“The Impact of Disruptive Behavior on Nursing Care and Patient Safety”

Alan H. Rosenstein  M.D., M.B.A.
Vice President & Medical Director VHA West Coast
Forum on the Future of Nursing
October 19, 2009
Outline

• What is it?
• Have you seen it
• Who does it?
• Where does it occur?
• What causes it?
• What’s the impact
• What can we do about it?
• Will it work?
• What if you don’t do anything about?
Original Research from VHA West Coast has shown:

- **2002**: High incidence of physician disruptive behavior with a significant impact on nurse satisfaction and retention
- **2005**: A significant impact of physician and nurse disruptive on psychological factors and clinical outcomes of care
- **2007**: A significant impact of physician and nurse disruptive on clinical outcomes of care in high stress areas
- **2008**: A significant impact of physician and nurse disruptive on psychological factors and clinical outcomes of care on patient safety
“Disruptive behavior” is defined as any inappropriate behavior, confrontation or conflict ranging from verbal abuse to physical or sexual harassment.
Disruptive Behavior:

Have you seen it?

Who & Where?

Are there any particular specialties where disruptive events occur most often?

- General Surgery: 28%
- Neurosurgery: 20%
- Cardiovascular: 13%
- Orthopedic: 10%
- Anesthesia: 7%
- OB/GYN: 6%
What are you doing about it?

Historical:
- New problem?
- Hierarchy
- Reluctance
- Conflict of interest
- Skill set
- Structure
- Commitment

Call to action:
- Nurse satisfaction
- Patient satisfaction
- Patient quality
- Patient safety
- Reputation
- Litigation
- Joint Commission
Data and Implications
Have You Ever Witnessed Disruptive Behavior From a Physician or Nurse at Your Hospital?

Have you ever witnessed disruptive behavior from a physician at your hospital?
- Aggregate: 77%
- MD: 51%
- RNs: 88%
- Admin: 78%
- Other: 66%

Have you ever witnessed disruptive behavior from a nurse at your hospital?
- Aggregate: 65%
- MD: 48%
- RNs: 73%
- Admin: 77%
- Other: 64%

Joint Commission Journal on Quality & Patient Safety August 2008
<table>
<thead>
<tr>
<th>How Often Does Disruptive Behavior Result in the Following?</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequent</th>
<th>Constant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frustration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of concentration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced team collaboration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced information transfer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired Nurse-Physician relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How often do you think disruptive behavior results in the following at your hospital?

- Stress
- Frustration
- Loss of concentration
- Reduced team collaboration
- Reduced information transfer
- Reduced communication
- Impaired RN-MD relationships

Significant Incidence

Joint Commission Journal on Quality & Patient Safety August 2008
Linkage Between Disruptive Behavior and Undesirable Behavioral Factors Occurring Sometimes, Frequent and Constant

- Stress: 95%
- Frustration: 95%
- Loss of Concentration: 85%
- Reduced RN/MD Collaboration: 92%
- Reduced Information Transfer: 89%
- Reduced Communication: 95%

Percent
How Often Do You Think There Is a Link Between Disruptive Behavior and the Following?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequent</th>
<th>Constant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Events*</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Errors</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Patient safety</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Quality of care</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Patient mortality</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Nurse satisfaction</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Physician satisfaction</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

*Adverse Events: Any undesirable clinical patient experience that occurred during the hospitalization
How Often Do You Think There Is a Link Between Disruptive Behavior and the Following?

How often do you think there is a link between disruptive behavior and the following clinical outcomes at your hospital?

- Adverse events
- Medical errors
- Impaired patient safety
- Impaired quality
- Patient mortality

Significant Incidence
Linkage of Disruptive Behavior to Undesirable Clinical Outcomes Occurring Sometimes, Frequent, and Constant

Joint Commission Journal on Quality & Patient Safety August 2008
Are You Aware of Any Specific Adverse Event That Occurred as a Result of Disruptive Behavior

Are you aware of any specific adverse events that did occur as a result of disruptive behavior?

- Aggregate: 18%
- MD: 12%
- RNs: 20%
- Admin: 21%
- Other: 11%

Joint Commission Journal on Quality & Patient Safety August 2008
Comments:

- Most nurses are afraid to call Dr. X when they need to, and frequently won’t call. Their patient’s medical safety is always in jeopardy because of this.
- My concern is that the new nurses are afraid to call about patient problems and issues that truly need to be addressed in a timely manner impacting outcomes.
- Cardiologist upset by phone calls and refused to come in. RN told it was not her job to think, just to follow orders. Rx delayed. MI extended.
- Poor communication post-op because of disruptive reputation resulted in delayed treatment, aspiration and eventual demise.
- When patient brought to unit for GI bleeding patient saw MD yelling at nurses. Patient asked if that was his doctor. Yes. Patient refused treatment and was transferred to another hospital. I am retiring early and never recommend someone becoming a nurse.
- “Are you aware of any specific adverse events ….?” Yes. Death as a result of disruptive behavior. Staff nurses advocated for better patient care but MD would not willing to listen to reason. As a result patient died. The doctor chose to undo all the help that various staff had been working on for weeks to get this patient the help so badly needed.
- Yes, many incidents are preventable if both parties are willing to listen to each other, but many doctors are unwilling to accept a nurse’s opinion just as some nurses are unwilling to listen to the opinions of LVNs, techs or CNAs, and it may have to do with the entrenched pecking order that exists at most hospitals.
- The disruptive behavior from nurses is much more upsetting because I expect that behavior from the surgeons NOT the nurses b/c I rely on them as my peers (RN).
Behavioral Initiators

What causes people to act and react the way they do?

- **People:**
  - Age (generation)
  - Gender
  - Culture and ethnicity
  - Family/ life values and experiences
  - Training
  - Personality style

- **Problems:**
  - Emotional intelligence
  - Stress and frustration
  - Fatigue/ Burnout
  - Depression
  - Substance abuse

- **Situational:**
  - Environmental
  - Provoked response
  - Mood of the day
How does this all fit together?

Multifactorial Input:
- Internal
  - Deep seated values and perceptions
  - Contributing factors
  - Recent experiences
  - Emotional Intelligence
- External
  - Unexpected event
  - Situational/ Environmental/ workplace contributions

Output:
- Actions/ words
- Body language
- Non- actions
Recommendations: Ten Point Plan

1. Cultural commitment/ Leadership endorsement
2. Recognition and awareness
   - Self
   - Staff
3. General education
   - Unit/ Department
   - Medical Staff
   - Administration
   - Board
   - Students
4. Advanced Education/ Training
   - Diversity
   - Competency (Knowledge/ Technical/ Communication)
   - Assertiveness
5. Collaboration/ Communication tools
6. Clinical Champions
7. Policies and procedures
8. Reporting mechanisms
9. Compliance adherence: Intervention/ Feedback
10. Reinforcement of patient safety initiatives
Conclusion

Serious issue
Sensitive issue
Significant impact
Understand
React
Enforce
Commitment
Policies & Procedures
Training & Education

* Risks of non-compliance

arozenst@vha.com
415 370 7754