DISRUPTIVE BEHAVIOR IN THE RESPIRATORY WORKPLACE

By

Amanda L. Roby

Submitted in Partial Fulfillment of the Requirements

for the Degree of

Master of Health and Human Services

in the

Bitonte College of Health and Human Services

YOUNGSTOWN STATE UNIVERSITY

May, 2011

DISRUPTIVE BEHAVIOR IN THE RESPIRATORY WORKPLACE

Amanda L. Roby

I hereby release this thesis to the public. I understand that this thesis will be made available from the OhioLINK ETD Center and the Maag Library Circulation Desk for public access. I also authorize the University or other individuals to make copies of this thesis as needed for scholarly research.

Signature:

_____

Amanda L. Roby, Student   Date

Approvals:

_____

Teresa A. Volsko, Thesis Advisor   Date

_____

Dr. Salvatore A. Sanders, Committee Member   Date

_____

Dr. John M. Hazy, Committee Member   Date

_____

Dr. Peter J. Kasvinsky, Dean of School of Graduate Studies and Research Date

Abstract

The purpose of this study was to investigate disruptive behavior in the respiratory workplace. The prevalence, clinical setting, sources and types of disruptive behavior were explored. Four hypotheses were tested: First, respiratory therapists experience disruptive behavior in the workplace. Second, Verbal disruptive behavior is the most common form found in the healthcare environment. Third, the incidence of disruptive behavior is higher among bedside caregivers compared to managers and educators. Finally, the greatest source of disruptive behavior is described. Methods: A 23 question survey gleaned data to evaluate disruptive behavior in the respiratory workplace. Informed consent was obtained. The survey was distributed electronically to respiratory therapists who were members of the American Association for Respiratory Care. Results: A total of 119 of a possible 3,941 participants (3%) completed the survey. Ninety six percent of individuals surveyed had experienced a form of disruptive behavior. An equivalent percentage of individuals, 96%, witnessed a co-worker experiencing a disruptive event. No difference in the type of disruptive behavior was experienced by job class. Bedside practitioners or staff respiratory therapists did not experience disruptive behavior more often than department technical directors, educators or supervisors. Disruptive behavior was deemed unacceptable. "Zero tolerance" initiatives were identified as a means to control disruptive behavior. Conclusions: Respiratory therapists in all job categories experience disruptive behavior. Victims are willing to explore effective ways to control disruptive behavior.

Acknowledgements

This thesis would not have been possible without the guidance and the help of several individuals who in one way or another contributed and extended their valuable assistance in the preparation and completion of this study.

First and foremost, my utmost gratitude to my thesis advisor and mentor, Mrs. Teresa Volsko, whose sincerity and encouragement I will never forget. Mrs. Teresa Volsko has been my inspiration as I hurdle all obstacles in the completion of this research endeavor. I would also like to thank the members of my thesis committee, Dr. Salvatore Sanders and Dr. John Hazy, who have supported me throughout my thesis with patience and knowledge while allowing me the room to work in my own way. One simply could not wish or hope for a better thesis committee.

A special thanks to the American Association for Respiratory Care (AARC) executive committee that allowed me to continue this research endeavor. Without their knowledge and hard work the execution of this study would not have been possible.

Finally, I would like to thank my family and friends for their, patience understanding and endless love in my pursuit of this graduate degree.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER I

INTRODUCTION

As workplace disruptive behavior in the health care sector gains increasing

recognition as a major concern, there is a growing need for research. Violence in

healthcare settings is a pervasive problem and an epidemic that constitutes an

occupational hazard (Rippon, 2000). There is no doubt that disruptive behavior and

threats of violence are major stressors for nurses and other hospital employees (Leppanen

& Olkinuora 1987). This problem is further exacerbated and complicated due to the fact

that there is a lack of agreement on the definition of what constitutes aggression and

disruptive behavior within health care professions. In addition there is no uniform testing

instrument to measure disruptive behavior.

Research published in this area seems to focus on nursing for the largest extent.

Up to this point, there is dearth of published studies that relate disruptive behavior to the

field of respiratory care. Respiratory care practitioners have a vital role in healthcare.

They function along the continuum of care and often participate in complex invasive

procedures. The purpose of this research is to identify if disruptive behavior is present in

the respiratory care workplace, where disruptive behavior is most prevalent in regards to

work environments, and to determine if disruptive behavior is higher among bedside care

givers or managers and educators.

Disruptive behavior has been recognized in healthcare by leading national

organizations. The National Crime Victimization Surveys (NCVS) along with The Joint

Commission (TJC) compiled facts and evidence on disruptive behavior in the Healthcare

environment. In its July 9, 2008, issue of Sentinel Event Alert, the Joint Commission

detailed the negative effects that intimidating and disruptive behaviors create for the health care organization's culture of safety. None of this was breaking news to most health care workers and leaders. Rather than providing a definition for disruptive behavior, the TJC offered examples of such conduct, including verbal outbursts, uncooperative attitudes, and impatience with questions. The American Medical Association (AMA) has also had their voice heard in this matter. The AMA has stated: "Personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively constitutes disruptive behavior" (AMA, 2002).

The hospital setting is one of the most stressful environments an individual can work in. Stress can compound exponentially, first from environmental factors inherent to working in acute care coupled with the stress created when disruptive behavior is allowed, can inherently contribute to physiological effects as well as adoption of adverse health behaviors. Given that thought, behavior that induces stress can lead to hypertension, ulcers, mental exhaustion, and other disease processes. Added to genetic background, behavior triggered by stress such as smoking, overeating and substance abuse, can put the health care professional and patients at risk (Ripen, 2000).

This issue of disruptive behavior fits the Stress, coping and Health Behavior model due to its adaptive properties as well as adaptive results of coping skills. Stress contributes directly through physiological effects (hypertension, stomach disorders) and indirectly by adoption of adverse health behaviors (smoking, poor habits). Studies have been done by biologists and psycho-physiologists focusing on the application of stressful stimuli (Cannon, 1932). The "Fight or Flight" response often presents itself when

identified stressors are applied externally or internally. The stressors upset the homeostasis or balance of overall well being.

The Social Readjustment Rating Scale (SRSS) is a tool to measure stressful life events; the higher the score, the higher the incidents of illness (Holmes and Rahe, 1967). Studies then evolved into the view of stress as a "transactional phenomenon" which recognized that stress was only as harmful as the perceived threat of that stress by the individual (Lazarus, 1966 and Antonvsky, 1979). In addition that phenomenon then spilled over into occupational health and the view of stress and its effect on the work environment or the "person environment fit" (French and Kahn, 1962).

Eventually the Transactional Model of Stress and Coping gave rise and provided a framework for evaluating the process of coping with stressful events. The Transactional Model of Stress and Coping is directly related to the situation, dispositional coping styles and the ability to self appraise attitudes that affect the level of threat. The basic sequence of this model looked something like: appraisals-coping efforts-coping outcomes. The primary appraisal is dependent upon the individual perception about an event and whether it is: stressful, positive, controllable, challenging, benign or irrelevant. The same stressor can have different effects based on individual perceptions. The secondary appraisal focuses on what can be done about the stressful situation. It addresses what are the perceived abilities to change the situation and control one's emotional reaction along with addressing the effectiveness of coping mechanisms. It also relies heavily on social support which is essential to survive in the health care setting. Assessment through the primary and secondary appraisals can not only identify stressors in an attempt to resolve disruptive triggers but also move towards coping mechanism and stress management

skills. Social support has been determined to have a positive effect on physical and psychological well-being. It works in two specific ways; that is to compare one's self to a positive outcome or to consider that someone is always worse off than she/he is himself.   Empowering the employee to promote change can be an added benefit. Adopting positive coping skills should be a goal of the administrative team to support the staff and guard against untold effects of stress.

Once the homeostasis is out of balance, overall wellbeing is at risk. Whether that is psychological or physical in manifestation, the result can be devastating to self esteem especially when coworkers are part of the stressor. There is advocacy for the patient but what about the ones who serve them?

Statement of the Research Problem

Disruptive behavior in the healthcare setting has been a problem for many years. Within healthcare facilities, disruptive behavior is more widespread and no longer is limited by professional or clinical departments. In an effort to ensure the delivery and safety of quality healthcare, there is a need to examine possible disruptive behavior in the respiratory workplace.

Statement of Purpose

The purpose of this study is to investigate disruptive behavior in the respiratory workplace. The prevalence, sources, and types of disruptive behavior will be explored. The clinical setting in which the disruptive behavior is most commonly exhibited will be determined.

Hypothesis

The four hypotheses tested were: (1) Respiratory therapists experience disruptive behavior in the workplace. (2) Verbal disruptive behavior is the most common form found in the healthcare environment. (3) The incidence of disruptive behavior is higher among bedside caregivers compared to managers and educators. (4) The greatest source of disruptive behavior will be described.

Delimitations of Study

This study was delimited to: licensed respiratory therapists holding membership in the American Association of Respiratory Care (AARC) who subscribe to the adult acute care, management and education specialty sections and are ages 18 and older.

Limitations of the Study

The limitations of this study were inclusive of respiratory care practitioners that:

1. Currently are members of the AARC.

2. AARC members who subscribe to the adult acute care, management and education specialty sections

3. Voluntarily agreed to participate in this research endeavor.

4. Sample size

Assumptions of the Study

Relative to this proposed study, the following assumptions were made:

1. All practitioners graduated from accredited respiratory therapy programs.

2. Respiratory care practitioners would consent to participation.

3. AARC would consent to the release of its membership directory.

Operational Definitions

American Association for Respiratory Care (AARC) - the only professional society for respiratory therapists in hospitals and with home care companies, managers of respiratory and cardiopulmonary services and educators who provide respiratory care (www.aarc.org).

Adverse event- an injury resulting from a medical intervention and is not due to the patients underlying condition (Rostenstein & Daniel, 2005).

American Medical Association (AMA) - the largest association of physicians and medical students in the United States, with a mission to promote the art and science of medicine for the betterment of the public health (www.ama.org).

Certified Respiratory Therapist (CRT) - the entry level credential for the respiratory care practitioners, awarded after successful completion of the certification credentialing examination (O'Donohue, 1978).

Disruptive Behavior- a behavior of one person which, through words, tone, manner, or other nonverbal cues, uses power of a dominant position inappropriately toward an actual or perceived subordinate (Bruder, 2001).

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) - a private, not

for profit group that provides accreditation to U.S. hospitals and other healthcare facilities

(www.jcaho.org).

National Board for Respiratory Care (NBRC) - a voluntary health certifying board which

was created in 1960 to evaluate the professional competence of respiratory therapists

(www.nbrc.org).

Physical Abuse-one or more episodes of aggressive behavior, usually resulting in

physical injury with possible damage to internal organs, sense organs, the central nervous

system, or the musculoskeletal system of another person (Mosby Medical Dictionary,

2009).

Psychological Abuse- Emotional abuse, mental abuse. A form of mistreatment in which

there is intent to cause mental or emotional pain or injury; PA includes verbal aggression,

statements intended to humiliate or infantilize, insults, threats of abandonment or

institutionalization; PA results in stress, social withdrawal, long-term or recalcitrant

depression, anxiety (Mosby Medical Dictionary, 2009).

Registered Respiratory Therapist (RRT)- the advanced practice credential for

practitioners in the field of respiratory care, awarded to individuals receiving a passing

score on both the written registry and clinical simulation examination created by the

NBRC (Chuntz, 1978).

Sexual Abuse- the sexual mistreatment of another person by fondling, rape, or forced

participation in unnatural sex acts or other perverted behavior. Victims tend to experience

a traumatic feeling of loss of control of themselves (Mosby Medical Dictionary, 2009).

Verbal Abuse- a concept that indicates some form of mistreatment, spoken or unspoken, that leaves you feeling personally or professionally attacked, devalued, or humiliated. It is communication through word, tone, or manner that patronizes, threatens, accuses, or is disrespectful toward another (Watson, Steiert, 2002).

Workplace Violence- Any physical assault, threatening behavior or verbal abuse occurring in the work setting (Sofield, Salmond, 2003).

Summary

Respiratory care practitioners play an integral role in the healthcare work force. Their role expands beyond the scope of traditional care and encompasses routine bedside care to complex invasive procedures. Assessment of the respiratory environment in regards to disruptive behavior may improve working conditions and improve patient care.

Chapter II provides a review of the literature relevant to disruptive behavior in the healthcare environment. Chapter III presents the study design, sample and tools used to assess disruptive behavior. Chapter IV reveals the results of the data analysis in addition to a discussion of the relationship between disruptive behavior and particular work environments (example: Intensive Care Unit compared to General Care Wards). Chapter V discusses the summary of the study, the findings, limitations and implications. Recommendations for future research are detailed in this chapter.

CHAPTER II

LITERATURE REVIEW

The purpose of this exploratory study is to determine the extent of disruptive behavior present in the respiratory field, determine its prevalence and to identify who experiences it the most, bedside caregivers or non-bedside caregivers. Once the fact that disruptive behavior exists is supported, effects will be identified and correlations examined. This chapter contains a comprehensive review of the literature specific to disruptive behavior in healthcare.

Disruptive behavior can be physical, verbal, psychological or sexual. Disruptive behavior comes from many sources, patients, families, subordinates, coworkers, supervisors, administration and physicians. Dissatisfaction with definite resolution of conflict leaves the healthcare worker open for disruptive behavior by physicians, coworkers, patients and families. The most common form of disruptive behavior is verbal. A study in 1999 found that 94% of healthcare workers surveyed had experienced verbal disruptive behavior during their career. Verbal disruptive behavior is something that happens but is seldom discussed, reported, acknowledged, or seen as "disruptive". Society knows it happens, but it is not discussed and the thought is that it will just go away. Research has shown that verbal disruptive behaviors are running rampant in the healthcare world. Professions within the healthcare industry are becoming increasingly violent places in which to work, with healthcare professionals being common targets for violent and aggressive behavior (Rippon, 2000).

Healthcare workers have accepted disruptive behavior for years as an occupational hazard. More often than not it is viewed as acceptable behavior excusing it

9

to a mere venting of frustration (Cannon, 2000). However, if left untreated it can become quite serious and lead to other forms of violence.

"Verbal disruptive behavior is a form of workplace violence that leaves no visible scars; however, the emotional damage to the inner core of the victims self can be devastating" (Sofield and Salmond, 2003, p. 274). Another way to define disruptive behavior is the behavior of an individual that uses words, tones and non-verbal mannerisms that could cause physical or emotional trauma to another person. Disruptive behavior can also be seen as a person using their power over another with the attempt to dominate. Other terms in the literature that describe emotional, verbal and/or physical disruptive behaviors between workers include bullying, horizontal or lateral violence, and mobbing. The term bullying is prevalent in today's society and often describes situations of repetitive harassment that occur between one person who has some type of authority over another such as a manager to a staff member (Bray,2001). Horizontal or lateral violence has been associated with displays of aggression towards someone on the same hierarchical level such as staff nurse to staff nurse (Longo and Sherman, 2007). When the same behaviors stem from a group and impact one individual, this behavior is termed mobbing (Zapf, 1999). All of these displays of aggression share one thing in common, they can cause a breakdown in the relationships among healthcare workers, thereby threatening patient and staff well being.

Hamlin and Hoffman (2002) separate effects to the individual and the institution. Their primary focus on disruptive behavior was sexual harassment but they also addressed other forms of disruptive behavior. For the individuals they identified physical, psychological, and financial consequences related to disruptive behavior.

Physical and psychological effects included nausea, stomach aches, headaches, weight change, blood pressure changes, fatigue, and insomnia. Job loss and willingness to change jobs were also identified as results of disruptive behavior. As for institutional effects they listed litigation, job performance issues, job dissatisfaction, decreased work effectiveness, decreased productivity, high absenteeism, low staff morale, and high staff turnover. All this adds up to money spent for the institution. It costs hospitals large amount of money to replace staff either permanently when they leave or daily when they report off work (Hamlin & Hoffman, 2002).

Disruptive behavior, aggression, and violence negatively impact both the workplace and its employees. For the organization, greater financial costs can be incurred due to increased absences, early retirement and reduced quality of care (Hoel, Sparks, Cooper, 2001). For the healthcare worker however, psychological damage such as post traumatic stress can result (Rippon, 2000), in addition to a decrease in job motivation (Arnetz and Arnetz, 2000).

The1998 National Crime victimization Survey (NCVS), which looked specifically at violence and or disruptive behavior in the healthcare setting, estimated that approximately 160,000 healthcare providers are victimized each year by disruptive workplace behavior (Elliott, 1998). The assaults were not limited to physical: they were comprised of other forms of aggression such as stalking, harassment, and verbal disruptive behavior. The NCVS is the nation's primary source of information on criminal victimization. The American Nurse Association has taken the stance that they believe verbal disruptive behavior goes under reported and that the incidence of disruptive behavior could be higher than the numbers reported in current literature (Sofield &

Salmond, 2003). Other research has contended that "Healthcare providers are 16 times

greater at risk for violence than other workers" (Elliott, 1997, p. 458). A recent study

from Veteran Hospital Association (VHA), an alliance of not-for-profit hospitals and

health systems, surveyed 1,500 doctors and nurses in twelve states and found that 86% of

nurses and 49% of doctors had witnessed some form of disruptive behavior towards

healthcare workers (Oriovsky, 2005). Disruptive Behavior among healthcare workers

threatens the safety and well being of both patients and staff. By not addressing these

behaviors, organizations have silently supported and reinforced these behaviors. The

good news is that these disruptive behaviors have come under scrutiny.

     Although disruptive behavior can stem from many sources, physicians have been

identified as a "major source of verbal disruptive behavior to both staff and managers"

(Manderino & Berkley, 1997, p.49). Physicians occasionally believe that they are above

the rules, behavioral standards, and social etiquette to which others are held. Some

physicians who generate a lot of money seem to be immune to punishment. How frequent

are the problems of disruptive behavior? In a 2004 poll 1627 American College of

Physician Executives members, 18% of physician's behavior problems occurred on a

monthly basis, and 14% of these problems occurred on a weekly basis (Gallup, 2005).

     Although all areas can be affected by disruptive behavior, the connection between

high acuity care units and a higher incidence of disruptive behavior has been noted. The

Intensive Care Units (ICU), Post Anesthesia Care Unit (PACU), Emergency Department

(ED) and other procedural areas have been cited (Watson and Steiert, 2002). Because

respiratory practitioners are stationed in all of these areas, a connection will be made.

Summary

Studies show that disruptive behavior in the healthcare setting has increased dramatically, with concern to all parties involved. This literature review presented a relationship between disruptive events and negative outcomes such as impaired healthcare professional relationships, lack of communication, decreased job satisfaction, and impaired patient care. Chapter III presents the study design, sample and tools used to assess disruptive behavior. Chapter IV reveals the results of the data analysis in addition to a discussion of the relationship between disruptive behavior and particular work environments (example: Intensive Care Unit compared to General Care Wards). Chapter V discusses the summary of the study, the findings, limitations and implications. Recommendations for future research are detailed in this chapter.

CHAPTER III

PROCEDURES

The purpose of this study is to investigate disruptive behavior in the respiratory

care workplace. Chapter III provides a description of the methodology used in this

research endeavor to determine the prevalence and effects of disruptive behavior among

respiratory professionals. An explanation of the research design, instrument, validation

of the instrument, selection of subjects, treatment of subjects, data collection and analysis

is discussed.

Research Design

Survey data was acquired to describe the type, and impact of disruptive behavior

in the respiratory care profession and examine where it is most prevalent. This study was

conducted in a non-experimental approach. Active members of the AARC were the

target population for this research endeavor. The study examined past and current

experience participants' have with disruptive behavior in the workplace. Descriptive

research can provide an accurate account of the experiences respiratory staff encounter,

the relationship between job function and disruptive behavior prevalence and type, and

allow for discovery of new data to identify the frequency of which this type of behavior

occurs.

The sample population was comprised of respiratory therapists that are members

of the American Association for Respiratory Care, the field's professional organization.

A convenience sample of members that subscribe to specialty sections was used to

comprise the study sample. This sub-section was selected to make efficient use of the

research time and financial resources. A list of 3,961 individual AARC members who

subscribe to the adult acute care, management and education specialty sections were accessed through the association's member services. This listing included all credentialed respiratory care practitioners with a current state license, where applicable, who were members of the professional organization (AARC) and one or more of the aforementioned specialty sections within this parent organization. If the AARC member subscribed to more than 1 specialty section, the respective member's name was only listed once. Executive approval for distribution of the study to AARC members was obtained from the Association President and Executive Board prior to the commencement of this research endeavor.

Instrument

The testing instrument, Appendix A, was a survey used for the purpose of data collection. A survey instrument was constructed since a published validated survey was not readily available. The survey consisted of 23 questions, 22 closed and one open-ended question. Six questions addressed demographic characteristics of the study population. The questions ascertained information regarding participant age, gender, and longevity in the field. Workplace data including organizational type, bed capacity and geographic location was also collected. The remainder of the survey questions elicited responses to the occurrence, setting and details of the disruptive experience of the participant along with types of disruptive behavior witnessed, and precipitators of the disruptive behavior. The open-ended question collected ideas for ways to minimize and/or eliminate disruptive behavior in the workplace.

Survey response rate was of particular concern; therefore a reminder e-mail was built into the electronic survey design to improve response rate and minimize the probability for inadequate sample size. A sample size of one hundred was targeted with more being acceptable and any number less than fifty being considered insufficient. The survey also did not allow the participant to ask questions, to clarify any questions or address concerns they may have had. However the contact numbers for the research team were provided to facilitate verbal communication in order to address concerns or clarification. An additional option for participants with concerns or questions was incorporated into the survey and allowed them to stop the survey and log out; yet return to the survey at a later time. The survey was developed with careful consideration based on the results of the validation study to minimize any potential bias and ensure clarity of content. Informed consent was implied and incorporated into the recruitment letter. Consent was obtained by virtue of the participant electing to respond to or complete the survey instrument. The survey was created in Survey Monkey under a Pro plan (www.surveymonkey.com).

Validation of the Instrument

Prior to the initiation of this research project, validation of the testing instrument was performed to test for construct and content validity. The respiratory care staff at a large academic medical center in Youngstown, Ohio was recruited. A hard copy of the testing instrument was distributed to credentialed and licensed respiratory therapists at a 500 bed acute care teaching facility. Surveys were administered to the respiratory therapists by the co-investigator after informed consent was obtained. The survey was anonymous and confidential. The instrument did not contain any identifying information

that would link the completed survey to the participant. Bedside caregivers, educators, supervisors and managers were eligible to participate in the validation study. Survey data were entered into Excel (Microsoft Inc., Redmond, CA). Thirty-two participants were recruited and a 100% survey return rate realized. This survey did allow the participant to ask questions, to clarify any questions, and/or address concerns they may have had prior to the completion of the instrument. Participant comments regarding question clarity were reviewed and used to refine questions for the final testing instrument.

Selection of Subjects

The sample consisted of practicing credentialed respiratory therapists who are also members of the AARC. A convenience sample of members that subscribe to specialty sections was used to comprise the study sample. This sub-section was selected to make efficient use of the research time and financial resources. Members of the AARC who subscribe to the adult acute care, management and education specialty sections were accessed through the association's member services. This sub-set of the population of credentialed AARC members provided the potential for 3,961 study participants. If the AARC member subscribed to more than 1 specialty section, the respective member's name was only listed once. Prior to the distribution of the survey the AARC president and executive committee reviewed the instrument and study procedures and approved distribution to the sample population.

Participants were not selected on the basis of job function, but will be stratified by job function for sub analysis and comparison of the incidence and type of disruptive behavior encountered by the respondent. Areas defined to categorize participants by job

17

classification include educators, managers and bedside practitioners. The researchers sought to recruit a minimum of one hundred participants.

Treatment of Subjects

Permission was granted by Youngstown State University's Institutional Review Board (IRB), as well as the president and executive board of the AARC to proceed with this research endeavor prior to participant selection. The survey was designed to be self-administered. Participant information and data regarding the facilities the subjects represented were anonymous and confidential.

Because the survey was distributed electronically informed consent was incorporated into the introductory e-mail, Figure 1. The introductory e-mail also provided information about the research team, how subjects were selected to participate, the study purpose, length of time for survey completion, timeline for study participation and a plan for dissemination of study results following analysis. A contact number and email address for the research team members was also be provided in case participant had questions or concerns. Participants were informed that once the study was completed an abstract of the study could be obtained by contacting a member of the researcher team.

Subjects consented to the study by proceeding to the survey and completing the twenty-three question assessment tool. Instructions for completing individual questions were incorporated into the survey. Directions were provided for both open ended and closed questions.

Data Collection and Analysis

The introductory remarks and link to survey tool were sent to the Director of Education and Management Services at the AARC. The Director of Education and Management Services informed the AARC specialty section chairs of the process for survey dissemination. The invitation to participate was distributed electronically through AARCConnect, the professional organization's online discussion board, to members of the acute care, education, and management specialty sections by the respective section chair. Each chair also was requested to post a message which contained an endorsement for this research endeavor on the discussion group for their respective section. Participants had three weeks to access and complete the survey.

Completed surveys were collected electronically through Survey Monkey. The researcher could access the data by entering in the correct user name and password into the Survey Monkey website. Data were entered into Statistical Package for the Social Sciences (SPSS) Version 15 for Windows, SPSS Incorporated, Chicago Illinois. Only the researcher and the thesis committee advisor had access to the data. Descriptive statistics were used to report incidence and type of disruptive behavior as well the main source of the disruptive behavior. The frequency and area at which verbal disruptive behavior occurred will also be reported. The proportion of subjects experiencing disruptive behavior by job classification was compared using Chi-Square. An ANOVA was used to detect differences in the incidence of disruptive behavior among bedside caregivers, managers, and educators. Statistical significance was established at $p < 0.05$.

Summary

Chapter III identified the research methodology used to determine the prevalence and effects of disruptive behavior among respiratory professionals. An explanation of the research design, instrument, validation of the instrument, selection of subjects, and treatment of subjects and data collection was discussed. Collection of data used a newly developed survey instrument made for this study. Chapter IV reveals the results of the data analysis in addition to a sub-analysis of the relationship between disruptive behavior and particular work environments (example: educator, technical or department director, supervisor/team leader, staff therapist). Chapter V discusses the summary of the study, including the findings, limitations and implications. Recommendations for future research are detailed in this chapter.

CHAPTER IV

RESULTS

The purpose of this study was to investigate disruptive behavior in the respiratory workplace. The prevalence, sources and types of disruptive behavior have been explored. The data were analyzed to test the four research hypotheses: (1) Respiratory therapists experience disruptive behavior in the workplace. (2) Verbal disruptive behavior is the most common form found in the healthcare environment. (3) The incidence of disruptive behavior is higher among bedside caregivers compared to managers and educators. (4) The greatest source of disruptive behavior is described.

Chapter IV provides a description of the demographic profile of the sample population, and the relationship between disruptive behavior and particular work environments.

Data Analysis

Data from the completed surveys were entered into the Statistical Package for the Social Sciences (SPSS) Version 15 for Windows (SPSS, INC. Chicago, Illinois). Frequency and contingency tables were compiled to report demographic data. The proportion of subjects experiencing disruptive behavior by job classification was compared using Chi-Square. Statistical significance was established at $p < 0.05$.

The proportion of subjects experiencing disruptive behavior by job classification was compared by Chi-Square. An ANOVA was used to detect differences in the incidence of disruptive behavior among bedside caregivers, managers, and educators. Statistical significance was established at $p < 0.05$. Open-ended questions were recorded and displayed within the text.

21

Demographic Profile of the Sample Population

A total of 119 from a possible 3,961 participants (3%) consented to participate in this study. Regional distribution of study participants are found in Figure 2. All participants completed the survey instrument. Subjects were predominately female n = 71(59.7%), Figure 3. Longevity in the field varied with a majority of participants, n = 56 (47.1%), having more than 30 years of experience in the field of respiratory care, Figure 4.   The participants worked predominately in health care facilities with bed capacities ranging from 1 to 100 beds to 400 or more beds, Figure 5. The participants in this study were employed in various positions and had different primary job functions. The majority of responses came from department or technical directors of respiratory care departments (47.9%); followed by educators (25.2%), staff respiratory therapists (10.9%), supervisor or team leader (7.6%), other with included responses such as quality specialist, manager, clinical coordinator and critical care transport (7.6%) and neonatal or pediatric specialist (0.8%), Figure 6. Staff respiratory therapists were defined as certified or registered respiratory therapists that function as primary bedside practitioners.

Primary work settings were also examined, with most participants working in the acute care hospital environment (75.6%). Educators represented (21.8%) of the study population and worked either as a clinical educator within a respiratory care department or faculty for a respiratory care program with a post secondary institution. A minority of participants, 0.8%, worked in other settings including the long term care setting (sub-acute care or skilled nursing facility) or in a physician's office. Figure 7 outlines the primary work environment setting for study participants.

Prevalence of Disruptive Behavior

Ninety six percent of individuals surveyed had experienced a form of disruptive

behavior. An equivalent percentage of individuals, 96%, witnessed a co-worker

experiencing a disruptive event. The disruptive behavior manifested itself in multiple

forms. The majority 55.5% of study subjects experienced verbal disruptive behavior.

While only a few individuals, 4.2%, identified sexual harassment and physical imposition

as the main form of disruptive behavior, Figure 8. No difference was found in the

disruptive behavior manifestation by job classification, $p = 0.29$, Table 1.

Bedside caregiver (57%), physician/surgeon (29%) and patient (7%), were

identified as the main sources of the disruptive behavior or offenders, the top three

responses were Figure 9.   Males exhibited disruptive behavior, 55.5%, more frequently

than females, 44.5%, Figure 10.

Participants ranked peers (44.7%) as the most common offenders of disruptive

behavior within the workplace, followed by a physician/surgeon (36%). Managers and

supervisors were reported as the least common offenders, with only 2 % reported as

displaying disruptive behavior, Figure 11. Bedside practitioners or staff respiratory

therapists did not experience disruptive behavior more often than department technical

directors, educators or supervisors, $p = 0.78$.

Exposure to disruptive behavior elicited varied emotional responses. Most

participants felt angered (36.1%), and embarrassed (21%) by the situation. Other

emotions reported included feeling powerless (10.1%), harassed (9.2%), fearful (5.9%),

confused (4.2%), and hostile (0.8%). Study participants were able to add other emotional

responses not displayed as an option by the researchers. Other emotional responses study

participants were reported in aggregate under the "other" category. Approximately 12.6% of respondents responded to the other category. Participants reported feeling disappointed, stressed, anxious, annoyed, shocked and frustrated in response to the disruptive event, Figure 12.

Most participants, 58%, indicated the disruptive event did not occur during or immediately following a high stress situation. Many triggers of disruptive behavior were identified. The most common trigger of a disruptive event was an innate need to be in control of a particular situation or event, so the perpetrator forces the respiratory therapist into a subordinate role, 73.9% Figure 13. More than 71% of respondents reported never contemplating leaving their respective employment position after experiencing disruptive behavior. A minority disclosed a willingness to leave the healthcare profession, 28.6%.

Disruptive behavior was reported to have an adverse effect on morale, 100%, and productivity, 93.8%. Respondents also attributed an increase in errors that prohibited the delivery of quality healthcare (87.6%), to disruptive behavior in the workplace. Respondents also reported experiencing physical ailments such as depression, anxiety and migraines, 94.6%, in response to the aforementioned behavior. A majority, 83.2%, of participants disagreed with the statement "Disruptive behavior occurs in healthcare. It is just something I must accept as a part of my job". A majority of participants, 75.6%, believed that the quality of patient care is adversely affected by disruptive behavior, Figure 14.

The majority of those surveyed reported the disruptive event (73.9%), and recognized (87.4%), that their institution has a Workplace Violence policy or Corporate Code of Conduct. A few participants, 4.2% acknowledged their respective healthcare

institution does not have the aforementioned policies, while 8.4% of the study population was unsure. More than half of participants, 67.2%, agreed that a "Zero Tolerance" policy and structured discipline would aid in the elimination or reduction of disruptive behavior, Figure15.

Open Ended Responses

Survey participants were permitted to express what they thought would be helpful measures to reduce or eliminate the occurrence of disruptive behavior. Response to this question was optional and some participants elected not to answer. Improved staffing, accountability for the corrective action plan, and education were among the major themes. Figure 16 lists all of the ideas that were expressed in free text form.

Summary

A total of 119 AARC members completed the Disruptive Behavior Survey through the Monkey Survey tool. Data from the completed surveys were entered into SPSS version 15.0 for windows (SPSS Inc., Chicago, Illinois). Frequency and contingency tables were compiled for demographic data. The proportion of subjects experiencing disruptive behavior by job classification was compared using Chi-Square. Statistical significance was established at $p < 0.05$.

Frequencies were used to report the rate at which the disruptive behavior occurred by job function. The proportion of subjects experiencing disruptive behavior by job classification was compared using Chi-Square. An ANOVA was used to detect

differences in the incidence of disruptive behavior among bedside caregivers, managers, and educators. Statistical significance was established at $p < 0.05$.

A participation rate of 3% was realized. More women (59.7%) then men (40.3%) participated in this study. A majority of participants (47.1%) worked in healthcare as a respiratory care practitioner for more than 30 years. Most participants were not direct bedside caregivers. Department or technical directors (47.9%); and educators (25.2%), comprised more than half of the sample. Only 10.9% of the study population was a direct bedside caregiver or staff respiratory therapist (10.9%). A few participants had bedside care and administrative responsibilities and were categorized as a supervisor or team leader (7.6%). The other category elicited responses such as quality specialist, manager, clinical coordinator and critical care transport team member (7.6%) and neonatal or pediatric specialist (0.8%)

Ninety six percent of individuals surveyed had experienced a form of disruptive behavior. An equal percent of individuals, 96%, witnessed a co-worker experiencing a disruptive event. Although the disruptive behavior manifested itself in multiple forms, the majority 55.5% of study subjects experienced verbal disruptive behavior.

Bedside caregiver (57%), physician/surgeon (29%) and patient (7%), were identified as the main sources of the disruptive behavior or offenders. Gender differences among offenders occurred. Males exhibited disruptive behavior, 55.5%, more frequently than females, 44.5%. No difference in the type of disruptive behavior was experienced by job class, $p = 0.28$. Bedside practitioners or staff respiratory therapists did not experience disruptive behavior more often than department technical directors,

educators or supervisors, $p = 0.78$. The study was further summarized in Chapter V.

Conclusions of the study, as well as recommendations for further research are presented.

CHAPTER V

SUMMARY, CONCLUSSIONS AND RECOMMENDATIONS

Summary

This chapter will discuss the data presented in Chapter IV. It will look at findings from two viewpoints, specifically statistical significance and clinical relevance. It is important to understand that the statistical significance denotes concepts regarding the null hypothesis. If something is found to be statistically significant, the null hypothesis is considered rejected. However, there are statistically significant findings that may not have definite or important implications in the respiratory clinical setting. There are times when no statistical significance is found yet findings are suggestive of clinical relevance. This chapter will address the following questions: Does disruptive behavior exist in the respiratory work place? Is verbal disruptive behavior more prevalent in healthcare environments? Is disruptive behavior higher among bedside caregivers compared to managers and educators? Who is the greatest source of disruptive behavior?

Nearly all, 114 (95.8%) study participants felt that disruptive behavior in the workplace occurred and occurred frequently. While there are multiple forms, verbal was the form which occurred at the greatest frequency. This type of disruptive behavior can manifest itself in multiple forms such as condescending, angry and accusatory forms as well as cursing. Bedside caregivers were most often disruptive to their subordinates (57.1%) but a number of the respondents reported that physicians/surgeons were among the top offenders (29.4%). From statistics presented in previous disruptive behavior studies, it is hard to discount the fact that disruptive behavior is definitely present in healthcare today. This research endeavor also provides statistics that disruptive behavior

is present in the respiratory setting. However, survey participants do not feel that disruptive behavior is something that just happens and must be tolerated. A majority, 83.2%, acknowledged that disruptive behavior does occur in healthcare, but do not feel it is something the healthcare professional must merely accept as a part of the job.

Respiratory therapists working in a disruptive environment show adaptive behaviors and possess significant coping skills. This is evidenced by the longevity in the field reported by the participants of this survey with nearly one half (47%) of respondents attained more than 30 years of working experience in the field of respiratory care. Greater than 71% of participants reported they had never contemplated leaving their respective employment position after experiencing disruptive behavior events. Perhaps it is these individuals that face this challenge head on and try to redirect the aggressive behavior and deescalate the situation. Participants reported that it is important to encourage staff to document and report disruptive behavior immediately. Individuals need to know that they will be supported if they come forward with concerns about another person's behavior.

There are respiratory therapists that, for reasons not assessed in this particular research endeavor, do not advocate for themselves and succumb to the stress of the healthcare environment. This group of individuals may be among the nearly 29% that contemplated leaving healthcare. It is essential for healthcare administrators to not allow the stress of the job to cloud their judgment when it comes to the complaints of employees about disruptive behavior in the workplace. Due to the severity of patient's status along with the technological environment we function in, time is of the essence and tempers tend to become inflamed. Although these conditions have been recognized in the references of this study and in this survey, no excuse for disruptive behavior is

acceptable. "Zero tolerance" initiatives are focusing on a means to control disruptive behavior (Rippon, 2000). These initiatives were also alluded to in the free text suggestions for strategies to minimize and or eliminate the occurrence of disruptive behavior.

This particular study did not find a statistically significant difference in the incidence of disruptive behavior among bedside caregivers compared to educators and administrative personnel, such as technical or department directors and supervisors. This finding may be attributed to a small sample size in each of the respective subgroups.

Participants in the study perceived that a stressed out work force has a significant impact on patient care and quality. A majority of participants, 75.6%, believe that the quality of patient care is affected by disruptive behavior. Disruptive behavior not only impacts those on the receiving end but it can possibly have ramifications for those who are in their care. This study reported that disruptive behavior has an adverse effect on morale, team work, productivity and caused an increase in errors that prohibited the delivery of quality healthcare. Contributing factors were an overall decrease in concentration and communication. Frustration significantly contributed to all these feelings and an overall helplessness to change the situation increased the incidence of negativity. Patients and positive clinical outcomes are one of the most important aspects related to healthcare and it is important that any possible barriers that cause less than optimal care be addressed.

A majority, 83.2%, of participants disagreed with the statement "Disruptive behavior occurs in healthcare. It is just something I must accept as a part of my job".

Disruptive behavior not only impacts those on the receiving end but it can possibly have ramifications for those who are in their care.

Certain situations have shown to trigger stress and possible disruptive behavior. Questions were placed on the survey to determine perceived triggers that lead to disruptive behavior. Triggers are stimuli that are occurring either internally or externally affecting the adaptive system. Participants were asked to indicate all that they felt would trigger these behaviors. Healthcare facilities often time allow the stress of the job to cloud their judgment when it comes to the complaints of employees about disruptive behavior in the workplace.

The challenge now becomes how we as healthcare advocates promote a better work environment for those who will care for us some day. The goal is to re-channel anger and frustration into productive measures to improve performance and quality care.

Conclusions

Information obtained from the study revealed the following:

- A total of 119 credentialed respiratory therapists completed the participant survey and yielded a 3% response rate.

- Participation in this research endeavor was limited due to the typical nature of a survey tool.

- Study participants felt that disruptive behavior in the respiratory workplace occurred and occurred frequently.

- The majority 55.5% of study subjects experienced verbal disruptive behavior. No difference was found in the disruptive behavior manifestation by job classification, $p = 0.29$.

- Bedside caregiver (57%), physician/surgeon (29%) and patient (7%), were identified as the main sources of the disruptive behavior or offenders.

- Bedside practitioners or staff respiratory therapists did not experience disruptive behavior more often than department technical directors, educators or supervisors, $p = 0.78$.

Implications

The findings in this research demonstrated the serious negative outcomes that disruptive behavior has on respiratory therapists, other health care providers and patients. The Joint Commission (2007) acknowledges that unresolved conflict and disruptive behavior can adversely affect safety and quality of care. The causes of disruptive behavior are complex but can be identified within the respiratory care workplace. It was evident by the responses that disruptive behavior exists within the respiratory workplace, yet there was no statistical difference found in the disruptive behavior manifestation by job classification. The consequences of disruptive behavior impede communication and erode teamwork which leads to compromises in quality care. In order to minimize the adverse effects of disruptive behavior, healthcare organizations need to develop policies, provide education to employees and patients, and implement strict standards to effectively deal with this issue. An increased understanding of the causes and consequences of disruptive behavior will help members of the respiratory team effectively deal with the disruptive events and high stress environments in which they work and help minimize displaced anger.

Recommendations for Further Research

Additional studies to determine the prevalence and the effects of disruptive behavior in the respiratory workplace are warranted. A more comprehensive, randomized study may determine if disruptive behavior is truly more prominent in certain respiratory positions. An analysis of the impact of disciplinary policies with respect to the various forms of disruptive behavior may be of value.

References

American Medical Association (2002). E-9.045 Physicians with disruptive behavior. Retrieved June 29, 2009, from www.peerreview.org/disruptive_physician/ articles/AMA%20(Professionalism)%20E-9_045%20Physicians%20with%20 Disruptive%20Behavior.htm

Arnetz, J.E. and Arnetz, B.B. (2000). Implementation and evaluation of a practical intervention program for dealing with violence towards health care workers. *Journal of Advanced Nursing*, 31(3): 668-680.

Bray, C. (2001). Bullying nurses at work: Theorizing a gendered experience. *Contemporary Nurse,10*(1-2), 21-29.

Chuntz, H. (1978), Concern over registry written exam pass rate. Respiratory care, 22(5), 458-464.

Elliott, P. P. (1997). Violence in healthcare: What nurse managers need to know. *Nursing*

Gallup MD, Donald G. (2006). The disruptive physician: Myth of reality. *American Journal of Obstetrics and Gynecology.* 195, 543-546.

Hamlin, L. & Hoffman, A. (2002). Perioperative nurses and sexual harassment, *AORN Journal,* 76(5), 855-860.

Health Behaviors and Health Education, Theory, Research, and Practice 3rd Edition

Hoel, H., Sparks, K.., cooper, C.L. (2001) The Cost of Violence? Stress at Work and the Benefits of a Violence/Stress-Free Working Environment. Report Commissioned by the International Labor Organization (ILO) Geneva; (University of Manchester Institute of Science and Technology).

Joint Commission (2008). *Sentinel event alert: Behaviors that undermine a culture of safety.* Retrieved November 12, 2010, from www.jointcommission.org/SentnelEvents/SentinelEventsAlert/sea40.htm

Leppanen and Olkinuora. (2000). Aggression and violence in health care professions. Journal of Advanced Nursing, 31 (2): 452-460.

Longo, J. & Sherman, R. (2007) Leveling horizontal violence. *Nursing Management*, *38*(3), 34-37, 50-51.

Manderino, M. A. & Berkey, N.(1997). Verbal abuse of staff nurses by physicians. *Journal of Professional Nursing.* 13 (1), 48-55.

Mosby Medical Dictionary (8th ed.)(2009) Elsevier, Inc.Press

Rippon, T.J. (2000) Aggression and violence in health care professions. Journal of Advanced Nursing, 31 (2): 452-460.

Solfield, L., Salmond, S. (2003). Workplace Violence: A focus on verbal abuse and intent to leave the organization. Othopaedic Nursing, 22, 274-282.

Watson, V., Steiert, M.J., (2002) Verbal Abuse and Violence: The Quest for Harmony in the OR. SSM, 8, 16-22.

Zapf, D. (1999). Organizational, work group related and personal causes of mobbing/bullying at Work [Electronic version]. *International Journal of Manpower, 20*(1-2), 70.

Manderino, M. A. & Berkey, N. (1997). Verbal abuse of staff nurses by physicians. *Journal of Professional Nursing.* 13 (1), 48-55.

Figure 1.
AARC Introductory e-mail

Dear Education Section Members:

In the message below is a description of a survey that has been approved by the AARC executive committee for distribution to AARC members who are subscribed to the management, education, and adult acute care sections. I ask that you consider completing the survey as your earliest convenience. Lynda

_____

Dear Respiratory Care Practitioner:

We are conducting a study to determine if disruptive behavior exists in the respiratory care work environments. The definition of disruptive behavior can be formed to include the fact that disruptive behavior can be physical, verbal, psychological or sexual. The Joint Commission states that: intimidating and disruptive behavior includes overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. In this study you will be asked to complete a short survey at https://www.surveymonkey.com/s/WG9KQR9 . Your participation should take approximately 10-15 minutes. There are no risks to you. The survey is anonymous and all information will be handled in a strictly confidential manner. No identifying information will be collected, so that no one will be able to identify you when the results are recorded and/or reported in the abstract submitted for publication and presentation at the AARC International Congress.

Your participation in this study is voluntary and you may withdraw at any time without negative consequences. If you wish to withdraw at

anytime during the study or have any questions concerning the study simply call:

Mrs. Terry Volsko, MHHS, RRT, FAARC, Principal Investigator
Director of Respiratory Care and Polysomnography Program
Youngstown State University 330-941-2009 tavolsko@ysu.edu

Mrs. Amanda Roby, BS, RRT, RPSGT, Co-investigator
    alroby@ysu.edu

Dr. Edward Orona, Director of Grants and Sponsored Programs
Youngstown State University 330-941-2377 eorona@ysu.edu

I understand the study described above and have been given a copy of the description as outlined above. I am 18 years of age or older and I agree to participate.

Lynda T. Goodfellow
Associate Professor and Director
School of Health Professions
Georgia State University
Atlanta, GA 30302 USA

Figure 2. Regional Distribution of Participants (n = 119)
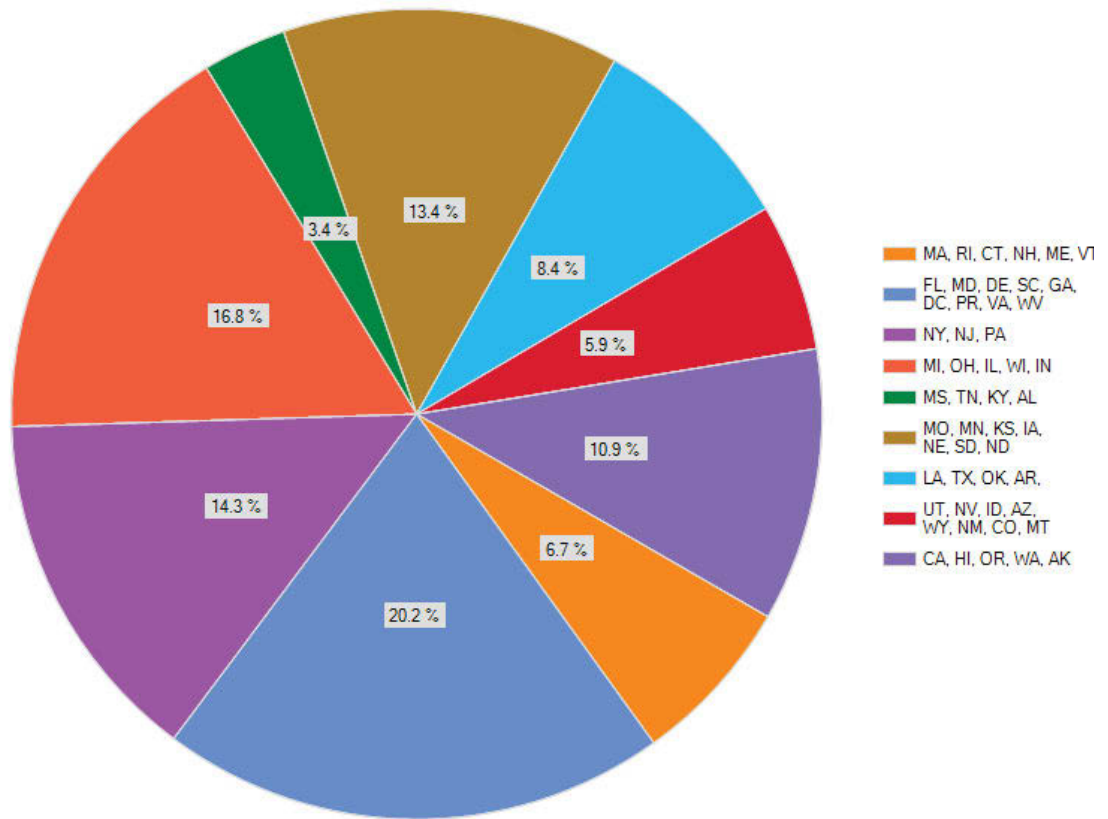
Figure 3: Gender of Research Participants (n = 119)
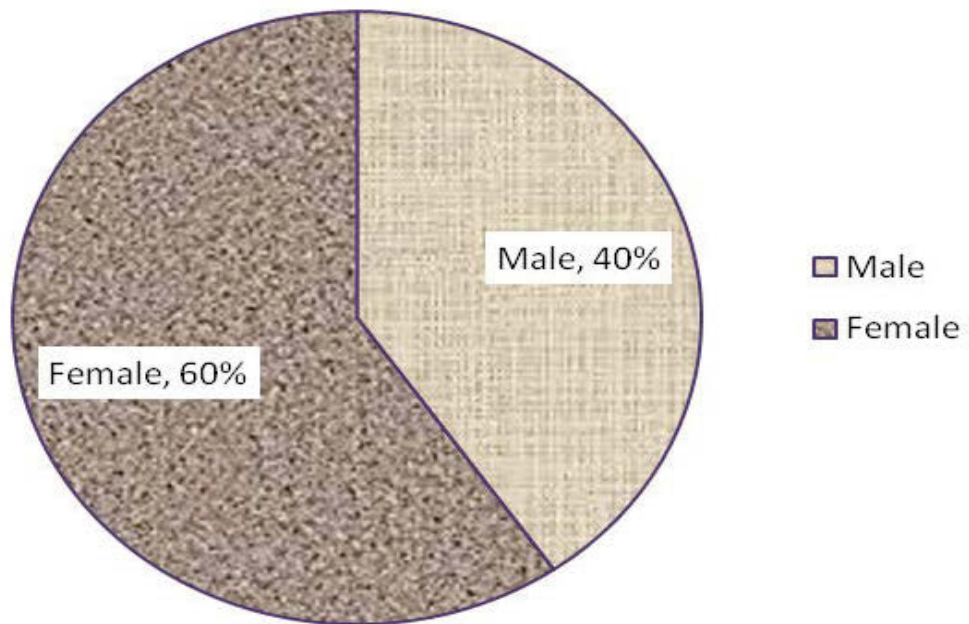
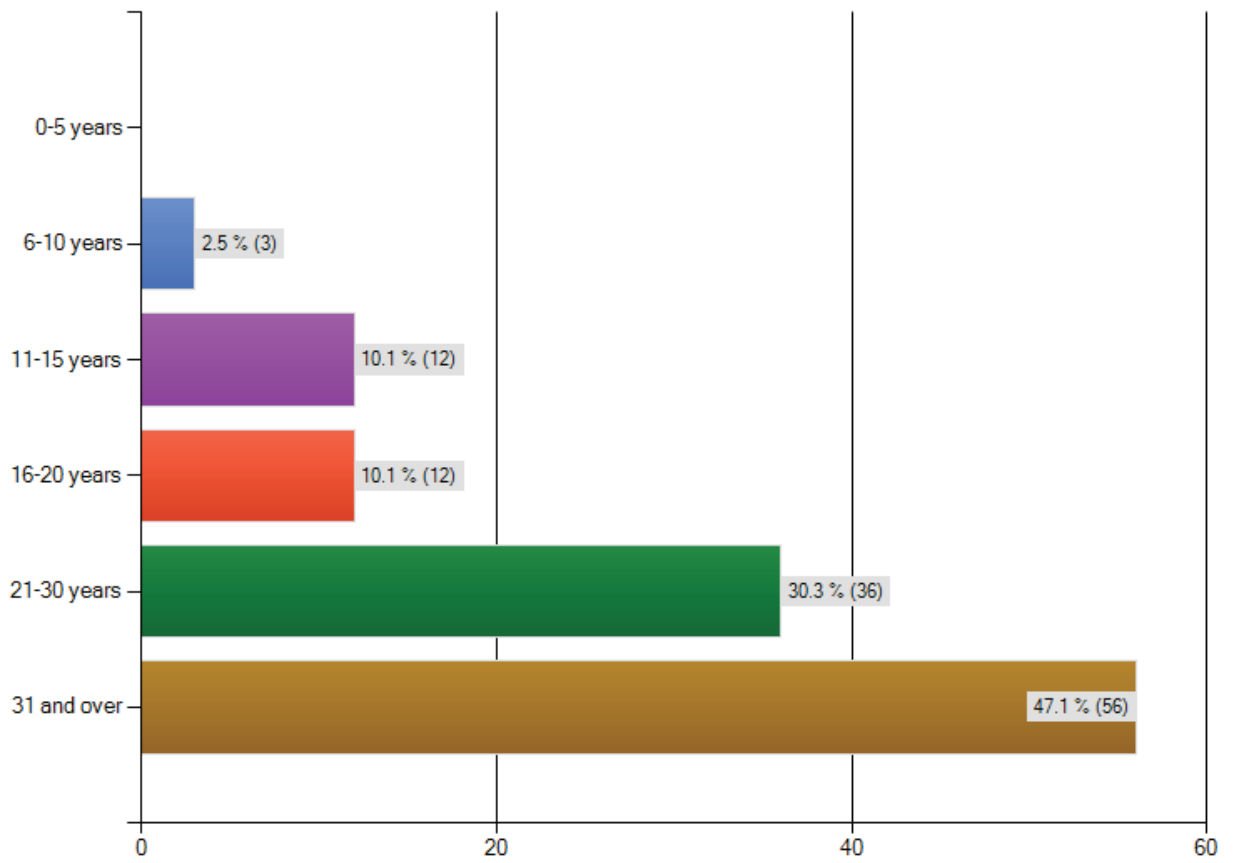Figure 4: Longevity in the Field (n = 119)

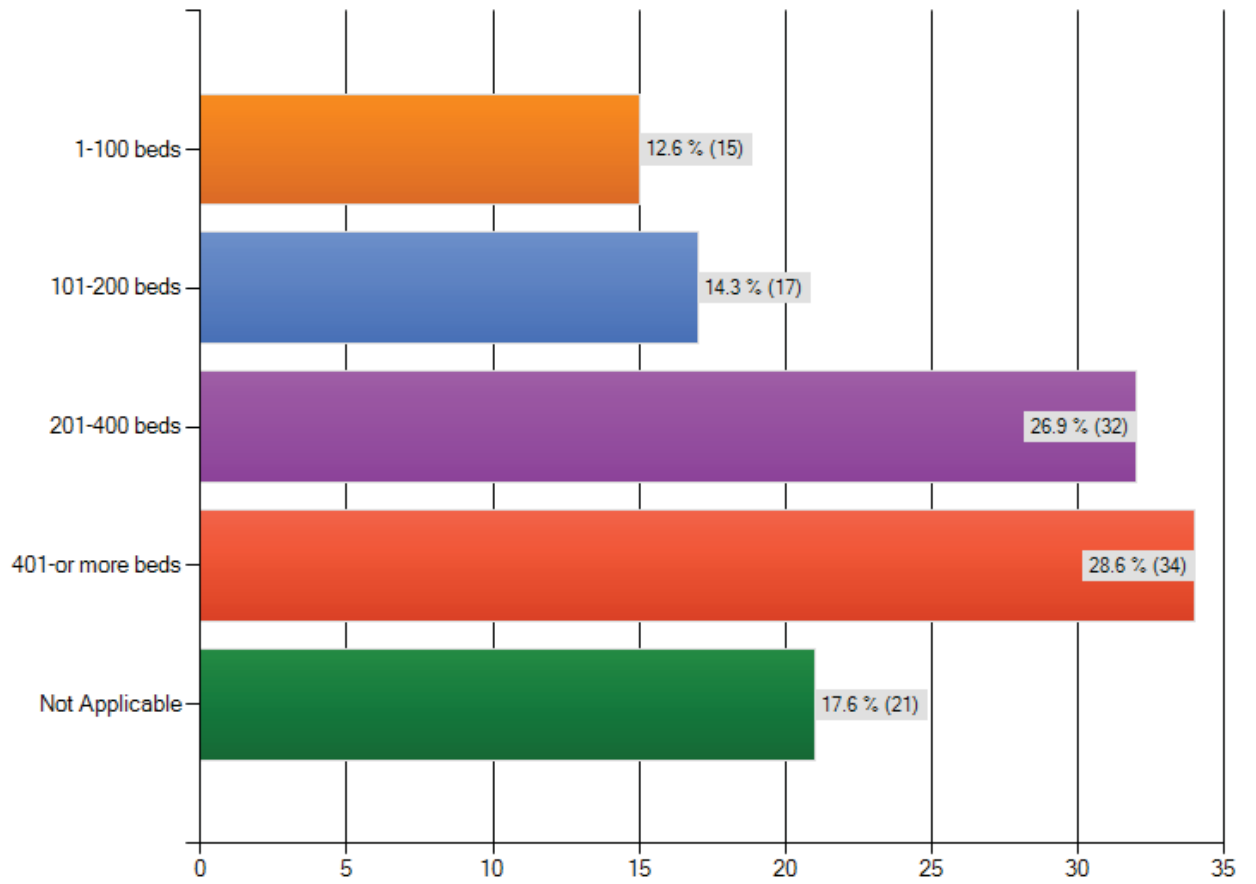Figure 5: Bed Capacity of Institutions Employing Study Participants (n = 119)

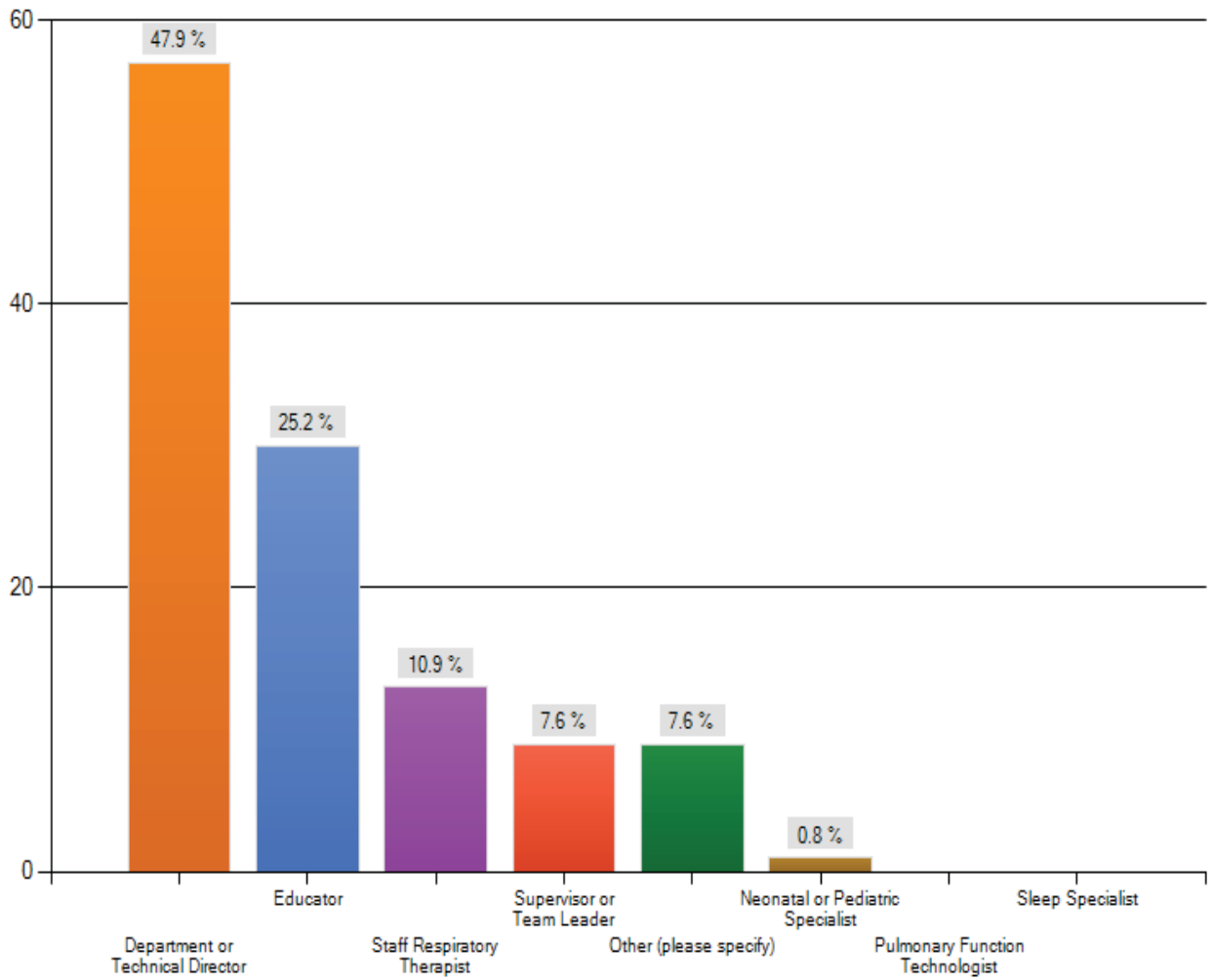Figure 6: Primary Job Function of Survey Respondents (n = 119)

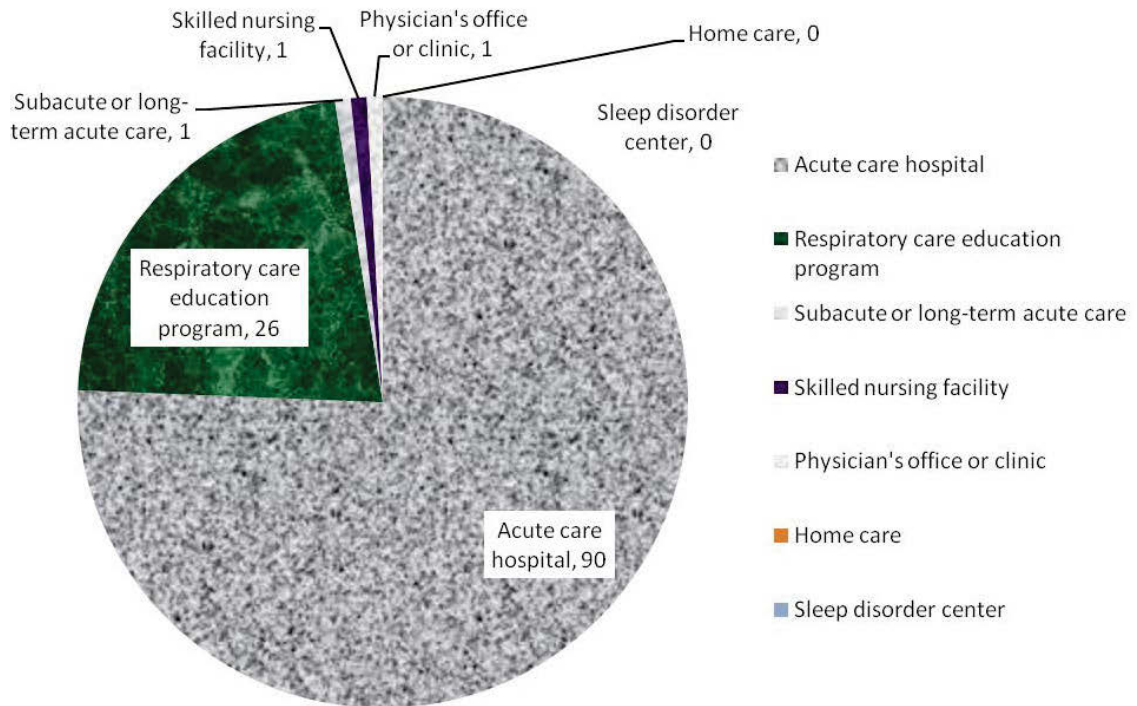Figure 7: Primary Work Environment Reported by Study Participants (n = 119)

Figure 8: Types of Disruptive Behavior Witnessed or Experienced by Study Participants (n = 119)
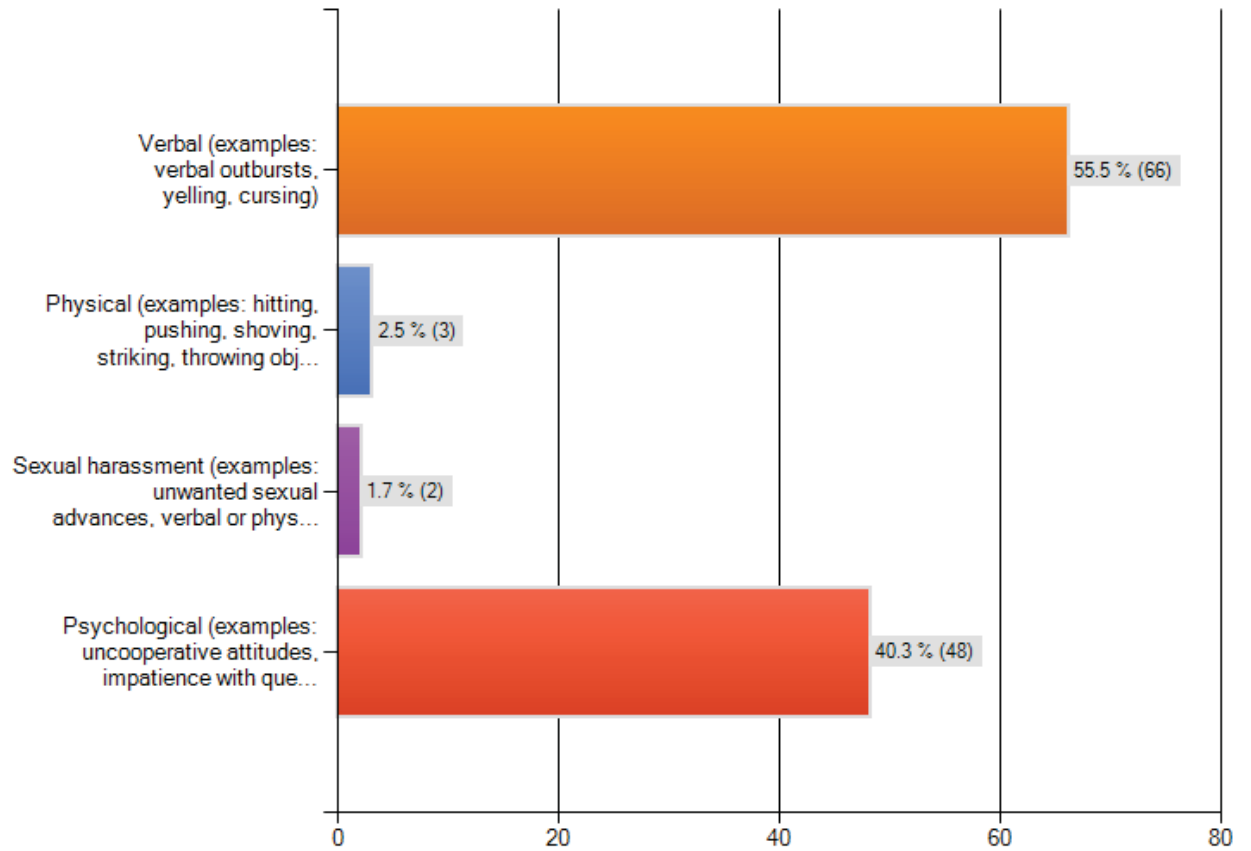
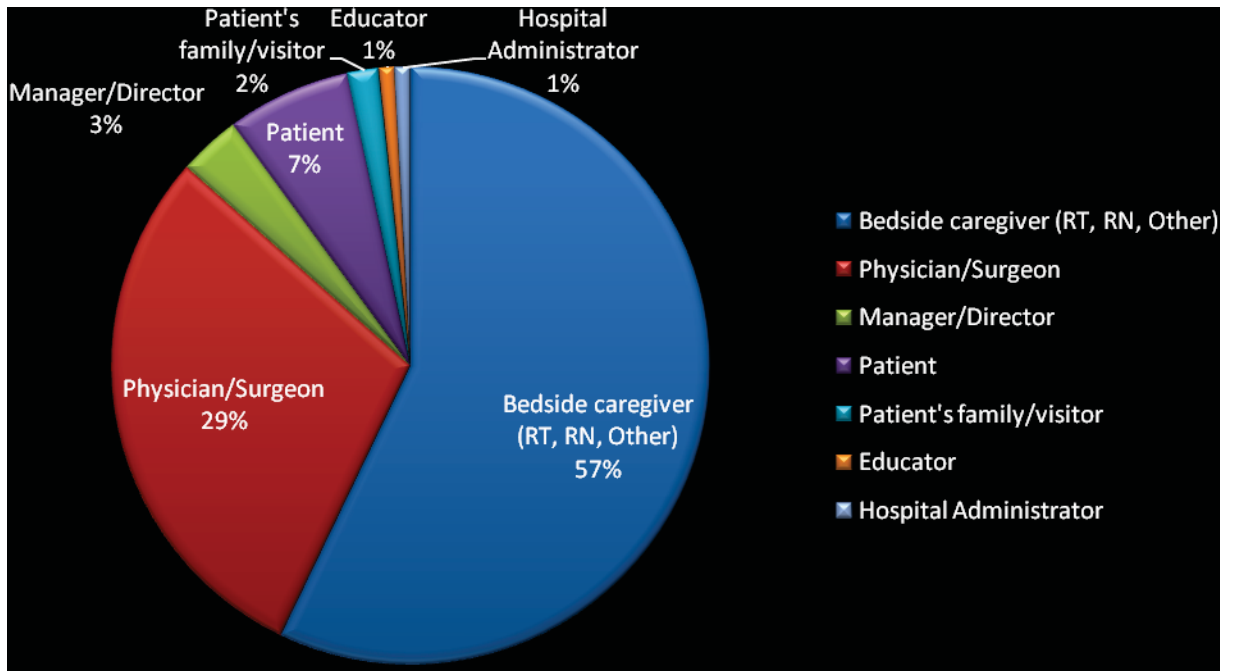Figure 9: Role of the Disruptive Behavior Offender (n = 119)

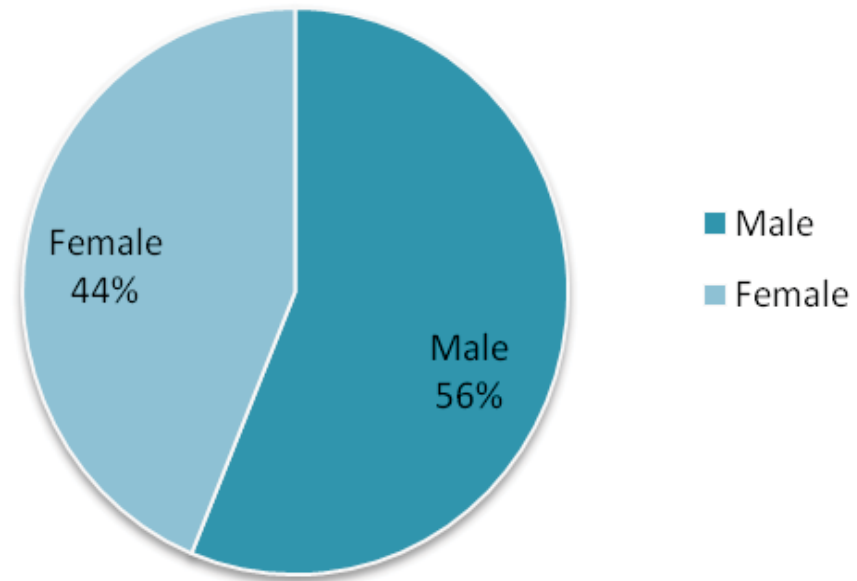Figure 10: Gender of the Disruptive Behavior Offender (n = 119)

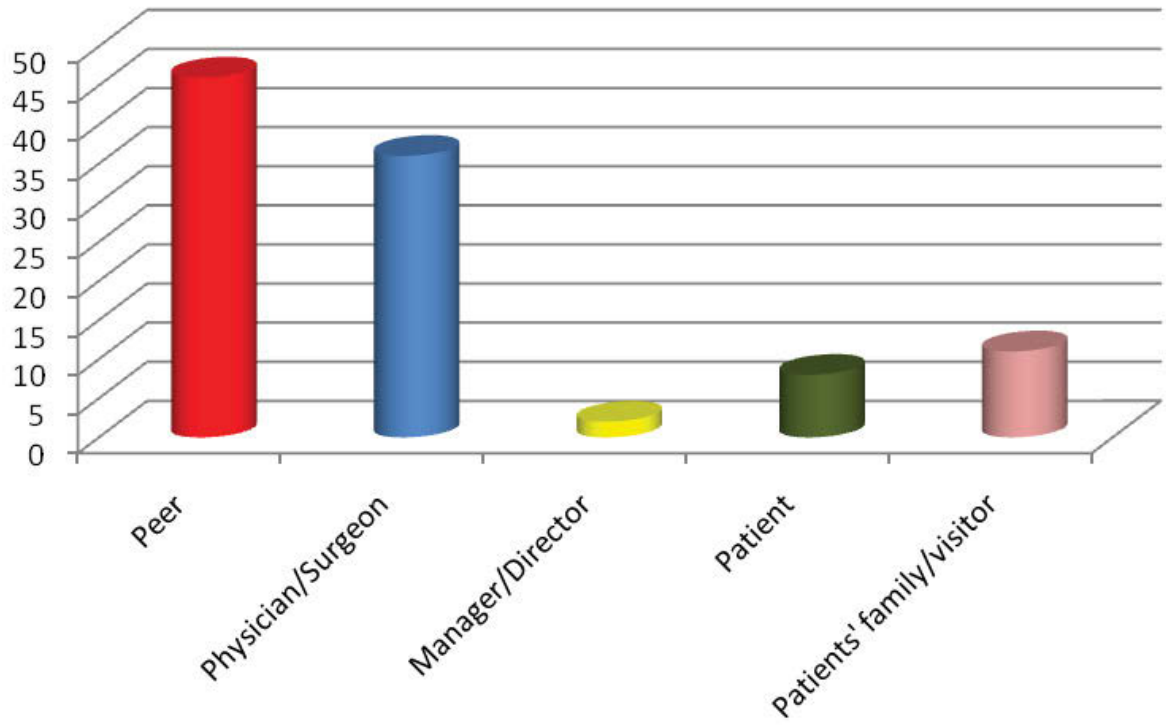Figure 11: Frequency of Disruptive Behavior, Ranked by Frequency of Offense (n = 119)

Figure 12: Emotional Response the Subject Experienced Following the Disruptive Event (n = 119)
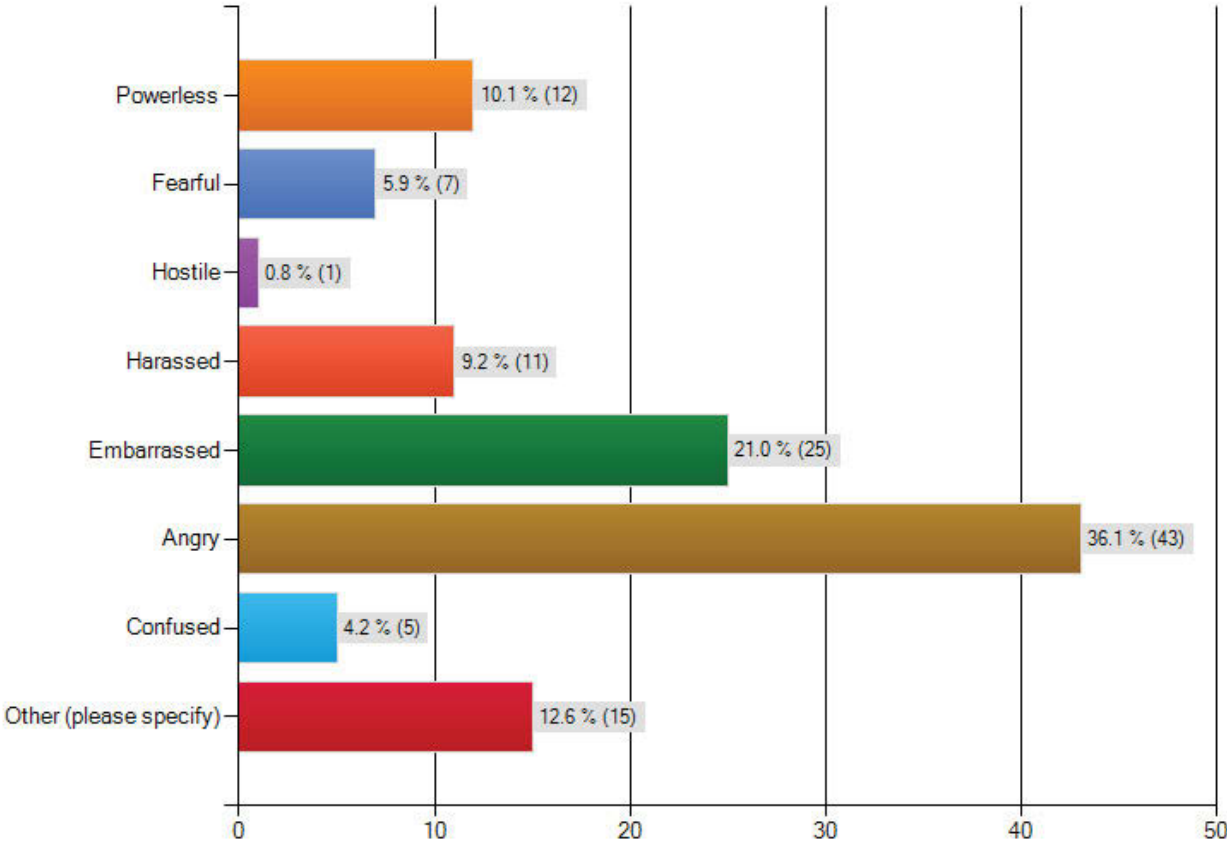
Figure 13: Triggers of the Disruptive Event (n = 119)
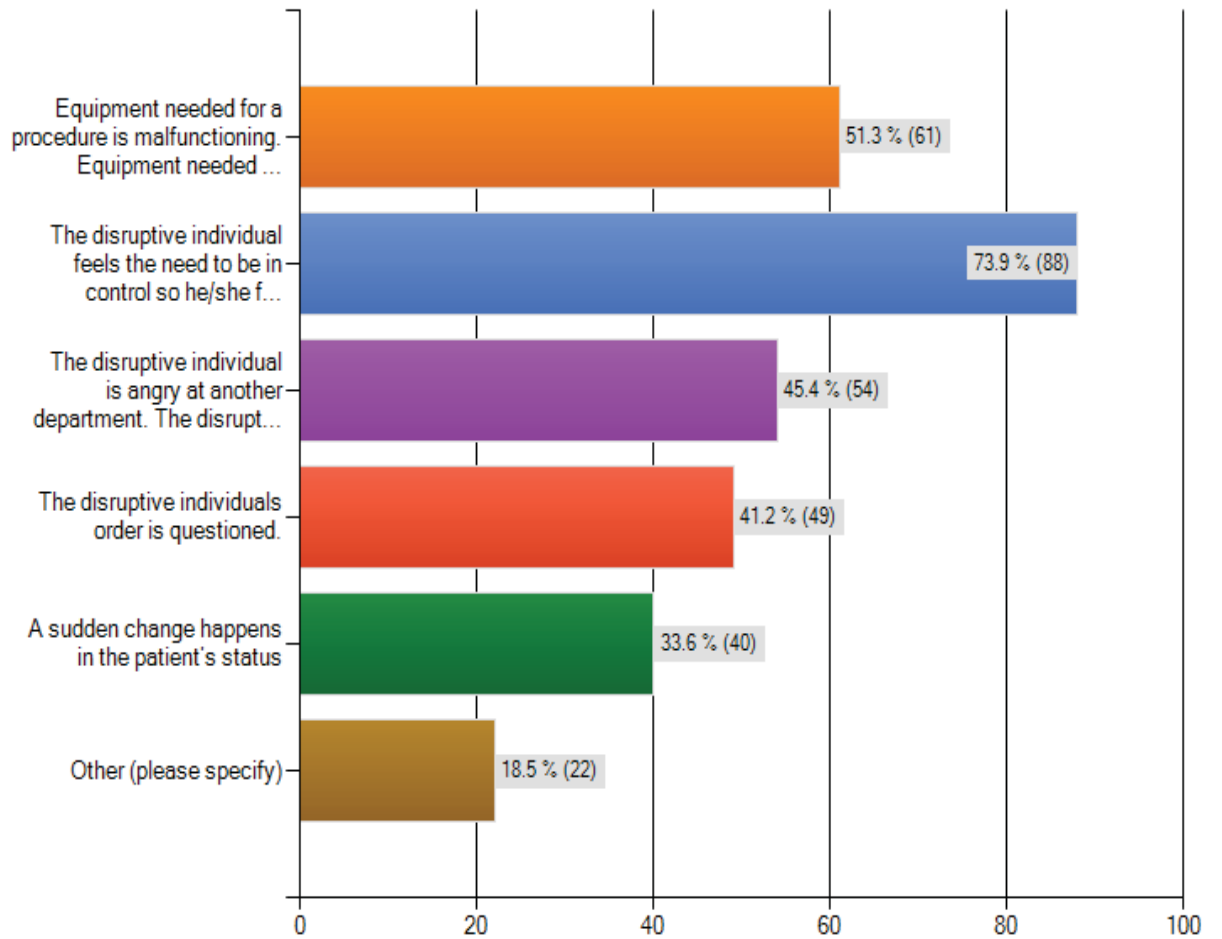
Figure 14: Effect the Disruptive Event Had on the Quality of Patient Care Delivered by the Victim of the Disruptive Event (n = 119)
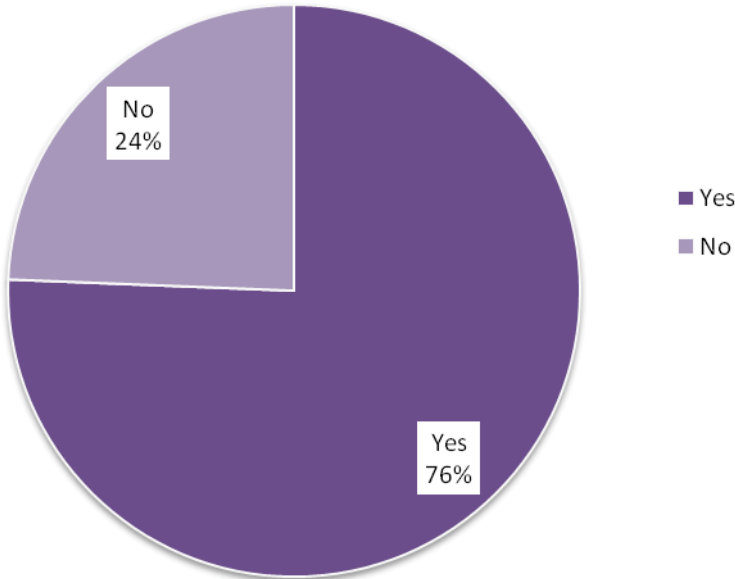
Figure 15: Beliefs regarding the ability of a Zero Tolerance Policy and Structured Disciplinary Process to Reduce or Eliminate Disruptive behavior. (n = 119)
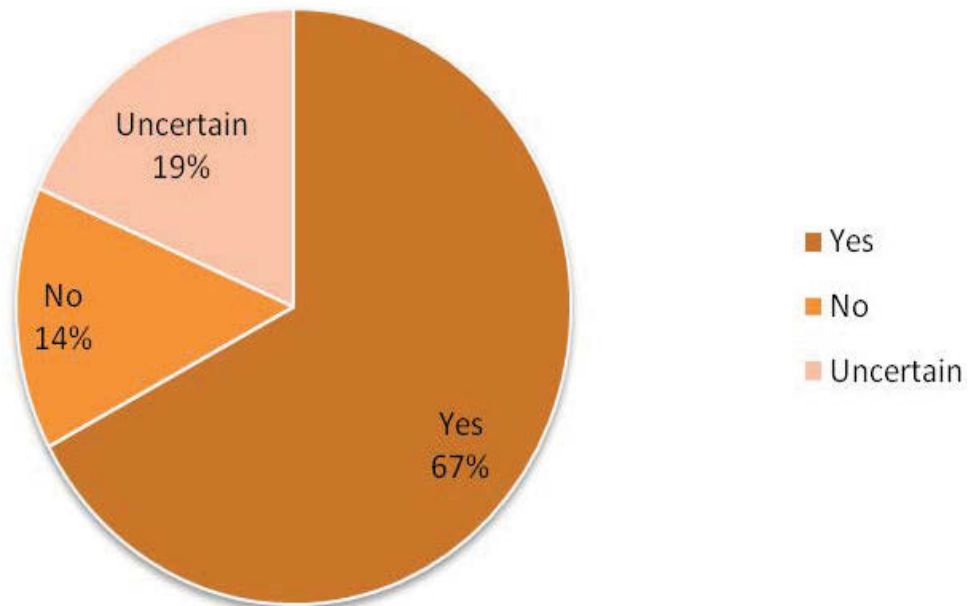
Yes = Zero Tolerance Policy and Structured Disciplinary Process will Reduce or Eliminate Disruptive Behavior.

No= Zero Tolerance Policy and Structured Disciplinary Process will not Reduce or Eliminate Disruptive Behavior.

Uncertain = Neutral feelings or unsure of effect Zero Tolerance Policy and Structured Disciplinary Process will have on Disruptive Behavioral occurrences

Figure 16: A listing of the free-text suggestions study participants provided to reduce or eliminate the incidence of disruptive behavior in the workplace.

- Hold individual workers accountable for their bad behavior - address the playground mentality demonstrated by front line staff (i.e., they won't report bad behavior because they don't want to be considered a "tattletale")

- More staff and training

- Nothing will. It happens at all levels, and in some degree is common everywhere.

- It needs to be addressed and the individual who addresses the issue needs to be 'safe' after initiating the concern.

- Holding employees accountable for their behavior.

- Not giving someone so much power such as a physician simply because they are a physician

- Fire the disruptive person

- Because of the high level of stress that can be seen in healthcare, everyone needs to be able vent sometimes. The venting can be an important way to relieve stress. If there was a way to vent without the disruptive behavior, that would be ideal. I am not sure what that should be though.

- Recurrent, required, education of all. Staff, physicians, patients, family members

- FIRST - LEADERSHIP CLARITY THAT SUCH BEHAVIOUR WILL NOT BE TOLERATED SECOND - THAT STRUCTURED DISCIPLINE OFFERING HELP TO OFFENDERS TO POSITIVELY CHANGE BEHAVIOUR THIRD - INSTITUTIONAL TRAINING TO DEAL WITH IT (EG CREW RESOURCE MANAGEMENT)

- Decrease work load to an acceptable level.

- Hold people accountable for their behavior with real consequences. For example, unpaid suspensions.

- Education and ease of reporting incidents

- Zero tolerance

- Continuing programs related to workplace environment, role playing, counseling and workplace observation.

- Re assure staff that we all get mad at others or situation. That if they must vent there is a place for it. I have them come to the supervisors office are my office and vent their frustration.

- Establish a culture of respect and equality.

- Stronger follow up by higher management and HR.

- Minimize staffing situations that lead to high stress and ultimately to disruptive behavior.

- Everyone needs education - start at a baseline. Put a system in place to provide reporting without retaliation. Encourage its use. Send individual offenders to repeat education and have them sign a contract to seek positive actions for their behavior change. Apply the Just Culture Algorithm to the letter for all staff.

- Question 22 above is correct if the policy is followed and the structured discipline is applied to the offender. Most often this is not the case.

- Holding those who exhibit disruptive behavior accountable for their actions, requiring an apology to the victim, putting an action plan in place to ensure that

necessary counseling and oversight are carried out. Support from hospital administration is critical.

- Develop the desired culture and hire individuals who fit the desired culture.

- Disruptive behavior can include workplace bullying which is not against the law and hard to prove. This makes it hard to stop the behavior.

- Hold physicians accountable to the same level as employees are held. Employees can receive Corrective Action, including termination. Physicians are usually sent a letter, if anything is done at all. Their behavior should set the example, and therefore their accountability should be the same; perhaps admitting privileges revoked, etc.

- Awareness and consequences among all participating parties.

- Support from management and administration. Counseling and Education for disruptive behavior.

- I think the 12-hour shift, several days in a row has increased disruptions. People are tired and irritable, so they blow up when things do not go their way.

- Guide offenders towards compliance, exit if they don't.

- Immediate dismissal from the worksite and suspension pending investigation of offense

- It is difficult to fire a disruptor with HR barriers, Union barriers and ability to prove in a he said/she said situation. Also, this survey was confusing because it

bounced from general questions to specific incidence questions, so your results will be skewed.

- I reported the behavior and stated I felt it was Work Place Violence; the therapist was counseled, but the behavior reoccurred intermittently and I feel nothing was done to correct the behavior.

- While policies are good; it is the enforcement of those policies that are required. If the offender just gets a slap on the hand, there is no incentive to discontinue such behavior.

- HR with a spine

- Be timely and consistent in enforcing bad behavior

- More support from HR in dealing with this behavior. This type of behavior cannot be changed, so giving the offender multiple chances to change is futile.

- Better communication.

- Prozac

- Physicians being held accountable for their actions. We are a large teaching hospital with many private practice physicians. They are really held to the same standards as the hospital employed physicians and therefore abuse their position with no accountability.

- Senior Administration must address issue with MD after reporting.

- Awareness. We have been effective in addressing issues with fellow associates and physicians, but the biggest challenge is impacting the way family members react.

- Get rid of disruptive employees. But patients and family members are always going to be a problem.

- As the director I don't tolerate abusive or disruptive behavior.

- So often the "employer" does not take action until several events have occurred. I believe action must be taken immediately - the situation is not going to just "go away" if you ignore it.

- Follow through when complaints are made, regardless of the person's role

- Hold physicians accountable for their disruptive behavior, but that won't happen, they (administration) will continue to make excuses for the physician because they do not want to lose them.

- Do a root cause analysis. Hold the offender(s) accountable. EAP involvement. Employee advocate

- Nothing. I have taken situations to top management and was told I would have to leave because the physician brings in the money and I was replaceable. With this response, how can I feel any change will ever be supported?

- Have proactive education for staff. Encourage people to speak up.

- Many times I see this come out in people after hire. People seem to bring this behavior with them. Best thing is to try and not hire these types of people or work them out of the system ASAP.

- Enforcement of the policies and willingness to come forward and report events without fear of retaliation, etc.

- I do think that the individual needs to be held accountable for their behavior and a formal apology should be required. Individuals need to look at why they reacted the way they did and change. If they can't or won't change, then dismissal is the only answer.

- Dissolution of departmental silos and a return to true team work, from physicians on. Patient/Family disruptive behaviors can be minimized with continuous open communication from staff.

- Less stress, more staffing

Table 1: Comparison of Disruptive Behavior by Job Classification

Type of Disruptive Behavior	Job Function				Total	p Value
	Educator	Department or Technical Director	Staff Therapist	Other		
Psychological n (%)	11 (9)	30 (25)	3 (3)	4 (3)	48 (40)	
Verbal n (%)	16 (13)	35 (29)	9 (8)	6 (5)	66 (55)	
Physical n (%)	2 (2)	0 (0)	1 (1)	0 (0)	3 (3)	
Sexual harassment n (%)	1 (1)	1 (1)	0 (0)	0 (0)	2 (2)	
					119 (100)	0.29

59

Disruptive Behavior in the Respiratory Workplace

1. In what region do you work?
   - ☐ MA, RI, CT, NH, ME, VT
   - ☐ FL, MD, DE, SC, GA, DC, PR, VA, WV
   - ☐ NY, NJ, PA
   - ☐ MI, OH, IL, WI, IN
   - ☐ MS, TN, KY, AL
   - ☐ MO, MN, KS, IA, NE, SD, ND
   - ☐ LA, TX, OK, AR,
   - ☐ UT, NV, ID, AZ, WY, NM, CO, MT
   - ☐ CA, HI, OR, WA, AK

2. In what setting do you primarily work?
   - ☐ Acute care hospital
   - ☐ Home care
   - ☐ Subacute or long-term acute care
   - ☐ Skilled nursing facility
   - ☐ Respiratory care education program
   - ☐ Physician's office or clinic
   - ☐ Sleep Disorder Center

3. If you work in an acute care hospital, what is the bed capacity?
   - ☐ 1-100 beds
   - ☐ 101-200 beds
   - ☐ 201-400 beds
   - ☐ 401-or more beds

4. What is your primary job function?
   - ☐ Staff Respiratory Therapist
   - ☐ Pulmonary Function Technologist
   - ☐ Sleep Specialist
   - ☐ Neonatal or Pediatric Specialist
   - ☐ Supervisor or Team Leader
   - ☐ Department or Technical Director
   - ☐ Educator
   - ☐ Other_____

5. How many years have you been in healthcare? (Check one)
- ☐ 0-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16-20 years
- ☐ 21-30 years
- ☐ 31 and over

6. Gender (check one)

☐ Male   ☐ Female

7. In your work experience in the hospital setting have you ever experienced a disruptive event? (Check one)

☐ Yes   ☐ No

8. In your work experience in the hospital setting have you ever witnessed a co-worker experiencing a disruptive event? (Check one)

☐ Yes   ☐ No

9. Which type of disruptive behavior have you experienced or witnessed the most? (Check one)

☐ Verbal (examples: verbal outbursts, yelling, cursing)

☐ Physical (examples: hitting, pushing, shoving, striking, throwing objects)

☐ Sexual harassment (unwanted sexual advances, verbal or physical)

☐ Psychological (examples: uncooperative attitudes, impatience with questions)

10. What role was the disruptive behavior offender functioning in? (Check only one)
- ☐ Bedside Caregiver (RT, RN, Other)
- ☐ Physician/Surgeon
- ☐ Manager/Director
- ☐ Patient
- ☐ Patient's family/visitor
- ☐ Educator
- ☐ Hospital Administrator

11. What was the gender of the person(s) who most frequently performs these disruptive behaviors? (Check one)

☐ Male   ☐ Female

12. Of the events you witnessed or experienced which of the following have been sources of disruptive behavior or unprofessional conduct? (Rank on frequency of offense) (1 = most common and 5=least or never)

Peer	1	2	3	4	5
Physician/Surgeon	1	2	3	4	5
Manager/Director	1	2	3	4	5
Patient	1	2	3	4	5
Patients' family/visitor	1	2	3	4	5

13. Which of the following best describes your feelings following a disruptive event? (Please check only one)
☐ Powerless
☐ Fearful
☐ Hostile
☐ Harassed
☐ Embarrassed
☐ Angry
☐ Confused
☐ Other: _____

14. Did the event occur during or immediately after a high stress situation (example: trauma teams, intensive care teams) for either you or the disruptive individual? (Check one)
☐ Yes ☐ No

15. Certain situations have been shown to trigger stress and possible disruptive behavior. Please indicate all that you feel would trigger these behaviors.
(Check all that apply).
☐ Equipment needed for a procedure is malfunctioning.
☐ Equipment needed for a procedure is not immediately available.
☐ The disruptive individual feels the need to be in control so he/she forces the therapist into
a subordinate role.
☐ The disruptive individual is angry at another department.
☐ The disruptive individual feels there is a time delay.
☐ The disruptive individuals order is questioned.
☐ A sudden change happens in the patient's status
☐ Other: _____

16. Have you ever contemplated leaving healthcare due to a disruptive event or behavior? (Check One)

       ☐ Yes   ☐ No

17. Based on your experience with disruptive behavior, respond to the questions below based on what you believe to be true.

a.   The incident can have a negative effect on morale? (Check one)

       ☐ Yes   ☐ No

b. The incident can decrease the victim's level of productivity for a period of time? (Check one)

       ☐ Yes   ☐ No

c. The incident could lead to an increase in medical errors? (Check one)

       ☐ Yes   ☐ No

 d. Repeated exposure will influence the caregivers or providers in a
     negative way? (Example: depression, anxiety, migraines)

       ☐ Yes   ☐ No

18. Do you believe that quality patient care provided by the victim is affected by disruptive behavior?

      ☐ No
      ☐ Yes, please explain: _____

      _____

19. Disruptive behavior occurs in healthcare. It is just something I must accept as a part of my job.

     ☐ agree with the statement
     ☐ disagree with the statement

20. Does your institution have a Workplace Violence Policy or Code of Conduct? (Check one)

      ☐ Yes   ☐ No   ☐ Unsure

21. Have you ever reported a disruptive incident? (Check one)

      ☐ Yes   ☐ No

22. Do you feel that a policy of zero tolerance for disruptive behavior and a structured discipline process for offenders would help to reduce or eliminate the use of disruptiveness? (Check one)

    ☐ Yes   ☐ No   ☐ Uncertain

23. What do you feel would help to reduce or eliminate the disruptive behavior?

_____

_____

_____

Youngstown
STATE UNIVERSITY

December 6, 2010

Ms. Terry Volsko, Principal Investigator
Ms. Amanda Roby, Co-investigator
Department of Health Professions
UNIVERSITY

RE: HSRC Protocol Number: 079-2011
       Title: Disruptive Behavior in the Respiratory Department Workplace

Dear Ms. Volsko and Roby:

The Human Subjects Research Committee has reviewed the abovementioned protocol and determined that it is exempt from full committee review based on a DHHS Category 2 exemption.

Any changes in your research activity should be promptly reported to the Human Subjects Research Committee and may not be initiated without HSRC approval except where necessary to eliminate hazard to human subjects. Any unanticipated problems involving risks to subjects should also be promptly reported to the Human Subjects Research Committee.

The HSRC would like to extend its best wishes to you in the conduct of this study.

Sincerely,

Peter J. Kasvinsky
Dean, School of Graduate Studies and Research
Research Compliance Officer

PJK/cc

c: Mr. Joseph Mistovich, Chair
      Department of Health Professions

www.ysu.edu YSU

APPENDIX C
Informed Consent

Youngstown State University
Human Subjects Research Committee
Informed Consent

Dear Respiratory Care Practitioner:

We are conducting a study to determine if disruptive behavior exists in the respiratory care work environments. The definition of disruptive behavior can be formed to include the fact that disruptive behavior can be physical, verbal, psychological or sexual. The Joint Commission states that: intimidating and disruptive behavior includes overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. In this study you will be asked to complete a short survey at https://www.surveymonkey.com/s/WG9KQR9. Your participation should take approximately 10-15 minutes. There are no risks to you.

The survey is anonymous and all information will be handled in a strictly confidential manner. No identifying information will be collected, so that no one will be able to identify you when the results are recorded and/or reported in the abstract submitted for publication and presentation at the AARC International Congress.

Your participation in this study is voluntary and you may withdraw at any time without negative consequences. If you wish to withdraw at anytime during the study or have any questions concerning the study simply call:

Mrs. Terry Volsko, MHHS, RRT, FAARC, Principal Investigator
Director of Respiratory Care and Polysomnography Program Youngstown State University
330-941-2009
tavolsko@ysu.edu
Mrs. Amanda Roby, BS, RRT, RPSGT, Co-investigator

alroby@ysu.edu
Dr. Edward Orona, Director of Grants and Sponsored Programs
Youngstown State University
330-941-2377
eorona@ysu.edu

I understand the study described above and have been given a copy of the description as outlined above. I am 18 years of age or older and I agree to participate.