1. Great presentation. Do you have data on how prevalent disruptive behavior is amongst non MD?

Yes, you can view the ISMP Survey from 2013 that Dr. Chassin referenced on slide 10. It can be found at: https://ismp.org/Survey/surveyresults/Survey0311.asp. There are also 2 articles available at that link: “Intimidation: Practitioners speak up about this unresolved problem (Part I)” and “Intimidation: Mapping a plan for cultural change in healthcare (Part II)”

2. How does the issue of competency fit within the continuum of blame?

There must be a balance between addressing system issues and holding staff accountable for adhering to safe practices. A person’s competency is both the responsibility of the organization and the individual. Was competency properly evaluated and established before the person began to work independently? Was the person given sufficient training and ongoing education to perform? Were policies and procedures related to the task or performance accessible, understandable, workable, correct and in routine use? If all of these questions can be answered yes, and yet the person did not perform a process or activity correctly, then discipline may be appropriate.

3. Are there resources available to enhance the relationship between providers and nurses?

Teamwork training and simulation training have both shown a positive impact on interactions between disciplines, including between providers and nursing staff. Some commonly referenced teamwork programs include TeamSTEPPS (freely available from the Agency for Healthcare Research and Quality website: https://www.ahrq.gov/teamstepps/index.html and Crew Resource Management (CRM) created by the commercial aviation industry. Creating multidisciplinary teams to address issues also helps to breakdown silos and promotes respectful communication.

4. Is there a best practice process improvement tool?

“Best practices” work well when the process you are trying to improve has a limited and known set of steps, such as central line insertion. When problems are difficult to solve and more complex, then the best approach is using Robust Process Improvement® (RPI®). RPI is the blended tool set of Lean, Six Sigma and formal Change Management. Together these tools enable you to solve even the most complex problems and to sustain the solutions. One of the important advantages of employing process improvement tools such as DMAIC (define, measure, analyze, improve, control) is that they provide a systematic approach to solving complex problems. Specifically, they guide improvement teams to examine why processes fail to achieve their desired results. It is this systematic search for causes of quality and safety problems and the assessment of the relative contribution of each cause that gives these improvement tools a great deal of their effectiveness. Experience with the application of the tools of RPI® in health care is consistent with that of other sectors of society.
The majority of health care organizations today do not use this full tool set and so the problems they are trying to improve keep popping back up. For more information: http://www.centerfortransforminghealthcare.org/about/rpi.aspx

5. How are RPIs and IHI's model for improvement different?

The Joint Commission’s improvement model is called Robust Process Improvement® or RPI®. It is comprised of Lean, Six Sigma and formal change management tools and processes. The IHI model for improvement consists of 3 fundamental questions and the Plan-Do-Study-Act (PDSA) cycle. Both approaches can be used to facilitate improvements. However, RPI is ideal for all types of improvement from small to large-sized and complex problems. RPI is also a very specific and prescriptive (roadmap) approach to problem solving, incorporating Lean Six Sigma and formal change management methods to accommodate the breadth of complex problem solving. PDSA is limited to small to medium-sized and localized projects. Although PDSA process is quicker and easier to begin, RPI will take the time necessary to gather data on variables and analyze these leading to targeted solutions and greater improvement. PDSA is more of a methodical “trial and error” approach, while RPI identifies the most significant root cause based on data and analytics, and targeted solutions that are specific for each root cause identified. RPI is also heavily focused not just on identifying the root causes and solutions leading to a greater improvement but also on how to sustain those improvements over time. RPI integrates formal change management for acceptance and buy-in with the Control phase of RPI which includes a plan and tools for sustainability.

6. How would you suggest creating more consistency in addressing culture of safety issues across a hospital system with multiple facilities that often have different ways of handling physicians with behavior issues?

Utilization of an incident decision tree or “just culture” algorithm that evaluates whether discipline is indicated and the creation and enforcement of a system code of conduct are two ways to achieve this. The system should take the time to evaluate the models that are available. The most commonly referenced and used models are that of James Reason (Incident Decision Tree) and that of David Marx. The system leaders must work with the bylaws committees at each facility to gain buy in and alignment on the use of the algorithm to evaluate patterns of behavior and mistakes made by staff and physicians alike. While Peer Review is the traditional method to handle practice issues, it doesn’t address behaviors and violations. All staff, whether employed by the system or independent, whether physician or non-physician staff, should be subject to this process. A code of conduct guides all staff in behavior and should include examples of acceptable and unacceptable behavior. The code is only as strong as its reinforcement, however, which highlights the importance of a structured tool used to evaluate behaviors as mentioned above.
7. Please explain ownership of the Experience between Clinical Leadership and Support Service Staff - Respect for all staff regardless of role without healthy infrastructure support the clinical experience could not occur safely.

The leadership of the organization has the primary responsibility to establish expectations around respectful interaction and communication. Organizations should establish a code of conduct which outlines acceptable and unacceptable behavior. Leadership, furthermore, should model these appropriate behaviors and respond quickly to reports of violations. Leadership sets the stage for what will be tolerated.

8. Are there any tools that's available for use to get an initial baseline?

I assume this question refers to baseline of Safety Culture. There are several tools available to measure Safety Culture, such as the Agency for Healthcare Research and Quality’s Survey on Patient Safety Culture. There are versions for various settings. Another option is the Safety Attitudes Questionnaire (SAQ). These surveys don’t include questions about disrespectful behavior, however. You may want to add a few questions from the survey done by ISMP (https://ismp.org/Survey/surveyresults/Survey0311.asp).

9. Have you found a difference in the acceptance of Safety Culture in instances where an organization's executive team is composed of physicians verses non-physicians?

We have not conducted studies on this. It sounds like an interesting research project.