

The Joint Commission Disruptive Behavior Standard: Intent and Impact

By Alan Rosenstein, MD, MBA, Medical Director of Physician Wellness Services, alan.rosenstein@workplacebehavioralsolutions.com

One of the Joint Commission's major areas of focus is to monitor health care organizations as to their ability to provide and deliver high quality care in a safe medical environment. One of the key findings from the Joint Commission research is that nearly 70% of sentinel events can be traced back to a gap in communication. In a recent Sentinel Event Alert the Joint Commission reported on the significance of disruptive behaviors in undermining a culture of patient safety. In January 2009 the Joint Commission introduced a new accreditation standard that required hospitals to: (1) have a disruptive behavior policy in place and, (2) develop processes and provide education that addresses disruptive behaviors. Coinciding with the Joint Commission Alert and new accreditation standard, we published an article in *The Joint Commission Journal on Quality and Patient Safety* to emphasize the importance of addressing disruptive behaviors as to its frequency of occurrence and downstream negative effect on patient outcomes of care.¹ Our response to The Joint Commission action was, "Thank you; it's about time."

Background

We originally began our research on disruptive behavior by focusing on the frequency and impact of physician disruptive behaviors on nurse satisfaction and retention. We quickly learned that the situation is not unique to physicians and the impact reached far beyond just nurse satisfaction and retention. Serious concerns were raised about the impact of physician, nurse and other staff behaviors on attitudes and actions affecting team collaboration, communication, and the ability to effectively transfer vital information which would affect the overall outcomes of patient care. The more we looked, the more we became concerned about the frequency and impact of these types of events and their downstream negative effect on patient safety and quality of care. In our efforts to make health care personnel more aware of the consequences of disruptive behavior we pushed forward with our research investigating why, where and how these events occurred, and what could be done to prevent or otherwise mitigate their effect on staff relationships and patient care. Recognizing the importance of raising physician awareness, understanding, individual responsibility, and engagement around this issue, we have developed a comprehensive program that emphasizes taking a positive approach to improving behavioral competence by addressing underlying factors that may provoke such events and focusing in on the opportunity to improve patient safety and overall quality of care. An overview of this approach is presented in Table 1 on the right.

Barriers

So what's taken us so long to address the issue? Is this a new occurrence brought on by the increasing stress in the medical marketplace, or is it something that's been going on for years but often "tolerated" by those in charge?

On one side is the historical reluctance of dealing with the problem. Who wants to "interfere" with a physician who brings his or her patients to the hospital, particularly if they are a major source of patient revenue? And even if you wanted to deal with the issue, peer to peer conflicts of interest and organizational bureaucracy may get in the way. One further limitation is the lack of the necessary skill set and training experience for leaders to deal with behavioral issues. Physicians are trained on monitoring performance in regard to technical and knowledge expertise. There is no formal training on how to judge performance based on behavioral competency. But now the environment has changed.

Table 1: Strategies for Addressing Disruptive Behavior

1. Organizational commitment	<ul style="list-style-type: none"> • Board/ Senior Leadership endorsement and support • Project champions
2. Raise level of awareness	<ul style="list-style-type: none"> • Internal assessment
3. Policies and Procedures	<ul style="list-style-type: none"> • Disruptive behavior policy (JC leadership standard)
4. Staff Education	<ul style="list-style-type: none"> • General education on cause and effect (JC leadership standard)
5. Training Workshops	<ul style="list-style-type: none"> • Assertiveness training/ Diversity training/ Conflict management ...
6. Communication/ Team collaboration Tools	<ul style="list-style-type: none"> • SBAR • Team building
7. Reporting policy	<ul style="list-style-type: none"> • Consistency in reporting process, evaluation and follow through
8. Compliance monitoring	<ul style="list-style-type: none"> • Staff skill training/ Counseling techniques to more effectively address disruptive behaviors • Credentialing
9. Support services	<ul style="list-style-type: none"> • Staff assistance/ Counseling/ EAP
10. Patient safety	<ul style="list-style-type: none"> • Integration with overall risk management/ patient safety programs

New Opportunities


The Joint Commission accreditation requirement has brought a needed stimulus for hospitals to more effectively address the issue of disruptive behavior. Whereas hospitals may have looked the

other way in the past or were suffering from the historical reluctance to do something about it, the Joint Commission has now given them reason and responsibility to react. At the front end is the issue of complying with the new accreditation standard. On the back end is the need to address communication and task responsibility issues that impact patient safety. After all, that's the business we are in. In the middle is the open door to approach physicians and other members of the hospital staff in helping them deal with workplace and personal issues that may affect their attitudes and performance. Physicians in particular have been reluctant to ask for help in dealing with personal life stresses that may affect their work and home environment. Hopefully now physicians will be more amenable to discuss these issues on their own as an opportunity for improvement rather than waiting to be told to do so by some external organization under a more punitive perspective.

In addition to the Joint Commission requirement, concerns about hospital reputation, staff satisfaction and retention, and a growing number of liability claims focusing on the consequences of disruptive behaviors have influenced many organizations to take a stronger position on addressing these behaviors. Some organizations have already begun to introduce behavioral performance criteria into the hospital privileging and credentialing process.

Recommendations

It's not that many individuals start out the day planning to be disruptive. It's just that they don't see the downstream effect of their actions. Raising the level of awareness is crucial. The overriding message is to provide the best possible patient care in the safest possible medical environment, and that's a message that nobody will ignore. While having the right policies and procedures in place to establish expected standards of behavior is part of the Joint Commission accreditation requirement, taking a positive approach as to the benefits of improving overall collaboration and communication in a stressful complex medical environment is preferable to taking a negative punitive approach focused on reprimands and discipline. Providing educational courses that teach communication and team collaboration skills and programs that address different values and beliefs of both physicians and hospital staff reflective of cultural diversity, gender and generational issues, personality styles, and training experiences, will often help in allowing individuals to gain a better understanding of how to more effectively communicate with their peers. Working with the Human Resources Department, further assistance through employee assistance programs, recommendations for specialized programs or workshops including stress management, conflict management and/ or diversity training, or in some cases individualized counseling may be necessary to achieve improvement.

1. Rosenstein, A., O'Daniel, M. "A Survey of the Impact of Disruptive Behaviors and Communication Defects on Patient Safety" *Joint Commission Journal on Quality and Patient Safety* Vol34 No8 August 2008 p.464-471 

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