

Culture of Safety and Non-Physical Harm from Disrespect in an  
Oregon Multi-Hospital Health System

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## **Abstract**

Over the past two decades, it has been increasingly acknowledged that patients and families can be harmed by interactions with the health care system. While most health care organizations predominantly focus on mitigating preventable physical harm, health care-associated harm extends beyond physical harm and injury to also encompass non-physical harms. Non-physical harm events can include emotional, psychological, socio-behavioral, and financial types of harm, and are rooted in the interrelated concepts of respect and dignity. A growing body of literature has demonstrated that disrespect is pervasive in health care and serves as a mechanism of injury, urging health systems to recognize failures of respect as equivalent to physical harm events, and to integrate non-physical harm tracking, analysis, and mitigation into existing quality and safety efforts. However, despite research indicating that non-physical harm should be incorporated into organizational patient safety and quality efforts, such actions are still in the nascent stages in terms of being systematically operationalized and mitigated by most health systems.

Building upon this foundation, the purpose of this mixed-methods study was to explore how a multi-hospital health system recognized and addressed non-physical harm within the context of organizational culture. This research first characterized non-physical harm events using patient/family-generated complaints and grievances occurring across hospitals and units through application of the Beth Israel Deaconess Medical Center (BIDMC) incident analysis framework. This study then quantitatively assessed both association and variation between patient experience of respect via patient experience survey data and staff perception of organizational safety culture through staff engagement surveys. Lastly, qualitative interviews were conducted with nurses,

physicians, and leaders to better understand if and how the organization recognized non-physical harm as a priority that necessitated formal integration into its existing organizational processes.

Findings from interviews illustrated that while all respondents recognized that patients and families can be harmed in a physical and emotional sense, the discussion of patient safety and harm was still primarily grounded in physical harm descriptions. The universal acknowledgement among respondents validated the importance of addressing this type of harm with varying understanding of its systematic adoption into quality and patient safety practices. In addition to discussing patient experiences of non-physical harm, there was a greater emphasis on staff experiences of disrespect. The relationship between the two contributes to the delivery of care and overarching culture of respect; as such, engaging and supporting the workforce represents a critical focus area for organizations and could be considered a precondition for establishing more effective strategies for improving the practice of respect.

Quantitatively, a significant association was not found between patient perceptions of respect and staff perceptions of safety culture. However, there were statistically notable variations in respect levels across almost all patient characteristics and organizational control variables, suggesting an area for further research to better understand and address this variation.

Lastly, the BIDMC framework provided a systematic approach to capture and learn from patient/family non-physical harm experiences. This research found that the ubiquity of disrespect in health systems is consequential and necessitates organizations addressing non-physical harm through existing quality and patient safety programs.

Given the overall results of this study, key recommendations to organizations, regulatory entities, and policymakers are proposed, including refinements to the BIDMC framework. While the notions of respect and dignity have long served as foundational concepts in health care, disrespect is pervasive in care delivery. Organizations should acknowledge the impact that disrespectful events can have on patients and families, the workforce, the organization's operations, and the larger health care community. As health system leaders, regulatory/accrediting entities, and policymakers seek new ways to address and improve patient safety, embracing a broadened definition of patient safety and harm to include non-physical harms can lead to the design of more inclusive policy and regulatory solutions, as well as the adoption of practices at the organizational level, all of which can advance the delivery of care and improve the patient/family experience.

## **Dedication**

*for mom, my first & best teacher,  
for dad, the original Dr. Walia,  
for pois, who makes every day full of joy*

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## Glossary

|        |  |
|--------|--|
| AACN   | American Association of Colleges of Nursing                      |
| AAMC   | Association of American Medical Colleges                         |
| ABMS   | American Board of Medical Specialties                            |
| ACA    | Patient Protection and Affordable Care Act                       |
| ACEN   | Accreditation Commission for Education in Nursing                |
| ACF    | Advocacy Coalition Framework                                     |
| ACGME  | Accreditation Council for Graduate Medical Education             |
| ACHE   | American College of Healthcare Executives                        |
| ADL    | Activities of Daily Living                                       |
| AHRQ   | Agency for Healthcare Research and Quality                       |
| AMA    | American Medical Association                                     |
| AMA    | Against Medical Advice   |
| AO     | Accreditation Organization                                       |
| BIDMC  | Beth Israel Deaconess Medical Center                             |
| CCNE   | Commission on Collegiate Nursing Education                       |
| CCT    | Customer Care Team   |
| CES    | Caregiver Experience Survey                                      |
| CHEA   | Council for Higher Education Accreditation                       |
| CHIP   | Children's Health Insurance Program                              |
| CITI   | Collaborative Institutional Training Initiative                  |
| CLIA   | Clinical Laboratory Improvement Amendments of 1988               |
| CMS    | Centers for Medicare & Medicaid Services                         |
| COCA   | Commission on Osteopathic College Accreditation                  |
| CoP    | Conditions of Participation                                      |
| DNV    | Det Norske Veritas Healthcare, Inc.                              |
| DO     | Doctor of Osteopathy   |
| DV     | Dependent Variable   |
| ED     | Emergency Department   |
| GME    | Graduate Medical Education                                       |
| HAC    | Hospital-Acquired Condition                                      |
| HCAHPS | Hospital Consumer Assessment of Healthcare Providers and Systems |
| HHS    | U.S. Department of Health and Human Services                     |
| H&P    | History and Physical   |
| HRO    | High Reliability Organization                                    |
| ICU    | Intensive Care Unit  |
| IHI    | Institute for Healthcare Improvement                             |
| IRB    | Institutional Review Board                                       |
| IOM    | Institute of Medicine  |
| IV     | Independent Variable   |
| KSA    | Knowledge, Skills, Attitudes                                     |
| LCME   | Liaison Committee on Medical Education                           |
| MD     | Doctor of Medicine   |
| NQF    | National Quality Forum   |

|      |   |
|------|---|
| OHSU | Oregon Health & Science University      |
| OLS  | Ordinary Least Squares                  |
| OR   | Operating Room                          |
| PDSA | Plan-Do-Study-Act                       |
| PSO  | Patient Safety Organization             |
| PSU  | Portland State University               |
| QSEN | Quality and Safety Education in Nursing |
| RN   | Registered Nurse                        |
| RWJF | Robert Wood Johnson Foundation          |
| SAQ  | Safety Attitudes Questionnaire          |
| SOPS | Survey on Patient Safety Culture        |
| SRH  | Safe & Reliable Healthcare              |
| TJC  | The Joint Commission                    |
| USDE | U.S. Department of Education            |

## Chapter One – Introduction

### Background: The Magnitude of Patient Harm

Over the past two decades, it has been increasingly acknowledged that patients can be harmed by interactions with the health care system (Bates & Singh, 2018; Frankel et al., 2017; Institute of Medicine [IOM], 2000; Sokol-Hessner et al., 2015). In 1999, the Institute of Medicine (IOM) (now the Health and Medicine Division [HMD] within the National Academies of Sciences, Engineering, and Medicine) released its seminal report, *To Err is Human: Building a Safer Health System*, which first quantified the magnitude of inpatient harm in the United States (U.S.), estimating that 44,000-98,000 people were dying in U.S. hospitals each year due to preventable medical errors (IOM, 2000). In more recent years, there have been estimates as high as 250,000 deaths of hospitalized patients due to preventable medical errors per year, catapulting preventable patient harm from the eighth leading cause of death in the U.S. to potentially as high as the third (Frankel et al., 2017; IOM, 2000; Makary & Daniel, 2016). Regardless of the variable and often-debated estimates that have surfaced over the years, the level of patient harm resulting from care delivery and interactions with the health care system is staggering.

While studies spotlighting the projected magnitude of harm help reinforce the importance of improving patient safety and the inherent responsibility of organizations to provide safe care to all (Frankel et al., 2017), it is essential to recognize the “overwhelming complexity and unpredictability of health care and human behaviour” (Thomas, 2020, p. 5). The inevitability of harms occurring in health care is often perceived as daunting to tackle, but recognizing their ubiquity underscores the necessity of unpacking the myriad causes and



contributing factors of errors potentially resulting in harm, providing a more feasible and attainable approach for identifying areas for improvement, with the larger goal of improving safety and reducing harm (Thomas, 2020). The complexity of patient safety and quality is discussed extensively throughout this dissertation.

### **Mobilization of the Patient Safety Movement**

The release of *To Err is Human* was a pivotal moment for gaining both industry and public attention to patient safety, which the IOM defined as “freedom from accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximizes the likelihood of intercepting them when they occur” (IOM, 2000, p. 211). The report served as an impactful and mobilizing event that sent reverberations throughout the health care community and the media, spurring the patient safety movement due to the effective presentation that quantified the patient safety issue and framed it in a way that warranted intervention (Altman et al., 2004; Bates & Singh, 2018; National Patient Safety Foundation [NPSF], 2015; Sokol-Hessner et al., 2015; Wachter, 2010). The report was fundamental in not only elucidating that patients are often harmed by interactions with the health care system, but also in demonstrating the subsequent costs and magnitude of loss – quantified in terms of lives lost, various financial costs incurred by both institutions and patients/families, and the loss of patient trust and satisfaction with health services, which has financial implications and also affects patient well-being (IOM, 2000). This depiction of loss underscored the inadequacy of existing efforts, unearthing systemic causes that necessitated improvement and supported the

call for coordinated, systemic action across the health services industry (IOM, 2000; NPSF, 2015).

*To Err is Human* focused specifically on setting standards and expectations for patient safety, which was an essential first step, and one of many components in improving health care quality overall (IOM, 2000, 2001). Soon after, the IOM issued a subsequent report, *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*, which focused more comprehensively on how the health care delivery system could be redesigned to improve the quality of care, referring to the “degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (IOM, 2001, p. 211).

The report emphasized the inadequacy of current conditions leading to care that failed to be as safe as it could be, asserting that “between the health care we have and the care we could have lies not just a gap, but a chasm” (IOM, 2001, p. 1). The report proffered six aims for the health care system, built upon Avedis Donabedian’s (1990) seven attributes that define quality, noting that care should be: safe, effective, efficient, timely, patient-centered, and equitable (Ayanian & Markel, 2016; IOM, 2001). These essential elements that define quality have largely been re-affirmed over the two subsequent decades with minimal revision; in 2020, the National Quality Forum (NQF) convened the National Quality Task Force and slightly modified two aims from the IOM’s original list, reframing “effective” to “appropriate” and “patient-centered” to “person-centered”, but otherwise leaving the original aims intact (National Quality Forum [NQF], 2020). Such modest modifications of these quality attributes over the past two decades reinforced the critical and enduring nature of these aims. Coupled together, the two IOM’s reports issued “calls to action”, recommending

strategies for providing safer care and also for strengthening and improving the delivery system overall to ensure the reliable and consistent delivery of high quality care to all patients across the care continuum (Frankel et al., 2017; IOM, 2000, 2001; Sokol-Hessner et al., 2015).

### **Health Care as an Open System**

At the core of the two IOM reports, and reinforced over the past 20 years, was a resounding appeal to re-design and change the health care system. Throughout the literature, there have been consistent perspectives detailing shortcomings and highlighting opportunities for improvement and innovation, often characterizing the industry as fragmented, decentralized, inefficient, inaccessible, and inherently complex given the various interrelated elements interacting with one another (Frankel et al., 2017; IOM, 2000, 2001; NPSF, 2015; Perla et al., 2013). This complexity can be understood by defining health care as a system, which refers to a “network of interdependent components that work together to try to accomplish [an] aim” (Deming, 1994, p. 95). The functioning of these interdependent elements in concert with one another creates a “complex whole” that is affected and influenced by particular behaviors of each of those elements (Batalden & Mohr, 1997, p. 2). Furthermore, the structure, behavior and performance of a single health care organization cannot be known without acknowledging and understanding the context in which it operates (Pfeffer & Salancik, 2003; Scott, 1992); this perspective assumes an “open systems” view, in that “organizations are systems of interdependent activities linking shifting coalitions of participants; the systems are embedded in – dependent on continuing exchanges with and constituted by – the environments in which they operate” (Scott, 1992, p. 25). In contrast,

rational and natural perspectives of organizations view an organization as a “closed system”, representing an institution that operates independently and closed-off from its environment, comprised of stable processes and participants (Scott, 1992). As will be described in more detail in Chapter Two, the dynamic nature of the health care system is ideally suited to be understood as an “open” system.

The IOM reports were successful in highlighting the importance of viewing the role of the system when focusing on quality, patient safety, the underlying causes of errors, and improvement (Bates & Singh, 2018; IOM, 2000, 2001). In order to better understand the source of errors within the larger context of a system, it is essential to emphasize that the majority of preventable harm events tend to result from fundamental system failures, which reflect “a fault, breakdown or dysfunction within an organization’s operational methods, processes or infrastructure” (World Health Organization [WHO], 2010, p. 18), inclusive of policies and organizational culture, and not because of malice, individual errors or deficiencies in knowledge or skills (Botwinick et al., 2006; Perla et al., 2013). Furthermore, it is important to note that errors, defined as the “failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim” (IOM, 2000, p. 4), stem from distinct types of failures, can occur across the care continuum, and do not always result in harm or injury to the patient (IOM, 2000). Errors that do cause harm or injury to patients are often referred to as preventable adverse events, meaning that the event is caused by an error as part of the medical care or intervention provided, although not all adverse events that occur are preventable (IOM, 2000). Additionally, the concept of “near-misses” refers to “events in which harm is averted because of chance or intervention” that should be routinely reported and analyzed as well given their occurrence “can be red flags for impending failure” (Van

Spall et al., 2015, p. 292). Importantly, regardless of whether an error caused harm in the form of a preventable adverse event, delving into errors and harm is at the core of quality, patient safety, and improvement, and must be viewed with a system lens (IOM, 2000).

Quality and safety are “inextricably linked,” and preventing errors requires designing safety into the different layers of the system (The Joint Commission [TJC], 2019, p. 1). Deming’s (1994) “appreciation for a system,” one of four interrelated components within his overarching system of profound knowledge, underpins this systems approach, emphasizing that improving processes is critical for improving overall quality (Batalden & Stoltz, 1993; IOM, 2000).

The relationship between quality and systems is complex but evident and can be understood by recognizing that “improving quality and safety is everyone’s job” (Botwinick et al., 2006, p. 13). An organization delivering care is comprised of individual participants, processes, and factors; however, through a systems perspective, a well-optimized system is akin to an “orchestra” in which the individuals collectively support one another (Deming, 1994, p. 96). Because of the nature of an open system, no one intervention, action nor individual can single-handedly improve quality and safety; instead, a collective, multi-faceted and coordinated approach across the care continuum is needed (IOM, 2000). Additionally, viewing individual stakeholders within an organization independent of the surrounding internal and external contexts ignores the significance and influence of these elements on organizational outcomes (Mullan, 2001; Pfeffer & Salancik, 2003). Applying a resource dependence perspective recognizes that “what happens in an organization is not only a function of the organization, its structure, its leadership, its procedures, or its goals...[it] is also a consequence of the environment and the particular contingencies and constraints

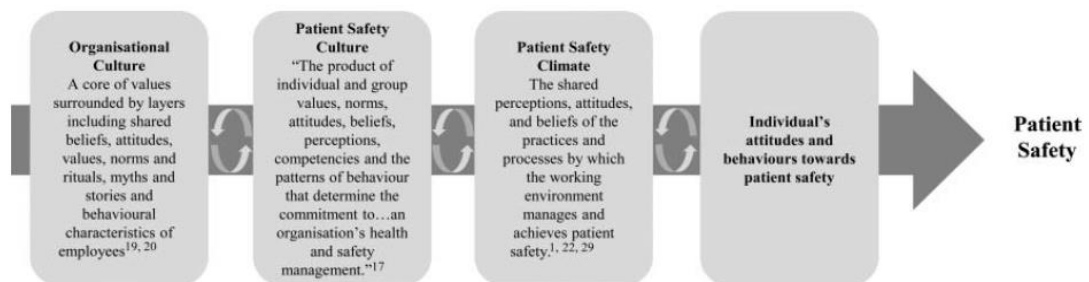
deriving from that environment” (Pfeffer & Salancik, 2003, p. 3). Importantly, while a myriad of stakeholders, individuals, organizations, and groups contribute to the different aspects of care delivery and quality across multiple levels and contexts, the concept of “many hands” being involved within the health care sphere can create challenges in establishing and maintaining safety improvement and accountability, which must be taken into consideration when identifying ways to improve safety (Dixon-Woods & Pronovost, 2016). Further detail about the intersections among quality, safety, and errors within a system lens will be discussed in Chapter Two.

### **Leadership and Safety Culture as Elements of High Reliability**

From an organizational perspective, the improvement of quality and patient safety depends upon a number of factors. Safety culture is a key factor driving the extent to which organizations track and mitigate patient harm events, as well as maintain safety improvement (Bates & Singh, 2018). Achieving progress to enhance patient safety requires acknowledging the complexity of the health care system; effective leadership and implementation of a safety culture are an essential part of becoming a high reliability organization (HRO), which reflects how learning from other industries can guide an organization’s philosophy of safety (Bates & Singh, 2018; Federico, 2018; Scott, 1992; Weick et al., 1999). Inherent within HROs is the essential role of leadership in fostering a culture of safety, which is a component of an organization’s overarching institutional culture (Bates & Singh, 2018; Botwinick et al., 2006; Morello et al., 2013), and refers to the “product of individual and group beliefs, values, attitudes, perceptions, competencies and patterns of behavior that determine the organization’s commitment to quality and patient safety” (TJC,

2019, p. 6). A culture of safety emphasizes reflection and learning, encourages transparency of both failures and successes, demonstrates resiliency, and promotes a “just culture” in which all staff, regardless of hierarchy, are empowered to raise concerns without fear of blame or rebuke, while also preserving accountability and “zero tolerance for reckless behavior” (AHRQ, 2019, para. 6). A just culture shifts the focus away from individual blame to a systems-based view by emphasizing the underlying “origins” of an event or situation (Marx, 2019, p. 245). The ultimate goal of a successful safety culture is not only organizational learning but coordinated actions aimed at mitigating and preventing similar occurrences from recurring (Edwards, 2017; Federico, 2018; Frankel et al., 2017). An organization’s patient safety climate is often described alongside safety culture, which refers to “employee perceptions and attitudes about the surface features of patient safety culture at a given point in time” (Morello et al., 2013, p. 11). Morello et al.’s (2013) patient safety culture model helps illustrate the relationship among organizational culture, safety culture, and safety climate as it contributes to patient safety overall (see Figure 1.1 below).

**Figure 1.1: Patient Safety Culture Model (Morello et al., 2013)**



## **Role of Safety Culture in Mitigating Harm**

The ongoing cultivation and pursuit of adoption of high reliability concepts and safety culture infrastructure is essential to address the underlying systemic causes of errors, thereby improving and sustaining delivery of safe and reliable care and minimizing preventable harms (Botwinick et al., 2006; Federico, 2018). While culture affects and is shaped by an organization's participants as well as those external to the organization, an organization's ability to effectively pursue and achieve quality and safety depends on the effectiveness of leadership in establishing quality and safety as an organizational strategy, and the reinforcement of the organizational aim through behaviors, mechanisms and processes that promote the realization of those goals (Batalden & Stoltz, 1993; Botwinick et al., 2006; Frankel et al., 2017; Sammer et al., 2010; Scott, 1992). However, sustaining a strong culture of safety that permeates all parts of an organization can be challenging and daunting (Frankel et al., 2017). Furthermore, there can be substantial differences in safety climate across units and professional disciplines within an organization; research on safety climate has largely highlighted differences in safety climate levels for different subgroups and hierarchical levels, and between clinicians and non-clinicians (Leape et al., 2012a; Ginsburg, 2015; Ginsburg & Oore, 2015; Hickner et al., 2016; Martinez et al., 2015; Schwendimenn et al., 2013; Singer et al., 2009; Singer & Vogus, 2013).

A more comprehensive discussion of the characteristics inherent within HROs, including the role of leadership in setting the institutional direction for quality and safety as well as the role of the organization's culture, safety culture and safety climate in relation to preserving patient safety, will be discussed in Chapter Two.



## **Regulatory Landscape and Non-Governmental Stakeholders**

After 1999, the regulatory and advocacy landscape evolved across multiple levels of the industry; *To Err is Human* and *Crossing the Quality Chasm* not only mobilized a patient safety and quality movement rooted in a systems perspective, but also stimulated development and/or refinement of governmental and non-governmental entities directing, developing, and influencing quality and patient safety activities (IOM, 2000, 2001; NPSF, 2015). True to the policy sector composition in general, the health services regulatory and policy realm is comprised of a diverse and extensive group of stakeholders and groups with complex interactions (Berman, 1978; Weible & Sabatier, 2017). Improvements in population health require the focus and actions of multiple actors in a coordinated way; various groups represent, advocate for, and influence different elements of patient safety and quality as a policy issue (Kindig & Stoddart, 2003; Weible & Sabatier, 2017).

At a broad level, health care falls victim to the notion of “many hands,” in which multiple stakeholders each contribute to an aspect of patient safety and health care delivery, but no single group can be held responsible (Dixon-Woods & Pronovost, 2016, p. 2). The variety and extent of the actors pose a challenge in that they are “autonomous, highly distributed and heterogeneous yet interdependent,” further exemplifying both the difficulty and underscoring the importance of coordination at a system level (Dixon-Woods & Pronovost, 2016, p. 2). Within health care, some of the most prominent and essential regulatory and non-regulatory (yet influential) stakeholder groups span a variety of levels, ranging from state and federal purview within the United States (U.S.) to non-governmental, influential entities with an international platform.

In response to an executive order signed by President Bill Clinton in December 1999, federal agencies were tasked with developing new activities and initiatives within 90 days targeted to bolster patient safety efforts; as a result, public and private organizations alike launched a myriad of programs aimed at promoting safety (Altman et al., 2004; Leape et al., 2009). From a federal perspective, the Centers for Medicare & Medicaid Services (CMS) serves as an agency within the U.S. Department of Health and Human Services (HHS) that provides health coverage through Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) and is charged with overseeing and improving the nation’s health care system as a whole (USA.Gov, n.d.).

While the creation of Medicare, Medicaid, and the CHIP were signed into law in 1965 and 1997, respectively – well before the release of *To Err is Human* – CMS has continued to refine its scope and oversight related to promoting safe, high quality care over the past two decades, including imposing payment rules on delivery organizations with the intent of promoting the improvement of care delivery (CMS, 2008, 2020a). CMS also partners with state governments and accrediting bodies, among other entities, in the monitoring and provision of high quality, safe care (Jha, 2018), which will be discussed in more depth in the following chapter. Also at the federal level, the Agency for Health Care Policy and Research was renamed to the Agency for Healthcare Research and Quality (AHRQ) and substantially increased its focus on quality and patient safety following the release of the IOM reports; it serves as the lead agency in sponsoring, developing, and supporting multidisciplinary research geared toward improving patient safety and quality in the U.S., partnering with HHS and other entities as appropriate (Agency for Healthcare Research and Quality [AHRQ], 2016; Armstrong & Sables-Baus, 2019; Bates & Singh,

2018). AHRQ, through the use of research, resources, and tools, quantified that the U.S. health care system “prevented 1.3 million errors, saved 50,000 lives, and avoided \$12 billion in wasteful spending” from 2010-2013 (AHRQ, 2016, para. 3); while these successes are not inconsequential, safety and quality continue to be identified as areas for improvement.

Since the release of the IOM’s reports, one of the most influential drivers of patient safety and quality has been the role of accreditation bodies; regulatory entities and accrediting organizations have a significant amount of authority in creating and enforcing standards for patient safety and quality, which have become more robust since 2001 (Devers et al., 2004; Jha, 2018; Wachter, 2010; Warburton, 2009). Although there is varying evidentiary support regarding the effectiveness of regulation on improving quality of care, institutional accreditation by The Joint Commission (TJC) in particular has been cited as a major driver of delivery system safety efforts, including its focus and required organizational compliance with National Patient Safety Goals and their revised survey inspection methodology (Brennan, 1998; Devers et al., 2004; Jha, 2018; Lam et al., 2018; Leape et al., 2009; Wachter, 2010; Warburton, 2009). Licensure, certification boards, and associations also followed suit in terms of not only recognizing the importance of patient safety and quality, but attempting to incorporate key tenets of providing safe, high quality care in their individual licensing requirements (Altman et al., 2004; Wachter, 2010). For example, for physicians, the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Medical Specialties (ABMS) promote competencies that emphasize systems-based practice in postgraduate training programs and professional board certification or maintenance (Altman et al., 2004; Wachter, 2010). In nursing, the American Association of Colleges of Nursing (AACN) updated the quality standards for nursing

education (referred to as the “Essentials”), including a “quality and safety” domain that highlights these two concepts as core values of nursing practice (AACN, 2021). The role and influence of accrediting bodies on organizations to establish and maintain baseline quality and patient safety efforts as well as on licensed health care professionals will be discussed in more depth in the following chapter.

Another essential group of stakeholder organizations within the nongovernmental regulatory sphere is the variety of organizations that fall under an umbrella term of “quality and safety advocacy groups” at the international, national, and state levels, including the NQF, the Institute for Healthcare Improvement (IHI), The Lucian Leape Institute, The Leapfrog Group, and state patient safety organizations and commissions, among countless others. These groups are broadly positioned as advocates for patients and families to partner with health care delivery systems to create and offer strategic, sustainable solutions, guidance, best practices, and data with the intent of streamlining processes, accelerating improvement and change, enhancing value, and achieving better patient outcomes (Institute for Healthcare Improvement [IHI], 2020; Leape et al., 2009; National Quality Forum [NQF], 2020; The Leapfrog Group, n.d.). For nursing specifically, the Quality and Safety Education in Nursing (QSEN) initiative developed and outlined knowledge, skills, and attitudes for six core competencies surrounding quality improvement competence for the different levels of nursing scope of care (Armstrong & Sables-Baus, 2019; Cronenwett et al., 2007). The impact of these organizations lies in their ability to influence change, foster transparency, spearhead innovations and initiatives and encourage widespread dissemination without having formal regulatory authority over delivery organizations (Bates & Singh, 2018). A more detailed account of the patient safety and quality regulatory and non-regulatory landscape as part of

the external environment within the system as a whole, and its role in imposing influence and constraints on health delivery organizations, will be discussed in Chapter Two.

### **Problem Statement**

At the core of health care is the moral imperative to not cause harm, first articulated by the Greek physician, Hippocrates, and reinforced over time (IOM, 2000; Sokol-Hessner et al., 2018). As Avedis Donabedian (as cited in Mullan, 2001, p. 140) noted, “it is the ethical dimension of individuals that is essential to a system’s success.” Yet, despite this ethical dictum, patients can be harmed by interactions with the health care system, both in a physical and non-physical sense (Bates & Singh, 2018; Botwinick et al., 2006; Frankel et al., 2017; IOM, 2000; Leape et al., 2012a, 2012b; NPSF, 2015; Sokol-Hessner et al., 2015, 2018, 2019).

While the extent of progress in addressing patient safety that has been achieved since 1999 has been contested, there is consistent acknowledgment that *To Err is Human* was “transformational” for the recognition of patient safety as an issue (Bates & Singh, 2018, p. 1736), in that it highlighted an initial estimate surrounding the prevalence and cost of errors, emphasized that errors are caused by systemic breakdowns, and implored a collective opportunity to prevent errors and improve safety (Altman et al., 2004; Bates & Singh, 2018; Devers et al., 2004; Frankel et al., 2017; NPSF, 2015; Wachter, 2010).

*To Err is Human* provided a compelling, albeit conservative and (knowingly) incomplete, picture of the extent of harm inflicted on patients by focusing on medication errors and physical harm injuries related to the hospital setting specifically; a variety of solutions came to fruition over the past two decades in response to the initial 1999 “call to

action” (IOM, 2000). Health delivery organizations started implementing specific interventions and prevention strategies related to hospital-acquired conditions (HACs) (such as catheter-associated urinary tract infections, for example) and medication errors, including bundles and surgical checklists (Bates & Singh, 2018). Contentious payment implications were implemented beginning in 2008, when CMS stopped reimbursing hospitals for a select subset of HACs (Bates & Singh, 2018). National policy in the form of the federal Patient Safety and Quality Improvement Act of 2005 led to the development of Patient Safety Organizations (PSOs), managed by AHRQ, which encourage sharing data for learning purposes (Bates & Singh, 2018). Modified regulation and accreditation standards related to facets of patient safety were enacted, and in general, actions were taken by hospitals that placed more emphasis on measurement and quality improvement and recognized the importance of establishing a safety culture stemming from regulatory mandates, best practices, and industry initiatives influenced by advocacy organizations (Bates & Singh, 2018; NPSF, 2015; Sammer et al., 2010).

While this list of interventions is not exhaustive, there is continued acknowledgement that the reasons they have fallen short in mitigating preventable patient harm are a) the piecemeal nature of these solutions targeting specific issues, as opposed to pursuing a more holistic view of patient safety through a systems approach, and b) that patient safety issues are far more complex and encompassing than initially defined (Bates & Singh, 2018; Leape et al., 2012a; NPSF, 2015; Sokol-Hessner et al., 2015).

## **Expansion of Preventable Harm**

In recent years, it has been recognized that while many health care organizations predominantly focus on mitigating physical harm, health care-associated harm extends beyond physical harm and injury to also encompass non-physical harms (Brown et al., 2018; Frankel et al., 2017; Gazarian et al., 2017; Sokol-Hessner et al., 2015, 2018, 2019). Non-physical harms include emotional, psychological, socio-behavioral, and financial types of harm, and are rooted in the interrelated concepts of respect and dignity (Brown et al., 2018; Ottosen et al., 2018; Sokol-Hessner et al., 2015, 2018, 2019). Dignity refers to the “intrinsic, unconditional value of each person,” and respect is defined as the collective “action(s) that honor and acknowledge dignity” (Sokol-Hessner et al., 2019, p. 658).

Despite the prevailing focus of patient safety improvement efforts on physical harm, disrespect is pervasive in health care and “is an affront to dignity and can cause harm” (Sokol-Hessner et al., 2018, p. 463); it is potentially more prevalent than physical harm occurrences (Bates & Singh, 2018; Frankel et al., 2017; Leape et al., 2012a; NPSF, 2015; Sokol-Hessner et al., 2015, 2019). While the experience of disrespect is in and of itself problematic and inherently harmful, secondary harms can result from disrespect, causing unnecessary suffering by patients and their families, subsequently affecting the relationship, and potentially eroding trust, between the patient/family and the provider or system, and/or leading to patient/family withdrawal from the health care system as a whole (Brown et al., 2018; Entwistle, 2008; Sokol-Hessner et al., 2015, 2019). While disrespect can be rooted in the individual (endogenous), it is also learned and perpetuated in an organization’s culture and environment (exogenous); a dysfunctional organizational culture rooted in disrespect threatens an organization’s safety culture strength and is a central barrier to patient safety

progress (Leape et al., 2012a). This led Leape et al. (2012b) to assert that a culture of respect is a “precondition” for the changes needed to make health care safer and for organizations to become highly reliable; establishing such a culture creates an organizational environment in which staff avoid experiences of burnout and are instead engaged and invested in their work (p. 853). Creating a culture of safety to ensure reliability, improvement and sustainability is foundational for solving safety issues, proactively avoiding issues, and establishing viable patient safety programs (Frankel et al., 2017).

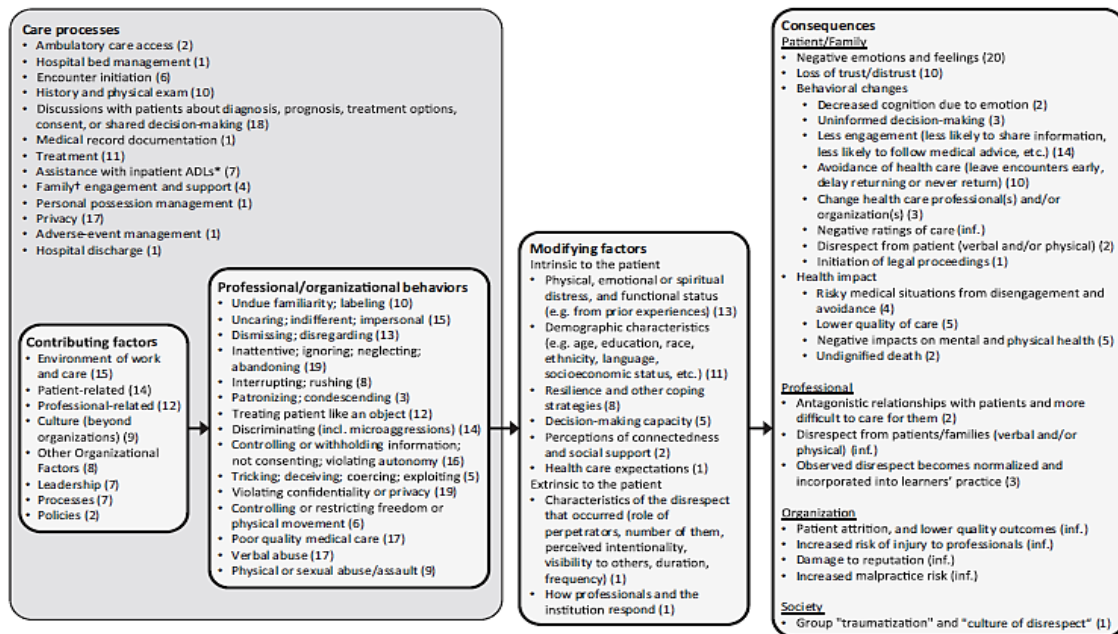
### **Framework for Understanding Patient/Family Disrespect**

Despite growing recognition that safety extends beyond the absence of physical harm and injury, “we are where we were with patient safety before 1999: we know they [non-physical harms] occur, but lacking a systematic approach to capture, categorise or assess them, we struggle to understand root causes and prevent future events” (Sokol-Hessner et al., 2015, p. 550). Expanding upon the work of Leape et al. (2012a, 2012b) and Gazarian et al. (2017), and emphasizing the importance of respect within health care, Beth Israel Deaconess Medical Center (BIDMC) in Boston, MA was an innovator in defining preventable patient harm in encompassing terms, recognizing it as “unintended physical or emotional injury in association with medical care (including the absence of indicated medical treatment) that requires or prolongs hospitalization and/or results in permanent disability or death” (Beth Israel Deaconess Medical Center [BIDMC], 2020, para. 3). With systematic approaches for tracking, addressing, and mitigating non-physical harms still in their infancy across the broad landscape of U.S. health services delivery, BIDMC became a health system pioneer in the non-physical harm sphere by conducting a scoping review and synthesizing it into a useable framework for non-physical harm incident analysis (Sokol-Hessner et al.,



2019). The five-component, improvement-oriented framework (Figure 1.2) was created for health system organizations to use as part of their existing quality and patient safety programs, with its application allowing for capture and characterization of experiences of disrespect, including: 1) care processes; 2) health care professional and organizational behaviors; 3) contributing factors, including patient and professional-related factors, the environment of care, leadership, policies, processes and culture; 4) important consequences of disrespect; and 5) factors both intrinsic and extrinsic to patients that can modify the consequences of disrespect (Sokol-Hessner et al., 2019, p. 657).

**Figure 1.2: Beth Israel Deaconess Medical Center Framework for Disrespect (Sokol-Hessner et al., 2019)**



The creation of the framework stemmed from an interdisciplinary consensus statement released in 2018 outlining the recommendation that organizations should “learn from episodes of disrespect by recognizing, capturing, categorizing and analyzing them, as is

done through incident analysis” in order to “prevent future harm by designing and implementing changes based on what is learned...” (Sokol-Hessner et al., 2018, p. 468). The BIDMC framework was the first developed for incident analysis of non-physical harm resulting from disrespect that was also tested and made available for application and was used as a guiding framework for this research (Sokol-Hessner et al., 2019). Building upon the patient safety and quality literature as well as BIDMC’s foundational work, the following research question and aims were crafted to assess organizational recognition and priority of non-physical harm as a meaningful component of patient safety efforts, worthy of inclusion in patient safety and quality improvement efforts.

### **Research Question and Aims**

This study explored the following question: “How does a multi-hospital health system recognize and address preventable non-physical harm?” In order to address this question, the following three aims were pursued:

1. Characterize non-physical harm events from disrespect occurring across organizational components (hospital and unit) through application of the Beth Israel Deaconess Medical Center (BIDMC) framework.
2. Identify associations between patient experience of respect and staff perception of safety culture and determine the extent of variations in respect and safety culture across hospitals and units.
3. Investigate how leadership and staff articulate and prioritize non-physical harm in the context of organizational culture and organizational commitment to patient safety.

Collectively, carrying out each of these aims allowed for the generation of potential refinements to the existing BIDMC framework, identifying recommendations for future research, and articulating policy and systems implications for a variety of stakeholders both

within the health system under study and for multiple stakeholders across the broader health care industry.

### **Overview of Design**

The research question and aims were addressed through an additional coverage mixed methods research design, in that the strengths of each proposed method were assigned to study distinct parts of the overarching research question; each method had a specific purpose within the larger context (Morgan, 2014). The study methodology applied patient/family-generated grievances/complaints (secondary data) to the BIDMC framework (Figure 1.2) in order to characterize events and conduct content analysis to address Aim 1; constructed multivariate logistic and ordinary least squares (OLS) regressions from three survey types (secondary data) to address Aim 2; and conducted primary data collection through qualitative interviews and subsequent analysis to investigate Aim 3. A mixed methods approach allowed for each method to be linked to a specific purpose; it was determined to be effective since the quantitative or qualitative approach independently could not adequately allow for the research problem to be understood (Creswell & Creswell, 2018, p. 19). A more detailed discussion regarding this study's design and methods is outlined in Chapter Three.

### **Study Setting and Rationale**

This study took place at a not-for-profit, multi-state health system that expressed willingness to participate and remained de-identified throughout the dissertation. The study focused on a subset of the overarching health system within the state of Oregon, as opposed to across the entire health system spanning several states. There were eight

hospitals located throughout Oregon that provided fundamental acute care services across a standard set of departments and units. Lastly, while patients may experience harm through interactions with the health care system spanning the care continuum, this study largely focused on the inpatient setting to manage the study's scope. More detailed information related to the organizational setting is discussed in Chapter Three.

Studies have found that safety climate variation is greatest within hospitals across departments, hierarchical levels, and professional disciplines (Schwendimann et al., 2013; Singer & Vogus, 2013). While safety climate “rarely coheres at the organizational level” (Singer & Vogus, 2013, p. 2), an organization’s mission, vision, values, and strategic priorities are intended to direct and influence its operational activities and culture, as well as permeate throughout the institutions that collectively comprise the overarching organization (Botwinick et al., 2006). As such, Aim 2 sought to quantitatively identify associations between patient experience of respect and staff perception of safety culture, and determine the extent of variations in respect and safety culture across hospitals and units, and Aim 3 assessed the overall organizational climate and attitudes surrounding patient safety and quality from nurse, physician, and leader perspectives.

### **Study Purpose**

While the concepts of respect and dignity are not new and represent the cornerstone of health care ethics, disrespect is pervasive in health care and organizations are not systematically addressing non-physical harms from disrespect, underscoring the purpose and relevance of this study (Brown et al., 2018; Entwistle, 2008; Leape et al., 2012a, 2012b; Sokol-Hessner et al., 2015, 2018, 2019). While the IOM’s seminal 1999 report mobilized the

patient safety movement, and subsequent actions and interventions were enacted in response to a mounting crisis, preventable patient harm persists (Frankel et al., 2017; Sokol-Hessner et al., 2015). Given an initial narrow focus on physical harm and injury as part of patient safety and quality efforts following the IOM's two reports, "harm from disrespect is the next frontier in preventable harm" (Sokol-Hessner et al., 2018, p. 475). As a result, this study sought to advance the understanding of preventable non-physical harm as a component of patient safety as a whole, with the broader intent to mitigate, and ultimately prevent, the occurrence of future harm.

### **Study Significance**

Patient safety is an important public health issue that can negatively affect patients and their families across all care settings (NPSF, 2015). Harkening back to the underlying ethical imperative, a core tenet of health care is to demonstrate respect and uphold safety (Entwistle, 2008; Leape et al., 2012a, 2012b; Sammer et al., 2010; Sokol-Hessner et al., 2015); "it is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort" (IOM, 2000, p. 3). The literature has indicated that non-physical harms resulting from interactions with the health care system are widespread, potentially more so than physical harms (Sokol-Hessner et al., 2015, 2018, 2019). Patient and family experiences of disrespect can result from professional and organizational factors, leading to significant, enduring consequences, not only for patients and their families, but also for employees, organizations, and the larger system (Brown et al., 2018; Sokol-Hessner et al., 2015, 2018). While the experience of disrespect is problematic and inherently harmful, patients and families may experience secondary harms resulting from disrespect, including unnecessary suffering, lower adherence to

treatment recommendations or follow-up, and subsequently impacting the relationship and potentially eroding trust between the patient/family and the provider or system (Brown et al., 2018; Entwistle, 2008; Sokol-Hessner et al., 2015, 2018, 2019). Disrespect has also been found to be a major contributing factor to diagnostic errors, which are one of the most prevalent causes of physical harm events (Giardina et al., 2018). An association between disrespect and the risk of physical harm has also been found; bias – a form of disrespect – has been associated with health care disparities, which can put patients at greater risk for preventable physical harm (Sokol-Hessner et al., 2018, 2019).

Disrespect is not only experienced by patients and families, but organizations and employees can also be impacted (Sokol-Hessner et al., 2018, 2019). Health care workers experiencing disrespectful occurrences and/or working in an organization that has a disrespectful culture can have considerable implications; given the multidisciplinary nature of care delivery, disrespect can hinder communication, teamwork, and cooperation, undermine morale, and contribute to or enhance burnout, potentially leading to the health care workforce disengaging from the organization or larger health system (Brown et al. 2018; Leape et al., 2012a; Sokol-Hessner et al., 2018, 2019).

### **Respect and Health Equity**

Given the moral imperative underpinning health care, it is recognized that health care providers generally do not intend to disrespect patients and families; a patient or family member's experience of disrespect may be a product of the patient's disease or situation, the environment or design of the delivery system, or many other reasons that may lead to patients and families experiencing disrespect that stem from their unique goals, values, preferences, and backgrounds (Sokol-Hessner et al., 2015, 2018).

As previously noted, Donabedian's (1990) seven attributes defining quality, the IOM's (2001) six aims, and the NQF's (2020) revised aims have all reinforced the imperative that the health care system must provide care that is equitable. The traction surrounding the adoption of an expanded view of patient safety to include non-physical harm recognition and mitigation has been identified in the literature, recognizing that "safety is more than the absence of physical harm; it is also the pursuit of dignity and equity" (Frankel et al., 2017; p. 4). It is essential to recognize, however, how progress around equity has "lagged behind," positioning equity as a "forgotten aim" (Wyatt et al., 2016, p. 4). Whitehead and Dahlgren (as cited in Wyatt et al., 2016, p. 8) describe achieving equity in health care in a way that "ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, no one should be disadvantaged from achieving this potential, if it can be avoided."

Research has indicated that an unintended consequence of aiming to improve respect and dignity in organizations could conversely exacerbate health inequities, as learning about experiences of disrespect may unintentionally place the burden on patients and families to voice concerns related to a care experience, thereby potentially alienating certain populations, and perpetuating the occurrences of non-physical harm from disrespect (Brown et al., 2018; Sokol-Hessner et al., 2018). As a result, an important component of fostering a culture steeped in respect necessitates setting the organizational expectation that all individuals have a right to be treated with respect, partnering with patients and families to acknowledge their experiences, and promoting health equity by honoring and understanding their unique values, beliefs, and preferences (Sokol-Hessner et al., 2018).

## Summary

As has been stated, patient safety is not solely the pursuit of reducing physical harm but must also encompass threats to patient well-being (Frankel et al., 2017). Recent research urges the recognition of failures of respect as tantamount to physical harm events and recommends using existing quality and safety mechanisms to ensure that the same level of rigor is applied to both; this recognition to tackle both physical and non-physical harm represents a more holistic view of patient safety and underscores the significance of studying non-physical harm (Brown et al., 2018; Sokol-Hessner et al., 2015, 2019). Failing to systematically characterize and address non-physical harm events ensures they will continue to affect not only patients and their families but can also lead to significant consequences for the health care system overall (Sokol-Hessner et al., 2015). Embracing a comprehensive view of patient safety that targets both physical and non-physical harm allows the health care system to move closer to delivering safer care to all patients.

In this dissertation, Chapter Two presents a detailed review of the literature and the foundational background for this study, Chapter Three outlines the study design and methodology, Chapter Four presents the results and discussion for Aim 1, Chapter Five discusses the results and key insights for Aim 2, and Chapter Six presents Aim 3 results and discussion. Finally, research implications, recommendations to key groups, study limitations, and suggestions for future research are all presented in Chapter Seven.



## Chapter Two – Literature Review

### Overview

This chapter provides an overview of the literature relevant to this dissertation.

This review is organized as follows:

1. An overview of the historical context related to patient safety and quality, including the emergence of patient safety as a public health issue, the evolution of patient safety as a policy problem, and a high-level review of key actions and interventions that were developed over the past two decades.
2. A discussion of systems and organizations, drawing upon applicable systems and organizational theories and concepts, as well as foundational quality and high reliability frameworks, to demonstrate the intricacies of the health care system and how it is influenced, shaped, and reinforced by ongoing, dynamic interactions of its many interrelated components and how this discussion applies to various levers for change in creating stronger systems of safety for patients.
3. An overview of key organizational and system factors influencing improvement in systems of patient safety, including the interdependencies among the factors upon which patient safety and quality improvement depend.
4. A broadened view of patient safety to include non-physical harms and the role of organizational culture in fostering safety, as well as the evolution of dignity and respect in health care, including a framework for understanding disrespect to patients/families.
5. An overview of the regulatory, accreditation, licensing, and certification landscape for institutions and select health care professionals, as well as general categories of standards governing the provision of safe, respectful, patient-centered care.
6. A concluding summary of the literature reviewed and implications for the study design and methods that are outlined in Chapter Three.

### **Section One: Emergence of Patient Safety as a Public Health Issue**

As noted in Chapter One, the release of the Institute of Medicine's (IOM) landmark report, *To Err is Human: Building a Safer Health System*, in late 1999, was a pivotal and foundational moment for patient safety (Bates & Singh, 2018; Leape et al., 2009; NPSF, 2015; Sammer et al., 2010; Wachter, 2010). This report is recognized for raising the fact that health care is unsafe (IOM, 2000). The report is largely credited for a)

stimulating collective action across the health care industry, b) mobilizing the patient safety movement given its ability to elucidate the ubiquity and key causes of medical errors, c) highlighting how errors disrupt the quality of care being delivered to patients and families, and d) making key recommendations to improve safety (Altman et al., 2004; Bates & Singh, 2018; Chassin, 2013; IOM, 2000; Leape et al., 2009; NPSF, 2015; Sammer et al., 2010; Sokol-Hessner et al., 2015; Wachter, 2010). As the report noted, “To err is human, but errors can be prevented” (IOM, 2000, p. 5); importantly, while safety is only one of many elements in improving the quality of care delivered to patients and their families, it is a “critical first step” in doing so (IOM, 2000, p. 5).

One of the most cited and noteworthy contributions embedded within the seminal report was the estimation of annual patient deaths in U.S. hospitals due to preventable medical errors (IOM, 2000). This initial estimate stems from the extrapolation of foundational medical error data first highlighted in the 1991 Harvard Medical Practice Study in New York and later supported by a similar study measuring the incidence and types of adverse events in Utah and Colorado in 1992 (Brennan et al., 1991; IOM, 2000; Thomas et al., 2000). The Harvard Medical Practice Study reviewed a random sample of over 30,000 patient medical records in 1984 to estimate the incidence of adverse events, defined as injuries caused by medical errors, and negligence, characterized as the delivery of substandard care, in hospitalized patients in New York (Brennan et al., 1991; IOM, 2000). Brennan et al. (1991) found that adverse events in the form of prolonged hospitalization or disability (or both) at the time of discharge occurred in 3.7 percent of the total hospitalizations included in the study (p. 371). The IOM (2000) highlighted the Harvard Medical Practice Study’s findings in *To Err is Human* by stating “the proportion

of adverse events attributable to errors (i.e. preventable adverse events) was 58 percent and the proportion of adverse events due to negligence was 27.6 percent” (p. 30).

The Harvard Medical Practice Study was followed by another study of adverse events in 1992, published in 2000, and mirrored its predecessor’s methodology by reviewing a random sample of over 15,000 discharges from a sample of hospitals in both Colorado and Utah (Thomas et al., 2000). This study largely reinforced the findings from the Harvard Medical Practice Study by highlighting that adverse events occurred in 2.9 percent of total hospitalizations within the study’s sample, and that the “proportion of adverse events due to negligence was 29.2 percent, and the proportion of adverse events that were preventable was 53 percent” (IOM, 2000, p. 30). However, given the variations in locations, health systems, patient populations, and other factors across the two major studies, there were some differences that resulted (IOM, 2000). One of the most notable variations related to adverse events leading to patient deaths; the New York study found that “13.6 percent of adverse events led to death...compared with 6.6 percent in Colorado and Utah. In New York, about one in four negligent adverse events led to death, while in Colorado and Utah, death resulted in about one out of every 11 negligent adverse events” (IOM, 2000, p. 30).

The results from these two seminal studies served as the foundation for the IOM’s extrapolation of the results to the 33.6 million admissions to U.S. hospitals in 1997; this translated to one of the most debated findings – that anywhere from 44,000 to 98,000 of patients die in U.S. hospitals each year due to medical errors (IOM, 2000, p. 26). The Colorado and Utah study generated the lower estimate, while application of the findings from the New York study implied the higher estimate (IOM, 2000). The IOM report’s

influence in activating subsequent patient safety-related efforts stems from its pioneering effort at quantifying the magnitude of patient safety as a public health crisis, while acknowledging that the statistics and figures highlighted throughout the document represented a modest and incomplete picture of the true impact of medical errors within health care (IOM, 2000).

### **Patient Safety as a Policy Issue**

Beyond viewing patient safety as a public health crisis, it can also be assessed as an ever-evolving policy problem. Drawing upon relevant historical context will help describe its evolution over time and using a policy lens to unpack its development as a concern worthwhile of focus and effort will allow exploration of the ongoing interactions among elements of the policy process, including actors, institutions, networks, ideas/beliefs, context and events, all specifically related to patient safety (Pronovost et al., 2015; Weible & Sabatier, 2017).

One of the most meaningful contributions from *To Err is Human* stemmed from its use of sobering data; the report opened with succinct but harrowing narratives of preventable safety errors resulting in patient deaths, supplemented by the estimation of 44,000-98,000 annual patient deaths in U.S. hospitals each year due to preventable medical errors (IOM, 2000). The release of this report served as a mobilizing event that sent reverberations throughout the health care delivery community, spurring the acceleration of the patient safety movement due to the report's clarity in quantifying the patient safety issue and framing it in a way that warranted intervention (Bates & Singh, 2018; NPSF, 2015; Sokol-Hessner et al., 2015).

The report was pivotal in elucidating that patients are often harmed by interactions with the health care system by highlighting the inadequacy of existing efforts, emphasizing the role of the system in quality and safety improvement by underscoring that the majority of medical errors result from faulty systems and processes as opposed to individual recklessness or ineptitude, unearthing systemic issues requiring correction, and imploring leaders to take coordinated, systemic action (IOM, 2000, 2001; NPSF, 2015). Through this depiction of harm, an urgent policy problem emerged.

It is evident from the policy literature that there are many ways in which a problem can be viewed, defined, and understood, depending on the theory or framework employed. While many well-known policy theories address each of the core elements of the policy process, each has different frames of reference and levels of analysis (Weible & Sabatier, 2017). For the purposes of explaining patient safety as a policy problem, Deborah Stone's (1989, 2012) model of political reasoning and causal stories framework will be used. Stone's (2012) collective-oriented polis approach to policymaking contrasts with the individualistic-driven market model, in which participants act in ways to "maximize their own self-interest" or welfare (p. 20). The polis model, however, highlights the importance of community; "public policy is about communities trying to achieve something through communities," with both politics and policy happening within the collective setting (p. 20). Stone (1989, 2012) focuses on employing symbolic devices to aid in the strategic portrayal of an issue as a means to view policy problem definition and interpretation, as well as in characterizing situations as amenable to intervention.

*To Err is Human* first demonstrated the magnitude of the patient safety issue with the use of symbolic devices and measurement in the form of narrative stories and

numbers (IOM, 2000; Stone, 2012). The report's effectiveness in spearheading a movement calling for system innovation and re-design throughout the health care community stemmed from its deliberate use and sequencing of a few, intentionally selected, headline-making narratives of preventable patient deaths resulting from medical errors, followed by presentation of numbers that elucidated the magnitude of loss and quantified in terms of lives lost, various financial costs incurred both to institutions and to patients/families, and the loss of trust and satisfaction, all of which have financial implications and impact patient well-being (IOM, 2000). The IOM's use of arresting narratives to characterize patient safety as a policy problem reinforced and reflected how the general public tends to experience exposure to issues of patient safety as well, as "most people learn about medical mistakes through anecdotes" (IOM, 2000, p. 43).

The use of numbers to depict different types of loss reinforces Stone's (2012) argument that using numbers to demonstrate the magnitude of an issue is "one of the most prominent forms of discourse in public policy" that serves as the "first step in promoting change" (pp. 183; 187-188). This philosophy underscores the value and influence of the deliberate use of language and symbols in getting an issue onto the public agenda, given their ability to strategically define problems and persuasively call for action and support; these devices helped patient safety become recognized as a problem for which inaction was not a viable response (Pronovost et al., 2015; Stone, 1989). The IOM's use of symbolic devices and measurement represented a "story of decline", which typically begins with highlighting facts and figures indicating a worsening situation, and a "prediction of crisis" coupled with a proposal for mitigation (Stone, 2012, pp. 159-161). Additionally, other symbolic devices, including the

synecdoche, which refers to “a whole [that] is represented by one of its parts”, is in use both within *To Err is Human* and within the health care literature in general; the utility and effectiveness of the synecdoche lies in its ability to make a problem “concrete” and more “manageable” (Stone, 2012, pp. 168-171). More specifically, the “horror story” as a synecdoche type was demonstrated as the IOM used a handful of harrowing narratives to illustrate the issue of patient deaths attributed to preventable medical errors and to garner support for policy and systemic action (Stone, 2012, pp. 168-169).

This use of symbolic devices in the policy process ties directly to the notion of bounded rationality, a concept that acknowledges human cognitive limitations in that no one person has the ability to have an all-encompassing repository of knowledge, information, or resources in order to consider all issues and solutions in an optimal way, so heuristics, or shortcuts, are used (Lindblom, 1979; Perl et al., 2018; Weible & Sabatier, 2017, p. 308). The role of symbols illustrating the extent and magnitude of harm related to patient safety served as a way to manipulate and influence the bounded rationality of others; despite the imperfect and incomplete nature of information depicting the patient safety environment and scope of impact, the patient safety crisis warranted intervention (Perl et al., 2018; Stone, 1989, 2012; Weible & Sabatier, 2017).

### **Causal Factors**

With the surfacing and initial defining of the policy problem occurring in *To Err is Human*, determining the cause(s) of the problem allowed for not only better understanding of the problem but also assignment of responsibility (Stone, 2012). One of the foremost causes leading to unsafe care stems from the characterization that the health care delivery system is complex, decentralized, and “fragmented,” serving as a deep-

seated metaphor that insinuates the importance of integration and collective action (IOM, 2000; Piña et al., 2015; Stone, 2012). Recognizing the multi-faceted nature of many policy problems, Stone (2012) offers several complex models of causal stories, which apply to patient safety and the delivery of health care. Two models – the “complex systems” and “institutional” complex cause models – can be used to explain the causes of patient safety issues, postulating that the social systems needed to solve the problem are complex, require multiple decision makers, recognize that failure is inevitable, and consist of a network of stakeholders and organizations with various levels of oversight and rules, pointing to inherent structural causes in several places leading to the problem (Stone, 2012, pp. 216-217). While these complex causal stories can serve as an excuse for maintaining the status quo and promoting inaction, given the intricacy leading to the problem, they also have the ability to mobilize reform and “empower people...to solve the problem” (Stone, 2012, p. 227). Similar to problem definition, causal theories “control interpretations and images of problems”, and their salience lies in challenging (substandard) existing rules or mechanisms in place, “locating moral responsibility”, “legitimizing” certain actor groups, and promoting “alliances” in order to target the problem (Stone, 2012, p. 227). While health care is delivered to humans by humans, harm events typically result from a multitude of contributing factors; “the problem is not bad people; the problem is that the system needs to be made safer,” necessitating coordinated action amongst all involved (IOM, 2000, p. 49).

### **Evolution of the Policy Problem**

The nature of policy problems and solutions is socially constructed, and the evolution of patient safety since 1999 can be described through the implementation



processes and varying effectiveness of different solutions that were trialed in response to the initial depiction of the policy problem (Perl et al., 2018). *To Err is Human* provided a compelling, albeit conservative and knowingly incomplete, picture of the extent of harm inflicted on patients by first focusing on medication errors and physical harm injuries specifically related to the hospital setting (Bates & Singh, 2018; IOM, 2000; Sokol-Hessner et al., 2015). As noted in Chapter One, a variety of solutions surfaced as responses to the initial “call to action” in 1999. While the extent of patient safety progress achieved has been contested, there is resounding acknowledgment that the release of *To Err is Human* represented a “watershed moment for the U.S. healthcare system” that “dramatically raised the profile of patient safety” (Bates & Singh, 2018, p. 1736) by elucidating that errors in health care are pervasive and costly, can largely be attributed to system failures, and can be improved through a total systems approach (Bates & Singh, 2018; Chassin, 2013; Frankel et al., 2017; IOM, 2000; Leape et al., 2009; Makary & Daniel, 2016; NPSF, 2015; Pronovost et al., 2015).

A number of interventions and actions were taken because of the report, mostly centered around hospital-based (inpatient) errors, which represent one facet of where patient safety may be compromised (Bates & Singh, 2018; Chassin, 2013; NPSF, 2015). Health care delivery organizations started implementing specific interventions and prevention strategies related to hospital-acquired conditions (HACs), including instituting safety procedure “bundles” to reduce hospital-acquired infections such as central line-associated blood stream infections (Bates & Singh, 2018; Sokol-Hessner et al., 2015). Medication errors were also identified as important causes of harm; as a result, different technology-based interventions were developed, including computerized order entry with

clinical decision support and bar coding of patient identification and medications, which have proven to have variable effectiveness in reducing errors (Bates & Singh, 2018; Pronovost et al., 2015). This is largely attributable to variability in implementation, including both technological and “sociotechnical” or “nontechnical factors” involved in electronic health record (EHR) adoption, primarily organizational issues such as workflows and training (Bates & Singh, 2018, p. 1737).

Beyond HACs and medication errors, surgical errors were also found to be a substantial cause of patient harm, leading to the development of the surgical checklist, led by surgeon Dr. Atul Gawande and his team at Brigham and Women’s Hospital; this work resulted in “a 36 percent decrease in the rate of adverse events and a 47 percent decrease in the mortality rate in a multinational study” (Haynes et al., 2009, as cited in Bates & Singh, 2018, p. 1737). However, similar to other interventions, the effectiveness of surgical checklists also varies (Bates & Singh, 2018). A heightened focus on the importance and improvement of hand hygiene became another concerted problem-solving effort (Bates & Singh, 2018; Chassin, 2013).

Various factors influence the effectiveness of the implementation of an intervention and lead to variability in success; improvements in patient safety hinge on multiple factors that are both technical and organizational in nature, such as leadership, change management, and culture, which will be discussed in more depth later in this chapter (Bates & Singh, 2018; Chassin, 2013). The ongoing variation in the effectiveness of these innovations, including during implementation, post-implementation, and sustainment, highlights the tension between implementing evidence-based guidelines and standardized interventions in a consistent approach, but recognizes that “one size does

not fit all” given the complexity inherent within quality and patient safety initiatives (Chassin, 2013).

Beyond hospital safety efforts, national policy and safety promotion practice initiatives came to fruition following *To Err is Human* (Bates & Singh, 2018; Pronovost et al., 2015). Some organizations spearheaded the “scaling of successful interventions” such as the IHI, the NPSF, and the Lucian Leape Institute (Bates & Singh, 2018, p. 1738). The Lucian Leape Institute was formed by the NPSF to serve as a “think tank that identifies novel approaches to improve safety and identifies risk areas that need system-level attention”, while the IHI launched large-scale campaigns, engaging hundreds of hospitals and health systems across the U.S. in adopting critical safety solutions (Bates & Singh, 2018, p. 1738). National policy in the form of the federal Patient Safety and Quality Improvement Act of 2005 led to the development of Patient Safety Organizations (PSOs), managed by the Agency for Healthcare Research and Quality (AHRQ), which encourage sharing data for learning purposes (Bates & Singh, 2018). As noted in Chapter One, AHRQ was renamed from the “Agency for Health Care Policy and Research” and substantially increased its focus on quality and patient safety following the release of the IOM reports (Armstrong & Sables-Baus, 2019).

Additionally, modified regulatory and accreditation standards related to facets of patient safety were enacted; this included new national patient safety goal requirements as part of the accreditation standards of TJC, the leading health organization accrediting agency, that had focused on quality in the late 1980s, but increased its focus on safety after the release of *To Err is Human* (Altman et al., 2004). In response, actions were taken by hospitals and health systems that placed more emphasis on measurement and

quality improvement, recognized the importance of establishing a safety culture stemming from regulatory mandates, and adopted best practices and industry initiatives influenced by advocacy organizations (Bates & Singh, 2018; NPSF, 2015; Sammer et al., 2010).

On a broader scale, guiding directives for health care started to emerge after the release of *To Err is Human*. As mentioned in Chapter One, the IOM issued a subsequent report, *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*, in 2001, which focused more comprehensively on how the health care delivery system could be redesigned to improve the quality of care (IOM, 2001). As previously noted, the report proffered six aims for the health care system, stemming from Avedis Donabedian's (1990) seven attributes that define quality; the IOM aims articulate that care should be safe, effective, efficient, timely, patient-centered, and equitable (Ayanian & Markel, 2016; IOM, 2001).

These essential elements that define quality have largely been re-affirmed over the two subsequent decades with minimal revision, demonstrating the critical and enduring nature of these aims. In 2020, the NQF convened the National Quality Task Force and slightly modified two aims from the IOM's original list, changing effective to appropriate, and patient-centered to person-centered; the modified six aims indicated that care must be safe, appropriate, person-centered, timely, efficient, and equitable (NQF, 2020). Trade-offs may occur in attempting to achieve the six aims; accomplishing one aim may come at the expense of another (Donabedian, 1990; Piña et al., 2015). Equity may be at odds with other pillars of quality, in that the most "equitable distribution of care may not...bring the greatest improvement of health at the lowest cost;" however,

given the ethical and moral considerations of providing equitable care, while also delivering care that meets the other five tenets outlined by the IOM, it is essential to pursue balance when viewing them collectively (Donabedian, 1990, p. 1118).

Coupled together, the IOM's two foundational "call to action" reports issued directives and recommended strategies for not only providing safer care, but also for strengthening and improving the delivery system overall to ensure the reliable and consistent delivery of high quality care across the care continuum (Frankel et al., 2017; IOM, 2000, 2001; Sokol-Hessner et al., 2015).

Another groundbreaking framework emerged in 2008; the IHI's Triple Aim framework was quickly adopted and serves as a guiding philosophy built upon the belief that systems must pursue three dimensions: 1) improve the individual's experience of care (quality and satisfaction), 2) improve the health of populations, and (3) reduce the per capita cost of health care (Berwick et al., 2008). The Triple Aim has been pivotal in guiding the country's national model for health care, essential in the implementation of the Patient Protection and Affordable Care Act (ACA) in 2010 and incorporated by AHRQ into the National Strategy for Quality Improvement in Health Care in 2011 (Whittington et al., 2015, p. 297). Similarly, the Triple Aim has been the foundation for state health reform initiatives, such as that adopted by Oregon in 2009 (Oregon Health Fund Board [OHFB], 2008).

Importantly, pursuit and achievement of the Triple Aim necessitates a focus on health equity as well as the three aims, as population health goals cannot be realized without addressing the "structural foundations of inequity, particular racism, in promoting health" (Wilkinson et al., 2017, p. s225). As such, the adoption of equity as a

“guiding framework for health transformation” underpinning the pursuit of the Triple Aim serves as a critical foundation for improving and optimizing quality and safety overall (Wilkinson et al., 2017, p. s223). Gandhi (2021) highlights the considerable “parallels” between the patient safety and health equity movements related to the strategies and processes that stakeholders must implement; as such, efforts and lessons learned for patient safety over the past two decades can “provide actionable insights into how to accelerate health equity” (p. 1). Reduction of both harm and inequities in health care becomes dual, essential goals in the pursuit of high-quality, safe, reliable care (Gandhi, 2021; Wilkinson et al., 2017).

In recent years, the addition of another goal to expand the Triple Aim to the Quadruple Aim has been introduced – one that focuses on improving the work life of the workforce and experience of providing care (Bodenheimer & Sinsky, 2014; Sikka et al., 2015). The addition of workforce well-being is argued to be a prerequisite for achieving the Triple Aim, as burnout “threatens” the goals inherent within the Triple Aim as well as patient-centeredness (Bodenheimer & Sinsky, 2014, p. 574). As will be discussed later in the chapter, the role of the workforce is an essential element in ensuring quality and safety. Additionally, the pursuit of health equity has been proposed as a fifth aim to expand the Triple and Quadruple Aims to the Quintuple Aim (Nundy et al., 2022). While this is a nascent proposal, the recommendation indicates how quality improvement efforts should be designed to address and improve health equity, which requires identifying disparities, developing evidence-based solutions to reduce them, focusing attention on equity measurement, and incentivizing achievement of equity (Nundy et al., 2022, p. 522).

This list of interventions, initiatives, and frameworks does not exhaustively capture the extent of activities that were launched in response to the IOM's inaugural reports, and the resulting actions vary in their effectiveness of reduction of errors and subsequent harms. However, together they illustrate how a series of actions were taken across a variety of levels and built upon a centering ethos and foundation of existing frameworks and directions that underscore the importance of providing safe care to patients and their families.

### **The Expansion of Patient Safety as a Policy Problem**

The patient safety literature in the past decade includes several status reports and updates on the perceived successes and shortcomings in patient safety at various time intervals since *To Err is Human*, with most commending specific achievements, while simultaneously recognizing pitfalls to date, and demonstrating anywhere from impatience to disappointment with the piecemeal nature of these solutions targeting specific issues as opposed to pursuing a more holistic view of patient safety through a systems approach (Bates & Singh, 2018; Chassin, 2013; Leape et al., 2009; NPSF, 2015; Pronovost et al., 2015; Sokol-Hessner et al., 2015; Wachter, 2010). The general sentiment echoed throughout the literature notes that desired patient safety progress has been tenuous, with targeted efforts leading to lukewarm results for the system overall, including challenges in sustaining improvements over time (Bates & Singh, 2018; Chassin, 2013, NPSF, 2015; Pronovost et al., 2015; Wachter, 2010). A critical component of this stalled progress stems from the fact that patient safety is inherently complex, and “complex problems defy simple solutions” (Chassin, 2013, p. 1763).

In recent years, it has been recognized that patient safety extends beyond physical harm and injury to encompass non-physical harms as well, which are rooted in dignity and respect, can encompass emotional, psychological, socio-behavioral and financial harms, and have equally injurious implications to both the patient/family and the health care system as physical harms (Brown et al., 2018; Frankel et al., 2017; NPSF, 2015; Sokol-Hessner et al., 2015, 2018, 2019). In this newer iteration of recognizing that “safety is more than the absence of physical harm; it is also the pursuit of dignity and equity” (Frankel et al., 2017, p. 4), preventable patient harm was catapulted from the eighth leading cause of death to the third (Frankel et al., 2017; IOM, 2000; Makary & Daniel, 2016). Additionally, while the focus of patient safety efforts has typically been on medication errors and physical harms in the inpatient setting, patients can also be harmed through interactions with the health care system spanning the care continuum, highlighting the need to incorporate all care settings and to broaden the original problem definition (Bates & Singh, 2018; Brown et al., 2018).

Tackling patient safety in its entirety is daunting, convoluted, and challenging; the initially narrowly defined view of patient safety, as well as the corresponding interventions and improvement efforts tailored to that definition, allowed for some progress to be made (NPSF, 2015). The piecemeal solutions and interventions that were implemented allowed for some isolated successes in certain areas but also were necessary and effective in their ability to uncover the need for larger, more coordinated systemic changes (Bates & Singh, 2018; NPSF, 2015; Pronovost et al., 2015; Sokol-Hessner et al., 2015).



The initial narrow definition of patient safety and subsequent improvement efforts, followed by persisting harm event occurrences, has led to a broadened definition and scope of patient safety. Early solutions to the narrower definition of patient safety helped illuminate that the problem was not defined adequately; as such, the ongoing, iterative definition of the problem allows for continued solutions to be implemented in order to truly address the extent of the issue. This iterative process ties to Lindblom's (1959) notion of incrementalism and juxtaposition between the Rational-Comprehensive Model (the "root") and Successive Limited Comparisons Model (the "branch") related to policy formulation and decision making for complex problems. Patient safety is a complex problem, and the "root" method is not feasible for complex policy questions (Chassin, 2013; Lindblom, 1959, 1979). As is evident from escalating amounts of harm, policy solutions and interventions are not made definitively and only once; instead, they are made and re-made continually through sequential changes, reflecting incrementalism which ties to the "branch" method (Lindblom, 1959, 1979). Importantly, incrementalism can be viewed either positively or negatively; in this circumstance, the incremental approach to policy formulation and decision making for this complex problem can be beneficial overall.

While there is both sluggish progress and a deeper understanding of the complexity of patient safety and harm, there is recent concern surrounding a "lessening intensity of focus on the issue" (NPSF, 2015, p. iv). Importantly, while studies identifying the projected magnitude of harm help reinforce the importance of improving patient safety and the inherent responsibility of organizations to provide safe care to all (Frankel et al., 2017), it is essential to underscore the "overwhelming complexity and

unpredictability of health care and human behaviour” (Thomas, 2020, p. 5). The inevitability of harms occurring in health care is often perceived as daunting to tackle, but recognizing their ubiquity underscores the necessity of unpacking the myriad causes and contributing factors of errors potentially resulting in harm, providing a more feasible and attainable approach for identifying areas for improvement, with the larger goal of improving safety and reducing harm (Thomas, 2020). This reframing of the problem allows for new ways of understanding the scope and depth of the persisting issue of harm (Bacchi, 2016), and for a more in-depth analysis of the role of the system and organizational factors in driving improvements in the delivery of care.

## **Section Two: Overview of Systems and Organizations**

While various interventions have been taken to improve patient safety in the two decades since *To Err is Human* and *Crossing the Quality Chasm*, preventable patient harm continues to persist, leading to a resounding acknowledgment that patient safety is far more complex than initially defined, improvement efforts have largely been targeted and standalone, and the health care delivery industry warrants re-design and change (Bates & Singh, 2018; IOM, 2000, 2001; Frankel et al., 2017; Leape et al., 2009; NPSF, 2015; Pronovost et al., 2015; Sokol-Hessner et al., 2015). Health care organizations are guided by an ethical imperative to not cause harm to patients and are mandated to deliver high quality care that is safe, reliable, and effective (Frankel et al., 2017; IOM, 2000, 2001; NPSF, 2015; Pronovost et al., 2015). Achieving this goal requires a comprehensive, systems-based approach that recognizes that health care is influenced,

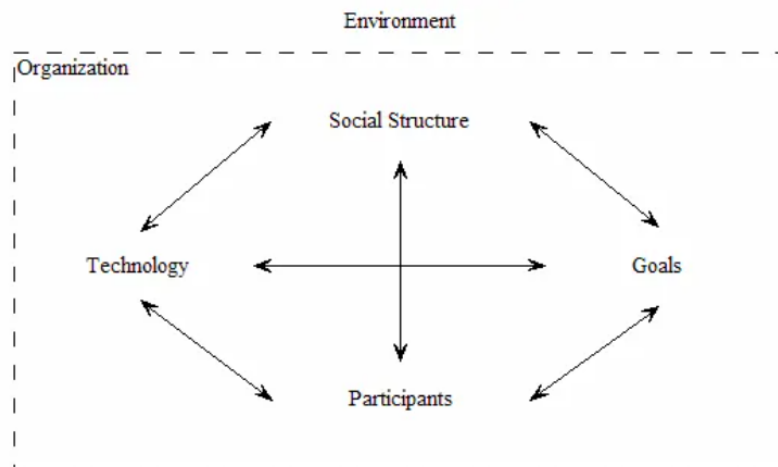
shaped, and reinforced by the ongoing, dynamic interactions of its many interrelated components (IOM, 2000; Federico, 2018; Frankel et al., 2017; Pronovost et al., 2015).

The complexity of health care can be understood and addressed by defining health care as a system within systems (IOM, 2000; Pronovost et al., 2015), with the concept of “system” referring to the “realization of a capability that cannot be achieved by any of its sub-parts alone...generally developed for specific applications to solve one or more problems” (Pronovost et al., 2015, p. 14). Deming (1994) described a system as a “network of interdependent components that work together to try to accomplish the aim of the system” (p. 95). The functioning of these interdependent elements in concert with one another creates a “complex whole” that is affected and influenced by the particular behaviors of each of those elements (Batalden & Mohr, 1997, p. 2). Instead of addressing safety in a segmented fashion, using a “systems approach” means reframing the problem and solutions holistically by acknowledging the many interdependent components that contribute to delivering safe care to patients (Pronovost et al., 2015). Improving patient safety holistically involves mitigating and preventing errors, which requires a systems approach to examine and modify the “conditions” that contribute to errors (IOM, 2000, p. 49). Drawing upon systems and organizational theories and concepts, as well as foundational quality and high reliability frameworks, is an effective way to demonstrate the intricacies of the health care system and how it is influenced, shaped, and reinforced by ongoing, dynamic interactions among its many interrelated components.

## Core Elements of Organizations

Before defining three prominent perspectives that can describe organizational structure, a foundational discussion of the core components within an organization is presented. In a simplified view, organizations are comprised of a few central, uniform elements, including social structure, participants, goals, technology, and environment (Scott, 1992). Scott (1992) adapted Leavitt's (1965) original model which included the first four internal organizational elements but omitted the external environmental component. As will be described in more detail later in this section, the addition of the external environment is critical in understanding organizational structure and behavior, particularly in health care where there are so many external forces, and was added by Scott (1992) as shown in Figure 2.1 below.

**Figure 2.1: Leavitt's (1965) Diamond: A Model of an Organization (Scott, 1992)**



The theoretical origin of each of these core components is described in more detail below which illustrates their collective and interrelated influence on establishing and promoting safety within the health care setting.

The **social structure** refers to the “patterned or regularized aspects of the relationships existing among participants in an organization” (Scott, 1992, p. 16). Within the social structure, Scott (1992) expanded upon Davis’s (1949) work to describe the two sub-elements of the social structure. The normative structure refers to the “values, norms, and role expectations” which serve as “relatively coherent and consistent set of beliefs and prescriptions governing the behavior of participants,” while the second component is referred to by Scott (1992) as the behavioral structure, which he defines as the actual behavior that is carried out, as opposed to “prescriptions for behavior” (p. 16-17). These two sub-elements are distinct yet interrelated, indicating their influence on one another (Scott, 1992). The role of an organization’s culture as a facet of the social structure and its influence on safety is described later in this chapter.

The **participants**, also referred to as social actors, are “individuals who, in return for a variety of inducements, make contributions to the organization” (Scott, 1992, p. 18). Social actors in an organization participate in multiple organizations, with variable contributions and involvement depending on their setting (Scott, 1992). For example, a nurse may be employed at a health system, but may also be a member of various professional nursing organizations. The demographic characteristics of social actors influence the structure and functions of the organization; conversely, the opportunities and processes that the organization creates for its participants from a human resources management perspective have implications for participants as well (Scott, 1992, p. 19). Simply stated, without social actors, an organization cannot function or exist; participants not only carry out the organization’s activities but respond to the organization’s structure as well (Scott, 1992). As described later in this chapter, the role that the workforce has in

delivering safe care to patients and families cannot be understated (Leape et al., 2009, 2012a, 2012b; Scott, 1992).

**Goals** can be defined as “conceptions of desired ends – conditions that participants attempt to effect through their performance of task activities,” although arriving at one definition that is both encompassing and consistent has been contested in organizational theory literature (Scott, 1992, p. 19). Different schools of thought have emphasized various facets of goals. Scott (1992) detailed how rational perspectives favor the “cognitive” functions of goals (p. 285); Simon (1964; 1976) emphasized how goals “provide directions for and constraints on decision making and action” (as cited in Scott, 1992, p. 285), whereas more natural system perspectives noted that goals serve as a “source of identification and motivation for participants,” as outlined by Barnard (1938) and Clark and Wilson (1961, as cited in Scott, 1992, p. 285). Alternatively, institutional analysts emphasized the “symbolic” nature of goals, emphasizing the meaning of goals for the various organizational “audiences” – such as regulatory entities, clients, and the public (Scott, 1992, p. 285).

Other authors have favored the concept of strategies instead of goals, defining strategy as “the determination of the basic long-range goals and objectives of an enterprise and the adoption of courses of action and the allocation of resources necessary for carrying out these goals” (Chandler, 1962, p. 13, as cited in Scott, 1992, p. 286). This definition of strategy in relation to goals ties the organization to its environment and implies a competitive positioning not otherwise captured in alternative definitions (Scott, 1992). While not exhaustive, the variable definitions of organizational goals outlined

above signify the diversity of thought in terms of the functions and properties of goals and their undeniable importance in the study of organizations (Scott, 1992).

**Technology** of an organization means to “view the organization as a place where some type of work is done, as allocation where energy is applied to the transformation of materials, as a mechanism for transforming inputs into outputs” (Scott, 1992, p. 20).

Every organization does some type of work and wields some sort of technology to carry out that work; in the case of a health care setting, the organization “processes” people (Scott, 1992, p. 20), carrying out work aimed to treat and care for patients and families and ideally leading to a healthier population (IOM, 2000).

Lastly, every organization “exists in a specific physical, technological, cultural, and social **environment** to which it must adapt,” and each of the four internal elements previously described can be viewed within a larger environmental context (Scott, 1992, p. 20). No organization is “self-sufficient” nor can be viewed in isolation from the larger environment; the organization and environment can be viewed as having a reciprocal relationship in that the environment affects the organization while the organization also influences its environments (Scott, 1992, p. 21). The role of the environment will be discussed in greater detail through the open systems perspective of organizational structure.

In viewing the organizational elements above in entirety, no single component of an organization supersedes another, reinforcing the view that “organizations are, first and foremost, systems of elements, each of which affects and is affected by the others” (Scott, 1992, p. 21). With a better understanding of the interdependencies of the central components of an organization from a foundational level, three perspectives on defining

organizations will be described to better understand the inherent complexity of health care as a system of systems: the rational system, the natural system, and the open system (IOM, 2000; Pronovost et al., 2015).

### **Rational, Natural, and Open System Perspectives**

The three major perspectives on organizations simultaneously “partially conflict, partially overlap, and partially complement one another” (Scott, 1992, p. 27). Scott (1992) offered a definition of organizations from a rational system perspective that builds upon and embodies components from other historical, prominent definitions, indicating that “organizations are collectivities oriented to the pursuit of relatively specific goals and exhibiting relatively highly formalized social structures” (Scott, 1992, p. 23). In contrast, a natural system perspective assumes that “organizations are collectivities whose participants share a common interest in the survival of the system and who engage in collective activities, informally structured, to secure this end” (Scott, 1992, p. 25). Both the rational system and natural system perspectives view organizations as entities and as closed systems, maintaining separation from their environments, and implying a semblance of participant stability (Scott, 1992, p. 25).

Alternatively, embracing an open system perspective means that the organization is no longer viewed as a formal or informal structure, but as a “system of interdependent activities linking shifting coalitions of participants; the systems are embedded in – dependent on continuing exchanges with and constituted by – the environments in which they operate” (Scott, 1992, p. 24). Viewing an organization independent of the surrounding internal and external contexts ignores the significance and influence of these



elements on organizational outcomes (Mullan, 2001; Pfeffer & Salancik, 2003). The open system perspective view will be applied as a lens in which to view patient safety and quality, including internal and external levers for improvement, given that a comprehensive view recognizing the interdependencies contributing to the health care system can help understand the broader factors contributing to quality and safety (Pronovost et al., 2015).

### **External and Internal Levers for Improvement within an Open Systems Perspective**

Change is fundamental to health system improvement, and holistic progress is more probable when a systems perspective underpins improvement efforts (NPSF, 2015; Perla et al., 2013). Addressing specific levers for change from both internal and external perspectives necessitates acknowledging a resource dependence perspective, recognizing that the health system cannot be viewed in isolation, independent of its context, and emphasizing that to understand the behavior of an organization, the environment of the organization is essential (Pfeffer & Salancik, 2003).

In order to shift away from piecemeal solutions that have historically led to siloed improvements, it is critical to embrace a systems approach to achieve more comprehensive systems of safety (Deming, 1994; Pronovost et al., 2015; Scott, 1992). This requires factoring in potential internal and external solutions and recognizing the interdependence between different organizations within the health care sphere to distinguish how each component contributes to the system overall (Batalden & Mohr, 1997; Scott, 1992). The open systems view posits that organizations are not impervious to their environment but are also not necessarily reactive to every disruption or input (Scott, 1992). While no single organization is self-sufficient and is greatly influenced by

its environment, including relying on resources, organizations also influence their environment as well, including through influencing demand for their services by differentiating themselves through quality, satisfaction, and experience (Scott, 1992).

### **External Levers**

The external environment imposing influence and constraints on a health care delivery organization can be parsed between regulatory requirements and ethical responsibility, which dovetail with best practices and industry influence. Government regulation and accreditation serve as exogenous influences that can exercise authority and influence organizational quality and patient safety (Lowi, 1972; Scott, 1992; Weick et al., 1999). Regulation and accreditation can be viewed as constraints on an organization, though not necessarily or wholly in a pejorative sense; constraints “facilitate the choice and decision process...[and] can...promote certain behaviors” (Pfeffer & Salancik, 2003, p. 15). More detail surrounding the regulatory, accreditation, licensing, and certification landscape will be described in more detail later in this chapter.

Another external lever for change involves partnerships with patients and families, who represent a critical group of stakeholders in improving quality and safety (Batalden et al., 2016). Engaging patients and families serve as an example of co-optation, in which patients and families act as external representatives advising or weighing in on organizational decisions (Scott, 1992). The engagement of patients and families is ubiquitous in guiding directives, frameworks, and best practices outlined by different advocacy groups. While most of these organizations do not assume formal authority, their recommendations uphold and promote the ethical premise of health care, providing guidance and pressure on organizations to meaningfully engage patients and

families in their quality and patient safety work, thereby also shaping delivery organizations' behavior (Scott, 1992). Further discussion around partnering with patients and families will be outlined later in this chapter.

Another external lever for change involves partnerships between health care delivery organizations and the variety of organizations that fall under the umbrella of quality and safety advocacy groups at the international, national, and state levels, including the NQF, the IHI, The Lucian Leape Institute, The Leapfrog Group, and state patient safety organizations and commissions, among others. These groups are broadly positioned as advocates for patients and families to partner with health care delivery systems to create and offer strategic, sustainable solutions, guidance, best practices, and data with the intent of streamlining processes, accelerating improvement and change, enhancing value, and achieving better patient outcomes (IHI, 2020; Leape et al., 2009; NQF, 2020; The Leapfrog Group, n.d.). The impact of these organizations stemmed from their ability to influence change, foster transparency, spearhead innovations and initiatives, and encourage widespread dissemination without having formal regulatory authority over delivery organizations (Bates & Singh, 2018).

Inherent in the discussion of partnerships with stakeholders is a recognition of the beliefs, values, and goals of these different groups, as well as their level of authority and power; some-frameworks, such as the Advocacy Coalition Framework (ACF), focus heavily on the people and groups influencing the policy process, underscoring the role of different types of beliefs in guiding actions (Weible & Sabatier, 2017). The various stakeholder groups highlight the magnitude of different actors involved within the health care system, suggesting the complexity in coordination and interaction, and given that

each actor may have different goals related to patient safety. Given there is no dedicated, overarching group or national strategy to align all of the different stakeholder groups involved in patient safety, the problem of coordination is compounded by the inability to identify the “locus of responsibility” (Dixon-Woods & Pronovost, 2016, p. 4), further exacerbating fragmentation and reinforcing the importance of a system-level approach when approaching quality and safety (Frankel et al., 2017; NPSF, 2015).

### **Internal Levers**

While external considerations help shape internal organizational behavior, from an organizational perspective, there are a number of factors to leverage that can lead to improvement in quality and patient safety, including effective leadership and implementation of a safety culture as part of becoming a highly reliable organization (HRO) (Bates & Singh, 2018; Federico, 2018; Scott, 1992; Weick et al., 1999).

Leadership is essential in providing oversight, setting the institutional tone for quality and safety, and shaping organizational activities (Leape et al., 2012b). The choices leadership makes “are the critical determinants of organizational structure and process” (Miles et al., 1978, p. 548). The onus resides with senior leadership to position quality and safety as a strategic priority for the organization, to champion learning through analysis and transparency of organizational activities (which can accelerate improvement), and to foster a culture of safety, which will be described in greater detail in the subsequent section (Batalden & Mohr, 1997; Batalden & Stoltz, 1993; Botwinick et al., 2006; NPSF, 2015; Sammer et al., 2010). Pfeffer & Salancik (2003) reinforce this view that “executives are a source of control, and it matters who is in control because control determines organizational activities” (p. 228).

Leadership is accountable for establishing and sustaining an effective safety culture, in which the organizational environment is designed to “identify errors, evaluate causes and take appropriate actions to improve performance in the future,” and in which staff are empowered to raise safety concerns without fear of blame or reproach (Frankel et al., 2017; IOM, 2000, p. 8). An effective safety culture permeates the organization across levels and profession types given the autonomy and interdependence among different departments comprising an organization, reinforcing that safety resides everywhere from the front-line to senior leadership (Morello et al., 2013; Sammer et al., 2010; Singer et al., 2009). The more that behaviors are repeated, the higher likelihood that they become embedded and formalized in the organization (Powell, 1990).

Inherent in a safety culture and becoming an HRO is routinely evaluating the quality of care, for which Donabedian (1966) outlined a triad comprised of structure, process, and outcome to evaluate quality (Ayanian & Markel, 2016). Structure refers to the administrative systems and settings that factor into the provision of care; process means the “components of care delivered”; and outcome refers to the “recovery, restoration of function, and survival,” which collectively serve as the basis of quality assessment (Ayanian & Markel, 2016; Donabedian, 1966). These concepts will be discussed in more depth in the following section.

### **Errors Stemming from the System**

The pursuit and achievement of widespread organizational safety, defined by the IOM (2000) as “freedom from accidental injury” (p. 4), has been identified as a prominent goal within health care (Federico, 2018; Frankel et al., 2017; NPSF, 2015;

Pronovost et al., 2015). Patient safety is at the core of improving quality in health care given that the two are “inextricably linked” (TJC, 2019, p. 1). The relationship between quality and systems is complex but evident; an organization delivering care is comprised of individual participants, processes and factors, and a well-optimized system is akin to an “orchestra” in which the individuals collectively support one another (Botwinick et al., 2006, p. 13; Deming, 1994, p. 96). As such, no single intervention, action, or individual can independently improve quality and safety, as safety does not “reside in a person, device or department, but emerges from the interactions of components of a system” (IOM, 2000, p. 58). Instead, a collective, multi-faceted, and coordinated approach across the care continuum is needed (NPSF, 2015). The IOM (2000) was revolutionary in its emphasis on the role of systems and systems thinking in aiming to improve patient safety, acknowledging that ensuring patient safety necessitates making environments safer by assessing and strengthening operational processes and systems to reduce the likelihood of errors resulting, thereby minimizing risk and increasing the reliability of patient care (IOM, 2000, p. 58).

In understanding the sources of errors and harm, the majority of safety errors and substandard quality of care typically result due to fundamental, systemic failures, referring to policies, processes, organizational structures, and cultures, and not because of malice, individual errors or deficiencies in knowledge or skills (Botwinick et al., 2006; IOM, 2000, 2001; NPSF, 2015; Perla et al., 2013). The IOM (2000) largely drew upon Charles Perrow’s and James Reason’s work on systems, accidents, and errors (Perrow, 1984; Reason, 1990). Reason’s work expanded on Perrow’s analysis of the role of systems in causing or preventing accidents, while also viewing the “human contribution

to accidents,” recognizing the interdependent elements within a system (IOM, 2000, p. 52).

The IOM (2000) adopted Reason’s definition of an error as “the failure of a planned action to be completed as intended (e.g., error of execution) or the use of a wrong plan to achieve an aim (e.g., error of planning)” (p. 54). Further defining errors necessitates differentiating between active and latent errors (Reason, 1990), with active errors occurring at the ‘front-line’ operator-level, “whose effects are felt almost immediately” (Reason, 1990, p. 173), whereas latent errors “tend to be removed from the direct control of the operator and include things such as poor design...bad management decisions, and poorly structured organizations” (IOM, 2000, p. 55; Reason, 1990). Analyses of major tragedies such as the *Challenger* explosion, Three Mile Island, and Chernobyl, among others, led to the determination that latent errors are most concerning with regard to safety given the difficulty in prompt detection, and their ability to result in active errors (IOM, 2000, Reason, 1990).

It is essential to emphasize that while errors stem from distinct types of failures and can occur across the care continuum, they do not always result in harm or injury to the patient (IOM, 2000). Errors that do cause harm or injury to patients are often referred to as preventable adverse events, meaning that the event is caused by an error as part of the care or intervention provided, though not all adverse events that occur are preventable (IOM, 2000). Additionally, the concept of “near-misses” refers to “events in which harm is averted because of chance or intervention” and should be routinely reported and analyzed, given that their occurrence “can be red flags for impending failure” (Van Spall et al., 2015, p. 292). As such, preventing errors requires designing safety into the

different layers of the system; Deming's (1994) "appreciation for a system," one of four interrelated components within the overarching system of profound knowledge, underpins this systems approach, emphasizing that improving processes is critical for improving overall quality (IOM, 2000). This emphasis of a systems-based view of safety shifts the source of errors from individuals making mistakes or having substandard skills, to a recognition of the inherent complexity of care delivery within a health system (IOM, 2000).

### **Section Three: Organizational and System Factors Influencing Patient Safety Improvement**

As discussed previously, the majority of health care errors tend to result from system failures (Botwinick et al., 2006; IOM, 2000; Perla et al., 2013), which reflect "a fault, breakdown or dysfunction within an organization's operational methods, processes or infrastructure" (WHO, 2010, p. 18). Achieving patient safety progress requires acknowledging the complexity of the health care system, comprised of ongoing interactions among various stakeholders, organizations, and processes within regulatory, legal, technological, and payment environments (Amalberti & Vincent, 2020; Federico, 2018; Pronovost et al., 2015). Given the interdependencies amongst the various components of the health care system, there are numerous organizational and system factors upon which patient safety and quality improvement depend (Bates & Singh, 2018; Frankel et al., 2017; Pronovost et al., 2015).

After 15 years of development, the Institute for Healthcare Improvement (IHI) and Safe & Reliable Healthcare (SRH) launched the Framework for Safe, Reliable, and



Effective Care in 2017, which highlighted the strategic, clinical, and operational components that are foundational to influencing safety and quality and developing systems of safety for both patients and the workforce (Frankel et al., 2017). While each of these salient elements has distinct properties, and they have been increasingly highlighted in the patient safety literature over the past two decades, their collective inclusion in one model demonstrated their interrelatedness and ability to influence one another. When optimized, each of these components can serve as effective facilitators of safety, whereas if they are neglected, poorly implemented, or inadequately managed within organizations, they can function as barriers (Frankel et al., 2017). Underpinning this framework was the recognition that “safety is more than the absence of physical harm; it is also the pursuit of dignity and equity,” acknowledging a broadened definition of patient safety as a goal (Frankel et al., 2017, p. 4).

The IHI/SRH circular model (Frankel et al., 2017) in Figure 2.2 below displays nine interrelated components stemming from two foundational domains – culture and the learning system – that are integral to strengthening patient safety through mitigating and managing safety issues; failure to focus on achieving any of these interconnected and interdependent elements can significantly attenuate the organization’s ability to deliver safe, effective, and reliable care (Frankel et al., 2017). Importantly, the engagement of patients and family is at the core, anchoring the framework (Frankel et al., 2017).

**Figure 2.2: Framework for Safe, Reliable, and Effective Care (Frankel et al., 2017)**



Collectively the nine components within the framework comprise the necessary elements needed for ensuring an organization can create a learning system and culture of safety to both address safety issues it contends with, as well as those that have yet to surface (Frankel et al., 2017). Both the learning system and culture of safety domains are foundational to improving the delivery of care and are synergistic, so addressing each of the embedded elements is essential but not dependent on a particular order given their interrelated nature (Frankel et al., 2017). These concepts will be described in greater detail to illustrate their interconnectedness and role in creating a safer delivery system, as well as the salient role that leadership has in creating and sustaining an organization's learning system and safety culture (Frankel et al., 2017).

## **Elements of the Learning System Domain**

Tackling a complex problem necessitates embracing multi-faceted solutions across various disciplines (Chassin, 2013; Federico, 2018; NPSF, 2015; Pronovost et al., 2015). As such, advancing patient safety progress requires acknowledging the complexity of the health care system and recognizing health care as “a system-of-systems problem” (Pronovost et al., 2015, p. 15). The following discussion highlights these key elements, including reliability, transparency, improvement, measurement, and continuous learning.

### **Reliability**

In the years since *To Err is Human* and subsequent “call to action” publications, there has been a greater focus in the literature on gleaning insights and embodying key characteristics from highly hazardous, safety-driven industries outside of health care to improve safety within health care (Bates & Singh, 2018; Federico, 2018; Leape et al., 2012b; Marx, 2019; Nolan et al., 2004; NPSF, 2015; Pronovost et al., 2015; Sutcliffe et al., 2017). Industries such as aviation, mining, automobile, and nuclear power have long embraced a systems-based approach to improving safety and have made considerable progress in their ability to manage organizational risk, resulting in strong safety records (Amalberti & Vincent, 2020; Federico, 2018; NPSF, 2015; Sutcliffe, 2017). Similar to other complex and high-risk industries, health care has identified the pursuit and achievement of widespread safety as a priority, leading to the adoption of various practices from other industries in an effort to improve safety, such as safety huddles and incident reporting (Federico, 2018; Frankel et al., 2017; Scott, 1992; Sutcliffe et al., 2017; Weick et al., 1999; Weick, 1987). However, unlike several of these other industries, achievement of overall quality and safety progress within health care has been

tenuous (Bates & Singh, 2018; NPSF, 2015; Sokol-Hessner et al., 2015; Wachter, 2010); one of the most echoed criticisms throughout the literature stems from a recognition that some improvements have been made, but in isolated circumstances and settings, and often in a superficial way (Bates & Singh, 2018; NPSF, 2015; Pronovost et al., 2015; Sutcliffe et al., 2017).

Given the persistence of patient safety concerns and harm, the health care industry has increasingly pushed for health systems to pursue becoming HROs (Federico, 2018; Nolan et al., 2004; Sutcliffe et al., 2017). HROs are organizations that “design work systems to anticipate, contain and recover from...the inevitable risks and hazards that are part of an indeterminate world, the health care world” (Sutcliffe et al., 2017, pp. 248-249). Becoming an HRO is not a panacea for patient safety but is one of many factors that can improve safety (Sutcliffe et al., 2017). Pursuing high reliability necessitates planning, anticipation, resilience, and recovery; “the hallmark of an HRO is not that it is error free but that errors do not disable it” (Sutcliffe et al., 2017, p. 249). A central feature of HROs stems from High Reliability Theory (HRT) and the development of “collective mindfulness,” a concept indicating that all participants in an organization recognize the inevitability and gravity of failures and understand the role of surfacing and mitigating errors (Chassin & Loeb, 2011; Leape et al., 2012b; Weick, 1987). Weick et al. (1999) developed a mindful infrastructure for high reliability, a five-point model of HROs that emphasizes: preoccupation with failure, reluctance to simplify interpretations, sensitivity to operations, commitment to resilience, and underspecification of structures. HROs embody a somewhat “paradoxical” nature by pursuing “an ideal of perfection but never expect[ing] to achieve it... dread[ing] surprise but always anticipat[ing] it...” (Rochlin,

1993, as cited in Weick et al., 1999, pp. 105, 107). The ability to provide safe, reliable, and effective care relies on an organization's ability to be resilient, respond to unexpected situations, and raise concerns about the underlying policies and processes leading to safety errors (Argyris, 1977; Federico, 2018).

While there appears to be ubiquitous agreement that health systems organized around high reliability show improvement in quality and safety, there is less consensus around the ultimate goal of pursuing reliability in the health care industry (Amalberti & Vincent, 2020; Sutcliffe et al., 2017; Thomas, 2020). The notion of creating “absolute safety” (Thomas, 2020, p. 4), which is also referred to as achieving “zero patient harm” (Mowll, 2019, p. ix) is one that is highly debated within the literature and does not align with the HRO philosophy. Some stakeholders within the patient safety realm argue for the achievement of zero harm, while others propose a reframing of how preventable harm reduction is viewed, discussed, and approached across the industry (Amalberti & Vincent, 2020; Thomas, 2020). Mowll (2019) argued that absolute safety should be “the norm, not a stretch goal” (p. ix), and highlighted extensive support from proponents across the industry advocating for the relentless pursuit of zero patient (preventable) harm, including:

- NPSF, which merged with the IHI, and collaborated with the American College of Healthcare Executives (ACHE) to develop a toolkit for achieving zero harm in 2017 (ACHE, IHI/NPSF, 2017);
- Solutions for Patient Safety, a collaborative of over 100 children's hospitals driven by a unified mission of achieving zero harm (Solutions for Patient Safety, n.d.);
- AHRQ, which articulated a zero harm strategy as part of their “Making Care Safer” initiative in 2011 (AHRQ, 2020);
- Leaders from TJC who have published literature supporting the achievement of zero harm; and

- Countless health systems across the country spearheading and supporting initiatives with a unified mission of pursuing zero harm.

Others have advocated shifting away from an emphasis on zero harm to focusing on the active management and reduction of risk in concert with continuing to improve and innovate (Amalberti & Vincent, 2020; Thomas, 2020), given the increasing “stress” experienced by health care systems (Amalberti & Vincent, 2020, p. 60). This reframing surfaces a longstanding tension between reducing risk versus eliminating all preventable harm with the acknowledgment that some errors and harms will occur, but this reality should not overshadow nor stymie the pursuit of reducing preventable harm in a comprehensive manner (Pronovost et al., 2015; Thomas, 2020).

Thomas (2020) argued that there are several potential detriments to describing patient safety pursuits as a zero harm goal, one of which involves potentially exacerbating the clinical workforce’s frustration and burnout by asking them to achieve an “unattainable goal” (Thomas, 2020, p. 5). Additionally, striving to measure all types of harm is not feasible, as “we do not have measurement systems that are reliable and valid enough to ensure patients that we have truly met or even made progress towards zero harm...[and] harms are only part of safety measurement” (Thomas, 2020, p. 5). Instead, Amalberti and Vincent (2020) and Thomas (2020) recommended drawing from “Safety I” and “Safety II” approaches. These emphasized more concrete and feasible methods for approaching safety through identifying and addressing types of harm that can be anticipated and prevented, striving to eliminate those where there are best practices to aid in preventability, improving the ability to identify risks and conducting more robust analyses to both prevent and mitigate unintended harms, measuring instances of harm

events that can be measured, celebrating successful approaches that prevent harm, and rewarding organization-wide learning and improvement (Thomas, 2020, p. 6).

While high reliability has been embedded within organizational behavior and theory, the literature related to health care organizations pursuing HRO principles is newer, with acknowledgment that health care “has not fully embraced safety as a science” (Pronovost et al., 2015, p. 10). Even still, while few organizations have truly become HROs, many health systems are pursuing the HRO pathway (Federico, 2018). Continued progress in pursuing high reliability, managing risks, and improving safety largely depends on leadership commitment to making HRO achievement a long-term priority and the establishment and maintenance of a safety culture (Chassin & Loeb, 2011; Federico, 2018; Frankel et al., 2017).

### **Transparency**

Leape et al. (2009) underscored the importance of transparency – “the free, uninhibited sharing of information” – as the “most important single attribute of a culture of safety” (p. 425). Continuous learning and improvement are not possible without transparency, in which all stakeholders involved – both in the daily provision of care and also external to the organization – have visibility into the daily, operational performance of processes and decision making (Frankel et al., 2017). Transparency implies the ability to openly discuss concerns, potential or actual errors, as well as successes, both within and external to the organization, among employees, and with patients and families (Leape et al., 2009). Frankel et al. (2017) outlined how transparency can manifest in a variety of ways depending on the stakeholders and contexts involved; pursuit of transparency

amongst all groups is needed at both an organizational level as well as a broader system, macro-level, to collectively enhance transparency across the health care industry.

Transparency across several different dimensions has been highlighted as integral to improving safety in a holistic sense (Betsy Lehman Center for Patient Safety, 2019; Frankel et al., 2017; Leape et al., 2009):

1. Transparency among staff implies the ability to freely provide feedback or concerns without fear of rebuke or retribution;
2. Transparency of health system leadership with patients/families, particularly after an adverse event, is essential from a moral perspective and may help rebuild and/or preserve trust; additionally, open communication by providers is linked with lower levels of patient harm (Betsy Lehman Center for Patient Safety, 2019, p. 7);
3. Transparency among organizations allows for broader learning of experiences and sharing of best practices; and
4. Transparency with the community necessitates information-sharing to allow patients to make “informed decisions and easily access the care they need” (Frankel et al., 2017, p. 17). The website “Care Compare” (formerly “Hospital Compare”) published by CMS serves as an industry standard that supports increased emphasis on transparency around safety and quality measures (CMS, 2021a).

Safety practices such as incident reporting systems, learning boards displaying key measures and processes, safety huddles, care resolution programs, and public reporting are all examples of interventions across these four dimensions that encourage transparency, learning, and accountability; however, an organization’s ability to empower transparency is largely dependent on the organization’s culture, which will be described in more detail below (Frankel et al., 2017; Leape et al., 2009).

### **Improvement, Measurement, and Continuous Learning**

Improvement, measurement, and continuous learning are elements of becoming an HRO and are embedded within the learning system domain of Frankel et al.’s (2017) framework. Before the goal of improvement can be achieved, an organization must first



be able to understand its current state to develop a feasible path forward in improvement. Deming's (1994) system of profound knowledge serves as a foundational model for improvement knowledge in health care (Batalden & Stoltz, 1993; Leape et al., 2009; Moen & Norman, 2016; Perla et al., 2013). Langley et al. (1996) built upon Deming's (1994) system of profound knowledge to coin "the science of improvement," outlining the key principles underlying improvement efforts, including identifying current state and employing a systematic approach (primarily the Model for Improvement) that necessitates stating an aim, identifying measures that will allow for recognition of improvement, developing ideas for changes, and testing/refining those changes to assess if they lead to improvement (implemented using the Plan-Do-Study-Act [PDSA] cycle) (Batalden & Stoltz, 1993; Langley et al., 1996). Ultimately, measurement, continuous learning, and improvement are embedded within the fabric of an organization through its daily operations and culture; data and information are only as useful as they are understood by staff at multiple levels throughout the organization and acted upon appropriately in a timely manner, and are critical for moving an organization towards becoming highly reliable (Frankel et al., 2017).

### **Elements of the Culture Domain**

Beyond embracing an improvement philosophy and implementing mechanisms to encourage ongoing learning, improving patient safety also necessitates fostering an organizational culture that "enables and prioritizes" safety (NPSF, 2015, p. 11). Safety must be an explicit organizational goal and core value (Pronovost et al., 2015; Sammer et al., 2010). Inherent in HROs is the essential role of leadership in fostering a culture of

safety (Botwinick et al., 2006), which refers to the “product of individual and group beliefs, values, attitudes, perceptions, competencies and patterns of behavior that determine the organization’s commitment to quality and patient safety” (The Joint Commission [TJC], 2019, p. 6). TJC uses Reason and Hobbs’ (2003) work on errors to distill an organization’s safety culture to the “sum of what an organization *is* and *does* in the pursuit of safety” (TJC, 2017, p. 2). Establishing and sustaining a culture of safety begins with leadership; while everyone in an organization maintains a responsibility to contribute to and demonstrate actions that uphold and promote safety, an organization’s leadership is ultimately accountable for setting the organizational tone in prioritizing and fostering a hospital or health system’s safety culture as part of its pursuit of becoming an HRO (Botwinick et al., 2006; Frankel et al., 2017; Kirk et al., 2007; Morello et al., 2013; NPSF, 2015; Sammer et al., 2010; Singer & Vogus, 2013; Sokol-Hessner et al., 2018; Sutcliffe et al., 2017). Ultimately, establishing and maintaining a culture of safety reflects both a “top-down” and “bottom-up” process (Sutcliffe et al., 2017, p. 250).

The components that fall within Frankel et al.’s (2017) framework within the culture domain include psychological safety, accountability, teamwork and communication, and negotiation, as well as leadership, which also contributes to the establishment and sustainment of an organization’s learning system. Each of these properties greatly influences an organization’s ability to maintain a strong culture of safety and will be discussed in greater detail later below.

### **Psychological Safety**

Safe and reliable care necessitates creating an environment of psychological safety, a concept that James Reason created and Amy Edmondson expanded upon

(Edmondson, 2012, 2019; Reason, 1997). An organizational culture that supports psychological safety is one that enables and empowers staff to speak up as opposed to staying silent, ask questions, or solicit feedback without fear of appearing incompetent, and/or offer suggestions or voice concerns without fear of reprimand or being suppressed (Edmondson, 2019; Federico, 2018; Frankel et al., 2017). Psychological safety can help prevent avoidable failure as well; Edmondson (2019) reinforced the importance of an organizational culture that encourages its workforce to “push back, share data, and actively report on what is really happening...so as to create a continuous loop of learning and agile execution” (p. 69). As such, transparency, improvement, and learning are all integral to the psychological safety of the environment and align directly with establishing a fair and “just” culture that promotes accountability described next.

### **Accountability and “Just” Culture**

An essential part of creating a robust culture of safety involves incorporating elements of accountability and fairness, which underpin the concept of a “just” culture (Frankel et al., 2017). In a just culture, it is recognized that individual staff should not be “held accountable for system failings over which they have no control” (NPSF, 2015, p. xii), while still holding staff responsible for their actions in accordance with organizational values and standards (Frankel et al., 2017; Sammer et al., 2010). A just culture is rooted in trust and psychological safety; staff feel empowered to voice concerns about safety, allowing for the investigation and transparent conversations needed to review errors and mitigate future occurrences (Federico, 2018; Gallagher & Mazor, 2015; Marx, 2019; Sammer et al., 2010).

From an organizational perspective, the organization has a fair and just process to promote a systematic assessment of errors or mistakes to determine the intent and origin of the actions that led to the error (Frankel et al., 2017; Marx, 2019). A just culture ensures the establishment of an “open learning culture,” shifting the focus away from judgment and punitive methods while allowing for a more “productive discussion about system design and behavioral choices” that upholds accountability (Marx, 2019, p. 245). A just culture means a culture of accountability for drilling down to investigate root causes of an error, but also does “not tolerate conscious disregard of clear risks to patients or gross misconduct,” reinforcing the importance of both fairness and accountability within a safety culture (NPSF, 2015, p. xii).

### **Teamwork, Communication, Negotiation and Conflict Management**

The complex and interconnected nature of health care delivery reinforces how vital collaboration and teamwork are in promoting a safe, reliable, and effective environment for both employees and patients/families (Sammer et al., 2010). “Quality suffers when caregivers do not work in teams” (Leape et al., 2012a, p. 845); given that care delivery is dependent on collaboration and interaction among various stakeholders spanning departments and specialties, a well-optimized system is similar to an “orchestra” in which the individuals work together and collectively support one another (Deming, 1994, p. 96). In a multidisciplinary approach to providing care for patients and families, teamwork and communication are essential for improving safety and enhancing care coordination; both influence and are influenced by an organization’s culture, particularly in managing interpersonal issues (Pronovost et al., 2015). Effective

communication among all members of the team is essential to building trust and, in turn, creating safe, reliable, and effective care of patients (Miltner et al., 2019).

At the heart of making health care safer lies organizational commitment to establishing a foundational culture of respect as part of its overarching culture, which promotes collaboration, teamwork, collegiality, and a shared organizational vision that prioritizes safety through valuing learning, transparency, accountability, communication, and respect (Leape et al., 2012b; Sokol-Hessner et al., 2018). Respect, transparency, open communication, and methods for managing conflict as cultural norms allow teams to thrive, as key facets of strong teams include “working together to plan forward, reflect back, communicate clearly, and manage risk” (Frankel et al., 2017, p. 14). An organization’s culture, with psychological safety as part of its culture, greatly influences the effectiveness of teams in building and maintaining trust and respect (Miltner et al., 2019). Not surprisingly, given the number of individuals involved in the provision of care and the ongoing interactions among stakeholders, organizations must develop effective means for negotiating and managing conflict as part of establishing a strong safety culture (Frankel et al., 2017). Additionally, since hierarchy can function as a barrier to effective, collaborative teams, those in leadership roles have an added responsibility to “flatten” the hierarchy by addressing problematic power dynamics that may inhibit communication and must be comfortable with voicing concerns, encouraging input, and ensuring each team member to feel respected and valued (Mowl, 2019, p. 56). Overall, the concepts of culture, respect, high reliability, and teamwork intersect and influence how effective an organization is in pursuing its HRO journey; “in contexts where trust and respect are the norm, people are more likely to both communicate their

interpretations to others, and through this communication, generate a clearer interpretation of the situation they face” (Sutcliffe et al., 2017, p. 249). This leads to higher employee morale and strengthens patient care coordination and outcomes (Leape et al., 2009).

### **Leadership**

As described above, a number of factors contribute to the improvement of quality and patient safety, with leadership serving as the cornerstone to pursue high reliability in health care and establish patient safety as a priority (Botwinick et al., 2006; IOM, 2000; NPSF, 2015). If there is incompatibility between leadership and other stakeholders of an organization, in the form of management failing to articulate the organization’s strategy and/or not shaping the organizational infrastructure needed to meet the strategy, an organization would resemble a “reactor” orientation (Miles et al., 1978), and would not be well-positioned nor structured to create and maintain a strong safety program, given the emphasis on proactivity in effective learning systems with strong patient safety programs (Balodi, 2014; Frankel et al., 2017; Mintzberg, 1980; Pfeffer & Salancik, 2003). In an HRO, an organization’s safety culture and overall safety climate relies on collective engagement of all members of an organization, regardless of role or hierarchy (Botwinick et al., 2006; Sutcliffe et al., 2017). It is noteworthy that “HROs loosen the designation of who is the “important” decision maker to allow decision making to migrate along with problems,” representing “selective decentralization” (Mintzberg, 1980; Weick et al., 1999, p. 103). However, it is ultimately leadership that greatly controls an organization’s ability to become an HRO (Botwinick et al., 2006; Chassin &

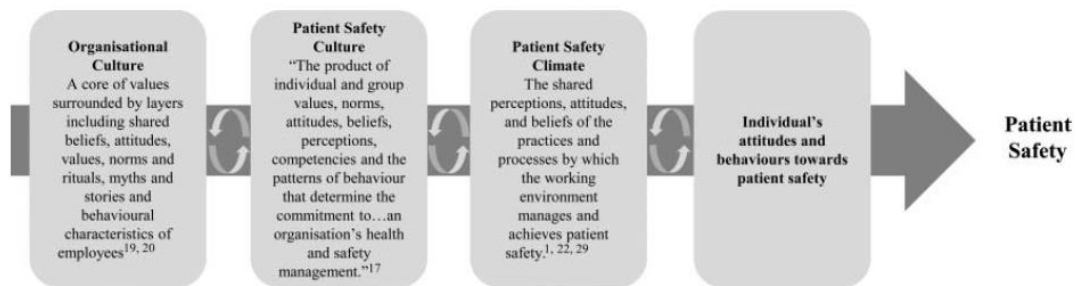
Loeb, 2011; Frankel et al., 2017), as the adoption and championing of these characteristics are “shaped by leaders’ actions, particularly the extent to which they demonstrate a commitment to safety through the visions they create, the goals they set and communications that signal what is and is not important” (Sutcliffe et al., 2017, p. 250).

The ongoing cultivation and pursuit of adoption of high reliability concepts and safety culture infrastructure are essential to address the underlying systemic causes of errors, thereby improving and sustaining delivery of safe and reliable care and minimizing preventable harms (Botwinick et al., 2006; Federico, 2018). While culture affects and is shaped by an organization’s participants as well as those external to the organization, an organization’s ability to effectively pursue and achieve quality and safety depends on the effectiveness of leadership in establishing quality and safety as an organizational strategy, and reinforcing the organizational aim through behaviors, mechanisms, and processes that promote the realization of those goals (Batalden & Stoltz, 1993; Botwinick et al., 2006; Frankel et al., 2017; Sammer et al., 2010; Scott, 1992). However, sustaining a strong culture of safety that permeates all parts of an organization can be challenging and daunting (Frankel et al., 2017). Furthermore, there can be substantial differences in safety climate across units and professional disciplines within an organization (Schwendimann et al., 2013; Singer et al., 2009; Singer & Vogus, 2013).

As described in Chapter One, safety culture is often described in tandem with an organization’s patient safety climate, which refers to “employee perceptions and attitudes about the surface features of patient safety culture at a given point in time” (Morello et

al., 2013, p. 11). Research on safety climate has largely highlighted differences in safety climate levels for different subgroups and hierarchical levels, and between clinicians and non-clinicians (Leape et al., 2012a; Ginsburg, 2015; Ginsburg & Oore, 2015; Hickner et al., 2016; Martinez et al., 2015; Schwendimenn et al., 2013; Singer et al., 2009; Singer & Vogus, 2013). As initially discussed in the previous chapter, Morello et al.'s (2013) patient safety culture model helps illustrate the relationship among organizational culture, safety culture and safety climate as they contribute to patient safety as a whole (see Figure 2.3 below, which duplicates Figure 1.1 in Chapter One).

**Figure 2.3: Patient Safety Culture Model (Morello et al., 2013)**



### Summary

The critical role that culture plays in establishing patient safety, as well as in total systems of care, cannot be overstated (NPSF, 2015). A culture of safety emphasizes reflection and learning, encourages transparency of both failures and successes, demonstrates resilience, and promotes a “just culture” in which all staff, regardless of hierarchy, are empowered to raise concerns without fear of blame or rebuke, with the intent of discussing and preventing similar occurrences from occurring again (Edwards, 2017; Federico, 2018; Frankel et al., 2017). The ongoing cultivation and pursuit of



adoption of high reliability concepts and safety culture infrastructure is essential to address the underlying systemic causes of errors, thereby improving and sustaining delivery of safe and reliable care and minimizing preventable harms (Botwinick et al., 2006; Federico, 2018). Creating a culture of safety to ensure reliability, improvement and sustainability is foundational for solving safety issues, proactively avoiding issues, and establishing viable patient safety programs (Frankel et al., 2017).

#### **Section Four: A Broadened View of Patient Safety – Non-Physical Harms**

As previously noted, after the IOM released both *To Err is Human* and *Crossing the Quality Chasm*, the patient safety efforts that followed predominantly focused on reducing preventable physical harm to patients (Bates & Singh, 2018; NPSF, 2015; Sokol-Hessner et al., 2015, 2018, 2019). Mitigation and prevention of physical harms and medication errors are critical and a mainstay of patient safety. However, health care-associated harm extends beyond the initial, narrow focus on physical harm and encapsulates non-physical harms – including emotional, psychological, socio-behavioral, and financial types – and can be rooted in respect and dignity (Brown et al., 2018; Frankel et al., 2017; Gazarian et al., 2017; Kuzel et al., 2004; Ottosen et al., 2021; Sokol-Hessner et al., 2015, 2018, 2019).

Despite the prevailing focus of patient safety improvement efforts on physical harm, disrespect is increasingly pervasive in health care, and is potentially more prevalent than physical harm occurrences (Frankel et al., 2017; Kuzel et al., 2004; Leape et al., 2012a; NPSF, 2015; Sokol-Hessner et al., 2015, 2019). Patients and families may experience non-physical harm (a consequence) that can be caused by many factors, one

of which is disrespect (Sokol-Hessner, personal communication, March 6, 2022). In this way, disrespect can be viewed as an “affront to dignity” which can cause harm to patients and their families (Sokol-Hessner et al., 2018, p. 463).

As a result, there is a growing perspective that improving patient safety must embrace a broadened, more holistic view that is inclusive of both physical and non-physical harms from disrespect (Frankel et al., 2017; Gazarian et al., 2017; Kuzel et al., 2004; Sokol-Hessner et al., 2015), given that harms caused by “indignities and inequities in health care are just as preventable, and just as unacceptable, as wrong-site surgeries and medication errors” (Frankel et al., 2017, p. 4).

Non-physical harm rooted in disrespect should be treated as a “quantifiable harm” (Brown et al., 2018, p. 1393) that necessitates formal assessment and mitigation to make an impact on future prevention and overall improvement in quality and safety (Sokol-Hessner et al., 2015, 2018, 2019). Formal assessment of non-physical harm warrants integrating it into existing organizational quality and patient safety programs; however, most health service organizations have not yet done this (Sokol-Hessner et al., 2019). Organizational hesitance and potential barriers to embracing a broadened definition of preventable patient harm can be attributed to a number of factors, including:

- Perceived difficulty in operationalizing seemingly subjective and nebulous concepts of dignity and respect,
- Not viewing them as harm events necessary of formal capture and review, and
- Potential concern over individual-level blame for non-physical harm events as opposed to recognizing that most health care errors tend to result from system failures (Botwinick et al., 2006; IOM, 2000; Sokol-Hessner et al., 2019).

Additionally, the health care system and patients may have differing priorities, adding an additional layer of complexity in measuring what matters, and ultimately

ensuring safety (Lee, 2002; Kuzel, 2004). Patients tend to recognize and report on feelings of non-physical harm more than physical harm, underscoring the influence that such adverse psychological interactions can have on patients and family members, and reinforcing the importance of broadening organizational quality and patient safety efforts to include non-physical harm from disrespect (Gazarian et al., 2017; Kuzel et al. 2004; Lee, 2002; Sokol-Hessner et al., 2015). Furthermore, it is critical to note that disrespect is inherent in non-physical harm, but is not necessarily a consequence of a person's failure to demonstrate respect; disrespect can also be a product of the patient's condition or the design of the health care setting, (Leape et al., 2012a; Sokol-Hessner et al., 2015). As such, engaging with patients and families is a critical aspect of providing high quality, respectful care, and will be discussed later in this section.

### **Organizational Culture of Respect**

At the core of health care delivery is the moral imperative to demonstrate respect and uphold safety (IOM, 2000; Leape et al., 2012a, 2012b; Sammer et al., 2010; Sokol-Hessner et al., 2015). Despite this ethical dictum, disrespect is pervasive in health care and can manifest in different ways (Leape et al., 2012a). Disrespect may be rooted in the individual (endogenous), and Brown et al. (2018) found that race, religion, sex, and sexual orientation – particularly when clinicians and patient differ in those aspects – may serve as barriers to the practice of respect. In addition to individual factors, disrespect is also learned and perpetuated in an organization's environment (exogenous); a dysfunctional culture rooted in disrespect threatens the strength of an organization's safety culture, and is a central barrier to patient safety progress (Leape et al., 2012a).

Making progress on quality and safety – inclusive of both physical and non-physical harm – necessitates examining the health care delivery environment and culture (Leape et al., 2012a).

As described earlier, culture affects and is shaped by an organization's participants as well as those external to the organization (Scott, 1992). Culture is an encompassing term, in which creating a culture of respect is a sub-component of the larger goal of creating a culture of safety, which influences the presence and strength of other significant, interrelated concepts inherent in HROs, including psychological safety, accountability, teamwork and communication, and negotiation (Frankel et al., 2017; Leape et al., 2012a, 2012b). A dysfunctional culture rooted in disrespect has been noted as a substantial barrier to patient safety progress (Leape et al., 2012a, 2012b; Sokol-Hessner et al., 2015, 2018, 2019). Leape et al. (2012b) asserted that a culture of respect is a “precondition” for the changes needed to make health care safer and a critical “first step” in organizations becoming highly reliable (p. 853). A culture of respect creates an organizational environment in which the workforce are engaged in their work, and where “mutual trust, collaboration, and accountability” are achieved, which translates to the delivery of safer, more reliable care (Leape et al., 2012b, p. 853).

While patient and family experience of disrespect is a core focus of broader patient safety and quality efforts, the health care workforce also experiences different types of disrespect, which stem from an organization's culture (Sokol-Hessner et al., 2018). As Leape et al. (2012a) emphasized, an organization “that supports and tolerates disrespectful behavior is unsafe for its patients and hostile for its workers” (p. 846). The onus for fostering and maintaining a culture of respect resides with an organization's

workforce across its many levels (Botwinick et al., 2006; Leape et al., 2012a, 2012b; Sokol-Hessner et al., 2018). Preventing non-physical harm is dependent on cultivating an environment where all levels of the workforce are held accountable for maintaining a culture of respect (Leape et al., 2012a, 2012b; Sokol-Hessner et al., 2015). Leadership is essential to the discussion of respect and in building a culture that upholds the practice of respect and dignity (Sokol-Hessner et al., 2018). Given the role of leadership in crafting an organization's infrastructure through establishing organizational standards, values, strategies, and culture, an organization's ability to recognize respect as a worthwhile component of patient safety stems largely from its leaders (Botwinick et al., 2006; Sokol-Hessner et al., 2018). Sokol-Hessner et al. (2018) developed a roadmap outlining recommendations and strategies for organizations to develop the practice of respect, with leadership strategies intentionally leading the list. This 2018 consensus statement reinforced the crucial role that leaders play by committing to uphold a culture of respect and dignity, modeling respectful behavior, communicating the integral values of dignity and respect, incorporating health equity as an essential component of a culture steeped in respect and dignity, developing and promoting a system structure that values dignity and respect, and imposing expectations and processes that embody fairness yet accountability (Sokol-Hessner et al., 2019, p. 468).

While the experience of disrespect is itself problematic and inherently harmful, organizations and their stakeholders may experience secondary harms resulting from disrespect, including causing unnecessary suffering by patients and their families, and subsequently impacting the relationship and potentially eroding trust between the patient/family and the provider or system (Brown et al., 2018; Entwistle, 2008; Sokol-

Hessner et al., 2015). An association between disrespect and the risk of physical harm has also found; additionally, bias – a form of disrespect – has been associated with health care disparities, which can put patients at greater risk for preventable physical harm (Sokol-Hessner et al., 2018, 2019). Disrespect threatens both patient and employee safety, as it can cause patients, families, and the health care workforce to disengage from the organization or larger health care system (Leape et al., 2012a; Sokol-Hessner et al., 2018, 2019). While there is limited research on long-term effects from experiencing different harms, Ottosen et al.’s (2018) research found that patients and families experience ongoing long-term impacts (LTIs) after harmful medical events, including psychological, social/behavioral, physical, and financial LTIs. For some patients and families who experienced profound LTIs, they reported these impacts evolving into secondary harms over 10 years after the harmful event they experienced (Ottosen et al., 2018). On the organizational side, a culture that breeds disrespect can inhibit collegiality, collaboration, transparency, and communication, while potentially hastening burnout and attrition, which can all threaten the essential hallmarks of provision of patient-centered care, described in more detail below (Leape et al., 2012a).

### **Evolution of Respect and Dignity in the Literature**

Despite heightened attention to the presence and implications of non-physical harm in recent years, and increased recognition that preventable harm encompasses both physical and non-physical harm, the concepts of dignity and respect within health care are not new (Beach et al., 2007; Brown et al., 2018; Gazarian et al., 2017; Sokol-Hessner et al., 2015). In *Crossing the Quality Chasm*, the IOM defined quality as “the degree to

which health care services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge” (IOM, 2001, p. 44). That report acknowledged that “desirable outcomes” could include focused attention on the “interpersonal aspects” of care, including addressing patients’ and families’ concerns, “spiritual well-being” and their “sense of dignity” (IOM, 2001, p. 44). Despite the definitions of these two often-coupled concepts appearing intuitive, ambiguity and multiple interpretations of these concepts tend to result within the health care setting (Beach et al., 2007; Brown et al., 2018). To better understand the evolution of respect and dignity in health care from a philosophical concept to an actionable cornerstone of providing patient-centered care, it was necessary to visit the origin of these concepts in the literature.

Brown et al. (2018) provided the Latin root meaning of both respect and dignity as a means to understand their modern-day application and operationalization within health care: “*respect* comes from the Latin meaning to “regard” or “look back at”; *dignity* comes from a Latin root meaning “worthy”. Roughly speaking, “respect and dignity” evoke someone who is *worth seeing*” (p. 1390). The concept of respect has been reinforced as a cornerstone of health professional ethics throughout the literature but has been rooted in ambiguity and subject to variable interpretations, underscoring the difficulty in making the concept actionable in a care delivery setting (Beach et al., 2004, 2007; Leape et al., 2012a). Despite the integral aspect of respect in health care, it is still in its infancy in terms of being recognized as an equally important type of harm to be addressed by health systems (Beach et al., 2007; Sokol-Hessner et al., 2015).

Additionally, respectful behavior and communication are often viewed as optional in the

delivery of care and are difficult to define and operationalize (Beach et al., 2007; Brown et al., 2018; Entwistle, 2008; Lee, 2013; Sokol-Hessner et al., 2015).

The concept of respect has evolved throughout a long history within the bioethics domain (Beach et al., 2007; Cassell, 2000; Lysaught, 2004). While the IOM's two landmark reports served as "calls to action" that mobilized quality and patient safety efforts across the health care industry, the publication of *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* in 1979 was "the first public sort of place that the notion of respect was articulated as a principle" (Lysaught, 2004, p. 668); more specifically, "respect for persons" was articulated with complementary principles of "beneficence" and "justice" pertaining to research with human subjects (Cassell, 2000). Although the initial focus of this report was to infuse key principles into the human participants research realm, the Belmont Principles manifest in modern health care through informed consent practices, the establishment of hospital functions that monitor the quality and appropriateness of care, and the general professional values and behavior of the contemporary patient-provider relationship (Cassell, 2000). In unpacking the meaning of "respect for persons", the *Belmont Report* articulated two convictions, specifically positing that individuals should be treated as autonomous persons, as well as persons with "diminished or absent" autonomy warranting "protection," highlighting the inverse relationship between the two – meaning that the less the autonomy, the more protection is needed for that individual (Lysaught, 2004, pp. 668-669).

The connotation of respect has evolved with time, with Beach et al. (2007) acknowledging the ubiquity and yet ambiguity of the concept within the health care



literature. Beach et al. (2007) found that the prevailing focus on respecting the autonomy of individuals was an incomplete account of respect, and clarified that showing respect to patients is independent from admiration of patients' personal characteristics by positing that respect for persons means that "all living human beings are persons, and consequently, deserving of respect..." (p. 693). Treating patients should not be predicated on the concept of "differential respect" in which the extent to which respect is afforded to patients is justified based on value judgments that are made based on their unique circumstances and characteristics (Beach et al., 2007, p. 693). As such, Beach et al. (2007) defined respect as the "unconditional value of patients as persons" which not only factors into honoring the autonomy of patients, hearkening back to earlier conceptions defined in the bioethics literature, but further expands the definition of respect to one that is more holistic and humanistic in recognizing the "unconditional value of patients as persons" that must be "accorded equally to all" (p. 692).

Although the foundation of health care is steeped in the concepts of dignity and respect, the operationalization of these concepts is newer. In recent years, Sokol-Hessner et al. (2015, 2018, 2019) built upon foundational literature to define dignity as the "intrinsic, unconditional value of each person," and respect as the collective "action(s) that honor and acknowledge dignity" (Sokol-Hessner et al., 2019, p. 658). Sokol-Hessner et al.'s (2018) interdisciplinary consensus statement urged organizations to "learn from episodes of disrespect by recognizing, capturing, categorizing and analyzing them, as is done through incident analysis" to "prevent future harm by designing and implementing changes based on what is learned about the practice of respect" (p. 468). Sokol-Hessner et al. (2019) developed a framework for non-physical harms experienced by patients and

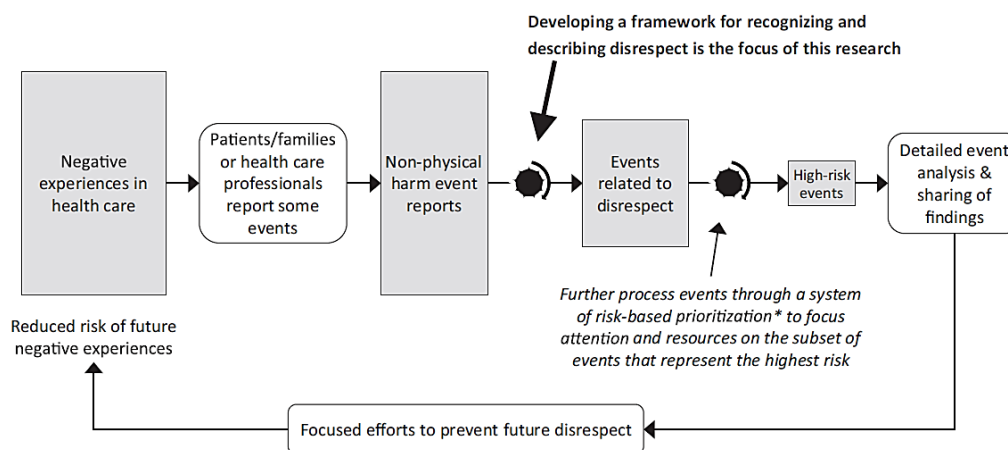
family members resulting from disrespect, which represents an “actionable component” of respect and dignity by making it measurable (Sokol-Hessner et al. 2018, p. 464).

### **Framework for Understanding Patient/Family Disrespect**

Despite growing recognition that non-physical harms from disrespect may be preventable and warrant identification, analysis, and mitigation, systematic, evidence-based approaches to aid organizations in tackling these non-physical harms have not existed (Sokol-Hessner et al., 2015, 2018, 2019). Foundational research emphasized the importance of respect within health care, with Beth Israel Deaconess Medical Center (BIDMC) in Boston, MA, building upon this foundation (Leape et al., 2012a, 2012b; Gazarian et al., 2017; Sokol-Hessner et al., 2015).

In 2019, leaders at BIDMC conducted a scoping review and synthesized the findings into a structured approach for preventing harm from disrespect by creating a generalizable, improvement-oriented framework for capturing and describing reports of non-physical harm from disrespect experienced by patients and/or families (Sokol-Hessner et al., 2019, p. 658). Figure 2.4 below illustrates how this framework can be applied to the larger system and how its application is oriented toward improvement and prevention of future disrespect (Sokol-Hessner et al., 2019).

**Figure 2.4: Comprehensive System for Preventing Harm from Disrespect (Sokol-Hessner et al., 2019)**



**Note:** Risk-based prioritization “involves considering both the severity of the event as well as the frequency with which such an event might recur. The events that represent the greatest risk of future harm are those that are most severe and most frequent, and focusing on them is more likely to build consensus for system changes designed to prevent future harm” (Sokol-Hessner et al., 2019, p. 659).

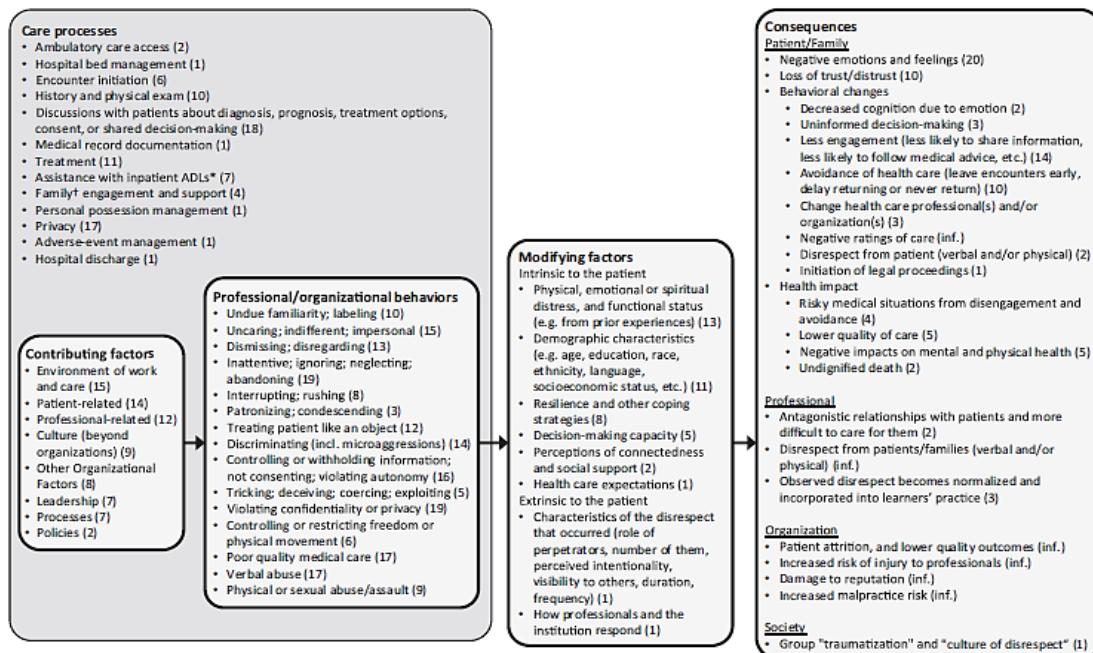
Sokol-Hessner et al.’s (2019) five-component framework (Figure 2.5 below, which is a duplicate of Figure 1.2 in Chapter One) was created for health system organizations to use as part of their existing quality and patient safety programs; its application allows organizations to capture and characterize experiences of disrespect for analysis, including:

1. **Care processes:** the “groups of related actions performed to fulfill patient-family care needs” (p. 659);
2. **Professional and organizational behaviors:** a description of the health care professional(s) and organization behaviors involved to allow for “application of just culture algorithms that consider the historical and environmental context in order to fairly balance accountability” (p. 659);
3. **Contributing factors:** patient and professional-related factors, the environment of care, leadership, policies, processes, and culture, which can all create an environment in which disrespectful behavior can occur;
4. **Consequences of disrespect:** the effects of disrespect on patients/family members, professional staff, the organization, and the society, which can provide a more holistic representation of the full extent of non-physical harms on different groups and across several levels; and

5. **Modifying factors:** factors both intrinsic and extrinsic to patients that can modify the consequences of disrespect and provide learning opportunities that can potentially minimize future harm.

Collectively, the five components in the framework represent essential elements that can aid in comprehensively learning from events related to disrespect, and in potentially mitigating and preventing future non-physical harms (Sokol-Hessner et al., 2019). A detailed discussion on how this framework was applied in the study design is presented in Chapter Three.

**Figure 2.5: Beth Israel Deaconess Medical Center Framework for Disrespect (Sokol-Hessner et al., 2019)**



### Respect as a Component of Person/Patient-Centered Care

The notion of actively encouraging participation of patients and families is embedded in a variety of health care concepts, which are not all synonymous but do factor into the importance of engaging patients in the care process, including: patient-

centeredness, person-centeredness, patient engagement, patient experience, and coproduction, among others (Batalden et al., 2016). The IOM's (2001) six aims for achieving a high-quality health system continue to be reinforced today, insisting that care should be: safe, effective, timely, efficient, equitable, and patient-centered. As previously mentioned, the NQF slightly modified these six aims, indicating that care must be safe, appropriate, timely, efficient, equitable, and person-centered, which acknowledges providing care that honors the unique circumstances and goals of the individual (NQF, 2020). Patient-centered care is defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions” (IOM, 2001, p. 6). Closely related is person-centered care, which is more inclusive in nature by encouraging care delivery that factors in the individuals' physical and mental health, social determinants of health and health disparities, and comprehensive well-care, while also focusing more upstream on the achievement of better health outcomes before the individual becomes a patient (NQF, 2020, p. 11).

Treating patients and their families with dignity and respect is central to providing person/patient-centered care; achieving patient-centered care stems from an organizational culture that prioritizes and fosters a culture of respect (Brown et al., 2018; Frankel et al., 2017; Gazarian et al., 2017; IOM, 2001; Leape et al., 2012a, 2012b; Sokol-Hessner et al., 2018). Past research has shown that patient involvement in their own care is associated with positive health outcomes at a lower cost (Batalden et al., 2016; Beach et al., 2005; Frankel et al., 2017). Not only should clinician and staff behaviors encourage

patient and family engagement but treating them with dignity is a key component of patient involvement in care (Beach et al., 2005; Frankel et al., 2017).

Barry and Edgman-Levitan (2012) expanded upon the notion of patient-centered care to emphasize the importance of shared decision making between clinicians and patients/families. Through shared decision making, clinicians have a pivotal role in helping patients see the importance of their personal values and preferences in making decisions that best support them (Barry & Edgman-Levitan, 2012, p. 780). However, shared decision making stems from breaking down barriers that inhibit this relationship; organizations need to instill shared decision making in their culture, so that clinicians are equipped to educate and inform patients about their essential role in being participants in their care. Additionally, clinicians must “relinquish their role as the single, paternalistic authority and train to become more effective coaches or partners- learning...how to ask, “what matters to you?” as well as “what is the matter?” (Barry & Edgman-Levitan, 2012, p. 781).

As previously mentioned, there is often discord between what a health system focuses on from a measurement perspective and measuring what matters to patients; while there are several factors that influence what health systems measure and report (including regulatory influences and standards), incorporating a philosophy of “what matters to you?” also ensures that organizations are embodying the essence of patient-centered care (Barry & Edgman-Levitan, 2012; Lee, 2002; Kuzel, 2004). Barry and Edgman-Levitan (2012) introduced the seemingly simple concept of “what matters to you” a decade ago, and the concept has continued to serve as a profound practice to engaging with patients and families; former IHI President and CEO Maureen Bisognano,

and the IHI as a whole, supported and contributed to the concept burgeoning into an international movement as well as an annual “What Matters to You?” Day celebrated each June (Bisognano, 2017; IHI, 2022).

### **Coproduction**

The concept of coproduction is newer. Developed by Batalden et al. in 2016, coproduction argues that health care is best characterized as a service (as opposed to a product) that is co-produced by providers and users of the service (Batalden et al., 2016; Batalden & Foster, 2021; Elwyn et al., 2020; Lachman & Nelson, 2021). Similar to how health care harnessed high reliability principles found in other dynamic and complex industries, core principles and the implications of coproduction have been evaluated in other industries such as banking, police and fire protection, higher education, agriculture, and urban planning, among others (Batalden et al., 2016). Partnership, engagement, and coproduction of services with patients and families have been acknowledged as critical for improvement and systems redesign within the literature, have been integrated into leading frameworks (including, as previously described, the IHI’s Framework for Safe, Reliable, and Effective Care, and the IOM’s six aims for the health care system), and recognized at a federal level through CMS’ identification of patient and family engagement as a pillar in its efforts to improve health care; however, the inclusion of patients and families has been haphazard, inconsistent, and not optimized (Batalden et al., 2016; Centers for Medicare & Medicaid Services [CMS], 2020b; Elwyn et al., 2020; Frankel et al., 2017; IOM, 2000).

Batalden and Foster (2021) highlighted the guiding question underpinning the intent and value of coproduction by asking: “How might we improve the value of the

contribution that health care services make to better health?” (p. ii12). Early efforts focused on improving quality, coined “Quality 1.0” by Batalden and Foster (2021), were centered around standardization and using quality improvement methodology as well as accreditation to achieve “basic standards...to certify acceptable performance and capability...[leading] to the formation of formal processes for review, documentation, external audits and a system for public notice and recognition” (p. ii11). “Quality 2.0” was focused on incorporating a systems-based and reliability-focused approach to tackling quality matters (Batalden & Foster, 2021). Most recently, Batalden and Foster (2021) deemed the coproduction of health care services and health as “Quality 3.0,” (p. ii12) drawing from economist Elinor Ostrom’s seminal work that the making of a service requires two parties – a professional and a beneficiary – working together to create that service (Ostrom & Ostrom, 1977). Within this view, coproduction of health care services can be defined as “the interdependent work of users and professionals to design, create, develop, deliver, assess and improve the relationships and actions that contribute to the health of individuals and populations” (Batalden et al., 2016; Elwyn et al., 2020, p. 712). As such, the development and increasing interest in coproduction underscores its value in establishing collaboration, shifting the traditional power dynamics between clinician and patient to instead emphasizing co-assessment and shared decision making in the interest of restoring or preserving health (Batalden et al., 2016; Elwyn et al., 2020).

Patient safety is not solely the pursuit of reducing physical harm but must also encompass threats to patient respect and dignity; embracing a comprehensive view of patient safety that targets both physical and non-physical harm helps the health care system to advance in delivering safer care to patients (Frankel et al., 2017; Sokol-Hessner



et al., 2015). The concept of respect is embedded within the provision of patient-centered care, and embracing newer conceptualizations of improvement, such as coproduction, can be effective in partnering with patients to improve care, relying on mutually respectful collaboration between producers and consumers of health care (Batalden et al., 2016; Elwyn et al., 2020; IOM, 2001; Sokol-Hessner et al., 2018). Literature supports the incorporation of non-physical harm into existing patient safety and quality improvement efforts within the organization (Sokol-Hessner et al., 2015, 2018, 2019).

### **Section Five: Regulatory, Accreditation, Licensure, and Certification Landscape**

The value of both *To Err is Human* and *Crossing the Quality Chasm* is evident: the reports mobilized a patient safety movement by highlighting the shortfalls of the health care delivery system, arguing for safety as a collective priority, and proposing solutions for how the system could be redesigned to innovate and improve care (IOM, 2000, 2001). There have been many subsequent reports from focused research offering guidance and best practices for addressing patient safety and quality; cumulatively, this information can be viewed as evidence that brought a critical issue to the forefront and informed the formulation and implementation of new regulations, programs, and policies (Bates & Singh, 2018; Weiss, 1977). In applying Weiss' (1977) "enlightenment model" of research as a lens, the "gradual cumulative effect" of continued, influential reports, research, frameworks, and data since *To Err is Human* has shaped quality and patient safety policy over time and has led to its prioritization in the policy-making and regulatory environments (p. 544).

The final section of this literature review provides a discussion of the regulatory landscape that guides how organizations approach quality and safety. Regulation is particularly important and prominent in the health care industry. Given the volume of literature and complex nuances surrounding regulation, accreditation, licensure, and certification, as well as the range of entities upholding these different functions, for the purposes of this dissertation the following terms are used as follows:

- “Regulation” is used to describe the imposition of external rules (Brennan, 1998), and serves as an umbrella term to describe the comprehensive landscape surrounding health care and patient safety.
- “Accreditation” is used to describe the peer review process applied to both health care delivery organizations where patient care is provided, and educational institutions and programs that provide prelicensure education to health professionals who ultimately provide and manage patient care within health systems (Gelmon & Tresidder, 2011).
- “Licensure” and “certification” are used primarily as the pathway to practice for individuals. Although it is recognized that facilities and organizations can also be licensed, and disease-specific programs can achieve certifications (Council on Accreditation [COA], 2017; TJC, 2022a).

In general, organizational pursuit of accreditation tends to be voluntary, although in actuality, given the risks associated with not pursuing accreditation, a majority of organizations elect to pursue accreditation as it can be tied to the organization (health or education) receiving critical funding, its ability to participate in certain federal government programs, and/or the gatekeeping role that is mandated in state statutes that individuals may only pursue licensure or certification by graduating from an accredited education program (Accreditation Commission for Education in Nursing [ACEN], 2020; CMS, 2021b; Council for Higher Education Accreditation [CHEA], n.d.; COA, 2017; Halstead, 2017; TJC, 2018). In this way, the role of accreditation serves as a critical pursuit for organizations in order to carry out their core functions. In contrast, licensing

tends to be involuntary, and is typically a requirement for individual clinicians to obtain to be able to practice and ultimately provide patient care (ACEN, 2020; Blouin et al., 2018; Boulet & van Zanten, 2014; COA, 2017). Lastly, certification also tends to be voluntary, but can also potentially be required by regulatory bodies, and often refers to an individual who has met a minimum set of standardized criteria to perform a specific or specialized function (Blouin et al., 2018; Boulet & van Zanten, 2014; COA, 2017).

### **Regulatory and Accrediting Agencies as Key Stakeholders**

In general, a policy sector is comprised of a diverse and extensive group of actors/stakeholders with complex interactions, and may be individually or collectively organized (Berman, 1978; Weible & Sabatier, 2017). Improvements in population health require the focus and actions of multiple actors in a coordinated way; various groups represent and advocate for and/or influence different parts of a policy issue (Kindig & Stoddart, 2003; Weible & Sabatier, 2017). At a broad level, health care is subject to the notion of “many hands,” in which multiple stakeholders each contribute to an aspect of patient safety and health care delivery, but no single stakeholder group can be held responsible (Dixon-Woods & Pronovost, 2016, p. 2). The variety and extent of the actors within health care pose a challenge in that they are “autonomous, highly distributed and heterogeneous yet interdependent,” further exemplifying both the difficulty, and underscoring the importance, of coordination at a system level (Dixon-Woods & Pronovost, 2016, p. 2).

Within health care, some of the most prominent and essential stakeholder groups include regulatory and accrediting entities, delivery systems (organizations/care settings),

patients/families, payers, drug and equipment manufacturers, professional associations, information technology vendors, and patient advocacy groups, among many others (Dixon-Woods & Pronovost, 2016). Regulatory entities, accrediting organizations and licensing bodies have considerable authority in creating and enforcing standards for patient safety and quality at both organization and professional levels and will be discussed in more depth below.

### **Regulation and Accreditation of Care Delivery Organizations**

It is important to note that there is a distinction between the two concepts of regulation and accreditation; regulation refers to “any set of influences or rules exterior to the practice of administration of [medical] care that imposes rules of behaviors” (Brennan, 1998, p. 710-711), or, more simply, “rules that must be followed” (Warburton, 2009, para. 5) that control who does what in institutions (Lowi, 1972), while accreditation refers to a “seal of approval certifying that an organization has met specific standards” (Warburton, 2009, para. 5).

With respect to health care delivery organizations, the role of accreditation (applied to an organization) has considerable weight and authority, as achieving and maintaining accreditation emphasizes an organization’s commitment to providing safe, high-quality care (Jha, 2018; Warburton, 2009). Additionally, there are essential financial incentives serving as a critical motivator in organizations pursuing accreditation (TJC, 2018). Accreditation and regulation are linked through a “deemed status” arrangement through section 1865(a)(1) of the Social Security Act, which allows CMS-approved accreditation organizations (AOs) to survey health care delivery institutions on behalf of

the federal government to validate the health care delivery system meets Medicare requirements, or Conditions of Participation (CoPs); these serve as Medicare's health and safety standards (CMS, 2021b; TJC, 2018). While accreditation is voluntary for delivery systems and not required for participation in the Medicare program (CMS, 2021b), health care institutions, including clinical laboratories, can opt to be accredited by CMS-approved AOs which determine compliance with Medicare CoPs (CMS, 2018, 2021b). CMS requires that hospitals be accredited by an appropriate accrediting body or pass state inspection to receive federal reimbursement, so organizations undertake the accreditation or state survey process at a cadence determined by the deeming agency (Brennan, 1998; CMS, 2021b; Jha, 2018; Lam et al., 2018; TJC, 2018). This deemed status arrangement necessitates that the organization must be in compliance with not only the federal CMS CoPs, but also state-specific rules and statutes and AO standards; these multiple standards demonstrate the different regulatory stakeholders involved and suggest the magnitude of interpretation and implementation responsibility on the organization seeking accreditation (TJC, 2018).

Accreditation in particular has been cited as a major driver of safety efforts, though there is varying evidence regarding its effectiveness in improving the quality of care (Brennan, 1998; Devers et al., 2004; Jha, 2018; Lam et al., 2018; Warburton, 2009). While CMS has approved nine accreditation programs/AOs, they span several Medicare facility types, including: hospitals, psychiatric hospitals, critical access hospitals, home health agencies, hospices, ambulatory surgery centers, outpatient physical therapy and speech-language pathology services, and rural health clinics (CMS, 2016). CMS also approved an additional seven AOs under the Clinical Laboratory Improvement

Amendments of 1988 (CLIA) (CMS, 2016). For hospitals specifically, TJC, formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), has dominated the health care accreditation landscape as the leading accrediting agency for health systems, capturing nearly 80% of the accreditation market (Lam et al., 2018). TJC became a deeming AO by CMS in 1965, with continued changes and improvements made to its methodology and scope since then (TJC, 2020).

Decades later, CMS granted deeming authority to Det Norske Veritas (DNV) Healthcare, Inc. in 2008, which is rooted in ongoing improvement through its methodology of integrating the ISO 9001 process standards; ISO 9001 is oriented to more complex, interrelated, and “people-powered” organizations in its accreditation process (DNV, n.d.). While there are additional hospital-specific AOs, with varying guiding philosophies, survey methodology, and frequency of surveys, the overall intent of the accreditation process is the same – for AOs to determine and validate organizations’ compliance in meeting or exceeding Medicare and Medicaid requirements (CMS, 2018; TJC, 2018). The layers of regulations and standards – federal, state, and nongovernmental accreditation – are rooted in ensuring the quality of care and safety of patients, and in both improving and maintaining a safe environment (TJC, 2018; 2019).

Regulation is one aspect of improving patient safety and quality through control (IOM, 2000; Lowi, 1972; Warburton, 2009). Government regulation of individuals and accreditation of organizations serve as exogenous influences that can exercise authority and impact organizational quality and patient safety (Lowi, 1972; Scott, 1992; Weick et al., 1999). Although there is not a preponderance of research and data on the utility of accreditation, there is some literature that scrutinizes the efficacy of accreditation and

regulation (Jha, 2018; Quick, 2014). A compelling argument is that accredited hospitals do not appear to provide better care than non-accredited hospitals, that there may be a “disconnect between what accreditation is meant to do versus what it might actually be doing”, and that it fails to focus on what truly matters to patients (Jha, 2018, p. 2410). However, despite drawbacks in the accreditation process, there is a resounding belief that accreditation is influential in its ability to mobilize organizations to establish baseline practices and processes in place to strengthen patient safety and quality and the existing literature has not undermined the influential and effective nature of accreditation overall (Devers et al., 2004; Jha, 2018; Warburton, 2009). Additionally, accreditation can be seen as a “powerful tool to offer assurance” to the public that accredited delivery systems provide safe, effective, and high-quality care (Jha, 2018, p. 2411). Beyond deeming authority and enhancing public perception, accreditation can also (TJC, 2022b):

- Provide organizations structure in how they organize their patient safety efforts;
- Improve risk management processes as standards are rooted in relevant and effective improvement strategies;
- Provide education and guidance to organizations;
- Offer a repository of tools and best practices organizations can pull from and customize to their needs;
- Provide a marketing advantage;
- Enhance an organization’s ability to recruit new talent;
- Support organizations’ eligibility for insurance reimbursement, depending on the market; and
- Fulfill state-specific regulatory requirements, depending on the state.

Additionally, alignment and consistency across different agencies and stakeholder groups of influence are critical; when law, regulation, accreditation, professional standards, and ethical guidelines all are consistently expressing the same message, positive behavior change is more likely (Quick, 2014).

## **Quality and Patient Safety Regulations and Standards for Delivery Organizations**

The types of quality and patient safety policies that have emerged in the past few decades have manifested through multiple regulatory rules, accreditation standards, and internal organizational policies. There are an immense number of CMS CoPs, state-based rules and statutes, and accreditation standards addressing the interrelated components contributing to quality and patient safety; these differ depending on setting, organization type or profession type.

For health delivery systems specifically, most of the standards and regulations have been oriented toward mitigation of physical harm, medication management, and direct organizational measurement and improvement. The major types of regulation, accreditation, and policy related to the provision of care stem from overarching categories related to: leadership, culture, environment of care, high reliability, data measurement, quality improvement, medication management, medical staff assessment, provision of nursing care, and patient rights, although quality and patient safety underpin each requirement as the entire process is designed to enhance patient safety and quality of care overall (CMS, 2020c; TJC, 2019). This breadth of categories underscores the complexity and multi-faceted nature of patient safety, with responsibility residing across the organization and embedded within practices and processes (Botwinick et al., 2006).

In looking at current regulations and standards that pertain to non-physical harms specifically, the Medicare CoPs for hospitals are outlined in 42 CFR Part 482, with a section specifically related to patients' rights, which are rooted in respect and dignity, detailed in **§482.13** (CMS, 2020c).

- **§482.13(c)(1)**: The patient has the right to personal privacy.



- Interpretive Guidelines §482.13(c)(1): “The underlying principle of this requirement is the patient’s basic right to respect, dignity and comfort while in the hospital” (CMS, 2020c).
- §482.13(c)(2): The patient has the right to receive care in a safe setting.
  - Interpretive Guidelines §482.13(c)(2): “The intention of this requirement is to specify that each patient receives care in an environment that a reasonable person would consider to be safe...this standard is intended to provide protection for the patient’s emotional health and safety as well as his/her physical safety. Respect, dignity and comfort would also be components of an emotionally safe environment” (CMS, 2020c).

TJC defines its accreditation standards (TJC, 2019) that crosswalk to the CMS

CoPs regarding rights and responsibility of the patient, including:

- **RI.01.01.01:** The hospital respects, protects, and promotes patient rights.
  - **EP 4:** The hospital treats the patient in a dignified and respectful manner that supports his or her dignity.
  - **EP 6:** The hospital respects the patient’s cultural and personal values, beliefs, and preferences.
  - **EP 7:** The hospital respects the patient’s right to privacy.

While patient rights as a category encompass standards related to treating patients with respect, there are no current regulations or standards guiding the proactive mitigation of non-physical harms. Regulations and accreditation standards range from prescriptive in nature to broader and more ambiguous, placing the onus on the organization to decipher and implement an appropriate response based on the institutional interpretation of the rule or standard (Warburton, 2009). For instance, TJC has a section of accreditation standards related to performance improvement, in which a broad standard indicates that “performance improvement priorities [are] identified by leaders” (TJC, 2019, p. 39). The cascading sub-standards provide more specificity as to the type of data that must be collected, which are oriented toward physical harm, including: “operative or other procedures that place patients at risk of disability or death, adverse events related to

moderate or deep sedation or anesthesia, the use of blood and blood components, transfusion reactions, medical errors, significant adverse drug reactions”, as well as patient perception of safety and quality of services (TJC, 2019, p. 39). While these examples represent key elements of physical harm that necessitate tracking, analysis, mitigation, and improvement, providing such specific examples may limit the organization’s measurement and improvement efforts; additionally, broader standards may be too ambiguous that non-physical harms from disrespect are not even considered as potential events warranting the same level of analysis and mitigation.

As is evident, quality and patient safety are inherently complex. In general, the policy literature outlines how “wicked” or complex social problems are multi-causal and generally mean that one-size-fits-all-policies are not feasible (Bacchi, 2016; Cerna, 2013). However, despite the complexity of patient safety and quality as a policy problem, regulatory and accreditation standards provide a foundational base of minimum, standard expectations that all care-providing organizations are required to adopt; in this circumstance, one-size-fits-all policies in the form of minimum requirements for providing safe, reliable care are warranted. In one way, system redesign and innovation can be “stymied when regulators dictate the details of their structure” (Brennan, 1998, p. 728), and often regulatory and accreditation language is deliberately broad, allowing for latitude in interpretation and implementation (Berman, 1978; Stone, 2012). Ambiguity promotes flexibility and can facilitate collective action and agreement across many actors, given that interpretation is inherent within the concept; ambiguity is a symbol in that it can “mean different things in different contexts,” and could be appealing to organizations from this perspective (Stone, 2012, p. 196). Conversely, ambiguous

regulatory guidance can create operationalization, interpretation and implementation uncertainty, which has direct implications to widespread quality and safety across various institutions (Berman, 1978; Stone, 2012; Weible & Sabatier, 2017).

From the resource dependence perspective previously discussed, regulation and accreditation can be viewed as a constraint on an organization, as constraints “facilitate the choice and decision process...[and] can...promote certain behaviors,” (Pfeffer & Salancik, 2003, p. 15). Additionally, regulatory and accrediting entities are able to monitor compliance and enforce sanctions through ongoing survey activity, investigations for egregious occurrences, and mandatory reporting mechanisms, demonstrating the visibility of an organization’s behavior and outcomes, and the influence that a regulatory or accrediting entity has on an organization (Pfeffer & Salancik, 2003, p. 104). While there is a deeming relationship between CMS and CMS-approved AO and state agencies, there is not always alignment among all agencies, leading to competing, and sometimes conflicting demands; again, this places interpretation and implementation burdens on the organization (Pfeffer & Salancik, 2003; Quick, 2014; TJC, 2018).

### **Accreditation, Licensure and Certification**

In addition to the regulation and accreditation of health delivery organizations, institutions providing educational preparation to the workforce who then become eligible to be licensed as health care providers in health delivery organizations are also subject to accreditation (Gelmon & Tresidder, 2011). Accreditation and licensure have played “major roles in regulating health professions education” (Gelmon et al., 1999, p. i), as

much of the workforce that comprises a health care delivery organization must first undergo appropriate education from an accredited organization which in turn leads to their ability to become licensed and potentially certified and then provide care in an organization (Blouin et al., 2018; Boulet & van Zanten, 2014). While clinical and non-clinical health professionals often obtain graduate degrees in administration or management from accredited educational institutions, accreditation of health professions organizations in this section focuses mainly on two core clinical professions: physicians and nurses, both of which are highly regulated.

### **Medical Accreditation, Licensure, Certification, and Competencies**

Similar to the assessment of health delivery organizations, the core intent of accreditation of educational institutions is rooted in the “protection of the public” (Gelmon & Tresidder, 2011, p. s20) by ensuring the quality of education and promoting quality assurance and improvement (Blouin et al., 2018), which allows for a “competent and relevant workforce” with “standardized competencies,” and ultimately contributes to the ability to provide optimal patient care (Gelmon & Tresidder, 2011, p. s20). For medical professionals, similar to the varied literature surrounding the effectiveness of accredited delivery organizations on the quality of care being delivered to patient and families, there is limited literature – with a need for additional evidence – to understand the relationship between regulatory activities and accreditation and patient outcomes (Boulet & van Zanten, 2014). However, “there is some evidence to support the value of medical school accreditation” (Boulet & van Zanten, 2014). Specifically for medical schools in the U.S., the Liaison Committee on Medical Education (LCME) is the accrediting authority for allopathic medical education programs, and the Commission on

Osteopathic College Accreditation (COCA) is the accrediting authority for osteopathic medical education programs (Boulet & van Zanten, 2014). Upon graduation from an accredited medical school, physicians then become eligible to apply for graduate medical education (GME) residency training positions, which are overseen by a single accreditation system, the Accreditation Council for Graduate Medical Education (ACGME); individuals are required to obtain a state medical license to provide medical care (Boulet & van Zanten, 2014).

In the early 2000s, ACMGE developed six general competencies deemed critical and foundational for every physician, including: practice-based learning and improvement, patient care and procedural skills, systems-based practice, medical knowledge, interpersonal and communication skills, and professionalism (Batalden et al., 2002; Swing, 2007). Beyond the six competencies, ACGME and the American Board of Medical Specialties (ABMS) developed specialty-specific milestones that stem from and support the core six competencies described; these knowledge and skills-based attributes are meant to help identify the readiness and ability of residents to provide care and work in health care delivery systems, as well as the efficacy of medical training programs (Swing, 2007).

Specifically related to the concept of respect, medical students and residents are expected to follow the Association of American Medical Colleges (AAMC) and ACMGE conditions that require them to “demonstrate” and “act with respect” (Beach et al., 2007, p. 694). Leape et al. (2012a) reinforce how respect is a “foundational element of professionalism that forms the core of the self-image of most physicians” with professionalism serving as a “critical element of the six competencies that form the

foundation of medical education and practice espoused by the [ACGME] and [ABMS]... showing respect for others is central to all aspects of professionalism” (p. 846).

Licensure in general involves credentialing and assessment, is granted by national or regional governments, and is required for “initial entry into the profession”, with initial licensure for medical professionals granted upon successfully completing the USMLE and/or COMLEX examinations (Boulet & van Zanten, 2014, p. 80). Alternatively, certification generally may occur through a non-governmental agency and generally implies a “higher level” of qualification (Boulet & van Zanten, 2014, p. 80). In general, the credentialing and assessment processes are built to validate that physician candidates applying for licensure and/or certification have met specific standards, as well as specializing from a specialty society or board, again with the intent of protecting the public (Boulet & van Zanten, 2014; Gelmon & Tresidder, 2011).

### **Nursing Accreditation, Licensure, Certification, and Competencies**

In nursing, similarly, the primary goal of accreditation of nursing educational programs is also related to protecting the interest of the public, while providing the foundation for quality assurance and improvement (Halstead, 2017). Eaton (2012, p. 14), as cited in Halstead (2017), noted how achievement of accreditation is acknowledgment of program quality “as determined by a standards-based, evidence-based, judgment-based, peer-based process” (p. 181), and differs from the regulatory authority related to a state-specific Board of Nursing approval, which is required to operate a nursing program (Halstead, 2017, p. 181). While all nursing students must graduate from a state-specific Board of Nursing-approved nursing program, an accredited nursing program offers additional leverage (Halstead, 2017). Additionally, specialized accreditation is required

for nursing programs preparing nursing students for an advanced practice role, such as a nurse practitioner, nurse anesthetist, clinical nurse specialist, or nurse midwife (ACEN, 2020).

The Accreditation Commission for Education in Nursing (ACEN) is recognized by the U.S. Department of Education (USDE) and the Council for Higher Education Accreditation (CHEA) as an accrediting agency that accredits all degree levels of nursing programs, including “transition-to-practice” programs (ACEN, 2024, para. 2). The Commission on Collegiate Nursing Education (CCNE), an autonomous accrediting agency “arm” of the American Association of Colleges of Nursing (AACN), also serves as a USDE-recognized accreditor, specifically for higher education institutions, including baccalaureate, graduate, and residency/fellowship programs in nursing (AACN, 2024, para. 1). While CCNE accreditation is technically voluntary, similar to other types of educational accreditation, and serves as a way to ensure that a nursing program meets standards related to the quality of nursing education, compliance with a state-based regulatory Board of Nursing is required in order for a nursing program to operate, and also has implications for the nursing candidate’s ability to take a nursing licensure examination, as many states require nursing students to graduate from an accredited program (AACN, 2021; Halstead, 2017).

In terms of standardized nursing competencies, the Quality and Safety Education in Nursing (QSEN) initiative, originally funded by the Robert Wood Johnson Foundation (RWJF), developed and outlined knowledge, skills, and attitudes (KSAs) for six core competencies critical for preparing nurses to improve the quality and safety of health care systems (Altmiller & Hopkins-Pepe, 2019; Armstrong & Sables-Baus, 2019; Cengiz &

Yoder, 2020; Cronenwett et al., 2007). These included five competencies as outlined by the 2003 IOM *Health Professions Education: A Bridge to Quality* report, challenging health care professionals to assume competencies in: patient-centered care, evidence-based practice, informatics, teamwork, and quality improvement (Armstrong & Sables-Baus, 2019; Cengiz & Yoder, 2020; Cronenwett et al., 2007; IOM, 2003). The nursing profession adopted the five IOM competencies, while adding a sixth, separate competency in patient safety, incorporating elements of systems, reliability, safety design, and safety culture as part of this competency (Cronenwett et al., 2007).

Nurses are integral to providing and managing care (Altmiller & Hopkins-Pepe, 2019), and are the “first line of patient care to prevent adverse events and improve patient outcomes” (Cengiz & Yoder, 2020, p. 276). As a result, nursing education has widely incorporated the six QSEN competencies so that nursing graduates are adequately prepared and well-equipped with the KSAs needed prior to entering the workforce (Cengiz & Yoder, 2020). Cengiz and Yoder (2020) published the first known systematic review that focused on evaluating student nurses’ perceptions of their KSAs within the six QSEN competencies and the effect of embedding QSEN competencies into educational curricula (p. 279). In their review of seven published studies, Cengiz and Yoder (2020) described how students perceived the patient-centered care competency as most frequently included in their curricula, with their perceived preparedness strongest in this particular competency, whereas topics related to the quality improvement competency were perceived as the least covered in nursing curricula, leading students to feel the least prepared to address skills related to the quality improvement competency (p. 279).



These perceptions of preparedness and competence have implications for both academic nursing programs as well as health care systems hiring nurses, with opportunities for academic institutions to ensure that pre-licensure curricula incorporate all six QSEN competencies so that nursing graduates have the KSAs needed to provide, monitor, and manage patient care (Cengiz & Yoder, 2020). Building the QSEN competencies in pre-licensure education ensures that there is a “standardized structure” in place that provides the foundation needed for nurses to deliver and promote safe, reliable, and effective care (Altmiller & Hopkins-Pepe, 2019, p. 200).

### **Alignment of Regulation, Accreditation, Licensure, and Certification to Quality and Safety**

While other health professions have licensure and certification requirements, as well as other facilities and programs have certification requirements, the focus of this study was on physicians and nurses specifically, as the design and methods outlined in Chapter Three were limited to those groups. Both professions, as described in the previous sections, have adopted competency models that emphasize quality and safety, and are used as the foundation for curriculum design and integrated into educational accreditation standards.

In general, regulation and accreditation on their own cannot lead to substantial improvements in patient safety (IOM, 2000). However, they are key drivers of patient safety efforts and the surrounding cultural, leadership, and improvement components that also influence patient safety effectiveness (Devers et al., 2004; IOM, 2000; Jha, 2018; Warburton, 2009). While a solution at the external, regulatory level cannot be viewed as a panacea, these various regulatory mechanisms (inclusive of accreditation, licensing, and

certification) have the ability to influence, and in some contexts mandate, organization-level responses, stimulating a widespread direction across health care delivery systems as opposed to relying on piecemeal, organization-specific initiatives, thus creating a “more level playing field throughout the industry” (Devers et al., 2004; IOM, 2000, p. 19; Jha, 2018; Warburton, 2009).

Importantly, policy change goes hand-in-hand with the contexts surrounding the policy intervention as well as policy implementation; policy enactment does not necessarily lead to the desired outcomes and depends on the effectiveness of both implementation and sustainment strategies, and must factor in that the same policy implemented in different ways based on the organizational setting can lead to different results than intended (Benach et al., 2013; Berman, 1978).

In health care, regulation, accreditation, licensure, and certification all play a pivotal role in ensuring a baseline of quality and safety are achieved at both organizational and professional levels. For health delivery organizations, accreditation and regulation are key drivers of patient safety efforts and the surrounding cultural, leadership, and improvement components that also influence patient safety effectiveness (Devers et al., 2004; IOM, 2000; Jha, 2018; Warburton, 2009). In health delivery organizations, regulations and accreditation standards address aspects of cultivating an environment that prioritizes quality and safety, but have typically been oriented toward physical harm and medication errors and direct organizational measurement and improvement geared to the narrow concept of patient safety (CMS, 2020c; Frankel et al., 2017; TJC, 2019). At the workforce level, accreditation of medical and nursing educational programs is meant to ensure that the curricula uphold a level of educational

quality needed for physician and nursing graduates to provide safe, effective, quality care to patients in the future (Boulet & van Zanten, 2014). Accreditation of these academic programs is essential for physician and nursing graduates to pursue licensure and certification, with licensure serving as a way to restrict professional practice to only those who demonstrate achievement of prescribed skills and competencies (Boulet & van Zanten, 2014). Ultimately, and collectively, these various regulatory activities serve as mechanisms to promote quality and patient safety at both the organizational and individual levels.

### **Section Six: Summary**

This chapter provided an overview of the relevant literature surrounding this dissertation focus area. Providing an outline of the historical context allowed for the depiction of the evolution of quality and patient safety as both a public health and policy issue. A discussion of applicable systems, organizational, quality, and high reliability theories, frameworks, and concepts provided a foundation for understanding how the various organization and system components of the health care system are interrelated and can influence patient safety and quality. Despite the various interventions and actions implemented among a varied set of stakeholder groups over the past two decades, preventable harm occurrences persist, reinforcing that patient safety is an enduring problem that has not yet been comprehensively addressed. The literature emphasized that the concept of harm has been broadened to include “any outcome that negatively affects the patient’s health and/or quality of life” (Sokol-Hessner et al., 2015, p. 550). Lastly, a high-level review of the roles of regulation, accreditation, licensure, competencies, and

certification of organizations and health care professionals underscores the key intent driving each of these activities, which is to protect the public by ensuring organizations and their workforces meet agreed-upon standards that demonstrate and uphold quality and safety (Boulet & van Zanten, 2014; Gelmon & Tresidder, 2011; Halstead, 2017; Jha, 2018; Lam et al., 2018; Warburton, 2009).

While the notions of respect and dignity are not new, disrespect is pervasive in health care (Brown et al., 2018; Entwistle, 2008; Leape et al., 2012; Sokol-Hessner et al., 2018), and organizations have an opportunity to systematically address non-physical harms from disrespect as the “next frontier in preventable harm” (Sokol-Hessner et al., 2018, p. 475). Recent research urged a recognition of failures of respect as equivalent to physical harm events and recommended using existing quality and safety mechanisms to ensure that the same level of rigor is applied to both; this recognition that both physical and non-physical harms represent a more holistic view of patient safety underscores the significance of studying non-physical harm and its relationship to safety culture (Brown et al., 2018; Sokol-Hessner et al., 2015, 2019). Despite research support indicating that non-physical harm from disrespect should be incorporated into organizational patient safety and quality efforts, this is still in its nascent stages in terms of being systematically operationalized and mitigated by health systems. As such, the study design and methods outlined in Chapter Three are oriented toward exploring how a health system recognized non-physical harm from disrespect as an organizational priority that necessitates formal integration into existing organizational processes to improve quality and safety delivered to patients and families.

## **Chapter Three – Approach, Design, and Methodology**

### **Overview**

This chapter presents the theoretical orientation, research study design, and methodology to answer the following research question: How does a multi-hospital health system recognize and address preventable non-physical harm? As introduced in Chapter One, this study had three aims:

1. Characterize non-physical harm events from disrespect occurring across organizational components (hospital and unit) through application of the Beth Israel Deaconess Medical Center (BIDMC) framework.
2. Identify associations between patient experience of respect and staff perception of safety culture, and determine the extent of variations in respect and safety culture across hospitals and units.
3. Investigate how leadership and staff articulate and prioritize non-physical harm in the context of organizational culture and organizational commitment to patient safety.

The theoretical approach, guiding frameworks, operationalization of key concepts, and a broad overview of the research approach and design are outlined in this chapter; Chapters Four, Five, and Six provide detailed discussions on the findings from each of the aims.

### **Theoretical Approach and Orientation**

This study was built upon a centering philosophy and a foundation of existing frameworks and directives that underscore the importance of providing safe care to patients and their families. As described in Chapter Two, the foundations for this work included the IOM-sponsored work that resulted in two seminal reports on quality and safety including the six aims for a high quality health system, the IHI's Triple Aim, and the IHI/SRH's Framework for Safe, Reliable, and Effective Care (Frankel et al., 2017).

Additionally, as noted in Chapter Two, embracing a systems-oriented view of patient safety acknowledged the inherent complexity of care delivery, comprised of ongoing interactions among various stakeholders, organizations, and processes within multifaceted environments (Amalberti & Vincent, 2020; Federico, 2018; IOM, 2000; Pronovost et al., 2015).

Improving safety and quality necessitates building safety into the system (IOM, 2000; Pronovost et al., 2015). Framing patient safety and quality through a systems lens embraces a more holistic view in recognizing the interdependencies contributing to the health care system and can help organizations better manage risk as well as understand the broader factors contributing to safety and quality (Deming, 1994; Pronovost et al., 2015; Scott, 1992).

Given the interdependencies among the various components of the health care system, there are numerous organizational and system factors upon which patient safety and quality improvement depend (Bates & Singh, 2018; Frankel et al., 2017; Pronovost et al., 2015). As introduced in Chapter Two (Figure 2.2), and duplicated in Figure 3.1 below, the Framework for Safe, Reliable, and Effective Care displays the nine interrelated components stemming from two foundational domains (culture and the learning system), with patients and families at the core (Frankel et al., 2017). The construction of this framework is rooted in the belief that each of the interconnected and interdependent elements is essential for delivering safe, effective, and reliable care, which reflects not only the “absence of physical harm” but also involves “the pursuit of dignity and equity”, reinforcing a broadened definition of patient safety to include both physical and non-physical harm (Frankel et al., 2017, p. 4).

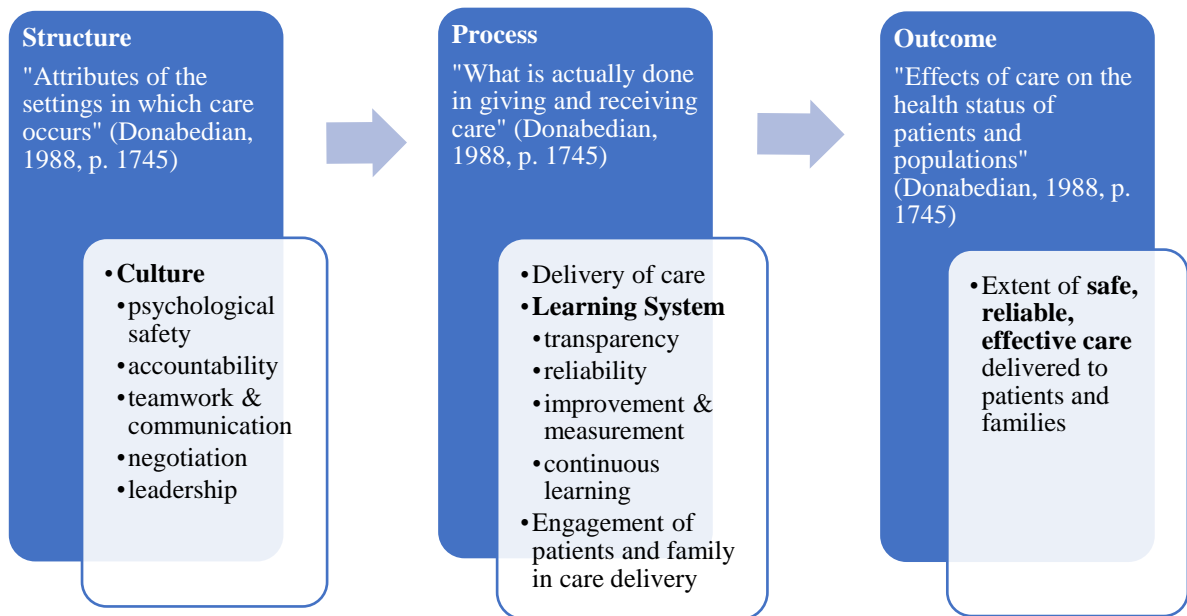
**Figure 3.1: Framework for Safe, Reliable, and Effective Care (Frankel et al., 2017)**



Donabedian’s (1966) structure-process-outcome triad, which serves as the basis for much of the work on quality assessment, was used as a foundational model, guiding this study, and helped to structure the core elements essential for the delivery of safe, effective, reliable care (Ayanian & Markel, 2016; Donabedian, 1966, 1988). The framework provided the rationale for shifting the evaluation of care quality to “what goes on here?” rather than “what is wrong, and how can it be made better?”, underscoring the importance of each element in understanding the quality of care (Donabedian, 1966, p. 196). Donabedian’s structure-process-outcome model was utilized to organize Frankel et al.’s (2017) strategic, clinical, and operational elements, which were previously defined in Chapter Two. In this context, culture falls under the “structure” category, and reflects the “individual and group values, attitudes, competencies, and behaviors that form a strong foundation on which to build a learning system” (Frankel et al., 2017, p. 7). The

learning system is characterized by “its ability to self-reflect and identify strengths and defects, both in real time and in periodic review intervals... [learning systems] identify defects and act on them; they reward proactivity rather than reactivity” (Frankel et al., 2017, pp. 7-8). Arguably, some of the components within the learning system could fall under both “structure” and “process” but are reflected under “process” as they are key process-based elements guiding the delivery of care and are integral to providing quality care.

**Figure 3.2: Donabedian’s (1966, 1988) Structure-Process-Outcome Framework Overlaid with Frankel et al.’s (2017) Framework for Safe, Reliable, Effective Care**

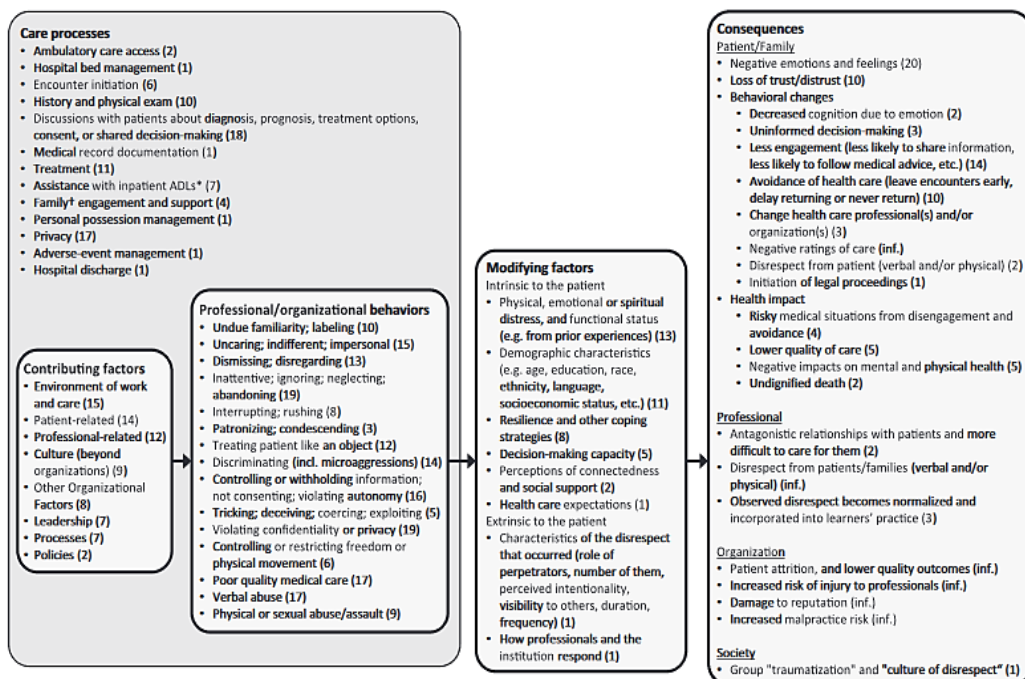


The collective structural elements create an environment that influences the care processes and how care is provided to patients/families, which can influence the type of care experienced by patients and their families. The three components in Donabedian’s model provided the foundational structure for understanding how key elements

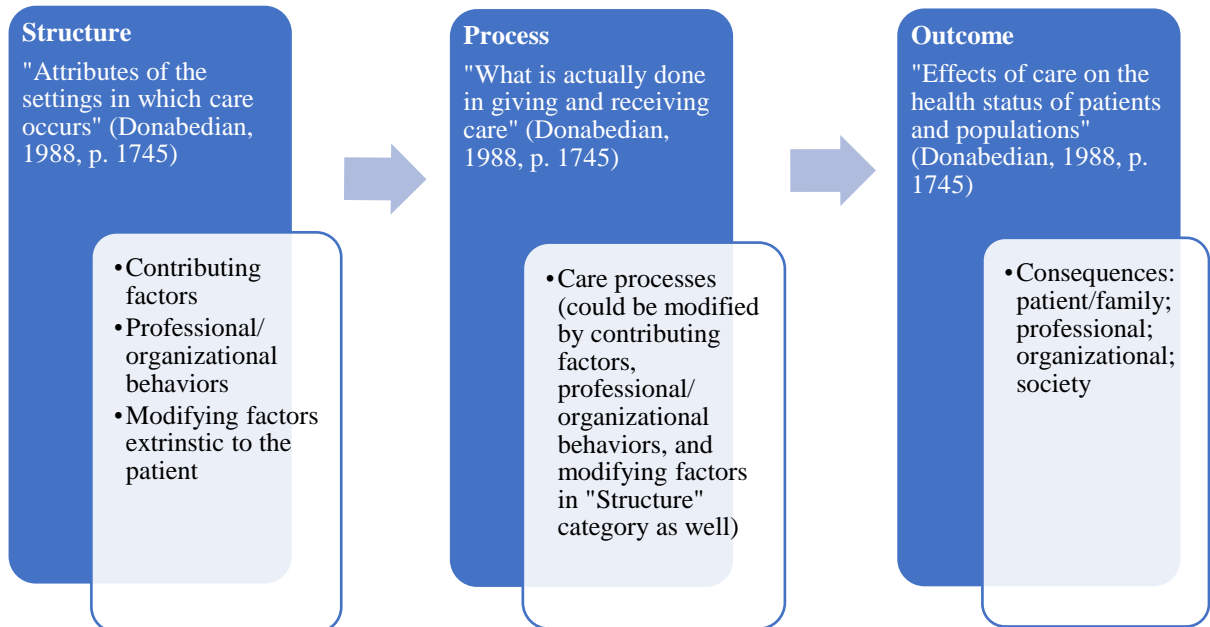


comprising an organization's structure can influence its ability to deliver care to patients and families. Mapping BIDMC's framework for disrespect (Figure 3.3), which was used in Aim 1, to the structure-process-outcome framework presented in Figure 3.4 articulated the structural and process elements that can lead to patient and family harms resulting from disrespect, as well as the negative consequences inflicted upon professional, organizational, and society levels (Sokol-Hessner et al., 2019).

**Figure 3.3: Beth Israel Deaconess Medical Center Framework for Disrespect (Sokol-Hessner et al., 2019)**

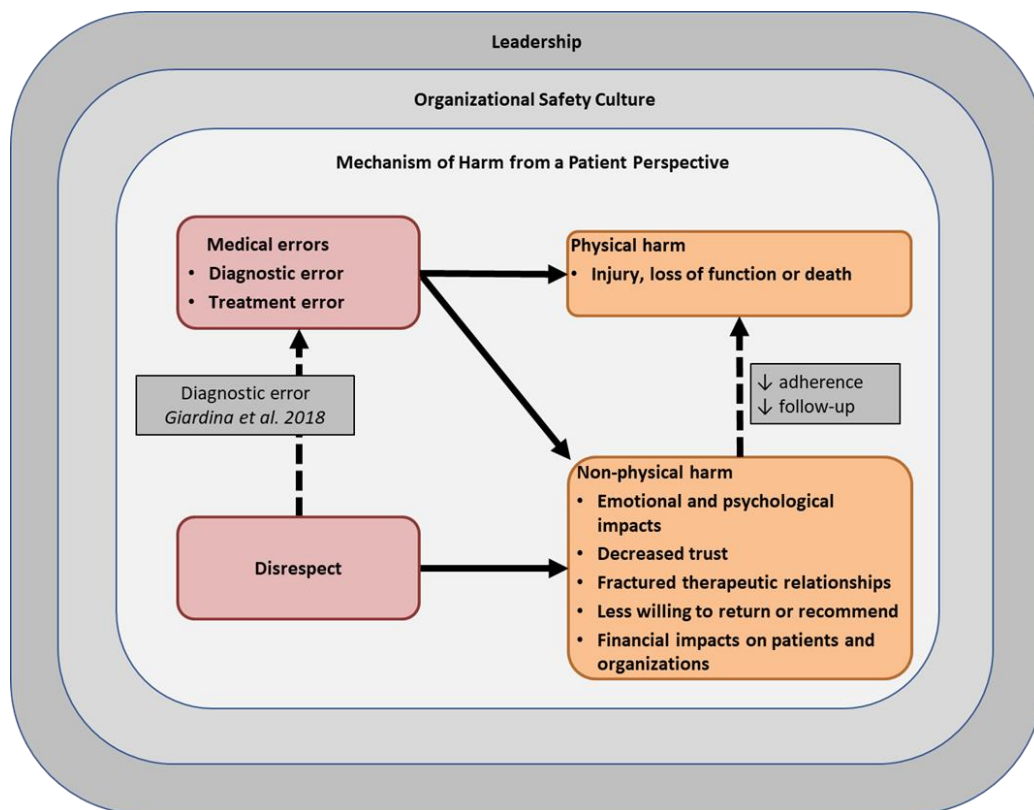


**Figure 3.4: Donabedian's (1966, 1988) Structure-Process-Outcome Framework Overlaid with BIDMC's Framework to Describe Patient and Family Harm from Disrespect (Sokol-Hessner et al., 2019)**



These guiding frameworks and concepts contributed to the proposed conceptual framework below, which were adapted from Sokol-Hessner's original conceptual framework illustrating the mechanism of harm from a patient perspective (Sokol-Hessner, personal communication, March 6, 2022).

**Figure 3.5: Conceptual Framework:  
Mechanism of Harm from a Patient Perspective  
(Sokol-Hessner, personal communication, March 6, 2022)**



The original graphical representation (depicted in red, dark gray, and orange boxes in the center of the diagram) as developed by Sokol-Hessner (personal communication, March 6, 2022) outlined the mechanism of harm from a patient perspective, illustrating how non-physical harm and disrespect are discrete but related concepts. Patients and families may experience non-physical harm (a consequence) that can be caused by many factors, one of which is disrespect (Sokol-Hessner, personal communication, March 6, 2022). As noted in Chapter Two, patients' experience of non-physical harm from disrespect can have lasting, negative consequences to the patient/family, the organization, and its employees, and influence the future interactions

of the patient/family with the health system (Brown et al., 2018; Sokol-Hessner et al., 2015, 2018, 2019). Disrespect has also been associated with a greater risk of physical harm; Figure 3.5 illustrates the relationship between the two types of harm (Sokol-Hessner et al., 2019). For the purposes of this research, the modifications to the conceptual framework add organizational safety culture and leadership as outer elements that influence the overall mechanism of harm. The addition of these concepts echoes the literature by indicating that leadership is pivotal in fostering a culture of safety, and safety culture directly impacts patient safety, with errors and disrespect modified by an organization's safety culture (Bates & Singh, 2018; Botwinick et al., 2006; Federico, 2018; Frankel et al., 2017; IOM, 2000; Leape et al., 2012b; Morello et al., 2013; NPSF, 2015; Sammer et al., 2010; Sutcliffe et al., 2017). This expanded conceptual framework framed this study's scope and focus.

### **Operationalization of Key Concepts**

Table 3.1 below defines and operationalizes the key concepts inherent within the research question and aims. This research took place within Oregon (referred to as the Oregon "region"), which is one of several states in which the overarching multi-hospital health system operates, and was largely focused on the acute setting, though this varied depending on the aim.

The patient-oriented data described in Aim 1 (patient grievance/complaint/abuse allegation data) included all settings, whereas Aim 2 patient data (patient experience of respect) were restricted to the inpatient setting— i.e. the context whereby patients are “admitted to a hospital for [inpatient] bed occupancy [to receive] inpatient hospital

services” (CMS, 2020a, p. 39), and a small subset of the emergency department.

Interviews conducted as part of Aim 3 were limited to nurses and physicians within the hospital setting, and leaders who were interviewed represented both hospital-oriented leaders as well as system-based leaders.

**Table 3.1: Operationalization of Key Concepts**

| <b>Key Term/<br/>Concept</b>                 | <b>Definition &amp; Source</b>   | <b>Aim</b> |
|--|--|------------|
| <b>Non-physical Harm</b>                     | Represents emotional, psychological, socio-behavioral, or financial harm resulting from interactions with the health care system that can be caused by many things, one of which is disrespect (Ottosen et al., 2018; Sokol-Hessner et al., 2018, 2019). | 1, 2, 3    |
| <b>Dignity</b>                               | Intrinsic, unconditional value of each person (Sokol-Hessner et al., 2019, p. 658).  | 1, 2, 3    |
| <b>Respect</b>                               | Action(s) that honor and acknowledge dignity; represents the operational component of dignity and respect (Sokol-Hessner et al., 2019, p. 658).  | 1, 2, 3    |
| <b>Disrespect</b>                            | An “affront” to dignity that can cause harm (Sokol-Hessner et al., 2018, p. 463); a “mechanism of injury” (Sokol-Hessner, personal communication, March 6, 2022).  | 1, 2, 3    |
| <b>Preventable Harm</b>                      | Physical or non-physical harm/injury stemming from, or in association with, errors resulting from care delivery and (mis)management (IOM, 2000, p. 4; BIDMC, 2020).  | 1, 3       |
| <b>Patient Grievance</b>                     | A formal or informal written or verbal complaint that is made to the hospital by a patient (or representative) regarding the patient’s care and/or issues with the hospital that is not resolved at the time of care (CMS, 2020a, p. 81).                | 1          |
| <b>Culture of Safety (or Safety Culture)</b> | The product of individual and group beliefs, values, attitudes...and patterns of behavior that determine the organization’s commitment to quality and patient safety (TJC, 2019, p. 6).  | 1, 2, 3    |

### **Overview of Research Approach and Design**

There are typically three core research approaches to structure the research process: qualitative, quantitative, and mixed methods (Creswell & Creswell, 2018; Morgan, 2014). Each of these approaches is best viewed as representing “different ends

of a continuum” as opposed to distinct categories (Creswell & Creswell, 2018, p. 3).

Selecting the most effective approach for a study depends on three essential components:

1) the underlying philosophical assumptions, epistemologies, or world views guiding the study and the researcher; 2) the research design, or type of inquiry, that directs the study (which could employ a qualitative, quantitative, or mixed methods approach); and 3) the specific research methods to be used, which encompass data collection, analysis, and interpretation (Creswell & Creswell, 2018).

Research design literature has begun to move away from rigid definitions of each research approach; however, there are general orientations and purposes for which each method is typically chosen (Creswell & Creswell, 2018; Kaur, 2016; Morgan, 2014).

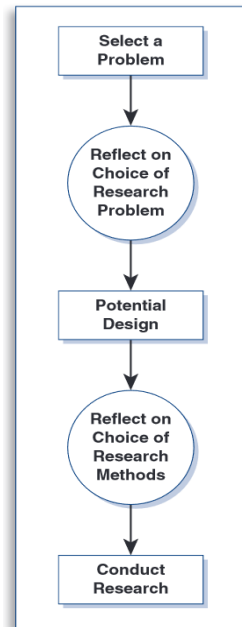
Morgan (2014) argues that qualitative research tends to be: 1) inductive, in which researcher observations are used to generate theory; 2) subjective, using research experiences to interpret the phenomena and social world; and 3) contextual, relying on detailed data to help explain settings and circumstances. Alternatively, quantitative research typically tends to be: 1) deductive, using observations to test theories; 2) objective, minimizing researcher involvement and interpretation of results; and 3) reliant on generality, allowing for data collection and analysis to be applied to a wider range of settings and circumstances (Morgan, 2014).

A qualitative approach tends to use language or textual data to develop an in-depth understanding – the ‘what’, ‘how’, or ‘why’ – of a phenomenon, whereas a quantitative approach tends to determine relationships among variables and uses numerical data to seek answers to questions regarding ‘how many’ or ‘how much’ along with ‘when’, ‘where’, and ‘who’ (Creswell & Creswell, 2018; Green & Thorogood, 2014;

Kaur, 2016). Solely characterizing qualitative and quantitative research in these terms neglects the nuances of each of these methods and perpetuates a division between two research approaches with unique strengths; instead, it is preferable to select a research approach that best addresses the overall research question and aims of the study (Green & Thorogood, 2014).

Different epistemologies or world views guide qualitative and quantitative studies, with positivist and postpositivist assumptions (also referred to as the scientific method and empiricism) typically directing quantitative research, and constructivism, interpretivism, and transformative logic (among others) guiding qualitative research (Creswell & Creswell, 2018; Green & Thorogood, 2014). Pragmatism serves as the theoretical underpinning and can be described as a “paradigm of choices” for mixed methods research by providing researchers a “shared view” of how to conduct research and implying a “conceptual agreement about research in terms of both the purposes it pursues and the procedures it uses to pursue those purposes” (Morgan, 2014, p. 8). Figure 3.6 replicates how Morgan (2014) draws upon Dewey’s Five-Step Model of Inquiry as applied to research as a way to summarize pragmatic inquiry, which highlights how research design serves as a pivotal link between the research question (the purpose) and specific procedures (the research methods) (p. 8).

**Figure 3.6: Dewey's Five-Step Model of Inquiry  
(Morgan, 2014)**



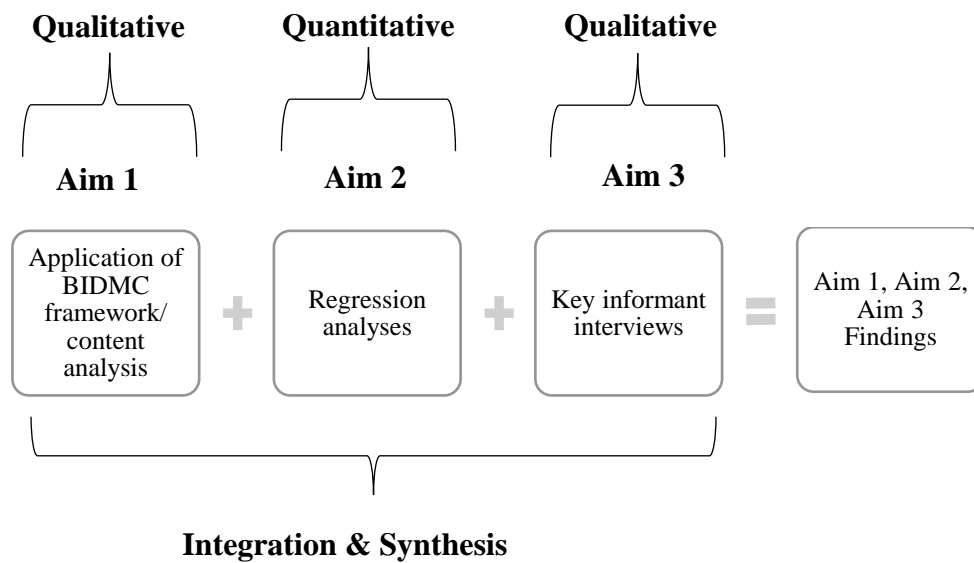
Pragmatism embraces flexibility in choosing methods and encourages leveraging the strengths of both quantitative and qualitative methods to arrive at a comprehensive understanding of a research problem (Creswell & Creswell, 2018; Morgan, 2014).

With this foundation, the research question and aims were addressed through a mixed methods research design, which used both qualitative and quantitative approaches and relied on the integration of these two forms of data to provide a more comprehensive analysis and understanding of the research question (Creswell & Creswell, 2018; Morgan, 2014). The methodology included applying patient/family-generated grievances/complaints (secondary data) to the BIDMC framework to characterize events and conduct content analysis to address Aim 1; constructing multivariate logistic and linear ordinary least squares (OLS) regressions from three survey types (secondary data) to address Aim 2; and carrying out primary data collection through qualitative interviews



and subsequent analysis to investigate Aim 3. A mixed methods approach allowed for each method to be linked to a specific purpose and was effective when the quantitative or qualitative approach independently did not adequately allow for a research problem to be understood (Creswell & Creswell, 2018, p. 19). Morgan (2014) describes three motivations for integrating qualitative and quantitative methods, including convergent findings (represented as Qual = Quant), additional coverage (Qual + Quant), and sequential contributions (Qual → Quant). This study reflected the additional coverage perspective, in that the strengths of each proposed method were assigned to study distinct parts of the overarching research question; each method had a specific purpose within the larger context (Morgan, 2014). Figure 3.7 illustrates the additional coverage mixed methods study design.

**Figure 3.7: Study Design**



The data sources, methods, and analyses for each of the three aims are summarized in Table 3.2 below.

**Table 3.2: Summary of Study**

| Aim |   | Data Source(s)  | Method & Analysis  |
|-----|---|---|--|
| 1   | Characterize non-physical harm events from disrespect occurring across organizational components (hospital and unit) through application of the BIDMC framework.                                    | Patient complaints, grievances, and abuse allegations (“cases”) logged into “Feedback” module within organization’s incident reporting system (“Datix”)   | Event/case characterization; content analyses  |
| 2   | Identify associations between patient experience of respect and staff perception of safety culture and determine the extent of variations in respect and safety culture across hospitals and units. | Patient experience of respect: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience surveys<br><br>Staff perception of safety culture: 2 different surveys<br>1) Caregiver Experience Survey (CES)- for nursing (RN) perspectives only<br>2) Provider Survey- for physician (MD/DO) perspectives only | Multivariate logistic and ordinary least squares (OLS) regressions   |
| 3   | Investigate how leadership and staff articulate and prioritize non-physical harm in the context of organizational culture and organizational commitment to patient safety.                          | Interview transcripts   | Primary data collection: Semi-structured key informant interviews (n=12); thematic content analyses derived from coded interview transcripts |

**Study Setting/Organizational Context**

The organization where this study took place was a not-for-profit, multi-state health system that employed over 120,000 staff, and operated a network of over 50 hospitals, 1,000+ clinics, a health plan, home health services, and housing facilities, and conducts research. This study focused exclusively on services in Oregon as opposed to

the entire health system across multiple states (see Table 3.3 for a high-level snapshot of the Oregon region and Table 3.4 for a profile of each hospital within the state).

Within Oregon, there were eight hospitals, over 90 clinics, a health plan, home health services, administrative offices, and other health services across the state. The Oregon region of this system employed over 600 physicians (MD and DO) and over 5,000 nurses (RN, with potentially additional qualifications). The eight institutions were classified as different hospital types based on several factors including, but not limited to, geographic location, scope of services/specialties offered, and licensed bed capacity. Despite differences in hospital type, all eight hospitals provided fundamental medical and surgical acute care services across a standard set of departments and units.

**Table 3.3: Profile of Oregon Region within Overarching Multi-State Health System**

| <b>Profile of Oregon Region</b>  |  |
|--|--|
| <b>Hospitals</b>   | 8  |
| <b>Clinics</b>   | >90  |
| <b>Total Employees</b>   | >20,000  |
| <b>Geographic Service Areas</b>  | Urban, suburban, and rural service areas across Oregon   |
| <b>Employed Physicians (MD, DO)</b><br><i>(does not reflect affiliated physicians)</i> | >600   |
| <b>Nurses (RN)</b>   | >5,500   |
| <b>Licensed Beds per Facility</b>  | 25-523   |
| <b>Scope of Hospital Services</b><br><i>(varies by facility)</i>                       | Emergency services, general surgery, specialty surgery, intensive care, birth center, primary and specialty care, radiology, diagnostic imaging, pathology, rehabilitation, pediatrics |
| <b>Hospital Types</b>  | Critical access, community, teaching, tertiary, full-service   |

Note: Information obtained from organization's website.

**Table 3.4: Detailed Profile of Oregon-based Hospitals**

| <b>Hospital</b>   | <b>Location / Geographic Service Area</b> | <b>Type</b>                | <b>Licensed Beds</b> | <b>General Scope of Services</b>   |
|-------------------|---|----------------------------|----------------------|--|
| <b>Hospital 1</b> | Urban                                     | Tertiary care/<br>Teaching | 400+                 | Emergency, general and specialty surgery, radiology, diagnostic imaging, pathology, birth center, primary and specialty care |
| <b>Hospital 2</b> | Urban                                     | Tertiary care/<br>Teaching | 400+                 | Emergency, general and specialty surgery, radiology, diagnostic imaging, pathology, birth center, primary and specialty care |
| <b>Hospital 3</b> | Suburban                                  | Community/<br>Acute care   | 100-399              | Emergency, general surgery, radiology, diagnostic imaging, pathology, primary and specialty care, birth center               |
| <b>Hospital 4</b> | Suburban                                  | Community/<br>Acute care   | <100                 | Emergency, primary and specialty care, general surgery, radiology, diagnostic imaging, pathology                             |
| <b>Hospital 5</b> | Suburban                                  | Community/<br>Acute care   | <100                 | Emergency, general medicine, general surgery, diagnostic imaging, obstetrics and gynecology, pediatrics, sleep center        |
| <b>Hospital 6</b> | Rural                                     | Critical Access Hospital   | <100                 | Emergency, general surgery, radiology, diagnostic imaging, pathology, primary and specialty care, birth center               |
| <b>Hospital 7</b> | Rural                                     | Critical Access Hospital   | <100                 | Emergency, primary and specialty care, birth center, general surgery, radiology, diagnostic imaging, pathology               |
| <b>Hospital 8</b> | Urban                                     | Community/<br>Acute care   | 100-399              | Emergency, primary and specialty care, surgical services, stroke care, cardiac, vascular, birth center                       |

Note: Information obtained from organization’s website.

### **Approach to Address Aim 1**

#### **Overview**

Aim 1 sought to characterize non-physical harm events occurring across the eight hospitals within the Oregon region through application of BIDMC’s framework (Figure

3.3) to describe patient and family harm from disrespect. As noted in Chapter Two, despite growing recognition that non-physical harm from disrespect may be preventable and warrant identification, analysis, and mitigation, systematic evidence-based approaches to aid organizations in tackling these non-physical harms have not been available to date (Sokol-Hessner et al., 2015, 2018, 2019).

In 2019, leaders at BIDMC developed a five-component, improvement-oriented framework for capturing and describing reports of non-physical harm from disrespect experienced by patients and/or families (Sokol-Hessner et al., 2019). Applying this framework to organizational non-physical harm events allowed the researcher to carry out content/incident analyses of cases that met inclusion criteria described below by testing the categories developed in the BIDMC framework and identifying how this framework works in application. Employing the framework allowed the researcher to conduct incident analyses of actual cases and frame non-physical harm with a systems lens. This allowed for the identification of the main factors contributing to non-physical harm events and potential consequences from patient/family, professional, organizational, and societal levels (of particular importance to organizational leaders), and surfaced opportunities for quality and safety improvement (Sokol-Hessner et al., 2019).

### **Qualitative Design and Rationale**

Disrespectful behavior threatens organizational culture and patient safety (Leape et al., 2012a). It is the root cause of dysfunctional (organizational) culture that permeates health care and impedes progress in patient safety and is also a product of that culture (Leape et al., 2012a). Sokol-Hessner et al.'s (2018) interdisciplinary consensus statement urged organizations to “learn from episodes of disrespect by recognizing, capturing,

categorizing and analyzing them, as is done through incident analysis” to “prevent future harm by designing and implementing changes based on what is learned about the practice of respect” (p. 468). While a patient and/or family member may experience disrespect during interactions with the health care system, it is rarely due to a staff member being intentionally disrespectful; as such, using the BIDMC framework allowed development of a deeper awareness of the system factors that potentially contribute to the experience of disrespect felt by patients and families (Sokol-Hessner et al., 2015). Applying the organization’s patient/family-generated grievances and complaints to the five-component BIDMC framework (Sokol-Hessner et al., 2019) allowed for these events to be systematically captured and characterized for analysis, using the following components as a coding scheme:

1. **Care processes:** the “groups of related actions performed to fulfill patient-family care needs” (Sokol-Hessner et al., 2019, p. 659);
2. **Professional and organizational behaviors:** a description of the health care professional(s) and organization behaviors involved to allow for “application of just culture algorithms that consider the historical and environmental context in order to fairly balance accountability” (Sokol-Hessner et al., 2019, p. 659);
3. **Contributing factors:** patient and professional-related factors, the environment of care, leadership, policies, processes, and culture, which may create an environment in which disrespectful behavior may occur;
4. **Consequences of disrespect:** the effects of disrespect on patients/family members, professional staff, the organization, and the society, which may provide a more holistic representation of the full extent of non-physical harms on different groups and across several levels; and
5. **Modifying factors:** factors both intrinsic and extrinsic to patients that may modify the consequences of disrespect and provide learning opportunities that can potentially minimize future harm.

## **Data Sources**

Individual descriptions of non-physical harm event cases that were applied to the framework were extracted from the “Feedback” module within the organization’s

incident reporting portal (“Datix”). The Feedback module within Datix served as the central repository for capturing patient/family grievances and complaints during the study timeframe (2021). Complaints and grievances logged in Datix came directly from patient/family/legal representative calls, written communications, and electronic communications (e-mail), as well as from the Compliance Hotline and Patient Experience departments, when direct patient/family complaints or grievances are captured through those mechanisms. The Feedback module was maintained by one central department (the Customer Care Team [CCT], a team within the regional Quality Management and Medical Staff Services department) for all eight hospitals to streamline the management and grievance/complaint process from intake to investigation to resolution; the CCT team’s role was to engage the care delivery team members and leaders involved in the event as needed to support investigation and resolution of the grievance/complaint. The CCT team consisted of three employees, including a clinical nursing supervisor and two non-clinical patient liaisons.

Within the Feedback module, there were 13 core subjects to which the complaints and grievances were assigned, and by which the data were sorted; these data are displayed in Chapter Four. Each of those core domains also included sub-subjects to further categorize each of the events. The data could be filtered by date, staff type (i.e. RN, MD/DO, other professions), hospital, and unit.

### **Data Collection, Sampling/Case Selection, and Data Analysis**

One year of cases logged in the Feedback module (within Datix) was selected for the study. Cases from calendar year 2021 were chosen given unparalleled circumstances arising during the COVID-19 pandemic (officially designated in March 2020) and the

potential implications influencing the grievance and complaint process as well as the care delivery process.

Recognizing that each case represented a unique circumstance, and that the severity of each case might vary, BIDMC developed a Standardized Prioritization Schema (Appendix A) to determine inclusion/exclusion of cases to be analyzed using the BIDMC framework. Cases meet inclusion criteria (for incident analysis using the BIDMC framework) if they meet at least one criterion under the “high risk factors” section, or if they meet at least two of the criteria in the “moderate risk factors” section (see Appendix A). For events logged in Datix during 2021 that met the prioritization inclusion criteria, the researcher applied those event descriptions to the BIDMC framework and used the coding scheme outlined in the BIDMC framework (Figure 3.3) to conduct the incident analysis/characterization. While the case characteristics varied in level of detail depending on how the grievance or complaint was issued to the organization (for example, a patient writing a letter to a hospital typically had more information than a legal representative initiating a brief phone call with a CCT member), all documentation included within the case event was reviewed in an attempt to gain a comprehensive account of the complaint or grievance.

The Feedback module captured events that were patient/family-reported as opposed to staff-reported; disrespect must be “defined from the perspective of the person experiencing harm” (Sokol-Hessner, personal communication, March 6, 2022). The use of patient complaints describing non-physical harm events is an essential information source that organizations can leverage for improvement efforts; however, many organizations have not yet learned to integrate these complaints systematically into



existing quality and patient safety efforts (de Vos et al., 2018; Gallagher & Mazor, 2015; Gillespie & Reader, 2016; King et al., 2017; Raynaud-Lambinet et al., 2011; Reader et al., 2014; Sokol-Hessner et al., 2019, p. 658; Wofford et al., 2004).

Applying events to the framework aided in comprehensively learning from events related to disrespect, and in potentially mitigating and preventing future non-physical harms (Sokol-Hessner et al., 2019). An example of how the BIDMC framework was applied to an event by Sokol-Hessner et al. (2019) can be viewed in Appendix B. An example of how the researcher applied the BIDMC schema and framework for this research can be viewed in Appendix C. Sokol-Hessner et al.'s (2019) framework is the first published method that has been designed for organizations to conduct incident analysis to better understand disrespect experienced by patients and families. Applying this framework to organizational events aligned with the original authors' recommendations for additional testing of the framework to further refine and enhance its utility (Sokol-Hessner et al., 2019).

## **Approach to Address Aim 2**

### **Overview**

Aim 2 sought to quantitatively identify associations between patient experience of respect and staff perception of safety culture, and to determine the extent of variations in respect and safety culture across hospitals and units. Since non-physical harms can be caused by disrespect, and given that Sokol-Hessner et al.'s (2019) framework used for Aim 1 was meant to aid organizations in describing and characterizing harm from disrespect to promote quality and safety improvement, Aim 2 quantitatively assessed

patient perception of respect through data collected via the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience survey (Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS], 2020), assessed whether patient perception was associated with staff perception of organizational safety culture, as measured through the organization's two employee experience surveys, and identified the extent of variations of both respect and safety culture across hospitals and units.

### **Quantitative Research Design and Rationale**

Focusing on respect represented the measurable and “actionable component” of respect and dignity (Sokol-Hessner et al. 2018, p. 464). As previously discussed, safety culture is often described in tandem with an organization's patient safety climate, referring to “employee perceptions and attitudes about the surface features of patient safety culture at a given point in time” (Morello et al., 2013, p. 11). Research has largely highlighted differences in safety climate levels for different subgroups and hierarchical levels, and between clinicians and non-clinicians, reinforcing the study's purpose in assessing both association and variation (Leape et al., 2012a; Ginsburg, 2015; Ginsburg & Oore, 2015; Hickner et al., 2016; Martinez et al., 2015; Schwendimenn et al., 2013; Singer et al., 2009; Singer & Vogus, 2013). Understanding the relationship between patient respect and employee safety culture perception and variation across hospitals and units were assessed using multivariate logistic and OLS regressions.

### **Data Sources and Data Collection**

Three secondary data sources were used to carry out this aim. Collectively, these surveys reflected different perspectives on hospital performance from both patient and

staff viewpoints. The researcher worked with organizational staff from five different teams across the system to secure the needed data.

### **Data Source for Patient Perspective**

The HCAHPS patient experience survey, administered through independent vendor Press Ganey, is a nationally recognized, standardized, publicly reported survey designed to measure patients' perceptions of care received in the hospital setting. The survey is administered to a random sample of patients through a variety of modalities including a combination of phone, e-mail, and/or mail as soon as 48 hours post-discharge, and up to six weeks after leaving the facility (CMS, 2020d; HCAHPS, 2020). There are several limitations to the survey, including language restrictions, which are described in more detail in Chapter Seven. Data from surveys received in calendar year 2022 were used for this study, as 2022 reflected the most current, fully completed year at the time of data collection. There were 6,305 patient survey responses in 2022 included in the sample; the response rate was unavailable.

Given the different hospital types and services provided, there were variations in the types and number of units and specialties at each of the eight hospitals. In order to maximize consistency of data across all hospitals, the units that were selected for analyses were the intensive care unit (ICU), the operating room (OR)/surgical services, and medical/surgical inpatient units, as these were present at all eight hospitals. Seven of the eight hospitals had a labor and delivery unit, which was also included in the analysis. Lastly, a sample of the emergency department (ED) data was also included and only represented patients who came through the ED and were subsequently hospitalized. It is important to note that patients who only received care through the ED and were directly

discharged home from that setting received a separate survey (Emergency Department [ED] CAHPS instead of HCAHPS), which was not included in this study. As a result, these survey responses do not wholly represent patient perceptions of respect in the emergency department. However, given there was a small sample size of HCAHPS surveys within the overall patient sample that were tied to emergency services received among later hospitalized patients, this department type was also included.

### **Data Source for Employee Perspective (Nurses Only)**

At this organization, culture of safety was measured through the Caregiver Experience Survey (CES), which is administered annually to employees of the organization, except for physicians and physician assistants, through an independent vendor. The survey consisted of 89 survey items (questions) grouped under 17 composite measures/domains (see Appendix D for the full CES); however, for this research, only the responses to 13 safety culture questions grouped under two domains (safety and teamwork) were used. Seven questions cascaded from the safety category, and six questions comprised the teamwork domain; collectively, these 13 questions represented the Safety Attitudes Questionnaire (SAQ) “Short Form”, which stems from a larger validated tool (the full Safety Attitudes Questionnaire). The Short Form version reflects a pared-down subset of questions spanning only the safety and teamwork domains that organizations can use to assess safety culture (Sexton et al., 2006). All nurse responses in 2022 across units and all eight hospitals (n=3,098) served as the sample (response rate was unavailable) given that the most recent available safety culture data for physicians was also 2022, and the most complete HCAHPS dataset was for 2022.

### **Data Source for Employee Perspective (Physicians Only)**

At this organization, physician perception of safety culture was measured through a separate Provider Survey (not through the CES described above), which is administered every two years to physician providers through independent vendor Press Ganey (see Appendix E for the full Provider Survey). As with the CES, the Provider Survey is designed to measure physicians' experience, and consisted of 56 survey items (questions) grouped under eight core domains with only partial overlap with those in the CES, including organizational resources, access to information, leadership, quality, safety, and teamwork, among others. Completed responses to the same 13 safety and teamwork questions mentioned above (collectively representing the safety culture score) in 2022 served as the sample. Whereas nurse response data were available by unit and hospital, physician response data were available across physician specialty type and hospital for all eight hospitals. Additionally, the sample size was much lower for physicians compared to nursing (n=934 total physician responses across the eight hospitals compared to n=3,098 for nursing responses across the eight hospitals). Similar to nursing, the response rate for physicians was also unknown. As such, the results reflect the data available to the researcher at the time of the study. Data limitations are discussed in more detail in Chapter Seven.

The CES and Provider Survey were comprised of numerous questions that were grouped by several key categories. While the two surveys were not identical, both surveys included the same 13 questions related to two core domains (safety and teamwork). There were seven questions cascading from the safety category, and six questions comprising the teamwork domain; collectively, these 13 questions represented

the Safety Attitudes Questionnaire (SAQ) “Short Form”, which stems from a larger validated tool (the Safety Attitudes Questionnaire).

In its comprehensive version, the full SAQ has 60 questions and is used to measure employee attitudes around six safety-related domains (teamwork, safety, job satisfaction, stress recognition, and working conditions); the Short Form version reflects a pared-down subset of questions spanning only the safety and teamwork domains that organizations can use to assess safety culture (Sexton et al., 2006). Table 3.5 outlines the 13 questions comprising the SAQ Short Form.

**Table 3.5: SAQ Short Form as part of the CES and Provider Survey (Sexton et al., 2006)**

| Safety Domain  | Teamwork Domain   |
|--|---|
| The culture in this work setting makes it easy to learn from the errors of others.               | My input is well received in this work setting.   |
| In this work setting, it is difficult to discuss errors.   | I have the support I need from others in this work setting to care for patients.  |
| Medical errors are handled appropriately in this work setting.                                   | It is easy for personnel here to ask questions when there is something that they do not understand.                       |
| I know the proper channels to direct questions regarding patient safety in this work setting.    | People in this work setting work together as a well-coordinated team.   |
| I receive appropriate feedback about my performance.   | In this work setting, it is difficult to speak up if I perceive a problem with patient care.                              |
| I am encouraged by others in this work setting to report any patient safety concerns I may have. | Disagreements in this work setting are resolved appropriately (i.e., not who is right, but what is best for the patient). |
| I would feel safe being treated here as a patient.   |   |

The SAQ demonstrates strong psychometric properties, with its lineage originating in the aviation industry; while the survey’s current form is a modified version of the Intensive Care Unit Management Attitudes Questionnaire, the original iteration was derived from the Flight Management Attitudes Questionnaire (Sexton et al., 2006).

In addition to the SAQ, the other prevailing validated instrument used to measure culture of safety is the Survey on Patient Safety Culture (SOPS), which is administered through the Agency for Healthcare Research and Quality (AHRQ), and similarly measures safety culture perception (Etchegaray & Thomas, 2012; Sorra et al., 2019). Since the study organization used the SAQ Short Form within both its CES and Provider Survey, these safety and teamwork measures were used as measures to determine staff perception of safety culture.

These three survey types (HCAHPS for patients, and the CES and Provider Survey for employees) represented the most appropriate and accessible data sources to explore Aim 2. Additionally, it is a TJC accreditation requirement that organizations collect data on patient perception of care and experience, as well as regularly assess organizational safety culture using validated tools (TJC, 2019), rendering these three data sources as viable and appropriate survey instruments.

### **Measures for Identifying Associations between Respect and Safety Culture**

Associations between patient respect and staff perception of safety culture were assessed using multivariate logistic regressions, a statistical technique that allows for analysis of the relationship of a dichotomous dependent variable to one or more independent variables (Segrin, 2012). Odds ratios (ORs) were generated to describe the relationship between the variables, indicating how much more likely an outcome would occur in one group compared to another (Salkind, 2010).

*Dependent Variables:* The outcome, or dependent, variable (DV) for the first part of Aim 2 was patient experience of respect, which was separated into respect by a nurse and respect by a physician; as a result, there were two separate DVs. Within the HCAHPS survey, two questions were analyzed:

- During this hospital stay, how often did **nurses** treat you with courtesy and respect?
- During this hospital stay, how often did **doctors** treat you with courtesy and respect?

While this overarching study focused more on the notion of respect, HCAHPS couples “courtesy” with “respect”; while the concepts are not interchangeable, it can be argued that courtesy is a facet of respect based on how existing research has positioned the concept alongside respect (Beach et al., 2007; IOM, 2001; Mayfield et al., 2020).

Respondents were given a Likert-type scale with four options: ‘never,’ ‘sometimes,’ ‘usually,’ and ‘always,’ which were first collapsed into dichotomous variables with ‘never’/‘sometimes’ as one pair and ‘usually’/‘always’ as another. After running frequency distributions in Stata on this approach, it was found that 97% of all respondents answered ‘always’/‘usually’ for being treated with respect by nurses and doctors. As a result, new calculated variables for both patient experience of doctor and nurse respect were created with ‘always’ as one response option and ‘usually’/‘sometimes’/‘never’ collapsed into the second response option. Eighty-seven percent (87%) of patients reported always being treated with courtesy and respect by nurses and doctors when the four response options were collapsed in this way. Overall, consolidating the four categories into two allowed for simplified logistic regression models for dichotomous outcomes to be developed, which will be discussed in more detail below (Segrin, 2012).

*Independent Variables of Interest:* The main independent variable (IV) of interest for the first part of Aim 2 (identifying general associations between patient respect and staff perception of safety culture) was perception of safety culture as measured by the



aggregate of the 13 questions within the two safety culture domains (safety and teamwork), collected separately for nurses and physicians. Regressions were run on the overall aggregate of the two key domains (safety and teamwork) provided in the data that created a safety culture score by hospital, per unit, for nurses and physicians.

*Control Variables:* Control variables, or confounders, represent variables that are not of direct interest but influence the outcome measure independent of the IV(s) of interest and thus their effect(s) need to be “controlled for” or removed (Pole & Bondy, 2010, p. 253). This study controlled for patient characteristics, including age, sex, patient language, patient education level, patient self-assessment of mental/emotional health, and race/ethnicity. In addition, dummy variables for specific hospital and unit types were used to control for any other unmeasured hospital or unit type effects.

### **Measures for Determining Variations in Respect and Safety Culture**

The second part of Aim 2 involved determining the extent of variations in respect and safety culture across hospitals and units. For the respect measure, variation was identified through the hospital and unit measures used in the initial logistic regressions. Safety culture was assessed using linear OLS regressions, as described below, with the measures differing from those outlined above for the first part of Aim 2.

*Dependent Variables:* The DVs for this second portion of Aim 2 were the safety culture measures described above, which functioned as IVs in the first part of Aim 2. This resulted in two separate regressions with each safety culture measure as a separate DV (one regression for nurse safety culture and one regression for physician safety culture).

*Independent Variables of Interest:* Hospital and unit type (e.g. ICU) dummy variables served as the variables of interest, which are used when categorical variables are of interest in a regression (Chen, 2012). The regression held one hospital (Hospital 1) and one unit (Med/Surg) as referent groups and others included in the study were recoded as dummy variables.

*Control Variables:* As with the first part of this aim, patient characteristics were also controlled for in this second set of regressions.

### **Data Analysis**

Statistical software (Stata version 18.0) was used to first derive basic descriptive statistics for exploratory purposes prior to conducting the set of logistic regression models (StataCorp, 2024). A series of separate regressions were then conducted to determine whether there was a generalized relationship between patient experience of respect and staff perception of safety culture, and to determine the extent of variations in respect and safety culture across hospitals and units. As Aim 2 was comprised of two parts, two (separate) base regression models were created in order to collectively answer the aim. After conducting the two full logistic regressions to determine the associations between patient experience of nurse and physician respect with nurse and physician perception of safety culture, linear OLS regressions were run to assess variations in safety culture perception among hospitals and units. As previously discussed, for the respect measure, variation was identified through the hospital and unit measures used in the initial logistic regressions. Safety culture was then assessed using linear OLS regressions. For these sets of regressions, the outcomes (DVs) were the safety culture measures for nurses and physicians. Hospital and unit type served as the variables of interest, which are used

when categorical variables are of interest in a regression (Chen, 2012). Chapter Five describes the results and analyses in more detail.

### **Approach to Address Aim 3**

#### **Overview**

Aim 3 investigated how leadership and staff articulated and prioritized non-physical harm in the context of organizational culture and organizational commitment to patient safety. In order to address this aim, the researcher conducted primary data collection through qualitative semi-structured key informant interviews, intended to extend and elucidate this research by addressing questions that arise that cannot solely be answered by the methods proposed for Aims 1 and 2 (Creswell & Creswell, 2018; Morgan, 2014).

#### **Qualitative Design Rationale**

The intent behind this aim was to explore how interviewees recognized and described non-physical harm events, articulated the importance of taking actions to prevent these types of events, and better understand the priority of such actions relative to other organizational priorities. As noted in Chapter Two, while research has increasingly argued that non-physical harm merits the same level of rigor and attention as physical harm, there are many barriers that can impede an organization's ability and/or receptivity to incorporate this other type of harm into existing patient safety and quality programs (Sokol-Hessner et al., 2015, 2018, 2019). Engaging leaders to commit to fostering a culture of respect and, more broadly, focusing on non-physical harm necessitates illustrating the costs of not systematically recognizing and addressing these pivotal concepts as foundational to the organization's well-being and performance – including

financial, reputation, workforce retention, and other perspectives (Sokol-Hessner et al., 2018). Conducting interviews allowed for further understanding how and if the organization recognized non-physical harm as a priority that necessitates formal integration into its existing organizational processes.

A semi-structured interview guide (Appendix F) was developed to guide the conduct of in-depth interviews, allowing for both flexibility and consistency in general topics to be covered with each interviewee through a set of pre-determined, open-ended questions with simple probes that guided and structured the interview process (Remler & Van Ryzin, 2015). The semi-structured nature allowed for more descriptive answers from each interviewee as opposed to brief responses that lacked richness in detail.

A multi-pronged recruitment approach spanning six months (February through July 2023) was used to engage a diverse set of interviewees across both the various hospitals and regional teams, ensuring representation from the subgroups of interest: nurses, physicians, and senior/executive leadership. Given that leadership is ultimately accountable for setting the organizational tone in prioritizing and fostering a hospital's culture of safety and patient safety program, interviewing leaders was a priority for the researcher (Botwinick et al., 2006; Frankel et al., 2017; Kirk et al., 2007; Morello et al., 2013; Sammer et al., 2010; Singer & Vogus, 2013; Sokol-Hessner et al., 2018).

The researcher initially proposed conducting 18-24 interviews, sampling across four core groups (nurses, physicians, hospital leaders, and regional executive leaders) to ensure diversity of respondent type and representation across all eight hospitals and regional executive administration ("C-Suite"); ultimately only 12 were carried out given

difficulty with recruitment, substantive organizational changes/circumstances at the time of data collection, and achievement of saturation.

### **Data Collection**

Interviews were conducted in-person and virtually via Microsoft Teams, depending on interviewee preference and availability. Interviews were audio-recorded (with permission) to assist in capturing the language data generated by participants. Note-taking by the researcher supplemented audio recordings of interviews.

### **Data Analysis**

After completion of the interviews, the recorded interview data were transcribed by the researcher and reviewed, with researcher observations and notes also summarized. The data analysis and interpretation process followed Creswell & Creswell's (2018) sequential, five-step approach: 1) organizing and preparing the data for analysis, 2) reading through the available data and noting initial reflections, 3) coding the data by organizing and bracketing segments of the interview transcripts and using short phrases to represent each section, 4) using the coding process to generate descriptions and themes, and 5) representing the descriptions and themes through identification of narratives, including interpreting the meaning of the descriptions and themes identified (pp. 193-196). Interview data tends to be rich in detail and subsequently dense; because it was not possible to use all information collected during interviews, the coding/analysis process necessitated "winnowing" the data, which involved focusing on key portions of interest and disregarding other parts of the data (Creswell & Creswell, 2018). Additional information around Aim 3 coding and data analyses is described in Chapter Six.

## **Interview Guide**

The interview guide created for this study reflected semi-structured, open-ended interview questions derived from key literature supporting this study. Sokol-Hessner et al.'s (2018) consensus statement provided a road map for organizations in advancing the practice of respect through the development of six high-level recommendations and 25 associated strategies which were referenced in the creation of this study's interview guide. Additionally, key elements of Frankel et al.'s (2017) Framework for Safe, Reliable, and Effective Care also informed interview questions. Reflections and insights gleaned from Aim 1 results helped ground some of these key concepts within the organizational context. A copy of the proposed interview guide can be found in Appendix F. A more detailed discussion of the processes surrounding the recruitment, data collection, and data analyses is presented in Chapter Six.

## **Protection of Human Participants**

The research process was supervised by the doctoral dissertation committee chair and committee, and adhered to the ethical standards for research involving human participants as outlined by the health system in which this study will take place. Before proceeding with data collection and analyses for all three aims, the researcher completed the online Collaborative Institutional Training Initiative (CITI) training as required by the study organization and by Portland State University (PSU). All data collection methods and instruments were submitted by the researcher to the organization's Institutional Review Board (IRB) through an e-IRB account for approval. PSU ceded IRB approval to the organization's IRB. The organization in which this study took place remains de-

identified at the organization's request, and all key identifying information obtained through both primary and secondary data collection was anonymized.

## **Conclusion**

Integrating the results from the quantitative and qualitative aspects of this study allowed for a joint and comprehensive view of the data (Clark & Ivankova, 2017). The quantitative data provided insights into the relationship between patient experience of disrespect/respect with staff perception of safety culture by unit and profession, whereas the interviews were meant to ascertain employee perceptions of culture of safety and non-physical harm within the larger context of patient safety; reviewing these data in a connected, integrated approach aimed to provide a more comprehensive foundation from which to draw conclusions from both methods and determine how they jointly addressed the overarching research question. All three aims were addressed by distinct methods that allowed the researcher to explore different and distinct aspects that related to the overarching research question. Collectively, the integration and synthesis of qualitative and quantitative results from all three aims allowed for a more comprehensive understanding of the distinct but interrelated concepts that will inform conclusions about the overarching research question. Chapters Four, Five, and Six discuss and synthesize the findings from Aims 1, 2, and 3. Chapter Seven presents overarching conclusions, recommendations, limitations, and implications for future research.

## **Chapter Four – Aim 1 Results**

### **Overview**

As introduced in the first three chapters, this research sought to explore how a multi-hospital health system recognizes and addresses preventable non-physical harm. This chapter describes the process carried out to investigate Aim 1, which characterized non-physical harm events. Following the results of the data analyses, a discussion of key findings, themes, and recommendations are presented. A broader discussion of the research implications, recommendations to key groups, study limitations, and suggestions for future research is presented in Chapter Seven.

### **Aim 1 Results: Characterizing Complaints/Grievances**

Aim 1 sought to characterize non-physical harm events from disrespect occurring across hospitals and units through application of the BIDMC incident analysis framework. The sections below describe the data collection, inclusion/exclusion process, and analyses.

#### **Sample and Data Collection**

To assess all complaints/grievances from 2021 (also referred to as “cases” throughout this chapter) logged within the Feedback module of Datix, eight Excel documents (by hospital) that outlined every complaint/grievance (per hospital, with eight total hospitals) were provided to the researcher by the Customer Care Team (CCT) nurse supervisor. Each of these lists included all complaints and grievances received from January 1, 2021-December 31, 2021 in all settings for the particular hospital, including



inpatient units/departments, outpatient settings (e.g., clinics, pharmacy, and laboratory), the emergency department, and ancillary departments (e.g., access services, parking, and volunteer services). This study included all complaints for 2021 rather than limiting the scope to inpatient units only, given that the complaint or harm experienced often had implications beyond how it was classified by organizational staff.

There were 1,037 cases across all eight hospitals from 2021 reviewed. It is presumed that the number of total cases captured in 2021 across the eight hospitals underrepresent the true extent of patient/family complaints and grievances. In looking at patient safety events reports as a comparison, which are typically reported by health care staff and represent incidents that could or did result in patient harm, it has been found that those events are typically underreported (Betsy Lehman Center for Patient Safety, 2022; Brown et al., 2018; Schulson et al., 2021). While the volume of event reporting can vary across hospitals and health systems, research has indicated that many hospitals receive anywhere from 5,000-15,000 patient safety event reports per year (Brown et al., 2018; Levtzion-Korach et al., 2010; Schulson et al., 2021). Based on the underreporting of patient safety events, and considering the drawbacks of mechanisms in which patients and families can report complaints or grievances, it is also likely that the 1,037 complaints and grievances across eight hospitals are indicative of underreporting. However, the existing complaint and grievance data available was sufficient to carry out Aim 1.

Each of the eight lists displayed the same information, including the complaint reference number that the researcher used to look up each case in Datix, the case type (categorized as complaint, abuse allegation, or formal grievance; this classification has

internal organizational implications, as it determines timelines and expectations for investigation and follow-up), primary subject category, primary sub-subject/secondary category (which were developed by internal CCT staff based on their characterization of complaints, with the categories validated by executive organizational leadership), and the primary department/clinic/location. Although the primary location field indicates from where the grievance or complaint was generated, it did not necessarily represent the only setting in which the patient or family member experienced dissatisfaction during the patient visit. Given that each case record within Datix contained a variable amount of information and corresponding attachments (which will be described in more detail below), it was most appropriate for the CCT supervisor to provide the lists with each case reference number so that the researcher could access each case record within Datix, allowing for repeated access as needed to continue capturing information as part of the analysis.

The researcher expanded the spreadsheets provided by adding the same columns to each of the eight lists of complaints/grievances to collect key information for each case as available, including:

1. “Core description of the complaint/grievance” (the shorter summary/description of each event);
2. “Additional detail on the case” (additional narrative provided in the record on the particular case);
3. “Who initiated contact” (the source/who filed the complaint or grievance with the organization);
4. “Method of contact” (which methods were primarily used for filing complaints/ grievances);
5. “Letter or additional attachments provided” (additional information that could be accessed to support subsequent analysis).

The information used to complete these columns came directly from the case record and did not require the researcher to make any assumptions to complete each column.

The researcher then created columns in each of the spreadsheets that corresponded to the BIDMC Prioritization Schema (see Figure 4.1 below, also referenced in Appendix A). These allowed the researcher to determine, for each case, whether the case would be excluded or included for further analysis; subsequent analyses using the BIDMC incident analysis framework were conducted for cases that met criteria for inclusion, as defined by the BIDMC Prioritization Schema in Figure 4.1 below.

**Figure 4.1: BIDMC’s Standardized Prioritization Schema**

**BIDMC’s Standardized Prioritization Schema for patient-family complaints and grievances**

| <b>High risk factors – investigate and discuss events where ≥1 apply</b>   |
|--|
| <input type="checkbox"/> Patient/family stated intent to not return/recommend: <i>“I’m never going back to that doctor/your hospital”</i>  |
| <input type="checkbox"/> Patients that regularly experience inequities: people of color, limited English proficiency or health literacy, those that identify themselves as a member of an LGBTQ community, immigrant with tenuous legal status, unbefriended patients, those with disabilities, etc. |
| <input type="checkbox"/> Regulatory: e.g. DPH notified   |
| <input type="checkbox"/> Reputational: e.g. social media posting, shared with TV station, completed survey negatively, etc.  |
| <input type="checkbox"/> Malpractice risk: stated intent to sue  |
| <input type="checkbox"/> Reckless/egregious/intentional behavior by professional(s)  |
| <input type="checkbox"/> Other concerning behavior by professional(s): Sub-standard care, doesn’t pass “substitution test”, or there is a pattern of persistent “at-risk” behavior   |
| <input type="checkbox"/> Failure of post-death body management   |
| <b>Moderate risk factors – investigate and discuss events where ≥2 apply</b>   |
| <input type="checkbox"/> Patient/family describe experience in terms of “disrespect,” “indignity,” or loss of trust  |
| <input type="checkbox"/> Multiple additive issues occurred: i.e. a “thousand small cuts”, where one bad experience is followed by several more   |
| <input type="checkbox"/> Patient didn’t end up getting the service/care for which they came: e.g. never saw MD   |
| <input type="checkbox"/> Problems caused by the event are not “fixable”: e.g. irreplaceable item with sentimental value was lost   |
| <input type="checkbox"/> Event had multiple impacts: physical, emotional, financial, etc   |
| <input type="checkbox"/> Care team failed to respond appropriately after an event that had a negative impact on a patient-family: Care team knew about impact but didn’t apologize for the experience (e.g. <i>“I’m so sorry this happened to you”</i> )   |
| <input type="checkbox"/> Vulnerable: Physical frailty from health status: e.g. needs assistance to mobilize, or bed-bound  |
| <input type="checkbox"/> Vulnerable: Patients with confusion or cognitive impairment: e.g. delirium, dementia  |
| <input type="checkbox"/> Vulnerable: Evidence of significant anxiety or stress preceding the event: e.g. anxiety prior to an Oncology appointment where a biopsy result will be discussed  |
| <input type="checkbox"/> Event has a high likelihood of recurrence and risk of harm: based on Patient Safety/Relations judgment  |
| <b>Low risk – low priority to discuss individual cases, but document &amp; aggregate all to identify themes</b>  |
| <input type="checkbox"/> Patient/family indicate the event had no impact, or a minimal/short-term impact: e.g. <i>“I’m fine”</i>   |
| <input type="checkbox"/> Patient/family having trouble getting the patient’s medical records or an amendment, or an appointment  |
| <input type="checkbox"/> Patient/family with questions about their medical bills   |
| <input type="checkbox"/> Event not related to the patient’s care experience: e.g. problems with belongings, cafeteria, parking, etc.   |

The spreadsheet columns corresponding to the BIDMC Prioritization Schema were:

1. “High risk factors”;
2. “Moderate risk factors”;
3. “Second moderate risk factors”;
4. “Low risk factors”; and
5. “Additional detail on risk factors” (that allowed the researcher to input any notes or observations for future use).

The researcher built drop-down options in each of the case rows for the “high risk factors”, “moderate risk factors”, “second moderate risk factors”, and “low risk factors” boxes that matched the BIDMC Prioritization Schema. In addition to inputting the corresponding values under each respective “risk factory category”, the researcher also included “n/a” as a value option when a case did not have any values. The “additional detail on risk factors” category was included to capture free-form notes on each case’s applicability to the different levels of risk in the prioritization schema, and/or any observations on the schema itself when applied to cases. Tables 4.3 – 4.5 later in this chapter provide the results from the prioritization exercise.

Ultimately there were 39 columns in each of the eight hospital spreadsheets, presented in Table 4.1 below. All 39 columns were not necessarily completed for each case; their use and applicability were dependent on the information available in Datix for each case, and whether the particular case met the BIDMC Prioritization Schema criteria for inclusion, which led to subsequent analysis using the BIDMC incident analysis framework. An example of a compressed version of a spreadsheet is included in Appendix C.

**Table 4.1: Information Captured for Cases within Hospital Spreadsheets**

| Column Headers within Each Hospital Spreadsheet   | Purpose of Header / Information Gleaned   |
|---|---|
| <ol style="list-style-type: none"> <li>1. Reference number</li> <li>2. Feedback type (complaint, grievance, abuse allegation)</li> <li>3. Primary subject</li> <li>4. Sub-subject</li> <li>5. Department/clinic/location</li> <li>6. Description of event (from Datix)</li> <li>7. Comments/additional detail (from Datix)</li> <li>8. Origin of complaint/grievance</li> <li>9. Method/modality of contact</li> <li>10. Letter or attachments with additional details</li> <li>11. Level of detail in Datix (low, medium, high)</li> </ol>   | <p>Provided information regarding the actual case (complaint/grievance/abuse allegation), location, source, and supporting documentation outlining the event all from Datix.</p>  |
| <ol style="list-style-type: none"> <li>12. High risk factors</li> <li>13. Moderate risk factors</li> <li>14. Second moderate risk factors</li> <li>15. Low risk factors</li> <li>16. Additional detail on risk factors</li> <li>17. Included or excluded</li> <li>18. Rationale</li> </ol>  | <p>Pulled directly from the BIDMC schema in <b>Figure 4.1</b> above. Allowed researcher to document which factors applied to each case; led to ultimate determination of whether the case was included or excluded for subsequent analysis using the BIDMC framework.</p>   |
| <ol style="list-style-type: none"> <li>19. COVID-19 factors?</li> <li>20. Complaint/grievance substantiated? (determined/ documented by internal CCT staff resulting from internal investigation)</li> <li>21. Consideration for framework or schema (notes)</li> <li>22. Good case study to reference (notes)</li> </ol>   | <p>Additional information/context that was of interest to the researcher. There was a checkbox in each record indicating if the case was related to COVID-19; the researcher used this checkbox and own judgment, based on available documentation, to determine if the case had a COVID-19 element. For the “complaint/ grievance substantiated?” column, the researcher relied solely on the organization’s documentation around whether the complaint/grievance was “substantiated, partly, or not substantiated.”</p> |
| <ol style="list-style-type: none"> <li>23. Care process(es)</li> <li>24. Second care process(es)</li> <li>25. Notes/additional care process(es)</li> <li>26. Professional/organizational behaviors</li> <li>27. Second professional/organizational behaviors</li> <li>28. Notes/additional professional or organizational behavior(s)</li> <li>29. Contributing factors</li> <li>30. Second contributing factors</li> <li>31. Notes/additional contributing factor(s)</li> <li>32. Modifying factors</li> <li>33. Second modifying factors</li> <li>34. Notes/additional modifying factor(s)</li> <li>35. Potential consequences</li> <li>36. Second potential consequences</li> <li>37. Third potential consequences</li> <li>38. Notes/additional potential consequence(s)</li> <li>39. Opportunities to improve quality or safety</li> </ol> | <p>These columns reflect the core categories within the BIDMC incident analysis framework (Figure 4.3); researcher added “second” and/or “third” columns for each category in the event that a case had several factors for each category, as well as a “notes” section for additional observations to be captured freehand.</p>  |

## **Datix System and Overview of Data Analysis Process**

Each case (complaint/grievance/allegation) had a unique reference number that was used to search for cases within the Datix system. The researcher proceeded case-by-case and entered each reference ID number for each case in the Feedback module search box. Once in the individual case event file, each tab was reviewed to gather all information associated with each case. All cases had the same format and standard eight tabs available within Datix, although information was not always available in each tab and varied widely in terms of the level of detail provided by internal (organizational) staff.

No identifying information was collected (e.g., patient/staff names, date of birth, contact information) in the spreadsheets to maintain confidentiality; if the complaint/grievance named particular staff members, patient/family names, room numbers, or similar information, the researcher de-identified these (e.g., “Physician 1”). Each of the tabs in each case file within Datix included the elements listed in Table 4.2 below.

**Table 4.2: Datix System and Scope of Information Captured**

| <b>Tabs within Datix (for each case record)</b>                 | <b>Description of Information Available</b>  |
|---|--|
| <b>Feedback (event) overview</b>                                | <p>Within this tab, there were several fields, including:</p> <ul style="list-style-type: none"> <li>• A checkbox indicating if the event was associated with COVID-19</li> <li>• Name of person affected and date reported</li> <li>• Current status and organizational “owner”</li> <li>• Person providing feedback (e.g., patient, family, legal representative)</li> <li>• Snapshot of where the event took place <ul style="list-style-type: none"> <li>○ Service/setting type (hospital, clinic, lab, etc.)</li> <li>○ Reporting site/entity (hospital name)</li> <li>○ Department/unit/clinic/location of incident</li> </ul> </li> <li>• Details of feedback <ul style="list-style-type: none"> <li>○ When the complaint was received, event date, and description</li> <li>○ Method of contact (e.g., e-mail, telephone, in-person)</li> <li>○ Type of case (e.g., complaint, grievance, or abuse allegation)</li> <li>○ Required response timeframe (depending on type of case)</li> </ul> </li> </ul> |
| <b>Subjects</b>   | <p>This tab indicated the primary, overarching category/subject that the incident fit into (e.g., abuse allegation, discharge, communication), then provided a more detailed sub-subject, staff types, and subject notes history. The bulk of the information on the case was typically listed in this tab.</p>  |
| <b>Involved staff</b>   | <p>This tab listed all witnesses/others involved, including their role, and a separate section if the reporter was a resident physician, fellow, or student.</p>   |
| <b>Management review</b>  | <p>This tab outlined a series of checkboxes of the investigation components:</p> <ul style="list-style-type: none"> <li>○ Interviews conducted</li> <li>○ Discussions with care team</li> <li>○ Discussions with patient</li> <li>○ Examined physical location</li> <li>○ Reviewed policies/procedures, medical chart, and other (e.g., reviewed security video footage)</li> </ul> <p>This tab also included investigation findings/follow-up notes from members of the CCT team as well as leaders and physicians involved in the investigation.</p>   |
| <b>Overall outcomes (includes substantiation determination)</b> | <p>This tab included fields outlining the outcome and any additional actions taken. This tab also included a dropdown field that indicated whether the complaint/grievance was deemed “not substantiated”, “partly substantiated”, or “fully substantiated” based on organizational analysis/formal investigation. This field was often left blank which the researcher noted as “n/a” in data collection. This tab also included outcome history notes, and date the case was closed, reopened, and/or appealed (if applicable).</p>  |
| <b>Quality/Risk Management notes</b>                            | <p>This tab had a free-text space for Quality/Risk notes, and often was left blank and/or the information was captured elsewhere with the record.</p>  |
| <b>Payments</b>   | <p>This tab indicated notes of whether the organization covered a portion or the full visit and was left blank if not applicable.</p>  |
| <b>Documents and templates</b>                                  | <p>This tab included formal communication responses to patients/families, original source documents of communication (e.g., emails or scanned letters) from families, surveys, and/or regulatory agencies (if applicable), memos or communication exchanges to leadership, and interview/investigation notes, including an “abuse allegation toolkit” for alleged abuse incidents. Information contained in this tab was event-specific; many cases had very few or no attachments, making it more difficult to glean information, whereas other cases had substantial documentation in this tab.</p>  |

## **Inclusion/Exclusion of Cases Using the BIDMC Prioritization Schema**

There were 1,037 cases in 2021 across all eight hospitals that were reviewed; the researcher did not automatically screen out any cases from the original sample provided. Using the information available in each case record within Datix, the researcher used the BIDMC Prioritization Schema to evaluate how many high risk, moderate risk, and low risk factors were applicable in each case; this determined whether a case would be included or excluded for subsequent analysis using the BIDMC incident analysis framework. Following the guidance from the BIDMC Prioritization Schema (Figure 4.1 above), if a case met one or more criteria in the “high risk” category, and/or two or more criteria in the “moderate risk” category, the case was included for subsequent analysis and an “I” was noted in the “Included/Excluded” column in each spreadsheet. If a case did not meet criteria outlined in the BIDMC Prioritization Schema by only meeting “low risk” factors, one or less “moderate risk” factor, if there was insufficient information in Datix to make a true assessment of inclusion/exclusion, and/or if it was determined that subsequent analysis would not be possible with the limited information available, the case was excluded and an “E” was noted in the “Included/Excluded” column.

The amount of information as well as the quality of information captured varied considerably depending on the case, so the researcher reviewed each tab within each record to ensure all available documentation was considered. The researcher classified cases with “low” level of detail in Datix if there was documentation in 3 or fewer tabs within Datix; as “medium” if there was documentation/narrative in more than 3 tabs including limited or no additional attachments; or “high” if there were additional materials attached to the case file, as well as detailed documentation surrounding the



issue and investigation throughout most, if not all, of the eight tabs. The amount of information in each tab varied considerably, so it was possible that even if a case only had documentation in a few tabs, it could have had sufficient notes within those few tabs as opposed to spread across all eight tabs. Table 4.3 below illustrates how many cases met each of the risk factors across the eight hospitals.

**Table 4.3: Application of BIDMC’s Prioritization Schema: High Risk Factors (n= 1,037 cases)**

| High Risk Factors                                  | Hosp. 1<br>n= 320 | Hosp. 2<br>n=253 | Hosp. 3<br>n=107 | Hosp. 4<br>n=98 | Hosp. 5<br>n=65 | Hosp. 6<br>n=45 | Hosp. 7<br>n=50 | Hosp. 8<br>n=99 | Total<br>n=1037 |
|--|-------------------|------------------|------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Other concerning behavior                          | 18<br>(6%)        | 30<br>(12%)      | 10<br>(9%)       | 7<br>(7%)       | 3<br>(5%)       | 0<br>(0%)       | 2<br>(2%)       | 3<br>(3%)       | 73<br>(7%)      |
| Experience inequities                              | 12<br>(4%)        | 16<br>(6%)       | 4<br>(4%)        | 1<br>(2%)       | 0<br>(0%)       | 1<br>(2%)       | 2<br>(4%)       | 0<br>(0%)       | 36<br>(4%)      |
| Intent to not return/<br>recommend                 | 3<br>(<1%)        | 7<br>(3%)        | 2<br>(1.9%)      | 2<br>(2%)       | 2<br>(3%)       | 2<br>(4.4%)     | 4<br>(8%)       | 7<br>(7%)       | 29<br>(3%)      |
| Regulatory   | 4<br>(1%)         | 5<br>(2%)        | 2<br>(2%)        | 3<br>(3%)       | 1<br>(1.5%)     | 0<br>(0%)       | 1<br>(2%)       | 2<br>(2%)       | 18<br>(2%)      |
| Malpractice risk                                   | 0<br>(0%)         | 5<br>(2%)        | 2<br>(2%)        | 1<br>(1%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 8<br>(<1%)      |
| Reckless/<br>egregious/<br>intentional<br>behavior | 2<br>(<1%)        | 5<br>(2%)        | 0<br>(0%)        | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 1<br>(1%)       | 8<br>(<1%)      |
| Failure of<br>post-death<br>body<br>management     | 2<br>(<1%)        | 1<br>(<1%)       | 0<br>(0%)        | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 2<br>(2%)       | 5<br>(<1%)      |
| Reputational                                       | 0<br>(0%)         | 3<br>(1%)        | 0<br>(0%)        | 0<br>(0%)       | 0<br>(0%)       | 1<br>(2%)       | 0<br>(0%)       | 1<br>(1%)       | 5<br>(<1%)      |
| n/a  | 277<br>(87%)      | 181<br>(72%)     | 87<br>(81%)      | 85<br>(87%)     | 59<br>(91%)     | 42<br>(93%)     | 41<br>(82%)     | 83<br>(84%)     | 855<br>(82%)    |

*Note: numbers may not add up to the total ‘n’ for each hospital as each case could have multiple high risk factors, one, or none.*

Of the 1,037 cases reviewed, there were 171 cases (16%) that had high risk factors present, with 11 individual cases having more than one high risk factor present, indicating that there were 182 instances of high risk factors resulting from the care

interaction. The three high risk factors that were found most often were: 1) other concerning behavior by professionals (73 cases, or 7%), 2) patients that regularly experienced inequities (36 cases, or 3%), and 3) patients/families stated their intent to never return and/or recommend to others (29 cases, or 3%). Cases that were coded as having “other concerning behavior” often reflected patient/family concerns of inappropriate behavior by staff during their care interaction. Further reflections around the “inequities” high risk factor are outlined in the discussion section below.

Table 4.4 below displays the results for cases that met moderate risk factors. There were 248 cases (24%) that had two or more moderate risk factors present; in total, there were 1,041 instances of moderate risk factors identified within the 1,037 cases reviewed across all eight hospitals. The four moderate risk factors that were found most frequently were: 1) event had multiple impacts: physical, emotional, financial, etc. (324 cases, or 31%), 2) patient did not get the service/care for which they came (232 cases, or 22%), 3) multiple additive issues occurred, where one bad experience was followed by several more (195 cases, or 19%), and 4) patient/family described their experience in terms of “disrespect”, “indignity”, or loss of trust (95 cases, or 9%).

**Table 4.4: Application of BIDMC’s Prioritization Schema: Moderate Risk Factors (n=1,037)**

| <b>Moderate Risk Factors</b>                                       | <b>Hosp. 1<br/>n= 320</b> | <b>Hosp. 2<br/>n=253</b> | <b>Hosp. 3<br/>n=107</b> | <b>Hosp. 4<br/>n=98</b> | <b>Hosp. 5<br/>n=65</b> | <b>Hosp. 6<br/>n=45</b> | <b>Hosp. 7<br/>n=50</b> | <b>Hosp. 8<br/>n=99</b> | <b>Total<br/>n=1037</b> |
|--|---------------------------|--------------------------|--------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| Multiple impacts   | 124<br>(39%)              | 72<br>(29%)              | 29<br>(27%)              | 29<br>(30%)             | 23<br>(35%)             | 3<br>(7%)               | 15<br>(30%)             | 29<br>(29%)             | 324<br>(31%)            |
| Did not get care for which they came                               | 62<br>(19%)               | 54<br>(21%)              | 33<br>(31%)              | 29<br>(30%)             | 11<br>(17%)             | 3<br>(7%)               | 15<br>(30%)             | 25<br>(25%)             | 232<br>(22%)            |
| Multiple additive issues occurred                                  | 65<br>(20%)               | 43<br>(17%)              | 20<br>(18%)              | 19<br>(19%)             | 12<br>(19%)             | 8<br>(18%)              | 3<br>(6%)               | 25<br>(25%)             | 195<br>(19%)            |
| Experience described using disrespect, indignity, or loss of trust | 30<br>(9%)                | 19<br>(8%)               | 13<br>(12%)              | 7<br>(7%)               | 8<br>(12%)              | 7<br>(16%)              | 3<br>(6%)               | 8<br>(8%)               | 95<br>(9%)              |
| Inappropriate response from care team                              | 22<br>(7%)                | 12<br>(5%)               | 9<br>(8%)                | 12<br>(12%)             | 7<br>(11%)              | 1<br>(2%)               | 2<br>(4%)               | 2<br>(2%)               | 67<br>(7%)              |
| High likelihood of recurrence and risk of harm                     | 10<br>(3%)                | 9<br>(4%)                | 6<br>(6%)                | 3<br>(3%)               | 6<br>(9%)               | 1<br>(2%)               | 4<br>(8%)               | 1<br>(1%)               | 40<br>(4%)              |
| Vulnerable pt. with confusion or cog. Impairment                   | 8<br>(3%)                 | 11<br>(4%)               | 4<br>(4%)                | 7<br>(7%)               | 3<br>(5%)               | 0<br>(0%)               | 1<br>(2%)               | 6<br>(6.1%)             | 40<br>(4%)              |
| Vulnerable pt. with evidence of anxiety or stress                  | 7<br>(2%)                 | 8<br>(3%)                | 1<br>(<1%)               | 2<br>(2%)               | 2<br>(3%)               | 3<br>(7%)               | 2<br>(4%)               | 1<br>(1%)               | 26<br>(3%)              |
| Problems caused are not “fixable”                                  | 4<br>(1%)                 | 5<br>(2%)                | 0<br>(0%)                | 1<br>(1%)               | 0<br>(0%)               | 0<br>(0%)               | 1<br>(2%)               | 1<br>(1%)               | 12<br>(1%)              |
| Vulnerable pt. physical frailty                                    | 1<br>(<1%)                | 6<br>(2%)                | 0<br>(0%)                | 0<br>(0%)               | 1<br>(2%)               | 0<br>(0%)               | 1<br>(2%)               | 1<br>(1%)               | 10<br>(<1%)             |

*Note: numbers will not add up to the total ‘n’ for each hospital as each case could have multiple moderate risk factors, one, or none.*

Table 4.5 below displays the results of cases that met low risk factors; 259 low risk factors were found (in 27% of the 1,037 cases). Eighteen cases (2%) had more than one low risk factor present.

**Table 4.5: Application of BIDMC’s Prioritization Schema: Low Risk Factors  
(n=1,037 cases)**

| <b>Low Risk Factors</b>                                    | <b>Hosp. 1<br/>n= 320</b> | <b>Hosp. 2<br/>n=253</b> | <b>Hosp. 3<br/>n=107</b> | <b>Hosp. 4<br/>n=98</b> | <b>Hosp. 5<br/>n=65</b> | <b>Hosp. 6<br/>n=45</b> | <b>Hosp. 7<br/>n=50</b> | <b>Hosp. 8<br/>n=99</b> | <b>Total<br/>n=1037</b> |
|--|---------------------------|--------------------------|--------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| Medical bill questions                                     | 51<br>(16%)               | 43<br>(17%)              | 18<br>(17%)              | 18<br>(18%)             | 9<br>(14%)              | 0<br>(0%)               | 8<br>(16%)              | 11<br>(11%)             | 158<br>(15%)            |
| Difficulty with medical records or appointment             | 11<br>(3%)                | 22<br>(9%)               | 6<br>(6%)                | 1<br>(1%)               | 5<br>(8%)               | 4<br>(9%)               | 4<br>(8%)               | 4<br>(4%)               | 57<br>(6%)              |
| Event not related to care experience                       | 9<br>(3%)                 | 14<br>(6%)               | 2<br>(2%)                | 5<br>(5%)               | 0<br>(0%)               | 0<br>(0%)               | 2<br>(4%)               | 4<br>(4%)               | 36<br>(4%)              |
| No, minimal, or short-term impact indicated by pt./ family | 3<br>(<1%)                | 5<br>(2%)                | 0<br>(0%)                | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 8<br>(<1%)              |
| n/a  | 246<br>(77%)              | 169<br>(67%)             | 81<br>(76%)              | 74<br>(77%)             | 51<br>(79%)             | 18<br>(40%)             | 36<br>(72%)             | 80<br>(81%)             | 755<br>(73%)            |

*Note: numbers will not add up to the total ‘n’ for each hospital as each case could have multiple risk factors, one, or none.*

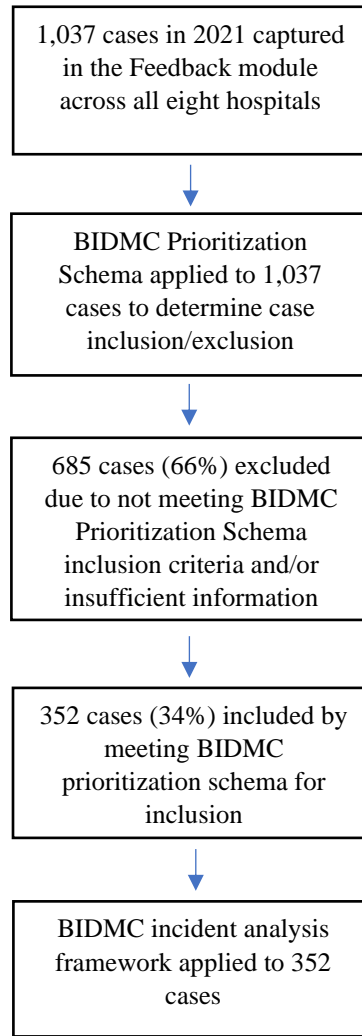
The low risk factor that was identified most often among reviewed cases was patients/families having questions about or disputing their medical bill (158 cases, or 15%). If a case only met low risk factors, it was not included for subsequent analysis; however, some cases met several moderate and/or high risk factors in addition to a low risk factor, which necessitated their inclusion. Out of the 352 included cases, 29 (8%) also had a low risk factor in addition to high and/or moderate risk factors. While billing issues were classified as a low risk factor, the review revealed that approximately 8% of all cases that had a billing factor as a low risk factor (13 of the 158 cases that had billing as an element) met the criteria for inclusion due to greater issues found with the person’s care experience; for these cases, the billing component was secondary, and the larger

issue either met high risk or medium risk factors first, which led patients/families to dispute their bill.

As noted in Table 4.1 above, the researcher captured the final outcome of the complaint or grievance (not substantiated, partly substantiated, or fully substantiated) as determined and documented by the organization; however, the outcome determined by the organization had no bearing on whether the case was included or excluded for this research given that regardless of the outcome, the patient/family felt dissatisfied, disrespected, frustrated, and/or upset about the situation. Additionally, the internal organizational investigation of a complaint/grievance focused foremost on the appropriateness of care delivery, clinical care, and adherence to standards of care, policies, and protocols, as opposed to the perception of care or experience felt by the patient/family. The organization generated a form letter tailored to each patient/family member in response to complaints, grievances, and abuse allegations received that acknowledged the patient/family's experience and, in certain circumstances, outcomes of the investigation. Additionally, 523 of the 1,037 cases (50%) did not have the formal outcome documented within Datix, further reinforcing the decision not to use the organization's degree of substantiation as a factor in inclusion/exclusion.

Of the 1,037 cases, 352 cases (34%) met criteria for inclusion based on application of the BIDMC Prioritization Schema (Figure 4.2). BIDMC's incident analysis framework was then applied to the 352 cases for subsequent analysis.

**Figure 4.2: Case Selection Flow Diagram**



While 34% of all cases met inclusion criteria for subsequent analysis using BIDMC’s incident analysis framework, this did not suggest that only those complaints/grievances in 2021 reflected non-physical harm from disrespect. Many cases were excluded due to limited information that would make application of the BIDMC framework difficult or unrealistic. Collectively across all eight hospitals, 76% of cases (784 of 1,037 cases) were classified as having a “low” or minimal amount of information,

214 had a “medium” amount of information (21%), and only 4% of cases (39 cases) were determined to have a “high” amount of information. All 39 cases classified as having a “high” amount of information were included for subsequent analyses (100% met inclusion criteria), 156 of the 214 cases having a “medium” amount of information (73%) met inclusion criteria, and only 20% of cases (157 of the 784 cases) having “low” or minimal detail met inclusion criteria for subsequent analyses; these proportions represent the breakdown of the 352 included cases.

Limited information in the Datix record was due to a number of observed reasons including: the documentation of information provided directly from the patient was minimal, the management investigation (and/or documentation of the investigation) was limited, the staff were unable to reach the patient/family for additional follow-up, and/or no referenced original source document (e.g., letter or e-mail) was attached in the Datix file. Additionally, in some circumstances, the patient’s experience was broadly and/or too generically summarized by the intake team in the Datix record (i.e., “the patient was upset about their care”), the documented summary provided insufficient detail to meet inclusion criteria, and/or had inadequate information in the patient/family member’s voice to allow for subsequent analysis using the BIDMC incident analysis framework.

### **Describing the Nature of Complaints/Grievances/Allegations**

Table 4.6 below presents all the 2021 cases (including how they were categorized by the organization by complaint/formal grievance/abuse allegation) across each of the eight hospitals.

**Table 4.6: Descriptive Summary of Cases by Hospital**

|  | Hosp.<br>1          | Hosp.<br>2          | Hosp.<br>3          | Hosp.<br>4         | Hosp.<br>5        | Hosp.<br>6        | Hosp.<br>7        | Hosp.<br>8         | Total                  |
|--|---------------------|---------------------|---------------------|--------------------|-------------------|-------------------|-------------------|--------------------|------------------------|
| <b>Total cases in 2021 logged within Datix</b> | <b>320</b><br>(31%) | <b>253</b><br>(24%) | <b>107</b><br>(10%) | <b>98</b><br>(10%) | <b>65</b><br>(6%) | <b>45</b><br>(4%) | <b>50</b><br>(5%) | <b>99</b><br>(10%) | <b>1,037</b><br>(100%) |
| <b>Formal grievances</b>                       | 208<br>(65%)        | 140<br>(55%)        | 72<br>(67%)         | 68<br>(69%)        | 47<br>(72%)       | 24<br>(53%)       | 28<br>(56%)       | 67<br>(68%)        | 654<br>(63%)           |
| <b>Complaints</b>                              | 94<br>(29%)         | 92<br>(36%)         | 28<br>(26%)         | 25<br>(26%)        | 16<br>(25%)       | 21<br>(47%)       | 21<br>(42%)       | 31<br>(31%)        | 328<br>(32%)           |
| <b>Abuse allegations</b>                       | 18<br>(6%)          | 21<br>(8%)          | 7<br>(7%)           | 5<br>(5%)          | 2<br>(3%)         | 0<br>(0%)         | 1<br>(2%)         | 1<br>(1%)          | 55<br>(5%)             |

Table 4.7 outlines the breakdown of cases and how they were assigned to primary subject categories by the organization; the CCT tagged each complaint/grievance case using a primary subject category. The two most prevalent categories across all eight hospitals were “care quality” (44% of all cases), and “staff attitude/behavior” (17% of all cases).



**Table 4.7: Primary Categorization Across All Cases**

|                                       | Hosp.<br>1<br>n=320 | Hosp.<br>2<br>n=253 | Hosp.<br>3<br>n=107 | Hosp.<br>4<br>n=98 | Hosp.<br>5<br>n=65 | Hosp.<br>6<br>n=45 | Hosp.<br>7<br>n=50 | Hosp.<br>8<br>n=99 | Total<br>n=<br>1,037 |
|---------------------------------------|---------------------|---------------------|---------------------|--------------------|--------------------|--------------------|--------------------|--------------------|----------------------|
| <b>Care quality</b>                   | 145<br>(45%)        | 96<br>(38%)         | 45<br>(42%)         | 46<br>(47%)        | 33<br>(51%)        | 16<br>(36%)        | 23<br>(46%)        | 47<br>(47%)        | 451<br>(44%)         |
| <b>Attitude/<br/>behavior</b>         | 46<br>(14%)         | 39<br>(15%)         | 18<br>(17%)         | 22<br>(22%)        | 8<br>(12%)         | 13<br>(29%)        | 7<br>(14%)         | 22<br>(22%)        | 175<br>(17%)         |
| <b>Comm.</b>                          | 29<br>(9%)          | 24<br>(10%)         | 7<br>(7%)           | 7<br>(7%)          | 8<br>(12%)         | 4<br>(9%)          | 3<br>(6%)          | 7<br>(7%)          | 89<br>(9%)           |
| <b>Access to<br/>care</b>             | 20<br>(6%)          | 27<br>(11%)         | 8<br>(8%)           | 7<br>(7%)          | 4<br>(6%)          | 3<br>(7%)          | 6<br>(12%)         | 10<br>(10%)        | 85<br>(8%)           |
| <b>Billing</b>                        | 18<br>(6%)          | 17<br>(7%)          | 11<br>(10%)         | 4<br>(4%)          | 7<br>(11%)         | 6<br>(13%)         | 3<br>(6%)          | 5<br>(5%)          | 71<br>(7%)           |
| <b>Abuse<br/>allegation</b>           | 18<br>(6%)          | 21<br>(8%)          | 7<br>(7%)           | 5<br>(5%)          | 2<br>(3%)          | 0<br>(0%)          | 1<br>(2%)          | 1<br>(1%)          | 55<br>(5%)           |
| <b>Care<br/>coord.</b>                | 17<br>(5.3%)        | 14<br>(5.5%)        | 3<br>(3%)           | 2<br>(2%)          | 1<br>(2%)          | 2<br>(4%)          | 5<br>(10%)         | 3<br>(3%)          | 47<br>(5%)           |
| <b>Patient<br/>rights</b>             | 13<br>(4%)          | 4<br>(2%)           | 1<br>(<1%)          | 1<br>(1%)          | 1<br>(2%)          | 0<br>(0%)          | 1<br>(2%)          | 3<br>(3%)          | 24<br>(2%)           |
| <b>Environ./<br/>Facilities</b>       | 3<br>(<1%)          | 7<br>(3%)           | 2<br>(2%)           | 2<br>(2%)          | 1<br>(2%)          | 0<br>(0%)          | 0<br>(0%)          | 0<br>(0%)          | 15<br>(1%)           |
| <b>Discrim.</b>                       | 5<br>(2%)           | 3<br>(1%)           | 3<br>(3%)           | 1<br>(1%)          | 0<br>(0%)          | 0<br>(0%)          | 1<br>(2%)          | 0<br>(0%)          | 13<br>(1%)           |
| <b>Medical<br/>records</b>            | 4<br>(1%)           | 1<br>(<1%)          | 2<br>(2%)           | 1<br>(1%)          | 0<br>(0%)          | 1<br>(2%)          | 0<br>(0%)          | 1<br>(1%)          | 10<br>(1%)           |
| <b>Lost/<br/>damaged<br/>property</b> | 2<br>(<1%)          | 2<br>(<1%)          | 0<br>(0%)           | 0<br>(0%)          | 0<br>(0%)          | 0<br>(0%)          | 0<br>(0%)          | 0<br>(0%)          | 4<br>(<1%)           |
| <b>Dietary<br/>Services</b>           | 0<br>(0%)           | 1<br>(<1%)          | 0<br>(0%)           | 0<br>(0%)          | 0<br>(0%)          | 0<br>(0%)          | 0<br>(0%)          | 0<br>(0%)          | 1<br>(<1%)           |

Table 4.8 presents the breakdown of how the 352 cases were categorized by complaint/formal grievance/abuse allegation across each of the eight hospitals. Of the 352 cases, 243 were classified as formal grievances (69%), 66 as complaints (19%), and 43 abuse allegations (12%).

**Table 4.8: Breakdown of Included Cases**

|                          | Hosp. 1<br>n=99 | Hosp. 2<br>n=118 | Hosp. 3<br>n=36 | Hosp. 4<br>n=28 | Hosp. 5<br>n=17 | Hosp. 6<br>n=19 | Hosp. 7<br>n=13 | Hosp. 8<br>n=22 | Total<br>n=352 |
|--------------------------|-----------------|------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|----------------|
| <b>Formal grievances</b> | 71<br>(72%)     | 73<br>(62%)      | 27<br>(75%)     | 21<br>(75%)     | 13<br>(76%)     | 12<br>(63%)     | 8<br>(62%)      | 18<br>(82%)     | 243<br>(69%)   |
| <b>Complaints</b>        | 17<br>(17%)     | 24<br>(20%)      | 4<br>(11%)      | 3<br>(11%)      | 3<br>(18%)      | 7<br>(37%)      | 4<br>(31%)      | 4<br>(18%)      | 66<br>(19%)    |
| <b>Abuse allegations</b> | 11<br>(11%)     | 21<br>(18%)      | 5<br>(14%)      | 4<br>(14%)      | 1<br>(6%)       | 0<br>(0%)       | 1<br>(8%)       | 0<br>(0%)       | 43<br>(12%)    |

Table 4.9 below highlights how included cases were categorized by the organization.

**Table 4.9: Primary Categorization Across “Included” Cases**

|                              | Hosp. 1<br>n=99 | Hosp. 2<br>n=118 | Hosp. 3<br>n=36 | Hosp. 4<br>n=28 | Hosp. 5<br>n=17 | Hosp. 6<br>n=19 | Hosp. 7<br>n=13 | Hosp. 8<br>n=22 | Total<br>n=352 |
|------------------------------|-----------------|------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|----------------|
| <b>Care quality</b>          | 38<br>(38%)     | 41<br>(35%)      | 15<br>(42%)     | 12<br>(43%)     | 11<br>(65%)     | 7<br>(37%)      | 3<br>(23%)      | 10<br>(45%)     | 137<br>(39%)   |
| <b>Attitude/behavior</b>     | 18<br>(18%)     | 27<br>(23%)      | 10<br>(28%)     | 6<br>(21%)      | 3<br>(18%)      | 8<br>(42%)      | 3<br>(23%)      | 6<br>(27%)      | 81<br>(23%)    |
| <b>Abuse allegation</b>      | 9<br>(9%)       | 18<br>(15%)      | 5<br>(14%)      | 4<br>(14%)      | 1<br>(6%)       | 0<br>(0%)       | 1<br>(8%)       | 0<br>(0%)       | 38<br>(11%)    |
| <b>Access to care</b>        | 5<br>(5%)       | 9<br>(8%)        | 1<br>(3%)       | 3<br>(11%)      | 0<br>(0%)       | 3<br>(16%)      | 3<br>(23%)      | 2<br>(1%)       | 26<br>(7%)     |
| <b>Comm.</b>                 | 9<br>(9%)       | 10<br>(9%)       | 0<br>(0%)       | 1<br>(4%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 2<br>(1%)       | 22<br>(6%)     |
| <b>Patient rights</b>        | 6<br>(6%)       | 4<br>(3%)        | 0<br>(0%)       | 0<br>(0%)       | 1<br>(6%)       | 0<br>(0%)       | 1<br>(8%)       | 1<br>(5%)       | 13<br>(4%)     |
| <b>Care coord.</b>           | 7<br>(7%)       | 1<br>(1%)        | 2<br>(6%)       | 1<br>(4%)       | 0<br>(0%)       | 1<br>(5%)       | 1<br>(8%)       | 0<br>(0%)       | 13<br>(4%)     |
| <b>Discrim.</b>              | 4<br>(4%)       | 3<br>(3%)        | 3<br>(8%)       | 1<br>(4%)       | 0<br>(0%)       | 0<br>(0%)       | 1<br>(8%)       | 0<br>(0%)       | 12<br>(3%)     |
| <b>Environ./Facilities</b>   | 1<br>(1%)       | 3<br>(3%)        | 0<br>(0%)       | 0<br>(0%)       | 1<br>(6%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 5<br>(1%)      |
| <b>Medical records</b>       | 2<br>(2%)       | 0<br>(0%)        | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 1<br>(5%)       | 3<br>(1%)      |
| <b>Billing</b>               | 0<br>(0%)       | 2<br>(2%)        | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 2<br>(<1%)     |
| <b>Dietary Services</b>      | 0<br>(0%)       | 0<br>(0%)        | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)      |
| <b>Lost/damaged property</b> | 0<br>(0%)       | 0<br>(0%)        | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)      |

Across all hospitals except Hospital 6, care quality was the most prevalent category across the included cases (similar to Table 4.7 across all 1,037 cases), with attitude/behavior as the second largest category. Hospital 2 had the highest amount of abuse allegations (18 of the 118 included cases, or 15%), and also the most included cases among the other hospitals; for both Hospitals 3 and 4, 14% of included cases (n=36 and n=28, respectively) were categorized as abuse allegations. These categories did not factor into the inclusion/exclusion process, nor the subsequent analysis for the included cases, but are included in Table 4.9 above to characterize the general nature of the cases.

Table 4.10 below highlights the distribution of included cases (inclusive of complaints/grievances/abuse allegations) by unique location (e.g., unit, department, or clinic), indicating where a complaint/grievance/allegation was logged. Given the variation in both number and type of departments, units, and locations across the eight hospitals, similar settings were grouped together in the table for simplicity and to keep hospital identities blinded. As a result, it is not indicated as “n/a” if a hospital does not have a particular unit.

**Table 4.10: Distribution of “Included” Complaints by Location**

| <b>Department / Location</b>  | <b>Hosp. 1<br/>n=99</b> | <b>Hosp. 2<br/>n=118</b> | <b>Hosp. 3<br/>n=36</b> | <b>Hosp. 4<br/>n=28</b> | <b>Hosp. 5<br/>n=17</b> | <b>Hosp. 6<br/>n=19</b> | <b>Hosp. 7<br/>n=13</b> | <b>Hosp. 8<br/>n=22</b> | <b>Total<br/>n=352</b> |
|---|-------------------------|--------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|------------------------|
| Emergency Department [ED] <i>(and Clinical Decision Unit, if applicable)</i>  | 37                      | 31                       | 17                      | 13                      | 11                      | 4                       | 4                       | 8                       | 125<br>(36%)           |
| Medical/ Surgical Units   | 26                      | 32                       | 4                       | 4                       | 3                       | 4                       | 0                       | 6                       | 79<br>(22%)            |
| Surgical Services <i>(Short Stay Unit [SSU], Operating Room [OR], Endoscopy, Post-anesthesia Care Unit [PACU], if applicable)</i> | 11                      | 14                       | 4                       | 1                       | 1                       | 0                       | 0                       | 4                       | 35<br>(10%)            |
| Critical Care <i>(Intensive Care Unit [ICU]/ Neuro Critical Care Unit [NCCU], Cardiovascular ICU [CVICU], if applicable)</i>      | 9                       | 3                        | 0                       | 2                       | 0                       | 1                       | 0                       | 1                       | 16<br>(5%)             |
| Behavioral Health <i>(IP &amp; OP, if applicable)</i>   | 3                       | 8                        | 4                       | 0                       | 0                       | 0                       | 0                       | 0                       | 15<br>(4%)             |
| Labor & Delivery/ Maternity Services <i>(if applicable)</i>   | 5                       | 4                        | 2                       | 0                       | 0                       | 2                       | 0                       | 0                       | 13<br>(4%)             |
| Ancillary Services <i>(lab, EEG/EKG, OP clinics, sleep lab, pharmacy, rehab, radiology/ diagnostic imaging)</i>                   | 4                       | 23                       | 5                       | 6                       | 1                       | 8                       | 8                       | 3                       | 58<br>(16%)            |
| Other/Non-Patient Care <i>(volunteer services, access services, security, cafeteria, parking)</i>                                 | 4                       | 3                        | 0                       | 2                       | 1                       | 0                       | 1                       | 0                       | 11<br>(3%)             |

The majority of complaints and grievances logged within Datix across all hospitals occurred in the emergency department (ED); 445 (43%) of all complaints and grievances across all 1,037 cases in 2021 occurred in the ED. Of the total 445 ED cases, Table 4.10 above highlights that 125 ED cases (36%) met BIDMC inclusion criteria. This may have been due to the unpredictability of the ED environment, variability of patient acuity, and breadth of patient presentations; as well, given that many ED patients return home sooner as opposed to being admitted to the hospital for additional care, they may be more inclined, and able, to submit a complaint or grievance.

Seventy-nine cases (22%) occurred on medical/surgical floors, 58 cases (16%) occurred in ancillary departments/settings, and 35 (10%) cases occurred across surgical services. As discussed in Chapter Two, while the literature highlighted the particular vulnerability of patients/families in critical care settings experiencing threats to respect and dignity (Brown et al., 2018), few complaints originated and/or were tagged to critical care units by organizational staff; 21 cases (2%) of all 1,037 cases occurred in critical care settings, including the ICU, CVICU, and NCCU. Among the 352 included cases, Table 4.10 above illustrates that 16 of the total 21 critical care cases (5%) met inclusion criteria. This does not suggest that disrespect did not occur in critical care units, but could have been low due to underreporting based on patients' medical conditions in critical care settings (e.g., too sick, intubated, sedated), the complexity of the unit setting (Brown et al., 2018), staff addressing complaints/grievances in the moment (and not subsequently logging them into Datix), and/or potentially related to how the internal organizational staff tagged the origin of the complaint or grievance.

Since the hospitals varied in size, hospital type, services offered, and unit/department/clinic types, and due to the number of locations that had complaints and grievances, only the core services/department types that were consistent across the majority (or all) of the eight hospitals were identified in Table 4.10; outpatient clinics and ancillary services, such as pharmacy, rehabilitation, laboratory, radiology, and imaging were combined together as one category for efficiency. It is recognized that each of these departments has their own particular workflows and care teams. Other/non-patient care settings (such as parking/valet services, the cafeteria, and volunteer services, among others) were combined into an overarching “other/non-patient care” category. Each of the locations included in the “other” category generally had a low volume of complaints/grievances but were nonetheless included in the sample to capture the full list of all complaints and grievances received during 2021. Further, the wide distribution of locations revealed that complaints and grievances occurred across the entire spectrum of care across these eight hospitals.

As shown in Table 4.10, 16% of included cases occurred in either outpatient clinics, or ancillary services, reinforcing how non-physical harm events can occur across care settings, including in outpatient settings and environments involving a variety of clinical and non-clinical workforce. While the location categories were helpful for an initial understanding of where the event was tagged by organizational staff, such categorization may be reductive. An event may have primarily occurred in one location, but in many circumstances events occurred over multiple locations, while in some cases location was not a relevant factor.

Table 4.11 below illustrates the level of substantiation deemed by internal (organizational) investigation; the organization employed the terminology “substantiated,” “partly substantiated,” and “not substantiated” within Datix, although in many cases this information was not documented. Only 8% of the 1,037 complaints/grievances were fully substantiated by the organization, 8.5% were partly substantiated, 33% were not substantiated, and 50% did not have this information documented.

**Table 4.11: Organizational Substantiation of Complaints/Grievances/Abuse Allegations**

|                           | Hosp. 1<br>n=320 | Hosp. 2<br>n=253 | Hosp. 3<br>n=107 | Hosp. 4<br>n=98 | Hosp. 5<br>n=65 | Hosp. 6<br>n=45 | Hosp. 7<br>n=50 | Hosp. 8<br>n=99 | Total<br>n=1037 |
|---------------------------|------------------|------------------|------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| <b>Yes</b>                | 21<br>(7%)       | 24<br>(10%)      | 7<br>(7%)        | 6<br>(6%)       | 8<br>(12%)      | 4<br>(9%)       | 6<br>(12%)      | 9<br>(9%)       | 85<br>(8%)      |
| <b>Partly</b>             | 31<br>(10%)      | 21<br>(8%)       | 11<br>(10%)      | 6<br>(6%)       | 5<br>(8%)       | 3<br>(7%)       | 3<br>(6%)       | 8<br>(8%)       | 88<br>(9%)      |
| <b>No</b>                 | 114<br>(36%)     | 77<br>(30%)      | 41<br>(38%)      | 35<br>(36%)     | 23<br>(35%)     | 7<br>(16%)      | 12<br>(24%)     | 32<br>(32%)     | 341<br>(33%)    |
| <b>Unknown (not doc.)</b> | 154<br>(48%)     | 131<br>(52%)     | 48<br>(45%)      | 51<br>(52%)     | 29<br>(45%)     | 31<br>(69%)     | 29<br>(58%)     | 50<br>(51%)     | 523<br>(50%)    |

Table 4.12 below outlines the same information for included cases, which is similar to Table 4.11 results; of the 352 included cases, 8% were fully substantiated by the organization, 12% were partly substantiated, 36% were not substantiated, and 44% did not have this outcome documented. As noted above, organizational determination of substantiation was not factored into inclusion/exclusion but was captured to demonstrate the distribution of substantiation. Within the included cases, approximately 20% of all cases were either partly or fully substantiated by the organization. Patient/family claims

were often determined to be “not substantiated” if internal investigation indicated the clinical care or appropriate standard of care was followed.

**Table 4.12: Organizational Substantiation of Complaints/Grievances/Abuse Allegations – Included Cases**

|                               | Hosp.<br>1<br>n=99 | Hosp.<br>2<br>n=118 | Hosp.<br>3<br>n=36 | Hosp.<br>4<br>n=28 | Hosp.<br>5<br>n=17 | Hosp.<br>6<br>n=19 | Hosp.<br>7<br>n=13 | Hosp.<br>8<br>n=22 | Total<br>n=352 |
|-------------------------------|--------------------|---------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|----------------|
| <b>Yes</b>                    | 6<br>(6%)          | 11<br>(9%)          | 2<br>(6%)          | 2<br>(7%)          | 2<br>(12%)         | 3<br>(16%)         | 1<br>(8%)          | 2<br>(9%)          | 29<br>(8%)     |
| <b>Partly</b>                 | 14<br>(14%)        | 13<br>(11%)         | 4<br>(11%)         | 4<br>(14%)         | 2<br>(12%)         | 0<br>(0%)          | 2<br>(15%)         | 4<br>(18%)         | 43<br>(12%)    |
| <b>No</b>                     | 37<br>(37%)        | 47<br>(40%)         | 13<br>(36%)        | 12<br>(43%)        | 7<br>(41%)         | 4<br>(21%)         | 3<br>(23%)         | 4<br>(18%)         | 127<br>(36%)   |
| <b>Unknown<br/>(not doc.)</b> | 42<br>(42%)        | 47<br>(40%)         | 17<br>(47%)        | 10<br>(36%)        | 6<br>(35%)         | 12<br>(63%)        | 7<br>(54%)         | 12<br>(55%)        | 153<br>(44%)   |

To better illustrate who issued complaints/grievances to the organization, and how, Table 4.13 below presents the origin (who initiated contact) and method/modality of each received complaint/grievance/allegation.



**Table 4.13: Origin and Modality of Complaint/Grievance/Allegation**

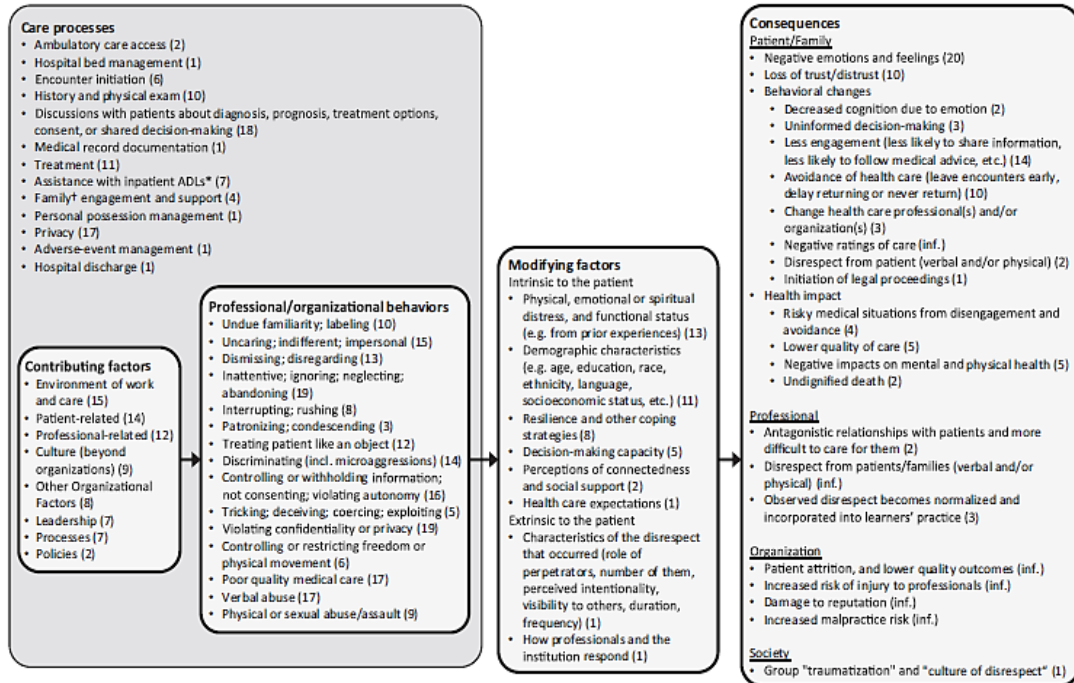
| Type          |                                 | Hosp. 1<br>n=320 | Hosp. 2<br>n=253 | Hosp. 3<br>n=107 | Hosp. 4<br>n=98 | Hosp. 5<br>n=65 | Hosp. 6<br>n=45 | Hosp. 7<br>n=50 | Hosp. 8<br>n=99 | Total<br>n=1037 |
|---------------|---------------------------------|------------------|------------------|------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| <b>Origin</b> | Patient                         | 200<br>(63%)     | 169<br>(67%)     | 70<br>(65%)      | 59<br>(60%)     | 42<br>(65%)     | 36<br>(80%)     | 36<br>(72%)     | 59<br>(60%)     | 671<br>(65%)    |
|               | Parent                          | 41<br>(13%)      | 14<br>(6%)       | 11<br>(10%)      | 10<br>(10%)     | 7<br>(11%)      | 1<br>(2%)       | 3<br>(6%)       | 7<br>(7%)       | 94<br>(9%)      |
|               | Spouse / partner                | 35<br>(11%)      | 25<br>(10%)      | 9<br>(8%)        | 8<br>(8%)       | 8<br>(12%)      | 5<br>(11%)      | 6<br>(12%)      | 12<br>(12%)     | 108<br>(10%)    |
|               | Other family mem.               | 29<br>(9%)       | 22<br>(9%)       | 10<br>(9%)       | 9<br>(9%)       | 6<br>(9%)       | 2<br>(4%)       | 3<br>(6%)       | 13<br>(13%)     | 94<br>(9%)      |
|               | Patient or rep. via staff       | 7<br>(2%)        | 14<br>(6%)       | 6<br>(6%)        | 7<br>(7%)       | 1<br>(2%)       | 0<br>(0%)       | 2<br>(4%)       | 5<br>(5%)       | 42<br>(4%)      |
|               | Patient or rep. via insur.      | 3<br>(<1%)       | 0<br>(0%)        | 0<br>(0%)        | 2<br>(2%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 5<br>(<1%)      |
|               | Patient or rep. via reg. agency | 2<br>(<1%)       | 2<br>(<1%)       | 1<br>(<1%)       | 2<br>(2%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 7<br>(<1%)      |
|               | Friend                          | 1<br>(<1%)       | 2<br>(<1%)       | 0<br>(0%)        | 0<br>(0%)       | 0<br>(0%)       | 1<br>(2%)       | 0<br>(0%)       | 0<br>(0%)       | 4<br>(<1%)      |
|               | Care-giver                      | 1<br>(<1%)       | 1<br>(<1%)       | 0<br>(0%)        | 1<br>(1%)       | 1<br>(2%)       | 0<br>(0%)       | 0<br>(0%)       | 2<br>(2%)       | 6<br>(<1%)      |
|               | Legal guard./ power of attny.   | 1<br>(<1%)       | 4<br>(2%)        | 0<br>(0%)        | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 1<br>(1%)       | 6<br>(<1%)      |
| <b>Method</b> | Phone/ voice-mail               | 250<br>(79%)     | 201<br>(79%)     | 90<br>(84%)      | 80<br>(82%)     | 58<br>(89%)     | 36<br>(80%)     | 42<br>(84%)     | 96<br>(97%)     | 853<br>(82%)    |
|               | In writing                      | 55<br>(17%)      | 30<br>(12%)      | 14<br>(13%)      | 12<br>(12%)     | 4<br>(6%)       | 7<br>(16%)      | 3<br>(6%)       | 2<br>(2%)       | 127<br>(12%)    |
|               | In person                       | 11<br>(3%)       | 19<br>(8%)       | 1<br>(<1%)       | 6<br>(6%)       | 3<br>(5%)       | n/a<br>(0%)     | 4<br>(8%)       | 1<br>(1%)       | 45<br>(4%)      |
|               | Survey                          | 2<br>(<1%)       | 1<br>(<1%)       | 1<br>(<1%)       | n/a<br>(0%)     | n/a<br>(0%)     | 2<br>(4%)       | n/a<br>(0%)     | n/a<br>(0%)     | 6<br>(<1%)      |
|               | Event /Datix (pt. via staff)    | 2<br>(<1%)       | 2<br>(<1%)       | 1<br>(<1%)       | n/a<br>(0%)     | n/a<br>(0%)     | n/a<br>(0%)     | 1<br>(2%)       | n/a<br>(0%)     | 6<br>(<1%)      |

Across all eight hospitals, 65% of all complaints/grievances (671 cases) were filed directly by the patient, predominantly via telephone (82%), which included having an active discussion with a CCT staff member and/or leaving a voicemail for the CCT and/or the Integrity Hotline. Twelve percent of all complaints/grievances (127 cases) were filed in written format, including hand-written, email, MyChart messages, and/or through comment cards. Family members generated approximately 28% of complaints/grievances, with similar proportions of responses generated by a patient's spouse/partner (10%), parent (9%), or other family member which included a sibling, son/daughter, or unspecified (9%). The remaining complaints/grievances (<10%) were generated by a friend, caregiver, regulatory agency (via patient or representative), legal guardian/power of attorney, insurance agency (via patient or representative), or staff (via patient or representative). The subsequent narrative will focus on application of the BIDMC incident analysis framework to the 352 included cases.

### **Results: Applying the BIDMC Incident Analysis Framework**

For each of the 352 cases that met the BIDMC inclusion criteria, the researcher used the information captured in Datix, as well as initial information captured in the analysis spreadsheet, to code each case using the BIDMC incident analysis framework in Figure 4.3 (previously presented in Figures 1.2, 2.5, and 3.3). As mentioned in the previous chapters, Sokol-Hessner et al.'s (2019) five-component framework was created for health system organizations to use as part of their existing quality and patient safety programs.

**Figure 4.3: Beth Israel Deaconess Medical Center Framework for Disrespect (Sokol-Hessner et al., 2019)**



Application of the framework allows organizations to capture and characterize experiences of disrespect for analysis, including:

1. **Care processes:** the “groups of related actions performed to fulfill patient-family care needs” (p. 659);
2. **Professional and organizational behaviors:** a description of the health care professional(s) and organization behaviors involved to allow for “application of just culture algorithms that consider the historical and environmental context in order to fairly balance accountability” (p. 659);
3. **Contributing factors:** patient and professional-related factors, the environment of care, leadership, policies, processes, and culture, which can all create an environment in which disrespectful behavior can occur;
4. **Consequences of disrespect:** the effects of disrespect on patients/family members, professional staff, the organization, and the society, which can provide a more holistic representation of the full extent of non-physical harms on different groups and across several levels; and
5. **Modifying factors:** factors both intrinsic and extrinsic to patients that can modify the consequences of disrespect and provide learning opportunities that can potentially minimize future harm.

Collectively, the five components in the framework represent essential elements that aid in comprehensively learning from events related to disrespect, and in potentially mitigating and preventing future non-physical harms (Sokol-Hessner et al., 2019).

Employing this framework allowed the researcher to conduct incident analysis of actual organizational cases that met inclusion criteria, and to frame non-physical harm with a systems lens while identifying how this framework worked in application.

The following discussion and tables present the results of applying the information available for each complaint/grievance to the BIDMC framework. The majority of the complaints/grievances were coded with multiple themes within each pillar of the framework, particularly in the “professional/organizational behaviors”, “contributing factors”, and “consequences” sections, underscoring the multifaceted nature of complaints/grievances and the complexity in both understanding and addressing them. Each component of the framework, and examples from cases, is summarized in more detail below.

### **BIDMC Framework: Care Processes**

Table 4.14 quantifies the care processes where patients experienced non-physical harm, with many cases coded with more than one process type. Patients primarily felt non-physical harm from disrespect related to processes related to their treatment (39.8%) (related to medication administration, pain management, performing procedures, restraint management, delirium management, and/or psychosocial support, as defined by Sokol-Hessner et al., 2019) and in discussions about diagnosis, prognosis, treatment options, consent, and shared decision-making (35.5%). The discussion below provides examples of the nature of cases that met the different care processes.

**Table 4.14: Distribution of Care Processes among Cases**

| Care Processes                 | Hosp. 1<br>n=99 | Hosp. 2<br>n=118 | Hosp. 3<br>n=36 | Hosp. 4<br>n=28 | Hosp. 5<br>n=17 | Hosp. 6<br>n=19 | Hosp. 7<br>n=13 | Hosp. 8<br>n=22 | Total<br>n=352 |
|--------------------------------|-----------------|------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|----------------|
| Ambulatory care access         | 4<br>(4%)       | 8<br>(7%)        | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 1<br>(5%)       | 3<br>(23%)      | 2<br>(9%)       | 18<br>(5%)     |
| Hospital bed mgmt.             | 4<br>(4%)       | 2<br>(2%)        | 1<br>(3%)       | 1<br>(4%)       | 0<br>(0%)       | 1<br>(5%)       | 1<br>(8%)       | 1<br>(5%)       | 11<br>(3%)     |
| Encounter initiation           | 13<br>(13%)     | 9<br>(8%)        | 9<br>(25%)      | 2<br>(7%)       | 2<br>(12%)      | 5<br>(26%)      | 3<br>(23%)      | 1<br>(5%)       | 44<br>(13%)    |
| History and physical exam      | 1<br>(1%)       | 2<br>(2%)        | 5<br>(14%)      | 1<br>(4%)       | 0<br>(0%)       | 6<br>(32%)      | 1<br>(8%)       | 0<br>(0%)       | 16<br>(5%)     |
| Discussions with patients      | 38<br>(38%)     | 36<br>(31%)      | 15<br>(42%)     | 13<br>(46%)     | 9<br>(53%)      | 3<br>(16%)      | 3<br>(23%)      | 8<br>(36%)      | 125<br>(36%)   |
| Medical record doc.            | 10<br>(10%)     | 8<br>(7%)        | 1<br>(3%)       | 2<br>(7%)       | 0<br>(0%)       | 0<br>(0%)       | 2<br>(15%)      | 1<br>(5%)       | 24<br>(7%)     |
| Treatment                      | 28<br>(28%)     | 60<br>(51%)      | 14<br>(39%)     | 16<br>(57%)     | 7<br>(41%)      | 6<br>(32%)      | 3<br>(23%)      | 6<br>(27%)      | 140<br>(40%)   |
| Assistance with inpatient ADLs | 13<br>(13%)     | 20<br>(17%)      | 4<br>(11%)      | 2<br>(7%)       | 2<br>(12%)      | 0<br>(0%)       | 0<br>(0%)       | 1<br>(5%)       | 42<br>(12%)    |
| Family engagement and support  | 25<br>(25%)     | 12<br>(10%)      | 4<br>(11%)      | 5<br>(18%)      | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 3<br>(14%)      | 49<br>(14%)    |
| Personal possession mgmt.      | 2<br>(2%)       | 1<br>(<1%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 3<br>(1%)      |
| Privacy                        | 8<br>(8%)       | 9<br>(8%)        | 1<br>(3%)       | 1<br>(4%)       | 2<br>(12%)      | 0<br>(0%)       | 0<br>(0%)       | 2<br>(9%)       | 23<br>(7%)     |
| Adverse event mgmt.            | 1<br>(1%)       | 3<br>(3%)        | 1<br>(3%)       | 2<br>(7%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 7<br>(2%)      |
| Hospital discharge             | 24<br>(24%)     | 12<br>(10%)      | 7<br>(20%)      | 5<br>(18%)      | 0<br>(0%)       | 4<br>(21%)      | 0<br>(0%)       | 2<br>(9%)       | 54<br>(15%)    |

*Note: The order of care processes mirrors Sokol-Hessner et al.'s (2019) organization of care processes and is based on the typical sequence from the patient perspective. Note 2: The values in the table will not add up to the total 'n' for each hospital as each case could have multiple care processes, one, or none.*

### *Ambulatory Care Access*

Across all 8 hospitals, 18 of the 352 cases (5.1%) were coded as patient experiences of disrespect related to the care process of ambulatory care access. The majority of these cases were related to patients or their representative/family expressing frustration or concern that they were not provided timely care or care in general. In some instances, patients/families indicated their denial of access to care was based on their race and ethnicity.

### *Hospital Bed Management*

Eleven cases (3.1%) were coded as having a hospital bed management component. Some of the common themes across cases that met this particular care process indicated that patients/families felt they were unnecessarily moved between units without clear information as to why and/or feeling uncomfortable regarding a room placement either due to lack of privacy or having to share the room with a stranger. In one case, a female patient was told by a staff member that she could stay in a room as a safe haven from a traumatic experience, only to be questioned and berated by another staff member soon after who was not aware of the arrangement. The patient was able to remain in the room, but this example highlighted a breakdown in communication among staff members with a patient in a vulnerable state.

### *Encounter Initiation*

Forty-four cases (12.5%) across all eight hospitals were coded as having an encounter initiation component, which refers to introductions and room entry (Sokol-Hessner et al., 2019). Most of the cases that met this particular care process presented similar themes reported by the patient/family member, including either not receiving an

introduction or being addressed by the care team, feeling neglected by not having an intake assessment or having care addressed in a timely manner, feeling that needs or requests were not being addressed or acknowledged, and/or care team addressing the patients/family members in a rude, dismissive, or disrespectful way.

#### *History & Physical Exam*

Sixteen cases (4.5%) across six of the eight hospitals were coded as having a history and physical (H&P) component, which included patients/families experiencing dissatisfaction or disrespect while providing a history of illness/condition, screening for domestic violence, or during the actual physical exam (Sokol-Hessner et al., 2019). In one example, a patient felt she was denied care given her inability to answer the physician's questions "adequately" during the H&P exam. In several examples, patients highlighted how their descriptions of symptoms during the H&P exam were not acknowledged by the provider.

#### *Discussions with Patients*

There were 125 cases (35.5%) across all eight hospitals that were coded as meeting the care process related to "discussions with patients about diagnosis, prognosis, treatment options, informed consent, answering patients' questions, or shared decision-making". This category had the second highest application across complaints and grievances that were included and represents a number of discussions and processes that rely heavily on communication. Many of these cases came from family or other representatives of the patient, who expressed frustration, hurt, and/or concern over not being included in discussions with the patient related to diagnosis, treatment options, or prognosis, and/or having unanswered questions. In other cases, there were similar themes

of patients themselves not feeling informed about their condition or options for treatment, and/or not feeling they had a choice in treatment options, instead feeling pressured or swayed by the care team to follow their advice without having their circumstances or considerations acknowledged. Other cases indicated that this care process represented a one-sided discussion as opposed to a shared, respectful encounter, with one patient feeling “lectured,” while being “interrupted,” and “talked at” throughout the course of their stay.

Another theme involved patients or family members/representatives indicating that the diagnosis communicated to them appeared discordant with the treatment(s) and care being provided, often leading to “broken trust” and/or leaving the hospital “worse” than on arrival. Many cases indicated how patients and families wanted to receive more communication and transparency than they received by either the full or selected members of their care team, illustrating the widespread interest in patient/family inclusion in discussions and decision-making. Given the number of cases meeting this category, these complaints represented a key area for focusing improvement efforts for this organization and ensuring that patients and families felt cared for and heard, as well as understood critical discussions.

#### *Medical Record Documentation*

Across all eight hospitals, 24 cases (6.8%) were coded as relating to medical record documentation. In some instances, this was represented by a patient or family member indicating they had been told about treatment or an adverse reaction to an intervention, but not seeing that information represented in the medical chart. Other examples indicated that key contact information, historical personal information, and/or



communication provided to the patient and family member were incorrect, leading to patient/family frustration, confusion, and a loss of trust and confidence in the health system. In one case, a parent of a patient felt that the documentation she reviewed “labeled” her daughter, negatively affecting her subsequent care. In another case, a parent was distraught over learning (through documentation) about her teenage daughter receiving a pregnancy test without her knowledge, despite this being a routine process given the patient’s presentation.

Another case indicated the patient felt disrespected reviewing documentation that both mis-gendered and mischaracterized him as being “unwilling to participate” and disengaged from the care conversation. In another example, a patient indicated that the health system’s consistent disregard of his Indigenous address was discriminatory and disrespectful, underscoring a larger systemic issue. Lastly, several cases indicated how documented clinical/medical language served as a means of unintentional disrespect, with one patient indicating feeling dismissed by reading her results as “unremarkable” in her medical chart, and another patient indicating the number of times her after visit summary (AVS) indicated she was “morbidly obese” was “unnecessary” and “degrading”.

### *Treatment*

There were 140 cases (40%) across all eight hospitals that were coded as occurring during the “treatment” process, which was the category with the highest frequency across all complaints/grievances. Many of the cases related to pain management, procedures (including perceived delays in timing of procedures as well as discomfort during procedures), and/or being restrained. Many cases indicated a miscommunication or discordance between what was communicated to the patient in

terms of duration of assessment or procedure, level of discomfort/pain, treatment, or surgery outcomes, and/or any subsequent procedures needed, and what the patient experienced. In some instances, the patient or family member communicated extreme pain, anxiety, or concerns, and/or felt their experiences were minimized or dismissed by the care team. There were also several cases where a patient received unwarranted or unauthorized force or restraints, and/or felt dehumanized by the experience.

#### *Assistance with Inpatient Activities of Daily Living (ADLs)*

Forty-two cases (12%) across six hospitals were coded as involving assistance with inpatient ADLs. Common themes from the cases reviewed indicated dissatisfaction, “humiliation”, “traumatization”, and/or feelings of being “neglected” related to maintaining hygiene/grooming/bathing, clothing, and continence care/toileting. Some patients/families noted that basic needs were not met during the hospital stay, including timely response to call buttons when needing assistance for toileting support, help with supporting basic hygiene, lack of clean/dry clothing after continence issues, feeling unsupported in maintaining decency through clothing and privacy, and/or unmet nutrition needs.

#### *Family Engagement and Support*

Across the eight hospitals, 49 cases (14%) were coded as having a family engagement and support component. In some instances, the complaint/grievance stemmed from family members feeling excluded from critical conversations surrounding diagnoses, care delivery, treatment plans, and/or updates on health status, often leading to extreme frustration, emotion, disrespect, and stress. Many indicated the staff were “too busy” to regularly inform patients/families about notable updates. Several cases indicated

how loved ones would not learn of critical changes in the patient's health status, leading to feelings of devastation if a patient unexpectedly passed away, and loved ones being surprised, not informed of the seriousness or acuity of the patient's condition, and/or unable to say goodbye. Given that the cases reviewed occurred in 2021, several of these cases of family members feeling excluded from care stemmed from hospital policy surrounding visitor restrictions due to the COVID-19 pandemic. Further detail regarding the impact of COVID-19 on the cases reviewed is discussed later in this chapter.

#### *Personal Possession Management*

Only 3 of the 352 cases (<1%) across two hospitals were coded as having a personal possession management component. Two of the cases involved the hospital misplacing or losing patients' personal possessions, including clothes and objects. The third case represented how a harmful personal item was retained and unnoticed as opposed to being lost; a legal guardian issued a grievance when learning that her granddaughter had somehow concealed, obtained, or found a razor blade while in the emergency room and harmed herself during a behavioral event crisis.

#### *Privacy*

Across all eight hospitals, 23 cases (6.5%) related to privacy being identified as a process in which disrespect was experienced. In many cases, this related to patients or families overhearing others' medical conditions or treatment, or feeling as though their information was not protected either because of the physical space or how the care team was discussing their private information. In one case, a patient felt disrespected given how the care team interacted with her in a vulnerable position and felt that the care team exhibited "inappropriate behavior" when her personal body parts were exposed that

caused her to be “humiliated”. In another example, a patient indicated that the disrespectful event occurred with one provider who asked a series of “very personal but necessary questions” loudly about the patient’s symptoms while his door was open, with a hallway full of people immediately outside. The patient perceived the provider’s approach to questioning without attempting to respect his privacy as “extraordinarily abrasive, intrusive, and seemingly judgmental” and was “infuriated”, felt “taken advantage of,” and extremely “disrespected” that the provider made “no effort to quiet her voice or keep the information private”.

While many cases surfaced opportunities for staff behavioral improvement in maintaining patient privacy (or improvement in department culture in maintaining privacy), most of the cases relating to privacy concerns largely aligned with Sokol-Hessner et al.’s (2015) assertion that disrespect is not necessarily due to staff’s failure to demonstrate respect but stems from the hospital environment/design facilitating an environment where patients feel disrespected.

#### *Adverse Event Management*

Seven of the 352 cases (2%) were coded as having an adverse event management component; given the nature of adverse events, these cases can be considered particularly egregious. In one case, a patient filed a grievance after developing an infection as a result of a routine, same-day procedure that resulted in several subsequent procedures, and an over two-month hospital stay. The grievance indicated mismanagement of an adverse event. Another case outlined how a mother was not told why her daughter was dying and felt her daughter’s unique circumstances provided an opportunity for staff “to practice”

while being “clueless to sensitivity,” highlighting the learning opportunity and medical responsibility from the hospital perspective at the cost of the family feeling disrespected.

### *Hospital Discharge*

Fifty-four cases (15%) across six hospitals were coded as having a hospital discharge component. The most dominant theme was the patient or family/representative indicating a premature discharge. In many of these instances, whoever issued the complaint or grievance indicated that the patient was readmitted soon after being sent home. Another common theme that arose in these cases indicated that patients/families felt dismissed and/or “pushed out” of the hospital and did not have a clear understanding of discharge instructions.

### *Summary*

This discussion illustrates how the researcher coded cases into different process categories and provides a snapshot of the process types that the 352 complaints/grievances met. However, no one category within the framework should be reviewed independently from the other categories when trying to comprehensively characterize the nature of these cases, as doing so provides a limited and insufficient view of the case.

### **BIDMC Framework: Professional/Organizational Behaviors**

After a case was assigned a code (or codes) for the “care processes” category, the researcher reviewed the available case information to code the professional and organizational behaviors that were present in the complaint or grievance. Table 4.15 below illustrates the distribution of the professional/organizational behaviors that were present in the cases across each of the eight hospitals that contributed to the patient/family experience of non-physical harm from disrespect.

**Table 4.15: Distribution of Professional/Organizational Behaviors**

| <b>Prof./ Org. Behaviors</b>   | <b>Hosp. 1<br/>n=99</b> | <b>Hosp. 2<br/>n=118</b> | <b>Hosp. 3<br/>n=36</b> | <b>Hosp. 4<br/>n=28</b> | <b>Hosp. 5<br/>n=17</b> | <b>Hosp. 6<br/>n=19</b> | <b>Hosp. 7<br/>n=13</b> | <b>Hosp. 8<br/>n=22</b> | <b>Total<br/>n=352</b> |
|--|-------------------------|--------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|------------------------|
| Undue familiarity; labeling  | 3<br>(3%)               | 0<br>(0%)                | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 3<br>(<1%)             |
| Uncaring; indifferent; impersonal  | 28<br>(28%)             | 28<br>(24%)              | 11<br>(31%)             | 4<br>(14%)              | 10<br>(59%)             | 6<br>(32%)              | 4<br>(31%)              | 8<br>(36%)              | 99<br>(28%)            |
| Dismissing; disregarding   | 31<br>(31%)             | 21<br>(18%)              | 11<br>(31%)             | 11<br>(39%)             | 9<br>(53%)              | 10<br>(53%)             | 6<br>(46%)              | 8<br>(36%)              | 107<br>(30%)           |
| Inattentive; ignoring; neglecting; abandoning                              | 21<br>(21%)             | 34<br>(29%)              | 7<br>(19%)              | 7<br>(25%)              | 2<br>(12%)              | 4<br>(21%)              | 6<br>(46%)              | 5<br>(23%)              | 86<br>(24%)            |
| Interrupting; rushing  | 6<br>(6%)               | 5<br>(4%)                | 2<br>(6%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 2<br>(9%)               | 15<br>(4%)             |
| Patronizing; condescending   | 6<br>(6%)               | 6<br>(5%)                | 2<br>(6%)               | 1<br>(4%)               | 1<br>(6%)               | 2<br>(11%)              | 1<br>(8%)               | 0<br>(0%)               | 19<br>(5%)             |
| Treating patient like an object  | 6<br>(6%)               | 3<br>(3%)                | 0<br>(0%)               | 2<br>(7%)               | 0<br>(0%)               | 0<br>(0%)               | 1<br>(8%)               | 1<br>(5%)               | 13<br>(4%)             |
| Discriminating   | 8<br>(8%)               | 13<br>(11%)              | 3<br>(8%)               | 1<br>(4%)               | 1<br>(5.9%)             | 1<br>(5.3%)             | 2<br>(15%)              | 1<br>(5%)               | 30<br>(9%)             |
| Controlling or withholding information; not consenting; violating autonomy | 32<br>(32%)             | 17<br>(14%)              | 10<br>(28%)             | 7<br>(25%)              | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 5<br>(23%)              | 71<br>(20%)            |
| Tricking; deceiving; coercing; exploiting                                  | 4<br>(4%)               | 3<br>(3%)                | 5<br>(14%)              | 1<br>(4%)               | 0<br>(0%)               | 1<br>(5%)               | 0<br>(0%)               | 2<br>(9%)               | 16<br>(5%)             |
| Violating confidentiality or privacy                                       | 2<br>(2%)               | 4<br>(3%)                | 1<br>(3%)               | 1<br>(4%)               | 2<br>(12%)              | 0<br>(0%)               | 0<br>(0%)               | 2<br>(9%)               | 12<br>(3%)             |
| Controlling or restricting freedom or movement                             | 4<br>(4%)               | 9<br>(8%)                | 1<br>(3%)               | 1<br>(4%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 1<br>(5%)               | 16<br>(5%)             |
| Poor quality medical care  | 16<br>(16%)             | 32<br>(27%)              | 10<br>(28%)             | 5<br>(18%)              | 6<br>(35%)              | 7<br>(37%)              | 2<br>(15%)              | 4<br>(18%)              | 82<br>(23%)            |
| Verbal abuse   | 5<br>(5%)               | 2<br>(2%)                | 2<br>(6%)               | 1<br>(4%)               | 0<br>(0%)               | 0<br>(0%)               | 1<br>(8%)               | 2<br>(9%)               | 13<br>(4%)             |
| Physical or sexual abuse/assault   | 11<br>(11%)             | 17<br>(14%)              | 4<br>(11%)              | 3<br>(11%)              | 1<br>(5.9%)             | 0<br>(0%)               | 1<br>(8%)               | 1<br>(5%)               | 38<br>(11%)            |

*Note: Behaviors are displayed from lower to higher severity, as described in Sokol-Hessner et al. (2019). Note 2: The values in the table will not add up to the total 'n' for each hospital as each case could have multiple care processes, one, or none.*

Five categories of professional/organizational behaviors were most prevalent among the cases: 1) dismissing; disregarding (30%); 2) uncaring, indifferent, impersonal (28%); 3) inattentive, ignoring, neglecting, abandoning (24%); 4) poor quality medical care (23%); and 5) controlling or withholding information, not consenting, violating autonomy (20%). Many of these behaviors were similar in nature, and many cases met several of these categories given their similarities or ability to influence one another. As a result, most cases were coded as meeting more than one category of professional/organizational behaviors. The discussion below provides examples illustrating how cases met each of the categories below. Many of the cases were attributable to interactions with specific professionals, while some were attributed to the organization, particularly related to the “interrupted, rushing” category.

#### *Undue Familiarity and/or Labeling*

Only 3 cases (<1%) reviewed were coded as having professional/organizational behaviors of undue familiarity or labeling, all of which occurred at one hospital. In one example, the patient’s mother believed the patient was wrongfully labeled as a drug abuser/addict in medical record documentation, and that such labeling was an “assassination” of the patient’s character, negatively influencing the patient’s subsequent care. Another example indicated unwelcome familiarity between the health care professional and the patient’s family; the patient’s mother indicated that the provider delivering care “unloaded” on her about the challenges of her job, neglecting to focus on the care needed and demonstrating insensitivity to the mother’s own challenges.

### *Uncaring, Indifferent, and/or Impersonal*

Ninety-nine cases (28%) were coded as professional/organizational behaviors that were uncaring, indifferent, and/or impersonal; these experiences were experienced and captured across all eight hospitals. Many of the cases demonstrated similar themes, in which complainants felt hospital staff were uninterested in responding to patient needs, were abrupt or brusque in nature, did not greet the patient either at all or in a delayed manner, and lacked empathy, compassion, and/or sympathy toward the patient's unique situation. Some cases reflected patients or families feeling that the health care professionals did not take their condition seriously, felt like they "didn't matter", or indicated how "insensitive comments" that did not demonstrate "kindness" or "compassion", particularly for patients who felt vulnerable or scared, exacerbated their feelings of disrespect, and in many cases accelerated their desire to leave the hospital and/or not return.

### *Dismissing and/or Disregarding*

There were 107 cases (30%) across all eight hospitals coded as illustrating professional/organizational behaviors that were dismissive and/or disregarding; this was the most prevalent category. Many cases had similar themes where the patient or family member said that they did not feel that the health care professional believed them and/or took their experiences seriously when describing symptoms or concerns, leading the patient/family to feel subsequently dismissed, demeaned, insulted, neglected, unsupported, and/or unsure of next steps. There were many instances of patients/families experiencing strong emotions as a result of being disregarded, with many indicating they were "traumatized", "distressed", and "lost all trust" in the care team, hospital, and/or



organization by the experience. There were also several occurrences where patients/families felt the health care providers ignored preferred pronouns and other fundamental information that led to patients/families not feeling understood, heard, and recognized as a person needing support. In a few examples, patients were described as “too sensitive” by members of their care team when describing their pain tolerance, and subsequently felt dismissed and a lack of compassion from these health care professionals.

*Inattentive, Ignoring, Neglecting, and/or Abandoning*

There were 86 cases (24%) across all eight hospitals that were coded as illustrating professional/organizational behaviors that were inattentive, ignoring, neglecting, and/or abandoning. Several of the major themes that resulted across these cases included patients or their family members feeling ignored, not feeling heard, not having questions answered or explained, having limited conversations with distracted professionals, and/or generally feeling that concerns and basic needs were not addressed, particularly when it came to support with ADLs, and in circumstances where patients/families asked for additional information prior to discharge. A few cases had similar themes where patients either left the hospital prior to having a scheduled procedure, or threatened hospital staff they would leave against medical advice (AMA) given extreme delays in care, lack of communication, information, and interactions with key care providers, again highlighting the sense of being ignored or “not important enough”.

### *Interrupting and/or Rushing*

There were 15 cases (4%) in four of the eight hospitals that were coded as illustrating professional/organizational behaviors that were perceived as interrupting and/or rushing. Common themes indicated that patients/families felt they were being “pushed out of the hospital” prematurely, felt that staff were “always in a hurry,” “impatient”, “abrupt,” and/or “too busy”, leaving patients/families often feeling “uneasy” and/or “unclear” about their status, next steps, or discharge instructions. Some examples also indicated that such rushing led to the patient being readmitted soon after discharge. For most of the cases that met this category, these descriptions were attributable across most or all interactions, as opposed to with a particular staff member, which has broader implications to consider factors such as hospital capacity and staff workload. A detailed discussion of these considerations and implications will be discussed in the final chapter.

### *Patronizing and/or Condescending*

There were 19 cases (5%) across seven hospitals that were coded as illustrating professional/organizational behaviors that were patronizing and/or condescending. Some patients felt “written off” or disregarded by providers; one patient was told there was “nothing wrong with her” and she was overweight and should return home to “eat grilled chicken and lose weight”, with the patient admitted to another hospital within days of discharge, and subsequently diagnosed with other conditions. Another patient indicated that a staff member “brushed off” the patient when describing her “excruciating” back pain, saying that “yoga works” and that she needed to “just stretch it out,” making the patient feel her pain was minimized. Another theme in several cases indicated that patients felt the health care professional was intentionally creating a “power imbalance”

between the patient/family and staff. There were also several cases where patients/families stated staff often indicated how they were “inconvenienced” and/or made patient/families feel like they were acting “entitled” when they vocalized a need for basic supports, such as being able to take a shower, obtain dry and clean bed linens, and/or other fundamental needs; one patient noted that she “was made to feel like a bad child” in her interactions with a care team member.

#### *Treated Patient as an Object*

There were 13 cases (4%) across five hospitals that were coded as a patient/family member feeling that the health care professional treated them as an object. Common themes that arose from these cases indicated that patients felt they were not being “treated as a person”, did not feel that staff cared or showed interest in them as humans, and had a more mechanistic approach to care that was devoid of kindness, compassion, or empathy. Some cases indicated that the staff were “going through the motions” of providing care without acknowledging (or minimizing) pain or discomfort. One example indicated the relief a patient felt when another care team member took over for a previous staff member whose demeanor was “aggressive and callous”, and the staff member who took over made the patient feel she was “cared for” and “mattered”.

Cases that met this criterion were also often coded as patients/families feeling “ignored, abandoned, or neglected”, and/or “dismissed or disregarded”. One patient felt that she was instantly labeled as a drug seeker and was subsequently treated by staff with a “look of disgust”.

### *Discriminating (including Microaggressions)*

There were 30 cases (8.5%) across the eight hospitals that were coded as patients/family members feeling discriminated against by a health care professional due to their gender identity, sexuality, financial status, race, ethnicity, and/or vaccination status. Many patients and families who had complaints/grievances that were coded in this way indicated feeling neglected and not acknowledged during the check-in and waiting process, with several patients indicating they had inordinate wait times due to the color of their skin. Other examples indicated that patients experienced microaggressions; in one case, a pregnant Black woman indicated she had experienced “wonderful care” overall, but received comments from a staff member perpetuating misconceptions that she should have a “higher pain tolerance” given her race. In another example, a patient’s father described racial discrimination as information was withheld from him and instead directed to his wife, who was the same ethnicity as the primary staff member who was caring for the patient. Further discussion of patients/families experiencing discrimination in relation to COVID-19 will be discussed later in the chapter.

### *Controlling or Withholding Information, Not Consenting, and/or Violating Autonomy*

There were 70 cases (20%) across five hospitals where the patient/family member/representative perceived the health care professional(s) was controlling or withholding information, not obtaining consent, and/or violating autonomy. Common themes indicated that patients/families were often not clear on the purpose of each staff person’s visit, and did not have enough information, subsequently feeling uninformed about their conditions, treatments options, or discharge/post-discharge plans, and not being treated as a partner in discussions about their care. Patients and families expressed

feeling uninformed depending on the situation, and there was a widespread undercurrent of patients/families experiencing worry, frustration, stress, angst, neglect, and demoralization. One example took place in the labor and delivery unit of a hospital, with a new mother experiencing “extreme stress” and an “emotionally painful” time immediately after giving birth; her experience indicated that hospital staff kept her and her husband “in the dark” by not sharing essential information about what was happening, why she was being transferred, and why her baby was taken from her to a separate unit. She indicated how being “physically separated” from her new family was “incredibly emotionally painful”, noting how “transparency goes a long way”. In another example, the son of a patient who passed away in the hospital was not notified when the hospital released his father’s body to a funeral home to the surprise of both the funeral home and the son; the hospital had not engaged the son in the post-death management and coordination of transport of the body.

*Tricking, Deceiving, Coercing, and/or Exploiting*

There were 16 cases (4.5%) across six hospitals that were coded as having professional/organizational behaviors that the patient or family member viewed as tricking, deceiving, coercing, and/or exploiting. One couple felt both discriminated against and lied to, and that hospital staff applied the visitor policy differently toward them because they were a gay couple. In another instance, a patient’s son felt the care team “went behind his back” by not including him in his mother’s discharge plan, and that the team “quit” once she did not agree with their recommendation for discharge to a particular post-acute location. Another family felt “distressed” and “traumatized” given the “lies” and misinformation they were given by their care team, initially being told that

their child had abnormal blood work and was dying which “scared [the parents] into visiting another health system” to validate the information, which was dispelled. Another patient felt misled and threatened by a provider who indicated he would “take his driver’s license” from the patient if he did not accept discharge to a rehabilitation facility instead of his preferred location of home. Lastly, a patient felt “railroaded” by her care team, indicating that different members were providing conflicting information, did not explain the need for an ultrasound, and described the experience as a “high pressure sale at a car dealership” with one of her care providers, indicating that the staff member made her feel she would be “doomed” if she did not go forward with an ultrasound in that moment. Across these cases in particular, most feelings of being deceived or lied to were described by family members of the patient, rather than the patient themselves. Many family members indicated that they were not included in decision-making, kept apprised of key updates, and/or often placated by staff when they raised concerns, frustration, or asked questions about the patient’s care, leading family members to be distrustful.

#### *Violating Confidentiality or Privacy*

Twelve cases (3%) across six hospitals were coded as having professional/organizational behaviors that were perceived by patients or families as violating confidentiality or privacy. Many of these were attributable to environmental factors, as several cases indicated privacy concerns due to being in curtained areas and/or shared spaces. Many complaints/grievances indicated that patients felt uneasy that they could hear others’ detailed personal information in discussions with staff, and felt distressed, frustrated, or anxious in their presumptions that others could hear or see them during their own interactions with staff. A few examples indicated discomfort with

sharing spaces with strangers; one patient noted how she was the only female patient in her immediate vicinity and felt “extremely intimidated and embarrassed” to use the restroom knowing she could hear fellow male patients in close proximity.

#### *Controlling or Restricting Freedom or Physical Movement*

There were 16 cases (4.5%) across five hospitals that were coded as having professional/organizational behaviors where the patient/family felt their physical movement/freedom was controlled or restricted. A few examples indicated that patients/families felt the care team was physically “rough” and that patients were often “restrained” in bed, either through staff members physically restraining them or using actual restraints, with many patients/families indicating such force was unwarranted and/or unexpected. In one case, a patient indicated he was “scared” of a staff member who used “intimidation” and physical force by pushing the patient down, indicating to the patient there “would be problems” if he tried to get up.

#### *Poor Quality Medical Care*

There were 82 cases (23%) across all eight hospitals that were coded as patients or families perceived health care professionals delivering poor quality medical care. In many of these cases, patients/families often described the positive interactions and aspects of care that worked well before contrasting those experiences with specific instances of how care delivery or interactions with a particular staff member were poor. Many of the cases that met this criterion indicated that care was delayed, either with patients waiting an exorbitant amount of time and/or not being notified or acknowledged throughout their stay, or delays in discussions and/or treatments with the care team. Many patients/families indicated that their assessments with providers were substandard, with

staff not conducting tactile assessments, and/or seemingly having their “own agenda” instead of focusing on the reason the patient was hospitalized, and/or addressing concerns articulated by patients/families. Other instances outlined how patients had essential findings “missed” or “ignored”, leading them to obtain second opinions at other facilities that provided diagnoses and care that were not achieved during the original visit.

Other cases indicated that many patients felt their pain was poorly controlled, symptoms were not acknowledged or validated by the care team, and indicated premature discharges, many of which led to patients/families indicating they were readmitted soon after. In one instance, a patient was discharged with her medication port still accessed due to a newer staff member’s unfamiliarity with discharging patients with ports. In many examples, families indicated that they learned of critical information through medical record documentation as opposed to being notified by the care team and/or being included in care discussions or decisions; one family noted they found out about their parent’s cancer diagnosis through documentation. Another family indicated that the patient’s preference was to pass away at home, and the family was left in distress, without information, wondering if they could have done anything differently to honor the patient’s wishes.

#### *Verbal Abuse*

There were 13 cases (4%) across six hospitals that were coded as patients or their families experiencing verbal abuse from health care professionals and/or hospital staff. One case occurred before the patient and family member entered the hospital; a daughter recounted having an attendant “screaming” at her for parking in the wrong spot and being told in a “snarky” tone “welcome to the hospital; people do die here,” which was



distressing and “triggering” for the daughter. Many instances involved patients/families feeling the health care professional they interacted with “lost their temper,” treated them with “disdain” and seemingly “scolded” the patients/families, spoke to the patient or family in an “insulting” way that led to the patient/family member feeling “humiliated” and “belittled,” “intimidated” the patient by making “threats” related to their outcomes if they did not follow the medical advice provided, and/or felt “blamed” by the health care professional. One patient indicated how she felt pain when receiving repeated “needle pokes,” and the provider kept blaming the patient for not being in the correct position and made the patient “feel worse” through the “aggressive” and “unpleasant” interaction. One spouse expressed shock at the bluntness of a provider in delivering a prognosis, stating “there’s nothing more to do, [the patient] will die within a few months”. Other members of the care team offered apologies to the spouse, but throughout the patient’s stay there were repeated interactions with the provider that were “hostile”, “aggressive”, and “lacking compassion”. Lastly, some interactions were perceived as verbal abuse to patients/families due to the inappropriate use of humor; one patient said that a physician looking at a stomach incision noted that she would “not win any modeling contests,” contributing to her feeling humiliated, dismissed, and “written off” by the care team.

#### *Physical or Sexual Abuse/Assault*

Lastly, 38 cases (11%) across seven hospitals were coded as patients or their families experiencing physical or sexual abuse/assault from health care professionals. The most common themes that resulted in these cases related to the patient being inappropriately touched by a staff member, inappropriate and/or unwelcome displays of affection (e.g., hugs, massages, or being kissed on the cheek), and/or overly “aggressive,”

“rough handling,” or “unauthorized force” on the patient while receiving care, including during supporting patient ADLs. Some patients or family members recounted being “yanked” or “pushed” by their care team to have them sit in their wheelchair or bed. Given the severity of these perceived behaviors, it is essential to not solely look at cases that meet these behaviors in isolation and to instead understand the contributing factors and components that can influence the perception of the experience of these behaviors.

### *Summary*

The professional/organizational behaviors presented above mirror Sokol-Hessner et al.’s (2019) organization of lower to higher severity. Overall, across all 352 cases reviewed, the severity of behaviors experienced by patients/families ranged from mild (lower) to severe (higher). As indicated by the findings presented above, three of the most frequent behaviors that were coded as more severe in nature were “controlling or withholding information,” “poor quality medical care,” and “physical or sexual abuse/assault”. While each of these categories was viewed independently, when looking at experiences of disrespect, categories should not be viewed in isolation, but instead holistically to understand not the patient/family perception and other contributing factors.

### **BIDMC Framework: Contributing Factors**

As Sokol-Hessner et al. (2019) state, the contributing factors category within the BIDMC framework “sets the stage” for disrespectful behaviors and included patient-related and professional-related factors, the environment of work and care, leadership, processes, policies, other organizational factors, and culture (p. 663). The researcher used Sokol-Hessner et al.’s (2019) descriptions of contributing factors to code the 352 cases, which is presented in Table 4.16 below.

**Table 4.16: Distribution of Contributing Factors**

| <b>Contributing Factors</b>  | <b>Hosp. 1<br/>n=99</b> | <b>Hosp. 2<br/>n=118</b> | <b>Hosp. 3<br/>n=36</b> | <b>Hosp. 4<br/>n=28</b> | <b>Hosp. 5<br/>n=17</b> | <b>Hosp. 6<br/>n=19</b> | <b>Hosp. 7<br/>n=13</b> | <b>Hosp. 8<br/>n=22</b> | <b>Total<br/>n=352</b> |
|------------------------------|-------------------------|--------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|------------------------|
| Professional-Related         | 45<br>(46%)             | 71<br>(60%)              | 23<br>(64%)             | 15<br>(54%)             | 9<br>(53%)              | 14<br>(74%)             | 7<br>(54%)              | 15<br>(68%)             | 199<br>(57%)           |
| Patient-Related              | 48<br>(49%)             | 60<br>(51%)              | 14<br>(39%)             | 12<br>(43%)             | 10<br>(59%)             | 3<br>(16%)              | 5<br>(39%)              | 5<br>(23%)              | 157<br>(45%)           |
| Processes                    | 42<br>(42%)             | 63<br>(53%)              | 10<br>(28%)             | 8<br>(29%)              | 7<br>(41%)              | 5<br>(26%)              | 4<br>(31%)              | 3<br>(14%)              | 142<br>(40%)           |
| Environment of Work and Care | 35<br>(35%)             | 39<br>(33%)              | 13<br>(36%)             | 15<br>(54%)             | 4<br>(24%)              | 1<br>(5.3%)             | 2<br>(15%)              | 8<br>(36%)              | 117<br>(33%)           |
| Policies                     | 19<br>(19%)             | 13<br>(11%)              | 6<br>(17%)              | 1<br>(4%)               | 1<br>(6%)               | 2<br>(11%)              | 3<br>(23%)              | 5<br>(23%)              | 50<br>(14%)            |
| Other Org. Factors           | 5<br>(5%)               | 2<br>(2%)                | 1<br>(3%)               | 0<br>(0%)               | 1<br>(6%)               | 2<br>(11%)              | 2<br>(15%)              | 2<br>(9%)               | 15<br>(4%)             |
| Culture (beyond org.)        | 4<br>(4%)               | 0<br>(0%)                | 2<br>(6%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 6<br>(2%)              |
| Leadership                   | 1<br>(1%)               | 2<br>(2%)                | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 1<br>(5%)               | 4<br>(1%)              |

*Note: The values in the table will not add up to the total 'n' for each hospital as each case could have multiple contributing factors, one, or none.*

Cases were coded with patient-related contributing factors when it was apparent through the available documentation that key characteristics, such as condition/illness, demographics, socioeconomic status, language, factored into the feeling of disrespect. As Sokol-Hessner et al. (2019) note, patient-related factors are “not causative of disrespectful behavior” but are significant because they are “associated with a higher likelihood of disrespect” (p. 663). There were 157 cases (45%) that were coded as having patient-related contributing factors.

Policies and processes indicate organizational standards of care, workflows, or actions that were “oriented around the organization’s or professional’s needs rather than patient/family needs,” and cases were coded as meeting policy or process factors when it was clear that organizational guidelines influenced decision-making (Sokol-Hessner et

al., 2019, p. 663). While Sokol-Hessner et al. (2019) indicated policy factors were about “problematic” standards of care or governance, the researcher coded cases if it was found that the reason for patient/family experience of disrespect stemmed from a policy or process factor as opposed to a problematic one (p. 663). For example, given the influence of COVID-19 on operations in 2021, many policies and processes were amended to follow prevailing governmental guidance. Organizational policy around visitors was revised throughout the year and caused patients to experience restrictions related to the number and/or frequency of visitors. This proved to be distressing for many, and it was not necessarily deemed problematic but instead emblematic and clinically responsive to the current events.

Cases were coded as having professional-related contributing factors if the complaint/grievance was related to a negative interaction with a staff member and included the health care professional’s exhibited presence of burnout, compassion fatigue and/or lack of empathy, their biases and prejudices, their desire to maintain “control of situations,” and related characteristics (Sokol-Hessner et al., 2019, p. 663). Cases were also coded as having professional-related contributing factors if it was evident that the patient/family had limited time with the staff member and might have felt they had unanswered questions. In such cases it was also indicative in the documentation that additional factors were at play, such as the hospital was over capacity or perhaps experiencing a surge in patient population, indicating that workload and other pressures were factoring into minimizing staff time with patients. There were 199 cases (57%) that were coded as having professional-related contributing factors.

Cases coded as having environment of work and care contributing factors (117 cases, or 33%) indicated issues related to long wait times, the actual layout/design of the units or rooms, lack of resources, staffing considerations, working conditions, mentions of equipment or supplies, noise, hospital characteristics such as clothing (gowns), and challenges with privacy and hygienic conditions given the environmental layout (Sokol-Hessner et al., 2019).

Cases that were coded as having other organizational factors as a contributing factor (15 cases, or 4%) illustrated challenges related to inadequate duration of care and culture. The two contributing factors that were more difficult to assess based on accessible information, and were subsequently the two categories that had the fewest cases, were “culture (beyond organizations)” and “leadership”. Cases coded with these two contributing factors were primarily inferred by the researcher, and indicated there was “production pressure,” or a “lack of accountability” given the nature of the complaint/grievance for the “leadership” category, and largely “cultural differences” between professionals, patients, and families (Sokol-Hessner et al., 2019).

### **BIDMC Framework: Modifying Factors**

After coding the contributing factors, modifying factors were assessed, which can alter the potential consequences of disrespect that has occurred, and can be both intrinsic and extrinsic to the patient (Sokol-Hessner et al., 2019). Table 4.17 below illustrates the distribution of modifying factors among the 352 cases.

**Table 4.17: Distribution of Modifying Factors**

| <b>Modifying Factors</b>                                      | <b>Hosp. 1<br/>n=99</b> | <b>Hosp. 2<br/>n=118</b> | <b>Hosp. 3<br/>n=36</b> | <b>Hosp. 4<br/>n=28</b> | <b>Hosp. 5<br/>n=17</b> | <b>Hosp. 6<br/>n=19</b> | <b>Hosp. 7<br/>n=13</b> | <b>Hosp. 8<br/>n=22</b> | <b>Total<br/>n=352</b> |
|---|-------------------------|--------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|------------------------|
| <b>Intrinsic to the patient</b>                               |                         |                          |                         |                         |                         |                         |                         |                         |                        |
| Physical, emotional, or spiritual distress; functional status | 50<br>(51%)             | 23<br>(20%)              | 16<br>(44%)             | 20<br>(71%)             | 5<br>(30%)              | 14<br>(74%)             | 8<br>(62%)              | 8<br>(36%)              | 144<br>(41%)           |
| Demographic characteristics                                   | 14<br>(14%)             | 12<br>(10%)              | 4<br>(11%)              | 2<br>(7%)               | 0<br>(0%)               | 1<br>(5%)               | 1<br>(8%)               | 0<br>(0%)               | 34<br>(10%)            |
| Resilience and other coping strategies                        | 0<br>(0%)               | 0<br>(0%)                | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 1<br>(8%)               | 0<br>(0%)               | 1<br>(<1%)             |
| Decision-making capacity                                      | 5<br>(5%)               | 1<br>(<1%)               | 4<br>(11%)              | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 0<br>(0%)               | 2<br>(9%)               | 12<br>(3%)             |
| Perceptions of connectedness and social support               | 2<br>(2%)               | 0<br>(0%)                | 3<br>(8%)               | 0<br>(0%)               | 0<br>(0%)               | 2<br>(11%)              | 2<br>(15%)              | 1<br>(5%)               | 10<br>(3%)             |
| Health care expectations                                      | 5<br>(5%)               | 0<br>(0%)                | 1<br>(3%)               | 1<br>(4%)               | 0<br>(0%)               | 1<br>(5%)               | 0<br>(0%)               | 0<br>(0%)               | 8<br>(2%)              |
| <b>Extrinsic to the patient</b>                               |                         |                          |                         |                         |                         |                         |                         |                         |                        |
| Characteristics of disrespect that occurred                   | 20<br>(20%)             | 47<br>(40%)              | 11<br>(31%)             | 7<br>(25%)              | 12<br>(71%)             | 2<br>(11%)              | 3<br>(23%)              | 3<br>(14%)              | 105<br>(30%)           |
| How prof. and institution respond                             | 59<br>(60%)             | 51<br>(43%)              | 13<br>(36%)             | 17<br>(61%)             | 2<br>(12%)              | 6<br>(32%)              | 6<br>(46%)              | 15<br>(68%)             | 169<br>(48%)           |

Similar to the other components within this framework, cases often reflected more than one modifying factor category, based on available information in each case file within Datix. In addition to coding the cases with modifying factors, the researcher described the modifying factors in a notes section, which could not be quantified in the table above. In general, factors that were intrinsic to the patient were often captured when it was clear those factors were present and relevant prior to the disrespectful event occurring. As an example, some complaints/grievances indicated that the patient had

existing distress coming into the care interaction and/or shaping the patient's visit due to prior troubling experiences (such as prior abuse); as a result, those factors intrinsic to the patient were captured.

Factors that were extrinsic to the patient included detailing characteristics of the disrespectful occurrence and how the organization responded after the event occurred. In some cases, there was documentation outlining a staff member "explaining" the rationale behind another provider's actions or temperament with the patient as an explanation as to why the patient/family might have felt disrespected. Recommendations related to this section of the framework are outlined in the discussion section below, as well as in Chapter Seven, emphasizing the importance of the organization's response, rooted in transparency, compassion, and open communication, as an essential element in mitigating the severity and duration of emotional impact caused to patients and families after an event occurs (Prentice et al., 2020; Sokol-Hessner et al., 2024).

### **BIDMC Framework: Consequences**

After capturing modifying factors, potential consequences across different levels, including to the patient/family, health care professional, organization, and society were assessed. Table 4.18 presents the distribution of consequences to patients/families among the included cases. The three most prevalent patient/family consequences were: 1) negative emotions and feelings (90%); 2) negative ratings of care (43%); and 3) negative impacts on mental and physical health (39%). A summary of results for each of the potential consequences is presented below, including examples of how cases were coded to each potential consequence.

**Table 4.18: Distribution of Potential Consequences – Patient/Family**

| <b>Consequences</b>   | <b>Hosp.<br/>1<br/>n=99</b> | <b>Hosp.<br/>2<br/>n=118</b> | <b>Hosp.<br/>3<br/>n=36</b> | <b>Hosp.<br/>4<br/>n=28</b> | <b>Hosp.<br/>5<br/>n=17</b> | <b>Hosp.<br/>6<br/>n=19</b> | <b>Hosp.<br/>7<br/>n=13</b> | <b>Hosp.<br/>8<br/>n=22</b> | <b>Total<br/>n=352</b> |
|---|-----------------------------|------------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|------------------------|
| Neg. emotions/<br>feelings  | 92<br>(93%)                 | 115<br>(98%)                 | 26<br>(72%)                 | 24<br>(86%)                 | 17<br>(100%)                | 14<br>(74%)                 | 8<br>(62%)                  | 20<br>(91%)                 | 316<br>(90%)           |
| Loss of<br>trust/distrust   | 18<br>(18%)                 | 15<br>(13%)                  | 4<br>(11%)                  | 5<br>(18%)                  | 5<br>(30%)                  | 2<br>(11%)                  | 4<br>(31%)                  | 6<br>(27%)                  | 59<br>(17%)            |
| Behavioral<br>changes:<br>decreased<br>cognition due to<br>emotion                | 6<br>(6%)                   | 4<br>(3%)                    | 2<br>(6%)                   | 3<br>(11%)                  | 0<br>(0%)                   | 1<br>(5%)                   | 1<br>(8%)                   | 0<br>(0%)                   | 17<br>(4.8%)           |
| Behavioral:<br>uninformed<br>decision-<br>making                                  | 15<br>(15%)                 | 10<br>(9%)                   | 4<br>(11%)                  | 4<br>(14%)                  | 2<br>(12%)                  | 1<br>(5%)                   | 1<br>(8%)                   | 5<br>(23%)                  | 42<br>(12%)            |
| Behavioral:<br>Less<br>engagement   | 0<br>(0%)                   | 7<br>(6%)                    | 1<br>(3%)                   | 1<br>(4%)                   | 0<br>(0%)                   | 1<br>(5%)                   | 1<br>(8%)                   | 2<br>(9%)                   | 13<br>(4%)             |
| Behavioral:<br>avoidance of<br>health care  | 10<br>(10%)                 | 8<br>(7%)                    | 3<br>(8%)                   | 4<br>(14%)                  | 1<br>(6%)                   | 1<br>(5%)                   | 1<br>(8%)                   | 4<br>(18%)                  | 32<br>(9%)             |
| Behavioral:<br>change prof. or<br>organization                                    | 14<br>(14%)                 | 18<br>(15%)                  | 3<br>(8%)                   | 5<br>(18%)                  | 2<br>(12%)                  | 6<br>(32%)                  | 5<br>(39%)                  | 7<br>(32%)                  | 60<br>(17%)            |
| Behavioral: neg.<br>ratings of care   | 46<br>(47%)                 | 58<br>(49%)                  | 12<br>(33%)                 | 8<br>(29%)                  | 9<br>(53%)                  | 3<br>(16%)                  | 2<br>(15%)                  | 12<br>(55%)                 | 150<br>(43%)           |
| Behavioral:<br>disrespect from<br>patient   | 13<br>(13%)                 | 11<br>(9%)                   | 5<br>(14%)                  | 6<br>(21%)                  | 0<br>(0%)                   | 2<br>(11%)                  | 2<br>(15%)                  | 3<br>(14%)                  | 42<br>(12%)            |
| Behavioral:<br>Initiation of<br>legal<br>proceedings                              | 6<br>(6%)                   | 10<br>(9%)                   | 7<br>(19%)                  | 2<br>(7%)                   | 0<br>(0%)                   | 3<br>(16%)                  | 1<br>(8%)                   | 0<br>(0%)                   | 29<br>(8%)             |
| Health impact:<br>risky medical<br>situations from<br>disengagement/<br>avoidance | 4<br>(4%)                   | 0<br>(0%)                    | 2<br>(6%)                   | 1<br>(4%)                   | 0<br>(0%)                   | 0<br>(0%)                   | 1<br>(8%)                   | 2<br>(9%)                   | 10<br>(3%)             |
| Health impact:<br>lower quality of<br>care  | 15<br>(15%)                 | 16<br>(14%)                  | 9<br>(25%)                  | 8<br>(29%)                  | 2<br>(12%)                  | 2<br>(11%)                  | 2<br>(15%)                  | 3<br>(14%)                  | 57<br>(16%)            |
| Health impact:<br>neg. impacts on<br>mental/physical<br>health                    | 31<br>(31%)                 | 40<br>(34%)                  | 19<br>(53%)                 | 15<br>(54%)                 | 7<br>(41%)                  | 10<br>(53%)                 | 5<br>(39%)                  | 12<br>(55%)                 | 139<br>(39%)           |
| Health impact:<br>undignified<br>death  | 7<br>(7%)                   | 4<br>(3%)                    | 1<br>(3%)                   | 2<br>(7%)                   | 0<br>(0%)                   | 1<br>(5%)                   | 0<br>(0%)                   | 2<br>(9%)                   | 17<br>(5%)             |



### *Negative Emotions and Feelings*

Nearly 90% of cases (316 of 352 cases) were coded as patients/families experiencing negative emotions and feelings as a result of their disrespectful interactions. Many characteristics and criteria constitute this category as outlined by Sokol-Hessner et al. (2019), almost all of which were found in the cases reviewed. The most predominant emotions that were expressed throughout these cases related to negative feelings toward specific interaction(s) or consistently harmful experiences throughout the entire care experience, including:

- feeling traumatized or dehumanized;
- feeling abandoned, neglected, or unseen- like they “didn’t matter” or “weren’t cared for;”
- feeling anxious, stressed, and worried;
- feeling vulnerable and afraid;
- feeling humiliated, embarrassed, and belittled;
- feeling shamed, blamed, and/or insulted;
- feeling anger and frustration at not being listened to, not taken seriously, or feeling lied to;
- experiencing “horrible” care;
- feeling a power imbalance resulting in patients/families “feeling like a child,” and/or feeling insignificant and disparaged; and
- feeling unnecessarily distressed, hurt, excluded from conversations, unequipped with needed information, not being communicated to by the care team, and overall feeling disrespected.

### *Loss of Trust/Distrust*

There were 59 cases (17%) across all eight hospitals where the experience of disrespect led to the patient/family feeling a loss of trust or distrust in the health care professional, hospital, larger organization, or health care in general. In most of the cases, this loss of trust/loss of confidence in the organization was explicitly stated by the person who issued the complaint/grievance, with many indicating that they felt dismissed,

insulted, lied to, ignored, or not included in key decision-making, leading to a loss of trust. For some cases, a particular interaction or instance in their care delivery was challenging, while for others their loss of trust was built upon multiple additive issues that compounded and led to complete distrust in the health system. In other circumstances, this loss of trust was inferred through the indication that the individual/family would not return to the organization given the discomfort, disrespect, and disregard that was experienced.

*Behavioral Changes: Decreased Cognition Due to Emotion*

There were 17 cases (5%) across six hospitals where the care experience led to behavioral changes in the form of decreased cognition due to emotion. This was evident in patients indicating a decreased ability to process information, have sustained, productive conversations with actionable and clear next steps with staff, and/or make and understand decisions. In many cases that met this category, confusion and/or demonstrated lack of clear thinking and reasoning was documented, and patient-related factors had significant influence if a case was coded as having this potential consequence. In one example, a patient who had issued a formal grievance indicated being “laughed at” and “not allowed to leave” during her care encounter; upon reviewing the documentation included in the Datix report, it was noted throughout that the patient had confusion. This example underscores the importance of the patient’s condition(s) and mental/physical states when coding and interpreting results from the application of the framework and in ultimately determining whether or not the patient’s experience of disrespect might have been preventable. In this particular example, the patient felt “kidnapped,” but given her

documented confusion, there were protocols in place to limit her leaving under her own accord due to the high risk of serious harm that may have occurred.

*Behavioral Changes: Uninformed Decision-Making*

Forty-two (12%) patient/family disrespect experiences across all hospitals resulted in uninformed decision-making. In many of these cases, patients/families felt uninformed about treatment options, did not feel informed about their condition or subsequent treatment options, and indicated not being included in discussions with their care team nor believing that they provided informed consent for procedures. In one case, a patient's spouse indicated that he and his wife were not told about the necessity or rationale for a second surgery, did not believe that informed consent was obtained given they had "no idea of treatment options" prior to surgery, and noted that one of the providers seemed "oblivious" to their need for clarification and additional information.

*Behavioral Changes: Decreased Engagement*

Thirteen cases (4%) across six hospitals resulted in decreased engagement from patients/families. In these cases, one of the most common themes was patients tending to withdraw from the care experience in terms of not offering personal information and/or becoming more passive in their care by not asking questions, particularly if they were met with dismissive, judgmental, or discouraging comments from their care team. One patient indicated that because of continued poor interactions with one nurse, she asked to discharge early, and that she was having a difficult time "getting over the distress" she felt from her interactions with the one staff member. In many of these cases, it was evident that decreased engagement often occurred as a result of patients/families wanting

to minimize future interactions with a particular staff member given prior encounters that left them “uncomfortable,” “miserable,” or feeling “hopeless”.

*Behavioral Changes: Avoidance of Health Care*

Thirty-two cases (9%) across all hospitals resulted in avoidance of health care. In some cases, patients/families indicated their intention to cancel or avoid any subsequent visits with the organization given a previous poor experience. In several other cases, patients experienced dissatisfaction with the modality of follow-up care; in one example, a patient indicated her frustration, post-hospitalization, in the organization “not meeting her where she is” regarding intensive outpatient behavioral health services, and “discriminating” against patients by dictating how care is administered and not taking patient wishes into account. This particular patient was adamant about the harm and distress the organization caused her by not meeting her needs and threatened to avoid the care needed altogether.

*Behavioral Changes: Change Professional or Organization*

Sixty of the 352 cases (17%) across all hospitals led to the patient/family indicating they would change/discontinue care with a particular health professional or the organization, and/or discourage others from pursuing care with a particular health care professional or organization. In one example, a patient detailed an extremely poor interaction with a provider to other members of his care team; later in the patient’s stay, the provider indicated she was told that the patient had a problem with her, and the patient described his vulnerable state as he tried to navigate the conversation, with his “heart racing...in a hospital gown...about to go under anesthesia... EXTREMELY nervous and scared”. The provider delivered disturbing news to the patient prior to

surgery, leaving the patient to state “how DARE she treat ANY patient like this” and indicating that he would not only be reporting the incident to the medical board, but to dissuade anyone from receiving this type of care from this particular provider. This patient was particularly appreciative of the care received from other members of his care team but was so infuriated by this experience that he not only wanted to change professionals and organizations but was considering initiating legal proceedings as well.

*Behavioral Changes: Negative Ratings of Care*

There were 150 cases (43%) across all hospitals that resulted in negative ratings of care, which represented almost half of all included cases. This was illustrated through patients/ families indicating that they might not or would not return to the organization, and/or leaving prior to being seen, and/or prior to being discharged, given inordinate delays in care or disrespectful interactions in the hospital. Additionally, cases that met this category were found to have patients/families who expressed negative emotions toward care received, and/or unmet expectations during their experience. The frequency of this particular consequence could be helpful for organizations to interpret and contextualize lower patient experience survey scores (such as HCAHPS) as well.

*Behavioral Changes: Disrespect from Patient*

There were 42 cases (12%) across seven of the eight hospitals where patients and/or their families were documented as acting out in a disrespectful way. In some cases, the patient or family member had indicated how they had lost their temper, exhibited anger or irritation, raised their voice, and/or confronted staff either out of frustration for delays in care or unanswered questions, or as a response to disrespectful treatment from staff. In other cases, the researcher learned of patient/family disrespect

and/or challenging behaviors through notes in Datix from the organizational investigation notes that occurred in response to the issued complaint or grievance, which noted staff indicating if patients/families became “combative,” “started yelling,” became “accusatory” or “threatening”. As will be discussed in the presentation of Aim 3 results (Chapter Six), 12% was lower than expected given the increase of patient/family disrespectful behavior and communication over the past several years. Given that this particular documentation included patient/family-generated complaints and grievances (as opposed to staff-generated), this helped to contextualize the 12% observation. In general, tracking these data could serve as a helpful starting point for organizations to understand patient/family behavior toward staff, in addition to reviewing them in tandem with staff-generated reports of patient/family disrespect.

#### *Behavioral: Initiation of Legal Proceedings*

There were 29 cases (8%) across six hospitals where the disrespectful encounter led the patient or family member to indicate pursuit of legal action. Many of the cases reviewed indicated frustration, anger, hurt, disappointment, and incredulity about the care received or interactions with staff, with some indicating it was the “worst” health care experience they had ever had, leading patient/families to indicate they were securing, or had already engaged, an attorney, and/or would initiate action with different professional boards and/or regulatory authorities for additional investigation and resolution.

#### *Health Impact: Risky Medical Situations from Disengagement/Avoidance*

There were 10 cases (3%) across five hospitals where there was a perceived consequence of a risky medical situation due to the patient’s disengagement or avoidance of care due to their disrespectful experience. In one example, an elderly patient’s son

indicated he was never notified by the hospital when his mother had left the ED in the midst of being seen. The investigation notes indicated the ED was “extremely busy” that day with the patient’s nurse redirected to manage other acute patients; as a result, the elderly patient re-dressed herself and was found attempting to walk back to her care residence, when she was “picked up by a motorist” and safely taken back to her care home. The patient’s son’s emotional distress over the situation, including the physical risk that could have occurred with his elderly mother’s departure, and no one being aware of her attempted return back to her community facility, represented a potential risky medical situation resulting from disengagement with the health system in light of capacity and staffing issues and a potential lack of communication with the patient regarding wait times (and/or lack of communication in a manner understandable to the elderly patient), given the acuity of new patients entering the ED at the same time.

*Health Impact: Lower Quality of Care*

There were 57 cases (16%) across all hospitals that resulted in lower quality of care; many of the common themes indicated that there was delayed care, either due to inordinate wait times or patients being unclear about treatment options, not receiving enough information about treatment options, poor management of symptoms (such as pain or bleeding), and/or staff unresponsiveness to questions and immediate needs. There were also a few cases where the care team displayed disrespectful behavior among themselves in front of the patient/ family, causing patients/families to not only feel distressed during these interactions, but to potentially lose trust in the care team as well.

### *Health Impact: Negative Impacts on Mental and Physical Health*

There were 139 cases (39%) across all hospitals where the patient/family experience of disrespect resulted in negative impacts on both mental and physical health. In one case, a patient indicated that a surgical error during a scheduled procedure caused her an extended hospital stay, a longer recovery period, and subsequent “weakness” and “depression”. However, while she recounted her experience of physical suffering, she indicated she was “most hurt by the surgeon’s lack of caring”. Many cases that had negative impacts on both mental and physical health related to premature discharge; in one case, a patient felt “dismissed” and required a subsequent ED visit after being discharged with severe pain and other symptoms. Since she felt that she was not believed by staff, she went to a different organization for her follow-up care and subsequent emergency surgery given she was “too traumatized to go back” to the study organization after being discharged.

### *Health Impact: Undignified Death*

There were 17 cases (5%) across six hospitals where the patient/family experience resulted in an undignified death based on the patient’s family member’s or representative’s account. In one example, a mother recounted her distress while her daughter was dying, noting that she watched for hours as the care team “violated and abused her body when she was clearly gone,” outlining the difficulty in “watching all that was done...in the name of medicine and science.” Another case indicated the turmoil that the family experienced and the unanswered questions they had as a result of the patient’s death. The family indicated they had little information about the patient’s condition, and did not understand who was in charge, how to communicate concerns, or how to obtain



information, and felt that there was a delay in treatment leading to the patient’s untimely death. While some families threatened litigation in response to their distress, there were also many who pleaded for information, answers, and for someone to explain each step of the care provided as opposed to initiating legal action. There was more emphasis on understanding, and having compassionate, transparent interactions with hospital staff, as opposed to pursuing legal or regulatory action. Patient/family needs and expectations as they relate to disrespectful and poor care experiences will be discussed in more detail in the final chapter.

Table 4.19 below presents the distribution of professional consequences across the included cases across all eight hospitals.

**Table 4.19: Distribution of Potential Consequences – Professional**

| Consequences  | Hosp. 1<br>n=99 | Hosp. 2<br>n=118 | Hosp. 3<br>n=36 | Hosp. 4<br>n=28 | Hosp. 5<br>n=17 | Hosp. 6<br>n=19 | Hosp. 7<br>n=13 | Hosp. 8<br>n=22 | Total<br>n=352 |
|---|-----------------|------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|----------------|
| Antagonistic relationships with patients/ more difficult to care for them | 33<br>(3%)      | 27<br>(23%)      | 13<br>(36%)     | 10<br>(36%)     | 3<br>(18%)      | 3<br>(16%)      | 2<br>(15%)      | 5<br>(23%)      | 96<br>(27%)    |
| Disrespect from patients/ families  | 13<br>(13%)     | 11<br>(9%)       | 5<br>(14%)      | 6<br>(21%)      | 0<br>(0%)       | 2<br>(11%)      | 2<br>(15%)      | 3<br>(14%)      | 42<br>(12%)    |
| Observed disrespect normalized/ incorporated into learners’ practice      | 1<br>(1%)       | 4<br>(3%)        | 3<br>(8%)       | 1<br>(4%)       | 0<br>(0%)       | 1<br>(5%)       | 1<br>(8%)       | 2<br>(9%)       | 13<br>(3.6%)   |

Of the three potential professional-related consequences outlined in the BIDMC framework, antagonistic relationships with patients was the most predominant; the researcher inferred this based on the information provided for 96 of the 352 cases (27%).

In some cases, the patient or family member indicated they had lost their temper or raised their voice with staff in the complaint or grievance issued, while in other cases the researcher learned of patient/family disrespect and/or challenging behaviors through organizational investigation notes in Datix. In one instance, a provider indicated that the patient was “yelling and berating” the physician given her attempt to dissuade the patient from obtaining a certain test. These negative interactions have implications for the staff/patient relationship, and such strained relationships can potentially contribute to staff burnout, moral distress, fear of safety, empathy/compassion fatigue, and/or encourage attrition, and/or leaving the profession altogether (references here). This will be discussed in greater detail both in the Aim 3 results (Chapter Six) and in Chapter 7.

Similar to the “disrespect from patients/families” consequence above in the “patient/family” section, there were 42 cases (12%) where patients and/or their families were documented to have acted in a disrespectful way. In 13 cases (4%) it was inferred that observed disrespect became normalized and incorporated into the health care professional’s practice. In relation to the “observed disrespect becomes normalized into learners’ practice” category, cases/grievances were coded this way if it was indicated in Datix that the professional had multiple similar complaints in the past, indicating a problematic pattern or perpetuated behavior. Other examples were coded with this behavior if it was indicated that patients/ families had similar challenges with staff from the same unit either being unresponsive to patient needs or dismissive; in some circumstances, patients/families would indicate how their experience across other aspects of care were appropriate and positive until they reached a unit in which it appeared that there was a different, and more disrespectful, unit sub-culture.

Table 4.20 below presents the potential consequences to the organization across all eight hospitals based on the cases assessed.

**Table 4.20: Distribution of Potential Consequences – Organization**

| Consequences                              | Hosp.<br>1<br>n=99 | Hosp.<br>2<br>n=118 | Hosp.<br>3<br>n=36 | Hosp.<br>4<br>n=28 | Hosp.<br>5<br>n=17 | Hosp.<br>6<br>n=19 | Hosp.<br>7<br>n=13 | Hosp.<br>8<br>n=22 | Total<br>n=352 |
|---|--------------------|---------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|----------------|
| Patient attrition; lower quality outcomes | 3<br>(3%)          | 2<br>(2%)           | 7<br>(19%)         | 4<br>(14%)         | 0<br>(0%)          | 2<br>(11%)         | 4<br>(31%)         | 7<br>(32%)         | 29<br>(8%)     |
| Increased risk of injury to professionals | 4<br>(4%)          | 7<br>(6%)           | 1<br>(3%)          | 2<br>(7%)          | 0<br>(0%)          | 1<br>(5%)          | 0<br>(0%)          | 1<br>(5%)          | 16<br>(5%)     |
| Damage to reputation                      | 9<br>(9%)          | 5<br>(4%)           | 6<br>(17%)         | 4<br>(14%)         | 0<br>(0%)          | 5<br>(26%)         | 1<br>(7.7%)        | 6<br>(27%)         | 36<br>(10%)    |
| Increased malpractice risk                | 4<br>(4%)          | 2<br>(2%)           | 3<br>(8%)          | 3<br>(11%)         | 0<br>(0%)          | 1<br>(5%)          | 1<br>(8%)          | 2<br>(9%)          | 16<br>(5%)     |

The number of complaints/grievances that met the four different organization-related consequences were spread across all four factors. Damage to reputation (10%) and increased malpractice risk (5%) were coded based on comments in the complaints/grievances reviewed, several of which indicated that the patient/family would “pursue legal action” and/or “regulatory complaint processes”, would go to the media or post through social media about their experiences, and/or more broadly “discourage others” from receiving care at the organization. Many complaints/grievances were coded as having organizational consequences in the form of “patient attrition” if documentation indicated that the patient/family would “never return” to either the staff person, hospital, or the larger organization. Finally, in 16 (5%) of the complaints/grievances reviewed, documentation indicated that the patient or family member had been physical with and/or

verbally threatened a staff member, which allowed the researcher to infer that there was potential for increased risk of injury to professionals.

Lastly, there was one societal consequence outlined within the framework, and Table 4.21 illustrates this potential societal consequence among included cases across the eight hospitals.

**Table 4.21: Distribution of Potential Consequence – Society**

| Consequences                                     | Hosp. 1<br>n=99 | Hosp. 2<br>n=118 | Hosp. 3<br>n=36 | Hosp. 4<br>n=28 | Hosp. 5<br>n=17 | Hosp. 6<br>n=19 | Hosp. 7<br>n=13 | Hosp. 8<br>n=22 | Total<br>n=352 |
|--|-----------------|------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|----------------|
| Group traumatization and “culture of disrespect” | 0<br>(0%)       | 1<br>(<1%)       | 3<br>(8%)       | 0<br>(0%)       | 0<br>(0%)       | 0<br>(0%)       | 1<br>(8%)       | 1<br>(5%)       | 6<br>(2%)      |

The final group of potential consequences relates to broader, societal-level consequences that indicate “group traumatization and culture of disrespect”. Overall, this was difficult to assess based on available documentation within Datix; however, six of the 352 cases (2%) were coded as having this consequence. In one example, a patient told the CCT how she was “judged” and “mistreated” by the “entire medical system”, indicating her experience of “financial discrimination” and poor quality care, illustrating the patient’s deep traumatization by health care. In another example, a patient’s spouse outlined the gaps in care delivery and coordination he witnessed for his recently deceased wife’s hospital stay, emphasizing an “overall failure of the system”, without casting blame on any one individual. Instead, he holistically summarized the areas of opportunity across the delivery system. In his experiences, he noted “there was nothing compassionate in my wife’s stay, for her or me;” found that existing, historical patient

history information was “largely ignored;” was unsure of different steps in her care given it “wasn’t explained;” and did not know “what was happening or why,” highlighting a “lack of communication” among the care team, and wondering if enhanced communication, coordination, and understanding of his wife’s history “would have made a difference”. In each of the cases that met this category of “group traumatization” and “culture of disrespect”, the documentation reviewed indicated larger, systemic failures that represented breakdowns across the care continuum.

Table 4.22 below quantifies the results of the cases coded to each component within the BIDMC framework outlined in Tables 4.11-4.18 across the eight hospitals. Given that many cases were coded with multiple themes per framework component, the numbers below exceed the total number of included cases.

**Table 4.22: Summary of Results (n=352 cases)**

| Care Processes  | Professional/ Organizational Behaviors  | Contributing Factors   | Modifying Factors   | Potential Consequences  |
|---|---|--|---|---|
| <ul style="list-style-type: none"> <li>• <b>Ambulatory care access:</b> 18 cases (5%)</li> <li>• <b>Hospital bed management:</b> 11 (3%)</li> <li>• <b>Encounter initiation:</b> 44 (12.5%)</li> <li>• <b>H&amp;P exam:</b> 16 (4.5%)</li> <li>• <b>Discussions with patients about diagnosis, prognosis, treatment, etc.:</b> 125 (35.5%)</li> <li>• <b>Medical record documentation:</b> 24 (7%)</li> <li>• <b>Treatment:</b> 140 (40%)</li> <li>• <b>Assistance with inpatient ADLs:</b> 42 (12%)</li> <li>• <b>Family engagement and support:</b> 49 (14%)</li> <li>• <b>Personal possession management:</b> 3 (&lt;1%)</li> <li>• <b>Privacy:</b> 23 (6.5%)</li> <li>• <b>Adverse Event Management:</b> 7 (2%)</li> <li>• <b>Hospital Discharge:</b> 54 (15.3%)</li> </ul> | <ul style="list-style-type: none"> <li>• <b>Undue familiarity; labeling:</b> 3 (&lt;1%)</li> <li>• <b>Uncaring; indifferent; impersonal:</b> 99 (28%)</li> <li>• <b>Dismissing; disregarding:</b> 107 (30%)</li> <li>• <b>Inattentive; ignoring; neglecting; abandoning:</b> 86 (24%)</li> <li>• <b>Interrupting; rushing:</b> 15 (4%)</li> <li>• <b>Patronizing; condescending:</b> 19 (5%)</li> <li>• <b>Treating patient like an object:</b> 13 (4%)</li> <li>• <b>Discriminating:</b> 30 (9%)</li> <li>• <b>Controlling or withholding information; not consenting; violating autonomy:</b> 71 (20%)</li> <li>• <b>Tricking; deceiving; coercing; exploiting:</b> 16 (5%)</li> <li>• <b>Violating confidentiality or privacy:</b> 12 (3%)</li> <li>• <b>Controlling or restricting freedom or movement:</b> 16 (5%)</li> <li>• <b>Poor quality medical care:</b> 82 (23%)</li> <li>• <b>Verbal abuse:</b> 13 (4%)</li> <li>• <b>Physical or sexual abuse/assault:</b> 38 (11%)</li> </ul> | <ul style="list-style-type: none"> <li>• <b>Environment of work and care:</b> 117 (33%)</li> <li>• <b>Patient-related:</b> 157 (45%)</li> <li>• <b>Professional-related:</b> 199 (57%)</li> <li>• <b>Culture (beyond organization):</b> 6 (2%)</li> <li>• <b>Other organizational factors:</b> 15 (4%)</li> <li>• <b>Leadership:</b> 4 (1%)</li> <li>• <b>Processes:</b> 142 (40%)</li> <li>• <b>Policies:</b> 50 (14%)</li> </ul> | <p><b><u>Intrinsic to Patient:</u></b></p> <ul style="list-style-type: none"> <li>• <b>Physical, emotional, or spiritual distress, and functional status:</b> 144 (41%)</li> <li>• <b>Demographic characteristics:</b> 34 (10%)</li> <li>• <b>Resilience and other coping strategies:</b> 1 (&lt;1%)</li> <li>• <b>Decision-making capacity:</b> 12 (3%)</li> <li>• <b>Perceptions of connectedness and social support:</b> 10 (3%)</li> <li>• <b>Health care expectations:</b> 8 (2%)</li> </ul> <p><b><u>Extrinsic to Patient:</u></b></p> <ul style="list-style-type: none"> <li>• <b>Characteristics of the disrespect that occurred:</b> 105 (30%)</li> <li>• <b>How prof. and the institution respond:</b> 169 (48%)</li> </ul> | <p><b><u>Patient/Family:</u></b></p> <ul style="list-style-type: none"> <li>• <b>Negative emotions and feelings:</b> 316 (90%)</li> <li>• <b>Loss of trust/ distrust:</b> 59 (17%)</li> <li>• <b>Decreased cognition due to emotion:</b> 17 (5%)</li> <li>• <b>Uninformed decision- making:</b> 42 (12%)</li> <li>• <b>Less engagement:</b> 13 (4%)</li> <li>• <b>Avoidance of health care:</b> 32 (9%)</li> <li>• <b>Change professional or organization:</b> 60 (17%)</li> <li>• <b>Negative ratings of care:</b> 150 (43%)</li> <li>• <b>Disrespect from patient:</b> 42 (12%)</li> <li>• <b>Initiation of legal procedures:</b> 29 (8%)</li> <li>• <b>Risky medical situations from disengagement and avoidance:</b> 10 (3%)</li> <li>• <b>Lower quality of care:</b> 57 (16%)</li> <li>• <b>Negative impacts on mental and physical health:</b> 139 (39%)</li> <li>• <b>Undignified death:</b> 17 (5%)</li> </ul> <p><b><u>Professional:</u></b></p> <ul style="list-style-type: none"> <li>• <b>Antagonistic relationships with patients/more difficult to care for them:</b> 96 (27%)</li> <li>• <b>Disrespect from patients/families:</b> 42 (12%)</li> <li>• <b>Observed disrespect becomes normalized/ incorporated into learners’ practice:</b> 13 (4%)</li> </ul> <p><b><u>Organization:</u></b></p> <ul style="list-style-type: none"> <li>• <b>Patient attrition; lower outcomes:</b> 29 (8%)</li> <li>• <b>Increased risk of injury to prof:</b> 16 (5%)</li> <li>• <b>Damage to reputation:</b> 36 (10%)</li> <li>• <b>Increased malpractice risk:</b> 16 (5%)</li> </ul> <p><b><u>Society:</u></b></p> <ul style="list-style-type: none"> <li>• <b>Group “traumatization” and “culture of disrespect”:</b> 6 (2%)</li> </ul> |

## Implications of COVID-19

Given the timing of this research, and that the complaints and grievances reviewed came from 2021, one year into the COVID-19 pandemic, it is important to highlight the influence of the pandemic on these results. Of the 1,037 cases in 2021, 100 cases (10%) reflected an encounter that was influenced by COVID-19 in some way.

Table 4.23 below indicates that 46 of the 352 cases (13%) reflected such an encounter.

While Hospitals 1 and 2 had the highest number of COVID-19 related cases, the two smallest, rural hospitals (Hospitals 6 and 7) had a higher overall percentage of COVID-19 related cases which might reflect differences in patient population and staff beliefs around utility of masks and policies addressing government guidance around disease precautions.

**Table 4.23: Included Cases with COVID-19 Factors**

|  | Hosp.<br>1<br>n=99 | Hosp.<br>2<br>n=118 | Hosp.<br>3<br>n=36 | Hosp.<br>4<br>n=28 | Hosp.<br>5<br>n=17 | Hosp.<br>6<br>n=19 | Hosp.<br>7<br>n=13 | Hosp.<br>8<br>n=22 | Total<br>n=352 |
|--|--------------------|---------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|----------------|
| Cases with COVID 19-related factors documented | 11<br>(11%)        | 16<br>(14%)         | 3<br>(8%)          | 1<br>(4%)          | 3<br>(18%)         | 4<br>(21%)         | 4<br>(31%)         | 4<br>(18%)         | 46<br>(13%)    |

Disparate views on the utility of masks, visitor and vaccination policies, and the pandemic as a whole were found across both patients/families and health care professionals in the complaints/grievances reviewed. One patient indicated he was told he did not “deserve” to be in the hospital, “taking space of someone who really needed it,” and felt discriminated against given he was not vaccinated against COVID-19. In contrast, there were a few instances of patients/families indicating they felt uncomfortable seeing staff who were vocal against the utility of masks, were not attentive

to proper fit of their mask, and/or who were dismissive of the COVID-19 vaccine. In several other cases, many patients or family members were distressed or frustrated by the evolving visitor policies that either precluded or limited the number of visitors who were allowed on an inpatient unit. Another instance highlighted the intensity of the situation for both patients and staff and the heightened sense of maintaining distance and/or emotional distress; in one example, a provider and patient, along with the patient's spouse, had a series of fraught interactions that quickly escalated, and both the spouse and the provider yelled at one another at close proximity leading the provider to say "there's a pandemic going on...don't you ever get in my face again".

Masks also played a role in complaints/grievances, with patients/families opposing mask-wearing policies, receiving unwarranted criticism for not wearing masks appropriately, or expressing frustration with hospital staff for their relaxed approach to wearing masks. One patient indicated how her husband's mask fell below his nose and a staff person "barked" at him to pull his mask over his face. In another example, a patient felt she was being coerced into having similar opinions to a staff member, as the health care professional told her that "the whole COVID thing was blown out of proportion," with the patient feeling as though the staff person was emphasizing she got a vaccination exemption, did not believe in vaccinations, and "threw it in her face", leading to a "disrespectful" care visit. Further insights about how the COVID-19 pandemic influenced care delivery will be summarized below in the discussion section and in Aim 3 results (Chapter Six). Overall, complaints/grievances needed to be reviewed from a variety of perspectives and within their broader contexts to better understand causes of disrespect, and how to mitigate future occurrences. It is evident that the presence of COVID-19



impacted both the delivery and experience of care, and was a major challenge for hospitals and patients alike, particularly if they held different views on the modification of policies/processes and/or on the pandemic as a whole. However, given that only 13% of included cases related to COVID-19, it is important to recognize that COVID-19 was not the predominant cause of patients and families experiencing non-physical harm from disrespect in 2021.

### **Aim 1 Discussion and Recommendations**

As discussed above, of the 1,037 cases captured across eight hospitals in 2021, 352 (34%) met inclusion criteria as outlined in the BIDMC Prioritization Schema for subsequent analyses using BIDMC's incident analysis framework. This summary section describes the utility and challenges of, and proposed modifications to, both the BIDMC Prioritization Schema and incident analysis framework for future use by organizations, as well as observations and recommendations for organizations collecting complaints/grievances. The final chapter will provide additional commentary on the implications of this research, study limitations, and recommendations for future research.

While the Prioritization Schema and framework would ordinarily be used by a team in real-time to review and investigate cases, for the purposes of this study the researcher was able to conduct a fully retrospective review of a large number of cases using existing documentation within Datix in order to apply the schema and framework. While there are limitations to a single researcher coding data and conducting analyses (which will be discussed more in Chapter Seven), the ability to apply both the schema and framework to previous cases can be valuable for organizations to obtain a baseline

understanding of their current state. As a result, one conclusion is that organizations can use these tools both retrospectively and in real-time to review current complaints/grievances as a means to delve into patient/family experiences from disrespect and tailor solutions to address and mitigate future occurrences. For organizations that use the BIDMC framework moving forward, it is anticipated that the incident analysis process would involve multiple staff members conducting the review, which may allow for robust discussion during and after the analysis from multiple perspectives.

### **BIDMC Prioritization Schema: Utility and Opportunities for Refinement**

The original intent of the BIDMC Prioritization Schema was to support systematic winnowing of a high volume of data by identifying higher-risk cases that not only potentially represented a higher risk to future patients/families than lower-risk cases, but also signified risk to health care professionals and the organization (Sokol-Hessner, personal communication, October 5, 2023). Prior to this research, the application of the Prioritization Schema to identify higher risk cases had not been tested. Overall, based on the schema's application in this research, it is evident that it serves as a valuable and effective tool in surfacing higher-risk events for subsequent analysis using the BIDMC framework, given its clear criteria and methodology for inclusion. Applying the schema to each case proved to be both intuitive and systematic by providing direction on how to prioritize cases across different levels of risk, surfacing the highest-risk cases for investigation. Cases that met one or more high risk factors and/or two or more moderate risk factors indicated inclusion for investigation and discussion. Cases that solely met criteria for lower-risk factors did not necessitate the same level of review and

investigation. However, documenting and aggregating these cases in the future could provide direction to teams by surfacing key themes.

Based on the researcher's use of the schema in assessing inclusion/exclusion of cases across a one-year timeframe, the following observations and recommendations for refinement of the schema are provided below.

**Recommendation 1:** A new section within the schema should be developed that explicitly allows organizations to capture if there is limited information/insufficient documentation to include the case for subsequent analysis. In this study, there were a large number of cases that had limited documentation within Datix (76%). As such, this would be a valuable data point for health systems to collect to understand any patterns or insights around why certain cases have less information than others. As an example, one case reviewed was categorized by the organization as “discriminatory”, and the case would have met a high risk factor around “experiencing inequities” in the schema (thus qualifying it for inclusion in subsequent analysis using the BIDMC framework), but the case had such limited documentation that the researcher could not include it. As organizations can use the Prioritization Schema as a tool for systematically prioritizing cases across different risk levels, adding a section that captures the extent of information to make the determination would be valuable.

**Recommendation 2:** Based on the breadth of cases reviewed, adding a “high risk factor” that relates to the patient's family/representative blaming the care team/hospital for the patient's death is recommended. The severity and significance of this assertion warrants these types of cases to be classified as a high risk factor, leading to their inclusion for additional investigation through application of the BIDMC framework. This

would allow for a more in-depth review of standards of care followed, care coordination, communication, professional behaviors, and patient characteristics. Additionally, there may be many potential downstream consequences of the family/representative believing – and articulating the belief – that the care team or hospital caused a patient death; these could correspond to many of the consequences outlined in the BIDMC framework (e.g., loss of family trust/distrust, disrespect from patients/families toward the health care staff, damage to reputation, and/or increased malpractice risk) spanning the patient/family, professional, and organizational levels.

**Recommendation 3:** Another recommendation is to expand the “moderate risk factor” criterion that states patient/family describe their experience in terms of “disrespect”, “indignity,” or “loss of trust” to include other similar concepts and terms that signify an emotionally distressing experience as opposed to singularly grounding the experience in terms of disrespect. There were several repeated words that patients/families used throughout the reviewed cases, including describing their experience and/or interaction(s) as “dehumanizing,” “traumatizing,” and “degrading”. Brown et al. (2018) discussed disrespect and dehumanization within the ICU setting specifically, noting that dehumanization “overlaps substantially with disrespect and is a denial of dignity” (p. 1391), and that ICU patients, in particular, may experience dehumanization because of typical characteristics: “often lack[ing] many typical attributes of modern human beings: consciousness, agency, and self-determination” (p. 1390). Expanding this criterion to encompass these other key terms that share commonalities with respect, dignity, and loss of trust may allow for additional inclusion of patient/family experiences of considerable distress that warrant further analysis.

**Recommendation 4:** One final consideration for the schema relates to the “low risk” section. Cases that only met low risk factors within the schema represented a lower priority for the organization and did not meet inclusion criteria on their own. However, if cases met only low risk factors, the schema encouraged organizations to document and aggregate these cases to identify themes. Additionally, if a low risk factor was met in addition to moderate or high risk factors, the case would be included for subsequent analysis. Given the data reviewed for this study, one recommendation for expanding the low risk criteria “event not related to the patient’s care experience” and/or “patient/family having trouble getting medical records or appointment” relates to including “patient/family inconvenience or hardship experienced”. Some patients/families indicated difficulty in securing transportation to appointments, distance traveled to appointments (particularly for patients in rural communities), and/or work considerations with inflexible work schedules.

Capturing these data points can be important for organizations to understand patient/family social determinant-related hardships with patient populations across different socioeconomic backgrounds. As an example, a hospital canceling a surgery or appointment creates patient inconvenience at a minimum, as well as potentially emotional and financial distress due to missed wages from having to travel to an appointment that was canceled without the patient’s knowledge. This risk factor could range from a minor inconvenience to a greater hardship, particularly when coupled with moderate or high-risk factors (such as “event having multiple impacts” or “patients regularly experiencing inequities”) which would warrant additional analyses and mitigation.

Overall, the Prioritization Schema served as an effective tool for examining a large number of cases for risk prioritization and selecting higher-risk cases for subsequent analysis using the BIDMC framework. Some schema criteria may be easier to determine during a retrospective review compared to a real-time assessment in which not all information about the complaint/grievance may be known at the time. However, the schema serves as an effective way to discern and select cases systematically, while also including criteria framed in encompassing terms that allow for latitude in interpretation when including/excluding cases.

### **BIDMC Incident Analysis Framework: Utility and Opportunities for Refinement**

As previously noted, applying the organization's patient/family-generated grievances and complaints to Sokol-Hessner et al.'s (2019) five-component BIDMC framework allowed for these events to be systematically captured and characterized for analysis. The framework provided a structured, systems-oriented approach for assessing patient and family experiences of disrespect. Overall, it was found that most included cases could easily be applied across the framework, and the analysis generated insights surrounding the patient/family's experience of disrespect in a collective manner. Additionally, in many cases, patients/families issuing the complaint or grievance pinpointed the particular interaction or portion of their care that caused them emotional distress or the feeling of being disrespected, while acknowledging other interactions, care team members, and/or processes during their stay that were seamless, positive, and/or exceeded expectations. This observation underscores the utility of the BIDMC framework in allowing organizations to delve into a more holistic review of an event to better understand root causes of specific shortfalls.

Organizations can use the framework to drill down on individual, high-risk cases, and to aggregate analyses to identify patterns and areas of opportunity. Based on application of the BIDMC framework to this research, considerations for framework modifications across the five components are outlined below.

### *Care Processes*

Table 4.14 above quantified the “care processes” where patients experienced non-physical harm, with many cases coded with more than one process type, which is consistent with Sokol-Hessner et al.’s (2019) discussion. Within this research, it was found that patients primarily felt non-physical harm from disrespect related to processes around their treatment (40%) (which could include medication administration, pain management, performing procedures, restraint management, delirium management, and/or psychosocial support, as defined by Sokol-Hessner et al., 2019) and in discussions about diagnosis, prognosis, treatment options, consent, and shared decision-making (36%).

For this particular study organization as a case example, a recommendation would be to focus improvement efforts on optimizing treatment processes, communication processes specifically related to the way care teams speak with patients and families about their care and finding ways to ensure patients/families feel heard and cared for. These are all key areas for this organization to strengthen improvement efforts and may be relevant in other organizations applying the schema in a similar way.

Proposed recommendations to the framework specifically related to care processes based on reviewed cases include: 1) mimicking the “high risk” factor within the Prioritization Schema by adding a process around post-death management (inclusive

of documentation, body management, and emotional impact of post-death processes); 2) expanding the “discussions with patients...” care process to include culturally competent care delivery/ communication/processes (inclusive of interpreter services); and 3) adding transfer between units and/or facilities or expanding the “bed management” process to include transfers.

### *Professional and Organizational Behaviors*

Most of the “professional and organizational behaviors” outlined in this section of the framework were readily applicable to cases. As noted above in Table 4.15, five categories of professional/organizational behaviors were most prevalent among the cases: 1) dismissing and/or disregarding (30%); 2) uncaring, indifferent, and/or impersonal (28%); 3) inattentive, ignoring, neglecting, and/or abandoning (24%); 4) poor quality medical care (23%); and 5) controlling or withholding information, not consenting, and/or violating autonomy (20%). Many of these behaviors are similar in nature, and many cases reviewed met several of these categories given their similarities and/or ability to influence one another. As a result, most cases were coded as meeting more than one category of professional/organizational behaviors.

One suggestion for addition to this section within the framework involves including “blaming or shaming”. Patient/family experiences of feeling “blamed or shamed” by care providers surfaced in many cases, and while these occurrences could be coded under “patronizing; condescending” or “verbal abuse,” adding “blaming and/or shaming” is a consideration for refinement.



### *Contributing Factors*

As earlier noted, the “contributing factors” category within the BIDMC framework “sets the stage” for disrespectful behaviors and included patient-related and professional-related factors, the environment of work and care, leadership, processes, policies, other organizational factors, and culture (Sokol-Hessner et al., 2019, p. 663). As Table 4.16 highlighted, the core contributing factors within this research included professional-related (57%), patient-related (45%), processes (40%), and environment of work and care (33%). Often, cases were coded as having more than one contributing factor, and the factors identified in the framework were easily applied to reviewed cases overall. One factor that the researcher expected to use far more than was applicable was the “leadership” contributing factor given the abundance of existing research outlined in Chapter Two describing the role of leadership in establishing and maintaining quality, patient safety, and safety culture. However, given the existing documentation available to the researcher, it was difficult to assign to cases, with only 4% of cases coded as having a “leadership” contributing factor. This factor may be easier to ascertain when reviewing cases in real-time, and/or in looking across aggregated cases to determine if and how leadership engagement may need to be leveraged and prioritized to mitigate future occurrences as a higher-level intervention.

Echoing Sokol-Hessner et al.’s (2015) findings, this research found that some patient conditions, processes (e.g., catheter care), and/or the care environment (e.g., being in a curtained bay area instead of a private room) led to the patient/family feeling disrespected, as opposed to the care team intentionally showing disrespect. These

circumstances underscore the importance of organizational staff communicating and acknowledging the patient's/family's experiences and feelings.

Given the timeframe in which this research was conducted and the influence of the COVID-19 pandemic on all aspects of operations, one recommendation for refinement within the "Contributing Factors" section of the framework is adding "major organizational or environmental influences/circumstances". Characterizing complaints and grievances needs to occur within a broad context.

Consistent with the discussion surrounding Scott's (1992) model of an organization in Chapter Two, organizations cannot be viewed in isolation from their larger environment. The influence of the COVID-19 pandemic was pervasive throughout the analysis, and surfaced in different ways; for instance, it could have been at the root of the complaint/grievance, and/or influenced the investigation, as it impacted the environment of care, policies, processes, staffing, and other aspects of care delivery. Additionally, there were major institutional influences that were present during this research, including a major reorganization, workforce layoffs, contentious union negotiations and authorized labor strikes, financial concerns, and a health system workplace violence occurrence within the community, all of which had broader implications for workforce retention/engagement/satisfaction, processes, policies, delivery of care, and interactions with patients and families.

As a result, including a contributing factor such as "major organizational or environmental influences/circumstances" would be a beneficial addition to the framework, as these events are significant enough to influence and/or threaten operations, culture, policies, processes, care delivery, and workforce dynamics, including attitudes,

retention, engagement, and satisfaction. Recognizing this broader context is essential when characterizing, learning from instances of disrespect, and ultimately, mitigating such occurrences.

### *Modifying Factors*

As previously noted, “modifying factors” can alter the potential consequences of disrespect that has occurred and can be both intrinsic and extrinsic to the patient (Sokol-Hessner et al., 2019). Within this research, this was the most challenging component of the framework for the researcher to apply. Because there were two parts of the modifying factors component – “intrinsic to the patient” and “extrinsic to the patient” – it is believed that the intrinsic portion of the modifying factors component is already captured and addressed within other existing parts of the framework and could therefore be eliminated from this component of the framework to avoid duplication. This would leave the “extrinsic” portion as the focus for the modifying factors section, which would concentrate on the patient/family and organizational responses after a disrespectful event occurred.

Research has emphasized the importance of open organizational communication with patients and families after errors, and how this communication may affect the “scope, severity, and duration of emotional impact they suffer” (Sokol-Hessner et al., 2024, p. 1). This emphasis on understanding and strengthening responses after events have occurred allows organizations to learn and develop strategies for supporting patients and families, minimize suffering, and mitigating future occurrences of harm. Chapter Seven will provide additional context around how organizations can promote open

communication and transparency with patients and families through communication-and-resolution programs.

### *Consequences of Disrespect*

As with the other components of this framework, the “consequences” factors were overall easily applied to cases, with most complaints/grievances having multiple consequences across many levels (patient/family, professional, organization, and society).

Potential recommendations based on this research across the four levels include:

1. **Patient/family consequences:** There were some instances of patients/families indicating there was a need for additional care and/or procedures to address the poor quality medical care received, which could have stemmed from a disrespectful interaction with care providers. As such, “additional follow-up care required” could serve as a potential addition to the “health impact” portion of patient/family consequences, and/or the “risky medical situation from disengagement and avoidance” factor could be expanded to include “due to poor quality medical care or organizational response”.
2. **Professional consequences:** One timely and pertinent addition to the list of professional consequences is related to the mental and physical well-being of staff, inclusive of burnout, moral distress and/or injury, decreased empathy/ “empathy fatigue”, fear of safety, resignation, and/or leaving one’s profession altogether. As will be discussed in Aim 3’s findings (Chapter Six), almost all interviewees reinforced the presence of burnout, moral distress, fear of safety, decreased empathy due to continued antagonistic interactions and/or workforce demands, and/or colleagues leaving the profession altogether due to the ubiquity of these factors.
3. **Organizational consequences:** Within this level, and building upon the professional consequences above, one additional organizational consequence that could be added to the framework could include workforce retention and/or resignation. As noted above, these issues around retention and resignation surfaced in Aim 3 interview findings.
4. **Societal consequences:** Consequences relating to the society level were most difficult to assess based on the available documentation with Datix, with 2% of all cases coded as having potential societal consequences. One consideration that could be included here relates to “patient care spanning multiple institutions”. Patients often receive care from various settings and organizations to address their care needs, and a broader consideration for all organizations is to understand how

the way they deliver care contributes to the patient/family's overall, cumulative experience with the health care system at a broader level. A few cases reviewed within this research indicated that a patient received care within a hospital in the organization as well as a physician group clinic contracted with the organization; the investigation notes indicated that the organization did an internal review but ended with "closing the case out but with remaining questions to [contracted physician group]". It was unknown if the organization attempted to reconcile this complaint/grievance with the external, contracted partner. While each organization has its own processes, policies, workforce, and operations, this case example reinforces a broader question around how organizations learn from these experiences of disrespect and potential gaps in care when caring for patients and underscores that each care experience represents patient/family touchpoints with the broader health care system, which can collectively influence patients' overall perception and experience of health care.

### *Summary*

While collectively each component of this framework is necessary and valuable for understanding, learning from, and mitigating future occurrences, capturing the consequences of these experiences might be one of the most valuable and compelling components of the BIDMC framework. Consequences demonstrate to executive leaders the weight of non-physical harm events on patients/families, the organization's workforce, the organization as a whole, and within the larger health care market – and can mobilize efforts and continue progress in tracking and mitigation of these types of harms. Identifying and quantifying consequences of disrespectful occurrences provides essential data that have not typically been derived in a systematic way, and could provide crucial insights to garner support for continued tracking, review, and mitigation of non-physical harm, and to highlight the impacts to not only patient/family and workforce well-being, but to the organization's viability.

## **Reflections and Recommendations for Organizations**

As noted above in the “BIDMC Prioritization Schema – Utility and Opportunities for Refinement” section, many cases did not have enough information documented in the Datix record for them to be included for subsequent analysis using the BIDMC framework. Limited information in Datix was due to a number of observed reasons, including: the documentation of information provided directly from the patient was minimal; the organization’s internal investigation (and/or documentation of the investigation) was limited; the staff were unable to reach the patient/family for additional follow-up; and/or no referenced original source document (e.g., letter or e-mail from the patient/family) was attached in the Datix file. Additionally, in some circumstances the patient’s experience was broadly and/or too generically summarized by the intake team in the Datix record (i.e., “the patient was upset about their care”), the documented summary of the event provided insufficient detail to meet inclusion criteria, and/or there was inadequate information in the patient’s/family member’s voice to allow for subsequent analysis using the BIDMC incident analysis framework.

Such limited documentation of information can stem from a number of reasons, and have larger implications, including reflecting the strength of the organization’s culture of safety, the terminology and capabilities within the reporting system(s) used to capture/track/manage events, leadership’s interest in the information, and forums/mechanisms for the intake teams to regularly report and share information with leadership (as well as obtain feedback), among others. Reinforcing the above discussion regarding the BIDMC Prioritization Schema, it would behoove organizations to track cases that have limited information; including this component in the schema would be an

initial place where organizations could do this and aggregate evidence for further study to truly understand root causes of substandard documentation.

**Recommendation 1:** Based on the discussion above, organizations should strengthen and standardize the intake team’s process for receiving, capturing, and managing complaints/grievances to ensure less variation in documentation among cases, and to strengthen the organization’s understanding of the complaint/grievance. Datix records that had emails, letters, or voicemail transcripts directly from the patient/family offered a much clearer understanding of the issue from the patient/family perspective in their “voice” compared to solely relying on the organization’s documentation and the intake team’s summary of the patient/family perspective. Additionally, often the summarized statement by the intake team significantly underemphasized the magnitude of the patient/family’s true feelings and/or extent of the impact of the harmful event. For example, some cases had a summary statement from the intake team noting that “the patient was upset with their stay;” some of those cases then had additional documentation either directly from the patient/family or the intake team using verbatim language, indicating that the patient was “traumatized”, had a “dehumanizing” experience, “never wanted to return”, or “felt blamed, shamed, or humiliated”. These distinctions are critical in first learning from episodes of disrespect, and then advancing how organizations address and mitigate concerns.

Standardized training or guidance on entering complaints and grievances so that the voice of the person issuing the complaint or grievance is preserved to the extent possible would strengthen the intake process and subsequent analysis of complaints and grievances. Additionally, the organization’s incident reporting system may influence how

staff capture and resolve events, including the language used. For instance, the researcher reviewed cases logged in Datix to conduct this research; however, by the end of 2023, the organization had transitioned from Datix to Press Ganey’s “High Reliability Platform” that was equipped with enhanced reporting and improvement capabilities. While organizations have to prioritize training staff and leaders to leverage such technological capabilities to make them effective in capturing and learning from harm events, the transition to an event reporting system that is built to encourage improvement and learning, and uses more patient/family-centered terminology and approaches, may help promote enhanced ways for organizations to capture, understand, and mitigate preventable harms. Additionally, there may be an opportunity for incident reporting systems to indicate through a flag or alert when limited information is inputted to encourage the submitter to add more information about the event before submitting the report; this might encourage a more detailed account of the event, thereby allowing for a better opportunity to learn and improve from the occurrence.

**Recommendation 2:** A second recommendation is to capture more patient/family demographic data in the complaint/grievance process so organizations have a better understanding of who is generating complaints and grievances among their patient population, and to ensure they are hearing from individuals and groups who regularly experience inequities, and/or not unintentionally creating challenges for certain patient populations to speak up about their care. A high risk factor within the Prioritization Schema includes “patients who regularly experience inequities;” in this research it was difficult to determine this unless the patient or family member indicated they felt discriminated against in some way, and/or documentation from the investigation



indicated that the patient might have experienced inequitable care. As can be seen in Table 4.3 above, only 4% of all cases met this high risk factor, which may suggest that organizations are not regularly hearing from individuals who regularly experience inequities. As previously mentioned, it is possible that the number of grievances and complaints were underreported; the mechanisms in which patients/families can submit complaints and grievances may be limiting and unintentionally excluding certain patient populations from reaching the organization. For example, it may be more difficult for patients who speak languages other than English, or those without access to the internet or a phone to initiate a complaint or grievance. These equity implications need to be considered and addressed by organizations.

**Recommendation 3:** As highlighted above in Table 4.12 the organization employed the terminology “substantiated,” “partly substantiated,” and “not substantiated” within Datix, and while the organization’s determination of substantiation was not factored into this study’s inclusion/exclusion process, it was captured to demonstrate the distribution of substantiation. Of the 352 included cases, approximately 20% of all cases were either partly or fully substantiated by the organization, 36% were not substantiated, and 44% did not have this outcome documented in Datix. Regardless of whether the organization formally substantiated the complaint or grievance, it would be beneficial for organizations to recognize that the patient/family experienced disrespect; it was often found by the organization that there was no deviation from the standard of care, but the patient nevertheless felt dismissed, traumatized, or disrespected.

Proactive and respectful communication with patients/families about events, including those where the standard of care was met, is a critical part of reliable harm

response programs, and has been associated with a lower risk of prolonged emotional impact (Sokol-Hessner et al., 2024). Additionally, as organizations look to become more person/family-centered, using language that supports this shift from an adversarial and legal “substantiation” terminology to language that specifies a lapse or deviation in standard of care or best practice can still be indicative of whether the organization made an error, while acknowledging the patient’s negative experience and aiming to ease their suffering (Sokol-Hessner, personal communication, October 5, 2023).

### **Summary**

As previously discussed, 34% of all cases within a one-year time period met inclusion criteria. This does not suggest that only 34% of patients/families who issued complaints/grievances in 2021 felt disrespected; the total cases captured in 2021 and the included cases likely both underrepresent the true extent of patient/family experience of dissatisfaction and disrespect. Although there were almost certainly many more complaints and grievances during this study’s time period, and ways to improve reporting rates may be an important target for organizational improvement work, the existing quantity of complaint and grievance data appears more than sufficient to inform and drive organizational learning and improvement, at least at a system level across multiple hospitals.

Coding and aggregating complaints/grievances holistically is one way that organizations can leverage captured information and drive improvements, as opposed to solely managing and addressing cases as individual, isolated instances. Furthermore, the BIDMC Prioritization Schema is an effective tool in paring down a large number of

complaints/grievances for organizations to focus on risk prioritization. Coding and aggregating cases as opposed to solely viewing them as individual, isolated instances allows for broader insights to surface to drive improvements across a larger scale.

Consistent with Sokol-Hessner et al.'s (2019) findings, through application of the BIDMC incident analysis framework to cases occurring across eight hospitals, this study found that patient/family experiences of disrespect occurred across diverse care processes, resulted from a myriad of professional and organizational behaviors, were influenced and shaped by various contributing factors across different levels, and had lasting consequences across patient/family, professional, organizational, and societal levels. The BIDMC framework allowed the identification and reinforcement that patient/family experiences of disrespect are complex and multi-faceted, and must be viewed holistically in order to understand root causes and mitigate future events. While each factor within each category was explained independently above, it cannot be overstated that these categories must be reviewed collectively in order to better understand patient/family non-physical harm experienced and to encourage improvement, promoting a systems view of improvement as opposed to a piecemeal approach or narrow understanding of causes of disrespect. Chapter Seven will present implications of the research, recommendations for various interested parties, limitations of the study, opportunities for improving safety, and recommendations for future research.

## **Chapter Five – Aim 2 Results**

### **Overview**

In Aim 1, Sokol-Hessner et al.'s (2019) framework was used to describe and characterize harm from disrespect. The purpose of Aim 2 was to quantitatively assess patient perception of respect via the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience survey data, and determine whether patient experience was associated with staff perception of organizational safety culture. This chapter describes the process carried out to investigate this quantitative aim and presents key findings from the analyses. A discussion of the research implications, recommendations to key groups, study limitations, and suggestions for future research is presented in Chapter Seven.

### **Data Sources, Sample, and Data Collection**

Aim 2 sought to identify associations between patient experience of respect and staff perceptions of safety culture, and determine the extent of variations in respect and safety culture across hospitals and units. As previously discussed, safety culture is often described in tandem with an organization's patient safety climate, referring to "employee perceptions and attitudes about the surface features of patient safety culture at a given point in time" (Morello et al., 2013, p. 11). Research has largely highlighted differences in safety climate levels for different subgroups and hierarchical levels, and between clinicians and non-clinicians, reinforcing this study's purpose in assessing both association and variation (Leape et al., 2012a; Ginsburg, 2015; Ginsburg & Oore, 2015;

Hickner et al., 2016; Martinez et al., 2015; Schwendimenn et al., 2013; Singer et al., 2009; Singer & Vogus, 2013). The relationships between patient respect and employee safety culture perception and variation across hospitals and units were assessed using multivariate logistic and linear ordinary least squares (OLS) regressions.

As first introduced in Chapter Three, three secondary data sources were used to carry out this aim. Collectively, these surveys reflected different perspectives on hospital performance from both patient and staff viewpoints. The researcher worked with organizational staff from five different teams across the system to secure the needed data.

### **Data Source for Patient Perspective**

The HCAHPS patient experience survey, administered through independent vendor Press Ganey, is a nationally recognized, standardized, publicly reported survey designed to measure patients' perceptions of care received in the hospital setting. The survey is administered to a random sample of patients through a variety of modalities including a combination of phone, e-mail, and/or mail as soon as 48 hours post-discharge, and up to six weeks after leaving the facility (CMS, 2020d; HCAHPS, 2020). There are a number of limitations to the survey, including language restrictions, which are described in more detail in Chapter Seven. Data from surveys received in calendar year 2022 were used for this study, as 2022 reflected the most current, fully completed year at the time of data collection. There were 6,305 patient survey responses in 2022 included in the sample; the response rate was unavailable. Given the different hospital types and services provided, there were variations in the types and number of units and specialties at each of the eight hospitals. In order to maximize consistency of data across all hospitals, the units that were selected for analyses were the intensive care unit (ICU), the operating room

(OR)/surgical services, and medical/surgical inpatient units, as these were present at all eight hospitals. Seven of the eight hospitals had a labor and delivery unit, which was also included in the analysis. Lastly, a sample of the emergency department (ED) data was also included and only represented patients who came through the ED and were subsequently hospitalized. It is important to note that patients who only received care through the ED and were directly discharged home from that setting received a separate survey (Emergency Department [ED] CAHPS instead of HCAHPS), which was not included in this study. As a result, these survey responses do not wholly represent patient perceptions of respect in the emergency department. However, given there was a small sample size of HCAHPS surveys within the overall patient sample that were tied to emergency services received among later hospitalized patients, this department type was also included.

#### **Data Source for Employee Perspective (Nurses Only)**

At this organization, culture of safety was measured through the Caregiver Experience Survey (CES), which is administered annually to employees of the organization, except for physicians and physician assistants, through an independent vendor. The survey consisted of 89 survey items (questions) grouped under 17 composite measures/domains (see Appendix D for the full CES); however, for this research, only the responses to 13 safety culture questions grouped under two domains (safety and teamwork) were used. Seven questions cascaded from the safety category, and six questions comprised the teamwork domain; collectively, these 13 questions represented the Safety Attitudes Questionnaire (SAQ) “Short Form”, which stems from a larger validated tool (the full Safety Attitudes Questionnaire). The Short Form version reflects a

pared-down subset of questions spanning only the safety and teamwork domains that organizations can use to assess safety culture (Sexton et al., 2006). All nurse responses in 2022 across units and all eight hospitals (n=3,098) served as the sample (response rate was unavailable) given that the most recent available safety culture data for physicians was also 2022, and the most complete HCAHPS dataset was for 2022.

### **Data Source for Employee Perspective (Physicians Only)**

At this organization, physician perception of safety culture was measured through a separate Provider Survey (not through the CES described above), which is administered every two years to physician providers through independent vendor Press Ganey (see Appendix E for the full Provider Survey). Similar to the CES, the Provider Survey is designed to measure physicians' experience, and consisted of 56 survey items (questions) grouped under eight core domains with only partial overlap with those in the CES, including organizational resources, access to information, leadership, quality, safety, and teamwork, among others. Completed responses to the same 13 safety and teamwork questions mentioned above (collectively representing the safety culture score) in 2022 served as the sample. Whereas nurse response data were available by unit and hospital, physician response data were available across physician specialty type and hospital for all eight hospitals. Additionally, the sample size was much lower for physicians compared to nursing (n=934 total physician responses across the eight hospitals compared to n=3,098 for nursing responses across the eight hospitals). Similar to nursing, the response rate for physicians was also unavailable. As such, the results reflect the data available to the researcher at the time of the study. Data limitations are discussed more in Chapter Seven.

While the CES and Provider Survey were not identical, both surveys included the same safety and teamwork-oriented questions. Table 5.1 outlines the 13 questions comprising the SAQ Short Form (previously presented in Chapter Three as Table 3.5). The 13 questions comprising the safety and teamwork domains are subsequently referred to as the safety culture score. Chapter Three provided a detailed discussion of the psychometric properties of the SAQ and rationale for using these three data sources as viable and appropriate survey instruments.

**Table 5.1: SAQ Short Form as Part of the CES and Provider Survey (Sexton et al., 2006)**

| Safety Domain   | Teamwork Domain   |
|---|---|
| The culture in this work setting makes it easy to learn from the errors of others.            | My input is well received in this work setting.   |
| In this work setting, it is difficult to discuss errors.                                      | I have the support I need from others in this work setting to care for patients.  |
| Medical errors are handled appropriately in this work setting.                                | It is easy for personnel to ask questions when there is something they do not understand.                                 |
| I know the proper channels to direct questions regarding patient safety in this work setting. | People in this work setting work together as a well-coordinated team.   |
| I receive appropriate feedback about my performance.  | In this work setting, it is difficult to speak up if I perceive a problem with patient care.                              |
| I am encouraged by others in this work setting to report patient safety concerns I may have.  | Disagreements in this work setting are resolved appropriately (i.e., not who is right, but what is best for the patient). |
| I would feel safe being treated here as a patient.  |   |

### Data Preparation

As discussed in Chapter Three, all data collection, preparation, and analyses proceeded after obtaining IRB approval from the study organization. The statistical software Stata version 18.0 was used for the analyses (StataCorp, 2024). After collecting the relevant data sources needed for analyses, the researcher cleaned the separate datasets by ensuring consistency across all naming conventions (e.g., how units were classified), de-identifying confidential information (e.g., reassigning hospital names to numbers), and



consolidating the separate Excel data workbooks into one master spreadsheet that could be uploaded into Stata. The researcher then created calculated patient variables for inclusion in descriptive statistics and regression models in Stata. These variables were: patient age, patient language, patient race/ethnicity, patient education level, patient mental/emotional health, perception of being treated with courtesy/respect by nurses, perception of being treated with courtesy/respect by physicians, and numeric hospital and unit variables (instead of string variables).

Throughout the analyses below, a 5% level of significance was used. Odds ratios of “respect” were used to interpret results from the logistic regressions, and coefficients of the OLS regressions were interpreted as percentage point differences in safety scores.

### **Measures for Identifying Associations between Respect and Safety Culture**

Associations between patient respect and staff perception of safety culture were assessed using multivariate logistic regressions, a statistical technique that allows for analysis of the relationship of a dichotomous dependent variable to one or more independent variables (Segrin, 2012). Odds ratios (ORs) were generated to describe the relationship between the variables, indicating how much more likely an outcome would occur in one group compared to another (Salkind, 2010).

*Dependent Variables:* The outcome, or dependent, variable (DV) for the first part of Aim 2 was patient experience of respect, which was separated into respect by a nurse and respect by a physician; as a result, there were two separate DVs.

Within the HCAHPS survey, two questions were analyzed:

- During this hospital stay, how often did **nurses** treat you with courtesy and respect?
- During this hospital stay, how often did **doctors** treat you with courtesy and respect?

While this overarching study focused more on the notion of respect, HCAHPS couples “courtesy” with “respect;” while the concepts are not interchangeable, it can be argued that courtesy is a facet of respect based on how existing research has positioned the concept alongside respect (Beach et al., 2007; IOM, 2001; Mayfield et al., 2020).

Respondents were given a Likert-type scale with four options: ‘never,’ ‘sometimes,’ ‘usually,’ and ‘always,’ which were first collapsed into dichotomous variables with ‘never’/‘sometimes’ as one pair and ‘usually’/‘always’ as another. After running frequency distributions in Stata on this approach, it was found that 97% of all respondents answered ‘always’/‘usually’ for being treated with respect by nurses and doctors. As a result, new calculated variables for both patient experience of doctor and nurse respect were created with ‘always’ as one response option and ‘usually’/‘sometimes’/‘never’ collapsed into the second response option. Eighty-seven percent (87%) of patients reported always being treated with courtesy and respect by nurses and doctors when the four response options were collapsed in this way. Overall, consolidating the four categories into two allowed for simplified logistic regression models for dichotomous outcomes to be developed, which will be discussed in more detail below (Segrin, 2012).

*Independent Variables of Interest:* The main independent variable (IV) of interest for the first part of Aim 2 (identifying general associations between patient respect and

staff perception of safety culture) was perception of safety culture as measured by the aggregate of the 13 questions within the two safety culture domains (safety and teamwork), collected separately for nurses and physicians. Regressions were run on the overall aggregate of the two key domains (safety and teamwork) provided in the data that created a safety culture score by hospital, per unit, for nurses and physicians.

*Control Variables:* Control variables, or confounders, represent variables that are not of direct interest but influence the outcome measure independent of the IV(s) of interest and thus their effect(s) need to be “controlled for” or removed (Pole & Bondy, 2010, p. 253). This study controlled for patient characteristics, including age, sex, patient language, patient education level, patient self-assessment of mental/emotional health, and race/ethnicity. In addition, dummy variables for specific hospital and unit types were used to control for any other unmeasured hospital or unit type effects.

### **Measures for Determining Variations in Respect and Safety Culture**

The second part of Aim 2 involved determining the extent of variations in respect and safety culture across hospitals and units. For the respect measure, variation was identified through the hospital and unit measures used in the initial logistic regressions. Safety culture was assessed using linear OLS regressions, as described below, with the measures differing from those outlined above for the first part of Aim 2.

*Dependent Variables:* The DVs for this second portion of Aim 2 were the safety culture measures described above, which functioned as IVs in the first part of Aim 2. This resulted in two separate regressions with each safety culture measure as a separate

DV (one regression for nurse safety culture and one regression for physician safety culture).

*Independent Variables of Interest:* Hospital and unit type (e.g. ICU) dummy variables served as the variables of interest, which are used when categorical variables are of interest in a regression (Chen, 2012). The regression held one hospital (Hospital 1) and one unit (Med/Surg) as referent groups and others included in the study were recoded as dummy variables.

*Control Variables:* Similar to the first part of this aim, patient characteristics were also controlled for in this second set of regressions.

## **Aim 2 Results**

Basic descriptive statistics were first derived for exploratory purposes prior to conducting the set of regression models discussed above. Table 5.2 below outlines the characteristics of the patient respondents using the exact terminology and categories provided by the survey (e.g., “sex” was outlined as a binary category within the survey), including proportions of patients “always” being treated with courtesy and respect by nurses and physicians.

As Table 5.2 shows, all 6,305 respondents did not answer every demographic question within the HCAHPS survey; there were 100% of responses available for patient sex and age, but some missing data across other demographics, including patient language (n=372, or 6%), patient mental health (n=178, or 3%), patient education (n=299, or 5%), and race/ethnicity (n=605, or 10%). The sample sizes for the regression

models are also reported in the tables below and only include responses that had values across all factors in the respective models.

Of the patient respondents across all eight hospitals in 2022, almost 60% were female, 94% were English-speaking, 84% were non-Hispanic white, 55% were 66 years of age and older, and 87% of all respondents perceived their mental health as good, very good, or excellent.

**Table 5.2: Patient Characteristics and Perception of Treatment, 2022**

| <b>Patient Characteristics</b>                | <b>Sample Size<br/>n= 6,305<br/>n (%)</b> | <b>Patient “Always”<br/>Being Treated with<br/>Respect by RN</b> | <b>Patient “Always” Being<br/>Treated with Respect<br/>by MD/DO</b> |
|---|---|--|---|
| <b>Sex</b>                                    |   |  |   |
| Female  | 3,688 (58.5)                              | <b>3,122 (85.5)***</b>   | 3,151 (86.7)  |
| Male  | 2,617 (41.5)                              | <b>2,284 (88.4)***</b>   | 2,255 (87.1)  |
| <b>Language</b>                               |   |  |   |
| English-speaking                              | 5,590 (94.2)                              | <b>4,829 (86.8)*</b>   | <b>4,824 (86.9)**</b>   |
| Non-English Speaking                          | 343 (5.8)                                 | <b>309 (90.4)*</b>   | <b>314 (91.6)**</b>   |
| <b>Race/Ethnicity</b>                         |   |  |   |
| Non-Hispanic White                            | 4,788 (84.0)                              | 4,145 (87.0)   | <b>4,140 (87.1)**</b>   |
| Non-Hispanic Asian                            | 246 (4.3)                                 | 221 (90.2)   | <b>228 (92.7)**</b>   |
| Non-Hispanic Black or African American        | 96 (1.7)                                  | 82 (85.4)  | <b>85 (88.5)**</b>  |
| Non-Hispanic Hawaiian or Pacific Islander     | 40 (.7)                                   | 38 (95.0)  | <b>38 (95.0)**</b>  |
| Non-Hispanic American Indian or Alaska Native | 119 (2.1)                                 | 101 (87.1)   | <b>97 (81.5)**</b>  |
| Hispanic or Latino                            | 411 (7.2)                                 | 368 (89.5)   | <b>369 (90.0)**</b>   |
| <b>Patient Education</b>                      |   |  |   |
| Less than High School                         | 348 (5.8)                                 | 300 (86.7)   | <b>293 (84.7)*</b>  |
| High School Graduate                          | 1,254 (20.9)                              | 1,077 (86.6)   | <b>1,079 (86.5)*</b>  |
| Some College                                  | 2,044 (34.0)                              | 1,755 (86.2)   | <b>1,743 (86.0)*</b>  |
| College Graduate                              | 2,360 (39.3)                              | 2,059 (87.6)   | <b>2,081 (88.6)*</b>  |
| <b>Patient Age</b>                            |   |  |   |
| 0-17  | 7 (.1)                                    | 7 (100.0)  | 7 (100.0)   |
| 18-25   | 133 (2.1)                                 | 115 (87.1)   | 115 (86.5)  |
| 26-45   | 1,125 (17.8)                              | 988 (88.0)   | 986 (88.0)  |
| 46-65   | 1,556 (24.7)                              | 1,309 (84.7)   | 1,331 (86.2)  |
| 66+   | 3,484 (55.3)                              | 2,987 (87.1)   | 2,967 (86.8)  |
| <b>Patient Mental Health</b>                  |   |  |   |
| Excellent / Very Good / Good                  | 5,350 (87.3)                              | <b>4,700 (88.3)***</b>   | <b>4,719 (86.9)***</b>  |
| Fair / Poor                                   | 777 (12.7)                                | <b>590 (76.3)***</b>   | <b>570 (73.7)***</b>  |
| <b>Total</b>                                  | 6,305 (100.0)                             | 5,406 (86.7)   | 5,406 (86.8)  |

Note 1: All 6,305 respondents did not answer every demographic question within the HCAHPS survey.

Note 2: Patients “always” being treated with courtesy and respect scores resulted from Pearson chi-square tests; statistical significance denoted as: \* =  $p \leq 0.05$ ; \*\* =  $p \leq 0.01$ ; \*\*\* =  $p \leq 0.001$ .

Overall, 87% of patients “always” experienced courtesy and respect from both nurses and physicians. Table 5.2 above outlines how these percentages fluctuated based on various patient demographics. Sex ( $p \leq .001$ ), language ( $p \leq 0.05$ ), and patient-reported mental health ( $p \leq .001$ ) all showed statistically significant associations with patients’ experience of being treated with courtesy and respect by nurses. Language ( $p \leq 0.01$ ), race/ethnicity ( $p \leq 0.01$ ), patient education ( $p < 0.05$ ), and patient mental health ( $p \leq .001$ ) all showed statistically significant associations with patients’ experiences of being treated with courtesy and respect by physicians. As will be displayed below, these demographics were controlled for in the regression models.

Table 5.3 below outlines the number of patient responses by hospital and unit. Sixty-eight percent of responses (n=4,314) were tied to medical/surgical floors, 367 (6%) represented ICU scores, 753 (12%) were from labor and delivery units, 4% (n=229) were from the emergency department that became hospitalized/inpatient care, and 4% (n=230) represented operating room/surgical services. As noted earlier, given the different hospital types and services provided, there were variations in the types and number of units and specialties at each of the eight hospitals. As a result, the 412 survey responses from services and units only present at Hospitals 1 and 2 were not included in the regression analyses given that they were not captured at the other hospitals.

**Table 5.3: Count of Respondents Per Hospital and Unit Type**

|                        | Hosp. 1<br>n=2024 | Hosp. 2<br>n=1429 | Hosp. 3<br>n=681 | Hosp. 4<br>n=449 | Hosp. 5<br>n=477 | Hosp. 6<br>n=339 | Hosp. 7<br>n=206 | Hosp. 8<br>n=700 | Total<br>n=6305 |
|------------------------|-------------------|-------------------|------------------|------------------|------------------|------------------|------------------|------------------|-----------------|
| <b>Med/<br/>Surg</b>   | 1,276             | 819               | 496              | 401              | 336              | 217              | 178              | 591              | 4,314           |
| <b>ICU</b>             | 65                | 69                | 40               | 31               | 31               | 51               | 25               | 55               | 367             |
| <b>L&amp;D</b>         | 279               | 164               | 103              | n/a              | 97               | 67               | 3                | 40               | 753             |
| <b>ED</b>              | 43                | 121               | 24               | 16               | 11               | 3                | 0                | 11               | 229             |
| <b>OR</b>              | 53                | 152               | 18               | 1                | 2                | 1                | 0                | 3                | 230             |
| <b>Excl.<br/>units</b> | 308               | 104               | n/a              | n/a              | n/a              | n/a              | n/a              | n/a              | 412             |

Sample sizes from the ED and OR were considerably smaller compared to the other units; ED CAHPS surveys (instead of HCAHPS) were administered to patients who were discharged directly from the ED (as opposed to being admitted), which helps explain the smaller size. The number of responses across the OR/surgical services was also limited; while the actual response rate was not known for each hospital, it can be inferred that it was low, and/or patients might have received a survey tied to their care received in a different unit.

As noted earlier, the researcher did not know the response rates for all hospitals within the study organization across the modalities (mail, e-mail, and phone). In general, it is recognized that HCAHPS response rates are generally low; according to available national public reporting data for patients discharged from July 2021 to June 2022, the average HCAHPS response rate for mail-administered surveys was 21%, 25% for phone only, and 33% for mail and phone (HCAHPS, 2024). Considering these sample sizes helped provide additional context to interpret the results outlined below. The survey



methodology and low response rates can be attributed to several drawbacks within the survey as a tool for measuring patients’ experience of respect, including limited languages, survey administration, and systematic exclusion of certain patient populations (e.g., patients who are unhoused), all of which are described in more detail in the final chapter.

Table 5.4 below shows patients’ experience of always being treated with courtesy and respect by nurses and physicians and by unit type and hospital. As discussed above, 230 responses across all eight hospitals (4%) were tied to the OR; on average, patients reported the highest amount of always experiencing courtesy and respect in the OR/surgical services across most hospitals. This may be indicative of the state that patients are in during or immediately pre- and/or post-surgery (i.e. sedated or asleep); patients may have fewer opportunities to experience lower amounts of respect (or disrespect) as they may not be conscious for much of the encounter as compared to patients in other units.

**Table 5.4: Patient Experience of “Always” Being Treated with Courtesy and Respect by Nurse (RN) and Physician (MD/DO) by Hospital and Unit**

|                 | Hosp. 1        |                    | Hosp. 2        |                    | Hosp. 3        |                    | Hosp. 4        |                    | Hosp. 5        |                    | Hosp. 6        |                    | Hosp. 7        |                    | Hosp. 8        |                    |
|-----------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|----------------|--------------------|
|                 | Pt/<br>RN<br>% | Pt/<br>M<br>D<br>% | Pt/<br>RN<br>% | Pt/<br>M<br>D<br>% | Pt/<br>RN<br>% | Pt/<br>M<br>D<br>% | Pt/<br>RN<br>% | Pt/<br>M<br>D<br>% | Pt/<br>RN<br>% | Pt/<br>M<br>D<br>% | Pt/<br>RN<br>% | Pt/<br>M<br>D<br>% | Pt/<br>RN<br>% | Pt/<br>M<br>D<br>% | Pt/<br>RN<br>% | Pt/<br>M<br>D<br>% |
| <b>Med Surg</b> | 87             | 88                 | 88             | 89                 | 82             | 83                 | 86             | 84                 | 81             | 85                 | 89             | 84                 | 88             | 88                 | 84             | 82                 |
| <b>ICU</b>      | 89             | 91                 | 90             | 88                 | 93             | 88                 | 79             | 83                 | 84             | 87                 | 94             | 86                 | 83             | 88                 | 87             | 76                 |
| <b>L&amp;D</b>  | 89             | 94                 | 94             | 91                 | 82             | 91                 | n/a            | n/a                | 96             | 90                 | 99             | 100                | 100            | 100                | 90             | 87                 |
| <b>ED</b>       | 93             | 91                 | 83             | 83                 | n/a            | n/a                | 80             | 93                 | 82             | 73                 | n/a            | n/a                | n/a            | n/a                | n/a            | n/a                |
| <b>OR</b>       | 94             | 100                | 81             | 90                 | 100            | 94                 | 100            | 100                | 100            | 100                | 100            | 100                | n/a            | n/a                | 100            | 100                |

Note: ‘n/a’ reflects missing data. Additionally, Hospital 4 does not have labor and delivery services.

Table 5.5 below depicts the average/mean nurse and physician safety culture scores by hospital and unit, and the average safety culture score across nurses and physicians by hospital. This score shows the percent favorable (strength) of the average safety culture perception score.

**Table 5.5: Average Safety Culture Scores by Hospital/Unit and Total**

|                 | Hosp. 1     |            | Hosp. 2     |            | Hosp. 3    |           | Hosp. 4    |           | Hosp. 5    |           | Hosp. 6   |           | Hosp. 7   |           | Hosp. 8    |           |
|-----------------|-------------|------------|-------------|------------|------------|-----------|------------|-----------|------------|-----------|-----------|-----------|-----------|-----------|------------|-----------|
|                 | RN %        | M D/ DO %  | RN %        | MD / DO %  | RN %       | M D/ DO % | RN %       | MD / DO % | RN %       | MD / DO % | RN %      | MD / DO % | R N %     | MD / DO % | RN %       | MD / DO % |
| <b>n =</b>      | <b>1040</b> | <b>342</b> | <b>1008</b> | <b>319</b> | <b>258</b> | <b>44</b> | <b>152</b> | <b>36</b> | <b>114</b> | <b>59</b> | <b>87</b> | <b>32</b> | <b>81</b> | <b>17</b> | <b>358</b> | <b>85</b> |
| <b>Med Surg</b> | 81          | 76         | 77          | 75         | 68         | 76        | 73         | 87        | 74         | 87        | 68        | 81        | 80        | 67        | 77         | 78        |
| <b>ICU</b>      | 70          | 76         | 70          | 75         | 82         | 76        | 67         | 87        | 85         | 87        | 59        | 81        | 70        | 67        | 78         | 78        |
| <b>L&amp;D</b>  | 83          | 58         | 83          | 69         | 77         | 42        | n/a        | n/a       | 84         | 90        | 80        | n/a       | 87        | n/a       | 88         | 87        |
| <b>ED</b>       | 58          | 80         | 70          | 62         | 78         | 81        | 59         | 76        | 66         | 77        | 54        | 88        | 86        | 29        | 83         | 78        |
| <b>OR</b>       | 84          | 71         | 78          | 70         | 65         | 67        | 75         | 55        | 80         | 80        | 70        | 59        | 53        | 80        | 65         | 69        |
| <b>Avg.</b>     | 80          | 73         | 77          | 73         | 70         | 71        | 72         | 79        | 76         | 87        | 69        | 81        | 79        | 67        | 78         | 79        |

The sample size was much lower for physicians compared to nursing (n=934 total physician responses across the eight hospitals compared to n=3,098 nursing responses across the eight hospitals). Table 5.5 outlines the sample size by hospital, broken out by both professions. Across hospitals, nurses' perceptions of safety culture ranged from 69% favorable to 80%, and physicians' perceptions of safety culture ranged from 67% favorable to 81%. Nurse and physician perceptions of safety culture varied across hospitals and units, with nurses perceiving a stronger safety culture across some units compared to their physician counterparts (for example, in most labor and delivery units), whereas physicians experienced a stronger safety culture in other units compared to their

nursing colleagues (for example, physicians rated medical/surgical units and ICU safety cultures higher than nursing across more hospitals).

### **Regression Analyses**

A series of separate regression types were conducted to determine whether there was a generalized relationship between patients' experience of respect and staff perception of safety culture, and the extent of variation in the reliability of respect and in safety culture across hospitals and units. As Aim 2 was comprised of two parts, separate base regression models were created in order to collectively answer the aim. Associations between patient experiences of respect and staff perceptions of safety culture were assessed by running two multivariate logistic regressions, which allowed for the analysis of the relationship of a dichotomous dependent variable to one or more independent variables (Segrin, 2012). Table 5.6 below presents results for the two full logistic regression models for patient experience of respect by a nurse and nurse perception of safety culture, and patient experience of respect by a physician and physician perception of safety culture, controlling for patient characteristics (sex, age, patient education, mental health, race/ethnicity, and language), as well as hospital and unit effects.

For the nursing model, the results show that after controlling for patient characteristics, hospital, and unit type, the association between patient experience of being treated with respect by nurses and nurses' perception of safety culture was positive but not statistically significant (OR = 1.01;  $p = .43$ ). For physicians, after controlling for patient characteristics, hospital, and unit type, the association between patient experience of always being treated with respect by physicians and physicians' perception of safety culture was negative but not statistically significant (OR = .995;  $p = .62$ ).

For the nursing model, while the association between patient experience of nurse courtesy/respect and nurse perception of safety culture was not statistically significant when controlling for patient demographics, hospital, and unit, as shown in Table 5.6, several control variables had effects on the experience of respect, including sex, age, race/ethnicity, and patient mental health. For example, for patient mental health, Table 5.6 indicates that the odds of a patient always being treated with respect by a nurse were 2.3 times greater when a patient had excellent/very good/good mental health compared to the odds of always experiencing respect with fair or poor mental health (OR = 2.25;  $p < .001$ ).

**Table 5.6: Logistic Regressions for Associations of Patient Experience of Respect/Staff Perception of Safety Culture**

|  | Nurse<br>(n=5,101) |             |                 |                     | Physician (MD/DO)<br>(n=4,669) |             |                |                     |
|--|--------------------|-------------|-----------------|---------------------|--------------------------------|-------------|----------------|---------------------|
|  | OR                 | SE          | <i>p</i>        | 95% CI              | OR                             | SE          | <i>p</i>       | 95% CI              |
| <b>Exp. Of Respect/<br/>Safety Perception</b>        | 1.011              | .014        | .432            | (.98, 1.04)         | .995                           | .010        | .623           | (.97, 1.02)         |
| <b>Sex (ref= Male)</b>                               | <b>.713</b>        | <b>.066</b> | <b>0.000***</b> | <b>(.60, .85)</b>   | .976                           | .094        | .805           | (.81, 1.18)         |
| <b>Education (ref = Less than high school grad.)</b> |                    |             |                 |                     |                                |             |                |                     |
| High school grad.                                    | 1.13               | .239        | .562            | (.75, 1.71)         | 1.21                           | .260        | .376           | (.79, 1.84)         |
| Some college   | 1.05               | .217        | .778            | (.71, 1.58)         | 1.08                           | .224        | .708           | (.72, 1.62)         |
| College grad.  | .989               | .204        | .959            | (.67, 1.48)         | 1.20                           | .252        | .386           | (.79, 1.81)         |
| <b>Age</b>   |                    |             |                 |                     |                                |             |                |                     |
| 0-17   | 1                  | Empty       | empty           | empty               | 1                              | empty       | empty          | empty               |
| 18-25  | .827               | .336        | .639            | (.37, 1.83)         | .828                           | .340        | .646           | (.37, 1.85)         |
| 26-45  | <b>.575</b>        | <b>.094</b> | <b>.001***</b>  | <b>(.42, .79)</b>   | <b>.585</b>                    | <b>.101</b> | <b>.002**</b>  | <b>(.42, .82)</b>   |
| 46-65  | <b>.747</b>        | <b>.075</b> | <b>.004**</b>   | <b>(.61, .91)</b>   | .887                           | .097        | .273           | (.72, 1.10)         |
| 66+  | 1                  | omitted     | omitted         | omitted             | 1                              | omitted     | omitted        | omitted             |
| <b>Mental Health</b>                                 | <b>2.252</b>       | <b>.247</b> | <b>.000***</b>  | <b>(1.82, 2.79)</b> | <b>2.62</b>                    | <b>.298</b> | <b>.000***</b> | <b>(2.10, 3.28)</b> |
| <b>Race/ Ethnicity (ref = White)</b>                 |                    |             |                 |                     |                                |             |                |                     |
| Non-Hispanic Asian                                   | <b>1.78</b>        | <b>.533</b> | <b>.054*</b>    | <b>(.99, 3.20)</b>  | <b>2.75</b>                    | <b>1.05</b> | <b>.008**</b>  | <b>(1.30, 5.81)</b> |
| Non-Hispanic Black                                   | 1.044              | .382        | .906            | (.51, 2.14)         | 1.23                           | .504        | .612           | (.55, 2.75)         |
| Non-Hispanic AAPI                                    | 2.54               | 1.88        | .206            | (.60, 10.79)        | 2.24                           | 1.65        | .275           | (.53, 9.50)         |
| Non-Hispanic AIAN                                    | 1.03               | .306        | .923            | (.57, 1.84)         | .67                            | .175        | .125           | (.40, 1.12)         |
| Hispanic/Latino                                      | 1.262              | .279        | .294            | (.82, 1.95)         | 1.32                           | .314        | .247           | (.83, 2.10)         |
| <b>Language (ref=<br/>English)</b>                   | 1.03               | .273        | .897            | (.62, 1.74)         | 1.14                           | .329        | .661           | .64, 2.00)          |
| <b>Hospital (ref = Hosp. 1)</b>                      |                    |             |                 |                     |                                |             |                |                     |
| Hosp. 2  | 1.06               | .137        | .662            | (.82, 1.36)         | .949                           | .122        | .681           | (.74, 1.22)         |
| Hosp. 3  | .792               | .164        | .259            | (.53, 1.19)         | .754                           | .117        | .070           | (.56, 1.02)         |
| Hosp. 4  | .984               | .199        | .937            | (.66, 1.46)         | omitted                        | omitted     | omitted        | omitted             |
| Hosp. 5  | .719               | .126        | .061            | (.51, 1.02)         | .748                           | .167        | .194           | (.48, 1.16)         |
| Hosp. 6  | <b>1.84</b>        | <b>.547</b> | <b>.041*</b>    | <b>(1.02,3.29)</b>  | .753                           | .165        | .194           | (.49, 1.15)         |
| Hosp. 7  | 1.01               | .271        | .962            | (.60, 1.71)         | 1.17                           | .364        | .612           | (.64, 2.15)         |
| Hosp. 8  | .823               | .125        | .201            | (.61, 1.11)         | <b>.593</b>                    | <b>.089</b> | <b>.000***</b> | <b>(.44, .79)</b>   |
| <b>Unit (ref = Med Surg)</b>                         |                    |             |                 |                     |                                |             |                |                     |
| ICU  | 1.26               | .252        | .252            | (.85, 1.87)         | .946                           | .177        | .767           | (.66, 1.36)         |
| L&D  | <b>2.14</b>        | <b>.470</b> | <b>.001***</b>  | <b>(1.40, 3.29)</b> | <b>1.73</b>                    | <b>.433</b> | <b>.030*</b>   | <b>(1.06, 2.82)</b> |
| ED   | .948               | .226        | .824            | (.59, 1.51)         | .771                           | .176        | .255           | (.49, 1.21)         |
| OR   | .957               | .212        | .843            | (.62, 1.48)         | 1.59                           | .455        | .108           | (.90, 2.78)         |

Note: Statistical significance denoted as: \* =  $p \leq 0.05$ ; \*\* =  $p \leq 0.01$ ; \*\*\* =  $p \leq 0.001$ .

Patient respect varied by hospital and unit type. Hospital 6 and the labor and delivery unit showed statistical significance; these can be interpreted as the odds of a patient's perception of always being treated with respect by a nurse at Hospital 6 were 84% greater (OR = 1.84) than Hospital 1 (referent), and 2.1 times greater (OR = 2.14) in labor and delivery units than medical/surgical units (referent). This may be explained due to Hospital 6 being a smaller, rural hospital than Hospital 1, with lower patient acuity and average daily census, meaning that nurses may have been able to spend more time with each patient, and therefore patients may have been more likely to report always being treated with respect. Patient perception of always experiencing respect from nurses in labor and delivery units compared to medical/surgical units can potentially be explained by the fact that patients giving birth in labor and delivery units tend to be more positive and be planned experiences, whereas patients in medical/surgical units tend to be higher acuity and are less likely to express positive emotions about their experiences.

As with the nursing results above, while the association between patient experience of courtesy/respect from a physician was not statistically significant when controlling for patient demographics, hospital, and unit as presented in Table 5.6 above, several categories of control variables had effects on the experience of respect, including age, race/ethnicity, and patient mental health. These variables were the same as the nursing model except that sex was not found to have an effect in the physician model. For the physician regression model, patient respect also varied by hospital and unit type. Hospital 8 and the labor and delivery unit also were statistically significant; these can be interpreted as the odds of a patient's perception of always being treated with courtesy and respect by a doctor at Hospital 8 were 41% less (OR = .59) than the odds of a patient

always being treated with courtesy and respect by a doctor at Hospital 1, and the odds of a patient always experiencing courtesy and respect by a doctor in a labor and delivery unit were 73% greater (OR = 1.73) than the odds of always being respected in medical/surgical units. Again, after controlling for patient characteristics, hospital, and unit type, the association between patient experience of nurse courtesy/respect and nurse perception of safety culture, and the association between patient experience of physician courtesy/respect and physician perception of safety culture were no longer statistically significant.

After conducting the two full logistic regressions to determine the associations between patient experience of nurse and physician respect with nurse and physician perception of safety culture, linear OLS regressions were run to assess variations in safety culture perception among hospitals and units. For the respect measure, variation was identified through the hospital and unit measures used in the initial logistic regressions. Safety culture was then assessed using OLS regressions. For these regressions, the outcomes (DVs) were the safety culture measures for nurses and physicians. Hospital and unit type served as the variables of interest, which are used when categorical variables are of interest in a regression (Chen, 2012). The regression held one hospital (Hospital 1) and one unit (Med/Surg) as referent groups, and others in the study were recoded as dummy variables. Table 5.7 below shows the OLS regressions for nurse and physician perception of safety across hospitals and units, again controlling for patient demographics.

**Table 5.7: Linear OLS Regressions for Determining Variations in Safety Cultures**

|   | Nurse (RN)<br>(n=5,129) |      |         |                         | Physician (MD/DO)<br>(n=4,695) |         |         |                         |
|---|-------------------------|------|---------|-------------------------|--------------------------------|---------|---------|-------------------------|
|   | Coef.                   | SE   | p       | 95% CI                  | Coef.                          | SE      | p       | 95% CI                  |
| <b>Hospital (ref = Hosp. 1)</b>                                 |                         |      |         |                         |                                |         |         |                         |
| Hosp. 2   | <b>-2.83</b>            | .12  | .000*** | <b>(-3.05, -2.60)</b>   | -.038                          | .18     | .829    | (-.39, .31)             |
| Hosp. 3   | <b>-9.90</b>            | .15  | .000*** | <b>(-10.2, -9.61)</b>   | <b>-2.57</b>                   | .23     | .000*** | <b>(-3.01, -2.13)</b>   |
| Hosp. 4   | <b>-6.84</b>            | .17  | .000*** | <b>(-7.18, -6.50)</b>   | omitted                        | omitted | omitted | omitted                 |
| Hosp. 5   | <b>-4.00</b>            | .17  | .000*** | <b>(-4.33, -3.67)</b>   | <b>14.96</b>                   | .26     | .000*** | <b>(14.46, 15.46)</b>   |
| Hosp. 6   | <b>-11.33</b>           | .19  | .000*** | <b>(-11.71, -10.95)</b> | <b>5.58</b>                    | .33     | .000*** | <b>(4.93, 6.23)</b>     |
| Hosp. 7   | -.36                    | .25  | .143    | (-.85, .12)             | <b>-8.45</b>                   | .38     | .000*** | <b>(-9.20, -7.70)</b>   |
| Hosp. 8   | <b>-1.58</b>            | .15  | .000*** | <b>(-1.87, -1.29)</b>   | <b>4.00</b>                    | .23     | .000*** | <b>(3.56, 4.44)</b>     |
| <b>Unit (ref = Med/Surg)</b>                                    |                         |      |         |                         |                                |         |         |                         |
| ICU   | <b>-3.59</b>            | .18  | .000*** | <b>(-3.94, -3.24)</b>   | -.19                           | .28     | .500    | (-.75, .37)             |
| L&D   | <b>5.56</b>             | .20  | .000*** | <b>(5.17, 5.96)</b>     | <b>-12.49</b>                  | .32     | .000*** | <b>(-13.12, -11.86)</b> |
| ED  | <b>-7.88</b>            | .22  | .000*** | <b>(-8.31, -7.44)</b>   | <b>-6.53</b>                   | .35     | .000*** | <b>(-7.21, -5.85)</b>   |
| OR  | <b>1.22</b>             | .22  | .000*** | <b>(.80, 1.65)</b>      | <b>-5.40</b>                   | .33     | .000*** | <b>(6.05, -4.75)</b>    |
| <b>Sex (ref = Male)</b>   |                         |      |         |                         |                                |         |         |                         |
| Female  | -.07                    | .09  | .449    | (-.24, .11)             | .07                            | .14     | .604    | (-.21, .35)             |
| <b>Patient Education (ref = Less than high school graduate)</b> |                         |      |         |                         |                                |         |         |                         |
| High school grad  | -.31                    | .21  | .139    | (-.72, .10)             | .10                            | .33     | .760    | (-.55, .75)             |
| Some college  | -.11                    | .20  | .584    | (-.51, .29)             | -.12                           | .32     | .708    | (-.75, .51)             |
| College grad  | -.06                    | .20  | .761    | (-.46, .34)             | -.25                           | .32     | .447    | (-.88, .39)             |
| <b>Patient Age (ref = 0-17)</b>                                 |                         |      |         |                         |                                |         |         |                         |
| 18-25   | 1.13                    | 1.75 | .520    | (-2.31, 4.56)           | 4.54                           | 2.67    | .089    | (-.69, 9.77)            |
| 26-45   | .83                     | 1.73 | .629    | (-2.55, 4.22)           | 1.97                           | 2.63    | .454    | (-3.19, 7.13)           |
| 46-65   | .77                     | 1.73 | .655    | (-2.61, 4.16)           | 2.75                           | 2.63    | .296    | (-2.41, 7.91)           |
| 66+   | .39                     | 1.73 | .820    | (-2.99, 3.78)           | 2.74                           | 2.63    | .298    | (-2.42, 7.89)           |
| <b>Mental Health (ref = Poor/fair)</b>                          |                         |      |         |                         |                                |         |         |                         |
| Excellent/Very Good/Good  | .09                     | .24  | .490    | (-.16, .34)             | .20                            | .21     | .334    | (-.21, .60)             |
| <b>Race/Ethnicity (Ref = White)</b>                             |                         |      |         |                         |                                |         |         |                         |
| Non-Hispanic Asian  | <b>-.48</b>             | .24  | .042*   | <b>(-.94, -.02)</b>     | -.44                           | .37     | .225    | (-1.16, .27)            |
| Non-Hispanic Black  | -.19                    | .35  | .581    | (-.88, .49)             | -.09                           | .55     | .872    | (-1.16, .98)            |
| Non-Hispanic AAPI   | -.04                    | .51  | .944    | (-1.04, .97)            | .48                            | .79     | .542    | (-1.07, 2.04)           |
| Non-Hispanic AIAN   | -.04                    | .29  | .904    | (-.61, .54)             | <b>-1.08</b>                   | .46     | .018*   | <b>(-1.98, -.19)</b>    |
| Hispanic/Latino   | -.12                    | .20  | .553    | (-.51, .28)             | -.04                           | .32     | .909    | (-.66, .59)             |
| <b>Language (ref = English)</b>                                 |                         |      |         |                         |                                |         |         |                         |
| Non-English   | .04                     | .23  | .870    | (-.41, .48)             | <b>.73</b>                     | .36     | .041*   | <b>(.03, 1.42)</b>      |

Note: Statistical significance denoted as: \* =  $p \leq 0.05$ ; \*\* =  $p \leq 0.01$ ; \*\*\* =  $p \leq 0.001$ .



As Table 5.7 depicts, all coefficients for hospitals were negative on the nursing side, and almost all p-values for all hospitals were statistically significant ( $p < 0.001$ ) except for Hospital 7 ( $p = .143$ ). This suggests that the nurse safety culture scores for Hospitals 2, 3, 4, 5, 6, and 8 all were lower compared to Hospital 1 (referent). Two of the most prominent examples indicated that the nurse safety culture score for Hospital 6 was predicted to be 11.3% percentage points lower than Hospital 1's nurse safety culture score, and the nurse safety culture score for Hospital 3 was predicted to be 9.9% percentage points lower than Hospital 1. All units showed statistical significance ( $p < 0.001$ ), with labor and delivery nurse safety culture scores predicted to be 5.6% percentage points greater than medical/surgical units (referent), whereas the ED nurse culture safety score was predicted to be 7.8% percentage points lower than medical/surgical units.

For physicians, almost all p-values for all hospitals were statistically significant ( $p < 0.001$ ) except for Hospital 2 ( $p = .829$ ), and Hospital 4 where data were not available. Some of the most significant results indicated that physician safety scores in Hospital 5 were predicted to be almost 15% percentage points greater than physician safety culture perception in Hospital 1 and 5.6% percentage points greater in Hospital 6 than Hospital 1, but Hospital 7's physician perception of safety culture was predicted to be 8.5% percentage points less than Hospital 1. While two smaller suburban and rural hospitals (Hospitals 5 and 6) had positive associations, Hospital 7, which is also a smaller, rural hospital, had a negative association with Hospital 1, so it cannot be said that suburban and rural hospitals had stronger physician safety cultures than larger, urban hospitals (Hospital 1). Across units, labor and delivery, the ED, and the OR/surgical services, all

were found to be statistically significant ( $p < 0.001$ ). Interestingly, the inverse of the relationship found for nursing related to labor and delivery safety scores occurred for physicians; physician safety culture scores were predicted to be 12.5% percentage points less than physician perception of safety culture in medical/surgical units. It was also found that patient characteristics had little association with perceptions of safety in both OLS regression models.

### **Discussion**

Non-physical harms can be caused by disrespect, and focusing on respect represents the measurable and “actionable component” of respect and dignity (Sokol-Hessner et al., 2018, p. 464). As previously discussed, safety culture is often described in tandem with an organization’s patient safety climate, and research has largely highlighted differences in safety climate levels for different subgroups and hierarchical levels, reinforcing this study’s purpose in assessing both association and variation (Leape et al., 2012a; Ginsburg, 2015; Ginsburg & Oore, 2015; Hickner et al., 2016; Martinez et al., 2015; Schwendimenn et al., 2013; Singer et al., 2009; Singer & Vogus, 2013).

As described above, a series of separate regression types were conducted to determine whether there was a generalized relationship between patient experience of respect and staff perception of safety culture, and the extent of variations in respect and safety culture across hospitals and units. After controlling for patient, hospital, and unit characteristics, it was found that patient experiences of being treated with courtesy/respect by nurses and physicians were not independently associated with those health care professionals’ perceptions of safety culture. This might suggest that while respect is a component of safety culture, there are more factors that influence safety culture;

understanding the patient/family's experience of respect is not necessarily representative of staff perceptions of safety culture. Actions organizations take to improve patient/family experiences of respect may differ from actions needed to improve safety culture.

Additionally, while the main intent of the first set of regressions was to assess a relationship between staff perceptions of safety culture and patient perceptions of respect, there were statistically notable variations in respect levels across almost all patient and organizational control variables. This suggests that experiences of respect (and potentially disrespect) might be mediated by patient characteristics, in which certain patient characteristics might put some patients at a higher likelihood of experiencing respect as compared to others with a lower likelihood of experiencing respect.

The second part of Aim 2 involved determining the extent of variations in respect and safety culture across hospitals and units. Safety culture variation was assessed using OLS regressions; it was evident in both nursing and physician models across hospitals and units, which supports existing literature highlighting differences in safety culture levels. Results from the nursing model showed that all coefficients for hospitals were negative on the nursing side, and almost all p-values for all hospitals were statistically significant, suggesting that the nurse safety culture scores for Hospitals 2, 3, 4, 5, 6, and 8 all were lower compared to the Hospital 1 (referent), which was one of the largest hospitals within the health system. It is possible that the leadership team at Hospital 1 had prioritized key elements characteristic in a strong safety culture that were recognized by nursing (such as encouraging staff to speak up and promoting error reporting).

For the physician model, almost all p-values for all hospitals were statistically significant ( $p < 0.001$ ) except for two hospitals. Physician safety cultures within

Hospitals 5, 6, and 8 (which represent community/acute care and critical access hospitals across suburban, rural, and urban geographic areas – see Table 3.4 in Chapter 3 for hospital profiles) were all predicted to be anywhere from 4-15% percentage points greater than in Hospital 1, whereas three other hospitals (representing tertiary care/teaching, community/acute care, and critical access hospitals) all had negative associations with Hospital 1. As a result, it is difficult to draw conclusions about geographical or hospital types when assessing stronger or weaker safety cultures. Additionally, across some units, sample sizes were small, limiting the ability to draw meaningful conclusions about those subgroups. Based on these findings, safety culture may be driven by factors other than those included in the models.

To better understand variation in both respect and safety culture, future analyses could focus more on patient and organizational attributes. A broader discussion of the research implications, study and data limitations, and suggestions for future research is presented in Chapter Seven.

## Chapter Six – Aim 3 Results

### Overview

As described in Chapter Three, the goal of Aim 3 was to investigate how nurses, physicians, and leaders articulated and prioritized non-physical harm within the context of organizational culture and commitment to patient safety. To address this aim, primary data collection through qualitative semi-structured key informant interviews was conducted, with the intent to elucidate this research by addressing questions that could not solely be answered by Aims 1 and 2 (Creswell & Creswell, 2018; Morgan, 2014).

As noted in Chapter Two, while research has increasingly argued that non-physical harm merits the same level of rigor and attention as physical harm, there are barriers that can impede an organization's ability and/or receptivity to incorporate this type of harm into existing patient safety/quality programs (Sokol-Hessner et al., 2015, 2018, 2019). The intent of this aim was to explore how interviewees across four groups (nursing, physicians, hospital leaders/executives, and regional leaders/executives) recognized and described patient safety and harm events, articulated the importance of taking actions to prevent both physical and non-physical harm, and perceived the organization's safety culture(s), to understand the priority given to addressing non-physical harm relative to other organizational priorities. Given the diversity of respondents, including their position type, level, scope of responsibility, and tenure with the organization, it was of interest to study how each subgroup aligned or differed in their perspectives.

### **Aim 3 Results**

This chapter presents findings from Aim 3 research, including an overview of the study population, data collection process, and results from analyses, including key themes and descriptive detail to reinforce findings.

#### **Data Collection, Participant Recruitment, and Study Population**

A multi-pronged recruitment approach spanning six months (February through July 2023) was used to engage a diverse set of interviewees across both the various hospitals and regional teams, ensuring representation from the four subgroups of interest: 1) nurses, 2) physicians, 3) hospital senior and executive leadership, and 4) regional executive leadership. Although the researcher had aimed to conduct 18-24 interviews across the organization, only 12 were ultimately carried out across four of the eight hospitals given difficulty with recruitment, substantive organizational changes/ circumstances at the time of data collection, and achievement of saturation. Twenty-six individuals expressed interest in participating; however, eight did not meet the inclusion criteria given their role, primary setting of work, and/or geographical location within the organization, and the remaining six did not respond to two follow-up e-mails to schedule an interview. The researcher received inquiries from ancillary staff who did not meet the subgroups of interest inclusion criteria, and therefore were not interviewed for this study. However, this interest and support of the study's focus highlights opportunities for future research, and the need to expand beyond nursing, physician, and executive perspectives, which is discussed in greater detail in Chapter Seven.

Per organizational policy, the researcher was prohibited from directly contacting individuals via e-mail for recruitment but was allowed to use e-mail to initiate

introduction to the study and discuss appropriate forums for recruitment. In order to comply with the organization's institutional policy for research study recruitment within the various hospitals and to build trust and buy-in among leaders, the researcher sent a brief e-mail communication (see Appendix G) followed by a 15-minute meeting invitation to five of the eight hospitals' executive leadership team members, which included the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Nursing Officer (CNO), Chief Medical Officer (CMO), and/or the Chief Financial Officer (CFO). The five hospitals that were chosen represented each unique hospital type within the health system, and captured diverse geographies, patient populations, and scope of services, and included urban, community, and rural hospitals.

A brief meeting with each hospital's executive leader(s) allowed the researcher to provide an overview of the study and proposal, answer questions, and address concerns voiced by the leader(s); it also provided the opportunity for the researcher and executive(s) to identify the most appropriate forums and mechanisms for study recruitment. Given the range of hospital-specific challenges and activities occurring at the individual hospitals and across the broader health system at the time of recruitment (such as union contract negotiations and department restructuring), the researcher and hospital executive(s) discussed timing of recruitment in order to be sensitive to the burdens on hospital staff, and also determined whether the researcher or a member of the executive team would present the study request and/or distribute materials. A copy of the scripted message inviting participation that was used in staff meetings either by the researcher or a hospital executive in her place can be found in Appendix H.

In addition to reaching out to specific hospital leadership teams, the researcher also contacted other key teams supporting the eight Oregon hospitals from a “regional” perspective, including leaders from the Quality department, the Diversity, Equity, and Inclusion (DEI) team, and leaders overseeing the five core employee resource groups (ERGs), including chairs of the Asian American Pacific Islander (AAPI) ERG, Black ERG, Latinx ERG, Women’s ERG, and LGBTQIA+ ERG. Similar to the approach for hospital-specific recruitment, the researcher e-mailed the Quality, DEI, and ERG leaders with an introduction of the study, accompanied by an introductory meeting to gain buy-in from the leaders and determine the most appropriate and effective methods for recruitment. The researcher provided a flyer for the study for limited printed distribution in visible places such as break rooms (Appendix I) and asked ERG chairs to distribute the flyer electronically to groups for recruitment.

Following the various recruitment strategies outlined above, and once potential interviewee candidates initiated contact with the researcher expressing interest in participating, the researcher and interviewee exchanged e-mails to determine date and modality of the interview (in-person versus virtual); this scheduling process took anywhere from three days to over a month per individual in order to secure a viable date and time for the interview. If an individual who had expressed interest in participating did not respond to the researcher’s initial e-mail regarding scheduling, the researcher sent a follow-up e-mail seven days later. If there was no response to that e-mail, the researcher sent a final e-mail inquiry to the interested participant. In accordance with the IRB protocol, after the interviewee expressed interest in being interviewed, the researcher e-mailed a PDF version of the IRB-approved consent form (Appendix J) to the respondent



prior to the interview. At the beginning of each interview the researcher reviewed the most salient portions of the consent form, answered questions, and obtained verbal consent from each respondent prior to proceeding with the interview questions. The researcher informed respondents of their rights as research participants as well as the protections in place to ensure the confidentiality of their responses. Interviewees were also encouraged to notify the researcher of any sensitive information they would not want included in the transcript or any written summaries resulting from the interview.

### *Study Participants/Sample*

There were 12 interviewees (n=12) representing the core subgroups of physicians, nursing, hospital leadership, and regional executive leadership. Of the 12 respondents, there were two physicians, six nurses, and four non-clinical and clinical hospital and regional leaders, whose primary role, if clinical in background, was not related to delivering patient care. Eleven of the 12 interviewees worked across four of the eight Oregon hospitals that spanned tertiary care, community/acute care, and critical access facility types across urban, suburban, and rural settings, with three of the 11 hospital-based leaders also holding concurrent regional leadership roles. The one remaining respondent was solely classified as a regional executive. Given this, the two subcategories of hospital leadership and regional leadership were collapsed into one overarching “leadership” group for analysis and the following discussion of results. To maintain confidentiality, each respondent’s specific hospital and department location (if applicable) is not specified; however, Table 6.1 below (which is a duplicate of Table 3.4 in Chapter Three) provides a descriptive profile of each of the hospitals to provide context around the interviewees’ work settings.

**Table 6.1: Detailed Profile of Oregon-based Hospitals**

| <b>Hospital</b>   | <b>Location / Geographic Service Area</b> | <b>Type</b>                 | <b>Licensed Beds</b> | <b>General Scope of Services</b>   |
|-------------------|---|-----------------------------|----------------------|--|
| <b>Hospital 1</b> | Urban                                     | Tertiary care/<br>Teaching  | 400+                 | Emergency, general and specialty surgery, radiology, diagnostic imaging, pathology, birth center, primary and specialty care |
| <b>Hospital 2</b> | Urban                                     | Tertiary care/<br>Teaching  | 400+                 | Emergency, general and specialty surgery, radiology, diagnostic imaging, pathology, birth center, primary and specialty care |
| <b>Hospital 3</b> | Suburban                                  | Community/<br>Acute care    | 100-399              | Emergency, general surgery, radiology, diagnostic imaging, pathology, primary and specialty care, birth center               |
| <b>Hospital 4</b> | Suburban                                  | Community/<br>Acute care    | <100                 | Emergency, primary and specialty care, general surgery, radiology, diagnostic imaging, pathology                             |
| <b>Hospital 5</b> | Suburban                                  | Community/<br>Acute care    | <100                 | Emergency, general medicine, general surgery, diagnostic imaging, obstetrics and gynecology, pediatrics, sleep center        |
| <b>Hospital 6</b> | Rural                                     | Critical Access<br>Hospital | <100                 | Emergency, general surgery, radiology, diagnostic imaging, pathology, primary and specialty care, birth center               |
| <b>Hospital 7</b> | Rural                                     | Critical Access<br>Hospital | <100                 | Emergency, primary and specialty care, birth center, general surgery, radiology, diagnostic imaging, pathology               |
| <b>Hospital 8</b> | Urban                                     | Community/<br>Acute care    | 100-399              | Emergency, primary and specialty care, surgical services, stroke care, cardiac, vascular, birth center                       |

Note: Information obtained from organization’s website.

With the eight hospitals ranging in hospital type, size, and geography, the scope of services provided also varied depending on the facility; however, each hospital delivered fundamental medical and surgical acute care services across a standard set of departments and units.

Interviewees’ roles ranged from front-line (staff) nurses and physicians covering both day and night shifts across critical care units, labor and delivery/related maternity units, and medical/surgical inpatient units, to a variety of leaders, some of whom were non-clinical, and others who had clinical backgrounds (RN or MD). Specific professional titles of each of the respondents matched to a specific hospital are not disclosed in order

to protect confidentiality, particularly at the executive level where there is typically one type of specific title per hospital.

Ten of the 12 interviewees (83%) identified as female, and two (17%) identified as male. Three respondents identified as Asian, two identified as Latino/a/x, four respondents identified as Caucasian, and race/ethnicity was not addressed and/or disclosed with three respondents. Among the nurse interviewees, the median employment time at the organization was 10 years (with a range of 3 months to 27 years), among the physicians the median employment time was 15 years (range of 12 to 18 years), and among leaders the median employment time was 16 years (range of 2.5 to 25 years). The 12 interviews completed ranged from 35-90 minutes in length, with the majority (nine of the 12 interviews) averaging 45-60 minutes.

Interviews were conducted between March 2023 and July 2023. Four interviews were conducted in-person, and eight were conducted virtually via Microsoft Teams; the format was determined based on interviewee preference and availability. Interviews conducted in-person took place in a private location agreed upon by both the interviewee and interviewer (e.g., an office or conference room). Among the respondents, most (10 of 12) had held multiple roles across various departments and demonstrated varying levels of leadership and accountability within the organization during their tenure. This level of experience across one or more facilities and/or the larger region was helpful for providing historical context and speaking to the organization's evolution over time. Half of the interviewees provided direct patient care, while the other half provided reduced, minimal, or no patient care, with seven having a portion of their role or entire role comprised of administrative/leadership responsibilities. For those who had limited or no front-line care

delivery responsibilities, most of their direct interactions with patients and families involved managing real-time complaints or concerns, often as a result of escalation by bedside staff.

### *Interview Guide*

A semi-structured interview guide was developed to guide the in-depth, open-ended interviews, allowing for both flexibility and consistency in exploring fundamental topics with each interviewee (Remler & Van Ryzin, 2015). Questions were derived from the key literature supporting this study. Sokol-Hessner et al.'s (2018) consensus statement provided a road map for organizations in advancing the practice of respect through the development of six high-level recommendations and 25 associated strategies which were referenced in the creation of this study's interview guide. Additionally, key elements of Frankel et al.'s (2017) Framework for Safe, Reliable, and Effective Care informed interview question development. Overall, the interview protocol included questions related to overarching key topics intended to influence and/or have a role in the systematic adoption of non-physical harm from disrespect within an organization, which is outlined in Table 6.2 below.

**Table 6.2: Interview Guide Outline**

| <b>Interview Guide Sections/<br/>Key Topics</b>  | <b>Subtopics Addressed</b>  |
|--|---|
| 1. Role and Introductions                        | <ul style="list-style-type: none"> <li>• Tenure at organization</li> <li>• Evolution of work setting(s) culture</li> </ul>  |
| 2. Patient/Family Priorities                     | <ul style="list-style-type: none"> <li>• Patient/family interactions</li> <li>• Employee perspective of patient/family priorities</li> </ul>  |
| 3. Patient Safety and Harm                       | <ul style="list-style-type: none"> <li>• Definition and conceptualization of patient safety and harm</li> </ul>   |
| 4. Interacting with Staff/Teamwork               | <ul style="list-style-type: none"> <li>• Interpersonal interactions</li> <li>• Hierarchy/role differentiation</li> </ul>  |
| 5. Safety Culture /Error Reporting/ Transparency | <ul style="list-style-type: none"> <li>• Perception of safety culture/commitment to patient safety</li> <li>• Empowerment related to speaking up and/or reporting</li> <li>• Improvement opportunities</li> <li>• Management and resolution of patient safety concerns</li> <li>• Safety culture mechanisms</li> <li>• Barriers to patient safety and safety culture</li> </ul> |
| 6. Non-Physical Harm from Disrespect             | <ul style="list-style-type: none"> <li>• Definition and conceptualization of non-physical harm</li> <li>• Recognition, management, and mitigation of non-physical harm events</li> <li>• Benefits and risks to formal tracking and management</li> <li>• Respect and dignity</li> </ul>   |
| 7. Leadership and Organizational Priorities      | <ul style="list-style-type: none"> <li>• Perception of organizational priorities</li> <li>• Organizational resources</li> <li>• Organizational challenges</li> <li>• Respect</li> <li>• Health equity</li> </ul>  |
| 8. COVID-19 Pandemic                             | <ul style="list-style-type: none"> <li>• Impact on organizational priorities, patients, and workforce</li> </ul>  |

Note: See Appendix F for full Interview Guide.

Table 6.2 above outlines the key themes that were addressed in the interview guide. These categories of questions (see Table 6.2 and Appendix F) included: roles and introductions (questions 1 a-c), perceptions of patient/family priorities (questions 2 a-b), patient safety and harm (questions 3 a-b), interacting with staff/teamwork (question 4a), safety culture/error reporting/transparency (questions 5 a-g), non-physical harm from disrespect (questions 6 a-h), and leadership and organizational priorities (questions 7 a-e). Given the impact that COVID-19 has had on staff and policies, processes, workflows, and organizational priorities, a question related to the influence of COVID-19 was also asked during the interview (question 8).

## **Coding and Analysis**

The data analysis and interpretation process followed Creswell & Creswell's (2018) sequential, five-step approach: 1) organizing and preparing the data for analysis, 2) reading through the available data and noting initial reflections, 3) coding the data by organizing and bracketing segments of the interview transcripts and using short phrases to represent each section, 4) using the coding process to generate descriptions and themes, 5) representing the descriptions and themes through identification of narratives, including interpreting the meaning of the descriptions and themes identified (pp. 193-196). Interview data tends to be rich in detail and subsequently dense; because it is not possible to use all information collected during interviews, the coding/analysis process necessitates "winnowing" the data, which involves focusing on key portions of interest and disregarding other parts of the data (Creswell & Creswell, 2018).

All 12 interviews were audio-recorded, transcribed, and both deductively and inductively coded for key themes. All interviewees gave the researcher permission to record their respective interviews, which was done via Microsoft Teams (even for in-person interviews), and the researcher also took field notes during each interview to supplement the recordings and capture non-verbal cues. Interviews were transcribed verbatim into separate Microsoft Word documents, and all data files, including researcher field notes and interview transcripts, were managed on a secure, organization-issued, password-protected laptop. Each interview transcript was formatted and managed in a separate Microsoft Word document.

To begin organizing and subsequent analyses, the researcher read through each transcript to re-orient to the interview discussion. During the second and third read-

throughs of each transcript, the researcher employed line-by-line coding in the margins through the use of comments, noting observations, keywords, and themes, and also highlighting key phrases or examples that illustrated a core theme or concept. Each transcript was coded in a separate Microsoft Word document, and an Excel spreadsheet was maintained to track key themes for each category of questions, including similarities and notable differences among the 12 interview transcripts.

Drawing upon the existing literature and theoretical concepts identified in previous chapters, the researcher developed an initial codebook; codes were informed by the researcher's *a priori* knowledge of core frameworks, including Sokol-Hessner et al.'s (2018) consensus statement, Frankel et al.'s (2017) Framework for Safe, Reliable, and Effective Care, and findings from additional key literature reviewed (previously discussed in Chapter 2). This combination of deductive and inductive approaches allowed for predetermined codes to be developed based on the literature, while also allowing for new codes to emerge based on information gleaned during the data analysis process, including "surprising codes" (those that are remarkable and unexpected), and "codes of unusual or of conceptual interest" (Creswell & Creswell, 2018, pp. 195-196).

## **Results**

The findings below are organized in sections based on each core set of questions within the interview guide (Appendix F) and represent both similar and unique themes that surfaced from interviews, which are reinforced by selective quotations from interviewees. A summary of the findings is provided at the end of the discussion.

## **Patient and Family Priorities**

Within this category in the interview guide, two overarching questions were posed to all 12 respondents, asking them to describe 1) their interactions with patients and their families, and 2) their perspectives on what is most important to patients and families when they presented to the organization for care. There were also prompts for each of these questions including asking respondents to identify the biggest barriers to providing safe, reliable care, and their perception of how the organization delivers on meeting patient/family needs.

### *Patient/Family Expectations*

Most interviewees identified similar themes when describing their perception of patient and family priorities, including believing that patients and families wanted and expected “high-quality,” “safe,” “culturally competent,” “compassionate” care, and that their fundamental need was to “get better and leave the hospital” (Physician 2). Beyond the medical and technical aspects of coming to a hospital for care, 10 of the 12 respondents discussed their belief that at a foundational level, patients/families wanted to “be heard” / “listened to,” be “treated as a human being,” “included” in conversations and decision-making, “receive information,” and be “communicated with” including seeing “follow-through/follow-up” from the organization. A few respondents indicated that part of “being heard” included feeling that the care team took time to understand their issues and personal experience, feeling like a “priority,” and not being “dismissed”.

Three interviewees worked in a small, rural hospital, and all echoed similar sentiments related to how their facility is an important fixture in their community; when patients come to their institution for care, they want to be assured that the care they



receive is of the same quality found in larger, urban hospitals. Additionally, each of these three respondents highlighted the tight-knit community feel of providing care in a rural area, indicating that the patients they treat are their neighbors, family members, and friends; as such, each respondent noted it was their perception that their particular hospital emphasized carrying out small, meaningful aspects of care, or a more “personal touch” (Leader 2) that perhaps would not be as feasible within a larger hospital that had greater demands on its staffing, resources, and time.

In order to meet patient and family needs, some interviewees emphasized the importance of establishing “trust” and “building rapport” with the patient and family as a core way to put patients at ease. However, having sufficient time to form a trusted relationship led some interviewees to then discuss the many barriers hindering the provision of care that meets patients/family expectations, including how patient/family expectations have evolved over time. Three respondents who worked in the two largest, urban hospitals indicated a growing misalignment between patient/family expectations and the care team’s ability to meet those expectations. One leader noted:

...[T]he expectations of what patients have when they seek care – those expectations have evolved. And I think we’re in this tough place of trying to figure out what are patients’ expectations and are they realistic, are they reasonable, and can we even deliver? ... [W]e encounter a lot of workplace violence nowadays, even in settings that I consider a happy setting [labor and delivery] where you’re bringing babies into the world, but there’s still so much trauma within our patient population that...when they come and seek health care, I think there’s a misalignment on what we can actually deliver and what they’re expecting. (Leader 3)

Physician 2 reinforced the dynamic nature of patient/family-specific needs, and the challenge of meeting them in light of the rising workplace incivility toward staff,

resource constraints, additional administrative burdens, an increasingly divisive political climate and the proliferation of misinformation, widespread staff burnout, and varied medical literacy among patients.

Over the years as we move to more customer service-oriented care that's facilitated this kind of behavior [disrespect and abusive behavior from patients/families] ... now we're treated a lot like cashiers or staff at a store where people don't face any consequences... that's negatively impacted all of our mental health...and it's [*sic*] been worsened since the pandemic... I'm not saying that we need to move back toward a paternalistic style of medicine...but we need to use a less customer-is-always-right approach. We're providing professional services here and professional expertise and I think that's been lost...I think there has to be a balance between paternalistic medicine...and we're here to serve you, we'll do whatever you want, you're always right... It's harming the patient by just deferring to them automatically and whatever their needs are. I think there has to be a better way to handle these kinds of interactions...I just don't know what it is. (Physician 2)

#### *Key Barriers to Providing Care*

As is evident within the discussion of patient/family priorities above, there are a variety of barriers that serve as growing challenges that both the workforce and health care organizations must contend with, all of which potentially hinder the delivery of high-quality care that meets patient/family expectations. Most interviews surfaced similar themes when describing the biggest barriers to providing care. These core themes are organized in Table 6.3 below, which demonstrates the distribution of interviewee responses across the three groups of respondents in order to maintain the anonymization of responses. Each of the barriers listed corresponds to larger, overarching categories of fundamental barriers, such as workforce, organization-related, external/broader environmental influences, and patient-related factors.

**Table 6.3: Respondent-Specific Barriers to Providing Safe Care**

| Barriers  | Respondents      |                     |                 | Total               |
|---|------------------|---------------------|-----------------|---------------------|
|   | Leaders<br>(n=4) | Physicians<br>(n=2) | Nurses<br>(n=6) | Responses<br>(n=12) |
| Burnout and/or moral distress   | 4                | 2                   | 6               | 12<br>(100%)        |
| Staff physical safety concerns, workplace violence, abuse, incivility and/or disrespect                                     | 3                | 2                   | 5               | 10<br>(83%)         |
| Health profession turnover, retirement, and/or resignations   | 4                | 2                   | 5               | 11<br>(92%)         |
| Staffing challenges (e.g., perception of inadequate staffing, staff engagement, human capital, difficulty with recruitment) | 3                | 2                   | 6               | 11<br>(92%)         |
| Financial/resources (e.g., financial, equipment, supply chain)  | 4                | 2                   | 5               | 11<br>(92%)         |
| Regulatory-driven influences and administrative burdens (e.g., documentation, reimbursement, productivity targets)          | 2                | 2                   | 3               | 7<br>(58%)          |
| Organization-related (surges/ capacity, org. restructure, hospital size/structure)  | 4                | 2                   | 5               | 11<br>(92%)         |
| COVID-19 pandemic   | 4                | 2                   | 5               | 11<br>(92%)         |
| Political climate   | 0                | 1                   | 2               | 3<br>(25%)          |
| Misinformation  | 0                | 2                   | 2               | 4<br>(33%)          |
| Reputation/distrust   | 3                | 1                   | 1               | 5<br>(42%)          |
| Patient health literacy   | 2                | 2                   | 2               | 6<br>(50%)          |
| Patient expectations  | 2                | 2                   | 4               | 8<br>(67%)          |

The most notable challenges that all respondents raised relate to workforce-specific barriers, including overall workforce wellness, well-being, safety, retention, and recruitment. As Table 6.3 above shows, all 12 interviewees described burnout and/or moral distress as a predominant challenge impacting the workforce/organization and influencing patient/family interactions. Many of the leaders, nurses, and physicians

interviewed commented on the ubiquity of burnout and/or moral distress that had implications for the delivery of care, as staff experiencing burnout tended to “make more mistakes,” have “more apathy” or “compassion fatigue,” with unaddressed, sustained burnout potentially accelerating turnover – not only within the organization, but also potentially causing health care professionals to leave the profession altogether.

In addition to burnout and/or moral distress, there were a number of other barriers that were reinforced by over 80% of interviewees including: staff physical safety concerns, staffing challenges, organizational resource constraints and related influences, and implications resulting from the COVID-19 pandemic, which many respondents indicated exacerbated the other barriers that surfaced.

[The pandemic] allowed us to focus our priorities a little bit more. But I think in general it [the pandemic] has made everything else worse. Respect for the medical profession I think is at an all-time low now. I feel like many people view physicians and nurses and medical professionals like they used to back in the 1800s when we were all just quacks peddling the latest cure. I think people have a huge distrust of the medical profession thinking that we all have our own hidden agendas other than getting people better and impacting public health...I think the political climate, the misinformation on the Internet has done nothing but harm... and when patients come into the hospital they are often their own worst enemies...and you know, we've seen people who've refused care during COVID...when they're short of being intubated ... they are at death's door and then they find that at that point realized, I was wrong about this, but now it's too late. We've had a lot of preventable deaths from this, and that hurts. (Physician 2)

The prevalence of these barriers within most interviews underscores the interrelatedness of these challenges, the influence they have on the delivery of care, and the importance of addressing such organizational and workforce-related factors in order to strengthen the delivery of safe, reliable care to patients and families. Most interviewees mentioned how staffing shortages and other perceived lack of resources, and increasing

workplace incivility threats and violence seemingly exacerbated by the pandemic, led to a feeling of burnout, moral distress, employee turnover, and/or early retirement.

The toll of rising workplace threats toward staff led many interviewees to comment on the “distress” this form of disrespect has created for them and their colleagues. This is consistent with the literature, as health care workers experiencing disrespectful occurrences and/or working within a disrespectful culture can have considerable implications, including hindering communication and teamwork, undermining morale, and contributing to or enhancing burnout, potentially leading to the health care workforce disengaging from the organization or larger health system (Brown et al. 2018; Leape et al., 2012a; Sokol-Hessner et al., 2018, 2019). One physician referenced the direct relationship between increasing burnout and patient safety:

I think [burnout] is the number one issue now...and I think that will reflect itself in patient care down the line...I worry in the coming years we'll see a greater impact [of burnout on patient safety]...as an organization...as a society, we're not addressing it well enough. [I]t's one of the biggest areas of opportunity... Now we're facing people [patients and families] who are hostile to us and...this generation of nurses...doctors...nurse practitioners, I don't think this generation's ever going to fully recover from this. It's going to be years before the next generation can come through with the same kind of optimism as we used to have, and I think that's going to really negatively impact patient care. (Physician 2)

Physician 1 provided a nuanced perspective on patient needs and wants, indicating a profound difference between the two, within the context of worsening workplace concerns and challenges including workplace violence, incivility, and burnout.

...I think the trap that we find ourselves in – as health care providers we've got the medicine down pretty well...we've got a technical advantage there...[but] there's a broad range of what people need and want and feel...that's what makes it so easy to inadvertently harm someone. [And] all the people caring for patients are exhausted right now. They have, like, no reserves. So I think – and this is a hard thing for me to say – but the things that seem reasonable for patients to want,

people [staff] are still going to say “I’m going to work on it”. But the things that seem more unusual or more unreasonable, for a very fatigued workforce...are you kidding me?...[O]ur doctors and nurses get threatened, literally threatened, by family members...[and] maybe the first 10 times you’ve said something you say with a smile....[but] the 11<sup>th</sup> time you explain something, it’s like oh can you just give me a break?...Even in professions that select for people with tremendous empathy and kindness and patience...there are limits to all those things...[staff] certainly don’t come to work intending to [cause harm] but there’s a limit to what you can take. (Physician 1)

One nurse provided a unique perspective by acknowledging the mounting difficulties for health care staff in recent years, stating:

I feel like everybody uses the pandemic as an excuse. People are attributing everything to the pandemic. There are certain things of course...that have definitely been impacted. But I don’t think the way that people behave is because of the pandemic...I think if you already have tendencies toward violence, then this political atmosphere right now is just making it more permissive maybe. (Nurse 2)

Beyond burnout, workplace incivility, and strained resources, seven of the 12 interviewees referenced the growing regulatory and administrative demands on staff time that place additional burden on the workforce, seemingly redirecting and/or fracturing focus on areas needing more time and attention and minimizing the amount of available time to spend with the patient and family members. One clinician reinforced this belief, stating:

...I think it’s inherently a flawed system...with the current medical climate, the current financial climate...we’re pushed to be more productive as providers, to see more patients, to do more with the same amount of time...And I think that’s not just here in this hospital, I think that’s everywhere. When you have a bigger administrative burden of making sure you document, making sure you cross XYZ off your list, and then see more patients than you’re normally seeing...something has to give, and unfortunately, in order to make this career sustainable, what gives is spending that time with your patients...it’s not necessarily just the fault of this hospital or organization in general, I think just the way things are working these days has failed our patients. (Physician 2)

For another respondent who was relatively new to nursing, the extent of documentation requirements proved to be a prevailing and frustrating aspect of providing nursing care:

[T]hat whole idea of being at the bedside, listening to patients and families...I thought that was going to be like 90% [of the job], and as I got into it, I was like, oh, this is like 75% charting, and 25% of me in the room. (Nurse 6)

As the discussion above highlights, several similar themes surfaced among interviewees around patient and family priorities, with some respondents describing the evolution of and distinction between patient/family needs and wants, and the complexities surrounding meeting those expectations in light of several multifaceted barriers. In general, the core challenges that were raised by interviewees were consistent, regardless of profession and hospital type, with different interviewee subgroups perceiving and feeling the weight of those barriers in diverse ways.

### **Patient Safety & Harm**

The primary questions within the patient safety and harm category of the interview guide asked respondents to define patient safety, describe safe care delivery, define patient harm, and discuss the types of events that constituted patient harm. The intent of these questions was to understand how various professional types across different levels perceived and recognized patient safety and harm, and to determine if it was primarily physical harm-focused, or if interviewees recognized a broader, more holistic view of patient safety and harm.

A number of valuable insights emerged from this set of questions. At least half of the participants described patient safety and patient harm in a predominantly physical sense, describing patient harm as an “immediate threat” or “loss of life or limb” (Leader

1, Physician 1), and patient safety as “doing what we intended to do...reliably and well” (Physician 1). Others indicated patient safety meant “not causing harm”, “whether it’s intended or unintended” (Physician 1, Nurse 1, Leader 3), ensuring that patients “get what they came for with the best possible outcome and no unexpected outcomes along the way...no complications” (Nurse 5), or, more simply, “treating the right patient for the right situation” (Nurse 4). Both physicians indicated the importance of not only communicating “realistic expectations”, along with the “benefits and risks” associated with care, but also in ensuring patient/family comprehension of those benefits and risks. One nurse discussed the inherent responsibility of the care team to be “vigilant” about following evidence-based practices and high reliability tools. Another nurse emphasized the importance of maintaining requisite competencies and skillsets to be responsive to patient and family needs and to “do no harm while delivering care” (Nurse 1). Additionally, most interviewees indicated delivering safe care meant minimizing the chance of an adverse event or something going wrong, but also “communicating if something does go wrong” (Physician 2). One bedside nurse emphasized the complexity of how patient harm and errors are described, indicating:

...[T]here are a lot of very sick people in the hospital, and if something happens to them, it’s not always preventable patient harm. It is sometimes the natural course of their disease, and unfortunately, despite our most heroic efforts, we were not able to change that and sometimes those things get conflated. So when I think of patient harm, I think of things that are very clearly related to some kind of shortcoming that could have been anticipated, should have been prevented, and had we done things differently, the patient would not have gone on to experience that event. (Nurse 5)

As noted in previous chapters, it is essential to emphasize that while errors stem from distinct types of failures and can occur across the care continuum, they do not



always result in harm or injury to the patient (IOM, 2000). Errors that do cause harm or injury to patients are often referred to as preventable adverse events, meaning that the event is caused by an error as part of the care or intervention provided, although not all adverse events that occur are preventable (IOM, 2000).

Four nurses explicitly referenced the “vulnerability” of patients visiting a hospital for care, although this concept was implied and coded as such in 11 of the 12 interview transcripts. One nurse described patient safety as “keeping the most vulnerable person safe...speaking up for the people who can’t speak for themselves, and making sure they get the best possible care even when nobody else is watching” (Nurse 3). Another nurse reinforced that the most complex and challenging patients necessitate ongoing compassion and effort:

We’re actually here to take care of the most vulnerable [patients], the ones that actually, like, really do need that extra care. It’s not the patient that does everything we tell them to and we only see them once a year and they go on their way...I mean, those [patients] are great, but that’s not why we’re here... (Nurse 2)

Five respondents described patient safety and harm more holistically, emphasizing its multifaceted nature, and indicating that delivering safe care involves “treating the right patient for the right situation, including physically and emotionally” (Nurse 4), ensuring the care delivered, and the environment in which care is being delivered, does not cause undue stress or burden in a “physical or emotional sense” (Nurse 2). One nurse described her perspective that patient harm encompassed both more “obvious” physical harm, but also “more and more emotional harm,” explaining how certain workforce attitudes and behaviors can cause emotional harm to patients.

[Staff] don't even mean it as harmful but [emotional harm to patients] comes across as a lack of caring...apathy...you can tell if they [staff] don't want to be there...[and] preconceived notions and judgments that providers have...whether it's an overweight patient, a patient on drugs...I think that is truly hurtful. (Nurse 3)

Another nurse indicated:

To me, patient harm is anything that is, like, physical...they've been harmed because of something we did or didn't do...but also, when they come into the hospital or clinic, they're already in a really vulnerable space, right? They're here for a reason. So we also don't want to place any mental, emotional harm either...I feel like with every patient we should take care of them...holistically. (Nurse 2)

Overall, many respondents, including physicians, leaders, and nurses, initially described harm and patient safety in a more traditional, physical harm sense. However, all interviewees acknowledged that harm could occur both physically and emotionally toward patients and families, with some recognizing both types in their initial description to the researcher. A more detailed discussion regarding non-physical harm from disrespect is described below.

### **Safety Culture/Error Reporting/Transparency**

As discussed in previous chapters, from an organizational perspective, safety culture is a key factor driving the extent to which organizations track and mitigate patient harm events, as well as maintain safety (Bates & Singh, 2018). Interviewees were asked a series of questions about safety culture, errors, reporting, interpersonal interactions/teamwork, and transparency. These questions included describing their unit/hospital/organization's safety culture and commitment to patient safety, receptiveness and approach to addressing safety concerns, perception of staff empowerment in speaking up and/or reporting concerns or safety events, areas for improvement, and existing safety mechanisms and practices to foster a safety culture.

Enhancing patient safety requires acknowledging the complexity of the health care system; as discussed in previous chapters, effective leadership and implementation of a safety culture are an essential part of becoming a high reliability organization (HRO) (Bates & Singh, 2018; Federico, 2018; Scott, 1992; Weick et al., 1999). Inherent within HROs is the essential role of leadership in fostering a culture of safety, which emphasizes reflection and learning, encourages transparency of both failures and successes, demonstrates resiliency, and promotes a “just culture” in which all staff, regardless of hierarchy, are empowered to raise concerns without fear of blame or rebuke, while also preserving accountability (Bates & Singh, 2018; Botwinick et al., 2006; Morello et al., 2013) and “zero tolerance for reckless behavior” (AHRQ, 2019, para. 6). A just culture shifts the focus away from individual blame to a systems-based view by emphasizing the underlying “origins” of an event or situation (Marx, 2019, p. 245). The ultimate goal stemming from a successful safety culture is not only organizational learning but coordinated actions aimed at mitigating and preventing similar occurrences from recurring (Edwards, 2017; Federico, 2018; Frankel et al., 2017).

There was a consistent view across all interviewees except for one staff nurse that their particular department(s) and/or hospital fostered a culture of high reliability; 11 of the 12 participants mentioned that the organization was a HRO, and all 11 commended how the use and overall receptivity to consistent HRO tools and principles within their particular department(s) and/or hospital allowed staff to have a common set of tools, vocabulary, and practices to discuss safety, and to feel more comfortable with speaking up without fear of blame, reporting, sharing, debriefing, and learning from concerns and/or events. There was a strong emphasis on personal comfort with reporting and escalating concerns, near misses, and/or errors among respondents delivering care. Among the interviewees in

leadership roles, there was a similar consistent belief that their department(s) and/or hospital not only encouraged reporting but leveraged the information gleaned as learning opportunities. Many responses and phrases used by interviewees mirrored and reinforced this message, with most indicating how they approached safety events with curiosity, asking “what went wrong?”, “where were the gaps?”, “what were the barriers?”, “what could have worked better?”, with the emphasis on sharing information to learn, improve, and mitigate future occurrences. One leader had stated:

What we try to never do is make it punitive, and to always make it a learning opportunity...lead[ing] with compassion and using instances as a teaching moment. We had an instance where there was a significant patient fall...and it was a very young nurse who had been watching the patient, and he was in a bathroom by himself when he fell...[and] we used that as an opportunity for broad teaching...we didn't want this young nurse to have this as a [negative] stamp on her career. (Leader 1)

Three interviewees attributed their facilities' overall improvement in safety culture due to the widespread adoption of foundational HRO concepts and practices. One leader who had been with the organization for 25 years stated:

The blame-free thing has really gotten better with people reporting Datixes [incident reports through Datix] and knowing that there won't be, you know, it's not a “you report it and we're going to slam you down.” It's to learn about process improvement. And I think that culture has changed. When we went with HRO, and we've spent many years now teaching that and demonstrating that...I think [our culture] is the best it's ever been in these last two years...because of the encouragement to report errors and to self-report errors. (Leader 2)

A physician who works at a different hospital echoed the value of HRO training on his hospital's safety culture and commitment to patient safety, indicating:

...[I]t's actually one of the biggest improvements that we've had over the past several years...I can't speak for the rest of the hospitals, but [adopting] HRO training has actually done a really good job at improving the culture of safety here. It makes us all accountable to each other to make sure we're delivering safe care...and it's infused itself in all aspects of our jobs. (Physician 2)

One nurse, who had spent her entire 27-year career at the same hospital, emphasized the value of HRO tools in allowing staff to identify safety issues, encouraging appropriate escalation, and deciphering the nature of the incident, including understanding if it was an isolated or systems issue. She reinforced how HRO tools allow for teams to be increasingly transparent over time with a goal of mitigation and future prevention of similar occurrences, although they also surfaced how different profession types viewed reporting, including discussing the role of hierarchy within the context of safety culture.

I feel like we don't do the blame game...although ... a side effect of encouraging people to write a Datix...is that sometimes [reporting] inevitably can feel like it's punitive...it's *[sic]* come up recently like in surgical services when the physicians are written up, they feel like it's punitive. They feel like why don't you just come and have a conversation with me? There's a bit of a hierarchy, no matter what people say, it exists, right? In reality, there's the doctors, and there's the nurses, and then there's the CNAs, and as much as we'd like to say, like, we're all a team, which is how I view it and how I present it to teams, but when nurses have an issue with a physician in particular, it's really, really hard for them to go to that person directly, unless they have that kind of rapport. (Nurse 2)

Most interviewees personally indicated that they felt comfortable reporting an unsafe circumstance and, if applicable, believed that their teams also felt empowered to report and/or escalate a concern. One nurse, who primarily worked night shift at a mid-

size community hospital, stated: “I don’t think I’ve ever had any situation where I haven’t felt comfortable coming to my managers” (Nurse 4). This nurse offered a unique perspective based on her night shift schedule and described perceptible differences around care delivery and general culture based on her experiences of both day and night shifts.

[I]t’s a whole different culture...I’ve picked up extra shifts on days, and yeah, it’s just hustle and bustle. You do your work and you’re out. Whereas night shift, there’s camaraderie among your staff and between your patients...nurses can really bond with their patients, you have more alone time with your patient and really get to know them. And the more information you have the better care you can give. [And among staff], we’re just more team-oriented, [and] we really have to rely on each other. (Nurse 4)

This comfort and receptiveness to reporting speaks to the presence and importance of psychological safety culture established by staff and leaders.

#### *Psychological Safety, Empowerment, and Hierarchy*

As discussed in previous chapters and in the discussion of Aim 2 results, a core facet of safety culture involves the workforce’s sense of empowerment, comfort, and psychological safety around speaking up around safety concerns. The nature of all respondents’ roles necessitated ongoing teamwork and collaboration across diverse, multidisciplinary teams, with colleagues across various levels of leadership and position types. The concepts of empowerment and hierarchy were discussed across many interviews, with respondents indicating that they themselves felt comfortable raising and/or formally reporting concerns, and/or felt as though their staff felt comfortable speaking up with safety concerns. Perspectives on hierarchy were similar, to an extent, across the interviewees, acknowledging that overall, hierarchical differences were still

somewhat palpable among different position types, but they also believed hierarchical differences and fear of reporting, particularly between nurses and physicians, were not as strong as they have typically been in the past. One physician credited the rollout and adoption of HRO principles as a key factor in facilitating this slightly “leveled out” landscape. Many respondents shared similar perspectives that other profession types, particularly outside of nursing and medicine, were seemingly more inhibited to speak up.

Nurses tend to have a very strong voice, and so if you’re not a nurse, where does your voice fit in? The best practice is if you see something, you say something, right? Not every non-nursing department can do that. Environmental Services, Dietary, a lot of them [other positions/departments], it feels like they’re going to their manager who then is coming to me. So then it’s our responsibility to figure out, okay, how do we bridge that gap? (Nurse 1)

Despite 11 of the 12 interviewees recognizing the adoption of HRO within their department or larger hospital, there was a divergence in opinions regarding the strength of safety culture and commitment to HRO principles across the overarching organization. In general, all interviewees who assumed middle management roles over specific units and those who provided front-line care (with the exception of one nurse) stated that they genuinely and strongly believed their department(s) had strong safety principles and practices; they provided a more localized perspective illustrating how their immediate areas embraced key principles of HRO and strong safety cultures. Additionally, all hospital leaders interviewed had indicated their perceptions that, overall, their hospital-specific safety culture was relatively strong. While most interviewees believed that providing safe, reliable care was a priority of the larger organization, there was a strong belief that safety culture was a more localized perspective as opposed to organization-wide.

One nurse believed her units and hospital as a whole focused on key facets of fostering a strong safety culture, and learning from events for the purposes of mitigating future events, but did not believe this extended to the overarching organization where there was a “disconnect” between the local hospital’s intent behind analyzing safety events, and the organization’s priorities:

The sense I get organizationally is that the focus is not around culture of safety. We had an event, and we needed to do a root cause analysis...and the [regional-based] Quality team was pushing to just get it done...they needed the [completed analysis] on their books, because they need to do a certain number per year to meet whatever [regulatory] thing. It was like...that’s not what this is about... (Nurse 1)

There was also acknowledgment that safety culture can vary among units within a single hospital. One leader articulated how her hospital had strong safety culture principles and practices in place but had recently learned that there was one unit that deviated from her perception of the hospital-wide norm.

As a leadership team, we understand psychological safety. We understand what we need to role model is a safe environment to be able to report concerns or issues. We have felt, and I have felt, that we’ve built a strong trusted culture among our leadership team and there has been regular reporting of issues...We found out, however, that there was a department that I [and other members of the executive team] was not really connected very closely with and we were deferring to the manager and believed he...had everything under control. We suddenly received significant feedback from his staff that was very troubling and took us very much by surprise. [The manager] had written up one of his employees for speaking negatively. The act of writing her up to HR had the effect of keeping her quiet and not giving her voice the credibility it needed when she was raising a safety concern over a year ago about the performance of some of our equipment. And it was what she felt like was very unsafe and very dangerous...[H]er concerns weren’t taken seriously by him...[and] it could have led to very serious harm. The severity of the situation was finally discovered and suddenly very, very quickly remediated. But I never heard anything about this because it was kept in a silo. I thought that we had a very strong culture [and that experience] exposed...how fragile that can be in even just one area. [And] with the



organization restructure, he [the manager] didn't report locally [to any leader within the specific hospital, but instead a regional leader]. We put too much stock into what we were hearing [from him]....There's a level of trust with recognizing what leaders of their areas are saying. We were off fighting other fires. We didn't have our eyes on what was right in front of us. (Leader 1)

This example reinforces existing literature about hospital subcultures and differences in safety culture across an organization; as noted in Chapter Two, there is considerable research highlighting substantial differences in safety climate across units and professional disciplines within an organization, and between clinicians and non-clinicians (Leape et al., 2012a; Ginsburg, 2015; Ginsburg & Oore, 2015; Hickner et al., 2016; Martinez et al., 2015; Schwendimenn et al., 2013; Singer et al., 2009; Singer & Vogus, 2013). Given the complexity of health delivery organizations, it is unsurprising that sustaining a strong culture of safety that permeates all parts of an organization can be challenging and daunting (Frankel et al., 2017). Beyond illustrating variations among units, this example also speaks to the weight that organizational structure and personnel management can have on creating and maintaining a subculture within the hospital. Since Leader 1 and her hospital leadership team did not have direct/local oversight over the department manager and entrusted the manager in his supervision of his staff, the manager's "intimidation" tactics and the detrimental effects on his team were not discovered until the annual hospital-wide staff experience survey indicated concerning behavior and practices that were antithetical to the expected behaviors and practices.

Overall, it was evident that every hospital-based interviewee, except for one staff nurse who did not reference HRO nor felt like she could speak to safety culture in general, genuinely believed and emphasized that the adoption of standard HRO principles

and training across their hospitals was palpable, embedded within their daily operations and philosophy guiding their work, and, in many cases, had been a key driver in leading improvement in their immediate unit(s) and/or hospital. While it was evident that safety subcultures were present, and there was variation in how some interviewees perceived safety culture strength across other units, hospitals, or the overarching organization, overall, core HRO principles and practices had undeniably permeated across the environments in which the interviewees worked.

### **Non-Physical Harm from Disrespect**

There were eight questions in this category, including initially establishing a basic understanding of whether interviewees were familiar with the general concept of non-physical harm from disrespect, and asking them to describe their understanding of it. Other questions addressed disrespect occurring to patients/families during their care experience, and also inquired about disrespect among staff and between patients/families and staff, in addition to the hospital and/or larger organization's commitment and philosophy around maintaining a culture of respect.

Overall, there was general awareness of non-physical harm from disrespect across all 12 respondents, usually referred to as emotional or psychological harm from most of the respondents, with many confirming its presence in interactions with patients and families, and validating its importance in addressing and improving, but with varying support and understanding for its systematic adoption into quality and patient safety practices. As previously discussed in the "patient safety and harm" section above, there were five respondents who, unprompted by the researcher, described patient safety and harm more holistically by indicating that patients and families can be harmed both in a

physical and non-physical, or emotional, sense. One hospital leader had specifically elucidated the existence of non-physical harm by stating:

I think we can describe harm in so many ways... there's the physical harm of... we did something inadvertently that... physically changed the body or removed or added something that was unintended. I think there's also another harm that we don't necessarily record or keep track of, but it's the psychological harm of when you're in a hospital and what you experience...[W]e were debriefing a significant event here recently and we talked about all the things that went wrong and what we can do to fix and prevent the next time. And at the very end [of the debrief], it was this moment of "and what did the patient feel and hear during this time, and what was the impact?" We really don't have a way of evaluating or assessing that impact, but we know that something traumatic happened and we don't ever really get to know that psychological harm that is done. I think it's [treating everyone with respect and dignity] at the forefront of our expected behavior and treatment of all of our patients...it's even in our values of honoring and respecting the integrity of each of our patients. (Leader 3)

One physician had viewed non-physical harm as the following:

I think for patients it's this feeling of not being listened to, not being included in decision making. Not having their specific personal, religious, cultural beliefs included in their assessment and treatment. And not being made to feel like a person. Patients can feel the way they feel. Whether they're right or wrong or not. Because they just feel that way, right? So it may be completely inappropriate for you to get an MRI for something, but it's our job to either give [the patient] the MRI, which may be the wrong thing to do, or explain to them...why they don't need it to the point where they go "oh." They heard me. They understood. Yeah, it's not what I need. I need this other thing. And they've explained it to me in a way that I feel good about it. (Physician 1)

One nurse described the importance of honoring spiritual and religious beliefs related to end-of-life care as a way to preserve dignity and show respect toward the deceased patient and family members.

We had end of life on our unit...[and] in this patient's tradition and culture, you have to open up a window so their spirit can leave...and that was really important for this group of people...and, you know, prepping the body in ways that were acceptable for the family, and making sure that we respected everybody's way of

doing things... I do think there just definitely needs to be more training on how to, I guess, help staff understand the patient's back story... trauma and culture play so much of a role in how to adequately care for your patient [in a holistic way]. (Nurse 4)

A common theme among respondents who recognized the importance of not causing non-physical harm from disrespect was the widespread uncertainty around learning how to integrate and systematically track not only the specific example of non-physical harm inflicted upon patients and families but mitigating and preventing future experiences.

I do think that it would be helpful to do that, to be able to assess it. A lot of our patients that we often find difficult to handle in the hospital have had negative experiences in the hospital previously. And so we kind of are attributing to the problem we're having. We don't know how we're attributing to it. And so I think there would be some insight that we would glean from knowing what are the things that would have been helpful. (Nurse 2)

And I think the...dilemma is that nobody comes to work intending to make somebody feel that way exactly. And unlike a CAUTI [catheter-associated urinary tract infection] or CLABSI [central line-associated blood stream infection], which, there's a definition that's really easy, a medication that was given wrong or procedure done the wrong site, those things, everybody would agree that those are, like, right or wrong if you will. But there may be a perception on the part of a patient which is the product of not having all the knowledge or unrealistic expectations, so for providers and clinicians who are taking care of them to be like "why are they mad at me when that's like a completely crazy thing to want or need now they still want or need it?" They still perceive what they perceive. But I think when you ask a lot of people...it's an easier one [type of harm] to cause...and I think a more difficult one to prevent. (Physician 1)

Another interviewee who works as an emergency department nurse provided several examples of the often unpredictable, emergent, and acute nature of some patient encounters that necessitate rapid decision-making and medically necessary interventions that may be at odds with preserving patient respect and dignity.

Sometimes the situation to keep the patient [physically] safe outweighs the disrespect they might experience. And there's clinical support for what was done, but it might be emotionally harmful, and it may contribute to longer term issues or distrust...like maybe next time she won't go to the ED because of that [previous] experience. (Nurse 3)

This is consistent with Sokol-Hessner et al.'s (2015, 2018, 2019) research that disrespect is often not intentional, but may be a result of the circumstances surrounding the encounter. Given the moral imperative underpinning health care, it is recognized that a vast majority of health care providers do not intend to disrespect patients and families; a patient or family member's experience of disrespect may be a product of the patient's disease or situation, the environment or design of the delivery system, or many other reasons that may lead to patients and families experiencing disrespect that stem from their unique goals, values, preferences, and backgrounds (Sokol-Hessner et al., 2015, 2018). Another nurse emphasized how previous disrespectful interactions can influence future experiences, and the importance of trust in fostering and maintaining an environment that translates to care that does not cause non-physical harm from disrespect to patients and families.

I think in general we try really hard to be transparent as much as possible...[but] I think what it boils down to is trust, right? If a patient has a bad experience with us, the next time they're going to be less trusting of their next interaction with the health care provider we [or leaders] don't follow through with what they say...if staff are dismissive or whatever it is. (Nurse 2)

One leader highlighted existing systems and tools used broadly by health systems that may be inadvertently perpetuating non-physical harm from disrespect to patients, providing examples of patient satisfaction survey language and limited documentation capabilities to capture correct pronouns or a patient's Indigenous mailing address, stating

“there are mechanisms in place that need to be changed or...evolved to make sure that people feel that the language is inclusive” (Leader 1).

While the focus of this research is specifically around patient/family experience of disrespect, some interview questions were targeted toward staff experience of disrespect, either from patients/families or fellow organizational staff. Every interview yielded an equal or greater emphasis on staff being disrespected, verbally threatened, and/or physically abused by patients/families than around patient/family disrespect and threats to dignity. Nurse 4 indicated how in her interactions with patients and families she emphasizes that they have “a right to quality and dignity...in their care...” while also stating “we want to make sure that’s also reciprocated to all of our staff.” As previously stated in the discussion of the most prominent barriers influencing the delivery of care, staff safety and wellbeing was vocalized as a primary concern, particularly in recent years; this focus on workforce will be discussed in more detail in the subsequent chapter.

### **Leadership and Organizational Priorities**

The last set of questions that were asked of all interviewees pertained to perceptions of the organization’s core priorities and prioritization of resources to support those priorities, questions around how the concepts of respect and equity fit into the organization’s operations and priorities, and how those concepts are reinforced and/or evident in organizational operations.

Many of the barriers raised by respondents in Table 6.2 above, including burnout, staffing challenges, resource constraints, and staff physical safety concerns, were recognized as key organizational concerns needing to be addressed. A common theme that resulted from most interviews was the palpable pressure that leaders, nurses, and

physicians all felt around “doing more with less.” As one leader noted, “meeting the interest groups of two parties [staff and patients] is not always easy, and not always 50/50” (Leader 3). When asked about the organization’s core priorities, almost all respondents (11 of 12) unequivocally answered that the organization’s primary focus was on its financial health and performance, particularly in recent years in response to pressures exacerbated by COVID-19. Many noted how the structural decisions made in response to financial pressures (including re-structuring, layoffs, consolidations, concentrating services and/or centers of excellence, and other business decisions) was inevitable and not unique to this particular health system; however, depending on the role of the interviewee, not all recognized the extent to which health systems have had to contend with the ongoing challenges of increasing costs, regulatory expectations, and declining reimbursement.

Interviewees’ widespread perception that the organization was primarily prioritizing its focus on the financial side of the business, particularly given the timing of this research study and the impact that COVID-19 has continued to have on health care organizations across the country, is largely unsurprising. However, most front-line and middle-management clinicians who were interviewed (both nurses and physicians) emphasized their belief that health care is meant to be a holistic, healing environment, and not solely an institution that is dictated by financial factors in influencing its priorities. Conversely, all leaders who were interviewed reinforced the rationale for the organization’s focus on financial performance, and also indicated their perspectives that staff not in leadership roles often did not often understand or recognize the intricacies surrounding the financial viability of the organization given that they were not privy to

the “full financial picture,” and recognized the many parts were not “easily explainable nor well understood.” One assistant nurse manager, whose role had evolved from bedside nursing to middle management in her two-decade career in the organization, echoed this viewpoint, indicating:

When I was [solely] taking care of patients, it was sometimes annoying to me to be like, okay, now we have to do this. And now we have to do this other thing...direction comes down from above, and we just have to do it. But I understand the why behind it more now [as a supervisor]. I’m definitely more aware of regulations [and] systems issues, and why the system does what it does. (Nurse 2)

Many of the front-line and middle management clinicians interviewed felt the organization’s priorities were skewed, favoring regulatory and financial pressures over hospital operations and workforce (particularly front-line) needs.

I would like [the organization] to head in the direction of prioritizing the needs of the front-line to ensure that we’re making our front-line staff get what they need so they can provide the best care. The heart...of an organization [is] the managers and the supervisors and front-line staff, because we are the direct contact...but I don’t see that being a priority [and] I think it’s a missed opportunity because if you really take care of your managers and supervisors, you’re going to have a great outcome of your front-line staff. You’re going to have a reduction in burnout...and turnover... [W]hat I’m hearing [from peers] is it’s just a lot of people want to be directors because they want fewer core reports, right? A lot of the heavy lifting are your core reports. And they’re the foundation of providing great care, and they’re foundational to providing respect and dignity. (Nurse 1)

One leader recognized staff engagement and retention as one of the biggest priorities for the organization, reinforcing Nurse 1’s perspective above, indicating “we need to take care of our people so they can take care of patients” (Leader 4).

Many respondents highlighted their belief that the underlying philosophy guiding the overarching organizational mission was to provide safe, high quality care to patients and families. However, most respondents discussed that the actual operationalization and



interpretation of how to define and implement this type of care in practice is done on a local (hospital) followed by department-specific level, suggesting variation across the organization, and illustrating the complexity and difficulty of organization-wide intent reaching all levels of its individual hospitals. One leader echoed this concern by stating:

...I worry the bigger we [the organization] get, the more diffuse we get...Respect and trust are intertwined...and I worry what the years to come look like as we continue to stay in this [newly restructured] model. (Leader 1)

While several respondents indicated the importance of understanding and systematically tracking the impact of psychological, emotional, and non-physical harm from disrespect, many admitted the challenge of doing so.

I think part of the teachings from HRO is rooted in making sure that you hear and listen to everybody and... that nobody's opinions are worth more than others. And I think that's part of fostering mutual respect amongst at least staff ... I think it's harder to apply that to patients in general and I'm not sure that as an institution or as an organization, there's a lot of push for that...with the demands on everybody... It's going to draw people who are already interested in learning more...[but] I don't think that people who otherwise wouldn't be terribly interested in it or participating in it, you're not catching those folks. (Physician 2)

I do think that it would be helpful to be able to assess it...[and] I think [staff] are encouraged [to speak up about disrespectful encounters], but where I do feel there is a gap ... is how do we really expect resolution to it? (Leader 3)

A resounding theme throughout all interviews was an emphasis on how essential prioritizing the workforce is – including wellbeing, retention, safety, and engagement – and how front-line clinicians and leaders alike believe that addressing salient workforce issues is critical to care delivery and patient safety.

My visibility into the work...has been around the acknowledgment from the executive team that the more burned out our staff are, the more tired they are. We are looking to [understand] where our [staff] stand in terms of being connected to our purpose, to our mission, but also understand where they are frustrated and what we need to do to get them to feel that connection better. Staff engagement is

so important...how happy staff are comes across to every single patient that we care for, right? It comes across in our moods, it comes across in the way that we care for them, it comes across in the way we make them feel...so to me, there has been no higher priority than staff engagement and retention. (Leader 4)

While the extent to which different levels of staff and leaders interviewed believe that workforce issues are being tackled effectively varied, with some staff asking for additional support and others indicating that efforts to bolster the workforce challenges have been in process and are already a core priority for the organization, each of the interviewees highlighted the magnitude and importance of the health system concentrating on such an imperative, and fundamental, function of its operations. As illustrated above, addressing and improving workforce-related challenges is a key factor in influencing the delivery of care and providing safe, reliable, and holistic care to patients and families.

### **Discussion**

As noted in Chapter Two, while research has increasingly argued that non-physical harm merits the same level of rigor and attention as physical harm, there are many competing priorities and barriers that can impede an organization's ability and/or receptivity to incorporate this type of harm into existing patient safety and quality programs (Sokol-Hessner et al., 2015, 2018, 2019). Engaging leaders to commit to fostering a culture of respect and, more broadly, focusing on non-physical harm necessitates illustrating the costs of not systematically recognizing and addressing these pivotal concepts as foundational to the organization's well-being and performance, including financial, reputation, workforce retention, and other perspectives (Sokol-Hessner et al., 2018).

Interviews were conducted with the intent to better understand how and if the organization recognizes non-physical harm as a priority that necessitates formal integration into its existing organizational processes. Each of the categories of questions was intended to provide key insights into the perspectives of different profession types and levels of staff/leadership on key facets of patient safety. Having a clearer understanding of workforce perceptions of patient and family priorities, organizational priorities, department/hospital safety culture(s), patient safety, and leading barriers, including the magnitude of those barriers in impacting operations and staff wellbeing, is essential in understanding how non-physical harm from disrespect factors into a complex delivery system environment. While many interviewees primarily grounded their initial descriptions of patient safety and harm in physical harm descriptions, some respondents viewed patient safety and harm as being physical and non-physical in nature, and all respondents recognized that patients and families can be harmed in a physical and emotional sense. The universal acknowledgement among respondents validated the importance of addressing this type of harm, but with varying support and understanding for its systematic adoption into quality and patient safety practices, particularly in light of the current challenges that most interviewees indicated take precedence.

Interviews took place in 2023, and the longstanding demands, challenges, and impact that the COVID-19 pandemic has had on workforce wellbeing, financial performance, availability of resources, attitudes and behaviors, and other factors, undoubtedly influenced the interviewees' overall perceptions of health care and care delivery within the organization, as well as organizational priorities. One of the core findings resulting from this research was the elucidation and reinforcement of the links

between workforce well-being, workforce safety, and patient safety (Salvon-Harman, 2023). With this study taking place during a global pandemic that engendered upheaval and havoc on health care organizations, the workforce, and patients/families in diverse ways, interviewee responses underscored how the overarching health system, including behaviors, conditions, and operations, had been significantly affected by uncertainty and challenges. However, it was evident throughout 11 of the 12 interviews that while the collective fatigue and acknowledgment of seemingly never-ending resource constraints, staffing challenges, workforce well-being, and wellness concerns created an ongoing source of stress, strain, and, in some cases, exasperation, there was an unwavering element of resilience and continued commitment to providing safe, reliable care to patients and families. Among all nurses, physicians, and leaders who were interviewed, only one interviewee – a staff nurse who had been at the organization for less than five years – had a notably different perspective from the other interviewees, describing her views in primarily negative terms and expressing significant dissatisfaction with her role and the organization’s priorities.

In each of the 12 interviews, the researcher not only asked about challenges and barriers but also asked each respondent to describe their most enjoyable and positive aspects of their jobs. While each interview unearthed palpable frustrations, most of which appeared to be compounded by external, uncontrollable environmental forces, interviewees also expressed optimism, pride, appreciation, and a commitment to caring for patients and their families. Overall, the positive and hopeful perspectives that the majority of interviewees shared is encouraging, as it underscores the continued dedication to providing fundamental safe, high-quality care. Additionally, the growing awareness

that harm can be both physical and non-physical in nature is an important first step toward systematic adoption, learning, and mitigation of this type of harm.

As was evident throughout the interviews, there was a greater emphasis on staff experience of disrespect regardless of the research focus on patient/family disrespect; this is understandable as the relationship between the two contributes to the delivery of care and culture of respect. Additionally, this finding aligns with and reinforces Sokol-Hessner et al.'s (2018) work that identified the foundational role of organizational leadership in developing and fostering a culture of respect and dignity in “advancing the practice of respect” (p. 468), intentionally positioning this recommendation as first among the six final recommendations that resulted from the 2018 consensus statement.

The widespread, rising concern articulated by interviewees around staff safety, both in a physical and non-physical sense, suggests that addressing patient/family non-physical harm from disrespect caused by interactions with the health care system also warrants investigation of the reciprocal relationship and the incivility, abusive, and sometimes violent behaviors that staff experience from patients/families. A discussion of the implications of these interviews, including linking these findings to insights gleaned from Aims 1 and 2, as well as limitations and suggestions for future research, will be discussed in the final chapter.

## **Chapter Seven – Conclusions, Limitations, and Future Research**

### **Overview**

This final chapter presents a discussion of the conclusions of this research. It begins by restating the study's research question and aims, includes a summary of synthesized key themes and findings, provides high-level recommendations for different groups of interested parties, discusses study limitations, outlines potential areas for future research, and offers concluding comments.

### **Study Purpose and Summary of Key Findings**

In recent years, it has been recognized that while many health care organizations predominantly focus on mitigating physical harm, health care-associated harm extends beyond physical harm and injury to also encompass non-physical harms, which are rooted in the interrelated concepts of respect and dignity (Brown et al., 2018; Frankel et al., 2017; Gazarian et al., 2017; Ottosen et al., 2018; Sokol-Hessner et al., 2015, 2018, 2019). Despite the prevailing focus of patient safety improvement efforts on physical harm, disrespect is pervasive in health care and “is an affront to dignity and can cause harm” (Sokol-Hessner et al., 2018, p. 463). Additionally, non-physical harm events are potentially more prevalent than physical harm occurrences (Bates & Singh, 2018; Frankel et al., 2017; Leape et al., 2012a; NPSF, 2015; Sokol-Hessner et al., 2015, 2019). However, despite research indicating that addressing non-physical harm should be incorporated into organizational patient safety and quality efforts, such actions are still in the nascent stages

in terms of being systematically operationalized and mitigated by most health systems (Sokol-Hessner et al., 2018, 2019).

While disrespect can be rooted in the individual (endogenous), it is also learned and perpetuated in an organization's culture and environment (exogenous); a dysfunctional organizational culture rooted in disrespect threatens an organization's safety culture strength and is a central barrier to patient safety progress (Leape et al., 2012a). As such, a culture of respect is a "precondition" for the changes needed to make health care safer and for organizations to become highly reliable; establishing such a culture creates an organizational environment mitigating staff experiences of burnout and instead encourages engagement in work (Leape et al., 2012b, p. 853). Creating a culture of safety to ensure reliability, improvement, and sustainability is foundational for solving safety issues, proactively avoiding issues, and establishing viable patient safety programs (Frankel et al., 2017).

Building upon this foundation, the purpose of this study was to explore the following question: How does a multi-hospital health system recognize and address preventable non-physical harm? This research question was explored through three aims: 1) characterizing non-physical harm events from disrespect occurring across organizational components (hospital and unit) through application of the BIDMC incident analysis framework; 2) identifying associations between patient experiences of respect and staff perceptions of safety culture, and determining the extent of variations in respect and safety culture across hospitals and units; and 3) investigating how leadership and staff articulate and prioritize non-physical harm in the context of organizational culture and organizational commitment to patient safety.

## **Aim 1 Summary and Key Findings**

Of the 1,037 patient- and family-generated complaints and grievances captured across eight hospitals in 2021, 352 (34%) met inclusion criteria as outlined in the BIDMC Prioritization Schema for subsequent analyses using BIDMC's incident analysis framework. The framework provided a structured, systems-oriented approach for assessing problematic interactions between patients/families and health care professionals/organizations, which can be conceptualized as experiences of disrespect.

Consistent with Sokol-Hessner et al.'s (2019) findings, and through application of the BIDMC framework to complaints and grievances, it was found that patient/family experiences of disrespect occurred across diverse care processes, resulted from a myriad of professional and organizational behaviors, were influenced and shaped by various contributing factors across different levels, and had potentially lasting consequences across patient/family, professional, organizational, and societal levels. The BIDMC framework allowed for the identification and reinforcement that patient/family experiences of disrespect are complex and multi-faceted and must be viewed holistically to better understand the experience of non-physical harm and to encourage improvement; this promotes a systems view of improvement as opposed to a piecemeal approach or narrow understanding of causes of disrespect.

Chapter Four described the utility, challenges, and proposed modifications to both the BIDMC Prioritization Schema and incident analysis framework for future use by organizations, and provided observations and recommendations for organizations collecting complaints/grievances based on the findings.



At a high level, among the cases reviewed in this research it was found that patients primarily felt non-physical harm related to processes around their treatment (including medication administration, pain management, procedures, restraint management, delirium management, and/or psychosocial support) (40%), and in discussions about their care (inclusive of diagnosis, prognosis, treatment options, consent, and/or shared decision-making) (36%). Three of the most predominant professional/organizational behaviors that patients/families experienced included: 1) feeling dismissed or disregarded (30%); 2) perceiving staff to be uncaring, indifferent, and/or impersonal in interactions (28%); and 3) feeling that staff were inattentive, and/or being ignored, neglected, and/or abandoned (24%). Across the different levels of consequences, the three most frequent patient/family consequences were: 1) negative emotions and feelings (90%); 2) negative ratings of care (43%), and 3) negative impacts on mental and physical health (39%). The most predominant professional-related consequence from the cases reviewed resulted in an antagonistic relationship with patients (27%). From an organizational level, damage to reputation (10%) and patient attrition (8%) were the two primary organization-related consequences.

These results surfaced key overarching themes and underscore critical aspects for strengthening care delivery to patients and families and minimizing their disrespectful experiences of care.

### **Aim 2 Summary and Key Findings**

The purpose of Aim 2 was to quantitatively assess whether patient experience of respect reported via patient experience survey data was associated with staff perceptions of organizational safety culture through staff engagement surveys. A series of separate

regressions was conducted to determine whether there was a generalized relationship between patient experience of (dis)respect and staff perception of safety culture, and the extent of variation in respect and safety culture across hospitals and units.

After controlling for patient characteristics, hospital, and unit type, neither the association between patient experience of being treated with courtesy/respect by a nurse and nurse perception of safety culture, nor the association between patient experience of being treated with courtesy/respect by a physician and physician perception of safety culture, were statistically significant. To understand variation across units and hospitals in both nursing and physician models, it was found that variations among units and hospitals did exist, which is consistent with safety culture literature indicating differences in safety climate levels for different subgroups and hierarchical levels, and between clinicians and non-clinicians, reinforcing this study's purpose in assessing both association and variation (Ginsburg & Oore, 2015; Hickner et al., 2016; Martinez et al., 2015; Schwendimenn et al., 2013; Singer et al., 2009; Singer & Vogus, 2013). There was a notable contrast in findings around patient experience of respect between Aims 1 and 2; patient/family complaints and grievances (Aim 1) highlighted a considerable amount of distressing interactions between the patient/family member and the care team and/or organization, whereas the HCAHPS data (Aim 2) revealed that the majority of patients surveyed indicated they always experienced courtesy and respect by nurses and physicians. There are a number of limitations to HCAHPS, discussed below, that are important to recognize and could have influenced these results.

While the main intent of the first set of regressions was to assess a relationship between staff perceptions of safety culture and patient perceptions of respect, there were

statistically notable variations in respect levels across almost all patient and organizational control variables. This suggests that experiences of respect (and potentially disrespect) might be mediated by certain patient characteristics, which might put some patients at a higher likelihood of experiencing respect as compared to others with a lower likelihood of experiencing respect.

### **Aim 3 Summary and Key Findings**

Aim 3 was addressed through conducting 12 semi-structured interviews with nurses, physicians, and leaders at four of the eight hospitals with the overarching intent to better understand if and how the organization recognized non-physical harm as a priority that necessitated formal integration into its existing organizational processes. The interviews also focused on staff perceptions of patient/family priorities, interviewees' conceptualization of several concepts (including patient safety, harm, safety culture, and non-physical harm), team dynamics, error reporting, COVID-19 implications, and leadership/organizational priorities.

One of the main findings of Aim 3 was that while all respondents recognized that patients and families can be harmed in a physical and emotional sense, many interviewees primarily grounded their discussion of patient safety and harm in physical harm descriptions. The universal acknowledgement among respondents validated the importance of addressing this type of harm with varying support and understanding for its systematic adoption into quality and patient safety practices; several interviewees directly stated not knowing how to capture or address these experiences of disrespect given the inherent subjectivity of the concept.

Another core finding resulting from this research was the elucidation and reinforcement of the links between workforce well-being, workforce safety, and patient safety (Salvon-Harman, 2023). Since this study was conducted during a global pandemic that engendered upheaval and havoc on health care organizations, the workforce, and patients/families in diverse ways, interviewee responses underscored how the overarching health system, including behaviors, conditions, and operations, had been significantly affected by uncertainty and challenges. However, it was evident throughout most interviews that while the collective fatigue and acknowledgment of resource constraints, staffing challenges, workforce well-being, and wellness concerns created an ongoing source of strain, there was an unwavering element of resilience and continued commitment to providing safe, reliable care to patients and families.

It was evident throughout the interviews that there was a greater emphasis on staff experience of disrespect regardless of the research focus on patient/family disrespect; this is understandable as the relationship between the two contributes to the delivery of care and culture of respect. This finding aligns with and reinforces Sokol-Hessner et al.'s (2018) work that identified the foundational role of organizational leadership in developing and fostering a culture of respect and dignity in “advancing the practice of respect” (p. 468), intentionally positioning this recommendation as first among the six final recommendations that resulted from the 2018 consensus statement. In addition to leadership prioritizing a culture that promotes respect and dignity, “engaging and support[ing] the workforce” (p. 468) is a critical focus area for organizations and could be considered a precondition for establishing more effective strategies for improving the “practice of respect” (p. 468).

## **Recommendations for Key Groups**

There are several recommendations for key groups, including health system administrators, policymakers, and regulatory entities, derived from the findings of the investigation of the study's three aims. Rebuilding trust is a core theme underpinning many of the recommendations found below. Trust can be viewed as a "component of respect" (Sokol-Hessner et al., 2018, p. 474), and patients and families experiencing non-physical harm from disrespect can contribute to loss of trust in health care.

Aim 1 analyses revealed that many patients and families experienced strong emotions as a result of feeling disregarded and/or not feeling included in essential conversations; 17% of cases were coded as the experience of disrespect leading to the patient/family feeling a loss of trust or distrust in the health care professional, hospital, larger organization, or health care in general.

In most of these cases, this loss of trust and/or decline in confidence in the organization was explicitly stated by the person who issued the complaint/grievance, with many indicating that they felt dismissed, insulted, lied to, ignored, and/or not included in key decision-making, leading to a loss of trust. For some cases, a particular interaction or instance in their care delivery was challenging, while for others their loss of trust was built upon multiple additive issues that compounded and led to complete distrust in the health system – which had longer term implications. In other circumstances, distrust was inferred through the indication that the individual/family would not return to the organization given the discomfort, disrespect, and disregard that was experienced. There were also several occurrences where patients/ families felt the health care providers

ignored fundamental information that led to patients/families not feeling understood, heard, and/or recognized as a person needing support.

### **Recommendations for Health System Administrators**

**Recommendation 1:** One key area for organizations to focus efforts to strengthen patient/family loss of trust is improving and optimizing treatment processes through transparency and communication, and ensuring patients and families feel cared for and heard. Organizations should focus on strategies for rebuilding trust with patients and families to minimize experiences of disrespect. The importance of trust cannot be understated, as “trust in health care organizations...at least to some minimal extent, is undoubtedly a prerequisite to seeking health care at all...” (Platt & Dorr Goold, 2023, p. S53). Patients receiving care are dependent on the health care system when they are at their most vulnerable; as a result, striving to exhibit care, compassion, empathy with the patient’s circumstances, active listening, and understanding can all convey trustworthiness to patients and families, potentially improving care interactions (Platt & Dorr Goold, 2023; Rushton et al., 2021; Sullivan, 2023). In addition to rebuilding trust with patients and families, there is a broader imperative to restore trust by creating a safer environment for all – inclusive of patients, families, and the workforce, in their interactions with one another and with patients and families (Rushton et al., 2021).

**Recommendation 2:** Another concrete way to strengthen trust involves creating and/or optimizing an organization’s communication-and-resolution program (CRP) in order to bolster transparency. How organizations respond to patients and families who have experienced disrespect relates to the “modifying factors” component of the BIDMC framework and is an essential part of addressing and mitigating experiences of disrespect

experienced by patients and families (Sokol-Hessner et al., 2019). CRPs emphasize communication and transparency with patients and families by encouraging “the disclosure of unanticipated care outcomes to affected patients and proactively seek resolutions, including offering an apology, an explanation, and, where appropriate, reimbursement or compensation” (Mello et al., 2014, p. 20).

As was discussed in Chapter Four, often the organization found no deviation from the standard of care, nor was there an indication of poor clinical judgment, so the patient/family’s complaint or grievance was not formally “substantiated” by the organization, but the patient nevertheless felt dismissed, disrespected, and/or emotionally affected. This finding aligns with the experience of reliable harm response programs where the majority of physical harm events were not found to have been preventable (Mello et al., 2017). However, new research shows that there are associations between organizational communication and patients’ experience of “prolonged emotional impact following medical errors” (Sokol-Hessner et al., 2024). Proactive and respectful communication with patients and families about events, including those where the standard of care was met, is a critical part of reliable harm response programs, and has been associated with a lower risk of sustained emotional impact (Sokol-Hessner et al., 2024). As such, organizations should recognize the importance of communication, transparency, validating the patient/family’s poor experience, and aim to address their experience in efforts to alleviate suffering and rebuild trust through CRPs.

**Recommendation 3:** Disrespect must be “defined from the perspective of the person experiencing harm” (Sokol-Hessner, personal communication, March 6, 2022).

While many organizations have not yet optimized integrating complaints systematically

into existing quality and patient safety efforts, the use of patient complaints describing non-physical harm events is an essential information source that organizations can leverage for improvement efforts (de Vos et al., 2018; Gallagher & Mazor, 2015; Gillespie & Reader, 2016; King et al., 2017; Raynaud-Lambinet et al., 2011; Reader et al., 2014; Sokol-Hessner et al., 2019, p. 658; Wofford et al., 2004). This recommendation urges organizational leadership to acknowledge the impact that problematic, and often disrespectful, events can have on patients and families, the workforce, the organization's operations, and the larger health care community; it urges leaders to integrate the BIDMC framework as part of quality and patient safety programs to begin capturing non-physical harm events to learn from, and ideally mitigate future occurrences. Employing this framework recognizes that while a patient and/or family member may experience disrespect during interactions with the health care system, it is rarely due to a staff member being intentionally disrespectful; as such, using the BIDMC framework will allow for a deeper awareness of the system factors that potentially contribute to the experience of disrespect felt by patients and families (Sokol-Hessner et al., 2015, 2019).

Additionally, as stated in Chapter Four, organizations can use both the schema and framework retrospectively to obtain a baseline understanding of their current state, improve organizational awareness, aggregate results to identify patterns, and pinpoint areas for immediate and longer-term improvement efforts, and in real-time, allowing for the review of current complaints/grievances as a means to delve into patient/family experiences from disrespect and tailor solutions to address and mitigate future occurrences. Non-physical harm rooted in disrespect should be treated as a “quantifiable harm” (Brown et al., 2018, p. 1393) that necessitates formal assessment and mitigation to



make an impact on future prevention and overall improvement in quality and safety, while also being mindful of mitigating potential unintended consequences such as burnout, measurement fatigue, and the perpetuation of inequities (Brown et al., 2018; Sokol-Hessner et al., 2015, 2018, 2019). Approaching this work as “improving the practice of respect” (Sokol-Hessner et al., 2018, p. 475) aids in positioning it as an intentional step in advancing the organization’s journey to enhanced safety and reliability.

**Recommendation 4:** As previously discussed, while 34% of cases met inclusion criteria within this study, this does not suggest that only 34% of patients/families who issued complaints/grievances in 2021 felt disrespected; the total number of complaints and grievances captured in 2021 and the included cases likely both underrepresent the true extent of patient/family experiences of dissatisfaction and disrespect. As a result, improving reporting is an important target for organizational improvement work. A first step in improving reporting rates involves capturing patient/family demographic data in the complaint/grievance process. This will allow organizations to have a better understanding of who is generating complaints and grievances among their patient population, and not unintentionally creating challenges for certain patient populations to speak up about their care.

**Recommendation 5:** In Aim 2, one critical access hospital performed poorer than other hospitals in both physician and nursing analyses, suggesting that both nurses’ and physicians’ safety culture perceptions were lower than the reference hospital (a larger, urban, tertiary care/teaching hospital). However, three respondents (two administrative leaders and one nurse) who were interviewed from that same critical access hospital for

Aim 3 had particularly effusive feedback regarding safety culture and safety practices overall within their particular hospital. This variation between the quantitative and qualitative data reinforces the need for administrators to not rely on one limited data source to understand the broader context, and to remain open to learning across different modalities and perspectives in order to obtain a deeper understanding of current state.

**Recommendation 6:** The widespread, rising concern articulated by interviewees in Aim 3 about staff safety, both in a physical and non-physical sense, suggests that addressing patient/family non-physical harm from disrespect caused by interactions with the health care system also warrants investigation of the reciprocal relationship and the incivility, abusive, and sometimes violent behaviors that staff experience from patients/families. Considering Aim 3 results alongside Aim 1 findings underscores how staff have been experiencing a more antagonistic relationship with patients overall. Staff wellbeing and morale impacts quality and safety; as such, it is recommended that organizations balance patient and workforce needs by also prioritizing workforce wellbeing and wellness. Organizational policies and priorities, as well as regulatory guidance, need to emphasize the mutual treatment of respect across both parties (staff and patients/families), where patients and families also have a role in treating hospital staff with dignity and respect. As previously discussed, establishing and sustaining a culture of respect, and a culture of safety, begins with leadership; an organization's leadership is ultimately accountable and is essential in setting organizational priorities, inclusive of setting the organizational tone in prioritizing and fostering a hospital or health system's safety culture as part of its pursuit of becoming an HRO (Botwinick et al., 2006; Chassin & Loeb, 2011; Frankel et al., 2017; NPSF, 2015; Sammer et al., 2010; Sokol-Hessner et

al., 2018; Sutcliffe et al., 2017). The adoption and championing of these characteristics are “shaped by leaders’ actions, particularly the extent to which they demonstrate a commitment to safety through the visions they create, the goals they set, and communications that signal what is and is not important” (Sutcliffe et al., 2017, p. 250).

### **Recommendation for Policymakers**

**Recommendation 7:** Policymakers need to formally recognize and embrace a broadened definition of patient safety and harm to include non-physical harms when discussing and shaping patient safety policy solutions. A fundamental shift in how patient safety is viewed and discussed affects subsequent policy and regulatory infrastructure; as such, broadening a historically narrower view of patient safety can lead to the design of more inclusive policy and regulatory solutions that better fit the evolving landscape of care delivery.

Continued recognition of this broadened definition is underway; the World Health Organization (WHO) released its first Patient Safety Rights Charter in 2024, which outlines 10 fundamental patient safety rights (WHO, 2024). “Dignity, respect, non-discrimination, privacy, and confidentiality” are captured on the list as one of the 10 patient safety rights (WHO, 2024); the inclusion of these concepts within this charter can serve as a powerful foundation for entities developing legislation and guidelines addressing non-physical harm.

### **Recommendation for Regulatory and Accrediting Entities**

**Recommendation 8:** As was discussed in Chapter Two, regulation, accreditation, and certification are all prominent external influences that have considerable weight and influence over health systems and health care professionals. Accreditation in particular

has been cited as a major driver of safety efforts, although there is varying evidence regarding its effectiveness in improving the quality of care (Brennan, 1998; Devers et al., 2004; Jha, 2018; Lam et al., 2018; Warburton, 2009). However, despite drawbacks in the accreditation process, there is a resounding belief that accreditation is influential in its ability to mobilize organizations to establish baseline practices and processes in place to strengthen patient safety and quality (Devers et al., 2004; Jha, 2018; Warburton, 2009). As such, given the role that regulation and accreditation have as drivers in promoting the delivery of safe care, this study's final recommendation is for regulatory and accrediting entities to formally codify a broadened definition of patient safety and harm to include non-physical harms, and to include a requirement and accreditation standard requiring organizations to identify and track non-physical harm events and address their findings.

As described in Chapter Two, the types of quality and patient safety policies that have emerged in the past few decades have manifested through multiple regulatory rules, accreditation standards, and internal organizational policies. There are an immense number of CMS CoPs, state-based rules and statutes, and accreditation standards addressing the interrelated components contributing to quality and patient safety; for health delivery systems specifically, most of the standards and regulations have been oriented toward mitigation of physical harm, medication management, the role of leadership and culture, and direct organizational measurement and improvement. While patient rights as a category encompasses standards related to treating patients with respect, there are no current regulations or standards guiding the proactive mitigation of non-physical harms, nor emphasizing the value of strengthening trust. This recommendation encourages the development of regulatory and accreditation

requirements that encourage organizations to broaden their patient safety efforts by incorporating non-physical harms, inclusive of trust, as part of their existing quality and safety programs.

### **Limitations, Assumptions, and Positionality**

There were several limitations to this research related to the study design, data sources, study setting, and concerns resulting from a sole researcher.

#### **Study Design and Data Sources: Qualitative**

*Aim 1:* One of the limitations with using cases logged in the Feedback module of Datix was that while these data reflected patient/family/legal representative-generated complaints and grievances, the onus was on patients (and/or their representatives) to initiate contact with the organization to ensure their voices were heard. However, members of less advantaged populations are typically less likely to report concerns than individuals in more advantaged groups (Brown et al., 2018). This may mean that certain populations are underrepresented in the data if they do not know how to initiate contact with the organization, lack the means or ability to do so (for example, if they do not speak or write English), or are fearful of negative consequences resulting from reporting concerns, such as losing their access to health care, or being treated differently when next interacting with the health care system.

Another limitation to this research was that it was limited to the existing documentation available. Event characteristics varied in level of specificity and extent of information accessible depending on how the grievance or complaint was issued to the organization (for example, a patient writing a letter to a hospital may have had more

substantive detail and represented the direct “patient voice”, compared to an intake staff member summarizing the information from a brief phone call with a patient representative). Additionally, it is possible that many complaints and grievances were resolved during the patient visit and thus were not logged in Datix; it is more challenging to learn from these instances that are not captured and formally investigated even if they were potentially resolved in a satisfactory way in the moment.

*Aim 3:* Interpretation and possible subjectivity is inherent with qualitative interviews (Creswell & Creswell, 2018). As a result, the researcher practiced reflexivity in order to address qualitative validity concerns, acknowledging that researcher biases, values, and past experiences could influence and shape both how the qualitative component was designed and how data derived from interviews were interpreted (Creswell & Creswell, 2018). Another drawback related to the researcher’s presence and identity as an employee of the organization during the study that may have biased interviewee responses; additionally, there may have been the possibility of power dynamics between the researcher and interviewee (Creswell & Creswell, 2018).

### **Study Design and Data Sources: Quantitative**

*Aim 2:* For the quantitative analysis, respect was measured through two HCAHPS questions specifically tied to encounters with a single nurse and physician in order to develop a simplified, baseline understanding of patient experience of respect as a mechanism contributing to non-physical harm. However, there are often numerous interactions throughout a patient’s inpatient stay with several different nurses and physicians, as well as other clinician types, and the patient may not differentiate among these various staff members when responding to these two questions; their responses may

reflect their overall experiences with those they came into contact with, as opposed to a single nurse or physician.

Additionally, the HCAHPS survey has intrinsic bias in that it is only available in select languages, limiting access to those who read, speak, and comprehend a supported language: English, Spanish, Chinese, Vietnamese, Tagalog, Russian, Portuguese, German, and Arabic (HCAHPS, 2020). Furthermore, while HCAHPS is offered in the above-mentioned languages, it is the organization's responsibility to purchase surveys in modalities and languages that cover its patient populations, and this may vary depending on the organization's priorities, resources, and overall approach to soliciting patient feedback, among other factors. It is also recognized that patients' responses to the survey may have been affected by survey modality.

Additionally, criteria determining eligibility due to "logistical difficulties in collecting data" (CMS, n.d., para. 20) greatly restrict and exclude certain populations that may be at greater risk of disrespect, including patients discharged to hospice care, nursing homes, and skilled nursing facilities, court/law enforcement patients (i.e., prisoners), patients with a non-U.S. home address, and psychiatric patients (CMS, n.d.). There are several limitations to using HCAHPS data; however, these two HCAHPS measures provided a concrete starting point for assessing patient perception of respect for two key clinician groups on a limited scale.

In assessing culture of safety, because the organization's CES and Provider Survey only used the SAQ Short Form to determine employee perception of safety culture, this truncated version may have neglected other essential domains that influence and/or are key components of a safety culture. However, because the intent of the study was not centered

around validating the organization's employee experience surveys, and because the SAQ Short Form represented a validated tool, focusing on the safety and teamwork domains (collectively representing the SAQ Short Form, and holistically representing a single safety measure score) was an appropriate way to measure employee perception of safety culture for the purposes of this study.

Another drawback pertaining to measuring safety culture stemmed from two separate surveys being administered to different employee types; as noted above, all employees except physicians received the CES, and physicians answered a separate Provider Survey. Additionally, as noted in Chapter Five, the type of information varied across nurses and physicians; while safety culture scores were available by unit and hospitals for nursing, data for physicians were only available by hospital and specialty, not units. Therefore, the researcher matched physician specialty safety culture scores to unit types. Additionally, it was recognized that specialties could be assigned to more than one unit.

Lastly, this study focused specifically on nurses and physicians; however, it is acknowledged that other professionals from diverse backgrounds contribute to the quality of care and safety culture in hospitals. These other professionals may have differing perceptions on safety culture across different units and hospitals, which would have implications for safety culture given their perceived comfort level with speaking up or reporting errors if concerned.

### **Scope of Study Setting**

While this study included all complaints/grievances received during 2021 for Aim 1 across inpatient and outpatient settings, for Aims 2 and 3 there was an overall focus on the inpatient setting. However, it is recognized that safety is a concern across all health



care settings, and harm – both physical and non-physical – can occur across the care continuum (Bates & Singh, 2018; Kirk et al., 2007; Sarkar, 2016; Sokol-Hessner et al., 2019). This was particularly evident while conducting Aim 1 analyses. Additionally, given that this study was focused on hospitals within one state which were part of a larger multi-state, multi-hospital health system, these findings may not be fully generalizable to the overarching health system and/or other settings, or be representative of other hospitals or health systems. Ideally future research could be conducted on a broader scope that might produce broadly generalizable results.

### **Researcher Positionality**

One of the biggest limitations for both Aims 1 and 3 was that a single, non-clinical researcher conducted coding and subsequent analyses, leading to potential reliability and validity implications. Several strategies were employed to strengthen the study, including disclosing key information related to the survey instruments for the quantitative component, and member checking, using detailed descriptions, and exercising reflexivity for the qualitative component (Creswell & Creswell, 2018). Lastly, the researcher was an employee of the study organization. While this helped enhance the researcher's access to data sources and interviewees, it also may have affected how respondents answered interview questions. The researcher regularly interacted with the regional executive leadership team and hospital leaders in a professional capacity but kept the roles of employee and researcher separate to the extent possible.

## **Recommendations for Future Research**

There are opportunities for future research to expand upon this study. Some specific recommendations include:

**Recommendation 1: Expanding the scope of the study to include other settings beyond the inpatient setting.** Aims 2 and 3 focused more on the inpatient setting, whereas Aim 1 analyses initially included all complaints and grievances generated by patients/families in a one-year timeframe regardless of setting, given that the complaint or harm experienced often had implications beyond how it was classified by organizational staff. Harm extends beyond the inpatient setting and occurs across the continuum of care; future research should also explore how non-physical harm from disrespect occurs in non-acute/inpatient settings.

**Recommendation 2: Expand the scope of study to include other profession types.** There has been extensive research on nursing and physician attitudes and beliefs, but other profession types also contribute to safety culture and interact with patients and families, both in a clinical and non-clinical sense, including staff from pharmacy, therapy/rehabilitation, imaging, and environmental services. Future research should consider the perspectives of these other professionals, aligning with diversity, equity, and inclusion considerations. During Aim 3 interview recruitment, there were several profession types that expressed interest in participating but did not meet the subgroups of interest inclusion criteria, and therefore were not interviewed for this study. This interest and support of the study's focus highlights opportunities for future research, and the need to expand beyond nursing, physician, and executive perspectives.

**Recommendation 3: Conduct a pilot study and large-scale testing of the suggested refinements to the BIDMC schema and framework for disrespect.** Chapter Four provided several suggestions for refinements to both the schema and framework. Testing the proposed changes to the schema and framework would allow for further insight into the utility of these tools and additional strengthening of the framework to encourage broader use of these tools by organizations in capturing, characterizing, and learning from instances of disrespect. Organizations could start with a pilot study across one setting type before expanding across the system to multiple sites and settings.

**Recommendation 4: Explore organizational and unit variation in patient experience of respect.** Several control variables used in Aim 2 (sex, age, race/ethnicity, and patient mental health) had an effect on the experience of respect; future research could focus more on patient characteristics in their experiences of respect from health care professionals. Additionally, it was difficult to draw conclusions around geographical or hospital types when assessing stronger or weaker safety cultures; future analyses could focus on organizational factors to better understand causes in safety culture variation.

**Recommendation 5: Focus on organizational responses to experiences of disrespect.** Future research should focus on developing and optimizing organizational responses to patients and families who report experiences of feeling disrespected during their interactions with the health system. How organizations respond to patients and families who have experienced disrespect is an essential part of addressing and mitigating experiences of disrespect. It may be challenging, if not impossible, to prevent all disrespect, so as much as that should be a focus of health care organizations, responding

after disrespectful or distressing experiences have occurred should be a core function of every health care organization.

**Recommendation 6: Incorporate staff experiences of disrespect alongside patient and family experiences of disrespect.** Future research should review patient/family experiences of disrespect in tandem with staff reports of workplace incidents. As previously discussed, the toll of rising threats in the workplace toward staff led interviewees to comment on the distress this form of disrespect has created for the workforce. Health care professionals experiencing disrespect from patients and families can have consequences for patients/families, and patient/family experiences of distressing experiences can have implications for the workforce. While employee reports of workplace incidents are also presumed to be underreported, organizations are required to have mechanisms in place to track staff reports of workplace incidents, inclusive of incivility, harassment, abuse, and violence (Arnetz, 2022). As such, studies collectively reviewing aggregated patient/family and staff incidents could elucidate experiences of disrespect across both key groups and could provide valuable insights into the causes and impact of non-physical harm.

### **Conclusion**

While the notions of respect and dignity have long served as foundational concepts in health care, disrespect is pervasive in care delivery (Brown et al., 2018; Entwistle, 2008; Leape et al., 2012; Sokol-Hessner et al., 2018), and organizations have an opportunity to systematically address non-physical harms from disrespect as the “next frontier in preventable harm” (Sokol-Hessner et al., 2018, p. 475). Research within the

past decade has urged the recognition of non-physical harm as equivalent to physical harm events and recommended using existing quality and safety mechanisms to ensure the same level of rigor is applied to both; this recognition that both physical and non-physical harms represent a more holistic view of patient safety underscores the significance of studying non-physical harm and its relationship to safety culture (Brown et al., 2018; Sokol-Hessner et al., 2015, 2019).

The current study contributes to existing literature by recognizing the presence of non-physical harm from disrespect within health services delivery and reinforces the considerable influences of leadership and culture in the organization's environment and in care delivery. Health systems have an obligation to provide safe, effective, reliable, and equitable care to patients and families. This research reinforces existing literature that organizations should embrace a broadened view of patient safety and incorporate both physical and non-physical harm into their operations in order to continue advancing progress on patient safety and improving systems of safety in the delivery of care.

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## Appendix A: BIDMC's Standardized Prioritization Schema

| <b>High risk factors – investigate and discuss events where <math>\geq 1</math> apply</b>  |
|--|
| <input type="checkbox"/> Patient/family stated intent to not return/recommend: <i>"I'm never going back to that doctor/your hospital"</i>  |
| <input type="checkbox"/> Patients that regularly experience inequities: people of color, limited English proficiency or health literacy, those that identify themselves as a member of an LGBTQ community, immigrant with tenuous legal status, unbefriended patients, those with disabilities, etc. |
| <input type="checkbox"/> Regulatory: e.g. DPH notified   |
| <input type="checkbox"/> Reputational: e.g. social media posting, shared with TV station, completed survey negatively, etc.  |
| <input type="checkbox"/> Malpractice risk: stated intent to sue  |
| <input type="checkbox"/> Reckless/egregious/intentional behavior by professional(s)  |
| <input type="checkbox"/> Other concerning behavior by professional(s): Sub-standard care, doesn't pass "substitution test", or there is a pattern of persistent "at-risk" behavior   |
| <input type="checkbox"/> Failure of post-death body management   |

| <b>Moderate risk factors – investigate and discuss events where <math>\geq 2</math> apply</b>  |
|--|
| <input type="checkbox"/> Patient/family describe experience in terms of "disrespect," "indignity," or loss of trust  |
| <input type="checkbox"/> Multiple additive issues occurred: i.e. a "thousand small cuts", where one bad experience is followed by several more   |
| <input type="checkbox"/> Patient didn't end up getting the service/care for which they came: e.g. never saw MD   |
| <input type="checkbox"/> Problems caused by the event are not "fixable": e.g. irreplaceable item with sentimental value was lost   |
| <input type="checkbox"/> Event had multiple impacts: physical, emotional, financial, etc   |
| <input type="checkbox"/> Care team failed to respond appropriately after an event that had a negative impact on a patient-family: Care team knew about impact but didn't apologize for the experience (e.g. <i>"I'm so sorry this happened to you"</i> ) |
| <input type="checkbox"/> Vulnerable: Physical frailty from health status: e.g. needs assistance to mobilize, or bed-bound  |
| <input type="checkbox"/> Vulnerable: Patients with confusion or cognitive impairment: e.g. delirium, dementia  |
| <input type="checkbox"/> Vulnerable: Evidence of significant anxiety or stress preceding the event: e.g. anxiety prior to an Oncology appointment where a biopsy result will be discussed  |
| <input type="checkbox"/> Event has a high likelihood of recurrence and risk of harm: based on Patient Safety/Relations judgment  |

| <b>Low risk – low priority to discuss individual cases, but document &amp; aggregate all to identify themes</b>                      |
|--|
| <input type="checkbox"/> Patient/family indicate the event had no impact, or a minimal/short-term impact: e.g. <i>"I'm fine"</i>     |
| <input type="checkbox"/> Patient/family having trouble getting the patient's medical records or an amendment, or an appointment      |
| <input type="checkbox"/> Patient/family with questions about their medical bills   |
| <input type="checkbox"/> Event not related to the patient's care experience: e.g. problems with belongings, cafeteria, parking, etc. |

## Appendix B: Applying the BIDMC Framework for Describing Disrespect to a Case Example (Sokol-Hessner et al., 2019, p. 664)

| Event description <sup>a</sup>  | Care process(es)         | Prof./org. behav. <sup>b</sup>                          | Contributing factors <sup>c</sup>  | Modifying factors <sup>c</sup>   | Potential consequences   | Opportunities to improve quality or safety  |
|---|--------------------------|---|--|--|--|---|
| An 85-year-old man is admitted to the hospital with pneumonia. He is confused and his family is involved. He suffers a fall in the early evening. The medical team obtains X-rays and discovers he has fractured his hip. No one calls the family to let them know about the fall or the X-rays. The first notification is from the orthopedic surgeon calling to get operative consent for repair of the broken hip late that night. | Adverse event management | Controlling or withholding information (about the fall) | <ul style="list-style-type: none"> <li>• Patient-related: confusion</li> <li>• Policy: unclear who is responsible for notifying the family of confused patients</li> </ul> | Limited decision-making capacity, physical distress and impaired functional status from pneumonia and pain | <ul style="list-style-type: none"> <li>• Family feels excluded, angry</li> <li>• Family distrust of care team/hospital</li> <li>• Change healthcare professional</li> <li>• Initiation of legal proceedings</li> </ul> | Revise policy to standardize processes for notifications after adverse events like falls, especially when patients lack capacity and educate the involved professionals |

### Modified Example of Applying the BIDMC Framework for Describing Disrespect through Exclusively Using the High-Level Coding Scheme (Sokol-Hessner et al., 2019, p. 664)

| Event description   | Care process(es)         | Prof./org. behavior                    | Contributing factors      | Modifying factors  | Potential consequences  |
|---|--------------------------|--|---------------------------|--|---|
| An 85-year-old man is admitted to the hospital with pneumonia. He is confused and his family is involved. He suffers a fall in the early evening. The medical team obtains X-rays and discovers he has fractured his hip. No one calls the family to let them know about the fall or the X-rays. The first notification is from the orthopedic surgeon calling to get operative consent for repair of the broken hip late that night. | Adverse event management | Controlling or withholding information | Patient-related<br>Policy | Intrinsic to patient (decision-making capacity; physical distress; impaired functional status) | Patient/Family (loss of trust/distrust; negative emotions and feelings; change health care professional; initiation of legal proceedings) |

### Appendix C: Example of Applying the BIDMC Framework for Describing Disrespect within this Research

| Description (from Datix)  | Type & Subj.                   | Who Initiated Contact & Method | Moderate Risk Factors   | Care Processes   | Prof./ Org. Behaviors   | Contributing Factors   | Modifying Factors   | Potential Consequences  |
|---|--------------------------------|--------------------------------|---|--|---|--|---|---|
| Daughter called with questions and concerns regarding her father’s care while hospitalized. She noted first finding out about the patient’s cancer diagnosis via electronic chart with no notification from the provider. Daughter detailed the physical suffering of her father and perceived delays in procedures and treatment while in the hospital. She lastly indicated the emotional distress of having unanswered questions, “not knowing to whom or how to communicate concerns”, and the patient’s passing at the hospital despite his wishes to pass away at home. | Formal grievance; Care Quality | Daughter; phone                | <ol style="list-style-type: none"> <li>1) Multiple impacts – physical, emotional, financial, etc.</li> <li>2) Multiple additive issues occurred (one bad experience followed by another)</li> <li>3) Patient/ family describe experience in terms of “loss of trust”</li> <li>4) Care team failed to respond appropriately after an event that had a negative impact</li> </ol> | <ol style="list-style-type: none"> <li>1) Discussions with patients/ families about diagnosis, prognosis, treatment, consent, shared decision making</li> <li>2) Family engagement and support</li> <li>3) Treatment</li> <li>4) Medical record documentation</li> </ol> | <ol style="list-style-type: none"> <li>1) Controlling/ withholding information</li> <li>2) Inattentive; ignoring; neglecting; abandoning</li> </ol> | <ol style="list-style-type: none"> <li>1) Environment of work and care</li> <li>2) Professional-related</li> <li>3) Patient-related</li> <li>4) Processes</li> </ol> | <p>Intrinsic to patient:</p> <ol style="list-style-type: none"> <li>1) Demographic characteristics</li> <li>2) Physical, emotional or spiritual distress</li> </ol> <p>Extrinsic to patient:</p> <ol style="list-style-type: none"> <li>1) How the professionals and institution respond</li> </ol> | <p>Patient/Family:</p> <ol style="list-style-type: none"> <li>1) Negative ratings of care</li> <li>2) Uninformed decision-making</li> <li>3) Lower quality of care</li> <li>4) Negative emotions and feelings</li> <li>5) Undignified death (from daughter perspective)</li> </ol> <p>Organization:</p> <ol style="list-style-type: none"> <li>1) Damage to reputation</li> </ol> |

*Note: This reflects a pared-down example of the spreadsheets completed for each case across all eight hospitals. Additionally, the description has been edited down, and researcher notes have been omitted for conciseness and clarity purposes.*

## Appendix D: Caregiver Experience Survey (CES)

*Note: Items comprising the Safety and Teamwork categories represent the Safety Attitudes Questionnaire (SAQ) "Short Form".*

| Category   | Item Text   |
|--|---|
| <b>Mission &amp; Values</b>                                      | I am inspired by the benefit we provide to the communities we serve.  |
|  | My organization supports and promotes compassion.   |
|  | I personally identify with the Mission and our values.  |
|  | How we do our work is consistent with the Mission and our values.   |
| <b>Promise</b>   | The Promise of "Know me, care for me, ease my way" is reflected in my day-to-day work experience.               |
|  | The organization overall is good at delivering on the Promise of "Know me, care for me, ease my way."           |
|  | Executives are good at delivering on the Promise of "Know me, care for me, ease my way."                        |
|  | My supervisor is good at delivering on the Promise of "Know me, care for me, ease my way."                      |
|  | The people I work with are good at delivering on the Promise of "Know me, care for me, ease my way."            |
| <b>Engagement</b>  | I believe strongly in the goals and objectives of this organization.  |
|  | I am willing to put in a great deal of effort beyond what is normally expected to help my organization succeed. |
|  | I am proud to tell others I work for my organization.   |
|  | I am able to sustain the level of energy I need throughout the work day.  |
|  | My job provides me with a sense of personal accomplishment.   |
|  | My department is able to meet our work challenges effectively.  |
|  | I have access to the equipment and supplies I need to do my work.   |
|  | I would recommend this organization as a good place to work.  |
| There are no substantial obstacles at work to doing my job well. |   |
| <b>Survey Follow-up</b>  | Significant actions have been taken as a result of previous surveys.  |
| <b>Burnout</b>   | I feel burned out from my work.   |
|  | I have become more callous toward people since I took this job.   |
|  | My work provides me with a sense of meaning and purpose.  |
| <b>Workload</b>  | In general, the amount of work I am asked to do is reasonable.  |
|  | The stress levels at work are usually manageable.   |
|  | In my department, we have sufficient staff to work effectively.   |

|                          |  |
|--------------------------|--|
| <b>Senior Leadership</b> | I am confident in the long-term future of this organization.   |
|                          | I have confidence in senior leadership to make decisions that are in the best interest of patients and the communities we serve. |
|                          | Where I work, ethical issues and concerns can be reported without negative consequences.   |
|                          | I have trust and confidence in the job being done by the senior leadership of my organization.                                   |
|                          | Senior leaders at my organization are visible and accessible to caregivers.  |
|                          | I'm proud of the way we responded to the COVID-19 crisis.  |
|                          | Throughout COVID-19, senior leadership demonstrates caregiver health and well-being as a top priority.                           |
|                          | My organization is doing an excellent job of keeping caregivers informed about matters affecting us during this time.            |
| <b>Respect</b>           | I feel valued as a whole person, beyond the job that I do.   |
|                          | Caregivers in this organization are treated with dignity and respect, regardless of their position or background.                |
|                          | I am treated with fairness and respect.  |
|                          | Where I work, everyone is welcomed and treated as important.   |
|                          | I can be myself at this organization without worrying about how I will be accepted.  |
|                          | All caregivers have the same opportunity to advance in this organization.  |
| <b>Supervision</b>       | I feel appreciated by my supervisor.   |
|                          | My supervisor actively supports my growth and development.   |
|                          | My supervisor has helped me understand that what I do matters to the communities we serve.                                       |
|                          | My supervisor earns my trust through honest and ethical behavior.  |
|                          | My supervisor promotes compassion in my department.  |
|                          | My supervisor respects my ideas and opinions.  |
|                          | I will be treated fairly by my supervisor if I make an error.  |
|                          | Overall, my supervisor is effective at his or her job.   |
|                          | My supervisor is good at explaining the reasons for changes that happen in the organization.                                     |
|                          | My supervisor shows concern about my overall well-being.   |
|                          | I feel heard by my supervisor.   |
|                          | My supervisor demonstrates inclusive behavior to all team members.   |
|                          | My supervisor values different perspectives on my team.  |
|                          | I am getting the support I need (from my supervisor, team, etc.) during this time.   |

|  |  |
|--|--|
| <b>Community</b>                               | I feel connected to others at work.  |
|  | The people I work with collaborate to get the job done.  |
|  | Overall, this is a place where I feel I belong.  |
| <b>Empowerment</b>                             | I have the flexibility I need to do my best work.  |
|  | I am trusted to take actions that are in the best interests of those I serve.                    |
|  | I am comfortable voicing my ideas and opinions even when they are different than others.         |
|  | I have opportunities to provide input on how things are done in my department.                   |
| <b>Role Success</b>                            | The organization helps me with opportunities to learn new skills and develop myself.             |
|  | I receive the information I need to do my job effectively.                                       |
|  | I have received the training I need to do my job well.   |
|  | I can see a clear link between my work and my organization's goals.                              |
|  | My job makes good use of my strengths.   |
|  | I have a clear understanding of what I need to do to succeed in my current role.                 |
|  | I know what skills I need to develop to grow my career at this organization.                     |
| <b>Quality</b>                                 | I feel physically safe working here.   |
|  | I would recommend my organization to family and friends as a good place to receive medical care. |
|  | I am usually able to give compassion to people I work with (co-workers, patients, etc.).         |
|  | How often did YOU care for patients with genuine compassion?                                     |
|  | How often did OTHER doctors, nurses, and caregivers care for patients with genuine compassion?   |
|  |  |
| <b>Safety<br/>(Part of SAQ<br/>Short Form)</b> | The culture in this work setting makes it easy to learn from the errors of others.               |
|  | In this work setting, it is difficult to discuss errors. (N)                                     |
|  | Medical errors are handled appropriately in this work setting.                                   |
|  | I know the proper channels to direct questions regarding patient safety in this work setting.    |
|  | I receive appropriate feedback about my performance.   |
|  | I am encouraged by others in this work setting to report any patient safety concerns I may have. |
|  |  |
|  | I would feel safe being treated here as a patient.   |



|  |   |
|--|---|
| <b>Teamwork</b><br><i>(Part of SAQ Short Form)</i> | My input is well received in this work setting.   |
|  | I have the support I need from others in this work setting to care for patients.  |
|  | It is easy for personnel here to ask questions when there is something that they do not understand.                       |
|  | People in this work setting work together as a well coordinated team.   |
|  | In this work setting, it is difficult to speak up if I perceive a problem with patient care.                              |
|  | Disagreements in this work setting are resolved appropriately (i.e., not who is right, but what is best for the patient). |
| <b>Total Rewards</b>                               | I am satisfied with the benefits I receive at this organization.  |
|  | I am paid fairly given my performance and contributions to the organization.  |
|  | My organization is making it easier to access and use our benefits (e.g., healthcare, tele-health, well-being resources). |
| <b>Intent to Stay</b>                              | I intend to stay with this organization for the next 12 months.   |

## Appendix E: 2018 Provider Survey

*Note: Items comprising the Safety and Teamwork categories represent the Safety Attitudes Questionnaire (SAQ) “Short Form”.*

| <b>Questions from the 2018 Provider Survey</b>  |
|---|
| <b>Item</b>   |
| I am satisfied with the clinical care provided by hospitalists at this hospital.                      |
| I receive valuable information from hospital-based specialists regarding my patients' inpatient care. |
| Overall, I am satisfied with the performance of the nursing staff.                                    |
| I am satisfied with the level of collegiality among providers at this hospital.                       |
| I am satisfied with the ease of the registration process for my patients.                             |
| I am satisfied with the ease of the scheduling process for my patients.                               |
| I am satisfied with the appearance and cleanliness of the patient care areas.                         |
| I receive useful information about this hospital (e.g., new services) in a timely manner.             |
| I get the tools and resources I need to provide the best care/service for our clients/patients.       |
| This hospital cares about quality improvement.  |
| Hospital administration's actions support this hospital's mission and values.                         |
| This hospital provides high-quality care and service.   |
| This hospital makes every effort to deliver safe, error-free care to patients.                        |
| There is a climate of trust in this hospital.   |
| This hospital conducts business in an ethical manner.   |
| I have confidence this hospital will be successful in the coming years.                               |
| Hospital administration communicates important information effectively.                               |
| I have adequate input into decisions that affect how I practice medicine.                             |
| I can easily communicate any ideas and/or concerns I may have to hospital administration.             |
| Hospital administration is responsive to feedback from providers.                                     |
| I have confidence in hospital administration's leadership.  |
| This hospital treats providers with respect.  |
| Overall, I am satisfied with the performance of hospital administration.                              |
| Different departments work well together at this hospital.  |
| Overall, I am satisfied with the performance of laboratory services.                                  |
| Overall, I am satisfied with the performance of radiology services.                                   |
| I am satisfied with the performance of operating room services.                                       |
| Overall, I am satisfied with the performance of the emergency department.                             |
| I would recommend this hospital to family and friends who need care.                                  |

|   |
|---|
| I would recommend this hospital to others as a good place to practice.                              |
| I am proud to tell people I am affiliated with this hospital.                                       |
| I would stay with this hospital if offered a similar position elsewhere.                            |
| If practicing three years from now, I am confident I will be with this hospital.                    |
| Overall, I am satisfied working with this hospital.   |
| I rarely experience burnout from my work.   |
| I can enjoy my personal time without focusing on work matters.                                      |
| I am able to disconnect from work communications during my free time (emails/phone etc.).           |
| I rarely lose sleep over work issues.   |
| I am able to free my mind from work when I am away from it.   |
| I see every patient/client as an individual person with specific needs.                             |
| I care for all patients/clients equally even when it is difficult.                                  |
| My work is meaningful.  |
| The work I do makes a real difference.  |
| <b>Teamwork Domain (from SAQ Short Form)</b>  |
| My input is well received in this work setting.   |
| In this work setting, it is difficult to speak up if I perceive a problem with patient care.        |
| Disagreements in this work setting are resolved appropriately.                                      |
| I have the support I need from others in this work setting to care for patients.                    |
| It is easy for personnel here to ask questions when there is something that they do not understand. |
| People in this work setting work together as a well-coordinated team.                               |
| <b>Safety Domain (from SAQ Short Form)</b>  |
| I would feel safe being treated here as a patient.  |
| Medical errors are handled appropriately in this work setting.                                      |
| I know the proper channels to direct questions regarding patient safety in this work setting.       |
| I receive appropriate feedback about my performance.  |
| In this work setting, it is difficult to discuss errors.  |
| I am encouraged by others in this work setting to report any patient safety concerns I may have.    |
| The culture in this work setting makes it easy to learn from the errors of others.                  |

## Appendix F: Semi-Structured Interview Guide

**Date:**

**Respondent Name/ID and Role:**

**Introduction:**

My name is Sasha Walia, and I am an [organization name] employee as well as a sixth-year doctoral student in the Oregon Health and Science University (OHSU)/Portland State University (PSU) School of Public Health's Health Systems and Policy (HS&P) PhD program. I am meeting with you today in my capacity as a doctoral student.

To fulfill my doctoral program requirements, I am conducting dissertation research that seeks to learn more about patient safety and safety culture, specifically focusing on how a health system recognizes and addresses preventable non-physical harm to patients in the inpatient setting. As a/the [position of interviewee], you have been identified as having valuable expertise and insight into quality and safety within [organization, hospital, and/or department names]. I am interviewing a sample of other nurses, physicians, and leaders at both the facility and regional level who can answer a set of questions pertaining to their experiences with quality, safety, organizational culture, and organizational priorities.

This interview will last between 45 and 60 minutes, depending on the length of your answers. It is possible that I may reach out to you for follow-up or clarifications after the interview.

**Consent:**

I have provided the consent form ahead of time, and I want to ensure that you are clear on the expectations of your participation. I assume that your attendance here today indicates that you have read the consent form and agree to proceed with the interview. Do you have any questions about your participation in this research study? I would now like to receive verbal consent to participate from you.

*<Obtain verbal consent>*

**Audio Recording Instructions:**

I appreciate your willingness to offer your insights and expertise to my dissertation study. With your permission, I will take notes and record this interview. Your participation in this interview is voluntary; you do not have to answer any question that you do not want to answer, and you may stop the interview at any time. All individual responses will be kept confidential.

The recording and my notes will help me accurately represent our discussion. No other individual (other than my dissertation chair, as necessary) will hear the recordings or see the written transcripts. If there are things that you tell me that you do not wish repeated, please indicate this so that I do not include those comments in any summaries or reports

that I develop from this interview. All written syntheses and quotes will be blinded and presented without attribution to you or any other respondent I am interviewing.

If you would like the recording stopped at any time, please indicate this and I will turn off the device. Quotes will be selected to illustrate these broader themes and will be presented without attribution to individuals. Do I have your permission to record this interview?

*<Turn on recording device either in person or on Microsoft Teams>*

At this time do you have any other questions or concerns?

*<After addressing any questions and/or concerns>*

Let's begin the interview.

### **Questions:**

#### **1) Role & Introductions**

- a. Please tell me briefly about your history as an employee at [organization]. What is your current role and how long have you been with the organization?
- b. How has your particular work setting [unit/department, hospital, regional administration] evolved over the years in terms of safety culture, interactions with patients (if applicable), respect?
- c. From your perspective, have the organization's priorities with respect to respect of patients evolved over the years? If so, how?

#### **2) Patient/Family Priorities**

- a. Please tell me, in general, about your interactions with patients and their families.
  - i. Prompt: What works well/what do you enjoy most? What are some of the biggest challenges that you've experienced in your role?
- b. From your perspective, what do you think is most important to patients and their families when they come to this organization for care?
  - i. Prompt: How do you think your unit/department/hospital/organization delivers on this?

**3) Patient Safety & Harm**

- a. How do you define patient safety? What does delivering safe care look like?
- b. How do you define patient harm? What types of events constitute harm to patients?

**4) Interacting with Staff / Teamwork**

- a. Please describe the nature of interpersonal interactions among employees in your work area. Do you observe if interactions differ based on position or rank (as compared to a formal leader, or a physician)?

**5) Safety Culture/Error Reporting/Transparency**

- a. Demonstrating a "culture of safety" encompasses these key features:
  - i. acknowledgment of the high-risk nature of the organization's activities and the determination to achieve consistently safe operations
  - ii. a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment, yet an organization that enforces accountability
  - iii. encouragement of collaboration across positions and disciplines to seek solutions to patient safety problems
  - iv. organizational commitment of resources to address safety concerns
- b. In light of this definition, how do you describe your particular department/unit's safety culture and commitment to patient safety as compared to other departments? Your hospital? The Oregon region as a whole? (strong, moderate, weak)
- c. Please describe your unit/department and facility's receptiveness to addressing safety concerns raised by staff. Are concerns and harm events that are raised are managed in a fair and just manner?
- d. Do staff, regardless of role, feel empowered to speak up and/or report with concern of a safety event? Do you feel empowered to speak up and/or report a safety concern?
  - i. What types of safety concerns are generally reported?
- e. Are there areas for improvement (as related to patient safety, care delivery, interacting with fellow staff, reporting or debriefing about errors, addressing or managing burnout, listening to patients/families, etc.) in your department/unit? Hospital? Organization?
- f. What kinds of mechanisms are in place in your organization/unit to create a culture of safety? What kind of mechanisms are in place to encourage transparency and reporting? Please describe specific actions your organization/unit has taken to enhance your unit/department/organization's safety culture.
- g. Have you encountered any barriers in enhancing the safety culture of your department/hospital/organization? What about barriers to improving patient safety?

- i. Prompt: Fellow staff or providers, stakeholder resistance, workload, burnout, organizational policies/procedures/politics?

**6) Non-physical Harm from Disrespect**

- a. Are you familiar with the concept of non-physical harm? If so, please describe how you understand this concept. If not, I will provide some context.
  - i. [Interviewer to provide brief introduction to non-physical harm as defined by Sokol-Hessner et al., 2015, 2018, 2019, and supporting literature].
- b. If you see a patient or family member being disrespected, how is this addressed by your unit/hospital/organization?
- c. Have you personally experienced or witnessed a staff member being treated with disrespect either by a fellow organizational employee or by a patient and family member? Would you please tell me a bit about the event, without naming anyone?
- d. Are you encouraged to speak up about disrespectful encounters or concerns? Are you encouraged to report disrespectful incidents or concerns? Please elaborate.
- e. In what circumstances (if any) would you imagine reporting a violation of disrespect toward a patient or family member? Toward a staff member or yourself?
- f. What would be the benefits and risks for the organization in addressing disrespectful behavior in a manner similar to physical harm events? What are some of those risks from your perspective (to the patient/family, to staff, to the organization)?
- g. Do you think that your [unit/department/hospital/region] fosters a commitment to treating everyone with respect and dignity? If so, what are some examples of its actions?
- h. What are some meaningful ways to show respect to patients and families?
  - i. Prompt: preferences, recognize bias

**7) Leadership & Organizational Priorities**

- a) What do you believe are the organization's core priorities? Does it prioritize its efforts and resources to support those priorities?
  - a. Prompt: do you believe that the organization's priorities are rooted in providing safe, reliable care?
  - b. Do you think these priorities equally value employees and patients/families?
  - c. Do you think staff recognize these are top organizational priorities as well? (*ask leaders only*)
- b) What are some of the biggest challenges this health system/OR region faces?
  - a. Prompt: related to quality/safety, staffing/retention/recruitment, reputation, legal or regulatory pressures

- b. Do you view respect as a key component of providing safe, effective, reliable care?
- c) How does the concept of respect fit into the organization's operations and priorities?
- d) In your experience, is equity promoted as an integral component of this organization?
- e) In your experience, is there an expectation that patients, families, and staff all have a right to be treated with respect and dignity?
  - a. Do you believe that leaders of this organization communicate the importance of respect and dignity are fundamental to the success of the organization?
  - b. Do you see behavior either reinforcing or contrary to this belief?

**8) COVID-19 Pandemic**

- a. How do you feel that the COVID-19 pandemic has impacted or influenced the delivery of respect to patients/families, and amongst the workforce/staff/leaders?

**Concluding the Interview:**

Before we conclude, is there anything else we have not discussed that you would like to comment on based on your experience in this organization?

Thank you for participating in this interview, and for your thoughtful comments, insights, and candor. Please contact me if you think of anything else that is relevant that you would like to share with me. Findings from the interviews will be blinded and included in my dissertation and read by the OHSU-PSU School of Public Health faculty serving on my dissertation committee. At the conclusion of the study, I would be happy to share a report of the findings with you if you are interested. May I contact you if I have any follow-up questions? Thank you for your time and willingness to participate.



## Appendix G: Email Recruitment Script

### Subject Line: Quality & Patient Safety Research Study: Recruitment Support

Email Primary Contact:

Dear \_\_\_\_\_,

My name is Sasha Walia, and I am an [organization name] employee as well as a doctoral student in the Oregon Health and Science University (OHSU)/Portland State University (PSU) School of Public Health's Health Systems and Policy (HS&P) PhD program. I am reaching out to you in connection with a research study that I am conducting as part of my dissertation, under the supervision of Dr. Sherril Gelmon, Professor and Director of the HS&P PhD program, who is the chair of my dissertation committee. This research study seeks to learn more about patient safety and safety culture, specifically focusing on how the organization recognizes and addresses preventable non-physical harm to patients in the inpatient setting.

I am seeking to speak with a sample of nurses, physicians, and leaders who can answer a set of questions pertaining to their experiences with quality, safety, organizational culture, and organizational priorities as they relate to patient safety.

In order to comply with internal policy, I am contacting you to inquire if you would be willing to discuss appropriate recruitment methods for my research study. I have sent you a brief meeting invite to discuss in more detail.

This study is following the guidance provided by the [organization's name] Human Research Protection Program (HRPP). This study has been approved by [organization's name] local Institutional Review Board (IRB registration #IORG0010448) and the Portland State University (PSU) IRB has ceded authority.

If you have concerns about this research, please contact me at 785.554.2365, or [swalia@pdx.edu](mailto:swalia@pdx.edu), or Dr. Sherril Gelmon at 503.725.3044 or [gelmons@pdx.edu](mailto:gelmons@pdx.edu). Thank you in advance for your support of my dissertation research.

## **Appendix H: Script for Presentations during Staff/Leadership Meetings**

Thank you for giving me a few minutes on your meeting agenda today.

My name is Sasha Walia, and I am a PH&S employee as well as a sixth year doctoral candidate in the Oregon Health and Science University (OHSU)/Portland State University (PSU) School of Public Health's Health Systems and Policy (HS&P) PhD program. I am here today in my capacity as a doctoral student.

To fulfill my doctoral program requirements, I am conducting dissertation research that seeks to learn more about patient safety and safety culture, specifically focusing on how a health system recognizes and addresses preventable non-physical harm from disrespect to patients in the inpatient setting. I am interested in interviewing a sample of nurses, physicians, and leaders at both the facility and regional level who can answer a set of questions pertaining to their experiences with quality, safety, organizational culture, and organizational priorities. I am here today to let you all know about my study and to ask if anyone is interested in participating in an interview with me; and if so, to please contact me using the contact information I am leaving on the flyer I have brought with me today.

I believe that you all would have valuable expertise and insight into quality and safety within your specific role, and would appreciate the opportunity to interview any of you who express interest in participating in this research. If you are interested, I will provide greater detail regarding your rights as an interviewee, confidentiality, and logistics related to the interview, but want you all to be aware that the commitment is minimal, and consists of one 45-60 minute interview, which I can conduct in-person, via MS Teams, or by telephone, based on your availability and preference. If you consent to participate, your responses will be kept confidential, and please note that your participation will not have any impact on your employment status. You will not directly benefit from your participation in the research, but the results of the research may contribute to knowledge about non-physical harm from disrespect within a health care system that could help others in the future – both at our organization and at other health systems.

This study follows guidance provided by the [organization] Human Research Protection Program (HRPP) and has been approved by the [organization] Institutional Review Board (IRB).

I am able to provide additional information or answers to any questions you may have. Please contact me if interested via e-mail ([swalia@pdx.edu](mailto:swalia@pdx.edu)).

Thank you for your time.

## Appendix I: Flyer Invitation for Recruitment

### Invitation to Participate in Non-Physical Harm from Disrespect Dissertation Research Study

**What:** Doctoral candidate seeking nurses, physicians, and (clinical or non-clinical) department/program/hospital leaders to interview for doctoral dissertation research study

**Research Study Focus:** Patient safety and safety culture, specifically focusing on preventable non-physical harm from disrespect to patients in the inpatient setting

**Commitment:** One 45-60 minute interview, conducted either via MS Teams, in-person, or by telephone, based on location, preference, and interviewee availability

**When:** April to July 2023, scheduled around your availability

**Who to Contact to Learn More:** Sasha Walia, [swalia@pdx.edu](mailto:swalia@pdx.edu)

*Note: This study will follow guidance provided by the [organization] Human Research Protection Program (HRPP) and has been approved by the [organization] Institutional Review Board (IRB). Please note that if you consent to participate, **your responses will be kept confidential.***

## Appendix J: Research Information Sheet (Interview Consent Form)

<<Organization's logo in the header>>

**Title of research study:** Culture of Safety and Non-Physical Harm from Disrespect in a Multi-Hospital Health System

**Institution:** [organization name] (Oregon only)

**Investigator:** Sasha Walia

As a/the [position of interviewee], you have been identified as having valuable expertise and insight into quality, safety, and/or organizational priorities within [organization, hospital, and/or department names] and are being asked to participate in a research study.

The purpose of this study is to learn more about patient safety and safety culture, specifically focusing on how the organization recognizes and addresses preventable non-physical harm from disrespect to patients in the inpatient setting. I am interviewing a sample of other nurses, physicians, and leaders at both the facility and regional level who can answer a set of questions pertaining to their experiences with quality, patient safety, working with others, leadership, organizational culture, and organizational priorities.

If you consent to participate, your responses will be confidential. If you are interested in participating, I will arrange a time for us to have a 45-60 minute in-person, telephone, or video meeting via Microsoft Teams, depending on COVID-19 protocols in place and your preference, at your convenience but no later than [date]. The interview will last about 45 to 60 minutes, depending on the length of your answers. It is possible that I may reach out to you for follow-up or clarifications after the interview.

With your permission, I will take notes and record the interview, and the interview data will be transcribed and stored in a secure, password-protected database to help with later qualitative analysis. The recording and my notes will help me accurately represent our discussion. No other individual (other than my dissertation chair, Dr. Sherril Gelmon, as necessary) will hear the recordings or see the written transcripts. If there is information that you tell me that you do not wish repeated, please indicate this so that I do not include those comments in any summaries or reports that I develop from this interview. All written syntheses and quotes will be blinded and presented without attribution to you or any other respondent I am interviewing. If you would like the recording stopped at any time, please indicate this and I will turn off the device. Quotes will be selected to illustrate broader themes and will be presented without attribution to individuals.

All information collected about you during this study and that can identify you will be kept confidential to the extent possible. You will be assigned a study identification number to be used in place of your name in the research database and study records. Your identity and any personal identifying information will not appear in the interview transcripts or any published documents arising from this research. Research records connected to you will be stored for no more than 10 years in a secure place, and then destroyed. In terms of project team access, only I and Dr. Sherril Gelmon, my dissertation research chair, will have access to the study database. Additionally, individuals within the [organization name] Institutional Review Board will also have access to the information, and regulatory agencies responsible for the oversight of research may inspect records related to this study.

By agreeing to participate in this study you are giving your permission for me to collect information about you as described above. I will continue to use your information for this study until it is over. If you change your mind, you can request that I stop using your information; however, information that has been de-identified and can no longer be linked to you at the time of your request may continue to be used. I will take appropriate measures to keep your study information private and secure, but there is always the potential risk of a loss of confidentiality.

Your participation in this study is voluntary; you do not have to answer any question that you do not want to answer and may still remain in the study; you may also stop the interview at any time. Whatever decision you make about participation, there will be no penalty to you, and no loss of benefits to which you were otherwise entitled. Your participation will not have any impact on your employment status.

The potential risks or discomforts of the study are expected to be minimal. Some of the questions may be sensitive as they are related to your perceptions of organizational safety, dynamics, and culture; however, you are not required to answer any questions if they make you uncomfortable.

You will not directly benefit from your participation in the research, but the results of the research may contribute to knowledge about non-physical harm from disrespect within a health care system that could help others in the future – both at our organization and at other health systems.

You will not be paid for participating in this research study.

If you have questions, concerns, or complaints about the research study you can contact me (Sasha Walia) at [swalia@pdx.edu](mailto:swalia@pdx.edu), or my dissertation chair, Dr. Sherril Gelmon, at 503.725.3044 or [gelmons@pdx.edu](mailto:gelmons@pdx.edu).

If you have any questions about your rights while participating in this study, or if you have any concerns regarding the conduct of this study, you may also contact the

[organization name] Health Human Research Protection Program Office at [email] or [phone number].

Thank you for your contribution to my dissertation research.

**Consent to Participate:**

By proceeding you are confirming that you are 18 years of age or older, have read the above information, and voluntarily give your consent to participate in this study. You may save, request, or print a copy of this information sheet for your records.