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Prevention and Alleviation of Patient Emotional Harm

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Prevention and Alleviation of Patient Emotional Harm

by

Yolanda S. Neal, MSN, RN

A capstone project submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the degree of
Doctor of Nursing Practice

Boiling Springs, NC

2019

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Abstract

The healthcare encounter is a setting in which a patient experience or customer service concern can occur. Patients who experience disrespect in this encounter may be less likely to use health care services that improve health outcomes. Emotional harm has been defined as, "something that affects a patient's dignity by the failure to demonstrate adequate respect for the patient as a person. Emotional harm leaves the patient feeling violated, damages the patient-provider relationship and erodes trust", (Sokol-Hessner, Folcarelli, & Sands, 2015, p. 551). Kaplan (2015) suggested that emotional harms experienced by patients can erode trust and damage patient-provider relationships. Such injuries can be severe and long lasting, with adverse effects on the impacted parties' physical health. Failure to acknowledge and systematically address these harms ensure that they continue to occur within the healthcare system (Kaplan, 2015). While emotional harm is a new concept in healthcare, it likely has been experienced by patients, perpetrated by providers, and not recognized or addressed by healthcare organizations. Many healthcare providers are unaware that their actions or inactions can have lasting emotional effects on the patients they serve. The Disrespect as Harm Taskforce was created at the Medical Center to define the concept so that providers might recognize and prevent experiences leading to emotional harm and/or adequately address incidents of emotional harm to assure better patient outcomes. The goal of this DNP project was to develop a policy to prevent and alleviate emotional harm across the Medical Center.

Keywords: emotional harm, disrespect, dignity, patient experience

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To my DNP cohort, we started this process as strangers however leave as sisters. The laughter, tears, text, and prayers made this journey manageable. Judy King, you were charged to put up with me on two fronts. Thank you!

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Blessed is she who has believed that the Lord would fulfill his promises to her! Luke 1:45 NIV

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SECTION I

Problem Identification

Problem Recognition and Significance

Clinical Scenario

An experienced physician walked into a hospital room occupied by two middle aged women. The patient in bed one was admitted with chest pain. The patient in bed two was admitted with intractable nausea and weight loss. The physician sat at the end of the first bed. He introduced himself and began discussing the findings of some diagnostic tests. He informed the patient that she had an incurable cancer. The bedside nurse saw the physician leaving the room and checked to see if her patients had any needs. The patient in bed one was visibly upset and told the nurse that she thought that she was having heart problems but was just told that she was dying of cancer. The nurse noted that the patient complained of increased chest fullness. The nurse quickly realized that the physician delivered the diagnosis to the wrong patient! The nurse provided comfort to the patient and contacted the physician to make him aware of the error. The physician returned to the floor and spoke to the patient in bed two, however offered no apologies for the error to the patient in bed one.

Defining Emotional Harm

The healthcare encounter is a setting in which a patient experience or customer service concern can occur. Patients who experience disrespect in this encounter may be less likely to use health care services that improve health outcomes. Emotional harm has been defined as, "something that affects a patient's dignity by the failure to demonstrate adequate respect for the patient as a person. Emotional harm leaves the patient feeling

violated, damages the patient-provider relationship and erodes trust", (Sokol-Hessner et al., 2015, p. 551). A workgroup at Beth Israel Deaconess Medical Center (BIDMC) in Boston, Massachusetts, has taken on the issue of how emotional harms impact patients. Emotional and psychological harms related to adverse events and medical errors are common, significant to patients and families, and are sometimes experienced as severe harm (Bell et al., 2018). Patients who are harmed, including those who are seriously injured or lost a loved one, describe neglect, isolation, fear, anger and despair among other emotions, many of which are heightened by organizational silence and withholding of information (Bell et al., 2018). Iedema and Angell (2015) determined that when patients and family members experience concerns about their care, they want to be able to discuss those experiences with clinicians. Impacted patients desire explanations from professionals and dialogue about what happened, including the tensions, uncertainties, and contradictions in care that they experienced (Iedema and Angell, 2015). Kaplan (2015) suggested that emotional harms experienced by patients can erode trust and damage patient-provider relationships. Such injuries can be severe and long lasting, with adverse effects on the impacted parties' physical health. Failure to acknowledge and systematically address these harms ensure that they continue to occur within the healthcare system (Kaplan, 2015).

The Medical Center has developed a workgroup to define and establish protocols to address the issue of emotional harm within the organization. A Disrespect as Harm Taskforce has been established and meets regularly to address the issue. The focus of the taskforce is to create a mechanism by which emotional harms occurring across the Medical Center can be identified and categorized. This author is an active member of the

taskforce. For the final DNP project, this author, will create a policy to address emotional harm at the Medical Center.

Concept Analysis

Respect is a concept inherent to the profession of nursing. For the profession, respect as an entity is described in the American Nurses Association (ANA) practice standards (ANA, 2015a), and in the disciplinary content of many nursing education programs. Respect is a phenomenon that surfaces in nursing science, paradigms, and theories. Respect is also a central principle in other fields of study, professions, and disciplines other than nursing including psychology, medicine, human rights, and bioethics (Rewakowski, 2018). While the concept of respect is widely applied to various disciplines and professional groups, the perception of respect or its antithesis disrespect can be very subjective. Disrespectful behavior impacts communication and collaboration among team members, creates an unhealthy or hostile work environment, and ultimately can place patients in harm's way (Grissinger, 2017). Disrespectful behavior has been shown to impact patient's confidence, making them less likely to ask questions or provide important information (Grissinger, 2017). Disrespect can be harmful to patients and depending on the situation can cause prolonged emotional harm.

Defining Attributes

In the review of the literature for this project, this author discovered several definitions or interpretations of the terms respect, disrespect, and emotional harm. Merriam-Webster (2018) categorizes respect as a noun and a verb. Respect as a verb is defined as, "an action of giving particular attention" (Merriam-Webster, 2018). Respect as a noun is defined as, "a feeling of worthiness, high regard or esteem" (Merriam-

Webster, 2018). Rewakowski (2018) proposes that "respect honors inherent worth in the way that respect is felt and shown toward others simply because they are human beings" (Rewakowski, 2018, p. 190). The American Nurses Association (ANA) Code of Ethics (2015b), holds respect as a central principle and commands nurses to practice with "compassion and respect for the inherent dignity, worth, unique attributes, and human rights of all individuals" (ANA, 2015b, p. 17). Dr. Rosemarie Rizzo Parse (2010) postulates that respect is reverent recognition or acknowledgment of a presence, and recognition of human presence occurs by acknowledging uniqueness of others (Parse, 2010, p. 193). Law et al. (2019) defines respect as "the sum of actions we take to protect, preserve and enhance the dignity of our patients" (p. 276).

Merriam-Webster (2018) categorizes disrespect as a noun and a verb. Disrespect as a noun is defined as "low regard or esteem for someone, lack of respect" (Merriam-Webster, 2018). Disrespect as a verb is defined as "to lack special regard or respect for, to show or express contempt for" (Merriam-Webster, 2018). Parse (2010) suggested that disrespect is "hostile, belittling, and rude comments and actions" (p. 193) that are often used between and amongst nursing staff and other healthcare professionals. Parse identified disrespect as a "precursor to incivility" (Parse, 2010, p. 193).

Landers, Servilio, Alter, and Hayden (2011) observed that disrespect is an ambiguous term that has been shown to be predictive of emotional exhaustion and burnout. "The definition for disrespect may be becoming an all-encompassing descriptor for challenging behavior and, therefore, difficult to operationally define" (Landers et al., 2011, p. 14).

Grissinger (2017) suggested that disrespect causes the recipient to "experience fear, anger, shame, confusion, uncertainty, isolation, self-doubt, depression, and a whole host of physical ailments such as insomnia, fatigue, nausea, and hypertension" (Grissinger, 2017, p. 74). Understanding what makes patients from different backgrounds feel respected and disrespected, from the perspective of patients themselves, is vital to delivering health care that is truly patient centered (Beach, Branyon, & Saha, 2017).

When patients feel disrespected in the healthcare environment, non-physical harm can occur (Grissinger, 2017). The concept of emotional harm has been addressed in different disciplines, including law, child psychology, mental health, education, and healthcare. Emotional harm in healthcare has been defined as "harms to a patient's dignity caused by failure to demonstrate adequate respect for the patient as a person, which leaves the patient's feelings violated, damages the patient-provider relationship, and erodes trust" (Sokol-Hessner et al., 2015, p. 550). Stafford, Alexander, and Frye (2015) addressed emotional harm found in adolescent sports and adopted Scotland's national child protection guidance which states that emotional harm is "the persistent emotional neglect or ill treatment that has severe and persistent adverse effects on a child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may involve the imposition of age or developmentally inappropriate expectations of a child. It may involve causing children to feel frightened or in danger, or exploiting or corrupting children" (Stafford et al., 2015, p. 123). Edmonson and Lei (2014) addressed the concept of emotional harm and conceded that emotional harm in

psychological mental health often "results from a lack of support for engaging in risky interpersonal behaviors such as speaking up or asking for help" (p. 24). Kaplan (2015) defined emotional harm as "something that affects a patient's dignity by the failure to demonstrate adequate respect for the patient as a person" (p. 43).

Concept Definition

One reason that the definition of disrespect is so hard to capture is that disrespect is subjective, generally defined by the person who feels disrespected. Landers (2011) proposed that it is not the behavior that is disrespectful but rather the person's interpretation of that behavior. The behavior does not become disrespectful until the person feels disrespected (Landers, 2011). While certain behaviors can be easily identified as respectful or disrespectful, the individual's perception to the degree of respect or disrespect will vary. Since emotional harm is subjective, measurement tools and systematic methods to track emotional harm experiences need to be developed. Critical defining attributes include lack of respect, hostile or demeaning comments or actions, perceived damage to dignity or self-worth, and adverse feelings or thoughts regarding the healthcare experience. This author defines emotional harm as words, actions, or inactions from others that impact an individual's psyche, whether intentional or unintentional, resulting in a subjective perception of low regard for self, the individuals' care, or the care provider.

Model Case

Lisa is being seen in an outpatient clinic. She has been experiencing complications due to her stage four cancer. Lisa is scheduled to start chemotherapy and needs to complete several diagnostic tests prior to starting treatment. Lisa is optimistic

that she can beat the disease. She prays often and always wears her "blessed" necklace that she obtained during a trip with her mother several years ago to the Holy Land. In previous visits to the clinic, Lisa shared the story of how she obtained the necklace and its significance to her faith and connection to her mother, as her mother died shortly after that trip. While getting prepped for an MRI, Lisa was asked to remove her necklace. After the procedure a transporter arrives to take Lisa back to the clinic. She asks about her necklace and the staff realize that it is missing. Lisa becomes visibly upset and begins to cry (actions from others resulting in an impact to the individuals psyche and results in low regard of self, the individuals care and for the care provider). A different healthcare worker overhears the commotion and comes over to inquire about the situation. This healthcare worker asks Lisa to describe the necklace. Lisa reports that it is a necklace with a cross and with some other descriptors. The healthcare worker states, it sounds like you didn't lose much, they sell those necklaces for cheap at the flea market every day (words, actions, and inactions from others resulting in low regard for care provider and the individuals care). This case demonstrates the elements required to produce emotional harm.

Related Case

Ella is a 22-year-old Registered Nurse and has been seen in the Emergency Room (ER) of a local hospital for a persistent nose bleed. She has attempted to control the bleeding from her nose for several hours at home prior to being instructed by the physician to come into the ER for an evaluation. Ella is currently employed at the hospital however she does not have on scrubs at the time of her evaluation. The triage nurse enters Ella's room and asks, "how long have you been snorting cocaine" (words

unintentionally resulting in low regard for the care provided) Ella is taken aback by this situation as this question was unprompted and biased, in her opinion. Upon additional reflections, on the nursing judgement Ella realizes that the question might have been appropriate however the nurse could have delivered it differently.

Borderline Case

Courtney is a new nurse assigned to work on a labor and delivery unit. Courtney is assisting a 19-year-old woman through childbirth. The birthing process has progressed uneventfully and the time to deliver the baby is approaching slowly. The mother is uncomfortable and expresses her discomfort by screaming loudly. Courtney has attempted to calm the mother to no avail. Courtney contacts the MD to update on the patient's status and no new orders were provided. Courtney goes into the patient's room to explain the provider's response and the patient becomes upset and begins to berate Courtney. Courtney responds that, "The time for you to be upset and yelling is before you got knocked up. Now that you are about to be a mother, I need for you to calm down." (Words or actions that impact an individual's psyche).

Contrary Case

Sam is a staff nurse on an oncology unit. Sam is working her third 12-hour shift in a row. Sam often stops by the patient's room to reassess and provide emotional support. Several family members have submitted comments regarding how well they are cared for by Sam. Sam is described as patient, respectful, a patient advocate, and as an angel. Sam regularly provides patient teaching and emotional support to her patients and their families. Her coworkers describe her as a patient advocate. Sam received the employee of the month recognition for providing outstanding care to her patients. This case

demonstrates respect for the patients thereby eliminating the risks of a patient experiencing emotional harm (no presence of words, actions or inactions from others that impact an individual's psyche, whether intentional or unintentional, resulting in a subjective perception of low regard for self, the individuals' care, or the care provider).

Antecedents

The literature illustrates a few concepts that must be in place prior to the occurrence of emotional harm. Sokol-Hessner et al. (2015) identifies the following case, "A patient dies in the hospital and the next day the funeral home collects a body from the hospital morgue. After embalming the body, the funeral home is notified by the hospital that they were given the wrong body. Because of this error, it may not be possible to process the correct body in time for the wake the following day" (p. 550). Emotional harms can be conceptualized as harms to a patient's dignity which can be caused by a failure to demonstrate adequate respect for the patient as a person (Sokol-Hessner et al., 2015). The specific actions that constitute emotional harm may vary depending on the context of care. Patients and families may experience non-physical harm from interactions with the healthcare system, including emotional, psychological, socio-behavioral, or financial harm, some of which may be related to experiences of disrespect (Sokol-Hessner et al., 2018). Bell et al. (2018) postulates that non-physical harm may be perceived as subjective and prohibitively complex, bad experiences in healthcare may be attributed to patient factors or to isolated "bad professionals" rather than to a system failure, and targets for improvement may not be identified (p.2). Disrespect itself has been described as intrinsically wrong and harmful, several connections with secondary

harms have been described, including negative psychological and behavioral effects (Bell et al., 2018).

Professional burnout is considered a factor in the provision of quality of care. Professional burnout is characterized by high levels of emotional exhaustion, cynical attitudes and a diminished sense of personal accomplishment at work (Salyers et al., 2016). Contributing factors that precede the occurrence for disrespectful behavior included patient related and professional related factors, the environment of work and care, leadership, policies, processes and culture. Patient related factors were not causative of disrespectful behaviors but were associated with a higher likelihood of disrespect and included their illnesses and conditions, demographics, socioeconomic status and primary language (Sokol-Hessner et al., 2018).

One source of potential emotional harm for patients and families may be care they perceive as inadequately respectful, thereby violating the patient's dignity. Respect has been previously defined as the sum of actions we take to protect, preserve, and enhance the dignity of our patients (Law et al., 2019). Law et al. (2019) argued that disrespectful care, even when it does not lead to measurable psychologic distress, is intrinsically both a harm and a wrong. Disrespectful behavior can arise in any health care setting, and both the stressful nature of the environment and human nature play roles in this non-therapeutic behavior (Grissinger, 2017). Due to the subjectivity of emotional harm it is often the result of multiple failures. Contributing factors could include the healthcare providers' knowledge, skill and attitude, and the work environment, information technology systems and the communication between the care team (Sokol-Hessner et al.,

2015). The individuals' level of stress, perceptions and expectations as well as professional burnout must also be considered.

Consequences of Emotional Harm

According to Kaplan, "Emotional harms can erode trust, leave patients feeling violated and damage patient-provider relationships. Such injuries can be severe and long lasting, with adverse effects on physical health. Failure to acknowledge and systematically address these harms ensures that they continue" (Kaplan, 2015, p. 45). Emotional harm can have long lasting impacts on a patient's self-esteem, psyche, and overall perceived quality of life.

Empirical Referents

Empirical referents are measurable factors related to the concept. Databases of patient-generated and family-generated feedback, complaints and grievances, as well as adverse event reports from providers, are available in all hospitals in the United States and can be used to capture reports of emotional harm. However, these data likely significantly under-represent the total burden of emotional harm. Because of the historical neglect of these harms, there has been limited awareness or expectation of emotional harm as an experience. Consequently, few providers currently report these types of events, and furthermore, as with physical harms, many patients and families may be hesitant to report them. Those who are most vulnerable include those who are frail, from socioeconomically disadvantaged groups or have limited English proficiency (Sokol-Hessner et al., 2015). Currently there are no published tools available to validate or measure emotional harm. There are several tools available to measure incivility, such as the Organization Civility Scale (OCS) developed by Clark, Landrum, and Nguyen

(2013). The OCS measures the extent to which incivility is perceived to be a problem in a variety of health care and business settings, to identify the factors which contribute to it, and to generate solutions (Clark et al., 2013). Emotional harm can take a variety of forms. The OCS alone would not adequately identify and categorize emotional harms experienced by patients, their families or care providers.

Summary

While emotional harm is a new concept in healthcare, it likely has been experienced by patients, perpetrated by providers, and not recognized or addressed by healthcare organizations. Many healthcare providers are unaware that their actions or inactions can have lasting emotional effects on the patients they serve. The concept of disrespect as causing emotional harm was first introduced by Beth Israel Deaconess Medical Center (BIDMC) in 2015 (Sokol-Hessner et al., 2015). BIDMC currently is the leader in this initiative and additional research and best practices surrounding this topic are limited. Researchers have developed a practical, improvement-oriented framework to recognize, describe, and prevent emotional harms associated with disrespect (Sokol-Hessner et al., 2018). Sokol-Hessner et al. (2018) reported that several contributing factors are antecedents for emotional harm and include both patient related and professional related factors. Some of the professional related factors include culture, employee training, burnout, the desire to retain control of situations, and employee prejudice. Patient related factors include illness, demographics, socioeconomic status, and language (Sokol-Hessner et al., 2018). The authors predict that this framework can be used to help organizations better understand emotional harms experienced by patients and broad enough that the concepts can be integrated into existing operational systems within

organizations. Bell et al. (2018), identifies 20 steps that organizations can take now to prevent a research lag and initiate the discussion around emotional harm in their organizations. This author will use these existing frameworks as a template to develop an original policy for the Medical Center.

SECTION II

Needs Assessment

Target Population

The target population for this project are the clients at a large academic health center in the southeast United States. The Medical Center is one of three hospitals within the academic medical center. In response to a national concern for healthcare experiences resulting in emotional harm, the creation of a new policy based on current best practices will build the foundation for improving caregiver behaviors, protecting patients from the effects of emotional harm, and fostering a therapeutic environment of non-maleficence. The goal of this initiative promotes awareness and elevates the standard of care. The policy would be presented at the Medical Center for feedback from hospital based ad hoc committees prior to ultimate approval from hospital administration.

Sponsors and Stakeholders

A Disrespect as Harm Taskforce was established in March 2018 with the purpose of looking deeper into the patient engagement experiences. The Patient Safety Officer for the Medical Center attended the Institute for Healthcare Improvement (IHI) conference in December 2017 and presented the idea of the concept to the leadership team. The leadership team consists of the President, Chief Nursing Officer, Nursing Directors, Chief Financial Officer, Human Resources, Director of Building Management, and Patient Relations. The Patient Care Advocates (PCAs) from each unit were self-selected to participate on the Disrespect as Harm Taskforce. The PCAs are administrative staff and serve as guest services representatives. They work with consumers within the organization that might experience service concerns or failures. Additional Taskforce

members were self-selected based on their roles in Risk Management, Patient Care Services, or Patient Relation departments. The members of the Taskforce are interdisciplinary however all job responsibilities are related to patient care or patient experience.

Members of the leadership team do not hear the stories behind the data, conversely, they may have little emotional buy-in to identify opportunities for improvement. The Disrespect as Harm Taskforce was established at the organization to identify and address the issue of emotional harm. Sponsors of this DNP project include the members of this Taskforce as well as key leaders within the organization. Stakeholders of this project include patients, caregivers, employees, community members, and health system leadership. The concept of emotional harm is broad and has the possibility of impacting many within the community. Due to the overarching possibility of impact, the stakeholders of this project will be multifaceted, across community and healthcare settings. Internal stakeholders would include patients, employees, and leadership. External stakeholders would include the community.

Organizational Assessment

The Medical Centers' core values are Excellence, Innovation, Integrity, Teamwork and Respect. The Medical Center promotes that respect should be provided internally and externally to all consumers and care providers. The Organizational focus for 2018 was harm reduction. Harm reduction focuses on prevention of harms to include hospital-acquired infections, a wrong-site procedure, a fall or even delay in care. In addition, zero harm also impacts care providers with such harms as from needle sticks or sprains to symptoms of burnout. The Medical Center's goal for 2019 was zero harm.

Given the core values and the organizational focus, leadership was committed to explore how to classify, prevent, and alleviate disrespectful behaviors that might cause emotional harm.

Influencing the project may be the overall perception of burnout experienced by employees. Professional Burnout is a syndrome characterized by exhaustion, cynicism, and reduced effectiveness (Shanafelt & Noseworthy, 2017). Factors such as burnout might contribute to the overall disrespect experienced by the patients being served. Schwartz et al. (2019) conducted a cross sectional study to examine burnout and work/life balance, using electronic survey data collected from 10,627 healthcare workers across 440 work settings within seven large academic health systems on the east coast of the United States. The researchers concluded that healthcare is at a tipping point as professional burnout and dissatisfaction with work/life balance worsens (Schwartz et al., 2019). Improving healthcare workers' quality of life may improve organizational outcomes and ultimately the quality of care provided to patients (Schwartz et al., 2019).

A SWOT analysis was done to assess the Medical Center's readiness to successfully prevent and alleviate emotional harm (see Figure 1). Strengths include the formation of the Disrespect as Harm Taskforce, financial resources for new initiatives, Zero Harm introduced as part of the 2019 strategic plan, and perceived motivation from stakeholders and leaders within the Medical Center. Emotional harm complements The Joint Commission's interest in documenting emotional harms occurring within health systems as a critical event. The Medical Center leadership desires to be proactive in this potential reclassification of harms by The Joint Commission.

SWOT Analysis

Strengths	Weaknesses
-Formation of a Disrespect as Harm Task force -Financial resources to explore emotional harm - Zero Harms identified as focus for 2019 -Motivation of stakeholders and system leaders.	-No classification system for disrespectful behaviors that might produce emotional harm. -Lack of customer service training for healthcare providers -High burnout rate reported by staff
Opportunities	**Threats**
-Joint Commission's consideration of making emotional harm a critical event -BIDMC is the leader in this initiative, providing best evidence for others to use.	-There are no validated tools to measure emotional harm.

Figure 1. SWOT analysis

Current Complaint Process

The structure for managing patient complaints at the Medical Center is organized through the Patient and Visitor Relations Departments and supported by PCAs. As complaints are identified, PCAs manage the complaint actively, recording the issue and resolution in the Feedback module of the computer system. These complaints are categorized in a traditional manner, using common groupings such as communication failures or delays in care. There is currently no severity rating, other than differentiating between a grievance and complaint, based on Medicare Guidelines. Lack of dignity and respect, the emotional harms that patients and families might actually experience are not linked to the complaint. Management and reporting of aggregate complaint data is not structured to result in systematic improvement activities.

Resources

The development and initiation of a new policy required a limited amount of resources within the health system. The health system administratively approved the development of the Disrespect as Harm Taskforce. The Taskforce includes members from across the organization and meets the third Friday of each month. The initial introduction of the concept was presented at a Health Quality and Safety conference in March 2019. No additional office space, survey cost, marketing materials, or other resources were needed by this author. Labor costs for Taskforce members were covered in current FTE and salary.

Outcomes

The Disrespect as Harm Taskforce is creating a tool for the identification patient complaints that might illicit a level of emotional harm. In response to a national concern for healthcare experiences resulting in emotional harm, the creation of a new policy based on current best practices will build the foundation for improved caregiver behaviors, protect patients from the effects of emotional harm, and foster a therapeutic environment of non-maleficence. The goal of this policy is to promote awareness and elevate the standard of care in the organization.

Team Selection

There were three members on the project team. Dr. Deborah "Hutch" Allen was designated as a DNP practice partner. Dr. Allen was the Director of Nursing Research & Evidence Based Practice in the organization. Dr. Victoria Orto was a committee member and serves as the Chief Nursing Officer. Judy Milne was a committee member and served

as the Patient Safety Officer. All DNP team members were also a part of the Disrespect as Harm Taskforce and committed to the implementation of this concept.

Cost/Benefit Analysis

The Health System posted almost 69,000 inpatient stays and nearly 2.3 million outpatient visits in fiscal year 2018. Of the number of documented complaints and grievances, 70% of respondents expressed concerns regarding issues around communication, care/treatment, and attitude/courtesy. Due to the large number of patients receiving care daily at the medical center, as well as documented concerns regarding communication, care/treatment, and attitude/courtesy, it is likely that some patients might have experienced emotional harm. While there are no additional costs to implementing this project, there are significant potential benefits to the health of the Medical Center and the well-being of the patients served. In addition to an improvement in the overall care outcomes, the health system will likely retain active patients, have positive patient experience surveys, reduce incidents requiring compensation, and improve its reputation in the community.

Mission Statement

To create an environment that promotes respect and dignity for all patients, families, and employees.

Goals

1. Promote awareness of emotional harm and elevate the standard of patient care

2. Recognize that emotional harm can negatively impact patient outcomes.

3. Organizational assessment, collaboration with stakeholders, and implementation of best practice evidence regarding the prevention and alleviation of emotional harm.

Outcomes

The outcomes of this project include:

1. Development of a policy designed to prevent and alleviate emotional harm.

2. Inter-professional feedback on the policy.

3. Implementation of a concept that will enhance patient care outcomes

SECTION III

Theoretical Framework

Swanson's Theory of Caring

Kristen M. Swanson's Theory of Caring will guide the work on this project. As the cornerstone of nursing, the tenets of caring are described extensively in various publications and across multiple sources, both old and new. One of nursing's earliest grand theorists, Dr. Jean Watson, formalized and presented her own Theory of Transpersonal Caring in 1979 (Watson, 1997). It is an exciting and revolutionary grand theory that has stood the test of time. Dr. Watson's original theory described ten carative factors as a framework for providing structure and order for nursing phenomena. These ten carative factors served as a guide to frame the "Core of Nursing" (Watson, 1997, pg. 50). The Core of nursing refers to those aspects of nursing that actually potentiate therapeutic healing processes and relationships; they affect the one caring and the one being cared for (Watson, 1997, pg. 50).

Kristen Swanson was a student of Dr. Jean Watson. Swanson's Theory of Caring defines caring as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (Swanson, 1993, p. 354). Swanson (1993) defines other as someone whose "personhood nurses attend to, may be individuals or aggregates, i.e. families, groups or societies. Most often other, will be a specified individual or aggregate however it also be a generalized other. Other may include future generations, or social issues such as freedom of speech, human rights, or access to healthcare. Other also incorporates the concept of self as other and refers to nurses promoting care of self and the well-being of all nurses and their nursing" (Swanson, 1993, p. 354).

Swanson's Theory of Caring is a Middle-Range Theory and proposes five categories or processes: knowing, being with, doing for, enabling and maintaining belief (Swanson, 1991).

Knowing is "striving to understand an event as it has meaning in the life of the other and the impact or meaning of that event on the life of the other" (Swanson, 1991, pg. 163). Swanson (1991) proposes that, "When one is operating from a basis of knowing, the care-provider works to avoid a priori assumptions about the meaning of an event, centers on the one cared for; and conducts a thorough, ongoing cue-seeking assessment of the experience of the one cared for. In knowing, the provider should recognize the other as a significant being, engage with the other, and should seek to understand the reality of the person being cared" (Swanson, 1991, p. 163).

The second caring process, being with, is simply being emotionally present to the other. It proposes that ongoing availability, being there, and sharing feelings whether joyful of painful promote caring behaviors. Swanson cautions that presence and caring responsibly be monitored so that the one caring does not ultimately burden the one cared for (1991). In being with, the caregiver is emotionally open to the other's reality and conveys the message to the other that their experiences matter (Swanson, 1991).

In doing for, the caregiver provides care to the other in tasks that he or she would do if it were at all possible. Swanson (1991) states that, "care that is doing for is comforting, anticipatory, protective of the other's needs, and performed competently and skillfully. Dignity of the other must be maintained as care provided can be sensitive to the other (Swanson, 1991, p. 165). Enabling, the fourth process, means "facilitating the other's passage through life transitions and unfamiliar events. An enabling caregiver is

one who uses his or her expert knowledge to the betterment of the other. The purpose of enabling is to facilitate the other's capacity to grow, heal or practice self –care" (Swanson, 1991, p. 164). Enabling involves "providing information and explanations as well as offering emotional support in the form of allowing and validating the other's feelings. Enabling often includes assisting the ones cared for to focus on their concerns, generate alternatives and think through ways to look at or act on a situation" (Swanson, 1991, p. 164).

The final caring process is maintaining belief. In this process the focus is on "sustaining faith in the other's capacity to get through an event or transition and face a future with meaning" (Swanson, 1991, p. 166). Maintaining belief is a part of the nursing profession as nurses seek to assist client to attain, maintain, or regain meaning in their experiences of health and illness. This theoretical component requires the caregiver to regard the other with esteem and believe in that person. The individual caring for the other maintains an aura of hope and presents an optimistic portrayal that is held within realistic boundaries as the care-giver assists the other through the situation at hand (Swanson, 1993). (See Figure 2)

Knowing	Avoiding assumptions Centering on the one cared-for Assessing thoroughly Seeking cues Engaging the self of both
Being with	Being there Conveying ability Sharing feelings Not-burdening
Doing for	Comforting Anticipating Performing competently/ skillfully Protecting Preserving dignity
Enabling	Informing/explaining Supporting/allowing Focusing Generating alternatives/ thinking it through Validating/giving feedback
Maintaining belief	Believing in/ holding in esteem Maintaining a hope-filled attitude Offering realistic optimism "going the distance"

Figure 2. Swanson's Caring Theory with Sub-Dimensions (Swanson, 1991, p. 163).

The Medical Center uses Swanson's Theory of Caring as the corporate nursing

theory. This theory addresses the problem related to the lack of caring involved in

emotional harm as caring behaviors are the foundation of the theory and lack thereof can

produce emotional harm in individuals. Uncaring behaviors have been described by

Marcum (2011) as a "disposition or an attitude of a person who is unwilling, unable, or

incapable of feeling concern or empathy for another" (Marcum, 2011, p. 2).

Halldorsdottir (1996) analyzed caring and uncaring behaviors of healthcare professionals.

She proposes that as a bridge caring connects the healthcare professional and the patient at a fundamentally existential level (Halldorsdottir, 1996). Additionally, uncaring behaviors act as a wall, and symbolize the indifference on the part of the healthcare provider to the patient's needs. This indifference in the literature has been documented to impact patient outcomes and produce harms (Marcum, 2011).

Swanson's Theory of Caring aligns with the project and the mission of the Medical Center as a basis for the development of a policy to address the prevention and alleviation of emotional harm.

SECTION IV

Medical Center's Initiative

The Disrespect as Harm Taskforce was created to define the concept so that providers might recognize and prevent experiences leading to emotional harm and/or adequately address incidents of emotional harm to assure better patient outcomes. Additionally, the Disrespect as Harm Taskforce is developing a tool to identify and categorize emotional harms so that service recovery can be initiated when appropriate. The goal of this DNP project was to develop a policy to prevent and alleviate emotional harm across the Medical Center. This policy will be implemented at the Medical Center so that staff is educated on the concept of emotional harm and how it impacts patient care.

Launching the project, a *New Program to Prevent and Alleviate Emotional Harm in Patients at an Academic Medical Center,* was approved by the Institutional Review Board and presented at the Health Systems' Quality and Safety Conference in March 2019. This 14th annual conference was hosted by the Medical Centers' Center for Healthcare Safety and the Quality & Safety Office. This conference celebrates work in quality improvement, safety, and teamwork across the Medical Center. The purpose of the conference was to provide a forum for all Medical Center employees and affiliates to learn best practices and innovative concepts related to patient safety and quality from national and local content experts. Knowledge sharing of internal performance improvement projects occurred during the poster presentation session. The conference took place at a local convention center and over 1,000 participants attended the sold-out event.

This author presented "*When Disrespect is Harm: Journey to Zero Harm*", along with the Medical Center Patient Safety Officer. This podium presentation opened with three case examples of emotional harm in order to define the concept. Additionally, the author discussed the importance of recognizing emotional harm and the human consequences. A case analysis tool was also presented that the Disrespect as Harm Taskforce had begun to pilot in select areas across the health system. Approximately 75 attendees participated in the concurrent session and were asked to work in groups to complete the case analysis tool using fictional scenarios to determine if they might accurately predict the potential level of harm. The attendees discussed their ideas. The session was well received, with many attendees sharing their personal experiences with healthcare emotional harm. Attendees also expressed gratitude for the knowledge that they received from the session. One person suggested smaller groups and a longer timeframe in which to complete the case analysis activity.

Policy Development

The Research

An extensive search of the literature was conducted using combinations of key words including emotional harm, disrespect, respect, dignity, experiences, interactions, healthcare, and patient care. The author searched CINAHL, PubMed, and ProQuest databases with a search window of the last 20 years. Articles addressing the disrespect of healthcare professionals were excluded. The topic of respect and disrespect in the literature are widely published. The author elected to focus specifically on the topic of emotional harm. While the topic of emotional harm is relatively new, this concept has

been addressed in the literature for many years by various disciplines. Other sources of literature discovered for this topic, expound on the three articles as detailed below.

The phrase emotional harm first appeared in the healthcare literature in 2015 (Sokol-Hessner et al., 2015). The authors outlined their institution's focus on addressing the concept of emotional harm. A multidisciplinary group met regularly over the course of a year and the article describes the members of the group; the organization's definitions for emotional harm, respect and dignity; how the organization conceptualized their work into an existing preventable harm framework; as well the sustainability of the work. This article served as a template for the Medical Center when creating the Disrespect as Harm Taskforce.

As this is a new concept in healthcare, there is limited research specific to the topic of emotional harm available. Search results using the criteria of patient emotional harm and research yielded two studies. Bell et al. (2018) completed a study to establish a multi-stakeholder consensus driven research agenda for better understanding and supporting the emotional impact of harmful events in patients and families (Bell et al., 2018).   The researchers anticipated that defining a research agenda on emotional impacts of harmful events could lead to actionable change that may inform policy, improve communication, accountability, communication & resolution programs, safety programs, and patient & family recovery after medical harm (Bell et al., 2018). A multidisciplinary group of 45 stakeholders and industry leaders were assembled to attend a one-day conference in Boston in September 2016. The leaders represented patients and families, clinicians and clinician researchers, social scientists and legal/policy experts, as well as

foundation leaders. Focus groups were led by designated discussion leaders to identify four research priorities. The priorities included:

1. Establish conceptual framework and patient-centered taxonomy

2. Describe epidemiology of emotional harm

3. Determine how to make emotional harm and long term impacts visible

4. Actionable steps to better support patient and families (Bell et al., 2018).

Bell et al. (2018) highlights several take home messages from their research. While the study focused on the patients injured by medical events, the harm can have more reaching negative impacts on family, social networks, and even community and can last for years. Participants voiced that lack of transparency from the medical community after harmful events should be viewed as a form of disrespect. The tracking of harms on patients are not new for healthcare, existing tools should be leveraged quickly, to more adequately identify and track non-physical harms that are experienced by the patients (Bell et al., 2018). The researchers worked to develop a research agenda for emotional harm and provided 20 ways that healthcare systems could act to address emotional harm in their institutions. Implementation of these strategies might circumvent the research lag and help to decrease the numbers of patient and families who experience adverse events due to their care and treatment (Bell et al., 2018).

The second study, conducted by Goodridge, Martyniuk and Stempien (2018), addressed the risk of emotional harm on older adults receiving care in an emergency department. A qualitative, descriptive design was used on a purposive sample of older adults, recruited from local support groups, community agencies, and retirement homes in Canada. Eligibility criteria was limited to participants age 65 or older, admitted to the

emergency room in an urban area (population of 100, 000 or more) for care with the past two years. A total of 41 individuals met the criteria for the study and 10 focus groups took place. The objectives of the study were to:

1. Identify the health system and provider factors affecting the patient experience for older adults and their caregivers in the emergency room.

2. Describe the strategies used by older adults to negotiate the patient experience in the emergency room.

3. List key recommendations from older adult service users and their caregivers for enhancing the emergency room patient experience (Goodridge et al., 2018).

Findings from this study revealed that "emotional harm, resulting from both organizational and/or provider factors, is often an unintended consequence for older adults seeking care in the emergency room. Factors such as "ageism, perceptions of abandonment, loss of dignity, challenges with communication, failure to accommodate for age-related sensory changes, insensitivity to the unique challenges faced by older adults upon discharge, and an unpleasant physical environment compromised the patient's experiences" (Goodridge et al., 2018, p.4) The authors found that older adults receiving care in the emergency room are at risk for experiencing emotional harm. Health care providers should develop strategies to better support patient and caregivers in this care setting to mitigate the severity of the exposures. In this author's opinion, the size and diversity of the sample limited the study findings.

While researching the topic of emotional harm and in an attempt to determine if a policy exists, this author contacted one of the innovators of this initiative, Dr. Lauge

Sokol-Hessner at BIDMC. Dr. Sokol-Hessner is a physician and the Site Director of the

Harvard Medical School Fellowship in Patient Safety at Beth Israel Deaconess Medical

Center in Boston, Massachusetts. This author emailed Dr. Sokol-Hessner to determine if

his organization developed an emotional harm policy for BIDMC. This author received

the following response from Dr. Sokol-Hessner:

> We don't have a policy specific to this work, but since 2007 our hospital has
>
> publicly stated an (aspirational) goal to eliminate preventable harm, regardless of
>
> whether that harm is physical or "non-physical" (i.e. emotional, psychological,
>
> etc.). Our board of directors and senior leaders were part of this statement and are
>
> regularly engaged around this work and our ongoing opportunities to improve.
>
> We consider it complementary to our mission statement to provide extraordinary
>
> high-quality and well-coordinated care. Humbly, we still have much to do to
>
> make care safer but continue to believe that we are striving towards the right
>
> thing. We're in the middle of research on this topic now, and later this year we
>
> hope to publish more specific guidance on the optimal design of such systems.
>
> Thanks for your message and your interest in this work. It's great to know that
>
> you're wanting to bring it to your organization! (Sokol-Hessner, personal
>
> communication, March 31, 2019).

The Formation of an Emotional Harm Policy

In the development of a policy on emotional harm for the Medical Center, this

author solicited feedback from the Disrespect as Harm Taskforce. When considering staff

acceptance, it was felt that incorporating current procedures, if feasible, would promote

staff buy in. While reviewing the literature and in discussion with other organizations, a

policy specifically addressing the issue of emotional harm did not exist. This author utilized best practices and tenets discussed by Bell et al. (2018) in the formation of an original policy.

Bell et al. (2018) established four research priorities as detailed earlier. Additionally, the researchers provided a list of questions related to the research priorities with the intention of starting dialogue and exploration around this topic within organizations. This author reviewed several of the questions with select members of the Disrespect as Harm Taskforce in an effort to ensure consistency when writing the policy for the Medical Center. Bell et al. (2018) proposed the following questions:

- What mechanisms exist now for surveillance and reporting that we can tap into?

- How do we differentiate the underlying experience of illness from emotional harm?

- What do our stakeholders know or believe about emotional harm?

- What interventions are most effective at raising awareness about this topic?

- Who should be communicating with patient and families after harmful events?

- How do we make sure that best practices are widely shared and implemented? (Bell et al., 2018, p. 430).

Members of the Disrespect as Harm Taskforce articulated that the policy should reflect the desire of the organization to prevent and alleviate emotional harms on the patients and families served. The original policy was reviewed by select members of the Disrespect as Harm Taskforce and this author's practice partner prior to dissemination.

The policy was formally presented on three occasions to staff members participating in hospital-based committee meetings. Participants were provided a copy of the draft policy one week prior to the meeting and asked to provide feedback either orally or via written methods after the presentation. After receiving feedback following the first presentation of the policy, a PowerPoint presentation was developed as feedback suggested that some participants were not familiar with the topic, may not be present during the scheduled meeting, or may elect to view the presentation at a later time and provide feedback. The original policy draft can be seen in Figure 3.

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Title: Emotional Harm

Definitions

-Dignity-"the intrinsic, unconditional value of all persons" (Sokol-Hessner et al., 2015)
-Respect- "the sum of actions that honor or acknowledge a person's dignity", (Sokol-Hessner et al., 2015) Disrespect is an affront to dignity and may cause harm.
-Emotional harm has been defined as, "something that affects a patient's dignity by the failure to demonstrate adequate respect for the patient as a person" (Sokol-Hessner et al., 2015, p. 551).

Policy

Patients may experience emotional affects from the actions or inactions of healthcare providers, staff and learners during the delivery of care. These actions or inactions may be considered disrespectful and could have lasting emotional effects on the patient dignity. Emotional harm may occur when words, actions or inactions from others impact an individual's psyche, whether intentional or unintentional, resulting in a subjective perception of low regard for self, the individual's care, or the care provider. It is a core value of DUHS that all patients be treated with courtesy, dignity and respect.

1. Patients and their loved ones have the right and ability to report instances in which they feel they have been emotionally harmed by contacting a Patient Care Advocate (PCA) or calling the Patient and Visitor Relations department at (***)-***-****.
2. The PCA or designee will complete the Disrespect as Harm Case Analysis. The case analysis will be reviewed by the Patient and Family Advisory Council (PFAC). Cases deemed to need more immediate intervention will be forwarded to the Director of Guest and Community Engagement.
3. The Director of Guest and Community Engagement will consult leadership and management as needed.
4. We desire to provide appropriate response, emotional care and support to individuals experiencing emotionally harmful events.

</div>

Figure 3. Original Draft of Emotional Harm Policy

Feedback

A total of 19 staff members provided written feedback. Feedback was also received orally from several staff members after the presentation. As this author was not familiar with all the attendees present during the sessions, an accurate tally of feedback received per discipline and work responsibility is not available. Additionally, several comments received were editorial suggestions to the policy. Additional comments are detailed below:

- "How will patients learn about this right? Will this be something added into the registration statement/process when patients come in to the hospital? I mean we already tell them they have the right to file a complaint, will this be viewed as the same thing?"

- "I really like this policy. My only question is that it addresses harm that has occurred, what about prevention? How can we develop competencies for the staff so that they are aware that this policy is in place?"

- "What if a nurse, CNA or provider felt a patient had been harmed? What course of action would they need to follow? This policy clearly states if a patient or family member is concerned what the plan is. I may be missing the boat on this, for example, a nurse that witnesses/ is concerned about something, do they complete an incident report or what do they do? Not every patient that we care for has family support, so then what?"

- "I like the topic and it is sad that we have to have a policy and a taskforce for this. That being said, it is an important part of caring for our client's wellbeing

and holding each other accountable. For the future, I wonder what physiologic link to recovery and health can be made to emotional harm."

• "In terms of feedback, consider adding timeframe for review by Patient and Family Advisory Council (PFAC), that 30-day window should be consistent. Also consider in the policy as to whether or not PFAC will determine next steps or will they make recommendations on appropriate follow up? What are some of the appropriate avenues of follow up or recommendations such as formal written apology letters, face to face meetings with the patient, recommended bill waiver etc. Everyone needs to be clear as to who is responsible for this."

• "Should the cases go into the SRS system (system that houses incident reports)? What if anything should the staff document? Who will educate them on this if something is needed?

• "How does this work synergistically with the patient complaint policy?"

• "Could this be applied to lateral violence or incivility? We have a policy for that already."

• "Should this be called 'Patient' Emotional Harm? This can happen to the staff as well, but they are not the focus of this policy it seems."

• "Should there be some means of differentiating negligent infliction of emotional distress versus intentional?

• "I encountered a staff member being disrespectful to a patient/it was right on the line where she got away with it BUT I know in my heart it was wrong- to be honest it troubled me in my spirit after work.

• "This is the first that I have heard of this and I've worked here a number of years. If it is not so wide spread, do we really need another policy?"

• "Is this something that you want to give to PFAC? You do recall that there are community members heavily involved on that council?"

• "My husband had surgery in this hospital twice in 2009. He did not receive good care. They didn't seem to care if he lived or died. He died a few months later. I still think about our experiences at the hospital. That's why I'm here. I want to make sure nobody else has to go through that".

Policy Revision

Feedback was analyzed and reviewed with select members of the Disrespect as Harm Taskforce. In reviewing feedback, the author also considered areas from Bell et al. (2018), 20 things that organizations can do to address emotional harm. The areas the author sought to potentially incorporate in a policy revision included:

- Involve patients/families in research design, solution development, and after-event learning. Ask rather than assume what patients experience, want or can do.

- Leverage existing processes, tools, metrics (such as patient safety triggers, reporting tools) to capture patient/family accounts of what happened, and impacts or long-term consequences of harm.

- Routinely provide story follow-up, highlighting longitudinal aspects of healing after harm, sharing both data and stories with leaders at board and organizational meetings.

- Broaden safety culture beyond prevention of physical harms to include long term/ emotional/ psychosocial harm.

- Incorporate measurement and discussion of emotional h arm into quality improvement processes (e.g. dashboards, root cause analysis, clinician reporting, triggers, and quality assessments).

- Identify harmed patients: Ask about harmful events/emotional impact as part of routine cares (such as during a routine history).

- Add prior adverse event to a patient "problem list" or create an electronic health record flag and support such patients as needed at subsequent visits, perhaps with an assigned advocate.

- Educate clinicians about the short- and long-term emotional impact of harm on patients and families and help clinicians gain comfort with addressing emotion (their own and patient' family's) with communication training.

- Educate patient and family. Develop and distribute broadly public service announcements and an information card or brochure informing patient about what they may expect related to emotional consequences of safety events, particularly after harmful adverse events and medical errors.

- Engage educators to adapt existing clinician communication training to elicit and support patient and family emotional needs to develop and share resources for improved and communication strategies.

- Link clinicians and efforts focused on emotional harm, quality improvement,

  burnout reduction/finding meaning, respect and dignity, and culture change to

  synergize work, conceptual connections and urgency (Bell et al., 2018, p.

  430).

Based on feedback, revisions to the policy included clarifying who would be responsible

for each action, more definitions to clarify terms, and the addition of mandatory

timeframes for follow up. The revisions to the policy were reviewed by select members

of the Disrespect as Harm Taskforce, and the Director of Guest and Community

Relations. The revised policy statement is provided in Figure 4.

EMOTIONAL HARM

Definitions

-Dignity-"the intrinsic, unconditional value of all persons" (Sokol-Hessner et al., 2015)

-Respect- "the sum of actions that honor or acknowledge a person's dignity", (Sokol-   Hessner et al., 2015) Disrespect is an affront to dignity and may cause harm.

-Emotional harm- "something that affects a patient's dignity by the failure to   demonstrate adequate respect for the patient as a person" (Sokol-Hessner et al.,   2015, p. 551).

-Complaint- A concern brought to the attention of an employee while the patient is still   in-house.

-Grievance- A concern brought to the attention of an employee after the patient has been discharged.

Policy

It is a core value of the Medical Center that all patients be treated with courtesy, dignity and respect. Without doing so, patients may experience emotional affects from the actions or inactions of healthcare providers, staff and learners during the delivery of care. These actions or inactions may be considered disrespectful and could have lasting emotional effects on the patient dignity. Emotional harm may occur when words, actions or inactions from others impact an individual's psyche, whether intentional or unintentional, resulting in a perception of low regard for self, the individual's care, or the care provider.

1. _Patients and their loved ones have the right and ability to report instances in which they feel they have been emotionally harmed by contacting a Patient Care Advocate (PCA)._
2. _Patients desiring to file a complaint should contact a patient advocate at (***) ***-****._
3. _If a patient contacts an employee after discharge with a grievance, the employee should contact a PCA immediately for follow-up._
4. _The PCA will complete the Disrespect as Harm Case Analysis._
5. _The Office of Guest and Community Engagement is required to respond in writing within 7 calendar days to the patient or family member with acknowledgement that a grievance is being investigated. Additionally, a resolution must be provided in writing within 30 calendar days._
6. _The case analysis will be reviewed by the Disrespect as Harm Taskforce monthly._
7. _When appropriate, a member from Senior Leadership will review the documented cases for additional interventions._

It is the Medical Centers' desire to provide appropriate response, emotional care and support to individuals that might experience emotionally harmful events.

Figure 4. Revised Draft of Emotional Harm Policy

SECTION V

Sustainability

As this is a new concept in the Medical Center, data regarding the number of

patients that might experience emotional harm has not been tracked using the newly

developed Disrespect as Harm Analysis Tool until January 2019. Due to the limited data

available, the Leadership team felt that a full year of data as well as a feasibility study

was warranted prior to the implementation of an Emotional Harm Policy. Leadership

requested that a plan be developed to provide education to staff regarding the concept of

emotional harm to promote proactive prevention until the data is available and the policy

can be considered for full implementation. This author will continue to work with the

Disrespect as Harm Taskforce and will work to develop an educational initiative on

emotional harm to disseminate to the Medical Center staff. Once sufficient data is

obtained, this author will continue to edit the policy as needed for implementation

throughout the Medical Center.

SECTION VI

Conclusion

An original policy on emotional harm was created based on current processes utilized at the Medical Center and tenets found in the work of Bell et al. (2018). As this is a new concept for many in healthcare, the author regrets that a presentation was not developed and disseminated prior to the formal presentations so that attendees would have the opportunity to ask questions and more fully participate in discussion. The author would recommend the use of focus groups to gather feedback and ensure that multidisciplinary consensus to a policy statement is obtained. The focus group technique would also allow for a more efficient way to obtain and categorize the verbal feedback provided.

The presentation of the policy also initiated the discussion around incivility in the workplace. Specifically, the witnessing at times of uncivil or rude behaviors to patients and their families as perpetrated by staff. The issue of how to track the incident if an employee feels that the co-worker's actions might produce emotional harm and what process should be followed needs to be addressed in the near future. Issues surrounding healthcare worker burnout, resilience, and incivility have been widely addressed in the literature. The policy discussion created dialogue regarding how leaders at the Medical Center might address consumers whose actions produce negative emotional responses in staff members. Staff expressed experiencing negative comments from patients regarding racial, sexual and cultural differences. A culture of respect for patients entails a staff that is respectful of each other as well as the patient. Creating an environment that rigorously

prevents emotional harm among patients can only encourage respect and consideration among staff (Kaplan, 2015).

Ensuring that healthcare workers do not cause preventable harm to patients requires that leaders address emotional harms with the same rigor applied to prevention of physical harms (Sokol-Hessner et al., 2015). While the concept of emotional harm is new in healthcare, patients and their families have and will continue to experience emotional side effects from the actions and/or inactions of the people that they trust to provide their care. Beginning conversations within healthcare organizations regarding the prevention and alleviation of emotional harm will promote additional research and best practices. A collaboration between researchers addressing the issues of staff burnout, resiliency, incivility, and patient experience with in the Medical Center is warranted.

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