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PATIENT SAFETY NETWORK

How to Identify and Manage Problem Behaviors

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Perspective

The 1999 Institute of Medicine report highlighted the need for health care providers to address the serious concerns raised about the quality and safety of patient care being provided in our health care organizations.(1) Organizations responded by looking at new ways to fix the system, mostly through the introduction of new technologies and system/process redesign. Advances have been made, but there are still significant opportunities for improvement.(2-4) Is the barrier poor system or process design, or is it related to addressing basic human behaviors?

At about the same time of the Institute of Medicine report, we coincidentally began to look at the organizational impact of disruptive physician behaviors. As Medical Directors of VHA West Coast (AHR), one of 16 regional divisions of VHA Inc., a large nationwide health care alliance of more than 1600 not-for-profit hospitals, we query our hospital Medical Directors each year to assess the key concerns and priorities that keep them awake at night. For several years, disruptive physician behavior was flagged as one of the key issues.

Starting in 2001, the Medical Directors began to raise concerns about the nursing shortage and its impact on service delivery. We wondered whether the two phenomena—disruptive physician behavior and the nursing shortage—might be connected. We found very little in the medical literature other than a few passing remarks and anecdotal stories. Seeing an opportunity to contribute to a better understanding of this issue, we then developed our own survey to assess the impact of disruptive physician behavior on nurse satisfaction and morale. Published results confirmed our suspicions: disruptive behaviors occurred all too frequently and had a significant impact on nurse satisfaction, morale, and turnover.(5,6)

As a result of this survey, we learned a lot about the atmosphere and consequences of nurse-physician-staff relationships and proceeded to design phase two. In 2005, we published results on the frequency and severity of disruptive behaviors by physicians, nurses, and other staff and their impact on behavioral factors (stress, concentration, communication, collaboration, information transfer) known to adversely affect patient safety and quality outcomes of care (adverse events, errors, compromises in quality and mortality).(7)

Subsequent studies have looked at the impact of disruptive behaviors in perioperative and neurological services.(8,9) The implications went beyond just disruptive behaviors to the consequences of ineffective communication and collaboration and their effect on information transfer, assumption of and accountability for roles and responsibilities, and the effect on patient care. The Joint Commission states that nearly 70% of adverse sentinel events can be traced back to a failure in communication.(10) While there is a growing body of research that supports the benefits of strong team collaboration and communication and its value in improving patient outcomes of care, it is hard to find any references (beyond our work) on the negative effects of poor communication and collaboration.(11-13)

During the course of our research and experiences gained from over 7000 survey participants from more than 100 hospitals across the country, we began to investigate further what causes these types of behaviors to occur. We certainly agree that improving system design and process flow will enhance patient safety, but our results suggest that if you don't apply the same time and effort to addressing underlying human factor issues, you can only get so far.

Once we defined the extent of the problem and the relationship between disruptive behaviors and both patient safety and nurse recruitment/retention, we turned our attention to what we could do to make things better. Our improvement efforts have been geared toward (i) raising awareness, (ii) gaining cultural and organizational commitment, (iii) developing appropriate policies and procedures, (iv) fostering and supporting project and clinical champions, and (v) providing the necessary education to try to prevent these types of events from occurring.(14) These efforts have given us tremendous insights as to which strategies will and won't work, in a variety of health care organizations.

So what should you do? The first step is to **raise awareness.** One of the best ways to raise awareness is to do an internal assessment. Assessments must be confidential and non-punitive in design, yet be able to get to the heart of the issue by identifying opportunities for improvement and then doing something about it. An example of key questions from an internal assessment is shown in the accompanying document. The **organization needs to be committed** and openly supportive of a positive safety culture and environment. Commitment needs to come both from the top administrative and clinical leadership teams including the governing board, and filter up and down the organization with input, involvement, and support from the frontline clinical and nonclinical staff.

Appropriate **policies and procedures,** including a standardized, consistently applied code of behavior policies, disruptive behavior policies, and incident-reporting policies, need to be in place to outline and reinforce expected behaviors.(15) In return, the organization needs to be ready and willing to take action in situations in which providers do not comply. **Project champions** (clinical or nonclinical) who are respected peers and who are able to drive the process through the organization are often key enablers of success.

Education and training programs should be implemented at several different levels. The first is to raise the level of awareness of the status and significance of working relationships and communication and the role that each of us plays. The rallying point is the positive effect of effective and efficient collaboration and communication on improving patient safety and quality outcomes of care. The second level is to provide more detailed educational seminars and training workshops on such topics as diversity training, assertiveness training, team collaboration, and communication skills using such tools as the SBAR

(situation-background-assessment-recommendation) protocols and crew resource management techniques. In many organizations, specific communication courses offered to employees for whom English is their second language have been extremely beneficial in gaining an understanding of how to better converse and respond to tasks related specifically to the medical environment.

Phase three of our research is focusing on factors that cause bad behaviors to occur. Not surprisingly, we found that there is a multidimensional cause and effect relationship between certain deep-seated values and acute-phase irritants that prompt and influence individuals to behave the way they do.(16) We don't think that any individual intentionally starts out the day wanting to be either disruptive or a barrier to effective communication. So what causes people to behave the way they do? Communication is based on the values, principles, and perceptions gained through one's life experiences. These factors include deep-seated values and beliefs influenced by age and generation, culture and ethnicity, gender, personality traits, medical training, family upbringing and life events, and acute-phase stimulants (current health, stress, emotional factors, etc.) that affect the mood of the day. Having a better understanding and appreciation of these underlying factors will go a long way in improving perceptions and expectations that influence the communication interchange. The goal is to have a better understanding of how and why people react the way they do and, through this understanding, potentially prevent a disruptive event or communication mishap from occurring.

How do you identify and manage disruptive or inappropriate behaviors? In our survey tool, we defined disruptive behavior as "any inappropriate behavior, confrontation, or conflict ranging from verbal abuse to physical or sexual harassment." Criteria for appropriate behavior must be defined in the code of conduct policy. Employees agree to abide by this code of behavior as a prerequisite to employment. Physicians sign a statement of agreement with these policies as part of the credentialing/re-credentialing process. Once inappropriate behavior is identified, it must then be reported to an individual or committee with responsibility for assessing the complaint and taking appropriate action. Confidential reporting and follow-up are crucial steps in the process. Many individuals are reluctant to report events either in fear of retaliation or because they report and report and nothing ever seems to change.

The first step in management is prevention. Many of the educational programs and training sessions mentioned above are designed to improve understanding and responses to prevent the event from occurring. If the event occurs, addressing it in real time is essential to prevent a negative downstream effect. Assertiveness training has been a key asset in this area. Some organizations have implemented a "Code White" policy (similar to a "Code Blue" policy), under which key individuals are alerted to respond in person to help diffuse a charged situation. After the event, the issue must be addressed to prevent it from occurring again. We highly recommend a standardized process in which the organization evaluates and presents the situation to the individual(s) involved to discuss issues, perceptions, and implications of the incident, and to make recommendations for moving forward. In some cases, once such events are brought to the individual's attention, awareness as to perceptions and assumptions about the event lead to a better understanding, which is enough to prevent the event from occurring again. In other cases, individuals will need more intense individualized counseling in areas such as anger management, conflict management, diversity training, or team collaboration. In some cases, particularly with chronic offenders, disciplinary action needs to be taken, sometimes resulting in either termination of employment or suspension of staff

privileges (see Case Study).

Now that we understand the prevalence of disruptive behaviors and their impact on safety and the workforce, we understand that everyone on the health care team needs to take responsibility and accountability for understanding their role, their responsibilities, and their actions during every phase of the health care delivery process. Systems and procedures will improve process design, but human actions and reactions that involve effective communication, collaboration, information transfer, and task fulfillment are crucial aspects of an effective patient safety environment. Gaining a better understanding of human factor issues; providing education and workshops supported by appropriate policies, procedures, and communication tools; and holding individuals accountable for their actions will significantly improve patient safety and clinical outcomes of care.

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Case Study

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One organization was having a particularly difficult time with disruptive behavior in the operating room (OR). Many of the individuals who witnessed the behavior were afraid to speak up because of the prominence of the surgeon or anesthesiologist involved, and when they did informally speak up, there was reluctance on the part of the senior management and clinical leadership to address the issue head on. After one particular disruptive outburst, one of the nurses in the OR raised serious complaints about both staff and patient safety and threatened to quit and sue the hospital and physician for harassment if steps were not taken to address the issue. This was not the only complaint about this particular physician, and there were complaints about other surgeons and anesthesiologists on the staff. The hospital then decided to take a more active stance in addressing the issue. They reinforced compliance with the existing Code of Behavior policy, set up a more formalized structure for complaint review and action, and established a multidisciplinary disruptive behavior committee whose role was to address the more serious disruptive events. The process was instituted hospital-wide and was applicable to all hospital staff and physicians. The scope of the outcome was varied. In some cases, merely discussing the particular event with an individual would raise their awareness of the significance and implications of the event and, after self-recognition and appropriate reflection, nothing more needed to be said. In other cases, the individual involved would be required to take a special class in anger management, conflict management, diversity management, or the like. In a few cases, more intensive individual counseling was recommended. In the more extreme cases, the individual was either terminated or (in the case of physicians) had his or her medical privileges suspended. Termination or suspension is a very serious matter. Organizations need to

be committed to follow the right course of action (by recognizing the ramifications if they choose not to act), be able to document due cause, and make sure that all the review processes and procedures are consistently applied in a unbiased manner.

Sample Assessment Questions

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