

Violence in the OR

A Never Tolerated Event



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Violence in the Perioperative Workplace: Introduction to the Problem

William Schechter, MD FACS

Professor of Surgery

University of California, San Francisco

American College of Surgeons



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CSPS Member Organizations Represent 250,000 Healthcare Providers

- American Association of Nurse Anesthetists (AANA)
- American Association of Surgical Physician Assistants (AASPA)
- American College of Surgeons (ACS)
- American Society of Anesthesiologists (ASA)
- American Society of PeriAnesthesia Nurses (ASPAN)
- Association of periOperative Registered Nurses (AORN)
- Association of Surgical Technologists (AST)

Council on Surgical and Perioperative Safety

- **Vision:**

The CSPS envisions a world in which all patients receive the safest surgical care provided by an integrated team of dedicated professionals.

- **Mission:**

The CSPS promotes excellence in patient safety in the surgical and perioperative environment.

The CSPS and Workplace Violence

A violence-free culture of mutual respect, dignity and fairness among individuals and professional disciplines is essential for the teamwork and communication necessary for patient safety.

Prevalence of Workplace Assaults in 2000*

Nurses	Other Private Sector Industries
25/10,000 employees	2/10,000 employees

*Occupational Safety and Health Administration. *Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers*. 2004.
Available at: <http://www.osha.gov/Publications/OSHA3148/osha3148.html>. Accessed January 27, 2009.

True Prevalence of Healthcare Workplace Violence?

*Unknown!! Many HCWs believe
workplace assaults are part of the job and
do not report them* or fear retribution***

*Barthel VA, Roman L. We stop aggression as soon as it starts. RN: 2004;67(10):33-36.

**Rosenstein AH. Nurse-physician relationships: Impact on nurse satisfaction and retention. Am J Nursing 2002;102:26-34.

Spectrum of Workplace Violence

- Verbal Abuse
- Threats
- Bullying
- Lateral Violence
- Intimidation:
Stalking, coercion
- Property Damage
- Sexual Harassment
- Physical Attacks

What is Workplace Violence?

Workplace violence can be any act of physical violence, threats of physical violence, harassment, intimidation, or other threatening, disruptive behavior that occurs at the work site

Non-physical violence is a risk factor for physical violence!!

- Survey of 600 nurses, other clinical providers and staff for preceding 12 months
- 72.8% non-physical violence
- 21.8% physical violence
- Workers experiencing non-physical violence were 7 times more likely to have experienced physical violence

Traumatic Death in Healthcare Workers

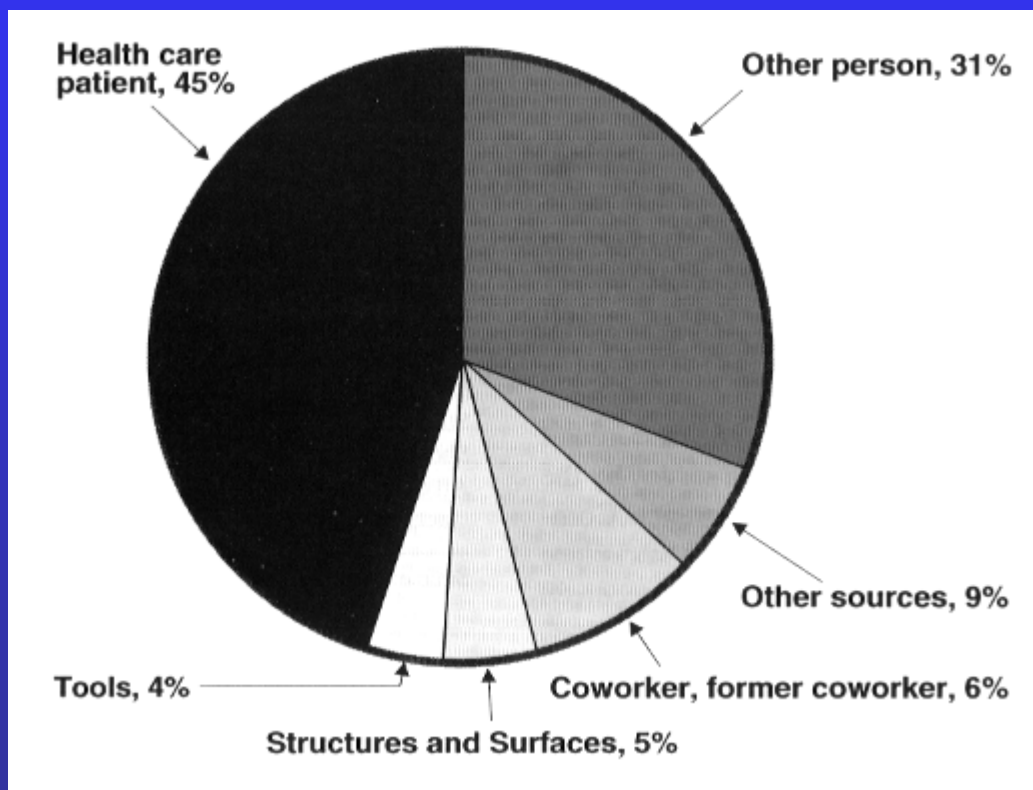
- 1980-1990 522 deaths due to injury
- 122 motor vehicle accident deaths
- 106 Homicides in healthcare workers while at work
- GSW caused death in 70% of cases
- 88 suicides

Goodman RA, Jenkins EL, Mercy JA. Workplace-related homicide among health care workers in the United States 1980-1990. JAMA 1994;272:1686-1688

Violent acts resulting in days away from work in 1992, by industry

Industry	Violent Acts resulting in days away from work (% Total)
<i>Services</i>	
Nursing home	64
Social Services	13
Hospitals	11
Other Services	13

Violent acts resulting in days away from work, by source of injury— United States, 1992.



Source: BLS, 1992

Workplace Traumatic Injury Reports in Health-Care and Social Assistance Workers in B.C. (2004)

Contact with objects & equipment	808
Falls	815
Body Reaction and exertion	3,539
Exposure to harmful substances	47
Transportation Accidents	71
Assaults and violent acts	275 (4.8%)
Unknown	2
Total	5,657

CBS News

<http://www.cbc.ca/news/background/workplace-safety/sick-workplace.html>

Emergency Department Workers are at High Risk

Study	n surveyed	n assaults
Gates et al.	242	329
Crilly et al.	71	110

Gates DM, Ross CS, McQueen L. Violence against emergency department workers. *J Emerg Med* 2006;31:331-7.

Crilly J, Chaboyer W, Creedy D. Violence towards emergency department nurses by patients. *Accid Emerg Nurs* 2004;12:67-73.

Nurses at Greatest Risk for Assault

Profession	% Reported Assaults
Nurses	43.4
Physicians	13.8

Winstanley S, Whittington R. Aggression towards health care staff in a UK general hospital: Variation among professions and departments. J Clin Nurs 2004;13:3-10.

Violence Against Surgical Residents

- Survey of 57 Residency Programs
- 475 Responses
- 179 residents reported having been assaulted
- 280 reported having witnessed an attack
- More attacks in public vs private hospitals ($p=0.05$)

Table 2.—Where Attacks Occur

Hospital Section	Reported Number of Attacks
Emergency room	173
Floor or ward	71
Parking lot	61
Hallway	16
Clinic	12
Cafeteria	1

Effective Violence Prevention Strategies

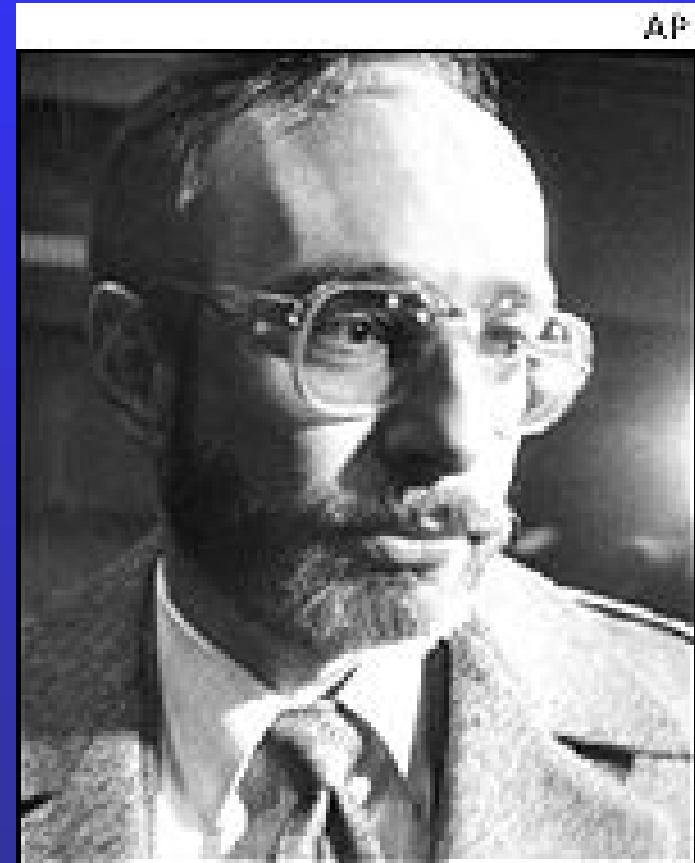
- Metal Detectors (Detroit Michigan)
- Data Base identifying patients with a history of violent behavior (91% reduction in violent attacks) (Portland, Oregon)
- Restriction or movement of hospital visitors (65% reduction in violent crimes) (NYC)

CDC/NIOSH. Violence: Occupational Hazards in Hospitals (DHHS NIOSH Publication No. 2002-101. April 2002. www.cdc.gov/niosh/2002-101.html

Homicide



Australian psychiatrist Margaret Tobin was shot dead by Jean Eric Gassy, a former colleague who has now been convicted of her murder



Dr. Slepain – murdered by anti-abortion activist

Risk Factors for Workplace Violence*

- Volatile Patients
- Understaffing
- Transporting patients
- Long waits for service
- Overcrowding
- Inadequate security
- Drug and alcohol use
- Lack of violence policies and training
- Poorly lit corridors
- Access to firearms

* NIOSH Violence. Occupational Hazards in Hospitals. DHHS (NIOSH)Publication No. 2002-101, April 2002. Available at:
<http://www.cdc.gov/niosh/2002-101.html#whatis>.

Consequences of Workplace Violence

- 25% Staff Turnover*
- Absenteeism**
- Post traumatic Stress***
- Heavier smoking, drinking, drug use*
- Loss of relationships*

*Speedy S. Workplace violence: The dark side of organizational life. Contemporary Nurse 2006;21: 239-50.

**Hutchinson, M. et al. They stand you in a corner; you are not to speak: Nurses tell of abusive Indoctrination in work teams dominated by bullies. Contemporary Nurse 2006;21:228-38.

***Henderson AD. Nurses and workplace violence: Nurses experiences of verbal and physical abuse At work. Nursing Leadership 2003;16:82-98

Who is Responsible ?

- Government
- Professional Organizations
- Regulatory Bodies
- Unions
- Healthcare Organizations—Employers
- Healthcare Providers
- Patients and Families

Key Elements of Workplace Violence Prevention Program*

- Policy
 - Zero Tolerance
 - Define behavior expectations
 - Whistle blower protection
 - Prompt reporting and response

*Occupational Safety and Health Administration. *Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers*. 2004. Available at:

<http://www.osha.gov/Publications/OSHA3148/osha3148.html>. Accessed January 27, 2009

Key Elements of Workplace Violence Prevention Program

- Confidential Analysis of all Workplace Violence Events
 - Individual vs. system causes
 - Timely performance improvement intervention
 - Violence reduction documented by outcome evaluation

Key Elements of Workplace Violence Prevention Program

- Safety and Security Plan
- Management and employee involvement
- Support services for victims of violence
- Legal Assistance
- Worksite analysis to identify hazards

Joint Commission Sentinel Event Alert—July 9, 2008

- Effective January 1, 2009
- Joint Commission Requirements
 - EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors
 - EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

Joint Commission Sentinel Event Alert—July 9, 2008

- Medical Staff Credentialing Process
 - Professionalism
 - Interpersonal Skills and Communication
- 11 other suggestions for reducing risk or dealing with work place violence

Joint Commission Suggestions

- Education of all team members re: professional behavior
- Hold all team members accountable for modeling desirable behavior
- Zero tolerance for disruptive behavior
- Defined organizational process for addressing disruptive behavior

Joint Commission Suggestions

- Skills based training of leaders to reduce conflict
- Assess staff perceptions re: seriousness of unprofessional behavior
- Develop reporting system for unprofessional behavior
- Support surveillance with tiered, non-confrontational interventions

Joint Commission Suggestions

- Conduct all interventions within an organizational framework with adequate resources
- Encourage inter-professional dialogues to address ongoing conflicts
- Document all attempts to address intimidating and disruptive behaviors

CSPS Recommendation

- The Council on Surgical & Perioperative Safety recommends that all healthcare organizations establish a health and safety committee to monitor, address and evaluate violence through a comprehensive workplace violence prevention program, which includes the following criteria

Creation and dissemination of a policy on workplace violence including the following provisions:

- a) Stipulating “zero tolerance” for violence.
- b) Communicating expectations to all employees and patients
- c) No reprisals for reporting
- d) Prompt reporting and leadership evaluation of incidents to assess risk and progress towards establishing a violence-free environment.

Perform a comprehensive and confidential analysis of all workplace violent events to determine

- a) If the cause(s) of a violent event are individual and/or system issues.
- b) The priority of potential solutions or changes.
- c) The timely implementation of individual and/or system improvement/process improvement actions.
- d) The success in reducing violence based on evaluation of outcomes.

3. Maintain a comprehensive plan for ensuring effective safety and security measures.

4. Require management commitment and employee/staff involvement.

5. Provide access to support services for victims of violent incidents.

6. Assist victims through the legal process.

7. Establish worksite analysis to view facilities records, trends, workplace security, and surveys for staff to identify hazards

What Does Violence Look Like ?

Sharon A. McNamara RN, MS, CNOR

Director Surgical Services

WakeMed Health & Hospitals Raleigh, N.C.

Association of periOperative Registered Nurses



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Behavior Exhibitors

- Physicians
- Registered Nurses
- Pharmacists
- Administrators
and Managers
- Allied Health
Personnel
- Patients
- BULLIES
- TORMENTORS
- DESPOTS
- UNCONSTRAINED
EGOMANIACS
- PSYCHIATRIC
DISORDERED
- SUBSTANCE
ABUSERS

Workplace Violence

- Intimidation: stalking, or engaging in actions intended to frighten or coerce
- Threats: an expression of intent to cause physical or mental harm
- Physical attacks
- Property damage: intentional damage to property
- Sexual Harassment

VERBAL ABUSE

- Verbal outbursts, yelling, screaming
- Exaggerated tone of voice
- Angry tone
- Derogatory statements
- Cursing, cussing, foul language
- Inappropriate language
- Racial or ethnic slurs

Non Verbal Abuse

- Raising eyebrows
- Face making
- Eye rolling
- Turning away
- Physically excluding another

Physical Abuse

- Threatening body language
- Aggressive movement, gestures.
- Actual physical attacks fighting, hitting, spitting, pushing, shoving, pinching, kicking.
- Any unwanted or hostile physical contact
- Throwing objects

SEXUAL HARRASSMENT

- Overly friendly or sexual behavior
- Lack of respect for the individual
- Invasion of personal space with intention to intimidate
- Verbal conduct of a sexual nature
- Vulgar, sexual language
- Off color, “dirty” jokes or stories

Sexual Harassment

- Referring to a persons body or sexually objectifying instruments, etc.
- Unwelcome advances
- Requests for sexual favors
- Physical conduct of a sexual nature
- Beware of double innuendos

Passive Behavior

- Refusing to return phone calls
- Not answering pages
- Using condescending language
- Displaying impatience with inquiries
- Not communicating complete information
- Silence

PASSIVE- AGGRESSIVE BEHAVIOR

- Badmouthing the organization, nursing staff or physicians to patients or others
- Discrediting leaders
- Encourage other practitioners to disregard policies & procedures
- Backstabbing
- Broken confidences

Inappropriate Employer Behavior

- Threats of reporting a person
- Threats of affecting employee's performance evaluation
- Demeaning staff
- Berating individuals in private or in front of others
- Denying staff's physical or emotional injury from an event

Risk Factors for Violence

- Increased patient acuity & decreased length of stay intensify the work place environment
- Inappropriate behaviors create distractions
- Fear of retaliation
- **Belief “nothing ever changes”**
- Inappropriate staffing volumes

Risks Continued

- Increased Pace
- Volumes
- Patient flow
- Capacity issues
- Extended shift & mandatory over time
- Working alone
- Transporting patients



Risks Continued

- Poor environmental design
- Overcrowded, uncomfortable waiting areas
- Poorly lit corridors, rooms, parking lots, etc.
- Unrestricted access & movement of the public
- Inadequate security
- Working understaffed
- Volatile people, under the influence of drugs, alcohol, or with psychiatric diagnosis or a history of violence
- Access to firearms or weapons

Fastest Growing Area of Workplace Violence “Bullying”

The International Labour Organization defines bullying as “offensive behavior through vindictive, cruel, malicious, or humiliating attempts to undermine an individual or group of employees”

Who Can Bully?

- Colleagues
- Physicians
- Employers
- Supervisors
- Managers
- Patients
- Families



Bullying Behaviors

- Sadistic or aggressive behavior over a period of time
- Exclusion from meetings or opportunities for advancement
- Persistent or unwarranted criticism in public or private
- Changing work responsibilities unreasonably or without justification

More Bullying Behavior

- Deliberately withholding information to affect work performance
- Punishing others for being too competent
- Overworking or overloading for purposes of punishment

Risk Factors for Workplace Bullying

- Stress
- Tension
- Frustration
- Poor Management Skills
- Poor policies or failure to enforce
- Lack of training to recognize or cope with bullying
- Lack of reporting systems
- Lack of punishment of perpetrators

Effects of the Problem

- Low staff morale
- Job dissatisfaction
- Increases stress levels & stress related illness
- Increased absenteeism
- Deterioration in the quality of patient care
- Sleeplessness & loss of appetite
- Depression, self blame, loss of self confidence putting the nurse and patient in danger
- Loss of creative problem solving capacity
- Poor performance & lost productivity
- Attrition

Effect on Patient Safety

- Pain or prolonged pain
- Receiving medications or antibiotics late
- Being mistreated
- Being misdiagnosed
- Dying
- Wrong site surgeries
- Wrong medications

We need to honor our diversity



Let's Take a Look at the Problem Through Research



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Panel Presenters

Pamela Windle MS, RN, NE-BC, CPAN, CAPA, FAAN
American Society of PeriAnesthesia Nurses
Nurse Manager, St. Luke's Episcopal Hospital
Houston, Texas

Tom McKibban CRNA, MS
American Association of Nurse Anesthetists

Margaret Rodriguez CST, CFA, BS
Association of Surgical Technologists
Associate Professor, El Paso Community College
El Paso, Texas

Voices of the Nurses

Pamela Windle MS, RN, NE-BC, CPAN, CAPA, FAAN
American Society of PeriAnesthesia Nurses
Nurse Manager, St. Luke's Episcopal Hospital
Houston, Texas



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Research Studies

- 81% of workplace bullies are done by “out of control” supervisors and managers & “control-freak physicians”
(Gary & Ruth Namie, PhD – bullyinginstitute.org)
- 90-97% of nurses experience verbal abuse from physicians in the US. (Manderins and Berkey 1997)
- Nurses are 57% more likely to be assaulted than physicians; (Department of Justice 2001) higher among ED nurses (Roll, 2005)
- Study on Nurses in Hostile Work Environment:
(Chiders 2004; Gary Namie 2003)
 - 70% leave their workplace after being targeted
 - 39% of targeted victims became depressed
 - 41% targeted women & 37% targeted men are diagnosed with post traumatic stress disorder (PTSD)
 - “Code Pink”...encircles the perpetrator in a group for unacceptable behavior

Research Studies

- Survey of 4,530 nurses, physicians & other health care employees & professionals:
 - 77% reported witnessing disruptive behavior by physicians
 - 65% reported witnessing disruptive behavior by nurses
 - 67% respondents agreed disruptive behaviors were linked with adverse events

(Rosenstein AH, 2005, Medical Director of VHA West Coast - study published in TJC Journal on Quality & patient safety, Aug 2008)

- Institute for Safe Medication Practices (ISMP) 2003 study on Intimidation:
 - 40% of health providers had kept quiet or remain passive rather than question a known bully during patient care events.

Lateral Violence (LV) in Nursing

- 25 out of 26 newly hired RNs in a Boston hospital experienced LV during orientation (*Griffin 2001 published in 2004*); new RNs were criticized and verbally abused. (*Bartholomew 2004*)
- 95% of 210 nursing participants reported having experienced LV during their nursing career. (*Random sample in Upstate South Carolina attending a workshop*)
- 34% of 551 student nurses surveyed reported incidence of LV. (*Leiper 2005*)

Lateral Violence (LV) in Nursing

- 55% of 1,129 nurses surveyed have witnessed at least one incident of LV. *(Nursing, 2006; web-based survey)*
 - One out of six nurses experience LV, and only 6% will report it. The most stressful is when the co-worker is the perpetrator. *(Center for American Nurses 2007)*
 - 60% new nurses leave their 1st professional position within 6 months because of some form of LV against them. 20% leave the profession forever. *(Griffin 2006)*
- “Zero Tolerance” or “Top down- bottom up” approach is required to effectively address LV in Nursing.*

International Studies

- “*The national survey report of work and health of nurses*” – study showed that Canadian nursing shortage will increase because of management issues in failure to control workplace bullying. (*Still, Shields & Wilkins 2005*)
- Feelings of helplessness lead to increase absenteeism, stress, resignation & nursing shortage. (*Canadian Institute for health Information 2007*)
- Other countries have reported workplace bullying among nurses: (*Cooper & Swanson 2002*)
 - United Kingdom (UK)
 - North America
 - Finland (5%)
 - Europe
 - Australia
- One in six reported experiencing workplace bullying among 4,500 nurses in the UK. (*Gilmour & Hernlin, 2003*)

Reasons for Underreporting Violence

- Many believe violence is just part of the job (Randle, 2003)
- More likely to report physical violence
 - require healthcare attention
 - usually involve a patient-related perpetrator
(Hodgson et al., 2004; Lanza et al., 2006)
- Less likely to report nonphysical violence
 - no injury occurred = so why report? No need to report
(Dunbar 2005; Gerberich et al., 2004; May & Grubbs, 2002)
- Perceived lack of support from supervisors (Farrell 1997; Alspach 2007)
- Supervisor is the perpetrator (Namie, 2003; Hastie 2002; Findorff et al., 2005)
 - raising of eyebrows, belittling, abrupt response, humiliation, etc
- Victims are labeled as “oversensitive & misinterpreting”
(Curtis, Ball & Kirkham 2006, Griffin 2005)
- Believe reporting would not make a difference
(Findorff et al., 2005; Gerberich et al., 2004; May & Grubbs, 2002; McKenna et al. 2003)

Are Physicians the worst offenders?

- **Probably...**
 - *Severity*
 - *Impact*
 - *Surgeons (Rosenstein 2006)*
- **Physicians as “customers”...**
 - *Impatient with questions*
 - *Condescending language or tone*
 - *Reluctance/refusal to answer questions or phone calls*
 - *Clarifying orders or not eligible handwriting*

What about Nurses? Allied Health Workers?

The answer is: WE are all offenders!

Workplace Violence – Not new!

- Over 25 yrs ...
- Estimated 1.7 million workers injured yearly during workplace assaults (Bureau of Statistics 2005); 18% are violent crimes in the US (Bureau of Justice Statistics 2001)
- Estimated 2,637 nonfatal assaults on hosp. workers occurred in 1999 (8.3 assaults/10,000 workers - B of Statistics)
- Legislation is calling for a workplace violence prevention program for health care workers.
- Effective January 1, 2009, TJC added a new leadership standard (LD.03.01.01) that addresses disruptive and inappropriate behaviors.

Impact of Workplace Violence

Disruptive behaviors can contribute to:

- Patient dissatisfaction
- Staff dissatisfaction
- Errors
- Resignation
- Staff turnover
- Increase in the cost of care
- Seeking new jobs with better professional working environment

Case Study A

A MVA patient was seen in the ED and several physicians were consulted. It was decided that the patient's injuries were not life-threatening by two other surgeons but a neurosurgeon decided the patient need to have surgery.

On arrival to the OR, the surgeon was notified that the surgery could not proceed until the instruments borrowed from another hospital were sterilized. The surgeon became mad, irate and demanded that the surgery proceed without completion of the sterilization process. The OR nurse refused.

The surgeon began screaming, yelling and threatening the nurse, who left the front desk and went to the women's locker room. The surgeon followed her, still screaming, and pushed her repeatedly. Another staff witnessed the behavior and called the hospital security. Two off-duty policemen came and arrested the surgeon and removed him from the premises.

Case Study A (cont'd)

There were reports of alcohol on the surgeon's breath, but breathalyzer tests were inconclusive. The hospital suspended the surgeon's privileges until further review by the service chief and medical staff director. The surgeon was reported to the state licensing board, which temporarily suspended his license pending a hearing.

At the hearing, the judge reinstated the physician's license, and the licensing board took no further action. The hospital then reinstated the physician's privileges and he went back to practice at the same hospital. The surgeon never apologized to the OR nurse.

The patient did have the surgery the next day with an uneventful event....

Case Study B

On a busy Thursday, the hospital census was full, ED was on drive-by, and surgeries were backlogged and “on hold” due to no PACU space available and the ICU-overflow patients from the night before were still in PACU. Anesthesiologist and surgeons were getting upset that their cases were placed on hold and were not allowed to start any other cases until further notice.

In the busy and crowded PACU, the charge nurse assigned an intubated Whipple patient to Nurse A, with less than one year experience, and had been taking care of another intubated ICU craniotomy patient who arrived 45 minutes ago. Nurse B, a very experienced ICU nurse, known to be abrasive toward her peers (particularly those who are inexperienced) had one stable outpatient.

Case Study B (cont'd)

During the course of recovery, Nurse A observed a worrisome pattern of weakness on one side and small seizure-like activity on her 1st patient, but was afraid to “speak up” to Nurse B or the charge nurse for help. She assumed that she had everything under control and did not call the physician for consult. She also felt intimidated and undermined by her colleagues.

After an hour later, the neurosurgeon came by to check the patient in PACU and noted the patient to be unresponsive. Nurse A was yelled at by the charge nurse and the surgeon. Nurse B grinned and gave her “the look”. Nurse A was humiliated, criticized and blamed for what happened.

The patient had an emergency CT Scan and was taken back to surgery for re-evacuation of hematoma. The patient was transferred to the Neuro ICU immediately after surgery.

Case Study C

As a new graduate RN, I quit my first job because I was so threatened and demeaned. I felt I could not focus on what I enjoyed most: taking care of surgical patients in the OR. I was trying to learn as fast as I can, but my preceptor was not defending me when I was yelled at by the physicians, co-workers or first assistants because I was S-L-O-W! Physicians threw instruments at me a few times and I received some inappropriate remarks from other nurses.

Why did I allow that physician or another co-worker to scream at me???

I wanted to leave the nursing profession. There are other professions where they don't tolerate abuse and I want to be respected as a professional, taking care of human lives. It's ironic that violence supposedly is due to a shortage of nurses; when this violence is what's causing nurses to leave.

It is all about
Professionalism, Respect
and Courtesy

Tom McKibban CRNA, MS
Past President AANA



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Our Environment

- Speaking from a clinical perspective
- We work in a high stress environment where decisions are made quickly and many times under stressful situations
- **HOWEVER:** This is no excuse for unprofessional or disruptive behavior!

Scenario One

- Physician not reporting to OR to do cases after tourniquet up for 30 minutes. RN and Anesthesia “wrote” behavior up – physician told RN she didn’t go to medical school, she was just a nurse and couldn’t tell him what to do. Anesthesia backed down and didn’t support RN. Threatened RN with her job.
- Not a JCH accredited hospital – Physician one of owners.

Scenario Two – Physician Specialty Hospital

- Dr. dropped implant & told RN to process - she put it in auotclave and he said that took too long to soak in cidex instead – put in cidex and he wanted it out after 2 minutes to use – RN filled out incident report on Dr. and he pulled RN aside and threatened her job

Scenario Three

- Anesthesia provider threatened RN job because of the way she positioned patient for a pain procedure. This was done in front of the awake patient. When confronted, physician told administration he was an owner and would do what he wanted. The behavior rules are for JCH accredited hospitals.

Something to Talk About

Margaret Rodriguez, CST, CFA, FAST, BS

Association of Surgical Technologists

Associate Professor, El Paso Community
College



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Topic of AST Discussion Board: “Abuse in the OR”

- Surgical Technologists and students post frequently on their discussion board about the culture of the OR.
- The research statistics for OR nurses apply equally to the allied health professionals.
- These are actual posts from 2006 to present.

Topic of Discussion : Abuse in the OR

“Help, I'm wondering if I can do this job!!! My first few weeks of clinicals I went home and cried every day. It is so stressful. I am so scared every morning, not just about the surgeries but about what preceptor and Dr's I will be with. The preceptors at our hospital hate having students with them and some of them won't even talk to us. Many of the Docs are jerks who have no patience for a student.”

Topic of Discussion : Abuse in the OR

“We all have had many nightmares, with docs, hospitals, vendors, etc. Focus on the end goal, pt. safety, and you will be fine, but is a rough road to hoe at times.”

Topic of Discussion : Abuse in the OR

“He's in fast motion and wants things BEFORE he asks for them. That's okay with me, I get along with most any personality type. Anyway, he's impatient and patronizing-you know the type. Well, on Friday, he kept jerking my hands all around during a knee scope and scolding me for not holding the knee correctly or in the right place, etc...

Continued...

“I was getting kind of uncomfortable, not from the scolding, but from the rough way he was physically placing my hands around. Then he literally shoved me back with his elbow. Okay, the floor can get extremely wet when you're doing a knee scope as you all know. He's really lucky I didn't slip and fall. ...

Continued...

“My problem is-I'm new and on probation for 3 months. I don't want to come across as a trouble maker or complainer but I'm afraid if he continues to treat me this way- I'm going to just end up responding to his roughness by saying something during surgery which I don't want to do. ...

Continued...

“What would some of you long time veterans do? No job is worth being treated this way but I do think there is potential here and don't want to quit before I really even begin.”

Topic of Discussion : Abuse in the OR

“I've tried to speak to people, they say ‘It's just how they are, you have to ignore them, what do you care, you still have your job, don't you??’”

“This is why I quit and went back to school. in any other job this would not be tolerated. Hospitals lose a lot of nice caring, considerate people this way.”

Topic of Discussion : Abuse in the OR

“There have been incidents in the holding area, where circulators and surgeons will verbally fight and yell at each other, throwing insults IN FRONT OF PATIENTS AND THEIR FAMILY. IN FRONT OF THE O.R MANAGER, that have nothing to do with the case.

I've also witnessed yelling and verbal abuse, and PHYSICAL abuse (including it happening to yours truly) while the patients were awake, or under local.”

Topic of Discussion : Abuse in the OR

“Remember, you are not a doormat, but there is a place and a time for asserting yourself. If a patient is going bad, it is not the time to call someone out on a power trip. As far as others, remember, no one can make you feel inferior without your consent. We are all adults in surgery, and it can be hard to remember to behave as such.”

Better teamwork in the
O.R. has been associated
with better patient
outcomes.

(Yule. Rlin. Maran. et al. “Surgeon’s Non-Technical Skills in the Operating Room.”
The World Journal of Surgery. April, 2008.)

Finally...

“He was sitting to do the case, the patient was up in stirrups, and for some reason we could not get the lights positioned to suit him. He was getting frustrated, grumpy and critical, and after a few minutes he finally yelled ‘The a\$\$hole!! Shine the light on the a\$\$hole!’

The circulator and I looked at each other and simultaneously, without a word, moved both lights to shine right on his HEAD! He looked up, around at the staff in the room, and announced ‘I guess I deserved that, didn't I?’ Everyone in the room giggled at that remark, he calmed down a little, and we finally got the lights to suit him.”

How can we help?

- Culture of safety in an organization
- Non-punitive approach to error management (systems vs human errors)
- Set behavioral expectations and disciplines for disruptive employees – which may endanger patients
- On-going education and training for employees



Safety for ALL



Patients and Practitioners!!!



“Our lives begin to
end the day when we
become silent about
things that matter”



Martin Luther King, Jr.

How Do We Move To And Maintain A Culture Of Safety?

Mark J. Lema M.D, Ph.D.
Professor of Anesthesiology and Oncology
Chair of Anesthesiology
University at Buffalo, SUNY
Roswell Park Cancer Institute



COUNCIL ON SURGICAL &
PERIOPERATIVE SAFETY

One Team. One Goal. Surgical Patient Safety.

Violence In The Healthcare Workplace: A Growing Concern

**Roswell Park Email Message sent to entire
Institute Staff – Initiated by the Medical Staff
Executive Committee**

Violence can include the following:

Intimidation

Verbal threats

Physical violence

Property damage

Sexual harassment

Violence In The Healthcare Workplace: A Growing Concern

- ...it is our responsibility to treat not only our patients and families, with respect, but also our colleagues and coworkers. Should interpersonal conflicts arise that are not resolved through routine informal dialogue, employees are encouraged to utilize available on-site resources, such as the **Conflict Resolution Support Service Process**

Violence In The Healthcare Workplace: A Growing Concern

Policies available RPCI website:

- RPCI Corporate Code of Conduct
- Employee Conduct Policy
- Non-Retaliation Policy
- Requirements for the Institute to Report Disciplinary Action and Professional Misconduct of Physicians and Other Professional Licensees

ROSWELL PARK CANCER INSTITUTE CORPORATE CODE OF CONDUCT

- Standard 1.6 – Discrimination

- No form of harassment or discrimination on the basis of sex, race, color, disability, age, religion or ethnic origin or disability or any other classification prohibited by law will be permitted. Each allegation of harassment or discrimination will be promptly investigated in accordance with applicable policies.

EMPLOYEE CONDUCT POLICY

- **D. POLICY / PROCEDURE**

Patients, visitors and other staff members will be treated with dignity, courtesy and friendliness. Employees may not mistreat, abuse, or intimidate other individuals, physically or verbally.

- **Physical violence will not be tolerated.** This includes, but is not limited to fighting, roughhousing, pushing around and wrestling.
- **Employees will speak in tones that are appropriate to a hospital environment.** Obscene and/or profane language is not acceptable. Raised voices are not acceptable in public, patient care or other work areas unless necessitated by an emergency situation.
- **All employees are expected to demonstrate a courteous, positive and helpful demeanor** when communicating with patients, visitors, staff and the public in all of their verbal and written communications. If an employee cannot answer a question, he or she is to refer the individual to an office or individual who can help.

NON-RETALIATION POLICY

D. POLICY / PROCEDURE

- ...In fact, **failure** to report known violations may be grounds for disciplinary action.
- Employees with knowledge of actual or potential wrongdoing, misconduct, or violations of the compliance plan, or who have a concern or problem regarding compliance are to report immediately to an appropriate internal resource, including:
 - The employee's supervisor
 - Any manager or administrator
 - RPCI's Compliance Officer by email or by telephone, or
 - The RPCI Corporate Compliance **HOTLINE**
 - Employee and Labor Relations Office

NON-RETALIATION POLICY

- Employees who report problems or concerns in good faith will be **protected from retaliation, retribution or harassment**.
- Employees who engage in retribution, retaliation or harassment or who intentionally make **false reports** will be subject to disciplinary action up to and including termination from employment...
- The RPCI Compliance Hotline permits individuals to call, **anonymously** or in confidence, to report problems and concerns or to seek clarification of compliance-related issues.
- Employees **cannot exempt themselves** from the consequences of wrongdoing **by self-reporting**, although self-reporting may be taken into account in determining the appropriate course of action.
- **Confidentiality** regarding employee concerns and problems will be maintained at all times **insofar as legal and practical**, informing only those personnel who have a need to know.

DISCIPLINARY ACTION AND PROFESSIONAL MISCONDUCT OF PHYSICIANS AND OTHER PROFESSIONAL LICENSEES POLICY

- **The reasons for reporting shall be related to:**
 - alleged mental or physical impairment, incompetence, malpractice, misconduct or endangering of patient safety or welfare;
 - voluntary or involuntary resignation or withdrawal of association, employment, or privileges with the hospital to avoid the imposition of disciplinary measures;
 - the receipt by the Institute of information concerning a conviction of a misdemeanor or felony.
- Physician or Physician's Assistant - Sent to the Office for Professional Medical Conduct – NYSDOH w/in 30 days
- Other Health Professionals, Including Students - Sent to the NYS Dept of Education w/in 30 days

www.cspsteam.org

RPCI Alternative

- **Conflict Resolution Support Service for Faculty and Staff**
 - Provides an early and efficient internal conflict resolution process for settling interpersonal conflicts that occur among employees
 - Offers a safe harbor to discuss any workplace concern, off the record.
 - Voluntary, non-legal process to prevent or resolve a dispute collaboratively

www.cspsteam.org

Conflict Resolution Support Service

- **Voluntary** – all parties must agree
- **Confidential** – no name based records
- **Informal** – office meeting
- **Expedient** – often resolved in a few hours
- **Empowering** – parties tailor their own course
- **Effective** – supports good work relationships
- **Subsidized** – no cost to parties
- **Available** to all

Conflict Resolution Support Service

For More Information:

Call Conflict Resolution Support Service at 716-845-3566 to:

- Discuss options for addressing a concern.
- Make an appointment.
- Schedule an educational presentation.
- Receive more information.

Conflict Resolution Support Service is Not for:

- Disputes with supervisors over teams and conditions of employment governed by the collective bargaining agreements (e.g., scheduling, discipline, etc.).
- Tenure decisions.
- Illegal discrimination or discriminatory harassment.
- Serious misconduct/criminal conduct.
- Discharge from the Institute.



Roswell Park Cancer Institute is committed to providing a timely and efficient internal conflict resolution process for settling interpersonal conflicts that occur among employees. This will allow those involved in such conflicts to continue working together productively. It is a completely voluntary process that does not replace or supersede any rights employees have under any Institute policy or applicable collective bargaining agreement. This process is simply another tool employees may use to help them resolve conflict on their own and develop positive working relationships. For further information, see RPCI Policy and Procedure #114.1.

Nondiscrimination Policy Statement

Roswell Park Cancer Institute prohibits all forms of employment discrimination. Employment discrimination describes actions, practices or employment decisions based on any of the following characteristics or status protected by law: race, sex, creed, color, religion, national origin, age, disability, sexual orientation, marital status, military status, pregnancy, or genetic predisposition or carrier status. It is the policy of the Institute to provide equal opportunity in all areas of employment including: recruitment, hiring, promotion, training and development, benefits and separation.



Elm & Carlton Streets • Buffalo, New York 14263
www.roswellpark.org
1-877-ASK-RPCI (1-877-275-7724)

A National Cancer Institute-Designated Comprehensive Cancer Center
A National Comprehensive Cancer Network Member
A Blue Distinction Center for Complex and Rare Cancers™

Conflict Resolution Support Service for Faculty and Staff



Your partner in understanding, addressing, and resolving workplace conflicts.



Corporate Compliance Hotline: 716.845.3566

Conflict Resolution Support Service

Individual Consultation

Helping You Discover Alternatives for Reaching a Solution

Consultation provides you with a safe harbor to discuss any workplace concern, off the record, and explore alternatives for addressing it. We will talk with you by phone (anonymously if you prefer), or meet with you in person. No one will be notified of your concern without your permission.

Conflict Resolution Support Service

Helping You Hold Difficult Conversations and Resolve Difficult Situations

Mediation is a voluntary process to head off or resolve a workplace dispute collaboratively. It allows two or more parties to communicate openly and honestly, in a safe and structured setting, about a disagreement. The professionally trained conflict resolution support service staff assists parties to hear each other, to understand each other's perspective, and to develop constructive outcomes.

Conflict Resolution Support Service is especially effective at the early stage of a disagreement, opening up communication before the concerns escalate. We encourage people to make use of our service sooner rather than later! However, later stage disputes can also be resolved successfully.



Giving You the Information You Need to Understand and Address Conflict

Conflict Resolution Support Service is a voluntary, non-legal process to prevent or resolve a dispute collaboratively. It allows two or more parties to communicate openly and honestly, in a safe and structured setting, regarding a conflict. The professional conflict resolution support service staff assists parties to hear each other, to understand each other's perspective, and to develop constructive outcomes.

Professional Conflict Resolution Support Service Staff on Hand

All Conflict Resolution Support Service staff are professionally trained and have a solid base of experience and expertise, including a wide knowledge of Institute policy and procedures.

When to Use Conflict Resolution Support Services

Conflict Resolution Support Service is appropriate and has been very effective for many issues, including:

- Differences or disagreements with colleagues and co-workers, including personality conflicts.
- Miscommunication or lack of communication.
- Tensions caused by the workload or by the work environment.
- Disagreements over job responsibilities.
- Concern over misunderstood discipline.
- Misunderstandings about department rules and regulations.
- Conflict between members of different departments who need to work together.

Conflict Resolution Support Service is...

- **Voluntary** - All participants choose whether or not to be involved in the process.
- **Confidential** - Conflict Resolution Support Service staff are bound to strict confidentiality, and no name-based records are kept.
- **Informal** - It often takes place around a table in a private office. Privacy is protected because there are no public hearings or public documents.
- **Expedient** - Sessions are usually scheduled for two hours, and many cases are settled within that time frame. Of course, additional sessions can be scheduled if needed.
- **Empowering** - Individuals involved create their own solution or course of action. It is far easier to follow through with a plan you have tailored to meet your needs than with a plan imposed on you by someone else.
- **Effective** - It is especially useful in the work place, where a good work relationship needs to continue. In mediation, no one loses.
- **Subsidized** - Conflict Resolution Support Service are supported by the Institute, at no cost to you or your department. A fee-for-service mediator from outside the Institute can be arranged, if preferred.
- **Available to all** - This Service is available to all people who work at the Institute and is intended to include managers, supervisors, employees, students, trainees, volunteers and supplemental staff employed through contract agreement.

Conflict Resolution Support Service

- **Effective in situations like:**
 - Differences or disagreements with colleagues and co-workers, including **personality conflicts**
 - Miscommunication or **lack of communication**
 - Tensions caused by **workload or work environment**
 - Disagreements over **job responsibilities**
 - Conflicts between members of different departments who **need to work together**

Conflict Resolution Support Service

- **This Service is NOT for:**
 - Disputes with supervisors over terms and conditions of employment governed by [unions]
 - Tenure decisions
 - Illegal discrimination or discriminatory harassment
 - Serious misconduct/criminal misconduct
 - Discharge from the Institute

PROFILE OF A DREAM TEAM

- **Works toward a common goal**
- **Develop its member skills**
- **Efficiently uses its time and talents**
- **Embraces the diversity of its members**
- **Is committed to continuous improvement**
- **Builds morale internally**
- **Performs effectively and produces results**
- **Accepts praise and criticism**
- **Cooperates rather than competes**

PROFILE OF A DREAM TEAM

- **Maintains a positive attitude toward everyone's ideas**
- **Stays on task**
- **Uses resources wisely**
- **Communicates openly**
- **Teaches and learns from one another**
- **Resolve conflicts effectively**
- **Welcomes challenges**
- **Shares pride in its accomplishments**
- **Celebrates success**

ALL I REALLY NEED TO KNOW I LEARNED IN KINDERGARTEN

- Share everything.
- Play fair.
- Don't hit people.
- Put things back where you found them.
- Clean up your own mess.
- Don't take things that aren't yours.
- Say you're sorry when you hurt somebody.
- Live a balanced life - learn some and think some and draw and paint and sing and dance and play and work every day some.
- When you go out in the world, watch out for traffic, hold hands and stick together. By Robert Fulghum www.robertfulghum.com/



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