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Disruptive Behavior in Health Care Settings

By Lisa Falzetta, NCPS nurse educator, Medical Team Training

A Fictional Example

Sarah is a recent graduate from nursing school and is working her first job on a medical-surgical floor. She is concerned that her patient, Mr. Green, is experiencing newly developed shortness of breath one day after his knee replacement surgery. Sarah calls the physician to report Mr. Green's status change. Being a new nurse, she is nervous and not very experienced in giving a clear and concise report. The physician becomes irritated with Sarah and tells her to call him back "when she has her information straight."

Sarah, visibly shaken by this encounter, approaches an experienced nurse, Mary, to ask for guidance. Mary, who is busy with her own patients, rudely dismisses Sarah's concerns saying, "Toughen up, honey. You won't make it far if you can't even deal with calling a physician."

Examining the Problem

How would you feel if you were Sarah? Would you have the courage to call the physician back or to ask another nurse for help? In future situations, would you be comfortable sharing information with physicians and other nurses or would you be reluctant, fearing you might be ridiculed again? Would you feel like you were in a safe environment where you could speak up regarding patient concerns and that your patients were receiving the best care possible?

Unfortunately, scenarios, like the one above involving intimidating and disruptive behavior, are common in health care today. Specific examples of this type of behavior include, but are not limited to, verbal outbursts, physical threats, insults or criticism, condescending language, impatience with questions, and refusal to return phone calls or pages.¹

Much attention in the literature has been given to abusive behavior by physicians

towards nurses or other members of the health care team. However, this conduct is not limited to physicians alone. Disruptive behavior has also been documented to occur regularly among nurses, pharmacists, and those working in radiology and the laboratory.²

Regardless of the source, health care professionals have reported that this behavior affects morale, decreases job satisfaction, increases job turnover, and is a threat to patient safety.

Nurses have rated disruptive behavior as the single most important contributing factor to job satisfaction and morale,² and it has been reported that 60 percent of nurses new to practice leave their first positions within six months because of some form of hostility directed toward them by another nurse.³

Patient safety is also affected by disruptive behavior. In a hostile environment, communication is hindered, which can have a direct impact on patient outcomes.⁴

A 2003 survey of nurses, physicians, and administrators examined disruptive behavior of physicians and nurses, as well as perceptions of its effects on providers and its impact on clinical outcomes. When asked "Do you think that disruptive behavior could potentially have a negative impact on patient outcomes?" 94 percent of respondents said "Yes."

Seventeen percent of respondents reported that they were aware of specific adverse events that actually did occur as a result of disruptive behavior; and, of these respondents, 78 percent reported that the adverse event could have been prevented.⁵

A 2004 survey by the Institute of Safe Medication Practices found that "49 percent of clinicians have felt pressured to dispense or administer a drug despite serious and unresolved safety concerns, and 40 percent have kept quiet rather than question a known intimidator."²

Developing a “Soft” Door to Prevent Suicides

By Joe Murphy, NCPS public affairs officer

The invention of a “soft” door by two VA employees has the potential to reduce suicides in mental health wards across the nation.

“Doors are the number one tool used on inpatient units for suicide,” said Jackie Van Mark. “People can use the hinges or the knob. They can even close a door with cloth or string wedged at the top or in a door hinge and hang themselves.”

Van Mark is a Public Affairs Specialist at the VA Medical Center, Sheridan, Wyo., who developed the concept for the soft door with fellow employee Lisa Garstad, the facility’s patient safety manager.

In 2007, NCPS sent out an “Environment of Care” checklist, designed to address suicide reduction on inpatient mental health units.

“The checklist really made us look at our units from a completely different perspective. One thing we had to deal with right away was the bathroom doors in patient rooms,” said Garstad. “We looked all over for alternatives.”

She first ordered a composite door to use as a trial. “It was made of three pieces. One section, ‘sandwiched’ in between the two main sides of the door, slid down if any weight was applied,” Garstad said. “We kept waiting for the door to arrive, but because so many people were in the same boat as we were, it was back ordered.”

During the wait, other VA medical centers conducted trials on the composite door and indicated that it was not meeting their requirements. “Our director said ‘Order one of these doors, but find an alternative fast,’” Garstad noted.

She decided to explore the Internet in the hope of finding an alternative: “I had a vision of doing something with vinyl. I was thinking of a sort of Wild West-type saloon door that would swing open and closed.”

The firms she contacted couldn’t provide the assistance she required.

Garstad wasn’t deterred. Solution? “I went to a local mom and pop awning shop in town,” she said.

The shop worked up a prototype, using half-inch plastic plumbing tubing that acted as the frame to support the vinyl. Along one side, a two-inch strip of Velcro was attached to act as the hinge. The vinyl wasn’t solid enough, even with the tubing support and Velcro hinges. “It was at this point that Jackie got involved,” said Garstad.

Van Mark believed that the door would function properly if it was supported by a solid core. A stroke of luck then led to a solution to this aspect of the door’s design.

Van Mark had ordered an item on the Internet: Foam sheets were used as part of the packing: “I opened the box and instead of looking at my purchase, I took out the packing foam sheet and got all excited and knew this material would be best for the door.”

She and Garstad settled on a lightweight foam that could be sewn within the vinyl of the prototype. “We had suddenly become a team and the project took off!” Van Mark said.

Unfortunately, the awning company couldn’t handle the project. “We went to see how things were progressing and were told that they didn’t have the manpower to push out the amount of doors we would need in the amount of time we required,” said Garstad.

The pair soon found a local firm that made windshield and engine covers for aircraft. “This company was familiar with the industrial aspect of manufacturing,” said Van Mark, “and it was in a niche market right here in Sheridan, Wyoming!”

The firm had the type of heavy-duty sewing machines necessary to create a prototype, as well as to produce them in large quantities.

Concurrent with the development of the prototype, VISN representatives toured the mental health ward as part of a risk assessment. “During the walk-

through, the VISN team noted framed art work,” said Van Mark.

The VISN team believed it was a potential hazard because the hooks and framing material could be used as a weapon.

“We still wanted to somehow make this clinical setting more comfortable. We mentioned this to the manufacturer,” she said. “It turns out he also owned a local graphic design company and suggested that we have outdoor photos printed on the doors so patients would have art work in their rooms.”

“The original prototype, made from dark brown vinyl, was functional but rather ugly, so when we could put photos on the doors we got really excited,” Van Mark added.

“The firm was also able to produce the prototype using military specifications, which means the doors are fire resistant and infection control needs are met,” Garstad said.

“Once we had the idea, and things started looking like this was going to work, our director suggested we get the door patented,” said Garstad.

“That opened up a new world to both of us. We didn’t realize how fast things could move once the VA approved the idea,” Van Mark said.

The medical center obtained a patent on the idea and the local firm has since secured a license to manufacture the doors under that patent.

“We really think it is cool that our facility has a patent. I mean, that usually happens for big research facilities, we are just a little hospital out on the prairie!” said Garstad.

“The soft suicide door is gaining recognition all over the country,” she said. “Since the first prototype, the door has gone through a few modifications. The next series of doors will be different from the last, but we think it will be a much better door.”

Three Hospitals Unite for Patient Safety

By Dea Hughes, MPH, patient safety manager, and Kim Arslanian, MBA, performance improvement manager VA N.Y. Harbor Healthcare System

In February 2008, three hospital affiliates came together to bridge their patient safety programs and improve staff education by establishing the Tri-Hospital Best Practices Council.

Council members include the VA New York Harbor Healthcare System, Bellevue Hospital, and New York University Tisch Medical Center.

The council was formed with the following objectives in mind:

- Standardize selected care processes across the three campuses in order to streamline and simplify the experience for residents who rotate through all three.
- Share lessons learned from adverse events that can result in effective system changes.
- Provide a forum for discussion about new regulatory mandates

and standardize approaches to ensure compliance.

Beginning with the first objective, the council set out to understand how each campus was conducting time-outs in the operating room (OR).

At each campus, time-outs in the OR are conducted in compliance with the Joint Commission's Universal Protocol. Time-outs must also be in compliance with the VHA's "Ensuring Correct Surgery and Invasive Procedures Directive: 2004-028."

Nuances between the processes exist at each campus, such as:

- Who calls a time-out.
- The level of ambient noise during a time-out.
- Whether a time-out is verbally scripted or impromptu.

- At what point the site is marked in relation to other pre-operative procedures.
- How the holding area is involved in pre-OR procedural verification.

With the original objective in mind, the council intends to establish a single process for conducting time-outs at the three campus ORs.

We expect that standardization will make it easier for surgical residents to understand and comply with this universal procedure.

The Tri-Hospital Best Practices Council is an exciting opportunity. With medical and surgical residents rotating through all three sites, the patient safety impact of this collaboration is far-reaching. Collaborating with hospitals in your area or your academic affiliates may enhance your local patient safety programs as well.

The Daily Plan: Synopsis of a Study on the Initial Pilot

By Beth J. King, R.N., B.S.N., M.A., NCPS program manager

Background

Patients are the only component of the health care delivery system that are always present – and yet the least likely to be used as a resource. Though patients and their families want to help ensure safety, there has been little professional attention on how best to actively involve patients in their care, or on how such involvement might affect patient safety.

The Daily Plan was developed to help resolve this problem. It is based on offering patients a single document that outlines what they can expect on a specific day of hospitalization.

Begun as a quality improvement program, the plan was piloted for two weeks at five volunteer VA medical centers' medical-surgical units, fall 2007 and winter 2007-2008. Participating patients received guidance on safeguarding their medical information during their introduction to the program. Patients were also

provided "The Daily Journal," a blank booklet where they or family members could make notes or list questions. To further enhance understanding, a nurse introduced the plan and reviewed it daily with each patient and/or family member.

Our Questions

We wanted to determine if a patient would be more comfortable asking questions if they received a daily written summary. We also wanted to determine if patient safety would be improved by talking with patients about what to anticipate daily so they would question if something seemed different than planned.

Results

Nearly 70 percent of the patients (101 evaluations) agreed or strongly agreed that having The Daily Plan made it easier for them to ask questions, increased their understanding of their hospital stay, and provided them with information

that helped improve their care. Nurses (92 reports) were asked to reflect upon their assigned patients receiving the plan during their shift and complete a single end-of-shift accumulated evaluation:

- One or more errors of omission were identified in 35 percent of the reports.
- Prevention of other potential adverse events were identified in 21 percent of the reports.

Conclusions

Our new program was able to prevent potential adverse events. We will use what was learned in the pilot to guide further implementation during the fiscal year 2009 Phase II Pilot. Our focus includes making The Daily Plan more user friendly for both patients and staff, as well as completing formal usability testing. For more information, contact us: NCPS@va.gov.

Disruptive Behavior in Health Care Settings

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For years, this type of behavior has been largely ignored and tolerated in health care. Victims often don't report disruptive behavior for fear of retaliation or being labeled a "whistle blower."¹ Under reporting of incidents leads to the issue not being addressed and gives perpetrators the freedom to continually act in the same unprofessional manner. What actions can a health care facility take to put an end to this?

- Develop a zero-tolerance policy for intimidating and/or disruptive behavior.¹ Physicians and staff need to know that any form of abusive behavior will not be permitted, and that disciplinary action will be taken if it is exhibited. In order for a zero-tolerance policy to be effective, workable definitions of disruptive and intimidating behaviors must be created and communicated to staff so that there is no confusion as to what they entail.
- Encourage staff to document and report abuse immediately. Individuals need to know that they will be supported if they come forward with concerns about another person's behavior.
- Provide training and coaching for leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution.¹
- Engage health care professionals in team training programs to educate them on how to improve teamwork and collaboration through standardized communication techniques. When professionals are taught techniques to communicate more effectively, the likelihood of conflict and poor behavior is decreased.

Enhancing Communication

NCPS' Medical Team Training (MTT) program is a primary example of an initiative that promotes good communication.

The MTT program was developed to improve outcomes of patient care and staff job satisfaction by enhancing communication and teamwork between health care professionals.

Per a recent article on MTT developed by NCPS staff members: "Unique features of MTT include a full-day interactive learning session (facilitated entirely by clinical peers in a health care context), administration of pre- and post-intervention safety attitudes questionnaires, and follow-up semi-structured interviews with reports of program activities and lessons learned from facilities that have participated in MTT."⁶

Since its creation in 2003, the MTT program has conducted 121 Learning Sessions with over 9,000 participants in 98 VA facilities. As a result of implementing MTT, facilities have reported increased teamwork and morale, as well as examples of undesirable patient care events avoided.

New Leadership Standard

Recognizing that disruptive behavior can result in negative patient outcomes, the Joint Commission has created a new leadership standard (LD.03.01.01) that addresses this behavior in two of its Elements of Performance.⁷

Effective Jan. 1, 2009, for all accreditation programs:

- The hospital/organization has a code of conduct that defines acceptable, disruptive, and inappropriate behaviors. (Element of Performance 4)
- Leaders create and implement a process for managing disruptive and inappropriate behaviors. (Element of Performance 5)

These new requirements will help to shift the culture of health care to one that will not be tolerant of disruptive or intimidating behavior any longer.

A More Productive Ending

A few seconds after Sarah walks away, Mary reassesses her reaction to Sarah's question and realizes that she may have been too harsh in her response. She approaches Sarah to apologize and to give her some helpful hints on how to effectively call a physician with a change in patient condition. Mary helps Sarah to organize her thoughts and stands by her when Sarah calls the physician back.

This time, the phone conversation goes much smoother and the physician compliments Sarah on her concise and well-prepared report. He also apologizes for his behavior on the previous phone call. He agrees that the patient's shortness of breath is of concern, assuring Sarah that he will be on the unit to assess Mr. Green, STAT.

Sarah is satisfied knowing that she has the support of her fellow nursing colleague, Mary, and that Mr. Green will receive the care that he deserves. Years from now when Sarah is an experienced nurse, she will remember this encounter and know how to positively respond to a new nurse when approached with a patient care question or concern.

Notes

References 1-7 available in the online edition of TIPS: <http://www.patientsafety.gov/pubs.html>

Learn more about MTT:

(VA employees) <http://vaww.ncps.med.va.gov/Education/MTT/index.html>

(Public site) <http://www.patientsafety.gov/mtt/>