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Thought Leader Forum

Workplace Intimidation: The Underestimated Threat to Patient Safety

Sponsored By

ASHRM
AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT

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AMERICAN SOCIETY FOR HEALTHCARE HUMAN RESOURCES ADMINISTRATION
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ASHRM AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT

Established in 1980, the American Society for Healthcare Risk Management is a personal membership group of the American Hospital Association with more than 5,400 members representing clinical, insurance, legal, and related professions.

ASHRM promotes effective and innovative risk management strategies and professional leadership through education, recognition, advocacy, publications, networking, and interactions with leading health care organizations and government agencies.

ASHRM initiatives focus on developing and implementing safe and effective patient care practices, the preservation of financial resources, and the maintenance of safe working environments.

Vision

To be the global thought and information leader in health care risk management and patient safety.

Mission

To advance health care risk management and patient safety.

Strategic Goals

Voice

ASHRM is the leading advocate for health care risk management and patient safety professionals, telling their story and promoting proactive, patient-centered practices.

Awareness

Working for positive awareness of the profession's contributions to health care, ASHRM helps members gain recognition as leaders in their organizations.

Information

ASHRM is moving forward as the primary resource for health care risk management and patient safety information via the web, the page, and face to face.

Development

ASHRM supports the development of tomorrow's top professionals with unmatched educational support and rewarding volunteer opportunities.

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AMERICAN SOCIETY FOR HEALTHCARE HUMAN RESOURCES ADMINISTRATION OF THE AMERICAN HOSPITAL ASSOCIATION

Founded in 1964, ASHHRA is the leading voice for HR professionals in health care - linking people and organizations to leadership practices, best practices to patient outcomes, and outcomes to business results. Headquartered in Chicago, IL, the society has more than 3,400 members and services the needs of over 50 chapters throughout the United States. For more information about ASHHRA, visit www.ashhra.org.

Mission

ASHHRA leads the way for members to become more effective, valued, and credible leaders in health care human resource administration.

Value Proposition

We offer high quality and effective resources, educational programs, and networking opportunities to human resource professionals in the health care industry.

Vision

By joining together, by raising our skills and by speaking with one voice, we, as ASHHRA members will enhance the well-being of our employees, our health care organizations, and the communities we serve.

- *Our purpose*: To establish the expertise of health care HR through our ability to learn and share knowledge, build relationships, and exemplify excellence.
- *Our power*: To influence and impact the future of the health care workforce and those they serve.
- *Our promise*: To keep in our minds and hearts the passion and commitment we have for our profession.

Introduction

The American Society for Healthcare Human Resources Administration (ASHHRA) and the American Society for Healthcare Risk Management (ASHRM), personal membership groups of the American Hospital Association (AHA), held a joint Thought Leader Forum on Thursday, July 22, 2010 in San Diego, California, prior to the 2010 AHA/Health Forum Leadership Summit.

Dan Zuhlke, Vice President, Human Resources, Intermountain Healthcare, Inc. and 2010 ASHHRA Immediate Past President, and Terie Zimmerman, Theresa Zimmerman Consultants and ASHRM president, co-chaired the proceedings. The discussion was moderated by Larry Walker, president of The Walker Company Healthcare Consulting, LLC.

A select group of thought leaders—human resource, risk management, and health care quality and patient safety experts—participated in the Forum, a two-hour session titled, "Workplace Intimidation: The Underestimated Threat to Patient Safety." The Thought Leader Forum participants included:

- James Battles, Agency for Healthcare Research and Quality, Rockville, Maryland
- Jerod Loeb, PhD, *Executive Vice President, Division of Quality Measurement and Research,* The Joint Commission, Oakbrook Terrace, Illinois
- Jeff Payne, *VP, Human Resources,* Lakeland Regional Medical Center, Lakeland, Florida
- Irma Babiak Pye, *SRVP and CHRO,* Valley Baptist Health System, Harlingen, Texas
- Pam T. Rudisill, *VP, Nursing and Patient Safety,* Health Management Associates, Inc., Mooresville, North Carolina, AONE President
- Barry Silbaugh, MD, *CEO,* American College of Physician Executives, Tampa, Florida
- Larry Veltman, MD, Women's Healthcare Association, Portland, Oregon
- Bob Walters, *Corporate Director, HR Operations,* Health First, Inc., Melbourne, Florida
- Terie Zimmerman, Theresa Zimmerman Consultants, Kansas City, Missouri
- Daniel Zuhlke, *VP, Human Resources,* Intermountain Healthcare, Inc., Salt Lake City, Utah.

"Insidious intimidation, the quiet, passive-aggressive type, seeps into our cultures and slowly changes our cultures so that breakdown of communication and teamwork is a result," said ASHRM President Terie Zimmerman. "If we don't have tactics and strategies available to us, we set ourselves up for failure," she added. Dan Zuhlke, ASHHRA Immediate Past President observed, "It's important for us to take these learnings and share them across our professions, and do something to make it better."

This Thought Leader Forum *Summary of Findings* is a strategic overview of the drivers of workplace intimidation, and the role that human resource and risk management professionals can have in eliminating intimidation from the workplace.

Contents

Recognizing the need and benefits of jointly addressing the issues, challenges and concerns of workplace intimidation, ASHHRA and ASHRM brought together a panel of ten leaders in human resources, risk management, and health care quality and patient safety to discuss "insidious intimidation in the workplace."

These thought leaders engaged in a robust discussion of thoughts, opinions, experiences, and ideas for combating intimidation. The discussion focused on:

- Defining "insidious workplace intimidation," discussing how it differs from more overt and commonly addressed forms of intimidation, and how insidious intimidation manifests itself in the workplace
- Why intimidation exists in the workplace
- The negative implications of workplace intimidation on delivering high quality and safe patient care
- Actions that can be taken to combat the forces of workplace intimidation
- The importance of partnerships and collaboration in addressing the issues.

Defining "Insidious Workplace Intimidation"

Workplace intimidation is most commonly thought of, discussed, and addressed as overt, dramatic events typically involving a doctor, nurse, or other executive or manager. The Forum leaders' discussion focused, however, on a more insidious form of intimidation—the subtle, passive-aggressive breakdown in communication and actions that may occur at any level and between any individuals, internal and external, involved in delivering care to patients.


Barry Silbaugh, MD

Intimidation in any form poses a significant risk to patients. Nevertheless, despite a large volume of data and information on the topic, many organizations continue to experience this dangerous behavior every day.

The results of insidious workplace intimidation are many: medical errors, poor patient satisfaction, preventable adverse outcomes, higher cost of care, low morale and increased workplace turnover, and potential litigation from employees and patients.

Through the conduct of numerous root cause investigations, leaders have begun to identify and discuss insidious intimidation, described by one leader as the "quiet, passive-aggressive actions that seep into [organizational] cultures and slowly change [those] cultures so that breakdown of communication and teamwork is a result," a result characterized as "the underestimated threat to patient safety."

The Joint Commission recognizes both overt and passive intimidation and disruptive behaviors. Acknowledging verbal outbursts and physical threats as overt actions, The Joint Commission also calls out passive actions such as "reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions" as behaviors that are damaging to team effectiveness and compromising to patient safety.

Drivers of Workplace Intimidation

With a clear definition of insidious intimidation and agreement on its detrimental effects to organizations and their ability to deliver quality care and patient safety, thought leaders identified and discussed the reasons for the continued occurrence of intimidating behaviors in today's health care culture.

- ***"We tolerate it"*** was the quickest explanation from thought leaders for the continued pervasiveness of workplace intimidation. Forum participants acknowledged that intimidation has been allowed to continue in the health care workplace far too long, and they expressed the need for organizations to discuss the issues and challenges insidious intimidation presents, and define opportunities for improvement.
- ***Undefined expectations.*** A failure to clearly define behavioral expectations for the workplace and the consequences for failing to meet those expectations was identified as an important factor in organizations' allowing intimidation to continue.

- ***Lack of tools for behavioral change.*** Not only have expectations too often not been set, organizations may lack the tools they need to change behaviors. At a strategic level, the participants discussed the need for organizations to be well-equipped to drive change in an organization's culture in order to eliminate intimidation from their workplace.

  At a more tactical level, it was observed that too few organizations have the policies and other resources needed to help management deal with issues and challenges of intimidation.

- ***Lack of appropriate educational training and role modeling early in the pipeline.*** Thought leaders were in agreement that medical students (doctors, nurses, and other health care professions) do not receive the strong, positive behavioral training and role modeling they need prior to entering the workforce. Teaching hospitals were identified as a crucial touch point for cultural change in developing "no tolerance" for workplace intimidation.

- ***Societal norms.*** Thought leaders discussed the implications to workplace culture in a society in which lack of respect, divisiveness, and unprofessional behavior is too often present, and to which individuals have become acculturated. Diane Felblinger, EdD, a registered nurse and associate professor of nursing at University of Cincinnati, wrote an article, published in a 2008 issue of the *Journal of Obstetric, Gynecologic, & Neonatal Nursing,* on the concept of the spectrum of incivility in the workplace, in which incivility rises to disrespect, then to intimidation and from there on to disruptive behavior was raised as a teaching model for the effects of intimidation.

- ***Independence that sets its own standard, the effect of hierarchy.*** Thought leaders noted that professional independence often connotes a license to set one's own standards of behavior. Further noted was the failure of executive leaders to set the standards of positive behavior.

- ***Challenges of unions.*** The divisive impact of union organizing and bargaining efforts often results in an "us and them" mentality that can open the door to opportunities for increased insidious intimidation.

- ***Intimidation can be inadvertent, and can result from poor cultural competency.*** Today's health care workforce is becoming increasingly more ethnically and culturally diverse. Difficulty understanding the accent of another individual, subsequent embarrassment from requests to repeat what was said by one person, and impatience at not being understood by the other can inadvertently lead to intimidation and communication break-downs as peers and subordinates are reluctant to engage in necessary discussions.

- ***Lack of visibility.*** By its very nature, insidious intimidation continues to exist in part because of its lack of visibility. Overt acts of intimidation garner attention and are easy to identify. Passive-aggressive acts are subtle and hard to pinpoint, and often may be difficult to prove. These acts are exacerbated by a culture of disincentives to reporting intimidation, whether out of fear of retaliation, the stigma associated with reporting another individual, or a precedent of failure on the part of some organizations to act on reported intimidation.

The Threat to Quality and Patient Safety

The Forum participants explored evidence that links intimidating behavior to patient safety. Many organizations have timely and important data resources available to them and information about the risks of workplace intimidation derived through employee satisfaction and engagement surveys, but often fail to link, compare, or contrast the data in

ways that will shed light on those areas where poor employee relations are or may be affecting quality and patient safety.

Leaders identified the need to link data and information from sources such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, Hospital Quality Alliance (HQA) measures, and other quality, safety and patient satisfaction indicators. Assessing the results by department or unit in this manner is non-threatening to employees. This allows the organization's leadership to identify and address areas where insidious intimidation and poor employee relations may exist, and may be negatively affecting the delivery of high quality and safe patient care.

Opportunities for Improvement

Eradicating intimidation and the threat it poses to quality and patient safety requires dedicated attention and commitment to identifying opportunities for improvement, and acting on them.

- ***Build stronger teamwork and encourage "cultures of respect."*** Patients increasingly want and expect more from their health care providers. In particular, they want better coordinated care and greater value. Consumer demand and new payment structures are changing the delivery system from one primarily dependent on individual expertise to one that relies on coordination and collaboration across a broad spectrum of health care professionals. The success of these new structures is highly dependent on the ability of providers to ensure strong communication and collaboration, factors that can be dangerously undermined by various forms of intimidation.

  To encourage a culture of respect and collaboration and overcome the risks of intimidation, Forum participants discussed the importance of addressing the issues of teamwork early in professionals' education and training. It was pointed out that doctors, nurses, pharmacists, administrators, and others are educated and trained in silos, and then are expected to work together in a team environment without the benefit of training that creates a collective mindfulness that is characteristic of high reliability in an organization. Leaders identified an opportunity for teaching hospitals to establish positive role modeling and team-based care.

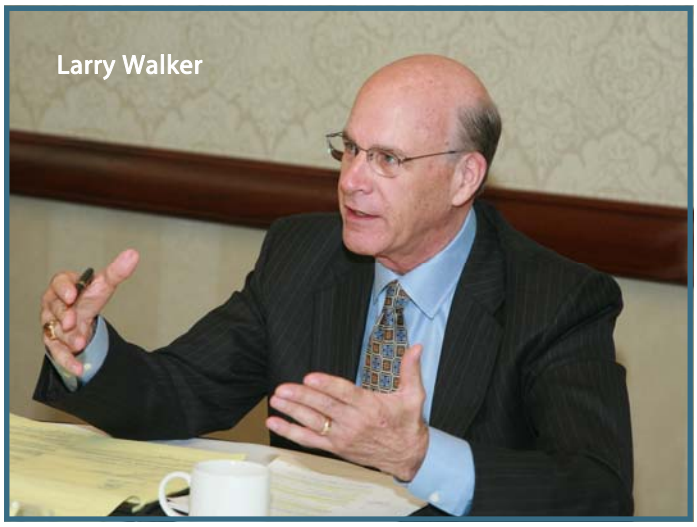
  In addition to breaking down silos established in education and training, there exists a need to integrate the multiple cultures (physician culture, nurse culture, administrative culture, etc.) found within health care organizations, and rebuild with a common culture of knowledge, attitudes, beliefs, and respect. Included in this is the need for shared vision and shared ownership, or accountability, for the risks at all levels within a unit and within the organization.

- ***Employ surveillance systems.*** In 2008, The Joint Commission issued a Sentinel Event Alert, "Behaviors that Undermine a Culture of Safety," which referenced the capture and reporting of patients' and families' observations and complaints as part of a surveillance system used to identify behaviors that create risk. Trust, reporting, and improvement were identified as the three keys to a culture of safety. Aviation was used as an example wherein establishing a system of trust, reporting, and improvement have resulted in measurable change. Through the Aviation Safety Reporting System, concerns and complaints are registered with NASA, as opposed to the FAA. As a result, it is viewed as a "safe," penalty-free means of reporting, with improvement as the driving incentive. To continue with the comparison to aviation, the point was made that health care's "near-miss" behaviors are too often not reported or acted

upon; only the "crashes" are consistently reported and acted upon.

- ***It's about the leadership.*** In order for change to take place, leadership and administration must not only support change but model expected behaviors, and strive to eliminate a long-standing tolerance within health care for intimidating behaviors. Managers and others expressing a "no tolerance" attitude towards intimidation must be supported and backed by governance and executive leadership.
- ***Putting the information to use.*** The tools and measures are available to create baseline evaluations of intimidating behavior and its effects in the workplace. Forum participants discussed the need to "connect the dots" among the various data sources, for example human resources' knowledge of problem individuals or units and risk management knowledge of events and/or outcomes. Leaders must put the results of these collaborative efforts to use to create needed change by establishing or acknowledging baselines and measuring progress made.
- ***Make mission and values count.*** Forum participants agreed that linking behaviors to the delivery of quality and safe care was critical, and a significant factor in fulfilling the organization's mission to provide for the health of the communities served. The fight against insidious intimidation can be elevated to strategic visibility and importance by its very threat to an organization's ability to deliver high quality and safe care.

  Values representing respect for others, termed the "I care" values of integrity, passion, accountability, respect, and excellence were recognized as tools and contributors to cultures with low tolerance for intimidating behaviors.



The Role of Human Resource and Risk Management Leaders in Addressing Intimidation

Human resource and risk management leaders identified opportunities to end the tolerance of insidious intimidation and its negative threats to quality and patient safety.

- ***Change human resource and risk management leadership perspectives.*** Human resource and risk management professionals must consider themselves health care executives first, ahead of their specific expertise in human resources or risk management. The first priority and responsibility is to the community, to providing quality and safe health care. It is about taking care of the patient.
- ***"Cross-pollinate" to break down human resource and risk management silos.*** Human resource and risk management leaders have an opportunity to lead the way by reaching across their own silos to work together in addressing the common challenges and issues of workplace intimidation. Comparing information such as departmental attendance, vacancies, disciplinary actions with medical errors and outcomes, working jointly on root cause accountabilities, and blending ideas for solutions holds significant potential for addressing the threat of intimidation to patient safety. The opportunity to "cross-pollinate" exists not only within an organization, but also between the membership of ASHRM and ASHHRA.
- ***Influence the culture through talent management.*** Human resources has an opportunity to positively influence an organization's culture on multiple levels, beginning with the hiring of individuals who exhibit a

"servant leader" mentality and an innate respect for others. Resetting the bar of cultural tolerance also begins with new hire orientation, which should include an expression of clear expectations for respect to all individuals throughout the organization. Human resource leaders also have a role to equip and ensure engaged leadership, moving ineffective and non-engaged leaders from their positions of leadership and influence.

- ***Provide the training, coaching, and tools needed to influence cultural change.*** Throughout the thought leader discussion, opportunities were identified for both human resource and risk managers to provide the training, coaching, and tools needed to provide individuals with the resources they need to influence cultural change.
  - Equip individuals with fundamental skills such as accepting and giving constructive feedback, understanding how they are perceived, and conflict management skills necessary to strengthen their emotional intelligence.
  - Provide policies, procedures, "scripting," and other tools to guide and support positive behaviors.
  - Develop interpersonal communication skills for challenging conversations.
  - Use simulations to practice and integrate the skills of teamwork in clinical settings, strengthening both employee skills and outcomes.

  In the daily course of their work, risk managers hear and investigate events resulting from insidious intimidation, providing them with an opportunity to translate those events into stories that can be incorporated into medical staff training sessions, departmental meetings, senior leadership meetings, and board meetings to help people understand the critical link between intimidating behavior and adverse outcomes, prompting them to action.

Conclusion

Human resource and risk management leaders have an opportunity and an obligation to assist in reducing the threat of insidious intimidation to patient safety. By working collaboratively to compare and contrast their different perspectives, data sources, and shared knowledge, human resource and risk management leaders together have an opportunity to powerfully demonstrate and then influence the cause and effect link between personal behaviors and patient outcomes.

Human resource and risk management leaders have the combined expertise needed to influence the health care culture and help eradicate insidious intimidation and its threat to patient safety through talent management, and training and equipping medical staff and our employees with the knowledge, tools, and resources needed to recognize, respond to, and eradicate intimidating behaviors.

The Forum participants challenged themselves to a commitment to drive insidious intimidation from the workplace as a critical component in ensuring that quality and patient safety are truly "job one" in all health care organizations.

Thought Leader Action Ideas

for Maximizing Human Resource and Risk Management Leaders' Roles in Eliminating Workplace Intimidation

Human Resource and Risk Management "Cross-pollination"

- Strengthen collaboration between human resources and risk management at all levels, within organizations and at the state and national association membership levels.
- Compare and contrast issues and data across HR and risk management to develop a more complete understanding of cause and effect situations, proactively identifying, and collaboratively sharing solutions in response to problem areas.
- Organize collaborative work groups with diverse representation from human resources, risk management, compliance, employee assistance programs, nursing, operations, and others designed to share knowledge and coordinate efforts to address workplace intimidation.

Training, Coaching, and Tools

- Set clear behavioral expectations related to workplace intimidation at new hire orientations.
- Provide interpersonal communication skills development training to equip individuals with fundamental skills such as accepting and giving constructive feedback, understanding how they are perceived by others, and conflict management.
- Provide training for challenging conversations through methods such as ARCC (Ask a question, make a Request, voice a Concern, and use Chain of command).
- Develop training to support and facilitate strong teamwork within units and across disciplines.
- Incorporate simulation into team training, quality, and safety programs.
- Develop a toolkit for front-line leaders. Include methodologies for developing baseline assessments and measuring progress and success, sample policies, sample training techniques, training videos, scripting, and methods for gaining leadership support.
- Offer training resources to medical staff who may not be equipped to confront colleagues exhibiting intimidating behaviors.
- Share best practices and success stories widely through newsletters, journals, the associations, conferences, and other channels.
- Incorporate relevant stories from risk management encounters into training programs at all levels within the organization, highlighting the cause and effect of intimidation on patient outcomes.
- Provide continuous coaching.

Manage Talent

- Train managers to hire individuals who exhibit a "servant leader" mentality and innate respect for others.
- Assist managers and medical staff to repair the behaviors of intimidation repeat offenders.
- Ensure engagement of leaders who will act not only on reports of intimidation, but will act to prevent intimidation from occurring. Move ineffective and non-engaged individuals from positions of leadership and influence.

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Thought Leader Action Ideas

for Maximizing Human Resource and Risk Management Leaders' Roles in Eliminating Workplace Intimidation

Surveillance Systems

- Strengthen cultures of quality and safety by building trust, enabling safe reporting, and making improvements to identified sources of problems.
- Develop and/or strengthen safe, penalty-free reporting systems.
- Develop trust in the system through safe reporting by acting upon reports, making improvements, ensuring leadership backing and support of individuals who step out to confront intimidation, and ensuring positive role modeling by leadership.
- Ensure "near-miss" or passive-aggressive behaviors are reported and acted upon, not just the overt "crashes."

Data and Information

- Link various data sources to create an aggregate picture of the causes and effects of workplace intimidation.
- Dissect the data on a unit-by-unit basis to identify problem areas.
- Establish baseline assessments and measure the success or influence of training programs on the organization's environment or culture.

Leadership

- Adopt an expectation to change the culture of tolerance for workplace intimidation.
- Adopt and widely promote a policy of "no tolerance" for workplace intimidation.
- Model desired behaviors.
- Support and back individuals who act appropriately to confront and respond to situations of intimidation.
- Create strategic visibility of the threat intimidation has to patient safety, linking intimidation's threat to the organizations' ability to achieve its mission of service to the health of the community.
- Advocate with teaching hospitals the need for education, training, and positive role modeling early in professionals' careers.

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