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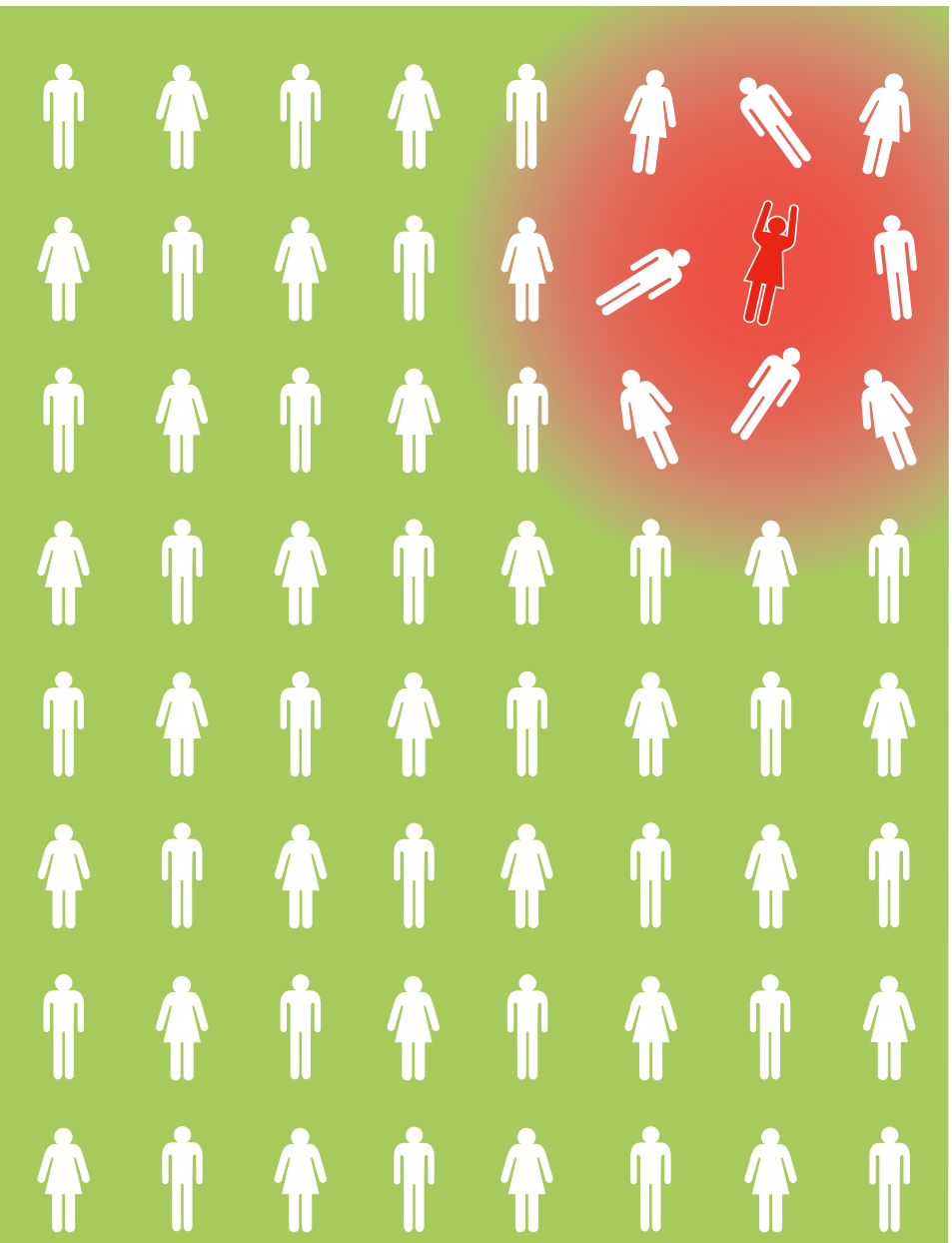

Managing
Disruptive Behaviour
in the Healthcare Workplace

PROVINCIAL FRAMEWORK

MARCH 2013

Contents

A CONSENSUS DOCUMENT SUPPORTED BY THE HEALTH QUALITY NETWORK, AN HQCA COLLABORATIVE CONSISTING OF: ALBERTA COLLEGE OF PHARMACISTS, ALBERTA FEDERATION OF REGULATED HEALTH PROFESSIONS, ALBERTA HEALTH, ALBERTA HEALTH SERVICES, ALBERTA MEDICAL ASSOCIATION, COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA, COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA, COVENANT HEALTH, HEALTH QUALITY COUNCIL OF ALBERTA.

Foreword

"EVERY ACTION DONE IN COMPANY, OUGHT TO BE WITH SOME SIGN OF RESPECT, TO THOSE THAT ARE PRESENT."[1]

– GEORGE WASHINGTON, C1748

We are beginning to hear more about workplace bullying and intimidation, the toll it takes on workers and the impact on the services they provide. Sadly healthcare providers often break the first rule of civility and decent behaviour recorded by George Washington when he was 16 years old, and the consequences for patient care can be significant or even deadly. Poor interpersonal behaviour erodes trust and respect, and results in communication breakdowns that can threaten the safety of our patients and the quality of their care experience. Building and maintaining respectful, trusting relationships is essential for communication of safety critical information in patient care. While the patient-caregiver relationship is of prime importance, other relationships can have a profound effect on patient safety and quality of care: relationships between colleagues and with other care providers, and relationships between healthcare organizations, their patients, and those who work with and for them to provide services.

To help healthcare organizations address this important issue, the Health Quality Council of Alberta (HQCA) is pleased to present the Provincial Framework for Managing Disruptive Behaviour in the Healthcare Workplace. The accompanying toolkit of resources is intended to support organizations in developing proactive policies and processes to address potentially disruptive behaviours before they negatively impact patient care.

I would like to acknowledge our partners in developing this framework: the College of Physicians & Surgeons of Alberta, Alberta Health Services, Covenant Health, the College and Association of Registered Nurses of Alberta, the Alberta College of Pharmacists, the Alberta Federation of Regulated Health Professions, the Alberta Medical Association, and Alberta Health. The work of this group modeled the level of collaboration and cooperation needed at all levels of the health system to create psychologically safe workplaces where both healthcare providers and the patients they serve feel respected and engaged in contributing to a safe and high quality care experience.

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March 2013

Introduction

QUALITY AND SAFETY IMPROVEMENT WILL OCCUR WHEN THOSE WHO WORK IN HEALTHCARE FEEL RESPECTED BY THEIR CO-WORKERS AND SAFE TO SPEAK UP IF THEY HAVE A CONCERN ABOUT PATIENT CARE.

Continual improvement in quality and safety of healthcare is most likely to be achieved in an environment where caregivers feel both respected by those they work with, and safe to speak up if they have a concern about a patient care issue. Unfortunately the disrespectful behaviour of a few individuals can have a chilling effect on the healthcare workplace, creating barriers to communication and effective teamwork that potentially threaten safety and quality of care. This issue affects and applies to all healthcare workers, including but not limited to: executives and senior leaders; managers; doctors and other frontline care providers; students and their preceptors; technical, administrative and support workers; and volunteers. It also impacts healthcare team members who collaborate to deliver care across different workplaces.

PURPOSE

This framework is intended to help organizations that deliver healthcare services or educate, regulate or support healthcare providers develop strategies to address disrespectful behaviour and contribute to the creation of a healthy workplace in which safe, high quality care can be provided. It will assist organizations in developing local policies and practices that enable healthcare workers to deal with disruptive behaviour at an interpersonal level, and establish a more formal process for dealing with unresolved or ongoing issues. By developing similar processes, educational programs for healthcare providers can emphasize teaching messages about the importance of respectful conduct to patient care, and protect their students and trainees. The framework will also be helpful to individuals who want to learn more about this issue specifically within healthcare.

BACKGROUND

The framework is based on the *Managing Disruptive Behavior in the Healthcare Workplace Guidance Document and Toolkit* published by the College of Physicians & Surgeons of Alberta (CPSA) in October 2010.[2] The original CPSA document incorporated feedback from various healthcare organizations and a comprehensive consultation process with the medical profession and related groups. Although it was doctor-focused, the CPSA document included strategies that are adaptable to other healthcare workers and workplaces. The CPSA worked closely with the HQCA and a multi-stakeholder working group to adapt their guidance document for a broader audience in Alberta's health system.

OVERVIEW

The framework describes the extent of disruptive behaviour in the healthcare workplace, outlines expectations for behaviour, and explains the implications of disruptive behaviour for individuals, the organization, and patient care. It articulates management principles, emphasizing prevention and the role of leadership, and the need to empower individuals to try to resolve interpersonal issues in a constructive way. A systematic approach to reporting, reviewing and resolving these difficult situations is outlined. The accompanying toolkit contains sample templates and checklists that can be used to develop local policies and tools to help manage this challenging issue.

Organizations can find guidance on this topic in other documents, such as legal statutes and regulations, contracts, and organizational policies and procedures. However laws, policies, information and tools are rarely enough to successfully address the issue of disrespectful and disruptive behaviour. A culture shift is also required to create psychologically healthy workplaces in which all individuals feel respected and empowered to address unacceptable behaviour at an interpersonal level before it becomes a problem. To make this kind of shift takes months, and sometimes years, but the improvement in morale, work performance, patient care and safety will be worth the effort.

THE FRAMEWORK DOES NOT:

- Address the issue of disrespectful or disruptive behaviour directed towards healthcare workers from patients/clients/residents or their supporters. This is an important issue that healthcare delivery organizations need to address but it is outside the scope of the framework.
- Outline how to deal with every possible form of unacceptable behaviour. Specific offenses not covered in this document should be dealt with under the relevant legislation, bylaws, professional standards of practice or codes of conduct.
- Provide legal advice, or advice regarding human rights or occupational health and safety legislation. It is offered as a guide to help organizations develop policies and procedures to manage disruptive behaviours of all those who work in a healthcare setting.

Defining Disruptive Behaviour

DISRUPTIVE BEHAVIOUR IS PERSONAL CONDUCT (WORDS, ACTIONS OR INACTIONS) BEYOND THAT NORMALLY ACCEPTED AS RESPECTFUL INTERPERSONAL BEHAVIOUR, WHICH DISTURBS THE WORK ENVIRONMENT AND/OR POTENTIALLY POSES A RISK TO DELIVERY OF SAFE AND QUALITY HEALTHCARE.

Finding a term to describe unacceptable interpersonal behaviour is difficult because the concept is influenced by people's ideas and perceptions of what constitutes acceptable and respectful behaviour, as well as by situational factors. For the purposes of this framework, the term 'disruptive behaviour' was chosen and is defined by both the behaviour and its consequences.

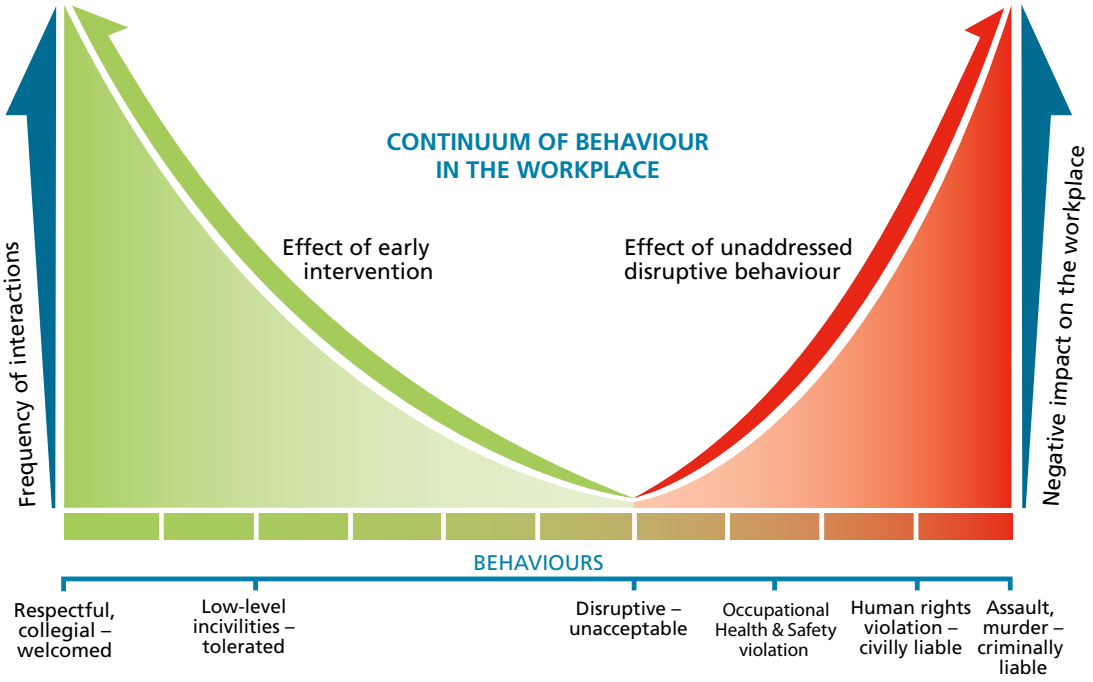
What constitutes unacceptable behaviour is somewhat subjective and exists on a continuum, from behaviours that may be distracting, annoying and irritating to some individuals but not others, to those that are more aggressive, deliberate, intentionally demeaning, psychologically harmful or physically threatening.[3] It can deteriorate into civilly liable conduct such as discrimination, or in very rare circumstances, criminal acts such as assault or murder. As shown in Figure 1, behaviour in the workplace lies on a continuum.[3, 4, 5] The vast majority of interpersonal interactions are positive, and unacceptable behaviour often can be changed by early intervention. Left unaddressed, disruptive behaviour can have a significant and escalating negative impact on the workplace and patient care.

IN TRYING TO DETERMINE WHETHER TO LABEL BEHAVIOUR AS 'DISRUPTIVE', IT IS IMPORTANT TO CONSIDER:

- ITS' NATURE
- THE CONTEXT IN WHICH IT ARISES
- THE CONSEQUENCES WHICH FLOW FROM IT

BEHAVIOUR CONSIDERED DISRUPTIVE USUALLY HAS AN ONGOING PATTERN, ESCALATES OVER TIME, AND IS CUMULATIVE IN ITS NEGATIVE EFFECTS.

FIGURE 1: CONTINUUM OF BEHAVIOUR IN THE WORKPLACE[3, 4, 5]



Of most concern is behaviour that negatively impacts the workplace, and potentially quality and safety of patient care. The Oxford Dictionary definition of disruptive "causing a disturbance or problems which interrupt an event, activity or process"[6] best reflects the effect of this behaviour in healthcare. 'Disruptive behaviour' is the term that has been adopted by the medical community.[7, 8] The nursing community is increasingly concerned with inconsiderate, disrespectful behaviour between nurses, referred to as 'lateral (or horizontal) violence' which encompasses incivility (low intensity inconsiderate conduct),[3, 9] bullying,[10] and intimidation.[11,12]

Behaviour considered to be disruptive usually has an ongoing or enduring pattern, or escalates over time, and is cumulative in its negative effects on an individual, the workplace or patient care. A single act of unacceptable behaviour does not necessarily reflect disruptive behaviour because it's understood that under certain circumstances anyone can make an error in judgment and behave inappropriately. However, a single incident of extreme behaviour might be considered disruptive in some circumstances; for example, if someone is harmed through an unexpected physical assault.

Overt behaviours that have a negative impact on others, such as condescending or objectionable language, yelling, uncontrolled anger, and verbal and physical threats are relatively easy to identify and label as disruptive. It is more difficult to pinpoint subtle yet equally disruptive behaviours such as persistent lateness; repeated refusal to comply with accepted policies, procedures and practice standards; chronic refusal to work collaboratively with colleagues, other staff and patients; and failure to respond to calls for assistance (for example, when on-call or expected to be available).[13] A more extensive list of unacceptable behaviours that could be considered disruptive depending on the context is found in Table 1.

TABLE 1: EXAMPLES OF DISRUPTIVE BEHAVIOUR[2, 8, 9, 11-18] (NOT AN EXHAUSTIVE LIST)

CATEGORY	EXAMPLE BEHAVIOURS
INAPPROPRIATE FORMS OF COMMUNICATION Unacceptable words or actions, used generally or as part of targeted harassment of an individual or group. *Intimidation* involves explicit or implied threats that create fear of the consequences of not complying.[12]	▪ Using profane, disrespectful, abusive, demeaning language. ▪ Using inappropriate labels or comments about others, name-calling. ▪ Patronizing and insulting remarks. ▪ Shaming others publicly. ▪ Exhibiting uncontrolled anger or engaging in public displays of temper. ▪ Yelling or screaming. ▪ Using intimidation tactics to gain compliance from others. ▪ Threatening others with retribution, litigation or violence. ▪ Verbal insidious intimidation e.g., gossiping, spreading rumors, sarcasm, constant criticism. ▪ Intimidating gestures such as slamming doors or throwing objects. ▪ Nonverbal e.g., rolling eyes, exaggerated sighing, making faces, glaring, turning away.
HARASSMENT A pattern of deliberate, persistent disrespectful behaviour targeting an individual that results in the recipient feeling intimidated, demeaned, humiliated or embarrassed. *Bullying* is usually psychological in nature, and intended to undermine or humiliate a particular person or group, often in a situation where there is a power imbalance.[9, 10, 15]	▪ Repeated use of inappropriate forms of communication (above) against a target. ▪ Intimidating, threatening or coercive actions such as threatening or implying unwarranted discipline or job loss. ▪ Berating an individual in front of others or in private. ▪ Excessive and unreasonable monitoring of someone's work. ▪ Sabotage or setting someone up to fail such as deliberately excluding someone from communication they need to be involved in, withholding information or resources needed to perform work, unreasonable work assignments. ▪ Cyberbullying - personal harassment occurring through electronic communication e.g., email, text messaging, Internet sites.
DISCRIMINATION Any unwelcome practice, comment or behaviour (intentional or not) related to the following grounds protected in legislation: race, colour, ancestry, place of origin, religious beliefs, gender, age, physical or mental disability, marital status, family status, source of income and sexual orientation.[16]	▪ Making derogatory comments related to protected grounds. ▪ Telling or posting of discriminatory jokes, slurs, posters, cartoons, etc. ▪ Drawing attention to an individual's protected grounds to undermine his/her role in a professional or business environment. ▪ Innuendo, taunting, or ostracizing an employee based on the protected grounds. ▪ Making an employment decision on protected grounds that negatively affects the individual.

TABLE 1: EXAMPLES OF DISRUPTIVE BEHAVIOUR[2, 8, 9, 11-18] (NOT AN EXHAUSTIVE LIST) – *continued from page 5*

CATEGORY	EXAMPLE BEHAVIOURS
SEXUAL HARASSMENT Behaviour that is sexual in nature, is not welcomed by the recipient, and adversely affects the recipient's working conditions, job security or prospects for promotion or earnings.[17] Sexual harassment is considered discrimination on the grounds of gender and is covered by human rights legislation.[16]	▪ Telling sexist jokes that are clearly embarrassing or offensive, especially after the joke teller has been asked not to. ▪ Leering, staring, commenting or gesturing in an obscene or sexual manner. ▪ Displaying degrading or stereotypical images of a sexual nature. ▪ Using sexually degrading words to describe a person. ▪ Making derogatory or degrading remarks toward a person's gender or sexual orientation. ▪ Making unwelcome inquiries or comments about a person's sexual life. ▪ Pursuing unwanted contact or attention in a persistent manner after a consensual relationship has ended. ▪ Requesting sexual favours. ▪ Making abusive or threatening verbal comments of a sexual nature. ▪ Imposing unwanted touching or committing sexual assault.
RETALIATION Making threats of or taking action against someone who reports disruptive behaviour or acts as a witness regarding disruptive behaviour. Making threats of or taking action against those expressing a difference of opinion, including involvement in appropriate advocacy or performance management activities.	▪ Unwarranted job dismissal of the reporter or witness. ▪ Demotion, transfer or denial of opportunities. ▪ Escalating personal harassment. ▪ Threats of retribution, litigation or violence.
UNCOOPERATIVE BEHAVIOURS Intentional behaviours that are subtle and uncooperative in nature, show disrespect for others and contribute to a negative workplace.	▪ Intentional noncompliance with clinical and administrative policies or processes, such as refusing to complete forms, manage records, sign orders, return calls in a timely manner. ▪ Intentional noncompliance with work schedules or assignments; chronic lateness. ▪ Refusal to work collaboratively e.g., not sharing information, not consulting when appropriate, not offering assistance when it is requested.
UNETHICAL PRACTICES	▪ Attempting to exploit others (e.g., patients and/or their family members or staff) for personal gain or status. For example, placing patients or families in the middle of a conflict between healthcare providers, or with a healthcare organization, or using care issues to meet one's own agenda. ▪ Taking credit for someone else's idea or work. ▪ Inappropriately accessing or using a co-worker's personal information.

WHAT DISRUPTIVE BEHAVIOUR IS NOT

Labeling behaviour as disruptive is challenging because of the need to consider both context and consequences, and because people involved in a conflict situation will view it differently. To help understand what disruptive behaviour is, it is important to consider what it is not.

Performance management: Managers have an obligation to direct their employees in achieving the desired outcomes of the job and the organization. It is not considered disruptive to give an employee objective, constructive feedback to help them improve their work performance as long as it is done in a respectful, fair, consistent and accountable manner.[14, 15]

Collaborative team interactions: Within a productive, collaborative team environment, expressing an opinion, speaking up about a patient safety or quality of care concern, or giving a colleague or team member constructive feedback in a respectful manner is not considered disruptive.

Healthcare advocacy: Advocacy by an individual or a group aims to influence decisions on clinical care, resource allocation, policies or processes that affect the health and wellness of Albertans. Healthcare professionals have an obligation to advocate for the best possible care of the individuals, communities and populations they serve. Advocacy activities, even those that challenge the status quo, are not considered disruptive when they are undertaken in a mutually respectful and collaborative manner, adhere to accepted principles of fair process, and are not directed at achieving personal gain or status at the expense of others.

Isolated incidents: Situations may arise in which individuals behave in a disrespectful way in a spontaneous, unexpected outburst. While repeated episodes of such behaviour are difficult to excuse, an isolated incident of disrespectful behaviour is generally not considered disruptive if the recipient is not put at risk of physical harm, patient care is not impacted, and the individual acknowledges that their behaviour was inappropriate.

Extent of Disruptive Behaviour in Healthcare

The extent of disruptive behaviour in the healthcare workplace is difficult to quantify. Most of the research has been done in acute care settings in the United States using self-reported surveys to estimate how often healthcare providers have observed or experienced this behaviour. The definition of disruptive behaviour and the survey instrument used varied between researchers.[19, 20] Most of the research in healthcare has focused on the behaviour of doctors although doctors can also be the target of disrespectful behaviour and intimidation tactics.[21] Understanding bullying and incivility among nurse colleagues is a strong theme in the nursing literature.[3, 9, 10, 22-24]

Extent of Disruptive Behaviour in Healthcare

RESEARCH SHOWS THAT:

- DISRUPTIVE BEHAVIOUR IS COMMON IN THE HEALTHCARE WORKPLACE
- A FEW INDIVIDUALS CAN HAVE A BIG IMPACT
- INAPPROPRIATE COMMUNICATION IS THE MOST COMMON PROBLEM
- HIGH INTENSITY CARE AREAS ARE MOST VULNERABLE

THEMES EMERGING FROM THE RESEARCH

- **Disruptive behaviour is common in the healthcare workplace.**
  Over 90% of survey respondents report witnessing or experiencing some form of disruptive behaviour within the past year,[19] 65-75% report witnessing it at least once a month,[7, 19, 20] and 10% report daily occurrence.[7] Eighteen per cent of nurses[22] and 25% of doctors[7] admit to having used bullying tactics or disruptive behaviours in some situations. Although data is lacking for healthcare workers other than doctors and nurses, it is expected that disrespectful behaviour occurs at all levels of an organization.
- **A small number of individuals can have a large impact.**
  It is estimated that 2 to 5% of doctors and nurses exhibit an ongoing pattern of this type of behaviour.[19, 25]
- **Inappropriate forms of communication are the most common behaviours reported.**
  Yelling/raised voice, disrespectful, degrading or insulting comments, condescending tone and berating others in front of colleagues are most often reported. Refusal to cooperate with other healthcare providers or follow established protocols are common subtle behaviours.[9, 13, 26]
- **Disruptive behaviour appears to be more common in high intensity care areas.**
  It is more often reported in acute care medical units, intensive care units, the perioperative arena, emergency rooms and in surgical subspecialties (e.g., general surgery, cardiovascular surgery, neurosurgery, orthopedic surgery).[27] Research is lacking about disruptive behaviour in continuing care or community practice settings.
- **Bullying (also called lateral or horizontal violence) is a concern within the nursing profession.**
  Depending on the methodology and definitions used, 17 to 76% of nurses report having experienced bullying, 75% have witnessed bullying at least weekly, and 88% say they work with someone who uses bullying tactics.[23] The perpetrator was most often a senior nurse or nurse manager (55%) and less often another staff nurse (15%) or physician (8%).[24]

CANADIAN DATA

In the 2005 National Survey of Work and Health of Nurses,[28] 45.3% of respondents reported being exposed to hostility or conflict from those they work with, or emotional abuse by a nurse colleague (11.7%), other healthcare worker (10.2%), or doctor (8.3%). Emotional abuse was reported more often in acute care settings (12 to 14%) compared to community care settings (4 to 8%).

In an unpublished study of 160 nurses at one hospital, 95% reported observing bullying behaviour between co-workers and 71% reported being a target.[10] In a survey of medical residents in Alberta, 73% of respondents reported experiencing intimidation or harassment from nurses (55%), staff physicians (42%), and other residents (25%).[29]

In a province-wide survey of physicians conducted by the HQCA in 2011 on the role and process of physician advocacy, 20% of respondents reported experiencing active harmful obstruction (threats, intimidation, censorship, punishment, ridicule) of their advocacy efforts.[21]

Consequences of Disruptive Behaviour

Disruptive behaviour can take a personal toll on the individuals involved and has negative effects on the work unit, patient safety and quality of care, and the organization. (Table 2) Loss of trust, impaired communication, and reduced collaboration and ability to effectively transfer vital patient-related information is the most immediate threat to patient care.[30] Overall, the effects are wide-reaching and costly to both individuals and organizations.

TABLE 2: CONSEQUENCES OF DISRUPTIVE BEHAVIOUR IN HEALTHCARE

HEALTHCARE WORKER	▪ psychological issues ▪ stress-related illness ▪ impaired job performance ▪ reduced job satisfaction ▪ adoption of disruptive behaviours ▪ loss of reputation, respect, trust – both perpetrator and target
TEAM AND WORK UNIT	▪ impaired professional relationships ▪ communication breakdown ▪ ineffective or absent collaboration ▪ loss of efficiency and effectiveness ▪ low morale
PATIENT CARE	▪ treatment delays ▪ improper or ineffective treatment ▪ adverse events related to care delivery ▪ loss of confidence, respect or trust in care providers or team ▪ increased number of complaints or legal action by patients and families
ORGANIZATION	▪ financial consequences of absenteeism, recruitment and retention ▪ impact on the human resources and legal departments – time, energy and stress of dealing with behaviour-related complaints ▪ loss of reputation of a care unit, facility or organization ▪ negative organizational culture ▪ loss of confidence in management and organization by staff ▪ increased numbers of grievances in unionized workplaces ▪ legal risk of human rights complaints

HEALTHCARE WORKER

Recipients of disruptive behaviour can experience:

- Psychological issues such as loss of self-esteem and self-confidence, stress, anxiety, depression, insomnia with nightmares and sleep deprivation, post-traumatic stress disorder. Attempted or successful suicide is a tragic consequence.
- Stress-related physical illness such as hypertension, weight gain, palpitations, irritable bowel and heart attacks.[9, 20, 31]
- Impaired job performance from inability to focus or concentrate on a task and decreased ability to engage in critical thinking.
- Reduced job satisfaction, workarounds to avoid the perpetrator such as requesting changes to work schedules or shifts, absenteeism, changing departments, or leaving the organization.[20]

Consequences of Disruptive Behaviour

PATIENTS AND FAMILIES MAY LOSE CONFIDENCE, RESPECT AND TRUST IN THEIR HEALTHCARE PROVIDER.

Students are vulnerable to disrespect from other team members, and can suffer as recipients of verbal or physical abuse, humiliation, harassment, intimidation and exploitation, resulting in self-doubt and loss of self-esteem.[7,30,32] Experiencing or witnessing disruptive behaviour may cause them to question their career choice, opt out of a program or profession, or seek employment elsewhere. Some may adopt the disrespectful behaviours of their mentors, believing that this is an acceptable way for professionals to behave.[7,32] Exposure to a negative role model at a critical time in development of professional identity could affect future relationships with patients, colleagues and other healthcare providers.

Individuals behaving in a disruptive way and their families can be affected by loss of reputation, respect and trust from patients, other care providers, colleagues, and potentially by the stress and cost of litigation should a situation deteriorate to that extent. If disruptive behaviour is dismissed as a personality quirk, underlying personal problems or contributing medical or psychiatric conditions may not be identified and addressed.

TEAM AND WORK UNIT

Breakdown in communication and collaboration impairs professional relationships leading to low morale among team members and loss of respect and trust. Stress, frustration, loss of concentration, reduced collaboration among team members, ineffective communication and impaired information transfer occur commonly.[18, 30, 33]

Impaired efficiency and effectiveness within the work unit can occur due to resistance to collaboration, confusion from unclear or absent communication, gaps in task completion, time delays, wasted efforts, and unnecessary duplication.[33] Loss of engagement can create silos and cliques that further fragment the work unit.

PATIENT CARE

Leape and colleagues state that, "A culture of disrespect is harmful for many reasons, but it is its effect on the safety and well-being of our patients that makes it a matter of urgency."[30] Impaired communication, collaboration and ability to effectively transfer vital information is the greatest threat to patient safety and quality of care.[33] Over 75% of sentinel events can be traced back to a communication issue such as when information is ignored, withheld, overlooked or not reported, or when misunderstandings, wrong assumptions and conclusions are made leading to delays or improper treatment.[34]

Subtle disruptive behaviours such as refusal to work collaboratively, noncompliance with role responsibilities and resistance to organizational expectations regarding use of standardized care protocols, resource utilization, or care planning processes also impact patient care.[30, 33]

Patients and families may lose confidence, respect and trust in their healthcare provider and the institution or organization involved if they witness or are the recipient of disruptive behaviour. As a result, they may be reluctant to share critical information, partner in their own care, or return for follow-up care. Some resort to workarounds to avoid contact with the individual (e.g., requesting transfer to a different unit or care facility).[25] Studies show a correlation between poor provider communication, patient dissatisfaction, complaints and the likelihood of legal action against the provider or healthcare delivery organization.[33]

ORGANIZATION

Potential financial consequences are many: absenteeism; direct and indirect (orientation, training, mentoring) costs of recruitment and retention; staff time, energy and stress associated with following through on a formal complaint and management process; inefficiencies in both the work unit and downstream; adverse events; and legal actions.[35] In the United States it is estimated that 60% of newly registered nurses leave their first job within six months as a result of bullying.[10] Poor communication among healthcare providers is estimated to cost more than $4 million annually for a 500-bed hospital in the United States.[35]

Loss of reputation of a patient care unit, healthcare delivery facility or organization may make it difficult to retain and attract staff.

When organizations ignore disruptive behaviour, healthcare workers lose confidence in their managers and organization, resulting in decreased commitment to the organization, disengagement, and loss of motivation for creativity and innovation.[9]

Contributing Factors

DISRUPTIVE BEHAVIOUR IS THE RESULT OF A COMPLEX INTERPLAY OF PERSONAL AND WORK-RELATED FACTORS.

Disruptive behaviour is the result of a complex interplay of personal and work-related factors (Table 3). Contributing personal factors include innate personality and character traits, acquired views of professional role and status, stress from life or work events, or underlying illness. Contributing workplace factors include culture of the healthcare system and the organization, other organizational factors, poor team dynamics and the nature of healthcare work.

TABLE 3. CONTRIBUTING FACTORS

PERSONAL	▪ personality and character traits ▪ professional identity ▪ lack of coping strategies ▪ underlying illness and age-related cognitive impairment
WORK-RELATED	▪ stressful nature of healthcare work ▪ culture of healthcare ▪ organizational culture ▪ system factors ▪ team dynamics, departmental subcultures

NEW HEALTHCARE PROFESSIONALS TEND TO ADOPT BOTH POSITIVE AND NEGATIVE BEHAVIOURS OF THEIR ROLE MODELS.

PERSONAL FACTORS

Personality and character traits

Unique personality factors develop over time and are influenced by inherited traits, family dynamics, culture and ethnicity, gender, education, and accumulated life experiences. Traits valued in many healthcare professions, such as attention to detail, perfectionism, personal discipline, idealism and a high degree of empathy may result in disruptive behaviour when the individual is stressed, faced with competition, or feels threatened.[2, 36] These traits are also associated with a higher risk for burnout and depression which can impair work performance and interpersonal relationships.[36] Traits such as self-centeredness, immaturity and defensiveness, compounded by a lack of interpersonal, coping or conflict management skills also contribute to disruptive behaviour.[9, 31, 37] Bullies often have low self-esteem, poor communication skills and insecurity in developing relationships with peers and in many cases were once targets of bullying themselves. However they are often intelligent, status-conscious individuals well-liked by their superiors.[31] Personality and character traits may be a contributing or mitigating factor to an incident but they should not be used as an excuse to tolerate continued disrespectful behaviour.

Professional identity

A healthcare professional's beliefs, understanding and attitudes about their role and behaviours are shaped by both explicit and tacit messages that students and new graduates are exposed to during their education and training. Although professionalism is emphasized in the undergraduate curricula, observation during formative practice experiences (the 'hidden curriculum') has a powerful and lasting influence.[32] New healthcare professionals tend to adopt both positive and negative behaviours of their role models.[30, 32] Healthcare professionals may not realize that they are conveying a negative role model to trainees. Individuals who are given specific feedback about their disruptive behaviours often respond with disbelief or justify their behaviour as necessary for good patient care.[38] In one survey, more than 10% of doctor respondents did not view physical or verbal abuse as intimidating, and some viewed this behaviour as justifiable under certain circumstances.[38]

Lack of individual coping strategies or resilience

Limited capacity to face and deal with personal adversity can result in disruptive behaviour in response to stressors at work (overwork, fatigue, task-related stress, isolation) and home (personal issues such as divorce or separation, family crises, financial issues). Maladaptive coping strategies such as substance abuse are estimated to be a contributing factor in approximately 20 per cent of cases where a formal complaint of physician disruptive behaviour is made.[25, 39]

Underlying health issues

Early recognition of contributing physical and mental health issues is critical. However, be cautious about attributing inappropriate behaviour to an underlying medical or psychological problem (pathologizing the behaviour) without proper evaluation of the individual.[25, 36, 39] Stress-related symptoms such as excessive anxiety, exhaustion, and sleep disturbances can contribute to a behaviour change. Burnout characterized by emotional exhaustion, depersonalization and cynicism, and feelings of ineffectiveness can develop in response to prolonged occupational stress and manifest as disruptive behaviour.[36] Among physicians referred for disruptive behaviour, psychiatric disorders are common, particularly depression which can coexist with or result from prolonged occupational stress.[36] Alcohol and substance abuse, bipolar disorder, obsessive compulsive disorder and personality disorders with features of narcissistic or obsessive compulsive traits are also seen.[39] Contributing health issues need to be recognized and treated, not used as a reason to tolerate continued disruptive behaviour.

STRESS, BURN-OUT AND ASSOCIATED DEPRESSION CAN MANIFEST AS DISRUPTIVE BEHAVIOUR.

WORK-RELATED FACTORS

Stressful nature of healthcare work

The challenge of caring for others places a demand on healthcare workers that can trigger disruptive behaviour when combined with predisposing personal factors and other organizational factors. Pressure on individuals is intensified in an already stressful care environment by:

- Increasing patient loads and escalating patient acuity and complexity at all levels of care.
- Facility capacity running at or exceeding 100% with less flexibility to accommodate unexpected situations.
- Increasing research, academic and administrative workloads on doctors and other healthcare professionals.
- Conflicting loyalties and the challenge of balancing responsibilities to and advocating for individual patients and populations of patients, one's profession, the organization and the healthcare system as a whole.[7]
- Persistent negative media attention to healthcare, which is demoralizing to healthcare providers.

Current healthcare culture

The healthcare environment is characterized by uncertainty and change, with a tension between the drive to simultaneously meet productivity and cost-containment requirements, and rising expectations for patient safety and quality of care. It is exacerbated by changing practice models with increasing emphasis on collaborative team-based care in which new roles, scopes of practice and empowerment of healthcare team members challenge traditional models of authority and autonomy.[11] Rising expectations of patients and clients for both the care they receive and its outcomes, and disrespectful behaviour from frustrated patients and families can also create stress for care providers.

Organizational culture

Rigid, hierarchical organizations which promote competition and in which technical expertise and interpersonal aggressiveness are valued over interpersonal skills and emotional intelligence are more likely to foster disruptive behaviour.[9, 23] Reliance on short-term planning, and an obsession with outcomes and 'making the numbers' also contribute.[4] A history of tolerance and indifference to disruptive behaviour in an organization or work unit normalizes it as acceptable, thus indirectly promoting it.[13, 23] Practices that perpetuate disruptive behaviour include failure to establish formal mechanisms to address it, failure to follow through with existing policies, or failure to support staff who report such behaviour. Negative role-modeling by leaders who engage in disruptive behaviour themselves sets a tone for the organization that is difficult to overcome.

TOLERANCE AND INDIFFERENCE TO DISRUPTIVE BEHAVIOUR IN A WORK UNIT OR ORGANIZATION SENDS THE MESSAGE THAT IT IS ACCEPTABLE.

System factors

Issues related to policies, processes, equipment and the physical work environment can contribute to frustration that is manifest in subtle or overt negative behaviours.[13]

- Competition for resources (financial, human, equipment and technology, physical space) needed by work units to meet rising performance expectations. Real or perceived inequities in distribution of resources is a major stressor that can have widespread consequences.[13]
- Change in staffing and increased staff turnover related to attempts to 'right size' the workforce creates fears over job security that can lead to bullying by those trying to retain their position.[23]

- Change in reporting structures that leaves healthcare workers confused about how to report safety concerns and administrative issues.[13]
- Process changes that are made without involving those at the frontline who are most affected.[13]
- Inadequate fatigue management policies that result in over-tired, irritable workers who are more likely to lash out at others.[11]

Team dynamics

Teams need sufficient time, space and opportunities to develop effective patterns of communication and collaboration. Resource constraints in an organization can limit effective team-building. Collaboration also becomes strained when professionals with strong role identities and opinions compete for power and engage in turf disputes.[9] Different generational perspectives on work-life balance and the role of technology in the workplace can create tension between younger and older team members. Departmental subcultures can also affect team dynamics.

Integrated Management Strategy for Disruptive Behaviour

MANAGEMENT STRATEGIES MUST APPLY TO EVERYONE WHO WORKS WITHIN A HEALTHCARE ORGANIZATION, FROM THE EXECUTIVE SUITE TO THE FRONTLINE.

Problems of complex etiology like disruptive behaviour, are rarely amenable to simple solutions. Addressing disruptive behaviour requires an ongoing multi-faceted and integrated approach that includes strategies by both individuals and the organization to establish expectations around acceptable conduct, minimize the occurrence or persistence of unacceptable conduct, and respond in a consistent stepwise manner when it inevitably occurs. Management strategies must apply to and be adopted by all who work within healthcare, regardless of whether they are an employee, contractor, consultant, volunteer, student or have privileges (e.g., doctors, dentists, midwives).

While everyone has a role to play, leadership is key. Without leadership and the will to lead by example and follow through on policies and procedures, disruptive behaviour will become entrenched in an organization. Senior leaders (board members, chief executive officer, senior executives and senior clinical leaders) who 'walk the talk' in their actions and behaviour set the tone and expectations for the rest of the organization. Frontline managers need to model behaviours expected of their staff, and clinical instructors and mentors of students and trainees need to demonstrate how professionalism is part of everyday practice.

A matrix of management strategies is presented in Table 4 and addressed in further detail below. Personal strategies are presented first because the decisions and actions of individuals will ultimately determine the success of organizational strategies. They apply to individuals who work together within a workplace or collaborate across workplaces. Organizational strategies can be adapted to different types of healthcare workplaces – small clinics or businesses, large and complex organizations, educational institutions and programs, and health profession regulators.

SEE 2. INTEGRATED MANAGEMENT STRATEGY CHECKLIST

LEADERSHIP IS KEY. THE WILL TO LEAD BY EXAMPLE AND FOLLOW THROUGH CONSISTENTLY IS ESSENTIAL.

TABLE 4. DISRUPTIVE BEHAVIOUR MANAGEMENT STRATEGIES MATRIX

	SETTING EXPECTATIONS	PREVENTION	RESPONSE
PERSONAL STRATEGIES	▪ Modeling of desired behaviours by leaders, managers and clinical faculty. ▪ Public support by executives and clinical leaders. ▪ Vocal support by respected champions in all areas.	▪ Improve general communication and team skills. ▪ Develop assertiveness and conflict management skills. ▪ Improve awareness about disruptive behaviour. ▪ Develop conflict management and intervention skills (leaders and managers).	▪ Confront disruptive behaviour when a target or when observing others being targeted. ▪ Document disruptive behaviour when it threatens individual well-being or patient care. ▪ Report appropriately. ▪ Support and advocate for colleagues who are targets.
ORGANIZATIONAL STRATEGIES	▪ Organizational definition. ▪ Code of conduct. ▪ Policies and procedures related to behaviour. ▪ Multiple stakeholder involvement. ▪ Behaviour included in recruitment, performance review, credentialing. ▪ Champions at all levels.	▪ Organizational culture of respect, trust and fairness. ▪ Education about expectations of behaviour, and related policies and procedures. ▪ Conflict management and Intervention skills training for leaders and managers. ▪ Tools to encourage desired behaviour and support follow-through. ▪ Surveillance system to identify problem areas. ▪ Risk management of psychological hazards and workplace stressors. ▪ Support programs related to stress and burnout.	▪ Reporting process. ▪ Evaluation and initial review process. ▪ Investigation process. ▪ Progressive approach to intervention. ▪ Resolution process. ▪ Documentation. ▪ Support for all individuals involved.

SETTING EXPECTATIONS

All strategies for addressing disruptive behaviour are founded on mutually determined and agreed-upon expectations for respectful, collegial behaviour that everyone in the organization is committed to demonstrating through their words and actions. Setting expectations is primarily a leadership and organizational responsibility. Executives, clinical leaders, frontline managers, and clinical faculty who mentor students must demonstrate their commitment to a respectful workplace through their words and actions. For healthcare professionals, expectations of behaviour are also set by their regulators and professional associations through documents such as a code of ethics, code of conduct and standards of practice. These are useful resource documents for organizations when setting expectations of behaviour; a profession's standards of behaviour will always take precedence over workplace standards for individual healthcare professionals. Educational programs should establish expectations of behaviour for their clinical faculty that consider both expectations of professionalism and behaviour expected in the healthcare workplace where they instruct students.

MANAGEMENT OF DISRUPTIVE BEHAVIOUR BEGINS WITH SETTING EXPECTATIONS FOR RESPECTFUL, COLLEGIAL BEHAVIOUR.

PERSONAL STRATEGIES TO SET EXPECTATIONS

The words and actions of leaders (administrative, clinical and frontline managers) set expectations of behaviour for a healthcare organization and work unit. Efforts to create a culture of respect will be quickly derailed if healthcare workers perceive a double standard in behaviour or a discrepancy between what their leaders say and how they act.

Leaders model behaviours in the code of conduct through their words and actions [11, 31, 35 ,37]

This includes executives and senior administrative leaders, clinical leaders, frontline managers, and clinical faculty who teach or mentor students or trainees.

Leaders publicly commit the organization to creating a respectful workplace

They acknowledge that while bullying and disruptive behaviour are part of all workplaces, the organization has a strategy in place and will follow through to create a respectful workplace.[37]

Influential champions for a respectful workplace are vocal in their support

Influencers who willingly step up to model and promote a high standard of behaviour from their colleagues can emerge at all levels of the organization – within the team or work unit, clinicians and clinical faculty, managers, union representatives, administrators and executives.[40]

ORGANIZATIONAL STRATEGIES TO SET EXPECTATIONS

Organizational commitment to creating a work environment in which all healthcare workers feel respected and safe to speak up begins with making explicit what the expectations are for acceptable interpersonal behaviour.

Organizational definition of disruptive behaviour

In order to deal with disruptive behaviour it must first be defined. This is usually part of a policy document or code of conduct. [37]

Code of conduct applicable to all who work in the organization [9, 11, 36, 37, 41-44]

A code of conduct sets explicit expectations of behaviour which then can be addressed through supporting policy and procedures (below). It is complementary to a code of ethics, which describes the ethics, value systems and moral principles that guide the conduct of a professional but often does not set out explicit expectations of behaviour. The code of conduct is usually part of a policy on behaviour. Contents of a code of conduct vary widely but typically include:[41-43]

- Description of underlying values or principles upon which the expectations of behaviour are founded.
- Statement of purpose which should explicitly make the link between healthcare worker behaviour and patient care.
- Statement about to whom it applies. It should articulate the expectation that it is everyone's job to model and enforce the code regardless of their relationship with the organization (e.g., employee, contractor, clinical faculty member, volunteer).
- Expected standard of behaviour or conduct with examples of reasonably expected behaviours.
- Examples of behaviour considered to be inappropriate or disruptive to make it clear the types of behaviours that are not acceptable. Behaviour exists on a continuum and there is often a 'grey zone' (inappropriate behaviour) between desired behaviour and disruptive behaviour that can signal a need for some kind of intervention. For an example, refer to the American Medical Association Model Code of Conduct.[42]
- Overview of the process to follow if there is a concern about breach of the code. This should include a statement that retaliation will not be tolerated. More details are provided in the accompanying policy and procedure related to behaviour.

Resource Toolkit

SEE 3.1 RESOURCES FOR DEVELOPING A CODE OF CONDUCT

Policy and procedure related to behaviour [11, 23, 37, 40, 43, 44]

Policy statements and procedure documents are insufficient on their own but are necessary to establish expectations which can then be reinforced through more active prevention and intervention strategies. They create a commitment to and process for following through on behaviours that do not meet the standard articulated in the code of conduct and that have a negative impact on the work unit and patient care. Zero tolerance policies are widely recommended in the literature, and unfortunately this can be interpreted as punishment for every incident. The preferred approach is to create policies and procedures which hold individuals accountable for their behaviour while acknowledging human fallibility and the inevitability that anyone can occasionally make a poor behavioural choice despite their best intentions. While some kind of intervention is necessary for most incidents, the focus is on remediation; disciplinary action is reserved for more severe disruptive behaviours or for repeat offenders who are not responsive to interventions intended to help them change their behaviour. Like the code of conduct, policies and procedures must apply to all who work in an organization. Human rights and occupational health and safety legislation are useful resources when developing policies and procedures related to behaviour.

Resource Toolkit

SEE 3.2 RESOURCES FOR DEVELOPING A BEHAVIOUR-RELATED POLICY
3.3.CHECKLIST FOR DEVELOPING A BEHAVIOUR-RELATED PROCEDURE

Multiple stakeholder involvement

Broad commitment throughout the organization is achieved by involving a wide representation of healthcare workers in developing expectations for behaviour and the intervention processes.[9, 31, 44]

Behaviour included in the recruitment, performance review and credentialing process

Including interpersonal behaviour in all aspects of the performance management system, from recruitment to performance review and credentialing, clearly establishes the importance of respectful, collegial behaviour as an essential value within the work environment.[35,37] When interpersonal behaviour is framed as a performance expectation, continual reinforcement becomes part of an ongoing performance improvement process rather than a disciplinary measure. For all new hires at every level of the organization, a probationary period followed by a performance review that includes interpersonal behaviour will help identify emerging issues. A useful strategy to gather information on interpersonal behaviour is multisource feedback ('360-degree' evaluations), where performance information is gathered from those who interact with an individual (colleagues, other team members, patients).[45]

Champions throughout the organization

For each area or target group of interest in the organization, try to identify at least one influential individual who has passion and enthusiasm for the cause, peer group respect, and the communication skills to make things happen.[9, 40]

EDUCATION TO DEVELOP INDIVIDUALS WHO FEEL EMPOWERED TO RESPOND TO DISRESPECTFUL BEHAVIOUR IN A CONFIDENT, CONSTRUCTIVE WAY IS A KEY PREVENTION STRATEGY.

PREVENTION

Prevention strategies are aimed at creating and sustaining an organizational and work unit culture of respect and trust where disruptive behaviour is minimized and individuals feel empowered to confront it in a constructive way when it happens. Individuals need to develop the communication and conflict management skills to act in a respectful, collegial manner and to assert themselves when faced with inappropriate behaviour from others. In addition, managers and leaders need the skills to intervene when someone's behaviour is not conducive to a respectful workplace. Organizational strategies are primarily focused on making opportunities available for individuals to develop the knowledge and skills to follow through on expectations of respectful behaviour and adhere to organizational policies and procedures.

PERSONAL STRATEGIES FOR PREVENTION

Prevention strategies at the individual level are primarily focused on developing the knowledge, skills and attitudes required to contribute to a positive workplace, and the confidence to follow through in a respectful and constructive way when unacceptable or disruptive behaviour occurs. Few healthcare workers, even the most highly skilled professionals or executives, understand the issues around disruptive behaviour and the impact it has, nor do they have the conflict management skills to deal with inevitable incidents. Individuals can develop the knowledge and skills they need by participating in education and training programs appropriate to their role. Undergraduate and postgraduate (e.g., residency programs) education programs for healthcare providers should explicitly address behavioural expectations of professionalism, and ensure that students and trainees have the communication and conflict management skills to contribute to a culture of respect in healthcare.

SEE 4.1 COULD THIS BE HARASSMENT? A SELF-TEST FOR HEALTHCARE WORKERS
4.2 IS DISRUPTIVE BEHAVIOUR THREATENING YOUR TEAM? A CHECKLIST FOR TEAMS
4.3 BUILDING A CULTURE OF RESPECT – A SELF-ASSESSMENT CHECKLIST FOR MANAGERS
4.4 IS YOUR WORKPLACE AT RISK FOR DISRUPTIVE BEHAVIOUR? A CHECKLIST FOR EMPLOYERS

General communication and team skills

All healthcare providers need to understand the critical role that communication plays in maintaining a respectful workplace and develop the communication skills to work in a respectful, collaborative team environment.[41]

Assertiveness or conflict management skills

All healthcare providers need the skills and confidence to be proactive in dealing with conflict and confronting unacceptable behaviour in a constructive way when it occurs, before it impacts patient care or the work unit.[41] Cognitive rehearsal has been shown to be an effective strategy in developing conflict management skills.[24] Crucial Conversations® is a well-respected program developed specifically for the healthcare environment.[46]

Awareness of behaviour-related policies and procedures

Everyone in the workplace needs to be aware of expectations of behaviour established in the code of conduct and related organizational policies and procedures that support a respectful work environment. They need to know how to recognize behaviour that is potentially detrimental to the workplace or patient care and what to do when it happens.[31]

EFFORTS TO CREATE AND SUSTAIN A POSITIVE ORGANIZATIONAL CULTURE ARE MUTUALLY SUPPORTIVE AND REINFORCING WITH THOSE TO ADDRESS DISRUPTIVE BEHAVIOUR.

Intervention and conflict management skills for managers, leaders and executives

Leaders at all levels of the organization play a critical role in creating and sustaining a respectful work environment, and need the skills and confidence to have difficult conversations with staff or colleagues about behaviour.[11, 31, 37] Managers and leaders also must be able to identify potential problem areas (e.g., work units with poor morale, high staff turnover or high absenteeism) and respond proactively to prevent disruptive behaviour from becoming entrenched.[41]

ORGANIZATIONAL STRATEGIES FOR PREVENTION

Organizational culture of respect, trust and fairness

An organizational culture in which individuals are treated with respect, understand what to do when things go wrong, and know that processes are fair and applied consistently is fundamental to achieving success in minimizing disruptive behaviour.[35] Efforts to create and sustain a positive organizational culture and to address disruptive behaviour are mutually supportive and reinforcing. The *Guarding Minds at Work* website (www.guardingmindsatwork.ca) and *Workplace Strategies for Mental Health* (www.gwlcentreformentalhealth.com) are excellent resources for organizations striving to create a positive, respectful, psychologically healthy workplace.

Education and training

An integrated program of communication, conflict management and intervention skills training that addresses the needs of all who work in the organization is a key organizational strategy to manage disruptive behaviour.[44] Communication and conflict management skills development should also be a requirement of undergraduate and postgraduate education and training programs. There may be an opportunity to collaborate on educational initiatives with unions, health profession regulators or other organizations with an interest in promoting healthy workplaces.

Tools and reminders

Organizations and academic programs need to make it easy for everyone to know the expectations of behaviour and what to do when confronted with inappropriate behaviour.[9] Examples of tools include posters promoting a respectful workplace; an easy-to-remember acronym for strategies to confront someone behaving in a disrespectful manner; documentation and reporting forms when further action is required; checklists to guide the intervention process; and online resources. Websites such as ePhysicianHealth.com and eWorkplaceHealth.com provide information, education and tools to help all those who work in healthcare to understand the issues, and provide suggestions for managing personal stress at work and disruptive behaviour situations.

SEE 4.5 USEFUL WEBSITES

Surveillance systems to flag potential problem areas

Workplace culture surveys, aggregate review of complaints and commendations from different departments and clinical areas, and exit interviews can be used to identify potential problem areas where awareness activities and training may need to be focused.[11, 23, 31, 44] Routine data collection and analysis to inform psychological health and safety management is a key recommendation of the psychological health and safety in the workplace standards document.[44]

Identify and address contributing system issues

Stress and frustration related to system issues (policies, processes, equipment, physical environment) can trigger disruptive behaviours. Proactive efforts to identify and address sources of workplace stress could be incorporated into ongoing patient care quality and safety improvement programs.[40, 44] Identifying contributing system issues should also be part of the response to reports of both overt and subtle disruptive behaviour.[13]

Support programs for individuals

Individuals should be encouraged to contact employee and family assistance programs offered by the organization, or assistance programs offered through professional associations or healthcare insurance programs to help them address personal contributing factors such as stress and burnout. [36, 39, 40]

RESPONSE

When disruptive behaviour occurs, a response that is applied consistently in all circumstances is needed. Ignoring the incident or intervening selectively gives tacit approval to the behaviour and feeds a downward spiral towards a hostile workplace where patient care can be impacted. The incident should be resolved at the lowest level possible, reserving a formal report and investigation process for serious issues or situations that cannot be handled at the interpersonal or informal level. The response should begin (and often ends) at the interpersonal level; individuals need to feel empowered and supported to respond by their managers and by organizational policies and procedures. In developing response strategies, relevant legislation and provisions of collective agreements need to be considered. Undergraduate and postgraduate educational programs should develop similar processes to help students or trainees.[32] A disruptive behaviour management flow chart is provided in Appendix 2.

PERSONAL RESPONSE STRATEGIES

Empowered individuals who feel safe in the knowledge that they will be supported by colleagues, managers, and the organization if they confront someone who is behaving in a disrespectful way are the cornerstone of effective intervention. Everyone who is the target of, witness to or recipient of a complaint about disruptive behaviour has a role to play in addressing this problem. The tip sheet 'Bullies at Work' at the Alberta Learning Information Service website lists some useful personal strategies.[15]

Individuals should feel empowered and supported to:

- **Inform the person who is behaving disrespectfully that their behaviour is inappropriate.**
  The focus must be on the behaviour and its effect on the target, not on the person who is behaving poorly. Targets should make it clear that the behaviour is unwelcome and ask that it stop.[15] Colleagues or supervisors who witness an episode or receive informal reports of unacceptable behaviour can use the informal 'cup of coffee conversation' intervention (see below) to respectfully reinforce accepted standards of behaviour.[32]
- **Enlist the support of a friend or colleague.**
  A witness is particularly important for targets of behaviours suggestive of harassment or bullying. If possible, individuals should avoid being alone with someone they feel is harassing them, and need to stay connected with friends and colleagues in the workplace to prevent becoming isolated.[15]

- **Document ongoing or significant disruptive behaviour.**
  Documenting an incident can help the target clarify and try to understand the situation and relieve stress. In addition, documentation will be needed to support a formal review and intervention process if this becomes necessary. Documentation by the target is strongly recommended when disrespectful behaviour occurs regularly (e.g., ongoing pattern suggesting harassment or bullying), is serious enough to affect the target (e.g., causes anxiety or stress), or threatens patient safety and quality of care. Individuals should maintain a personal record documenting the facts of each episode (e.g., date, time, what happened, the outcome, any witnesses present) while avoiding opinion, speculation or gossip.[15] Individuals who keep personal records of behaviour they consider objectionable that is directed towards themselves or others have an obligation to make their concerns known once a pattern can be demonstrated.

Resource Toolkit

SEE 5.1 PERSONAL DOCUMENTATION TEMPLATE

Seek confidential advice

If there is a pattern suggestive of personal harassment or bullying, potential resources within the organization on how to handle the situation include a supportive supervisor, the human resources department, or union representative. External resources include assistance programs (e.g., employee or through a professional association) or a health profession regulator. These resources will usually provide advice without requiring a formal complaint against an individual to be made. The identity of the individual whose behaviour is in question must not be revealed when seeking advice.

Report disrespectful behaviour that is recurring or serious

Reporting can be informal, such as to a supervisor or someone in the human resources department, or more formal, through the organization's reporting system that is described in the policy and procedure document.[15] When a supervisor is involved, individuals need to report their concern one, or even two, management levels above.[31] Centralized reporting systems provide better support for individuals in reporting a conflict with a supervisor.[40] Individuals are accountable for responsible reporting and refraining from vexatious or frivolous reporting. (Table 5) Serious disruptive behaviour (e.g., level 3 or 4 in Table 9) occurring across organizations or care settings (e.g., in community practice environments) can be reported to a health profession regulator. Such reporting should be reserved for situations where other means of addressing conflict have not been successful.

Offer support to colleagues who are targets

Supporters can be a silent witness or can speak up in defense of a target. They can help the target prepare a report or prepare for a meeting with a supervisor and accompany them to the meeting if necessary. Group action against an individual acting in a disruptive way is strongly discouraged because it may be perceived as intimidation or disruptive behaviour itself.[15, 31]

Follow-up by supervisors, managers, clinical leaders and executives

It is critical that everyone in a management or leadership role take action when they observe behaviour that is not consistent with the code of conduct, and in response to any informal or formal reports of disruptive behaviour regarding an employee, contractor or colleague.[14] Healthcare workers at all levels of the organization need to know that their complaints about disruptive behaviour will be acknowledged and dealt with according to the organizational policies and procedures.

AN ORGANIZATION'S RESPONSE TO DISRUPTIVE BEHAVIOUR SHOULD BE APPLIED CONSISTENTLY IN ALL SITUATIONS, BE TIMELY AND FAIR.

ORGANIZATIONAL RESPONSE STRATEGIES

There are seven main components of a strategy for responding to behaviour-related issues:

1. formal reporting process
2. evaluation and initial review
3. investigation
4. progressive approach to intervention with follow-up at each stage
5. resolution
6. documentation
7. support for those involved.

All components of the response should follow the principles of consistency, timeliness and natural justice (fair and without bias). Intervention should be focused on helping the individual change their behaviour if possible. Punitive consequences are reserved for individuals who have not responded to lower level intervention strategies or for serious incidents.

1. Formal reporting process

A reporting system is needed for situations in which interpersonal and informal response strategies fail, for more serious incidents that clearly disturb the work environment and/or pose a risk to safe and quality healthcare delivery, or incidents which may have legal implications (e.g., discrimination, harassment, assault).[37] Those who report (complainant) must feel safe, supported and free from fear of retaliation. In return they are accountable to avoid frivolous or vexatious reporting and to fairly report only facts, not opinion, speculation or gossip. (Table 5)

TABLE 5. RIGHTS AND RESPONSIBILITIES OF THE COMPLAINANT[2]

RIGHTS	RESPONSIBILITIES
▪ To be heard and be understood. ▪ To choose someone for support e.g., friend, relative, colleague, union representative or human resources professional. ▪ To have assistance in writing the report. ▪ To have no fear of retribution for reporting. ▪ To expect (and receive) confidentiality and respect for privacy balanced with principles of natural justice. ▪ To receive information about progress with the investigation and how the issue was resolved while respecting needs of confidentiality of the respondent. ▪ To meet safely with the subject of the complaint in person if appropriate.	▪ To be objective, fair and complete in reporting, focusing on the facts and avoiding opinion, gossip or speculation. ▪ To fairly weigh any apologies and commitments to change made by the respondent. ▪ To not commit frivolous or vexatious reporting. ▪ To reflect on one's own behavior and how it may have influenced the disruptive behaviour situation ▪ To maintain confidentiality and respect for privacy of everyone involved in the incident.

REPORTING AT THE WORK UNIT LEVEL ENCOURAGES MANAGERS TO BE ACCOUNTABLE FOR BEHAVIOUR IN THEIR AREA AND INTERVENE IN A TIMELY WAY.

- A written report that documents the facts of the situation is recommended to support the review, investigation and intervention process. Tools such as a paper or electronic documentation form or checklist can help ensure the required information is recorded.
- Reporting can occur at the work unit level, through a centralized system, or a combination of both. Reporting structures vary between organizations depending on the type and position of healthcare provider involved.[2] Reporting at the work unit level encourages managers to be accountable for behaviour in their area of responsibility and supports timely management of emerging issues. Intervention skills training can help frontline managers develop the skills needed to deal effectively with both informal and formal reports of disruptive behaviour. Centralized reporting systems ensure that all reports are dealt with in a consistent manner.[40] An option is a combined approach where reports are initiated at the work unit level, but serious issues, issues not resolved or not resolved appropriately at the work unit level can be escalated to a centralized reporting system.
- Confidential reporting is preferred to anonymous reporting. Although individuals may prefer the ability to report anonymously because they fear the consequences, the liabilities of anonymous reporting outweigh the benefits: complainant accountability is limited, review and follow-up is not possible, and unsubstantiated allegations can be damaging to the reputation of the accused and contribute to workplace hostility. A confidential reporting system in which the complainant is known only to the minimum number of people who need to know better supports intervention and remediation. The key to a successful reporting system is an organizational culture in which individuals feel safe to report and are confident that their complaint will be taken seriously and handled in a fair and consistent manner. Feedback to complainants on the status of their report will help reassure them that their report is being addressed.

CONFIDENTIAL REPORTING IS PREFERRED OVER ANONYMOUS REPORTING.

- Fear of retaliation and penalties for retaliation must be addressed by organizational policies.[41] The subject of a complaint (respondent) should be informed that attempts to intimidate or retaliate against a complainant will elevate the seriousness of the situation.
- Disruptive behaviour that is occurring across workplaces and that cannot be resolved at the interpersonal level or through processes in place in the respective workplaces can be reported to a health profession regulator. This should be reserved for serious situations where all other options have been unsuccessful.

Resource Toolkit

SEE 5.2 ORGANIZATIONAL REPORTING TEMPLATE

THE VAST MAJORITY OF INTERPERSONAL INTERACTIONS ARE POSITIVE. EVERY COMPLAINT MUST BE EVALUATED TO IDENTIFY THE BEST ROUTE TOWARDS RESOLUTION.

2. Evaluation and initial review

Every complaint, whether verbal or written needs to be evaluated as soon as possible to determine what action is required according to the organization's disruptive behaviour policy.[47] This can help identify situations of conflict that are better handled at the interpersonal level (e.g., complaints about behaviour that is irritating but does not require intervention) and escalate reports of serious incidents that warrant immediate intervention (e.g., assault).

The evaluation answers three questions:[47]

- Would a reasonable person find this behaviour objectionable or inappropriate?
- Does the behaviour meet the definition of inappropriate or unacceptable behaviour as described in the code of conduct?
- Was anyone harmed in the incident?

If the answer is No to these questions, a discussion with the complainant is warranted to determine how to resolve the issue.[47]

If the answer is Yes to any of these questions, an initial review is needed to verify the facts of the situation with all those involved (complainant, respondent, witnesses) in a timely, objective and fair manner. It is helpful to determine the complainant's expectations regarding the outcome.[2, 41] For level 1 behaviours (see below) the initial review could be done by an individual with authority in the work area (e.g., manager, department head) and may be all that is necessary to defuse the incident.[39, 41] Table 6 summarizes information that will be helpful in substantiating an allegation.

TABLE 6. FACT GATHERING IN THE INITIAL REVIEW[2, 37]

OBSERVED BEHAVIOURS	Objective description of the behaviour as related by the: ▪ Complainant (person reporting the incident) ▪ Respondent (person who is the subject of a complaint) ▪ Other witnesses e.g., co-workers, colleagues, patients or visitors, managers or administrators
FACTS ABOUT THE INCIDENT	▪ Where it occurred ▪ When it occurred ▪ Context (what was happening at the time, avoiding speculation)
COMPLAINANT EXPECTATIONS	What is the expected outcome of the complaint process

Resource Toolkit

SEE 5.3 WORKSHEET FOR INITIAL REVIEW OF A BEHAVIOUR COMPLAINT

Throughout the complaint management process the respondent must be treated respectfully and fairly regardless of the severity of the allegations. They have a right to be informed about the complaint against them and to provide their view of what happened. Additional rights and responsibilities of the respondent are summarized in Table 7.[2]

TABLE 7. RIGHTS AND RESPONSIBILITIES OF THE RESPONDENT[2]

RIGHTS	RESPONSIBILITIES
▪ To be informed of a report, its nature and the content of allegations. ▪ To choose someone for support e.g., friend, relative, colleague, union or human resources representative. ▪ To respond to allegations. ▪ To be heard and be understood. ▪ To receive a fair and objective investigation. ▪ To expect (and receive) confidentiality and respect for privacy, balanced with principles of natural justice. ▪ To engage legal counsel or union representation (as appropriate to their position). ▪ To meet safely with the complainant in person when appropriate. ▪ To receive information about progress and conclusions of the investigation. ▪ To respond to the investigation's conclusions or appeal an adverse outcome if appropriate. ▪ To expect efforts to reduce or eliminate contributing system stressors.	▪ To be fair and complete in responding to allegations. ▪ To accept responsibility for one's own actions. ▪ To understand that others' perspectives are important. ▪ To cooperate in the review, assessments and follow-up evaluations of any intervention. ▪ To accept referral and recommendations for assistance or treatment if needed. ▪ To change behaviour if found to have been disruptive. ▪ To maintain confidentiality and respect for privacy of everyone involved in the incident.

In both the initial review and investigation process, information from others who may have observed the incident can be useful when trying to understand what happened. Both the complainant and the respondent should be given a chance to identify potential witnesses. Encourage witnesses to focus on the facts about what was happening at the time and what was observed in the interaction between complainant and respondent. Avoid speculation, information not personally observed and gossip about either of the individuals involved. Witnesses are expected to maintain the confidentiality of the complaint process.

3. Investigation

For ongoing or more serious behaviour-related issues (levels 2 to 4, below), an investigation is recommended. Through an investigation, additional information is gathered about contributing individual and system factors and the context in which the behaviour is occurring. The goal of an investigation is to determine if the allegation is founded and guide decision-making about intervention.[39] The term 'review' is preferred by some professions for this process (e.g., physicians) when it is undertaken by an organization where they work; 'investigation' typically refers to a similar process used by a health profession regulator in responding to a complaint against a member.

An investigation should be conducted by a neutral individual or team from outside the work unit (e.g., from human resources or another department) who is experienced in this process.[2] When individuals from more than one healthcare discipline are involved in a conflict, a team approach demonstrates a fair and balanced process. Confidentiality from all parties and of all information collected throughout the investigation process is essential. Elements of an investigation are summarized in Table 8.[2]

A PROGRESSIVE APPROACH TO MANAGEMENT IS RECOMMENDED IN WHICH INDIVIDUALS ARE SUPPORTED TO CHANGE THEIR BEHAVIOUR WHENEVER POSSIBLE.

SEE 5.4 BEHAVIOUR INCIDENT INVESTIGATION CHECKLIST
5.5 FORMAL INVESTIGATION REPORT TEMPLATE

TABLE 8. ELEMENTS OF AN INVESTIGATION

INFORMATION GATHERING	CONSIDERATIONS IN INTERPRETATION OF INFORMATION
▪ Corroborating and correlating information about the incident from more than one person if possible. ▪ Objective accounts of witnessed behaviour. • For passive disruptive behaviour, documents such as minutes or correspondence may be used. ▪ Assessment and documentation of risks to patient care. ▪ Review of documentation concerning prior incidents involving the individuals (if applicable) and past interventions. ▪ Risk assessment for workplace and healthcare worker safety (complainant, respondent, others).	▪ Degree of concurrence among the information collected from different sources. ▪ Work context for the behaviour e.g., single event frustration, contributing system issues. ▪ Personal context for the behaviour e.g., personal and family circumstances, health issues. ▪ Potential for misunderstanding as a result of cultural, ethnic or religious background of individuals involved. ▪ Possibility of a false report if there are discrepancies in the information collected. ▪ Possibility of 'mobbing' i.e. submission of several trivial or false reports regarding an unpopular or vulnerable individual.

4. Progressive approach to intervention

A progressive approach to intervention that encourages and supports behaviour change is recommended. Individuals whose behaviour is disrespectful to the point of being disruptive are often highly skilled and competent healthcare providers who have much to offer to patient care. Management strategies should be:

- appropriate to the nature of the situation
- intensify with recurring incidents and limited success of lower level interventions
- directed towards helping individuals address personal contributing factors and to change their behaviour[37, 39, 41]

Punitive disciplinary action such as a formal reprimand, suspension, termination of employment or withdrawal of privileges should be reserved for more serious situations or when individuals refuse to change their behaviour despite repeated lower level interventions.

The intervention strategy will be influenced by severity of the behaviour (Table 9) as well as contributing and mitigating factors uncovered during the investigation. Multiple interventions over a period of time may be required to support individuals in changing their behaviour. Fairness, respect for the individuals involved, privacy and confidentiality must be maintained throughout the process.[2, 41] With every intervention there needs to be an agreed-upon action plan for change developed with the respondent. The action plan should include well-defined goals, actions for the individual to take, consequences for not following through, and a follow-up plan to assess success, reinforce expectations of accountability and encourage positive behavioural changes.[39]

TABLE 9: SEVERITY OF DISRUPTIVE BEHAVIOUR[2, 32, 37, 39]

LEVEL 1 FIRST REPORT, LOW SEVERITY	▪ First report (but not necessarily first incident) of behaviour not meeting the code of conduct – informal to a supervisor or manager or formal through a reporting system. ▪ Behaviour(s) may or may not meet a definition of 'disruptive' but has the potential to become disruptive if it continues or escalates; may be an isolated situation-related incident. ▪ Passive disruptive behaviours.
LEVEL 2 CONTINUING, MODERATE SEVERITY	▪ Behaviours that clearly meet the definition of disruptive - generally pose a risk to collaboration and cooperation in the work area and impact patient care. ▪ Ongoing pattern of behaviour not meeting the code of conduct despite intervention(s), including recurring level 1 behaviours. ▪ Lack of cooperation and inadequate or inappropriate response by the respondent to intervention strategies.
LEVEL 3 PERSISTENT OR ESCALATING, MEDIUM TO HIGH SEVERITY	▪ Persistent or escalating or serious disruptive behaviour despite repeated interventions. ▪ Conduct that raises specific concerns of harm to patients, the complainant, the respondent and/or others. ▪ Threat of retaliation by the respondent.
Level 4 EMERGENT, CRITICAL	▪ Civilly or criminally liable behaviour. ▪ Threats of or attempts to harm self or others. ▪ Immediate risk to staff and patient safety.

Rather than being prescriptive, a menu of intervention strategies is presented in Table 10 and described below. Select one or more intervention strategy to develop an intervention plan appropriate to the situation and the individual involved. Reserve punitive interventions (e.g., written warning, suspension, report to a health profession regulator, termination) for more serious behaviours.

CHOICE OF MANAGEMENT STRATEGIES FOR AN INDIVIDUAL WILL BE INFLUENCED BY SEVERITY OF THE BEHAVIOUR AND MITIGATING FACTORS.

TABLE 10. INTERVENTION STRATEGIES

SEVERITY OF BEHAVIOUR	INTERVENTION STRATEGY
LOW (Level1)	▪ Informal 'awareness' discussion ('cup of coffee conversation') ▪ Formal meeting ▪ Referral to a support or assistance program
MODERATE (Level 2)	▪ Coaching and mentoring ▪ Assessment of contributing factors ▪ Counseling ▪ Clinical assessment and interventions
MEDIUM TO HIGH (Level 3)	▪ Mediation ▪ Behaviour-focused training ▪ Work restrictions ▪ Written warning ▪ Suspension
CRITICAL (Level 4)	▪ Report to a health profession regulator when legally or ethically required ▪ Termination of employment ▪ Legal action

Informal 'awareness' discussion

A manager or respected colleague meets with the individual in private to briefly review the observations and invite the individual to offer an explanation of what happened. The individual is reminded about expectations for respectful conduct towards others on the healthcare team.[32] This is most appropriate when there has been no formal report of disruptive behaviour, the colleague or manager who is intervening has witnessed the behaviour, and no immediate consequences for patient care were evident. Depending on the situation it may also be appropriate in response to an informal, verbal complaint.[39] Notes about the discussion kept in the supervisor's performance management file are prudent, especially if this kind of discussion is needed repeatedly.[32,39] Follow-up is recommended, even if it is informal such as a quick chat after a few days or weeks to acknowledge positive behavioural change.[39] Interventions of this type are encouraged and can resolve a lot of budding issues if handled in a supportive, respectful way.

Formal meeting

An individual with authority (e.g., supervisor, manager, clinical leader) meets with the respondent in private to discuss an informal complaint or formal report of disruptive behaviour or to follow-up when there has been no or limited response to previous interventions. The respondent may ask someone else to attend with them, such as a union or other representative as appropriate or legal counsel. Unionized employees are entitled to have a union representative present at all meetings. If the dispute is between members of the same union, each should have a representative. Use information from supporting documentation such as that collected through a review or investigation to structure the discussion. The discussion should always be behaviour-focused, and include:

- A description of the unacceptable behaviour with concrete examples if possible.
- A statement about the impact of the behaviour on others.
- A request to change the behaviour.

Reinforce expectations of behaviour established in the code of conduct, and highlight the potential or real impact on patient safety and quality of care. Reaffirm the value of the individual to the organization while making it clear that no one is exempt from standards of behaviour.[39] The meeting should be documented and an action plan developed with the respondent. Documentation is kept in the supervisor's performance management file. Acknowledgement, apology and commitment to change behaviour may be all that is required of the respondent. If there are ongoing issues requiring repeated formal meetings, more aggressive behaviour change interventions may be required.[39]

SEE 5.6 CHECKLIST FOR PREPARING FOR A MEETING
5.7 SAMPLE PHRASES FOR A BEHAVIOUR-RELATED DISCUSSION
5.8 MEETING DOCUMENTATION TEMPLATE

Referral to a support or assistance program

The respondent is encouraged (but not mandated) to seek assessment for or help with potential contributing personal factors through an assistance plan appropriate to their position. This could be used as part of an informal discussion or in response to Level 1 behaviours.

Coaching and mentoring

A respected peer or supervisor can be assigned to help support the individual in addressing stressors contributing to early lower levels of disruptive behaviours when the respondent recognizes the need to make changes and commits to making changes on their own. Mentorship and coaching involves regular interaction to provide encouragement and feedback in a nonjudgmental manner.[41, 48]

Assessment of contributing factors

This may include an assessment of contributing system factors, an occupational assessment, or referral for medical and psychological assessment.[39] Unions often support their members through this process. It is most often used when disruptive behaviour recurs, escalates, or is minimally responsive to previous interventions. It may be appropriate for a first episode of extreme disruptive behaviour that is out of character for an individual, and that raises concerns about underlying contributing personal factors. Appropriate workplace health and safety experts should assist with the system and occupational assessment. Medical or psychological assessment should be referred to an external professional. Managers and leaders with a clinical background must resist the temptation to 'diagnose' the individual.

Counseling

Individual or group counseling can be helpful to support respondents through a complaint resolution or behaviour change process. This can be arranged through workplace health and safety programs, through an external counselor, or through an employee or health professional assistance program.

Clinical assessment and intervention

When a potentially contributing underlying treatable medical illness, psychiatric problem or substance abuse issue is suspected or identified, clinical assessment and intervention by an appropriate medical or mental health professional may be recommended.[36,39] To maintain privacy and confidentiality. this type of intervention is best coordinated by a workplace health and safety professional within the organization for employees. Non-employee professionals can access these services

through their profession's assistance program. Managers and supervisors have a right to know that an individual is following through on the recommendation to seek help, but do not need to be informed of the details of the diagnosis and treatment plan.

Mediation

A neutral, experienced mediator from within or outside the organization is an option to consider when the behaviour issue is clearly due to an ongoing interpersonal conflict between two individuals. The goal is to assist both individuals in coming to solutions for resolving the underlying issues.[41]

Behaviour-focused training

Referral to a specific education or training program can help individuals develop concrete skills to change their behaviour, for example communication skills, conflict resolution, anger management, stress management, or sensitivity training. Healthcare professionals resistant to other interventions can be referred to specialized programs designed to help them identify and address underlying personal issues that contribute to their ongoing behaviour problems.

Work restrictions or suspension

Disciplinary measures such as placing conditions on or restricting work activities (e.g., restriction of privileges), or temporary suspension can be considered after other interventions focused on helping the respondent to change their behaviour have failed, respondents are uncooperative, or the disruptive behaviour is serious. Suspensions can range from short term (e.g., one day) in which the respondent is expected to reflect on how they will comply with a proposed behaviour change plan,[48] to longer term removal from the workplace until factors contributing to the behaviour have been addressed. Return to work needs to be handled with care to ensure that both the respondent and co-workers are prepared and supported.

SEE 5.10 RETURN TO WORK CHECKLIST

Consult with or report to a health profession regulator

Involvement of a health profession regulator can be informal and discretionary or required by law or ethical practice. Organizations and individuals can contact a regulator informally and in confidence for advice and assistance in managing a professional's behaviour. The name of the individual involved must not be revealed to protect their privacy. A healthcare professional must be reported to their regulator under Section 57 of the *Health Professions Act* for unprofessional conduct that results in suspension, termination or resignation[49] or under the regulator's code of ethics, or duty to report concerns about competent practice as outlined in their standards of practice. Involving a regulator must be handled in a respectful way with the respondent even when reporting is required by law because it can be perceived as a threat or intimidation tactic.

Termination of employment

Dismissal or withdrawal of privileges may be warranted occasionally, in circumstances involving serious or critical behaviours or when all other intervention options have been exhausted.[39, 41, 48]

Legal action

In the rare situations when civilly liable conduct or criminal wrongdoing is documented or suspected, legal action may be required.

RESOLUTION CLOSES THE LOOP IN THE INTERVENTION PROCESS AND HELPS REPAIR DAMAGED RELATIONSHIPS.

5. Resolution

Resolution closes the loop in the intervention process and assists both the complainant and the respondent in seeking closure so that they can move on from the incident. It can help repair but perhaps never completely restore damaged relationships between all those involved. Many incidents can be solved quickly with a sincere apology, either verbal or in writing.[2] Effective apologies are complex and situation dependent. To help the healing process, the offended typically needs an apology that is personally delivered, sincere, acknowledges the offense, and includes acceptance of responsibility, an expression of remorse and a commitment to change behaviour.[50]

- Complainants typically want to know that their report is being addressed and that action is being taken so that they won't experience the same treatment by the respondent in the future. Determining the complainant's expectations for resolution during the review process can help ensure their needs are met, but also help them understand what a realistic outcome will be. Follow-up during and after the intervention process without breaching confidentiality of the respondent will help reassure them that action is being taken.
- Respondents will benefit from an action plan with clear goals for behaviour change, specific actions that will be taken by the individual and the work unit (e.g., contributing workplace factors that will be addressed), and when and how follow-up will occur. When the behaviour is more serious or the respondent is uncooperative with intervention efforts, a written remediation agreement that includes consequences for continued unacceptable behaviour may be required.[2] Success is achieved when there is a cessation of the target behaviours or at least a decrease to acceptable levels.[2]

SEE 5.9 ACTION PLAN FOR BEHAVIOUR CHANGE CHECKLIST

- When an individual is temporarily removed from the work unit as an intervention strategy, return to work will be stressful for everyone. A return-to-work plan will assist the respondent and their co-workers in coping with this difficult time, support ongoing remediation of behaviour, and promote resolution.

SEE 5.10 RETURN TO WORK CHECKLIST
5.11 MULTISOURCE FEEDBACK QUESTIONNAIRE – EXAMPLE

6. Documentation

Documentation is essential if it becomes necessary to follow through with disciplinary consequences (e.g., work restrictions, suspension, report to a health profession regulator, termination of employment) or if there is a potential for litigation. Documentation may be discretionary for an interpersonal or informal awareness conversation. It is strongly recommended for repeated informal awareness interventions, for formal meetings, or whenever an intervention plan based on an assessment of contributing

DOCUMENTATION IS ESSENTIAL TO ENABLE EFFECTIVE INTERVENTION AND FOLLOW-UP.

SUPPORT FOR EVERYONE INVOLVED IN A DISRUPTIVE BEHAVIOUR SITUATION IS NEEDED: RESPONDENT, COMPLAINANT, OTHERS IN THE WORK UNIT, AND MANAGERS OR LEADERS.

factors is developed. A record of each meeting should include date and time, individuals involved, issues discussed, recommended or mandated interventions, specific goals and timelines for change, and explicit consequences for failing to follow-through. Follow-up and evaluation activities should also be documented. The individual should be aware that documentation is occurring. Documentation should be maintained in the supervisor's performance management file until circumstances or policy require that a formal, written report be placed in the individual's employment record, usually associated with disciplinary measures.[2]

7. Support for all those engaged in a disruptive behaviour intervention

Managing behavioural issues is a stressful and often distressing process for all involved – the respondent and complainant, other target(s), and managers who have to lead the intervention process. Having support available for all those involved will help reinforce the organization's commitment to treating all healthcare workers with respect and compassion. A plan to support the respondent and complainant and possibly others on the healthcare team or in the patient care area is required.[31] Employee and physician or health professional assistance programs should be engaged early in the process.[40] When an individual must be temporarily removed from the workplace due to disruptive behaviour, there is often a lingering feeling of anger and frustration among other members of the healthcare team. Support for those in the workplace as well as development of a reintegration plan that is both clear and accepted by all parties is needed before the individual returns to work.[2]

Potential Management Issues

Determining what qualifies as disruptive behaviour and managing the situation effectively can be a challenge to individuals, programs, organizations and health profession regulators. The following issues may arise while managing incidents of disruptive behaviour:[2]

Late recognition of long-standing disruptive behaviour

When colleagues and/or administrators ignore minor issues or continue to handle repeated instances of disruptive behaviour informally, the situation will become increasingly difficult to manage. Similarly, it is important to address emerging patterns of disruptive behaviour in students and postgraduate trainees early to avoid a pattern of disruptive behaviour that could continue into their future career.

Recommendation: *Early and consistent management of* ***all*** *instances of disruptive behaviour is a key strategy. Documentation is essential to enable effective intervention and follow-up.*

Belief that disrespectful conduct is acceptable and even helpful to patient care

Some individuals may believe that acting in an aggressive, intimidating manner is normal or is acceptable because it is required to ensure care that is in the patient's best interest.[7, 39] When challenged, these individuals may respond with intimidation or threat of retaliation such as litigation.

Recommendation: *Inform individuals who express this view of disruptive behaviour about how such behaviour actually negatively impacts patient care, supported with actual examples from the care area if possible. Threats of retaliation should escalate the level of intervention.*

Support for, and tolerance of, a highly competent physician, administrator, or executive with disruptive behaviour

If the individual in question is competent, liked by superiors or peers, performs at a high standard of technical performance and patient care and/or is the only option for care in smaller/rural centers, acts of disruptive behaviour may be ignored or go unresolved.

Recommendation: *Leadership in applying intervention strategies consistently throughout an organization regardless of the position of the individuals involved is essential. The intervention plan may need to involve proactive planning for the possibility that a replacement may be needed, at least temporarily.*

Deferring the issue for others to deal with

Instead of staff in the work unit, managers, and/or administrators dealing directly with incidents of disruptive behaviour, the situation may be left for a new manager, administrator or clinical leader to deal with or may be referred to another organization e.g., health profession regulator. This undermines efforts of the organization to create a respectful and healthy workplace.

Recommendation: *Intervention skills training for supervisors and leaders will help reinforce the need to take decisive and consistent action on these issues. Prioritize behaviour intervention training for newly promoted managers.*

An individual reverts to disruptive behaviour after the issue has apparently resolved

Some of the more difficult situations involve healthcare providers who initially agree to make better behavioural choices and accept treatment, counseling or other interventions, then later revert to their previous behaviour. Individuals who lack insight into the effect of their behaviour on others or those who see themselves as a target will be resistant to change.

Recommendation: *A written intervention plan based on an objective assessment of contributing factors, with clear accountability, a follow-up and evaluation plan, and specific consequences if changes are not made is essential. Thorough documentation of all efforts to encourage and support behaviour change is needed if disciplinary consequences become necessary.*

Summary

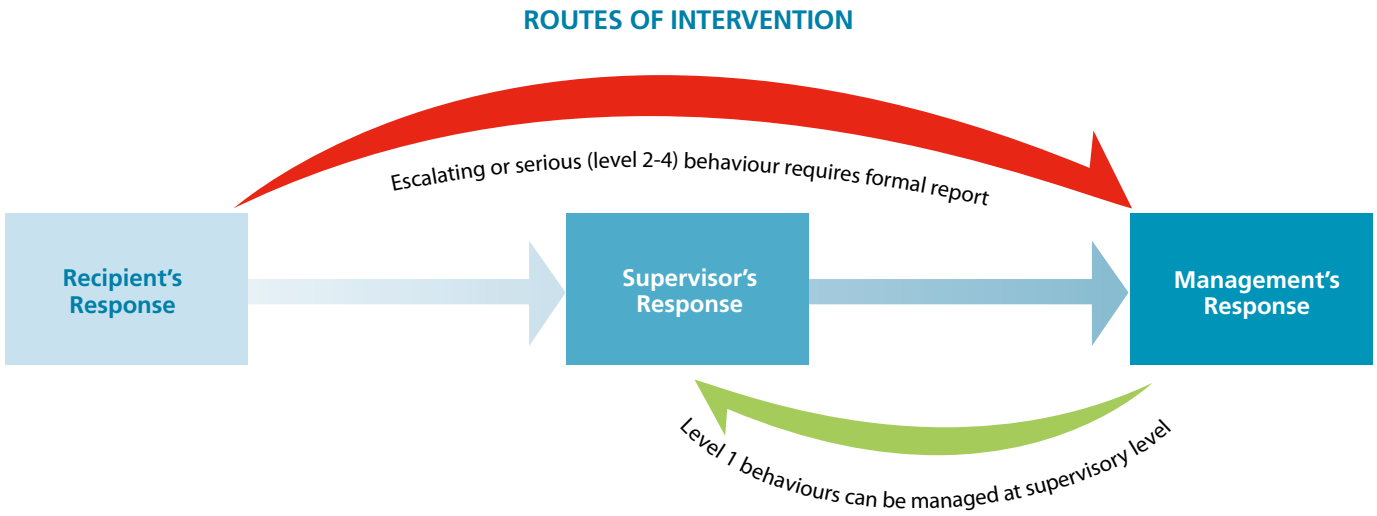
Creating a healthy workplace in which healthcare providers work together in a respectful and collegial way and have the confidence to voice patient care concerns without fear of retaliation or punishment will help ensure that the care patients and clients receive is safe and of high quality. There are no quick fixes for culture change – it is a continual process of setting expectations, being vocal about the desired state, providing positive role models, and following through consistently on policies and procedures designed to support individuals in doing the right thing. Given human nature, it is inevitable that individuals will sometimes behave in a disrespectful way or breach the code of conduct. Early intervention at the interpersonal and informal level, and successful management based on principles of timeliness, consistency, and fairness that is focused on supporting behaviour change, will minimize its impact, and result in healthcare providers who:[2]

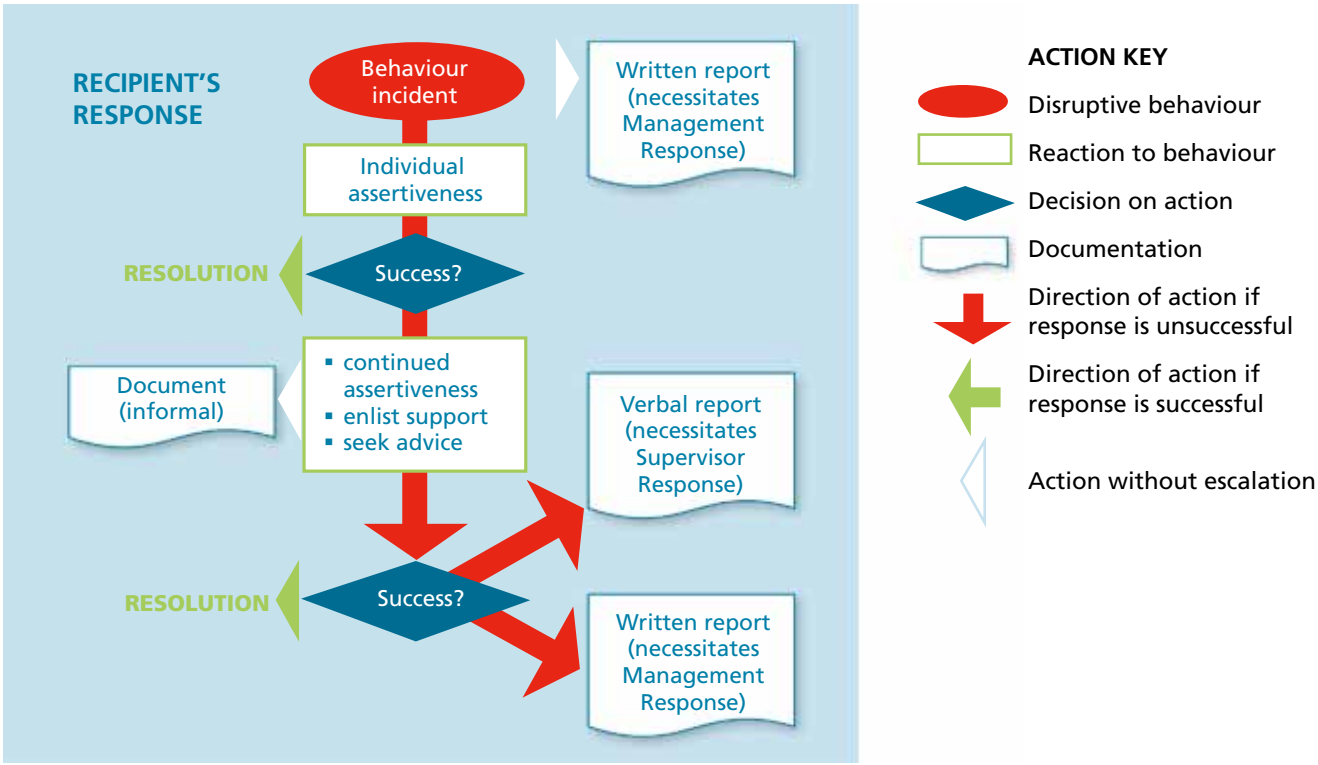
- remain approachable, even when under stress
- treat team members and other healthcare workers with respect
- handle conflict with difficult team members effectively
- remain open to suggestions
- respond to conflict by working out solutions
- adapt to changing policies, procedures and priorities

Appendix 1: Working Group Members

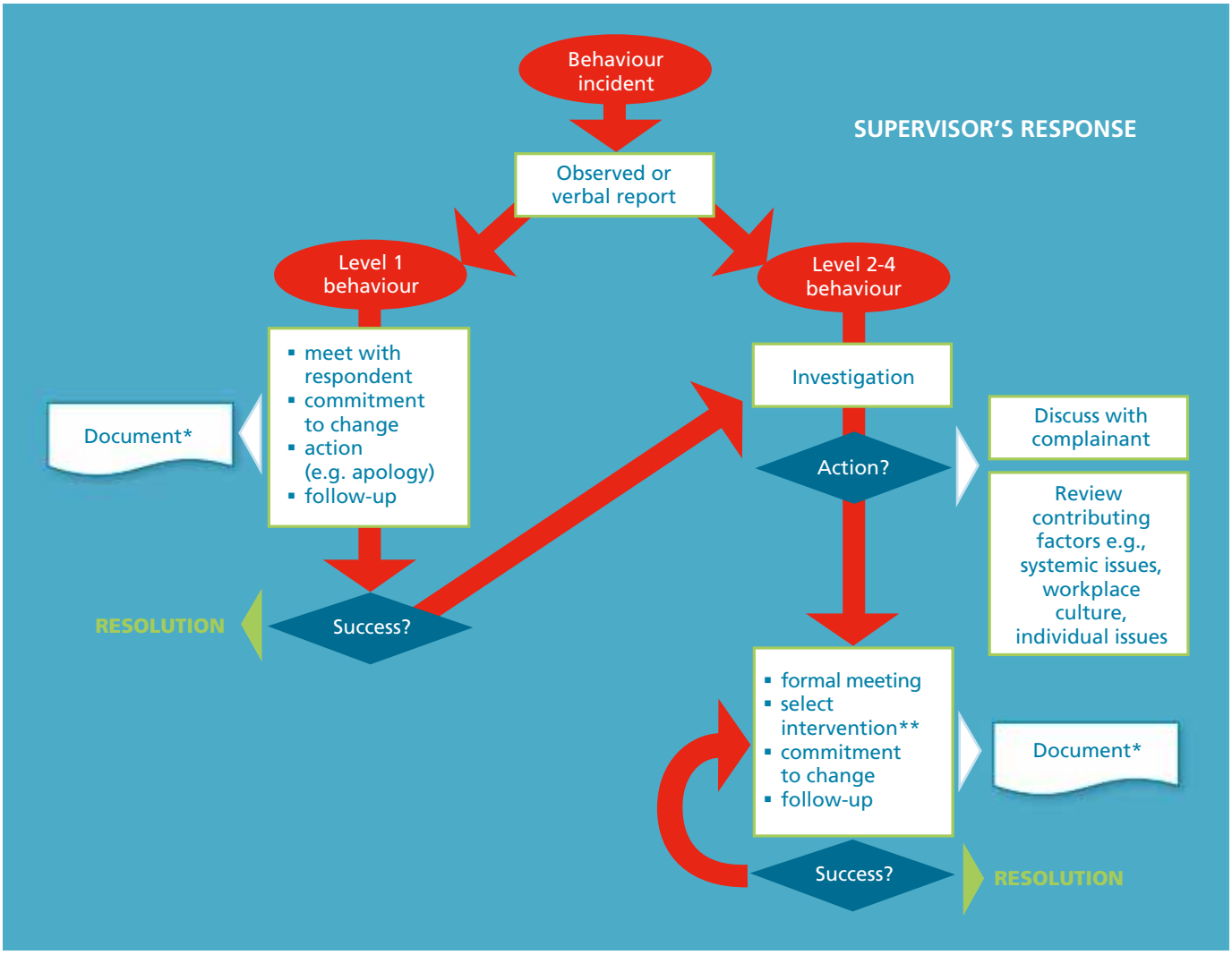
Dale Wright (Co-Chair)	Quality & Safety Initiatives Lead, Health Quality Council of Alberta
Janet Wright (Co-Chair)	Assistant Registrar, College of Physicians and Surgeons of Alberta
Lyle Mittelsteadt	Senior Medical Advisor, Alberta Medical Association
Debra Allen	Policy and Practice Consultant, College and Association of Registered Nurses of Alberta
Jim Krempien	Complaints Director, Alberta College of Pharmacists
Kathy Hilsenteger	Alberta Federation of Regulated Health Professions
Mona Sikal	Director, Employee Relations, Alberta Health Services
Dianne MacGregor	Executive Director, Interprofessional Education and Student Placements, Alberta Health Services
Rollie Nichol	Associate Chief Medical Officer, Alberta Health Services
Sandra Vanderzee	Director of Professional Practice, Covenant Health
Dean Jensen	Advisor, Human Resources, Misericordia, Covenant Health
Joan Berezanski	Executive Director and Senior Provincial Clinical Advisor, Alberta Health
Deb Prowse	Patient/Family Safety Advisory Panel, Health Quality Council of Alberta

Appendix 2: Disruptive Behaviour Management Flow Chart





Appendix 2: Disruptive Behaviour Management Flow Chart



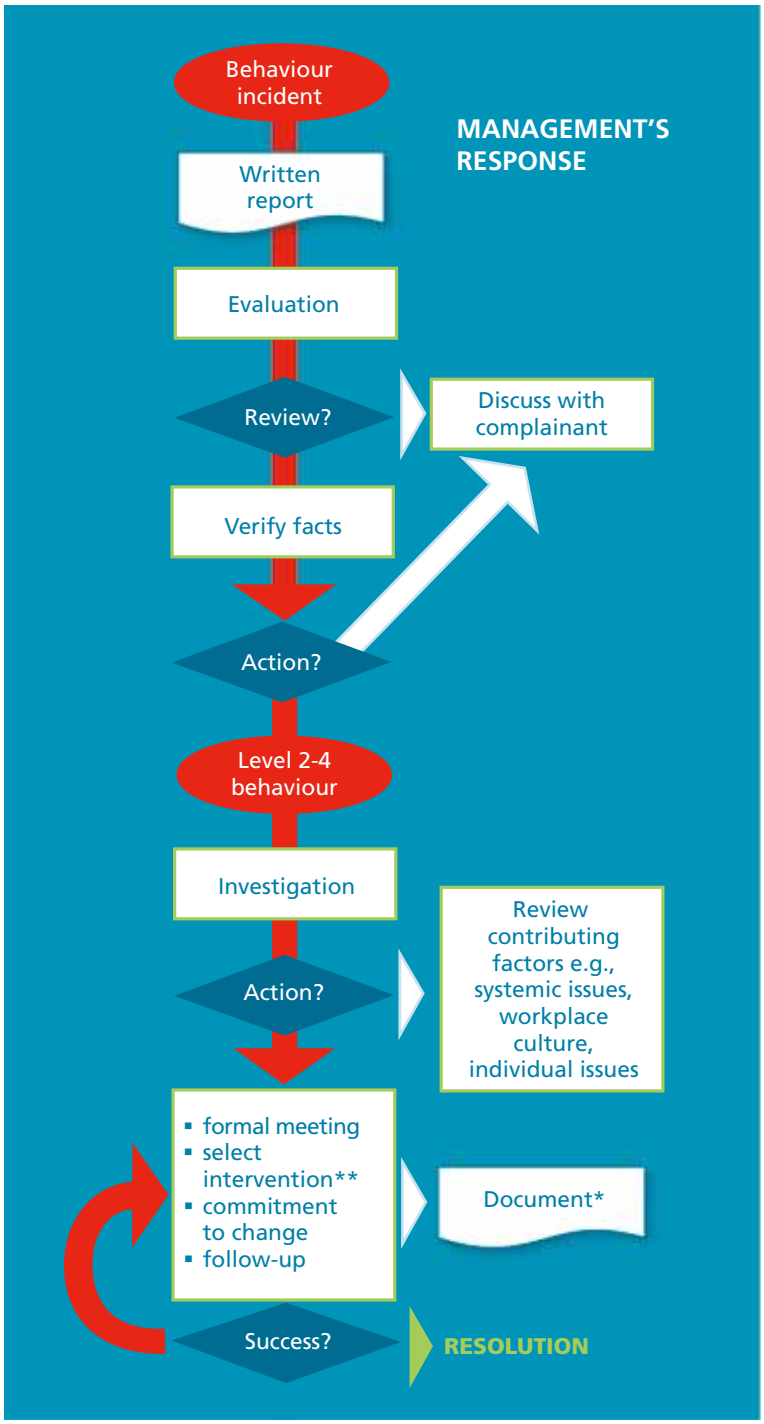
*Documentation maintained in supervisor's performance management file.

**INTERVENTION OPTIONS

- Referral to assistance program
- Coaching/mentoring
- Assessment
- Clinical intervention
- Counseling
- Mediation
- Written warning
- Behaviour-focussed training
- Work restrictions or suspension
- Contact or report to regulatory authority***
- Termination

***Discretionary or required, depending on the situation

Appendix 2: Disruptive Behaviour Management Flow Chart



ACTION KEY

- Disruptive behaviour
- Reaction to behaviour
- Decision on action
- Documentation
- Direction of action if response is unsuccessful
- Direction of action if response is successful
- Action without escalation

*Documentation maintained in supervisor's performance management file.

****INTERVENTION OPTIONS**

- Referral to assistance program
- Coaching/mentoring
- Assessment
- Clinical intervention
- Counseling
- Mediation
- Behaviour-focused training
- Work restrictions or suspension
- Contact or report to regulatory authority***
- Termination

***Discretionary or required, depending on the situation

Appendix 3:
Resource Toolkit Content

The Resource Toolkit to support the Managing Disruptive Behaviour in the Healthcare Workplace Provincial Framework is only provided electronically on the HQCA website. Toolkit documents are presented in a format that can be readily adapted by an organization or workplace.

TO DOWNLOAD THE TOOLKIT VISIT WWW.HQCA.CA

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Notes

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