Culture of Respect
Kate McCord, MSN, RN, NEA-BC, Chief Nursing Officer

In the August 2012 issue of Nurse-Advise-ERR, the cover article by Lucian Leape, MD, was a compelling call to action to establish a culture of respect. This topic has been in much of the literature lately as we continue to see bullying, incivility, and other types of disrespectful behavior in the workplace. One of the major reasons the disrespectful behaviors has gotten so much press is that it is now seen to put the patient in jeopardy and create an environment that is not safe for our patients. Following it further information from publications by Lucian Leape, MD et al.

Disrespectful behavior can affect patient safety in several ways:
- A sense of privacy and status can lead one health care worker to treat a perceived worker of lesser status with disrespect creating a barrier to open communication and feedback that are essential for safe care
- A sense of autonomy can be the reason that there is a resistance to following safe practices resulting in patient harm
- Absence of respect unravels the teamwork needed to improve practice
- Dismissive treatment of patients impairs communication and interferes in the role of partners in safe care

The disrespectful behaviors are seen at all levels in healthcare. Physician to nurse, nurse to physician, nurse to nurse, physician to anyone-nurses, colleagues, students, ancillary staff, administration, patients and families. The disrespectful behavior comes in many shapes and sizes—from outbursts of outrageous aggressive behavior to subtle behaviors that are so a part of the culture that they are accepted as normal.

What are some of the causes of disrespectful behavior?
1. Endogenous factors—certain personality characters are associated with disrespectful behaviors and are associated with threats to self esteem. If the self esteem is threatened, a response may be destructive interpersonal behavior as a way of establishing professional dominance.
2. Insecurity & anxiety—these come to light when there are concerns about whether an individual is up to the challenges of their role. This becomes more exaggerated under stress or when overworked. The blaming of others happens when things go wrong to divert the negative feelings from oneself.
3. Depression—surveys show that physicians and other health care workers have higher levels of depression and suicide rates than the general public. These individuals are hypercritical of themselves and others.
4. Narcissism—the investment of time and energy to succeed professionally in healthcare requires a high degree of self involvement—this leads to a focus on narcissistic character traits. It also becomes a means of survival in a competitive and stressful profession.
5. Aggressiveness—highly aggressive individuals enjoy combat and confrontation—they find reassurance in bullying others and it serves as a defense against their feelings of helplessness. The health care environment, for a long time, has tolerated and, in some cases, rewarded this behavior.
6. Exogenous behavior—these are characteristics of the workplace that facilitate disrespectful behavior e.g. “the way we do things here” and defines what is acceptable/unacceptable. Society is also influential esp. in the last 20 yrs of the assertiveness training era—“let it all hang out”, “tell it like it is” etc. The rise of social media, where insulting and derogatory speech is a norm, has also contributed to these behaviors.

This article has addressed the effects a culture of disrespect can have as well as the causes of this behavior. The next part in the October publication will touch on the types and conclude in November with what is the best way to change the culture of disrespect into one of respect---Our Patients Deserve Nothing Less.
The Nursing Practice Council reviewed the Pain Policy, current literature and contacted three pain nurse experts from other organizations. Patients trust us with their lives and we are accountable to perform at our highest professional standards.

**Sedation and pain reassessment following pain medications requires we wake our patients!** Our standard of care for patient pain assessment includes use of a pain scale (i.e. number or other scale) and RASS for sedation. So educate and partner with your patient. Let them know in advance their safety is our first priority and that includes waking you to assess your sedation and pain levels following pain medication. Sleep is important but safety is our top priority.

**Infection Control:** Our Penrose Nursing Vests are great! However, the literature reports a risk for spreading MRSA, C-Diff and other bacteria that linger on our uniforms. Some of us may view vests and jackets as “accent” pieces. **It is essential that we wash our uniform, vests and jackets after every wear to promote infection control and patient safety.**

Sandy Beers, RN, SFMC Surgery

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**Colorado Can Do 5! B.E.S.T. (Breastfeeding Excellence Starts Today) Award**

**Congratulations SFMC Birth Center!** “From a review of SFMC breastfeeding supportive polices your hospital has been selected to receive a Colorado Can Do 5! B.E.S.T. Award. Your documentation describes your hospital has polices for the Can Do 5! These practices include (1) the infant is breastfed in the first hour after birth, (2) the infant is fed only breast milk in the hospital, (3) the infant stays in the same room with the mother in the hospital, (4) the infant does not use a pacifier in the hospital, and (5) hospital staff gives the mother a telephone number to call for help with breastfeeding after discharge.

On behalf of the Colorado Dept of Public Health and Environment, the CO Breastfeeding Coalition, and the CO Perinatal Care Council, we are pleased to acknowledge your institution’s commitment to breastfeeding.”

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**Expanding our Pain and Palliative Care Team**

**Katie Lammi** is splitting her time between the Pain Service and Palliative Care Team. She is a Family Nurse Practitioner with a BSN from Concordia University in Wisconsin and MSN from the University of Wisconsin. Katie has experience in medical, surgical, intensive care, oncology, hematology and radiation oncology. Most recently she worked in the PSFHHS Float Pool while working as an NP in the community. She actively supports shared governance. Katie is currently in orientation and will begin work at St Francis Medical Center in October.

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**5th Annual Centura Health Evidence-Based Practice, Research and Innovation Conference**

**“Enhancing the Culture of Inquiry”**

**Purpose:** This conference will demonstrate how evidence-based practice and research provide a foundation for professional clinical practice.

**Friday, November 9, 2012 at DU School of Hotel, Restaurant, and Tourism**

Sign In: 7:15 a.m. – 8:00 a.m.
Conference: 8:00 a.m. – 4:00 p.m.

**Fee:** $45.00 for Centura Associates and Students
$75.00 for non-Centura attendees

Fee includes materials, refreshments, lunch and parking

**Pre-registration is required** before Friday, 10/26/12

**Cancellation:** The registration fee, less $15.00, will be refunded if you cancel on or before Thursday, 10/25/12. No refunds will be given after this date. Refunds will not be provided for no-shows. Email sheilahansen@centura.org to cancel.

**Limited enrollment. To register**
http://www.centurahealthconferences.org

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**Norma Johnson CNA on 11 surprised a patient who was completing his chemotherapy with the “I am outta here” award and her clown costume. Surrounding by nurse colleague Norma says “To see our patients walk out of here is great. To see them leave with a smile……Priceless.”**

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**Congratulations on achieving Certification/Degree!**

Julia Kokes, BSN, RN-BC, Cardiovascular Unit
Sandra Everett, ASN, RN, CMSRN, SFMC 5S
Fern Cuneio, ASN, RN-BC, SFMC 5N
Irene Pedley, BSN, CNOR, SFMC OR
Donna Hogan, BSN, CNOR, SFMC OR

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