Disruptive Patient Behavior As a Quality and Safety Concern

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Despite notable technological advances within health care, the greatest asset of our system remains the millions of clinicians who provide direct patient care and the affiliated staff who support their work. Protecting this valuable resource should be considered a top priority, as a safe and sound labor force is essential in the provision of safe and sound patient care.

Disruptive patient behavior has been relatively ignored

There have been a number of improvement efforts related to workplace safety in hospitals, including needle redesign to reduce needlestick injuries and ergonomically informed care activities to prevent back injuries associated with lifting or positioning of patients. Efforts have also been made to protect staff from conditions (such as fatigue or distraction) that are known to compromise the capacity to provide safe and empathic care. Yet neither of these types of efforts has addressed another cause of staff injury: patient-on-staff assault, reframed here as disruptive patient behavior (DPB).

When defined as any act by patients that threatens the safety of staff, creates an intimidating environment, or interferes with the capacity of staff to provide safe and empathic care, DPB is common. Though estimates vary based on definitions and care setting, the annualized incidence (derived from staff surveys) is approximately 13% for physical assault on staff and approximately three times that (38%) for verbal threats and intimidation. Rates may be even higher in some settings, such as the emergency department. These incidents have a tremendous negative impact on clinical staff, not only because they can cause physical injury, but because they generate emotional trauma as well.

Focus on “policing” solutions falls short

Despite the frequency and severity of this issue, DPB has received relatively little clinical attention. Historically it has not been considered a target for patient safety or quality improvement initiatives. When DPB is considered, it is often in the context of horrific events, such as shootings occurring within the hospital. For example, a recent article from the nursing literature begins, “In September 2010, Baltimore city police and a tactical team rushed to Johns Hopkins Medical Center to subdue a gunman on the eighth floor of the hospital.” The rare article on this topic in the medical literature carries a similar tone—as this quote from a recent commentary in the Journal of the American Medical Association illustrates: “On a September morning like any other, the son of an 84-year-old woman...”
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with cancer shot her surgeon outside his mother’s hospital room. Perhaps as a result, suggested solutions to DPB often embrace police and security tactics such as the use of uniformed security officers, metal detectors, wandings, and bag checks for weapon identification.

This focus on “violence,” and the recommendations that extend from it, are no doubt important components of hospital-wide disaster preparedness. In some ways, however, this focus has been misguided. While dramatic incidents like these do occur, they are actually quite rare—best estimates suggest that 2 hospitals in 1,000 will experience a shooting event during a given year, and of these events, approximately 40% will occur outside on hospital grounds. Whereas powerful vignettes can often be used to engage clinicians in safety efforts, the focus on “workplace violence” and the emphasis on security have little meaning for frontline clinical staff. Unfortunately, this may imply that all events of DPB are criminal acts and are somehow separate from the clinical care the staff are providing.

This emphasis on weapons-related violence is also not reflective of the focus of frontline staff, who appear to be more concerned about verbal and physical aggressive acts from hospitalized patients than weapons. Results of an internal staff survey of Massachusetts General Hospital (MGH) clinicians (N=769), demonstrated that there is a much greater concern about clinical factors than security factors, both in the genesis of and response to these events. On the basis of their experience, staff identified patients with delirium, mental illness, substance abuse or withdrawal, dementia, and traumatic brain injury as key at-risk groups that have been associated with DPB. This clinical orientation is highly consistent with our review of the 442 safety event reports submitted by MGH staff in 2011–2012 related to DPB. While the nature of the events is diverse, a consistent theme emerges of a neuropsychiatrically vulnerable patient interacting with a set of care-related variables, in the development of a disruptive patient behavior event. The following case vignette provides a prototypical example:

A 50-year-old woman was admitted to the hospital after presenting with a 10-day history of poor health characterized as conditions associated with a longstanding history of heavy daily alcohol use. On initial presentation her heart rate was elevated, but her general physical exam was otherwise unremarkable and her mental status was essentially normal. She was managed with intravenous fluids and anti-anxiety medications for possible alcohol withdrawal. She became progressively confused, paranoid, and agitated during her stay. On the third day of her hospitalization, the patient walked unnoticed to the nursing station, grabbed an air tube carrier, and struck a nurse over the head from behind, causing significant injury.

The differential diagnosis of the patient’s mental status changes included alcohol withdrawal, iatrogenic benzodiazepine toxicity, and brain inflammation. With close attention to management of her delirium, her medications, and continued hydration, her physical condition and mental status improved. She was discharged, fully recovered, on hospital day 11. The time course for recovery for the nurse who was assaulted and her colleagues on the unit was not as rapid.
Transferring information about patients in emergency rooms (ERs) is a key focus for clinicians as well as for medical and social science researchers. Extensive research has illustrated the complexity and fast-paced nature of handoffs, teamwork and communication in the ER. This article builds on the established evidence base by sharing findings from doctoral research on ER communication carried out over a 4-year period in 5 Australian ERs.

How information is used in the ER

The primary author’s observations of how clinicians use information in the ER reveal that information transfer practices frequently stray beyond safety into unsafety. When asked, clinicians will describe their practices as premised on the linear and safe sharing of information about a patient whose care is undertaken by several clinicians. This linear model of transfer of information can be characterized as consisting of 3 stages:

1. The process begins with the triage nurse, whose records document presenting symptoms and patient details.
2. This information then becomes known to and is acted on by the admitting or staff nurses.
3. The information is further explored by the junior doctor(s), before being overseen by the senior specialist(s).

These phases of care progress toward the transfer of patient-related, collegial, and situational information to clinicians who need it to move to the next stage of the patient’s care. The aim is to ensure that this information is communicated in such a way as to prevent gaps or glitches in how individual clinicians and the team care for each patient.

The study’s findings, however, reveal that ER clinicians often do not stick to this linear order in practice. Study observations showed that information pertaining to a single patient was developed by between 8 and 15 clinicians. It was found that nurses and doctors, as they approached patients, rarely relied on gathered and documented information, what they had been told by others, or what they had established themselves earlier in the day. Instead, they “refreshed” already established information by talking to the patient again in order to (re)discover, (re)inquire, or (re)confirm details. Indeed, the study suggested that this persistent practice of clinicians refreshing information was a principal activity. They repeatedly checked details, reminded themselves of what they knew, and confirmed facts.

Uncertainty as a factor

ER clinicians interviewed in the study gave the following reasons for this practice:

- Information from others is not always reliable, accurate, relevant, or up to date.
- Information needed clarification to prevent misunderstanding.
- Information needed updating, as a patient’s status may change.
- Information could vary as patients may provide different information on different occasions.

The persistent checking of information that has already been established was also due to ER clinicians’ sense that information is subject to uncertainty. Further, it is also apparent that ER clinicians are highly aware that they often forget.
confuse, or remember only selected aspects of what they have been told by patients or by colleagues, especially if they work over long periods of time or take in multiple pieces of information. This uncertainty leads ER clinicians to engage in what Roter calls the “enduring practice of talking.”

Discussion
Observations in the study noted a preponderance of repetition in patient-provider communication as clinicians seek to re-establish things they appear to have misremembered or forgotten (see Doctor-Patient Exchange). This redundancy is a safety mechanism, and it is germane to ER practice and how clinicians achieve safety. However, it also points to a systemic problem—the tension between the assumption that clinicians rely on the sufficiency of established institutional processes for information sharing (such as clinical notes and handoffs) and the clinicians’ actual practice, in which they employ additional checking and rechecking to compensate for the perceived unreliability of these information sources.

These findings illustrate 3 important concerns:

- Clinicians’ information may be less reliable than is commonly assumed. Clinicians are aware of the fragility of what they “know” and compensate for this uncertainty through a continual process of information renewal.
- The action of information renewal has advantages but it also has a cost: much talk and time needs to be expended to reconfirm information or to clarify what has been misremembered, misinterpreted, or lost.

ER practice is challenged when it comes to accumulating what clinicians know about their patients. The constant retracing of what is known about patients subjects care to fragmentation and increased likelihood of error. Because of the multistranded and fast-paced nature of conversations in the emergency room, what is known by a given clinician generally remains ad hoc and disconnected from what other clinicians know. The result is that information is approximate and highly variable.

It is reasonable to assume that the repeated questioning of patients can negatively affect their experience of ER care and detract from their faith in clinicians’ ability to manage information. This repetitive querying activity could then detract from patients’ faith in, and satisfaction with, the overall care service.

Safety and knowing in practice: conclusion
Persistent information checking detracts from patient safety and care efficiency due to the risk of information being lost, missed, or misinterpreted with each repetitive question. The problems identified here are not solved by codifying and formalizing teamwork protocols and handoffs. While handoffs themselves and protocols for handoffs and other practices play a critical role in clinicians’ work, the findings presented here call for greater concentration on how ER clinicians dynamically refresh what they know about their patients, over and above how they conduct handoffs.

So what might assist clinicians in ameliorating these problems? One frequently advocated solution is the use of mobile information technology (IT) devices to improve communication between clinicians, but there is the risk that IT tools, rather
Disruptive Patient Behavior

Disruptive patient behavior can be an outcome of care

This case and others like it have emphasized the risks involved in caring for patients with altered mental status, but have also provided an infusion of clinical interest into the review of these events. The MGH research team has come to believe that DPB is in many instances a clinical outcome of care akin to falls—and that to reduce or eliminate these events will require a careful examination of the processes of care associated with these at-risk populations. In this way, through the encouragement of reporting, thoughtful analysis, and implementation of continuous process improvement efforts, we hope to eliminate the risks associated with this population, improving the care they receive and keeping our staff safe at the same time. We are still in the very early days of this effort and still have much to learn. We have yet to find an adequate scale with reasonable sensitivity and specificity (akin to the Morse Fall Scale). Because the existing violence-prediction scales focus solely on patient factors and ignore elements of patient-provider interactions, a scale that incorporates these latter factors would help in the proactive identification of patients at risk for DPB. It is our hope that other organizations will take a similar, clinically informed look at disruptive patient behavior, so that we can expand the conversation and learn together from our findings. NPSF

References
than limiting clinicians' cognitive overload, may exacerbate it.²⁰ Another solution may be to ensure that ER patients are seen by senior clinicians in order to eliminate lengthy and sometimes ineffective treatment processes enacted by junior clinicians, thereby reducing uncertainty and the need for related information seeking and rechecking. While these solutions have merit, suggested avenues for improvement should also address frontline clinicians’ need for resources to assist them in handling the complexities they face in treating multiple patients, fitting into constantly changing team configurations, and managing constantly shifting information.

These complexities may not be readily “tamed” by imposing yet another technology, practice model, or communication procedure. Frontline clinicians working in the contemporary ER need instead to be supported to establish local solutions to these problems. New designs of ER care practice are needed to streamline not just the clinical care but also knowledge production and information sharing. ER teams should reflect on the reality of how they enact their practices, and on what these practices achieve. As those closest to the problems identified here, frontline clinicians are best placed to restructure the information sharing habits that currently shape their work, and to render these more effective and safe.  

References
Lucian Leape Institute Reports Address Workforce Safety, Care Coordination

Two recent reports from the Lucian Leape Institute at the National Patient Safety Foundation address issues the Institute identifies as critical to improving the safety and quality of the health care system.

**Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care**

Restoration of joy and meaning in work and the safety of the health care workforce are two of the concepts identified by the Lucian Leape Institute as essential objectives for improving safety and quality in the delivery of care. This white paper, the product of an expert roundtable convened by the Institute, argues that the safety of the health care workforce and the safety of patients are intrinsically connected: ensuring that workers receive the protection, respect, and support they need is therefore essential to the provision of safe and high-quality patient care. The report examines the current state of the health care workplace, describes the nature and causes of physical and psychological harm that workers may experience, and discusses the consequences for workers, patients, and the health care system. The report concludes with a list of recommendations for actions that organizations can take to promote improvement.

**Order from Chaos: Accelerating Care Integration**

This white paper, a product of the Lucian Leape Institute Roundtable on Care Integration, describes poorly integrated health care in the US as a pressing concern and discusses what can be done to address this issue. Although identified as a fundamental component of safe and high-quality health care, achieving integration in practice has been an elusive goal. After defining what is meant by care integration at the level of an individual patient’s experience, the authors discuss major barriers to integration and outline approaches to overcoming these obstacles.


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