Managing people

Toward an effective code of conduct

Some facilities have had a code of conduct for years, and managers say it works well. At others, nurses still are too intimidated to remind physicians to wash their hands.

In a lively discussion at the Managing Today’s OR Suite conference in October 2008 in Washington, DC, it was clear many organizations still have a ways to go in dealing with bad behavior.

The discussion was timely. New Joint Commission requirements for curbing bad behavior go into effect Jan 1, 2009. Under the new Leadership Standards, facilities must have a code of conduct and a process for managing disruptive behavior.

Though the issue of disruptive behavior has been discussed for years, one nurse consultant in the audience said she finds a lot of nurses are still too fearful to address it.

“They will not stop a surgeon who goes from the unclean area up to the belly during a GYN case because they are afraid of being called names. The advocacy for the patient is not there,” the consultant, Mary Lou O’Grady, RN, told the audience.

“When you ask why, they say, ‘I don’t want to see in my performance appraisal that my skills have gone down. The surgeon reported that to my superior.’”

She’s found senior leaders don’t want to take action, and the code of conduct is often sketchy and not enforced. Many in the audience nodded in assent.

Teeth behind the process

Managers can’t tackle the problem alone, stressed the speaker, Michelle Pelling, RN, MBA, head of the ProPell Group, Newberg, Oregon (www.propellgroup.com). They need an infrastructure for managing behavior.

“You can’t deal with disruptive behavior unless you have established a code of conduct that applies to all groups—that’s number 1,” she said. The code must include a well-developed definition of disruptive behavior.

“You also have to have policies and procedures approved by the medical staff and medical staff leaders. Then you have a foundation.”

Once you have a foundation, “you need to establish a process. You need to write that process into policies and procedures to say what to do when the code of conduct is breached. Then you need to educate the staff on the code of conduct, and the medical staff leadership has to do the same” (sidebar).

The Joint Commission standards put teeth behind the process, she added.

“Now you can say, ‘We have to have this, or we’ll get an RFI,’” referring to a requirement for improvement, a mark of noncompliance from the Joint Commission. Too many RFIs can jeopardize accreditation.

“What will surveyors be looking for?” one attendee asked.

Pelling said surveyors might ask a general question, such as, “How do you handle disruptive behavior?” Managers will want to be able to show them a copy of the code of conduct and policies and procedures and describe the process step by step, perhaps with examples. Surveyors may also talk to the staff about how effective they think the policy is.

Sharing successes

Several in the audience shared their successful processes. The best time to start is when you are not having a problem with any specific per-
son. Begin by asking, “What are our standards for behavior?” suggested Barbara Pankratz, RN, MSN, director of surgical services at the University of Wisconsin, Madison, which has had a disruptive behavior process for 10 years (related article, p 19).

“There is an established process for dealing with behavior that goes from counseling with a peer to suspension of privileges,” she noted. “When it needs real teeth, it plugs into the medical staff bylaws.”

Said another director, “We use the patient safety event report because, depending on what is happening with the patient, the behavior could be detrimental to safety.” If a circulator and surgical technologist are having a dispute, for example, it could distract the surgeon. “We address it either through the peer review process if it is a physician or the HR process if it is an employee.”

Pelling asked her, “Why would a staff member be comfortable writing a safety report about a surgeon who brings the most patients to the hospital?”

The director replied, “The way I’ve approached it with the staff is that it doesn’t matter who it is. If it’s a patient safety issue, that’s what you’re here for, and that’s what I will hold you accountable for. Then it’s my job to talk to the surgeon (who was disruptive) and say, ‘This is what has been reported. I need to hear from you.’ It’s more of an education process at that point. Maybe I hear it was an inexperienced staff member.”

It’s best to have a formal code of conduct and policies and procedures, even if the facility has strong leaders and a culture of safety, Pelling advised. Otherwise, what will happen if the current leaders leave?

Who should receive reports?

Consider carefully who should receive reports to avoid retaliation, one director cautioned. After she had been at her facility only a short time, she said: “I walked into a situation where a staff member would write up a physician, sign their name, and it would go to a physician committee. They would laugh, even if there were multiple nurses who had stated similar things.”

When the next incident occurred, she told the nurses not to write it up. Instead, “we went through the vice president for nursing to the CEO. That ended in a more satisfying situation for us.”

Pelling said her preference is to have a committee specifically to address disruptive behavior. The membership needs to be multidisciplinary—not just the discipline that is the subject of the complaint. She prefers that approach to using the peer review process, at least as the first step.

“If a physician is being disruptive, and the only option is to send the complaint to the medical executive committee, and the physician sits on the committee, that may not help,” she pointed out.

Having a disruptive behavior committee is not a Joint Commission requirement, she added. “Everyone needs to develop their own process. But I think it should be similar to a safety committee or ethics committee, with representatives from different disciplines.”

Is it disruptive behavior?

What about behaviors that are not as clear cut? A member of the audience asked about a surgeon who manipulates the OR schedule by booking cases outside regular hours and expecting his cases to be moved at the last minute. If he doesn’t get the time he wants, he cancels the case, but he’s not really rude about it.

It depends on how you define disruptive behavior, Pelling responded. You could include in the definition: “Failure to adhere to organizational policies.” Then if your department has written surgical scheduling policies, you could address it that way, she suggested.

Someone else asked about a situation in the postanesthesia care unit when a physician would not respond to a nurse’s page about a patient’s condition.

This is more of a chain of command issue, Pelling replied. Typically, the nurse would report this to the manager, who would take it to her superiors, who would address it with the medical staff.

“You would want to review the chain of command with your staff. I don’t see the
Joint Commission considering this as disruptive behavior. It’s a different issue—not that it isn’t important,” she said.

Concluding the discussion, O’Grady said she had attended a session on disruptive behavior at the AORN Congress 30 years ago.

“And it’s still here. Now it’s becoming another Joint Commission issue. But maybe this is what we need—maybe that’s our support.”

—Pat Patterson

More ideas for managing disruptive behavior were in the November OR Manager.

The Leadership Standard and Sentinel Event Alert on disruptive behavior are at www.jointcommission.org

A foundation for managing disruptive behavior

Code of conduct

The code of conduct defines acceptable, disruptive, and inappropriate behaviors.

Definition of disruptive behavior

Examples the definition could include are:

- profane language
- name calling
- sexual comments or inappropriate touching
- racial or ethnic jokes
- anger outbursts
- throwing instruments, charts, or other objects
- criticizing other caregivers in front of patients or other staff.

The definition could also include:

- deliberate failure to adhere to organizational policies
- failure to address safety concerns or patient care needs expressed by another caregiver.

Policy and procedures

The policy and procedures would include:

- definitions and examples of disruptive behavior
- potential consequences, eg, disciplinary actions such as suspension, termination, loss of clinical privileges
- method of reporting
- nonretaliation clause
- statement that disruptive conduct will not be tolerated
- connection between disruptive conduct and patient care and safety.

Actions

Actions to back the code and policy include:

- documenting disruptive behavior immediately
- documenting all attempts to address intimidating and disruptive behaviors
- tiered, nonconfrontational interventions
- progressive discipline
- preparation for administrative hearing or grievance process.

Staff education, accountability

- Educate staff on appropriate behavior, code of conduct.
- Hold staff accountable for behavior through approved consequences.
- Enforce code of conduct consistently and equitably.
Manager’s responsibility

- Know your organization’s policy on disruptive behavior.
- Get training on managing disruptive behavior.
- Help staff understand the policy and how to address and report disruptive behavior.
- Provide ongoing coaching and support.