Bullying: A Hidden Threat To Patient Safety

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Case Study: Liz’s Story

Liz, an experienced nurse working in hemodialysis, is filling in for the regularly scheduled charge nurse at an incenter dialysis facility. She is found sitting at the desk during the patient change of shift while the patient care technicians are caring for people receiving dialysis treatments. All of sudden, Liz begins speaking very loudly requesting her paper work. She eventually finds the papers on top of a machine and yells, “Who took my papers? I needed these.” Though nobody appears to be paying attention to Liz, you can hear quiet whispers. One technician states, “I try not to schedule myself when I know she will be in charge; she always treats us like we don’t know what we are doing.” Liz often yells and makes inappropriate comments about staff in front of patients. Staff members avoid her so they do not become victims of her rants. Though patient care does not appear to be interrupted, there is palpable tension when Liz is working, and several staff quit soon after being hired. Retention is an issue that leads the manager to often scramble to find adequate staff. Recently, this has been reflected in patient satisfaction scores for the facility.

Introduction

Patient safety is a priority in health care and the responsibility of all healthcare workers (Institute of Medicine [IOM], 2004). The IOM’s landmark report To Err is Human (2000) called attention to the high incidence of medical errors and challenged healthcare organizations to actively reduce errors and improve patient safety. To accomplish this goal, a cultural change needs to occur in which blame is not assigned, but rather, potential latent system issues that could contribute to error are examined. A safety culture is one defined by “the beliefs, attitudes, and values of an organization’s employees regarding the pursuit of safety” (The Joint Commission, 2009) and can influence safety behaviors as well as patient and worker outcomes (Flin, Burns, Mearns, Yule, & Robertson, 2006). One area often overlooked as an influence on safety is the work environment (Porto...
& Lauve, 2006). A high-quality work environment is essential for safety (Lowe, 2008). Factors such as staffing and work design can contribute to how care is delivered (IOM, 2004). Though efforts have been put into training and the redesigning of clinical processes, errors still occur, and consideration must also be given to human interactions, an important but often ignored source of error (Porto & Lauve, 2006).

A healthy work environment is defined as one that is safe, healing, humane, and respectful of all persons and fosters the initiative needed for delivery of quality (American Association of Critical Care Nurses [AACN], 2005). A potential threat to a healthy work environment is the behavior of healthcare workers; aggression and other inappropriate behaviors contribute to the likelihood of making an error, delays in care, conflict, and stress for healthcare workers, and become the root cause for adverse events and near misses (AACN, 2005; Farrell, Bobrowski, & Bobrowski, 2006; Jirapaet, Jirapaet, & Sopajaree, 2006; Rosenstein & O’Daniel, 2008; Veltman, 2007). In 2008, The Joint Commission issued a sentinel event alert concerning behaviors of healthcare workers that were recognized as undermining a culture of safety. This brought to the forefront an issue that has long existed in health care but was often ignored or accepted as part of the culture. By linking the behaviors to safety, the urgency of the problem is recognized, and this is an important first step in addressing the behaviors.

Whether part of a hospital system or a free-standing hemodialysis center, staff members are vulnerable to the same threats to safety that result from inappropriate work behaviors. To attend to this safety concern, it is important to understand what constitutes inappropriate behavior in the workplace, what contributes to and supports the behaviors, and what can be done to curtail them. With this knowledge, the work environment can be enhanced to support a culture of safety.

Bullying in Health Care

In the literature, several terms have been used to identify inappropriate work behaviors. These terms include incivility, bullying, horizontal violence, and mobbing. Though the terms are often used interchangeably, there are some subtle differences in meaning. The word incivility can be used as a general term to describe behaviors that disregard the expected norms in the workplace (Andersson & Pearson, 1999), and is often used in the study of behaviors among faculty and students in an academic setting (Altomiller, 2012; Clark, Olender, Kenski, & Cardoni, 2013; Robertson, 2012). Bullying is defined as “situations where an employee is persistently picked on or humiliated by leaders or fellow co-workers” (Einarsen, Raknes, & Mattheise, 1994, p. 382). Mobbing is a term used in Scandinavian countries (Einarsen et al., 1994) and often refers to situations in which a group of workers harass one person (Leymann, 1990). When behaviors are displayed among workers in the same rank, such as staff nurses, rather than across power gradients, it is referred to as horizontal or lateral violence (Vessey, Demarco, Gaffney, & Budin, 2009).

Behaviors can constitute emotional, verbal, or physical acts, including intimidation, talking behind someone’s back, belittling or criticizing a colleague in front of others, unjustified blame, being treated differently than others, exclusion, social isolation, humiliation, unreasonable demands, verbal abuse, and denied opportunities (Safety & Health Assessment and Research for Prevention [SHARP] Program, 2011; Vessey et al., 2009). Behaviors such as these have been allowed to exist in health care due to fear, lack of confidentiality around reporting, lack of managerial follow-through on complaints, lack of information about where to get help, and the victim’s concern for their job (Barnsteiner & Madigan, 2001; Rosenstein, 2002; Strauss, 2008).

Bullying behaviors can be displayed by any category of healthcare worker, including physician, manager, charge nurse, or staff members. Though physician behaviors have been scrutinized (Rosenstein & O’Daniel, 2008), other healthcare workers, including nurses, are a concern. In one study, 77% of workers reported witnessing inappropriate behaviors in physicians, and 65% identified the same behaviors in nurses (Rosenstein & O’Daniel, 2008). In another study, nurses were recognized as displaying inappropriate behaviors more frequently than physicians (51.9% vs. 49%) (Hader, 2008). The incidence of bullying according to nursing positions varies, with some studies reporting the behaviors more frequently from managers/supervisors (Johnson & Rea, 2000) and some from staff nurses (Vessey et al., 2009). Nurses report that aggression from colleagues is more stressful than aggression from others, such as physicians and patients (Farrell, 1999). Unlicensed assistive personnel have also been implicated as perpetrators (Dumont, Meisinger, Whitacre, & Corbin, 2012). In areas where there are several classifications of employees, such as in dialysis centers, it cannot be assumed that the employee with a higher ranking will be the aggressor; any worker can be a perpetrator of bullying. An experienced technician may demonstrate these behaviors towards a nurse or supervisor, so everyone must be diligent in their awareness of potential behavior issues.

Several studies have explored healthcare workers’ perceptions of a link between inappropriate behaviors and negative patient outcomes. In a survey of 2,095 healthcare providers, intimidation was reported to impact patient care by affecting the way medication orders are clarified (Institute for Safe Medication Practices [ISMP], 2004). In a study of 1,509 healthcare workers, of the 1,487 who responded to a question regarding awareness of potential adverse events resulting from disruptive behaviors, 60% reported they were aware of such events (Rosenstein & O’Daniel, 2005). In a subsequent study of 4,530 healthcare
workers, Rosenstein and O’Daniel (2008) found that “67% of the respondents felt that there was a linkage between disruptive behaviors and adverse events, 71% felt that there was a linkage to medical errors, and 27% felt that there was a linkage to patient mortality. Eighteen percent of the respondents reported that they were aware of a specific adverse event that occurred because of disruptive behavior, 73% of whom felt that the adverse event could have been prevented” (pp. 465-466). In a study of labor and delivery units, 53% of the participants reported that inappropriate behavior contributed to a near miss, and 41.6% stated a specific adverse outcome occurred due to an inappropriate behavior (Veltman, 2007). In addition to threatening the quality of care delivery to patients, inappropriate work behaviors can also impact the worker and the organization. Victims report digestive problems, insomnia, long-term sickness, and greater psychological distress than those not bullied (Ortega, Christensen, Hogh, Rugulies, & Borg, 2011; Rodwell, & Demir, 2012). Bullying has been shown to be negatively correlated with job satisfaction and productivity, and positively correlated with intent to leave, all of which can have fiscal implications for an organization (Berry, Gillespie, Gates, & Schafer, 2012; Hoel & Giga, 2006; Johnson & Rea, 2009).

Origins of Bullying

In order to fully understand bullying and other inappropriate behaviors, it is imperative to explore factors in the work environment that may support and contribute to the perpetuation of the behaviors. The main factor associated with bullying is power, real or perceived. Bullying specifically is concerned with a power differential (Lewis, 2006). Through the development of subgroups and cliques, bullying is hidden (Lewis, 2006). It is also possible that the manager can use bullying as a way to accomplish work (Lewis, 2006). The power struggle can originate from conflicting values at the workplace based on poor organizational conditions (Strandmark, & Hallberg, 2007). Adult bullies are seen to be jealous of those with higher qualifications (Johnson & Rea, 2009). Evaluation of the work environment needs to include managers’ examination of their own behaviors (Johnson & Rea, 2009). In cultures where bullying is supported, the manager may adopt bullying as a management style (Barber, 2012). Managers and charge nurses may use power to intimidate superiors and may turn a blind eye to the behaviors both around them or instigated by them (Dumont et al., 2012). Legitimate organizational processes may be misused to promote bullying, such as change or restructuring, using performance reviews as a way to harm others, and promoting themselves to enhance their private power and career opportunities (Hutchinson, Wilkes, Jackson, & Vickers, 2010).

When inappropriate behaviors occur between colleagues on the same level, behaviors are contributed to a specific power struggle called oppressed group behavior (Roberts, 1983). In these circumstances, oppressed individuals feel devalued, and as a result, have low self-esteem. They become angry and frustrated. They want to act out these frustrations, but cannot do so towards the oppressor, so they act out towards others. The oppression has been said to result from the position of nurses in the hierarchy of the hospital and female gender (Farrell, 2001). This can be extended to include anything that may hold back the ability to practice to the full extent of a position, resulting in feeling powerless to accomplish what needs to be done. Bullying then becomes the means of expression of perceived power.

Work Behaviors in Dialysis Centers

The impact of work relationships has been studied in dialysis environments. It has been found that when nurse-physician relationships and views of co-workers and administration are positive, there is lower job stress, lower emotional exhaustion, and lower depersonalization in nurses (Arikan, Köksal, & Gökçe, 2007). These evaluations are also associated with higher levels of perception of personal success and job satisfaction than those who rate the relationships as moderate or poor (Arikan et al., 2007). A lack of communication between the physician and the nurse can result in stress for the nurse (Dermody & Bennett, 2008), and conflict between nurses and physicians and between nurses results in feelings of anger and frustration (Wellard, 1992). Though there have been reports of poor relationships in dialysis units, there have also been reports of positive relationships (Thomas-Hawkins, Denno, Currier, & Wick, 2003). When asked about areas that can be improved in dialysis practice, staff relations have been identified as an area of concern (Perumal & Sehgal, 2003).

A work issue integral to dialysis centers is staff recognition. Nurses working in dialysis have reported the desire to be heard and recognized for their contributions to patient care (Gardner & Walton, 2011). These nurses reported that their opinions are not valued and said they would like to have a more active role in team-building and creating solutions (Gardner & Walton, 2011). Nurses working in dialysis also report wanting the opportunity to participate in policy decisions or internal governance of units (Thomas-Hawkins et al., 2003). In one study, only half of the nurses surveyed stated they had control over their practice or were supported in introducing new or innovative ideas (Thomas-Hawkins et al., 2003). Many conflicts that arise stem from the lack of power over practice (Wellard, 1992). When nurses feel empowered, there is less report of burnout, which ultimately influences the retention of nurses (O’Brien, 2011). It has been reported that one in three nurses working in dialysis centers experience burnout, and nurses report higher levels of burnout than physicians (Klersey et al, 2007; O’Brien, 2011). The higher level of burnout in nurses may be reflective of the closer intensity and
duration of the relationship with people with chronic disease receiving hemodialysis three times a week (Klersey et al., 2007). Regardless of the healthcare setting, structures and strategies that support empowerment of the nurses need to be in place.

**Healthy Work Environment To Counteract Behaviors**

In order to address inappropriate work behaviors, it is necessary to look for solutions within the work environment. A healthy work environment is one in which quality and safe care is delivered. Six standards have been identified as essential for a healthy work environment: 1) skilled communication, 2) true collaboration, 3) effective decision-making, 4) appropriate staffing levels, 5) meaningful recognition, and 6) authentic leadership (AACN, 2005). Each of these standards can be evaluated in terms of understanding and addressing inappropriate behaviors in healthcare environments, such as dialysis centers.

**Skilled Communication**

Skilled communication is foundational for nurses to exchange information with other healthcare workers and to inform patients of their health status and needs. It is recognized that communication is as important as any clinical skill (AACN, 2005). Communication is especially important when examining workplace behaviors at all levels. Nurses must have an outlet for voicing ideas and concerns related to patient care and delivery. If nurses feel they are being ignored or their concerns are not being taken seriously, it could prevent them from contributing to future discussions, and crucial input will be missed. If safety issues are being raised, it is imperative these are heard and addressed before they threaten patients.

Communication is also a means of providing nurses with the tools needed for patient care. When there is a change in policy or a new initiative to be carried out, the manager needs to inform the staff not only of the change but also the rationale for the change. Without this crucial piece of information, a misunderstanding of the intent may occur, and it may appear as if the staff member is being forced to carry out a task that may add unwarranted stress. This can be interpreted as bullying when in fact there is a legitimate reason for the change.

When bullying occurs, there should be appropriate dialogue between the parties involved. Bullying is likely to result in emotional responses. In such cases, communication may be curtailed, or the bullying may escalate. Conversations regarding disrespect and teamwork have been found to be challenging in health care, and as a result, may not be undertaken (Maxfield, Grenny, McMillan, Patterson, & Switzler, 2005). Education on how to respond to bullying through interventions, such as cognitive rehearsal (Griffin, 2004), offer assistance for starting these conversations.

An important step in tackling inappropriate behaviors such as bullying is to recognize the behaviors (American Nurses Association [ANA], 2012) and the potential detrimental effects on both patients and staff. Though the idea of bullying is not new in health care, it is now being discussed as a potential source of errors. Educating staff on appropriate and inappropriate behaviors and having organizational policies in place to address behaviors are ways of communicating acknowledgement that the behaviors are being taken seriously (The Joint Commission, 2008). This puts staff on alert that the behaviors will not be tolerated. Leaders need to communicate their expectations to all employees.

**True Collaboration**

Health care is provided through interdisciplinary means, and each discipline has an essential role to fulfill. It is important that nurses work collaboratively with other members of the healthcare team. A well-functioning team is essential to meet the needs of the patients. Interdisciplinary collaboration starts with intradisciplinary collaboration. It is essential that nurses support each other in their work. Without this solidarity, nurses will not be well represented when collaborating with other disciplines and staff. This support extends to instances when bullying occurs and the importance of assisting the victim even if it is just by listening to his or her story. Rallying around a victim in solidarity demonstrates a united front against the bully and is a means of taking power away, thus deflating the perceived outcomes from the bullying.

**Effective Decision-Making**

Effective decision-making entails valuing nurses’ partnership in making policy, directing and evaluating clinical care, and leading organizational operations (AACN, 2005). In such a model, everyone shares accountability. In addressing inappropriate work behaviors, decisions need to be made regarding reports of bullying and ways to address it, and it is imperative that all aspects of the situation are studied. In some instances, serious safety breeches are recognized. Without a proper means of communicating such concerns, the concerns are expressed through yelling or other forms of inappropriate behavior, earning the label of bullying. In the initial sentinel event alert issued by The Joint Commission, the term disruptive behavior was used to describe the inappropriate work behaviors. It was then recognized that at times disruption is needed to bring to light issues that could be impeding care, so the term was changed to “behavior or behaviors that threaten a culture of safety” (The Joint Commission, 2011). In light of this, each report of bullying needs to be properly investigated so appropriate decisions are made as to how to address the occurrence. This may involve bringing parties together to investigate circumstances and determine appropriate actions. These can range from work process changes to mentoring and coaching staff regarding behaviors. In some situations, the human resources department may become involved so that the rights of
all are protected in instances where termination is warranted.

**Appropriate Staffing**

Appropriate staffing implies there is an effective match between nurse competencies and patient needs (AACN, 2005). Though nurse-staffing ratios can be a concern in dialysis centers (Perumal & Sehgal, 2003), appropriate staffing can be built upon the use of support services and the inclusion of technology to increase effectiveness of nursing care delivery (AACN, 2005). When there are several categories of staff, it is imperative that the role of each is understood and each is acknowledged as integral to patient care. There is little evidence of what defines appropriate nurse staffing in dialysis centers (Wolfe, 2011). Interestingly, standards for staffing ratios for patient care techni-
cians to patients are prevalent in all states. In any circumstance, the staffing should meet the needs of the patients.

**Meaningful Recognition**

Meaningful recognition brings to light the value each member of the team brings to the work of the organization (AACN, 2005). According to the IOM (2010) report, *The Future of Nursing*, nurses must practice to their full potential to meet their responsibilities. To accomplish this, what they can contribute to patient care through knowledge and skills must be recognized. The dialysis work environment has been reported to be somewhat supportive in terms of nurses fully participating in practice and being valued (Gardener, Thomas-Hawkins, Fogg, & Latham, 2007), but is seen as an area for improvement (Flynn, Thomas-Hawkins, & Clark, 2009). Knowledge and skills can be seen as a source of power, and these provide a portal through which nurses can contribute to patient care. Recognition of these contributions encourages nurses to continue on in their pursuit of the delivery of quality care. In environments where nurses are recognized for their contributions, there is no sense of oppression or being held back, but rather, a sense of empowerment. Self-esteem is built rather than anger and frustration. Similar to hospitals, empowerment structures are important in dialysis centers (O’Brien, 2011). Dialysis can be very task-orient-
tated, so it is important that leaders support staff in all roles by recognizing the need for additional training.

**Authentic Leadership**

It would be difficult to establish and maintain a healthy work environment without the support of the leaders of the organization. Nurse leaders need to fully engage in the pursuit of healthy work environments through their own authenticity and commitment (AACN, 2005). This includes evaluation of leadership styles to assure that bullying or other inappropriate tactics are not being used to accomplish work or personal goals. Authentic leadership to address bullying includes setting standards for expected behaviors and fully investigating complaints of bullying from others. When the leaders do not follow through on complaints, it appears as if the behaviors are not being taken seriously or are being ignored, thus unwillingly allowing the behaviors to continue. When nurse managers demonstrate authentic leadership, lower levels of bullying are reported by newly licensed nurses (Laschinger & Fida, 2013).

It is essential that leaders in an organization demonstrate uniformity in addressing instances of bullying, starting with the investigation of allegations of bullying through carrying out the established policies. Through the use of skilled communication, the action plan can be disseminated though specific details and may be withheld due to confidentiality issues.

**Liz’s Story: Through the Lens Of a Healthy Work Environment**

Though several staff members have complained to the unit manager about Liz’s behavior, nothing appears to be done. The unit manager moves away, and a new manager, Doris, is hired. Upon hearing consistent stories about Liz’s behavior, Doris sets up a meeting with Liz to discuss the staff complaints. When Doris tells Liz how staff feel, Liz is shocked. She had been working at the same center for 20 years, and no one has ever approached her about her behavior before Doris. In fact, she often receives accolades from her patients and is seen as a hemodialysis expert. Upon further discussion, Doris learns that Liz enjoys caring for patients but has received little training in terms of management, though she frequently assumes the charge nurse role. Liz states: “When I am in charge, I have to make sure that everything gets done properly, and the only way that happens is if I show the others who is boss. No one knows how to do anything unless I tell them how.” Doris decides that there is an opportunity for skill building with Liz and arranges for her to attend charge nurse classes offered by the employer. In addition, Doris begins to meet regularly with staff to learn about challenges they face in the work setting. Within a few months, a change is seen in Liz and in the work environment. Staff satisfaction and retention improves. Patients who have been attending the center for a period of time notice a difference in staff demeanor and compliment Doris on the positive change they see in the unit.

**Conclusion**

Patient safety is an integral component of health care. Any possible means of interference to the provision of quality health care needs to be evaluated, and this can include behaviors of the nurses and other healthcare providers. A healthy work environment needs to be created in which nurses are empowered to practice to their full capacity and are acknowledged for their contributions. With these initiatives, there may be fewer power struggles that are demonstrated through inappropriate work behaviors, resulting in safer environments for patients and for nurses in dialysis centers.
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References


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**Bullying: A Hidden Threat to Patient Safety**

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5. I was able to meet the objectives of this educational activity:

   a. Define a healthy work environment. Strongly Disagree 1 2 3 4 5
   b. Discuss specific behaviors that are considered “bullying” behavior. Strongly Disagree 1 2 3 4 5
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