midland memorial hospital

Title:	Disruptive Behavior				
Version:	2	**Approved:**	Robert Dent (VP Patient Care Serv/CNE), Russell Meyers (Pres./Administrator)	**Date:**	10/02/2012

Purpose: To create a healthy work environment that fosters collaboration between all healthcare providers in order to enhance patient outcomes. Midland Memorial Hospital (MMH) supports a non-adversarial and non-retaliatory environment and is committed to reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of disruptive behavior.

DEFINING ZERO TOLERANCE

Zero tolerance means that all employees, contract personnel, or individuals with practice privileges must **STOP practicing and tolerating** unacceptable behaviors.

SPECIFIC PROTECTIONS FOR REPORTING UNPROFESSIONAL BEHAVIOR

Staff , contract staff and individuals with practice privileges within this organization who report in **good faith and in a non-retaliatory method** that they have been the victims of abuse, disruptive behavior, incivility and lateral violence will not be subjected to discrimination, retaliation, or termination for reporting their concerns to their supervisor, director or administration of this hospital. There will be no retaliation or harassment of employees who report possible violations.

BEHAVIORS REQUIRING INTERVENTION

Abuse, disruptive behavior, incivility and lateral violence impede with work performance, increases employee turnover, undermines organizational values, and impedes the delivery of high quality, and safe patient care. Behaviors that require intervention include but are not limited to the following:

Negative or disparaging **non-verbal innuendo**, suggestion, implication, hint, or overtone	**Verbal** affront, insult, disrespect, slight, offense, or to cause offense
Intentionally withholding information or support, that may keep a person from succeeding in their job or keep a person from providing the best care possible, undermining, purposeful exclusion of a team member	Back stabbing – if the words coming out of your mouth or actions do not increase a person's dignity, self-respect, self confidence or self-worth then it may be considered abusive behavior and abusive language
Failure to respect privacy – example purposeful sharing of past, current, or pending disciplinary action against one person. Purposely and actively sharing confidential information with a person that has no direct supervisory authority to know. Broken confidences	Infighting, bickering, squabbling, power struggle, trying to take control of a unit or department. Stating "I don't care what the new guidelines are; we will not change what we are doing"
Belittling gestures (deliberate rolling of eyes, feigning sleep, staring straight	Judging a person's work unjustly or in an offending manner, making excessive

ahead or "through") when communication about patient care or organizational goals, missions, visions or values are being discussed or addressed	demands, unfair evaluations of work, inequitable assignments
Sabotage, gossiping, overtly damaging a person's reputation, mocking others	Constant criticism, scapegoating, fault-finding, unwarranted criticism, sarcasm, or public criticism
Intimidation, threats (overt or covert). For example – a direct supervisor is aware that a staff member has requested to speak to his or her director or manager of a department. The direct supervisor decides to continuously roam the hallways near or around the administrative offices; making themselves highly visible while the staff member is meeting with a higher level of management.	Humiliation, damaging another's self-esteem, self-confidence, self-worth Ignoring, isolation, segregation, silent treatment, inflammatory, angry outbursts, impatience. Elitist attitudes regarding work area, education, experience.
Yelling, throwing items, overt violence	Insults, ridicule, patronizing, or condescending language or gestures
Lack of collaboration – for example someone stating "It's not my job", "It's not my patient", "This is another discipline's/unit's problem" or "I don't want you messing with my patient".	Disregard for interdisciplinary feedback about patient care or purposeful disruption of interdisciplinary patient care
Blaming others, arguing or participating in any type of abuse, disruptive behavior, incivility or lateral violence	Encouraging others to participate in bullying, incivility, lateral violence or ANY disruptive behavior

Unacceptable behavior includes violation or purposeful disregard of MMH's policies and procedures, values, mission and vision, or professional standards of practice, which include but are not limited to:

- Code of Conduct Policy
- Social Media/Networking Policy
- Standards of Care
- Licensing board rules and regulatory statutes
- Professional practice standards

ADDRESSING CONFLICT

MMH encourages, supports, and equips every person employed and associated with MMH to employ the use of Immediate Response Communication Techniques to immediately address and resolve disputes and/or concerns. These communication techniques include the use of assertion and advocacy skills, the two-challenge rule, the CUS acronym, the DESC script, and the power to halt the line to care deliveries when appropriate as illustrated in the table below.

Immediate Response Communication Techniques

Advocacy and Assertion	Invoked when disruptive behavior occurs. .	Assert a corrective action in a ***firm*** and ***respectful*** manner.	• Make an opening • Remind the person that disruptive behavior affects patient safety and is not in line with the values of this organization • State the concern • Offer a solution • Obtain an agreement
Two-Challenge Rule	Used when an initial assertion is ignored	It is every person's responsibility to assertively voice concern at least *two times* to ensure the concern has been heard. The team member being challenged must acknowledge.	If the outcome is still not acceptable: • Take a stronger course of action. • Utilize supervisor or chain of command. • All team members are empowered to "***stop the line***" if they sense or discover an essential safety breach or patient safety concern.
CUS acronym	Used when the two-challenge assertion is ignored.	Team members are empowered to "stop the line" because they have identified a safety breach or patient safety concern.	I am **C** oncerned I am **U** ncomfortable This is a **S** afety Issue ***Stop the line!***
DESC Script	A constructive approach for managing and resolving conflict.	Team members are empowered to mange and resolve conflict so that care deliveries are not compromised.	***D*** — Describe the specific situation or behavior; provide concrete data. ***E*** — Express how the situation makes you feel/what your concerns are. ***S*** — Suggest other alternatives and seek agreement. ***C*** — Consequences should be stated in terms of impact on established team goals; strive for consensus.

REPORTING UNACCEPTABLE BEHAVIOR BY EMPLOYEES AND CONTRACT EMPLOYEES

When immediate response techniques do not resolve the behavior between the individuals the following process must be initiated:

- The victim of disruptive behavior will notify the clinical manager/department manager for an immediate response to address the person behind the abusive behavior.
- The clinical manager/department manager must first verify with both parties that the victim attempted to use the guidelines listed above prior to initiating the MMH's Unsafe Acts Algorithm.
- The web-based incident report will be completed by the victim of disruptive behavior within 4 days documenting the specific behaviors that resulted in a need for an incident report. See Incident Reporting (Web Based) policy for more information.
- The director must follow up with both parties and explain the MMH's Unsafe Acts Algorithm and explain the process of applying the MMH's Unsafe Acts Algorithm, explain the Peer Review process and MMH's corrective action policy within 10 days of the incident report.

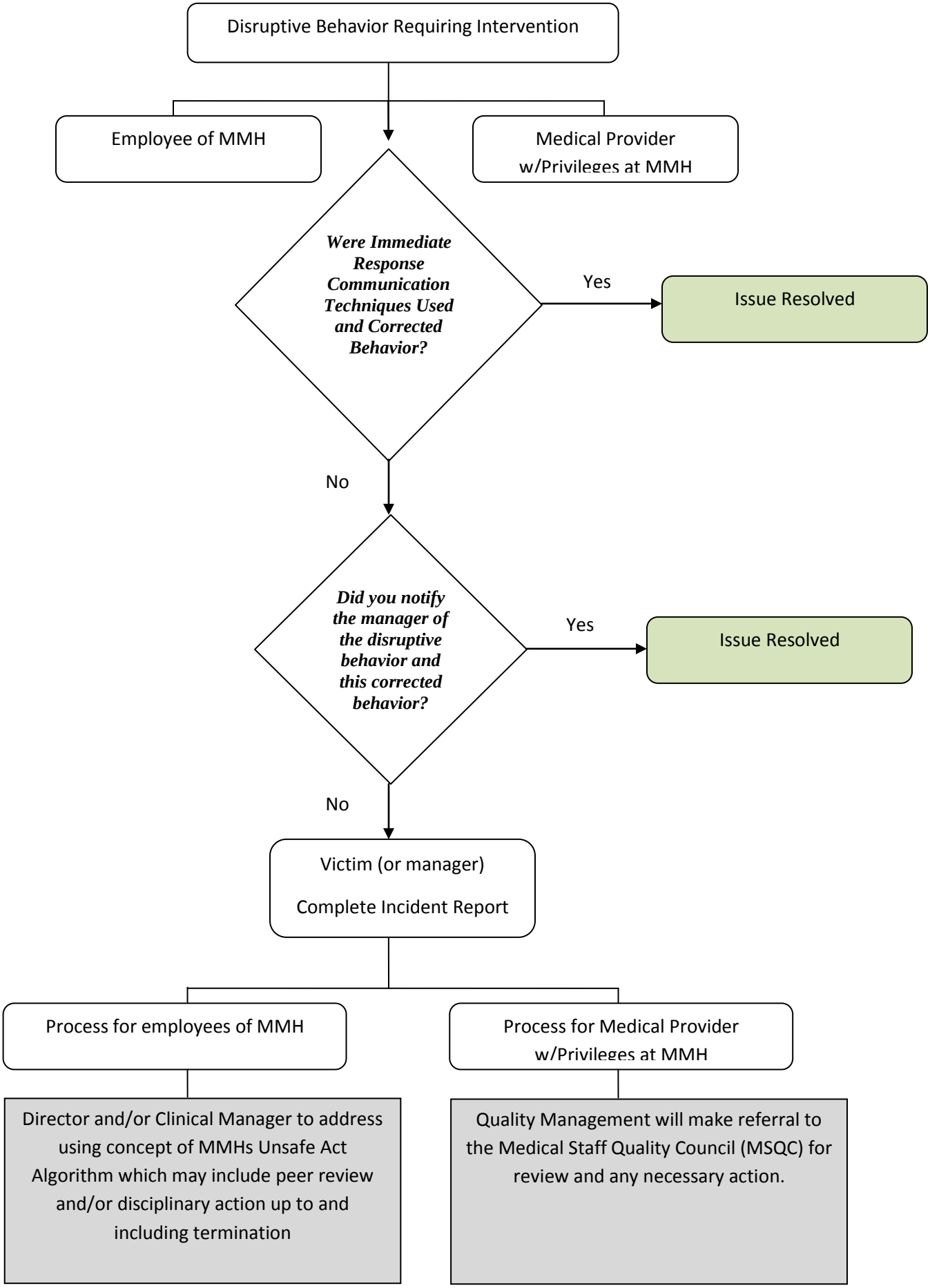
REPORTING UNACCEPTABLE BEHAVIOR BY PHYSICIANS AND OTHER INDIVIDUALS WITH PRACTICING PRIVILEGES.

When immediate response techniques do not resolve the behavior between the individual and the physician, the following process must be initiated:

All incidents of disruptive behavior must be documented to obtain an accurate description of the behavior. Any person in the hospital may report perceived disruptive behavior. Employees should document the incident using the web-based incident report.. Other members of the healthcare team may document the incident in writing and forward it to the Quality Management Department.

The Quality Management Department will review all incidents for appropriateness and refer all appropriate incidents involving other healthcare members to the Medical Staff Quality Committee (MSQC) for review and any necessary action.

In order to protect the confidentiality of all individual(s), the author of the documentation and the specific actions taken to resolve the incident will not be disclosed. However, the author of the documented incident will be notified in writing when the incident has been addressed by the Human Resources Department or the Medical Staff Quality Committee (MSQC).


Disruptive Behavior Requiring Intervention
Employee of MMH
Medical Provider w/Privileges at MMH
Were Immediate Response Communication Techniques Used and Corrected Behavior?
Yes
Issue Resolved
No
Did you notify the manager of the disruptive behavior and this corrected behavior?
Yes
Issue Resolved
No
Victim (or manager)
Complete Incident Report
Process for employees of MMH
Process for Medical Provider w/Privileges at MMH
Director and/or Clinical Manager to address using concept of MMHs Unsafe Act Algorithm which may include peer review and/or disciplinary action up to and including termination
Quality Management will make referral to the Medical Staff Quality Council (MSQC) for review and any necessary action.

References:

Agency for Healthcare Research and Quality (AHRQ). (n.d.). Disruptive and unprofessional behavior. Retrieved from http://www.psnet.ahrq.gov/primer.aspx?primerID=15.

Agency for Healthcare Research and Quality (AHRQ). (n.d.). Just culture. Retrieved from http://www.psnet.ahrq.gov/glossary.aspx?indexLetter=J.

American Medical Association. (2011). Organized Medical Staffs & Disruptive Behavior. Retrieved from www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/organized-medical-staff-section/helpful-resources/disruptive-behavior.shtml

American Nurses Credentialing Center (2012). 2012 ANCC Pathway to Excellence® Application Manual, p. 15-16.

Center for American Nurses. (2008). Bullying and horizontal violence: How to recognize it. How to handle it. Retrieved from http://www.can.affiniscape.com/displaycommon.cfm?an=1&subarticlenbr=283.

Center for American Nurses. (2008). Lateral violence and bullying in the workplace. Retrieved from http://www.centerforamericannurses.org/associations/9102/files/Position%20StatementLateral%20Violence%20and%20Bullying.pdf.

Embree, J., & White, A. (2010). Concept analysis: nurse-to-nurse lateral violence. *Nursing Forum*, *45*(3), 166-173. doi:10.1111/j.1744-6198.2010.00185.x

Kerfoot, K. (2007). On leadership. Leadership, civility, and the 'no jerks' rule. *Nursing Economic$*, *25*(4), 233.

Maxfield, D., Grenny,J., McMillan, R., Patterson, K., Switzler. A. (2005). Silence kills: The Seven Crucial Conversations ® for Healthcare. VitalSmarts, L.C.

Midland Memorial Hospital. (2004). Corrective Action - HR 501Section: Employee Rights and Responsibilities guidelines.

Midland Memorial Hospital. (2011). Disruptive behavior guidelines.

Midland Memorial Hospital. (2010). Just culture in patient safety guidelines.

Rosenstein, A.H. and O'Daniel, M. (2008). A survey of the impact of disruptive behaviors and communication defects on patient safety. *The Joint Commission Journal on Quality and Patient Safety*, 34(8), 464-471.

Revision number	Date	Description of Document or Document Change
2	10/02/2012	New Version; Corrected DESC instead of DECS within the TeamSTEPPS chart. Changed "corrective action" to "disciplinary action" within the algorhithm. "