Physician – Nurse Disruptive Behavior: How a Physician Champion Changes Outcomes

Helen Kuroki, MD, MS-HQS

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Objectives

• To understand the impact that medical inter-professional behavior can have on medical care delivery.

• To gain insight into the creation of a culture of safety and the need to continually reassess how the organization may better embed its processes.

• To review an example of how a multidisciplinary, collaborative patient safety action plan can decrease the power gradient and improve safety outcomes.
Why is this topic important?

• Patient safety is a #1 priority in healthcare

• Institute of Medicine (IOM), The Joint Commission (TJC), and the 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

• Physicians and nurses are major drivers in patient outcomes and patient care

• Patients and families assume that physicians and nurses regularly communicate about the plan of care and discharge process

• Culture of Safety assumes that physicians and nurses are working together and applying and integrating error prevention behaviors and tools into daily practice
Behavior Impacting a Culture of Safety

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

TJC (2011)
Strategy for Building a Strong Culture of Safety

What Leaders Do

- Set Expectations
- Educate & Build Skill
- Reinforce & Build Accountability

Make safety a core value

Find and fix problems

MIND THE GAP

An accountability system to convert behaviors to work habits
Physician-Nurse Behavior Survey

• Based on the survey used by the American College of Physician Executives in 2009

• Undertaken across Main Line Health, a 5 hospital community health system in Northeastern US in 2013

• Repeated in 2014 after culture of safety initial training completed and multiple embedding exercises undertaken to reinforce reduction of power gradient
<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Count ACPE</th>
<th>Response Percent MLH - 2013</th>
<th>Response Count MLH - 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Executive</td>
<td>67.2%</td>
<td>66.9%</td>
<td>67.5%</td>
</tr>
<tr>
<td>Direct Care Nurse</td>
<td></td>
<td>17.0%</td>
<td>20.9%</td>
</tr>
<tr>
<td>Physician Executive</td>
<td>32.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed Physician</td>
<td>5.4%</td>
<td>4.1%</td>
<td></td>
</tr>
<tr>
<td>Independent Practitioner</td>
<td>10.7%</td>
<td>7.5%</td>
<td></td>
</tr>
<tr>
<td><strong>answered question</strong></td>
<td>2,124</td>
<td>783</td>
<td>584</td>
</tr>
<tr>
<td><strong>skipped question</strong></td>
<td>33</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>
Does your health care organization ever experience behavior problems with doctors and nurses?

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<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>89.9%</td>
<td>668</td>
<td>90.7%</td>
<td>534</td>
</tr>
<tr>
<td>No</td>
<td>10.1%</td>
<td>75</td>
<td>9.3%</td>
<td>55</td>
</tr>
</tbody>
</table>

- answered question 743
- Answered question 589
- skipped question 5
- Skipped question 5
Generally speaking, how often do behavior problems arise between doctors and nurses at your health care organization?

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Daily</td>
<td>13.2%</td>
<td>97</td>
<td>12.4%</td>
<td>72</td>
</tr>
<tr>
<td>Weekly</td>
<td>24.9%</td>
<td>183</td>
<td>24.0%</td>
<td>139</td>
</tr>
<tr>
<td>Monthly</td>
<td>15.9%</td>
<td>117</td>
<td>19.8%</td>
<td>115</td>
</tr>
<tr>
<td>Several times a year</td>
<td>29.8%</td>
<td>219</td>
<td>26.9%</td>
<td>156</td>
</tr>
<tr>
<td>Once a year</td>
<td>6.3%</td>
<td>46</td>
<td>6.9%</td>
<td>40</td>
</tr>
<tr>
<td>Less than once a year</td>
<td>9.8%</td>
<td>72</td>
<td>10.0%</td>
<td>58</td>
</tr>
</tbody>
</table>

answered question 734 skipped question 15
At your health care organization, who most often exhibits behavior problems?

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>47.1%</td>
<td>334</td>
<td>47.8%</td>
<td>273</td>
</tr>
<tr>
<td>Nurses</td>
<td>9.7%</td>
<td>69</td>
<td>7.5%</td>
<td>43</td>
</tr>
<tr>
<td>A pretty even mix of doctors and nurses</td>
<td>43.2%</td>
<td>306</td>
<td>44.7%</td>
<td>255</td>
</tr>
</tbody>
</table>

answered question 709
Answered Question 571

skipped question 39
Skipped Question 23
In the last year, has your health care organization held any staff training programs to try to reduce behavior problems between doctors and nurses?

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>56.4%</td>
<td>407</td>
<td>53.6%</td>
<td>307</td>
</tr>
<tr>
<td>No</td>
<td>43.6%</td>
<td>315</td>
<td>46.4%</td>
<td>266</td>
</tr>
</tbody>
</table>

answered question 722

skipped question 26
Over the last three years, how would you characterize the number of behavior problems between doctors and nurses at your healthcare organization?

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>More behavior problems between doctors and nurses</td>
<td>11.3%</td>
<td>83</td>
<td>10.9%</td>
<td>63</td>
</tr>
<tr>
<td>About the same number of problems between doctors and nurses</td>
<td>48.2%</td>
<td>355</td>
<td>42.8%</td>
<td>248</td>
</tr>
<tr>
<td>Less behavior problems between doctors and nurses</td>
<td>40.6%</td>
<td>299</td>
<td>46.3%</td>
<td>268</td>
</tr>
</tbody>
</table>

answered question 737 answered Question 579

skipped question 11 skipped question 15
**Question for PHYSICIANS only**

What situation do you encounter that has the highest likelihood for the occurrence of disruptive behavior between a physician and a nurse?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent MLH</th>
<th>Response Count MLH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone call to discuss a change in a patient’s condition</td>
<td>9.2%</td>
<td>6</td>
</tr>
<tr>
<td>Telephone call for a patient for whom you are not the responsible physician at the time</td>
<td>36.9%</td>
<td>24</td>
</tr>
<tr>
<td>Questioning by the nurse about a written order</td>
<td>6.2%</td>
<td>4</td>
</tr>
<tr>
<td>Telephone call to report an error or patient injury</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Call in the middle of the night for an order for a change in medication</td>
<td>18.5%</td>
<td>12</td>
</tr>
<tr>
<td>In-person discussion questioning a treatment plan</td>
<td>29.2%</td>
<td>19</td>
</tr>
</tbody>
</table>

*answered question 65*

*skipped question 529*
Question for NURSES only
What situation do you encounter that has the highest likelihood for the occurrence of disruptive behavior between a physician and a nurse?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent MLH</th>
<th>Response Count MLH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeated phone calls without response and finally a response</td>
<td>41.2%</td>
<td>200</td>
</tr>
<tr>
<td>Questioning of an order</td>
<td>34.2%</td>
<td>166</td>
</tr>
<tr>
<td>Request for discharge as soon as possible</td>
<td>4.3%</td>
<td>21</td>
</tr>
<tr>
<td>Telephone call to report an error or patient injury</td>
<td>1.6%</td>
<td>8</td>
</tr>
<tr>
<td>Telephone call requesting order for a newly admitted patient</td>
<td>3.9%</td>
<td>19</td>
</tr>
<tr>
<td>Relaying request by the patient or family member to speak with the physician as soon as possible</td>
<td>14.6%</td>
<td>71</td>
</tr>
</tbody>
</table>

answered question 485

skipped question 109
Main Line Health
2014 Patient Safety Culture Survey Question Level Results

Communication openness

<table>
<thead>
<tr>
<th></th>
<th>Never / Rarely</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff will freely speak up about things that may negatively affect patient care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>5%</td>
<td>16%</td>
<td>43%</td>
<td>36%</td>
</tr>
<tr>
<td>2012</td>
<td>7%</td>
<td>19%</td>
<td>48%</td>
<td>26%</td>
</tr>
<tr>
<td>Staff are not afraid to ask questions *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>10%</td>
<td>24%</td>
<td>41%</td>
<td>24%</td>
</tr>
<tr>
<td>2012</td>
<td>13%</td>
<td>27%</td>
<td>42%</td>
<td>19%</td>
</tr>
<tr>
<td>Staff feel free to question the decisions of those with more authority</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>19%</td>
<td>28%</td>
<td>36%</td>
<td>17%</td>
</tr>
<tr>
<td>2012</td>
<td>24%</td>
<td>29%</td>
<td>34%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Staff feel free to question the decisions of those with more authority.

- Year: 2012, (2,369)
  - Strongly Disagree/Disagree: 24%
  - Neither: 29%
  - Agree: 34%
  - Strongly Agree: 13%

- Year: 2010, (1,882)
  - Strongly Disagree/Disagree: 27%
  - Neither: 28%
  - Agree: 34%
  - Strongly Agree: 10%

2014 N = 2,784 and 2012 N = 2,393. The N represents the number of respondents for the entire survey; the number of respondents for specific questions might be lower.

* Original negatively worded question have been reworded and rescored to read positively.

Performance Measurement and Analytics
Collaboration

How do we engage physicians and nurses in the work of collaboration?
Transforming Systems of Care: MLH Quality and Patient Safety Framework

Performance Improvement Leadership Council

*PI, Project Management Competencies & Perpetual Readiness

Financial, Clinical & Operational Analytic Competencies

Population Workgroups

Joint Replacements Knee Hip
Cardiovascular Conditions
Respiratory Conditions
**High Risk Care Management

Cross-functional Workgroups

Safety Initiatives: Reliable Culture of Safety, Eliminating Harm and Reducing Mortality

Quality Initiatives: Improving Transitions of Care, Patient Experience and Delivery of Culturally Competent Care

Clinical Infrastructure work: (e.g. Smart Chart and Next Gen optimization, 3M Clinical Documentation and Ambulatory Quality/ACO)

Optimizing the Clinical Environment: Accountability Infrastructure

System Clinical Operations Council

Campus Clinical Operations Teams

Clinical Environment Workgroups and Microsystems

Inpatient Medicine and Critical Care Microsystems
BMH LMC PH RH

Emergency Medicine Microsystems
BMH LMC PH RH

Women and Infants Microsystems
BMH LMC PH RH

Surgical Microsystems
BMH LMC PH RH

Rehab Services

Ambulatory Services

Revised: 4/29/2014

*Process Improvement

**Includes patients enrolled in Pay for Performance programs
Automatic Medication Stop Order Project: Improving the Reliability of Medication Administration

SUMMARY OF THE PROBLEM

Patient had serious illness due to missed medication which was discontinued according to hospital automatic medication discontinuation policy. Opportunities for improvement existed for prescribers, nurses and pharmacists.

INTERVENTIONS

1. Prescribers—make EMR order entry more intuitive
2. Nurses—allow them to see orders approaching expiration
3. Pharmacists—lengthen medication default durations
Automatic Medication Stop Order Project: Improving the Reliability of Medication Administration

GOALS

1. Reduce additional preventable harm events to ZERO.
2. Decrease pharmacy calls by 50%.

FINAL RESULTS

1. There have been no other preventable harm events associated with an inadvertently discontinued medication due to the Automatic Medication Stop Order Policy since the index event occurred in September of 2014.
2. 61% reduction in pharmacy medication clarification calls
Automatic Medication Stop Order Project: Improving the Reliability of Medication Administration

PRE-INTERVENTION

Prescriber Survey Results – Pre-Improvement Initiatives

A. Do you know that some medications are automatically stopped without you placing an order to discontinue the medication?

- Yes: 27%
- No: 73%

B. Do you think that any of your patients have experienced a safety event because a medication was automatically discontinued?

- Yes: 31%
- No: 35%
- Not Sure: 34%

C. Do you recognize this symbol?

- Yes: 56%
- No: 44%

D. Do you know how to extend a medication’s duration in the EMR?

- Yes: 29%
- No: 38%
- Not Sure: 33%

E. Do you think the process for extending duration of therapy in the EMR could be made easier?

- Yes: 13%
- No: 87%
**Changes to the EMR: Icons**

**Change 1: Order Approaching Expiration Indicator**

*Original Icon:*

![Original Icon Image]

*New Icon:*

![New Icon Image]

**Change 2: Cannot renew due to order having explicit stop date**

*Original Icon:*

N/A

*New Icon:*

![New Icon Image]

**Change 3: Cannot renew due to physician acknowledging the discontinuation**

*Original Icons:*

N/A

*New Icons:*

![New Icons Image]
NEW NURSE VIEW ONLY SCREEN: Orders Approaching Expiration List
- When a physician renews or acknowledges expirations, it will update automatically on Nursing View Screen

*Nurses have been asked to partner with physicians during rounds specifically regarding IV Fluids that are approaching expiration
Automatic Medication Stop Order Project: Improving the Reliability of Medication Administration

RESULTS

Percent Decrease in the Number of Medication Line Items requiring Pharmacists to call Prescribers. (Note: Approximately 5 calls are placed per Line Item during the attempt to reach the current provider.)

<table>
<thead>
<tr>
<th>Percent Decrease in Pharmacy Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline (Jan-Mar 2015)</strong></td>
</tr>
<tr>
<td># Rx Interventions</td>
</tr>
<tr>
<td>OVERALL</td>
</tr>
<tr>
<td>OVERALL ACUTE</td>
</tr>
<tr>
<td>OVERALL REHAB</td>
</tr>
</tbody>
</table>
Automatic Medication Stop Order Project: Improving the Reliability of Medication Administration

RESULTS

Figure 1. Total Monthly Pharmacy Rx Interventions by Hospital

- Pharmacy Policy Changes Start to be Made
- All Changes Fully Implemented – Status Update #1
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
Any questions?