Bullying in Healthcare: A Disruptive Force Linked to Compromised Patient Safety

Susan C. Wallace, MPH, CPHRM
Patient Safety Analyst
Kelly Gipson, BSN, RN, CPPS
Patient Safety Liaison
Pennsylvania Patient Safety Authority

ABSTRACT

Bullying or aggressive behaviors between healthcare providers, such as verbal abuse and intimidation, can be a threat to safe patient care. Bullying behaviors can inhibit teamwork, obstruct communication, and delay implementation of new practices; it can interfere with patient care. This type of behavior may contribute to low worker morale, absenteeism, and high rates of staff turnover. A query of the Pennsylvania Patient Safety Reporting System (PA-PSRS) database revealed 44 events associated with bullying behaviors over a two-year period. Strategies to reduce bullying behaviors include scripting methods to speak up to bullying in an assertive manner, such as D.E.S.C. (i.e., describe, express, suggest, consequences); role playing through simulation to practice confronting a bully; instituting zero tolerance anti-bullying policies with leadership enforcement; and enhancing staff awareness of human resources and management support. (Pa Pat Saf Advis 2017 Jun; 14(2): 64-70.)

Corresponding Author
Susan C. Wallace

INTRODUCTION

Patient safety officers (PSOs) from Pennsylvania facilities contacted the Pennsylvania Patient Safety Authority for information about workplace bullying to help healthcare workers address such behaviors. Bullying, a type of disrespect, is a threat to patient safety because it inhibits teamwork, obstructs communication, and impedes implementation of new practices.[1] A bullied healthcare worker may not speak up with pertinent clinical information or point out a safety problem to the team.[2]

Workplace bullying has increasingly become part of the national dialogue since the Joint Commission recommended adoption of a zero-tolerance policy toward bullying behaviors in 2008.[3] The Workplace Bullying Institute defines bullying* as repeated mistreatment of an intended target in one or more combinations of the following forms: verbal abuse; threatening, humiliating, or intimidating behaviors (including nonverbal); or work interference (e.g., sabotage).[4] The Joint Commission does not consider the following behaviors to be bullying: illegal harassment, discrimination, setting high workplace standards, having a different opinion, or giving constructive feedback.[5]

State legislators in 29 states, including Pennsylvania, and 2 territories have introduced bills to address workplace bullying.[6] In addition, the American Nurses Association,[7] the American College of Obstetricians and Gynecologists,[8] and the Lucian Leape Institute at the National Patient Safety Foundation[9] are among the institutions that have published position papers on this subject. The Institute for Safe Medication Practices (ISMP) conducted national surveys of healthcare workers about disrespectful behavior; results indicate that continued negative behaviors encountered by healthcare workers are influencing communication and suggest that healthcare facilities need to take further actions to address this issue.[10]

A 2010 *Pennsylvania Patient Safety Advisory* article on disruptive behavior reported delays in communication between clinicians could potentially compromise patient safety.[11] The recent PSO inquiries prompted an updated analysis of events reported through the Pennsylvania Patient Safety Reporting System (PA-PSRS), examination of the literature, and interviews of healthcare professionals who have explored this issue and taken steps towards decreasing bullying events.

METHODS

Analysts queried the PA-PSRS database for reports of events that occurred over a two-year period from July 1, 2014, through June 30, 2016, using the following keywords and derivations: bellig*, bully, coerc*, cried, cry, disrupt*, holler, in charge, intimidat*, profan*, refuse, repeated, rude, scream, threat, throw, upset, yell. The wildcard character (*) ensured that the search also yielded events containing other word forms (e.g., disrupt* returns both disruptive and disruption). Events identified by relevant monitor codes to classify events were also included in the dataset.

Analysts manually reviewed the resulting set of 5,807 event report narratives to identify reports describing behaviors synonymous with bullying using the Workplace Bullying Institute definition. Event reports were then grouped into related categories by harm score, event type categories, event reporting taxonomy, and care area. Excluded were event reports addressing bullying by or toward patients.

* The term bullying may overlap with terms such as incivility; horizontal, lateral, or workplace violence; and unprofessional, disruptive, or disrespectful behavior.

Analysts conducted a review of the literature to identify prevalence and strategies to reduce bullying in healthcare facilities. Interviews were conducted with executive leaders, clinical practitioners, and nurse educators to identify best practices and resources to reduce bullying and patient harm.

RESULTS

Analysts identified 44 events describing bullying between healthcare providers including physicians, nurses, and technicians. Although analysts recognize that bullying represents repetitive behaviors over time, the examples in PA-PSRS demonstrate individual situations in isolation that, if repeated, could confirm bullying.

The identified events were reported in five event type categories with 56.8% (n = 25 of 44) reported in "other/miscellaneous," followed by 27.3% (n = 12) reported in "error related to procedure/treatment/test" (Table 1).

Most of the events described overt bullying with no direct patient harm. Analysts found 77.3% (n = 34) of the PA-PSRS events involved a physician engaging in verbally abusive behavior. The remaining events (n = 10) involved a nurse or technician. Twenty-seven percent (n = 12) of the events were witnessed by a patient.

Examination of event descriptions revealed five categories of bullying behaviors based on the Workplace Bullying Institute definition. Analysts assigned some events to more than one category, resulting in 92 entries. The top two event categories in order of frequency were verbal abuse and intimidating behaviors (Table 2).

Analysis of care areas where bullying events were identified revealed three top areas where the events occurred: perioperative care areas 29.5% (n = 13 of 44); medical/surgical units 25.0% (n = 11); and the emergency department 15.9% (n = 7; Figure).

Bullying Events

Analysts interviewed a healthcare provider who spoke to the Authority on the condition of anonymity and described a bullying situation over the course of 15 years involving a nursing supervisor.[12] She described the supervisor as harsh and abrupt with others, who used condescending tones, eye rolling, and deep sighing when new workers did not understand instructions.

At least two nurses left their positions in a month's time after working with the supervisor, while other workers were afraid and avoided working with the individual, she said. Some repeat patients would request another nurse and indicated on questionnaires that the nurse was "mean," she said.[12] When the supervisor's behavior was brought to leadership's attention, the nurse said, it was not addressed. "We were told that this is just the way she is," she said.

Examples of bullying events reported to the Authority in PA-PSRS are presented by category, as follows:*

Verbal abuse

Night nurse yelled at other nurses with a negative and aggressive attitude after she was questioned about her documentation of assessments done during her shift. She stated, "How dare I question her" after asking for the information.

The radiology technician yelled at the nursing staff for not entering the procedure correctly [into the electronic health record]. This took place in front of the patient.

* The details of the PA-PSRS event narratives in this article have been modified to preserve confidentiality. None of these specific event narratives came from facilities interviewed for this article.

Table 1. Bullying Events by Event Type* (N = 44)

EVENT TYPE	NO. (%) OF EVENTS
Error related to procedure/treatment/test	12 (27.3)
Complication of procedure/treatment/test	5 (11.4)
Medication error	1 (2.3)
Transfusion	1 (2.3)
Other/miscellaneous	25 (56.8)

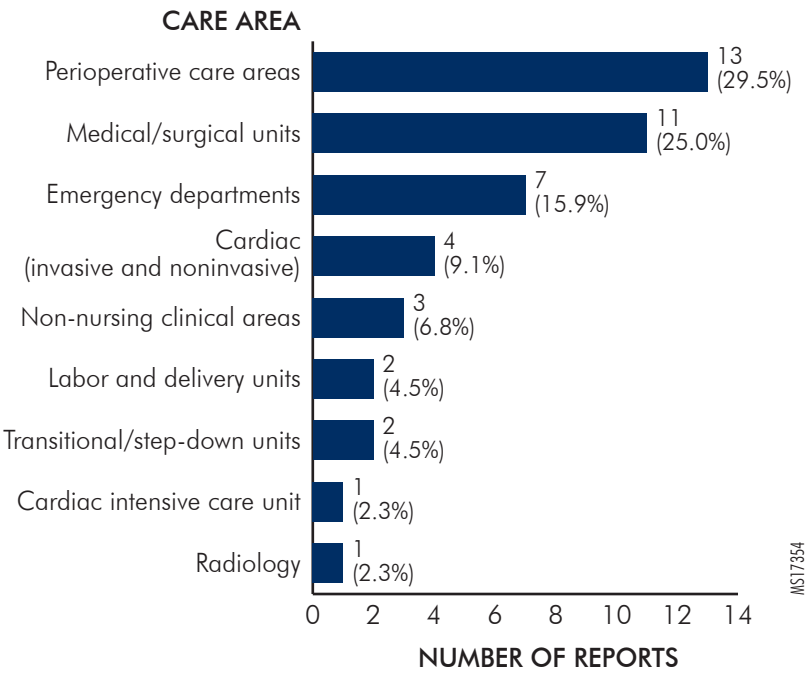
Note: As reported to the Pennsylvania Patient Safety Authority, July 1, 2014, through June 30, 2016.
* Event types are defined by Pennsylvania Patient Safety Reporting System taxonomy and are assigned to events by healthcare facilities at the time of report submission.

Table 2. Bullying Events by Description of Event* (N = 44)

CATEGORIES	NUMBER OF EVENTS	PERCENTAGE
Verbal abuse (e.g., rude behavior)	34	77.3
Intimidating behaviors (e.g., badgering)	32	72.7
Work interference (e.g., sabotage)	13	29.5
Humiliating behaviors (e.g., mimicking)	7	15.9
Threatening behaviors (e.g., frightening)	6	13.6

Note: As reported to the Pennsylvania Patient Safety Authority, July 1, 2014, through June 30, 2016.
* These events total more than 100% because some reports described more than one event category.

Figure. Bullying Events By Care Area (N = 44)



Note: As reported to the Pennsylvania Patient Safety Authority, July 1, 2014, through June 30, 2016.

Intimidating behaviors

Patient admitted with bleeding and needed an order and consent for a blood transfusion. Physician refused to speak to the patient to obtain the consent and told the nurse that it would be the nurse's fault if the patient dies. He repeated his order and hung up the phone.

Patient had been transferred from the cardiac care unit with stable vital signs. The patient's pulse became irregular and blood pressure dropped. Patient was otherwise without symptoms. [The nurse] called the physician and informed him of change in vital signs, and asked him if he wanted a cardiology consult. [The physician] told nurse several times [the nurse] was incompetent, never to call him again and tell him what to do. No new orders were given.

Work interference

Physician was notified of a patient injury by the charge nurse. Due to a miscommunication about which patient was involved with the event, the physician thought the patient was a new admission. Physician fired off multiple questions and would not allow the nurse to answer her inquiries. The nurse tried again to give appropriate information about the injury [using the facility-approved format] and the physician again interrupted the nurse.

Nurse asked physician to perform medication reconciliation together [to prepare a patient for discharge] and physician refused. The nurse attempted to go through the list; however, the physician continued to interrupt the nurse and stated everything was fine.

Threatening behaviors

Surgeon insisted on modifying equipment in a manner that was against hospital policy. After lengthy arguments between the healthcare workers, the surgeon refused to perform the procedure unless the modifications were made. The nurse stated she was being forced to practice contrary to hospital policy.

Humiliating behaviors

Nurse asked physician to re-sign a consent form since there was no witness for the original consent. Instead of signing the form where it was indicated, the physician signed it on the witness line and stated to the nurse, "There, you have a witness."

DISCUSSION

Impact of Bullying on Patient Safety

Of the 44 bullying events reported to PA-PSRS from July 1, 2014, through June 30, 2016, most occurred in the perioperative area, involved physicians as the perpetrators, and included verbal abuse and intimidating behaviors. The small number of events reports over the two-year period may reflect a lack of recognition of bullying behaviors, particularly if they are covert; a reluctance to report for fear of retribution; and absence of a PA-PSRS category for bullying as it relates to patient safety.

Leape and colleagues propose that disrespectful behavior causes the dysfunctional culture found in healthcare and inhibits progress in patient safety.[1] He attributes this to the high stress environment found in healthcare, the hierarchical structure of the workforce, and the autonomous behavior of professionals who resist following safe practices.[1] Disruptive behaviors can affect one's ability to think clearly, making unsafe acts and errors more likely. Caregivers may even divert

their attention from the patient to that of self-protection, as evidenced by avoidance of the instigator.[1] Bullying may inhibit cross-monitoring by team members who are reluctant to speak up.[13]

Understanding prevalence and consequences. The Workplace Bullying Institute estimates that 27% of adult Americans have experienced workplace bullying and another 21% have witnessed it.[14] A Joint Commission survey found 50% of nurses were victims of disruptive behaviors and 90% witnessed these behaviors.[3] Other researchers state the true number of bullying events is unknown, because it is often unrecognized and underreported.[15]

In ISMP's 2013 survey, 4,884 healthcare workers (i.e., physicians, nurses, pharmacists, quality/risk managers) responded that disrespectful behaviors most often encountered were as follows:[16]

- Negative comments about colleagues (73%)
- Reluctance or refusal to answer questions or return calls (77%)
- Condescending language or demeaning comments or insults (68%)
- Impatience with questions or hanging up the phone (69%)
- Reluctance to follow safety practices or work collaboratively (66%)

Compared with survey results from 10 years earlier, ISMP found disrespectful behaviors continue to be prevalent, with little improvement.[10]

Bullied workers may experience humiliation and powerlessness in response to behaviors that range from the overt such as verbal outbursts and physical threats, to the subtle or covert such as eye rolling or purposefully holding back patient information.[3,14] Bullying behaviors may contribute to low worker morale, absenteeism, and high rates of turnover of highly qualified staff.[3,5] There is also a financial cost associated with bullying such as training new staff, which is estimated at $100,000 per new hire.[17]

Evaluating the culture. In an interview with the Authority, Grena Porto, RN, ARM, CPHRM, vice president, risk management, ESIS ProClaim, and a member of the Joint Commission's Patient Safety Advisory Group, stated that as recently as 10 years ago, few people thought of bullying as a patient safety issue.[13] Porto, who was instrumental in developing the Joint Commission's Sentinel Event Alert on this topic, also stated that today, no one questions that bullying and other disruptive behaviors have a profound impact on patient safety.[13]

Hospitals can take the first step to determine how bullying impacts patient safety in their facility, by administering the AHRQ (Agency for Healthcare Research and Quality) survey on the patient safety culture, which can be accessed at http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html. Porto also recommends conducting focus groups of healthcare workers from various shifts and departments to gain a clearer understanding of the culture.[13]

Bullying on the Frontline. Bullying can occur in all areas of healthcare. It takes strong medical-staff leadership to tackle disruptive physician behavior, Porto said. "Depending on the situation, it may just mean sitting down with the physician over coffee," she said. More serious episodes of bullying or repeated patterns of bullying behavior may require a stronger approach, including discipline and termination as appropriate.[13] It is important to intervene early, tailor actions to the situation, and ensure that medical leaders are actively involved in the process, she said.[13]

Studies show yelling, insulting other healthcare workers usually of lesser status (i.e., medical students), and refusing to follow established policies are the most common types of behaviors reported for physicians.[9] Behaviors of physicians found by analysis of the PA-PSRS events included shouting and insulting language directed towards others in supporting positions (e.g., nurses, technicians).

Nurses can be compassionate to patients, but may also be "horrific" to each other, according to Renee Thompson, DNP, RN, CMSRN, CEO and president of RTConnections, LLC, based in Pittsburgh.[18] Thompson, an author and expert about nurse bullying, said, "Every single day of my life, a nurse reaches out to me about being a target of bullying."

Nurses work in extremely stressful situations in which they are dealing with life and death in unpredictable circumstances, Thompson said.[18] "We haven't taught nurses good coping mechanisms," she said. "So they lash out at each other and then that becomes their pattern."

Working with a bully can be a huge distractor that impacts patient safety, Thompson said.[18] "How can you really focus on your patient if you are worried about keeping out of harm's way of the bully," she said. "If you are uncomfortable about being open and honest with someone, how can you share information about your patients? It stops the flow of information."

Thompson advocates for training managers about bullying behaviors.[18] Frontline managers determine the culture in the nursing unit, but no one is teaching the frontline managers how to set expectations with the staff, how to hold people accountable, and how to create a culture of professionalism, she said.

The Role of Leadership

Leadership support is crucial in introducing, setting policy, and maintaining a successful anti-bullying program.[3,13,18] Kendra Aucker, president and CEO, Evangelical Community Hospital, Lewisburg, PA, discovered that 30% of the employees who completed a survey in 2015 measuring the "culture of respect" answered that abusive behavior

was tolerated at the hospital, 25% were frequently bullied, and 40% found it unpleasant to work with other departments.[19] "I read this and couldn't believe it," she said. "I thought this was unacceptable and we have to start now to address this."

Aucker introduced policies on anti-bullying and respectful workplaces (http://patientsafety.pa.gov/pst/Pages/PSAPatientSafetyTopicList.aspx) for every level of the organization to help establish a safety system and culture.[19] In addition, she met with about 1,100 employees over several months in informal meetings entitled "Coffee with Kendra" to get firsthand insight into the culture. "I was told about outbursts, shouting, passive-aggressive behaviors, and other ways we treated one another," she said. "We would never achieve a higher level of patient care unless we changed our attitudes and our behaviors. There is an expectation in the way you treat the people you work with, and that translates to how you treat the people you care for."

She worked in committees to alleviate some of the system problems causing frustrations that lead to bullying behaviors, focused on the departments with the lowest survey scores, instituted training programs for staff and managers, wrote about the improvements in e-mail blasts, and talked about the issues in a "state of the union" address.[19]

With someone willing to listen and determined to make changes, Aucker said, staff began speaking out about situations that could jeopardize patient safety. "The patient is the center of all that we do, and that includes our behavior," she said.[19] If employees could not change their behaviors, then this was not the organization for them anymore, she said. A year after the survey, Aucker said improvement was measured with an employee engagement survey, which found a 38% decrease in the percentage of employees who felt disengaged.

"I am very proud of the work force," she said. "Behavior isn't always black and white, but you have to feel free to speak up and stand up for yourself if you feel you are a victim of bullying or bad behavior. You have to take responsibility for yourself and other people. While there is still lots of work to be done, patients are talking to us about how kind and helpful staff are to them."[19]

It is imperative that hospitals develop a leadership team, including middle managers and unit managers who can lead by example and model the desired behaviors, Porto said. "It is critical to understand that even managers and senior leaders are capable of bullying behavior, and organizations who fail to identify and address such behaviors in leaders cannot succeed in establishing a culture of safety," Porto said.[13]

Limitations

Limitations of this study include scant detail in some PA-PSRS reports, the potential to misinterpret information in the narrative descriptions in the reports, and the possibility that reporters used terms not included in the search strategy. Although analysts recognize that bullying represents repetitive behaviors, PA-PSRS events demonstrate individual situations in isolation that, if repeated, could confirm bullying. Events may not be recognized as reportable by frontline staff if bullying is viewed as "normalized" behavior, because of the lack of a structured data field for reporting bullying or employee events or because of fear of retribution. Bullying events, especially those in which there is physical harm between providers, may be reported as an Infrastructure Failure, which is not reported to the Authority.

RISK REDUCTION STRATEGIES

The following strategies suggested in the literature, and by anti-bullying groups and professionals, may be useful to healthcare workers, managers, and senior leaders seeking to reduce bullying and other disruptive behaviors.

All Healthcare Workers

- Report and document bullying behaviors through established protocols.[20]
- Review personal behaviors (e.g., do you sometimes ridicule or joke about a new or inexperienced co-worker?) and take steps to modify these behaviors (e.g., seek out an Employee Assistance Program.)[18]
- Learn scripting techniques to help stop a bullying situation such as D.E.S.C. (i.e., describe, express, suggest, consequences).[21]
- Think about strategies to handle a bullying situation (e.g., staff members feeling tensions rising, can call out, "Tempo!" as a reminder for everyone to calm down, or when a bullying situation occurs, have workers notify others so they can stand beside and support the bullied worker).[22]
- Know your healthcare facility's policy and procedure on bullying, so you can refer to it and seek help, as needed.[20]

Managers

- Observe staff at work and during key interactions such as change-of-shift reports to identify patterns of unacceptable behavior or communication.[13]
- Appoint preceptors who will uphold a zero-tolerance policy for bullying behaviors and can serve as a resource for those on the receiving end of bullying behavior.[13,23]
- Ask senior leaders for educational classes on bullying for staff and managers.[20]
- Engage organizational staff members with expertise in this area (e.g., human resources experts) to be available to staff, as needed.[23]

- Know your facility's policy and procedure addressing bullying, and enforce it in your department.[20]
- Place posters and fact sheets about bullying in your break and locker rooms.[13,18]
- Ensure each bullying incident is resolved in a manner that protects the person being targeted and enhances the overall unit or departmental culture.[24]

Senior Leaders

- "Declare a new day" by not letting past events disrupt new efforts, and move forward regardless of past events.[25]
- Survey the staff to establish a baseline about bullying behaviors in your facility and conduct ongoing monitoring.[13,19]
- Develop or review existing policies and procedures on bullying, and make sure they follow current state and federal standards and professional behavior standards.[3,20] Recommended elements include zero tolerance, non-retaliation towards those who report/cooperate in investigations, responding to witness (e.g., patients), and defining disciplinary actions.[3]
- Ask for input from staff to ensure staff co-owns the process and expectations.[23]
- Establish a multi-disciplinary committee of senior leaders, managers, and healthcare workers to review bullying events.[3,10]
- Encourage employees to report incidents of bullying, and provide feedback on these behaviors to all employees.[19]
- Offer educational programs on strategies for conflict resolution and encourage employees to participate.[3]
- Lead by example and model non-bullying behaviors.[13]

CONCLUSION

Analysts identified 44 bullying events reported through PA-PSRS over a two-year period; most occurred in the peri-operative area and were overt actions such as verbal abuse and intimidating behaviors. Limitations of reporting bullying behaviors are discussed and include lack of recognition of bullying behaviors, particularly if they are covert, and a reluctance to report for fear of retribution. Bullying behaviors may threaten the safe care of patients by inhibiting teamwork, obstructing communication, and delaying implementation of new practices. Studies show that bullying decreases morale and increases absenteeism and turnover of highly qualified staff. Studies suggest that hospitals take a focused look at these behaviors and institute effective policies with leadership support, educate staff and managers to recognize and handle bullying situations, and involve medical staff leadership.

NOTES

1. Leape LL, Shore MF, Dienstag JL, Mayer RJ, Edgman-Levitan S, Meyer GS, Healy GB. Perspective: a culture of respect, part 1: the nature and causes of disrespectful behavior by physicians. Acad Med. 2012 Jul;87(7):845-52. Also available: http://dx.doi.org/10.1097/ACM.0b013e318258338d. PMID: 22622217
2. Patterson K, Grenny J, McMillan R, Switzler A. Crucial conversations: tools for talking when stakes are high. 2nd ed. New York (NY): McGraw-Hill; 2012.
3. Behaviors that undermine a culture of safety. The Joint Commission; 2008 Jul 9. 3 p. (Sentinel Event Alert; vol. 40, Also available: https://www.jointcommission.org/assets/1/18/SEA_40.PDF.
4. The healthy workplace bill: the problem. [internet]. Workplace Bullying Institute; 2016 [accessed 2016 Dec 30]. [3 p]. Available: http://healthyworkplacebill.org/problem/.
5. The Joint Commission. Bullying has no place in health care. Quick Saf. 2016 Jun;(24):1-4. Also available: https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_24_June_2016.pdf.
6. The healthy workplace bill: the states. [internet]. Workplace Bullying Institute; 2016 [accessed 2016 Dec 30]. [2 p]. Available: http://healthyworkplacebill.org/states/.
7. ANA position statement: Incivility, bullying, and workplace violence. Silver Spring (MD): American Nurses Association, Inc. (ANA); 2015 Jul 22. Also available: http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/bullyingworkplaceviolence/Incivility-Bullying-and-Workplace-Violence.html.
8. Committee on Patient Safety and Quality Improvement. Behavior that undermines a culture of safety. Washington (DC): American College of Obstetricians and Gynecologists (ACOG); 2017 Jan. 4 p. (ACOG Committee Opinion; no.683). Also available: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/Behavior-That-Undermines-a-Culture-of-Safety.
9. Lucian Leape Institute. Through the eyes of the workforce: creating joy, meaning, and safer health care. Boston (MA): National Patient Safety Foundation; 2013. 40 p. Also available: http://www.npsf.org/?page=throughtheeyes.
10. Part II: Disrespectful behaviors their impact, why they arise and persist, and how to address them. ISMP Med Saf Alert. 2014 Apr 24;19(8):1-4. Also available: http://www.ismp.org/Newsletters/acutecare/showarticle.aspx?id=78.
11. Chain of command: when disruptive behavior affects communication and teamwork. Pa Patient Saf Advis. 2010 Jun 16;7 (Suppl 2):4-13. Also available: http://patientsafety.pa.gov/ADVISORIES/Pages/2010sup2_04.aspx.

12. Anonymous. Conversation with: Pennsylvania Patient Safety Authority. 2016 Nov 1.
13. Porto G. (Vice president, risk management, ESIS ProClaim). Conversation with: Pennsylvania Patient Safety Authority. 2016 Nov 16.
14. Namie G, Christensen D, Phillips D. 2014 WBI U.S. Workplace Bullying Survey. Workplace Bullying Institute; 2014. 19 p.
15. Becher J, Visovsky C. Horizontal violence in nursing. Medsurg Nurs. 2012 Jul-Aug;21(4):210-3, 232. PMID: 22966523
16. Unresolved disrespectful behavior in healthcare practitioners speak up (again)-Part I. ISMP Med Saf Alert - Acute Care. 2013 Oct 3;18(20) Also available: http://www.ismp.org/Newsletters/acutecare/showarticle.aspx?id=60.
17. Hubbard P. What can be done about horizontal violence? Alta RN. 2014;69(4):16-8. PMID: 24730120
18. Thompson R. (CEO and president, RTConnections, LLC). Conversation with: Pennsylvania Patient Safety Authority. 2016 Nov 17.
19. Aucker K. (President, CEO, Evangelical Community Hospital, Lewisburg, PA). Conversation with: Pennsylvania Patient Safety Authority. 2016 Oct 28.
20. ANA sets 'zero tolerance' policy for workplace violence, bullying. Position statement calls on health care employers to implement violence prevention programs. Ala Nurse. 2015 Dec;42(4):17. PMID: 26749947
21. TeamSTEPPS® 2.0 Pocket Guide. (AHRQ Publication No. 14-0001-2). Rockville (MD): Agency for Healthcare Research and Quality; 2013 Dec. DESC Script. p. 31. Also available: http://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html#descscript.
22. Thompson R. What if the nurse bully is you? [internet]. Ft. Lauderdale (FL): NurseTogether.com; 2015 May 31 [accessed 2016 Dec 30]. [1]. Available: http://www.nursetogether.com/what-if-the-nurse-bully-is-you.
23. AONE Guiding Principles: mitigating violence in the workforce. Chicago (IL): American Organization of Nurse Executives (AONE); 2014. 5 p. Also available: http://www.aone.org/resources/mitigating-workplace-violence.pdf.
24. Johnson SL, Boutain DM, Tsai JH, Beaton R, de Castro AB. An exploration of managers' discourses of workplace bullying. Nurs Forum (Auckl). 2015 Oct-Dec;50(4):265-73. Also available: http://dx.doi.org/10.1111/nuf.12116. PMID: 25597260
25. Porto G. Reining in a disruptive clinician. OR Nurse 2010. 2010 Nov;4(6):5-8.

PENNSYLVANIA PATIENT SAFETY ADVISORY

This article is reprinted from the Pennsylvania Patient Safety Advisory, Vol. 14, No. 2–June 2017. The Advisory is a publication of the Pennsylvania Patient Safety Authority, produced by ECRI Institute and ISMP under contract to the Authority.

This publication is disseminated via e-mail. To subscribe, go to http://visitor.constantcontact.com/d.jsp?m=1103390819542&p=oi.

To see other articles or issues of the Advisory, visit our website at http://patientsafety.pa.gov.

THE PENNSYLVANIA PATIENT SAFETY AUTHORITY AND ITS CONTRACTORS

The Pennsylvania Patient Safety Authority is an independent state agency created by Act 13 of 2002, the Medical Care Availability and Reduction of Error ("Mcare") Act. Consistent with Act 13, ECRI Institute, as contractor for the Authority, is issuing this publication to advise medical facilities of immediate changes that can be instituted to reduce Serious Events and Incidents. For more information about the Pennsylvania Patient Safety Authority, see the Authority's website at http://patientsafety.pa.gov.

ECRI Institute, a nonprofit organization, dedicates itself to bringing the discipline of applied scientific research in healthcare to uncover the best approaches to improving patient care. As pioneers in this science for nearly 40 years, ECRI Institute marries experience and independence with the objectivity of evidence-based research. More than 5,000 healthcare organizations worldwide rely on ECRI Institute's expertise in patient safety improvement, risk and quality management, and healthcare processes, devices, procedures and drug technology.

The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit organization dedicated solely to medication error prevention and safe medication use. ISMP provides recommendations for the safe use of medications to the healthcare community including healthcare professionals, government agencies, accrediting organizations, and consumers. ISMP's efforts are built on a nonpunitive approach and systems-based solutions.

Scan this code with your mobile device's QR reader to subscribe to receive the Advisory *for free.*