Workplace Behaviors Affecting Patient Safety: Role of Nurses and Physicians as Partners in Change

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Workplace Behaviors

- Disruptive Behavior and its Effects on Workplace Safety: What Can Nurse Leaders Do? - Brooks
- Disruptive Behavior Between Physicians and Nurses: The Role of the Physician Leader - Kuroki
- Disruptive Behavior Between Physicians and Nursing: Building the Interdisciplinary Toolkit for Change- Polis

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Objectives

- Discuss the effect of disruptive behavior on patient safety
- Discuss the implications and role of nurses and physician leaders in building and sustaining safety
- Describe selected strategies used to enhance communication, accountability, and teamwork

Why is this topic important?

- Patient safety is a #1 priority in healthcare
- Institute of Medicine (IOM), The Joint Commission (TJC), Agency for Healthcare Research and Quality (AHRQ) have provided us with ongoing data about ways to improve safety
- Leaders and Healthcare organizations can do much more to improve and change the culture

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Background

- 5 hospital healthcare system outside Philadelphia
- Recognized for excellence and innovation- Joint Commission certifications, Magnet Hospital designation for 3 out of 5 hospitals, Beacon Awards for all ICUs etc
- Patient safety is # 1 priority for 10,000 employees and physicians

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Riddle Hospital

- Joined in April 2008 as VP, Patient Care Services
- Interviewed Department Chairs and other hospital leaders
- Perceptions shared were surprising and disappointing related to values, vision and mission
- Several physicians recommended “returning to the old head nurse model”
- Staff nurses were oftentimes characterized as “lacking in communication skills”

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Collaboration

How do we engage physicians and nurses in the work of collaboration?

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Collaboration

- Positive influence on patient outcomes (e.g., mortality, readmissions, length of stay)
- High levels of patient and provider satisfaction
- Transparency in communication and decision-making
- Shift from parallel players to partners
- Fosters innovation and creativity
- Positive work environment and nurse retention
- **Patient safety**

Collaboration

Jefferson Scale of Attitudes Towards Physician-Nurse

Measures the difference in attitude of physicians and nurses toward collaboration

- Clusters of interest on four point scale
  - Nurse autonomy
  - Physician authority
  - Shared education and collaboration
  - Caring versus curing
- Results reported strongly agree and tend to agree

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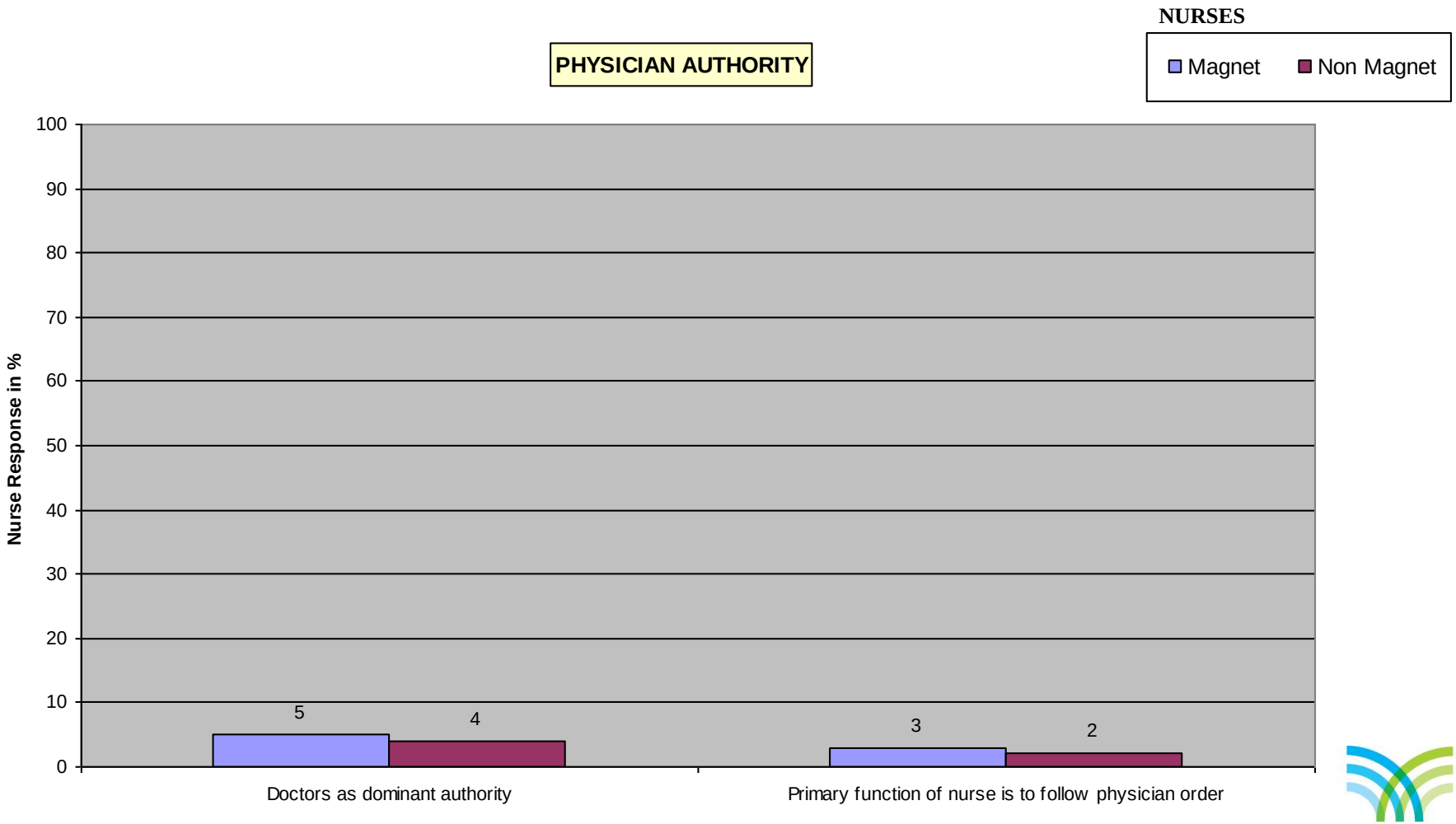
Jefferson Scale of Attitudes



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Collaboration
System Magnet Hospitals

What are the 3 top factors contributing to successful collaboration?

Physicians/Nurses - 100% agreement

- Respect
- Communication
- Listening

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Collaboration
Non-Magnet Hospitals

What are the top three factors contributing to success in system non-Magnet hospitals?

Physicians

- Efficiency
- Communication
- Teamwork

Nurses

- Mutual respect
- Communication
- Teamwork

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Collaborative strategies update

- 2009 Main Line Health Nursing – Partners
- Established Riddle Physician-Nurse Council
- Launched interdisciplinary- Stroke, Chest Pain and Hip and Knee programs
- Collaborated on Magnet Journey
- Updated “Zero tolerance on disruptive behavior” policy
- Developed system-wide Culture of Safety Program – 2010-2011

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Development of Culture of Safety (COS)

- System Culture of Leadership Team
- Local hospital based COS leadership teams
- Physician Leadership Teams
- Taught 300 system leaders – Leader Methods for Reliability and Error Prevention
- Taught 7200 employees in Error Prevention tools
- Physician training – Safety Culture 101

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Strategy for Building a Strong Culture of Safety

What Leaders Do

Set Expectations

Educate & Build Skill

Reinforce & Build Accountability

An accountability system to convert behaviors to work habits

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The Main Line Health Reliability Culture Toolkit for Leaders

Behaviors	Tools
Make Safety a Core Value *We put patient safety first by using our first words for patient safety. We ask the safety question first, and we ensure that good things always happen to those who speak-up for safety.*	1. Start every meeting with a safety / topic or story 2. Recognize & support people who ask the safety question or "stop the line for safety" 3. Transparency in sharing safety events 4. Embed safety in hiring and performance reviews 5. Encourage and reward reporting of safety events – eliminate fear of reporting
Find & Fix System Problems *We improve patient care every day by fixing system problems before they find us. We are sensitive to operations, identify problems that make safe patient care difficult to deliver, and solve the causes of those problems.*	1. Daily Check-In 2. Start the Clock for Safety 3. Brief / Executive / Debrief
Build Accountability *We make reliability a reality by building sound practice habits in our staff. We reinforce sound practice habits, we discipline those who make risky choices, and we never punish those who experience honest mistakes.*	1. 5:1 feedback 2. Rounding To Influence 3. Just Culture 4. Red Rules

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Error Prevention Tools

I Commit to… Our Safety Behaviors	*By Practicing…* Error Prevention Tools
Attention to Detail	• **Self Checking Using STAR** ▪ Stop ▪ Think ▪ Act ▪ Review
Communicate Clearly	• **3-Way Repeat Back & Read Back** • **Phonetic & Numeric Clarifications** • **Clarifying Questions**
Handoff Effectively	• **Use SBAR to handoff:** ▪ Situation ▪ Background ▪ Assessment ▪ Recommendation
Speak up for Safety	• **Question & Confirm** • **Use ARCC to escalate safety concerns** ▪ Ask a Question ▪ Make a Request ▪ Voice a Concern ▪ Use Chain of Command ▪ **Stop the Line, I need clarity**
Got Your Back!	• **Peer Checking** • **Peer Coaching**

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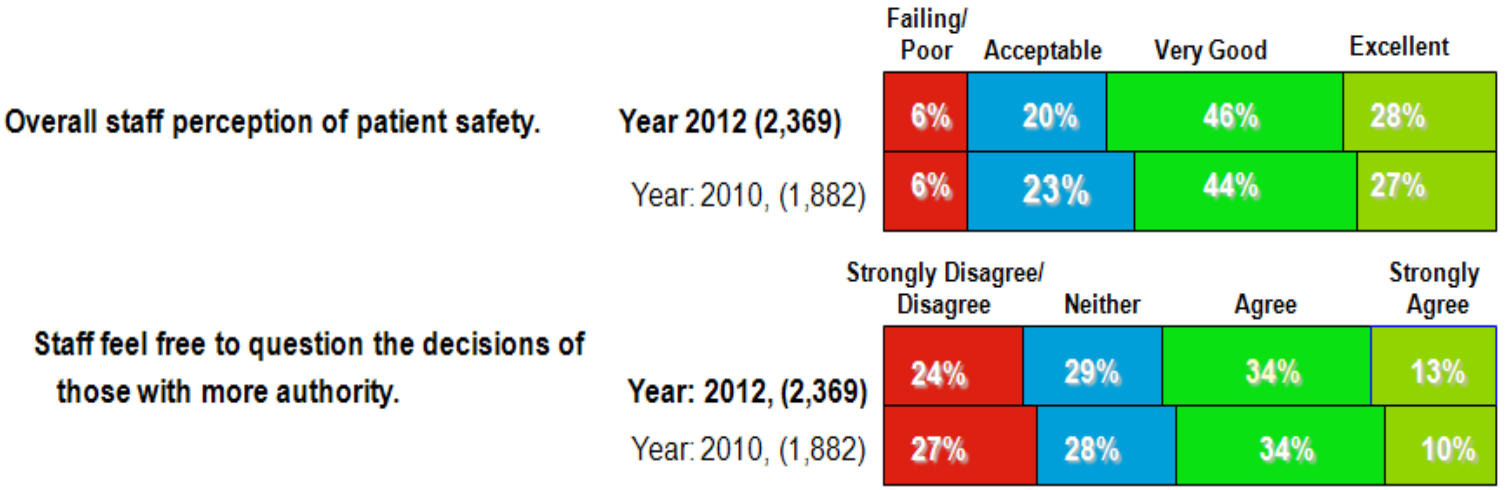
Data Driven

Figure 1 Our System's AHRQ Safety Culture Survey Results 2010 and 2012



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How are we doing?

- VPMA and CNO at Riddle sought data
- Replicated the 2009 Disruptive Physician Nurse Survey conducted by American College of Physician Executives (ACPE)
- Surveyed all physicians and nurses with Institutional Review approval across entire system

Definition

“conduct by staff and physicians working in the organization that intimidates others to the extent that quality and safety could be compromised.”

TJC (2011)

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"Workplace Behaviors Affecting Patient Safety" MLH Survey – March – April 2013

Demographics

1. Are you a nurse or physician? - 2013 MLH		
Answer Options	**Response Percent**	**Response Count**
Direct care nurse	66.9%	524
Indirect care nurse	17.0%	133
Physician employed by MLH	5.4%	42
Independent practitioner	10.7%	84
answered question		783
skipped question		3

1. Are you a nurse or physician? - 2009 ACPE		
Answer Options	**Response Percent**	**Response Count**
Nurse Executive	67.2%	1,428
Physician Executive	32.8%	696
answered question		2,124
skipped question		33

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2. Does your health care organization ever experience behavior problems with doctors and nurses? -				
Answer Options	Response Percent MLH	Response Count MLH	Response Percent ACPE	Response Count ACPE
Yes	89.6%	700	97.4%	2,088
No	10.4%	81	2.6%	55
answered question		781	*Answered question*	2,143
skipped question		5	*Skipped question*	14

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3. Over the last three years, how would you characterize the number of behavior problems between doctors and nurses at your healthcare organization?

Answer Options	Response Percent MLH	Response Count MLH	Response Percent ACPE	Response Count ACPE
More behavior problems between doctors and nurses	10.8%	84	12.0%	213
About the same number of problems between doctors and nurses	48.1%	373	52.3%	927
Less behavior problems between doctors and nurses	41.0%	318	35.7%	633
answered question		775	*answered question*	1,773
skipped question		11	*skipped question*	384

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4. Generally speaking, how often do behavior problems arise between doctors and nurses at your health care organization?

Answer Options	Response Percent MLH	Response Count MLH	Response Percent ACPE	Response
Daily	13.4%	103	9.5%	168
Weekly	24.5%	189	30.0%	530
Monthly	16.2%	125	25.6%	452
Several times a year	29.4%	227	30.9%	547
Once a year	6.4%	49	2.9%	51
Less than once a year	10.1%	78	1.2%	21
answered question		771	*answered question*	1,769
skipped question		15	*skipped question*	388

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5. In the last year, what types of behavior problems have you experienced at your health care organization between doctors and nurses? (Check all that apply)

Answer Options	Response Percent MLH	Response Count MLH
Degrading comments and insults	63.3%	468
Yelling	52.2%	368
Cursing	19.4%	1,493
Inappropriate joking	38.4%	679
Refusing to work together	45.5%	804
	answered question	1,766
	skipped question	391

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6. At your health care organization, who most often exhibits behavior problems? -				
Answer Options	Response Percent MLH	Response Count MLH	Response Percent ACPE	Response Count ACPE
Doctors	46.2%	343	45.4%	691
Nurses	10.6%	79	6.8%	103
A pretty even mix of doctors and nurses	43.2%	321	47.9%	729
answered question		743	*Answered Question*	1,523
skipped question		43	*Skipped question*	634

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7. In the last year at your health care organization, have there been any NURSES terminated due to behavior problems?

Answer Options	Response Percent MLH	Response Count MLH	Response Percent ACPE	Response Count ACPE
Yes	29.8%	218	61.2%	897
No	70.2%	514	38.8%	569
answered question		732	*Answered Question*	1,466
skipped question		54	*Skipped question*	691

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8. In the last year, has your health care organization held any staff training programs to try to reduce behavior problems between doctors and nurses?

Answer Options	Response Percent MLH	Response Count MLH	Response Percent ACPE	Response Count ACPE
Yes	55.9%	424	55.8%	839
No	44.1%	334	44.2%	664
answered question		758	*answered Question*	1,503
skipped question		28	*skipped Question*	654

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Follow-up 2013-2014

- Shared survey findings across the system
- Secured IRB approval for repeat in 2014 of 2013 Disruptive Physician Nurse survey
- Delayed launched because of system/hospital competing survey priorities
- Collected data on purposive sample of Riddle physicians and nurses

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Results

2014	2013
Riddle Nurses – 37 Nurses	MLH Nurses – 657 Nurses
27% Direct Care Nurses	80% Direct Care Nurses
73% Indirect Care Nurses	20% Indirect Care Nurses

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2. Does your health care organization ever experience behavior problems with doctors and nurses?

Answer Options	2014 Response Percent RH	2013 Response Percent MLH
Yes	100%	93.5% Direct care: 90.9% Indirect care: 96.2%
No	0%	6.5% Direct care: 9.1% Indirect care: 3.8%

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3. Over the last three years, how would you characterize the number of behavior problems between doctors and nurses at your health care organization?

Answer Options	2014 Response Percent RH	2013 Response Count MLH
More behavior problems between doctors and nurses	6%	12.2% Direct care: 12.9% Indirect care: 11.5%
About the same number of behavior problems between doctors and nurses	36%	46% Direct care: 50.8% Indirect care: 41.2%
Less behavior problems between doctors and nurses	58%	41.8% Direct care: 36.3% Indirect care: 47.3%

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4. Generally speaking, how often do behavior problems arise between doctors and nurses at your health care organization?

Answer Options	2013 Response Percent RH	2014 Response Count MLH
Daily	6%	14.4% Direct care: 15.0% Indirect care: 13.8%
Weekly	34%	27.75% Direct care: 26.3% Indirect care: 29.2%
Monthly	23%	17% Direct care: 14.8% Indirect care: 19.2%
Several times a year	32%	29% Direct care: 28.1% Indirect care: 30%
Once a year	3%	5.6% Direct care: 5.8% Indirect care: 5.4%
Less than once a year	0%	6.1% Direct care: 9.9% Indirect care: 2.3%

5. In the last year, what types of behavior problems have you encountered at your health care organization between doctors and nurses? (Choose most frequent behavior)

Answer Options	2014 Response Percent RH	2013 Response Count MLH
Degrading comments and insults	49%	66.3% Direct care: 65.3% Indirect care: 67.2%
Yelling	25%	58% Direct care: 51.9% Indirect care: 64.1%
Refusing to work together	17%	81.4% Direct care: 33.3% Indirect care: 48.1%
Cursing	0%	23% Direct care: 18.5% Indirect care: 27.5%
Spreading malicious rumors	0%	4.8% Direct care: 4.9% Indirect care: 4.65
Inappropriate joking	0%	28% Direct care: 29.25 Indirect care: 26.7%
Other	8%	21% Direct care: 17.6% Indirect care: 24.4%

6. At your health care organization, who most often exhibits behavior problems?		
Answer Options	2013 Response Percent RH	2014 Response Count MLH
Doctors	64%	53% Direct care: 48.6% Indirect care: 57.3%
Nurses	3%	6.2% Direct care: 9.3% Indirect care: 3.1%
A pretty even mix of doctors and nurses	33%	40.9% Direct care: 42.1% Indirect care: 39.7%

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10. In your experience, has the Main Line Health (MLH) culture of safety education and error prevention tools reduced the occurrence of disruptive behavior between physicians and nurses at MLH?

Answer Options	Response Percent RH	Response Count RH
Yes	78%	29
No	22%	8

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11. In your opinion, which error prevention tool is the most effective in preventing and/or managing disruptive behavior at MLH?

Answer Options	Response Percent RH	Response Count RH
Attention to Detail – STAR *(Stop, Think, Act, Review)*	8%	3
Communicate Clearly – Ask a clarifying question, Repeat Back	**31%**	**12**
Handoff Effectively – SBAR *(Situation, Background, Assessment, Recommendation)*	**14%**	**5**
Speak up for Safety – ARCC *(Ask a question, Make a Request, Voice a Concern, Chain of Command),* Stop the Line	**33%**	**12**
I've Got Your Back – Peer coaching and Peer checking	5%	2
None of these is very effective	9%	3

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12. What do you believe is the primary reason for disruptive behavior at MLH?

Answer Options	Response Percent RH	Response Count RH
Lack of understanding of the situation	16%	6
Lack of respect for teamwork	20%	7
Lack of time	0%	0
Lack of accountability for behavior	**64%**	**24**
Lack or peer coaching and checking	0%	0
Other	0%	0

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14. Which method addresses what *you* commonly do if you witness a disruptive behavior?

Answer Options	Response Percent RH	Response Count RH
Speak up and offer to help out with problem solving	**74%**	**27**
Offer support to the individual experiencing the disruptive behavior after the episode is over	5%	2
Ask the initiator of the disruptive behavior to discuss the issue with you privately	0%	0
Try not to get involved	14%	5
Call for outside assistance (such as a supervisor or administrator)	7%	3

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15. What situation do you encounter that has the highest likelihood for disruptive behavior?		
Answer Options	Response Percent RH	Response Count RH
Telephone call to discuss a change in patient's condition	16%	5
Telephone call for a patient for whom you are not the responsible physician at that time	**23%**	**9**
Questioning by the nurse over a written order	14%	5
Telephone call to report an error or patient injury	0%	0
Call in the middle of night for an order for a change in medication	**23%**	**9**
In-person discussion questioning a treatment plan	**24%**	**9**

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Survey Comments

- Lack of culture of accountability
- Lack of consistent enforcement of ZERO TOLERANCE policy with feedback
- Positive effect of Culture of Safety on staff willingness to speak up
- Optimism for the future because of patient care and safety outcomes achieved

Strategy for Building a Strong Culture of Safety

What Leaders Do

Set Expectations	Educate & Build Skill	Reinforce & Build Accountability
	MIND THE GAP	
Expand Expectations	Focused Education	Enhanced Partnership

Nurse Leader Strategies

- Lead
- Partner
- Align
- Maximize
- Collaborate
- Energize
- Coach
- Model
- PERSIST in partnership to achieve “SAFETY for one and all!”

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Common Ground

- SUPERIOR PATIENT CARE
- People want to do the “right thing”
- Promote “value driven” culture
- Embrace accountability
- Recognize and reward excellence
- Get to know each other as PEOPLE and partners

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