients receiving the wrong amount of medication, infusion contamination from a loosely connected spike, or patient/staff exposure to hazardous medications. The problem has also led to drug waste, therapy interruptions, and controlled substance management issues.

We understand that QuVa has stopped using these bags, but unused products that have not expired may still be available in organizations, and other sterile compounding companies may also be using them. Check with your pharmacy to see if these products are used in your organization. If used, nurses should insert the IV spike into the IV bag with a single motion that includes a firm, twisting action to achieve full insertion of the spike into the bag port. The spike should not be wiggled or removed and reinserted, as this could loosen the connection. Some IV sets contain shorter spikes, and some are lubricated with silicone. These two characteristics could lead to disconnections between the spike and the DMP IV bag. A letter from QuVa noted that DMP recommended wiping the spike off prior to insertion to remove excess silicone, which could help prevent the spike from sliding out. However, ECRI confirmed with DMP that the QuVa

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- Disrespect during virtual meetings, email, online
- Throwing objects
- Constant nitpicking/faultfinding
- Report you to your manager (threat/actual)

Offenders were frequently more senior in position (rank) than the target for these four disrespectful behaviors:

- Impatience with questions, interruptions
- Reluctant/refuse to answer questions, return calls
- Yelling, cursing, outbursts, verbal threats
- Condescending/demeaning comments, insults

When respondents were asked to specify the three most frequently encountered disrespectful behaviors during the past year, more than half included the following:

- Condescending/demeaning comments, insults (64%)
- Impatience with questions, interruptions (53%)
- Negative comments about colleagues/leaders (52%)

Although the following three disrespectful behaviors were, overall, among the least frequent behaviors encountered, it is troubling that more than one in 10 respondents told us at least one of these behaviors was among the three most frequently encountered during the year:

- Insulted due to race/religion/gender/appearance (8%)
- Throwing objects (3%)
- Physical abuse/assault (2%)

Impact on Safety

Unsafe practices, medical errors, and adverse patient outcomes can be clearly linked to disrespectful behaviors in healthcare. For example, in the 2021 survey, more than one in three respondents (40%) told us that their past experiences with disrespectful behaviors had altered the way they handled order clarifications or questions about medication orders. At least once during the past year, approximately half (51%) of the respondents had asked colleagues to help interpret an order or validate its safety to avoid interacting with a particular prescriber—11% reported this occurred more than 10 times throughout the past year (see **Table 2** online at: www.ismp.org/node/30409). Forty-one percent of the respondents had asked another professional to speak to a particularly disrespectful prescriber about the safety of an order at least once during the year, and nearly half (47%) admitted to feeling pressured to accept an order, dispense a product, or administer a drug despite concerns about its safety. At least once during the past year, more than one-third (35%) of the respondents had concerns about a medication order but assumed it was correct rather than interact with a particular prescriber. Similar results were reported when the prescriber's stellar clinical reputation led to a reluctance to question or clarify orders despite having concerns.

Furthermore, more than one-quarter (27%) of the respondents were aware of a medication error in the past year in which disrespectful behaviors played a role. Nearly 200 events were described by the respondents; see **Table 3** (page 5, right column) for a few examples. Many of the described events involved high-alert medications (e.g., neuromuscular blocking agents, anticoagulants, insulin, chemotherapy) and led to significant delays in care and/or serious adverse outcomes.

Organizational Management of Disrespectful Behaviors

It appears that most of the 2021 respondents were not satisfied with organizational efforts to address disrespectful behaviors. Three-quarters (75%) of the respondents reported that their organization does NOT effectively deal with disrespectful behaviors. Nearly half (45%) of the respondents reported that their organization has not clearly defined an

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letter did not correctly communicate input, as DMP does NOT recommend this strategy. We also do NOT recommend this strategy due to the risk of compromising sterility and introducing foreign material (e.g., cloth fibers).

Nonspecific PRN medication administration. If a medication is ordered "QID PRN," might a practitioner interpret this to mean that all four allowable doses that day could each be given at any frequency interval, let's say just 1 hour apart? What if oxy**CODONE** was ordered that way? Or ibuprofen? Technically, the answer is yes! Practitioners might interpret "QID PRN" to mean that four doses a day (QID) could be given at any frequency interval (as needed [PRN]) as long as it is administered just four times a day. And your electronic health record (EHR) system might allow these doses to be documented as such. However, this may not be the prescriber's intended meaning of the medication frequency and may not be safe for patients depending on the medication involved.

Frequencies such as BID PRN, TID PRN, and QID PRN do not provide clear directions regarding the interval between doses of a medication. They allow ambiguity that can foster practitioner-to-practitioner, shift-to-shift, and patient-to-patient variability in interpretation and may result in harmful outcomes. Such errors have been reported to ISMP.

We recommend eliminating the use of nonspecific PRN frequencies in all care settings (e.g., inpatient, outpatient, long-term care). Instead, the prescriber should specifically define, within the order, the minimum time (e.g., hours) between PRN doses. Frequencies such as "every 8 hours PRN" or "every 12 hours PRN," for example, provide specific directions regarding when medications can be administered by clearly defining the amount of elapsed time between doses. The order entry system should not allow nonspecific PRN frequencies as part of an order, and the electronic medication administration record (MAR) should warn users who attempt to administer medications outside of an organization's order-defined interval (e.g., if less than 75% of the dosing interval

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effective process for handling disagreements with the safety of an order, and for those who do, only 41% said that the process for handling clinical disagreements allows them to bypass a typical chain of command, if necessary. On the bright side, 65% of the respondents felt that their organization or manager would support them if they reported disrespectful behavior by another professional. While disrespectful behaviors typically occur every day, they often go unreported for a variety of reasons, not the least of which is the stigma associated with "whistle blowing." If disrespectful behaviors are known, leaders may be reluctant to confront individuals if they are powerful or high-revenue producers, or they may not know how to handle a problem with no obvious solution.

Have Disrespectful Behaviors in Healthcare Lessened?

The results of our 2003 and 2013 surveys painted a grim picture of a hostile work environment in which disrespectful behaviors eroded professional communication, which is imperative for patient safety. Unfortunately, the 2021 survey results suggest that disrespectful behaviors in healthcare continue to occur at an alarming rate, demonstrating little or no improvement, and in some cases, worsening. In 2021, respondents reported that disrespectful behaviors persist unchecked, they are not isolated events, they are not limited to only one or two offenders of a single gender, and they occur in both lateral (peer-to-peer) and hierarchical working relationships.

The 2021 respondent profile is similar to the respondent profiles for our 2003 and 2013 surveys. However:

- More respondents participated in the 2003 (N=2,095) and the 2013 (N=4,884) surveys than the 2021 survey (N=1,047).
- A higher percentage of pharmacists participated in the 2021 survey (37%) compared to the 2003 (17%) and the 2013 (14%) surveys.
- More physicians participated in the 2013 survey (more than 200) compared to the 2021 survey (32).

When comparing the 2021 results to our 2003 and 2013 survey results, the prevalence of most disrespectful behaviors included in the surveys generally stayed the same or increased (**Table 4**, page 5), with the most noteworthy increase between 2013 and 2021 in regard to making negative comments about colleagues and leaders. Responses from the 2013 survey participants suggested that some types of disrespectful behaviors lessened between 2003 and 2013, particularly impatience with questions and the use of condescending or demeaning comments and insults. However, 2021 respondents reported that both of these disrespectful behaviors rose in prevalence since 2013 to nearly or above the 2003 reported prevalence levels.

In the 2003, 2013, and 2021 surveys, repeated occurrences of disrespectful behaviors were not reported to arise from a single gender or from a single individual; 38% of the respondents in 2003, 36% in 2013, and 40% in 2021 reported that 3 to 5 individuals were involved; and 19%, 21%, and 35%, respectively, reported that more than 5 individuals were involved in occurrences during the past year. We saw a small reduction in the percentage of respondents who told us their past experiences with disrespectful behaviors had altered the way they handled order clarifications or questions about orders (2003: 49%; 2013: 44%; 2021: 40%). However, the percentage of respondents aware of medication errors in which disrespectful behaviors played a role during the past year more than doubled between 2013 (11%) and 2021 (27%). In the 2003 survey, 7% of the respondents told us they were personally involved in a medication error during the past year where intimidation played a role. Additionally, most respondents since 2003 have not been satisfied with organizational efforts to address disrespectful behaviors. While 70% of the respondents in 2003, 52% in 2013, and 65% in 2021 reported that their organization or manager would support them if they reported disrespectful behavior, only about one-quarter of all respondents (39%, 25%, 25% respectively) felt that their organization had effectively dealt with disrespectful behaviors.

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has elapsed). Also, all PRN medication orders should include the associated indication and dosing parameters.

Special Announcements

FREE webinars on drug diversion

Drug diversion in healthcare can significantly impact both patient and staff safety, but the full extent of the problem is rarely known because it may go unreported or undetected. Join us in April for three **FREE** webinars, each sponsored by Fresenius Kabi, as we explore how to manage drug diversion, quantify the costs of controlled substance waste, and mitigate the risk of diversion in the operating room (OR) and other procedural areas. For information and to register, click on the links below.

April 6: ***Diversion is a Threat to Patient Safety: Adopting Best Practices for Safe Management of Controlled Substances*** (www.ismp.org/node/29575)

April 13: ***Quantifying the Holistic Costs of Controlled Substance Medication Waste*** (www.ismp.org/node/29576)

April 28: ***Engaging the OR and Procedural Areas to Mitigate Risks with Controlled Substance Medications*** (www.ismp.org/node/29577)

Virtual MSI workshops

Don't miss the opportunity to register for one of our unique 2-day, virtual ***ISMP Medication Safety Intensive (MSI)*** workshops in 2022. Our next workshop is being held on **March 31 & April 1, 2022**. For details, and for more dates, please visit: www.ismp.org/node/127.

Evidence-based IV push checklist

A new evidence-based practice guide and checklist based on the Infusion Nurses Society's (INS) *Infusion Therapy Standards of Practice* and ISMP's ***Safe Practice Guidelines for Adult IV Push Medications*** have been published to educate student, novice, and experienced nurses and to assess competency related to IV push administration. For a copy, visit: www.ismp.org/ext/862.

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Summary

Our 2003, 2013, and 2021 surveys suggest that healthcare has a long history of tolerance and indifference to disrespectful behaviors. Our results revealed little or no improvement, and, in some cases, an increase in the prevalence of disrespectful behaviors between 2003, 2013, and 2021. Some respondents also commented that disrespectful behaviors have increased in patients, too! These behaviors are clearly learned, tolerated, and reinforced in the healthcare culture. In the hundreds of comments from respondents to the 2021 survey, you can feel the despair that disrespectful behaviors still cause as well as see their devastating impact on patient safety. Many 2021 respondents pointed out that the stressful healthcare environment, poor staffing levels, excessive workloads, power imbalances, and the ever-changing science and data associated with COVID-19 treatments were all influential factors contributing to the ongoing prevalence of disrespectful behaviors in healthcare. In many of the 2021 respondents' comments, the frustration associated with the lack of dealing effectively with disrespectful behaviors was evident, with many respondents claiming that the rank of the offender and professional staffing shortage have contributed to the problem. As one survey respondent noted, healthcare workers "are the most vulnerable, unappreciated, and bullied individuals," making healthcare facilities a hazardous place to work. Another respondent noted, "We need leaders and providers to display the best example of behaviors in order for others to be influenced by kindness and civility."

The 2021 survey results and the deep sense of frustration threaded through many of the comments from the survey suggest that now is the time for action. In **Part II** of our report, we will provide recommendations to help address this longstanding problem. In preparation, we would love to hear from organizations that have been working towards a culture of respect and learn more about which strategies have worked. Please send a message to: ismpinfo@ismp.org, if you would like to contribute to the dialogue on this important issue.

Table 4. Frequency of disrespectful behaviors often encountered (more than 10 times) within the previous year from the 2003, 2013, and 2021 surveys

Disrespectful Behaviors	2003 (N=2,095)	2013 (N=4,884)	2021 (N=1,047)	
	Encountered Often (%)	Encountered Often (%)	Experienced Often (%)	Witnessed Often (%)
Condescending/demeaning comments, insults	42	29	32	36
Reluctant/refuse to answer questions, return calls	28	25	29	33
Impatience with questions, interruptions	37	20	38	39
Yelling, cursing, outbursts, threats	9	12	12	14
Report you to your manager (threat/actual)	7	9	8	10
Physical abuse/assault	1	1	2	2
Negative comments about colleagues/leaders		39	44	52
Constant nitpicking/faultfinding		30	34	38
No teamwork/reluctant to follow safety practices		25	26	31
Shaming, spreading malicious rumors		17	18	22
Insulted due to race/religion/gender/appearance		5	5	7
Throwing objects		2	2	2
Disrespect during virtual meetings, email, online			11	13

Table 3. Examples of errors caused in part by disrespectful behaviors, 2021

A prescriber who ordered dofetilide refused to listen to concerns about QTc prolongation, reduced creatinine clearance, drug interactions, and recommended dosing and monitoring. After taking the drug, the patient developed torsades de pointes.
A surgeon's refusal to respond to a question about enoxaparin led to a critical bleeding event.
A nurse called the pharmacy to demand a norepinephrine infusion but refused to answer questions, threatening to report the pharmacy for a delay in care if the infusion was not dispensed. When the infusion arrived on the unit, the nurse started it via gravity and went to look for a smart infusion pump. The entire infusion was administered over 10 minutes instead of 10 hours.
A pharmacist was shamed by another pharmacist when seeking an independent double check for a vancomycin order, which was incorrectly timed. Dozens of errors happen each year because of the shaming culture when seeking an independent double check.
Inappropriate overlapping anticoagulants were ordered, but a pharmacist who questioned the duplicate therapy was shamed, and the pharmacy director told the pharmacist to just dispense both anticoagulants. Administration of both anticoagulants led to intracranial bleeding.
A nurse practitioner frequently insults nurses and pharmacists who bring up concerns during rounds, which led to a dosing error with methadone and a delay in therapy.
A **DOP**amine infusion was titrated incorrectly because nurses were not comfortable questioning the trauma team due to prior experiences with disrespectful behaviors.
A physician bullied a pharmacist to approve an order for hypertonic sodium chloride at an unsafe dose, route, and rate of administration. The patient's serum sodium level rose too quickly and exceeded safe recommendations.
A pharmacist was concerned about heparin dosing and contacted the prescriber. The prescriber hung up on the pharmacist, and the patient suffered a bleeding event that likely could have been avoided.
An anesthesiologist voiced demeaning and insulting comments towards a pharmacist during a code who was questioning an order, which resulted in administering sedation at too low of a dose during rapid sequence intubation.

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