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Setting the Standard for Professional Behavior

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***Professional behavior – having a spirit
of mutual respect and serving others
with compassion and sensitivity –
defines Catholic healthcare***

CHP – A Brief Overview

- **Catholic Healthcare Partners is the largest health system in Ohio and one of the largest nonprofit health systems in the U.S.**
- **Nearly 37,000 associates in more than 100 organizations, including 34 hospitals that serve the Ohio, Tennessee, Kentucky, Pennsylvania and contiguous states.**

CHP – Mission and Values

- **Catholic Healthcare Partners extends the healing ministry of Jesus by improving the health of our communities with emphasis on people who are poor and underserved.**
- **Our Six Core Values: Compassion, Excellence, Human Dignity, Justice, Sacredness of Life and Service.**

CHP's "Burning Platform" (2006)

- **Perinatal Safety Assessment and Findings**
- **Safety Practices in OR**
- **Risk and Legal Experience**
- **Medical Leadership Council**
- **Chief Nurse Executives**

CHP's First Step

- **Executive Management Team**

- **Operate the Ministry**

- **Board Support**

- **Task Force:**

- **Legal**
- **Chief Medical Officer**
- **Physician Services**
- **Corporate Responsibility**
- **Facility CEO**
- **Facility CNE**
- **Patient Safety**
- **Mission**

Task Force Mandate

- **To develop a system-wide understanding of what constitutes disruptive and unprofessional behavior and its impact on patient care.**
- **To clarify expectations of professional behavior in CHP facilities in the light of our Mission and Values.**
- **To promote behavioral improvement, including clarifying the disciplinary consequences of disruptive behavior.**
- **To develop appropriate measurements and monitoring processes.**

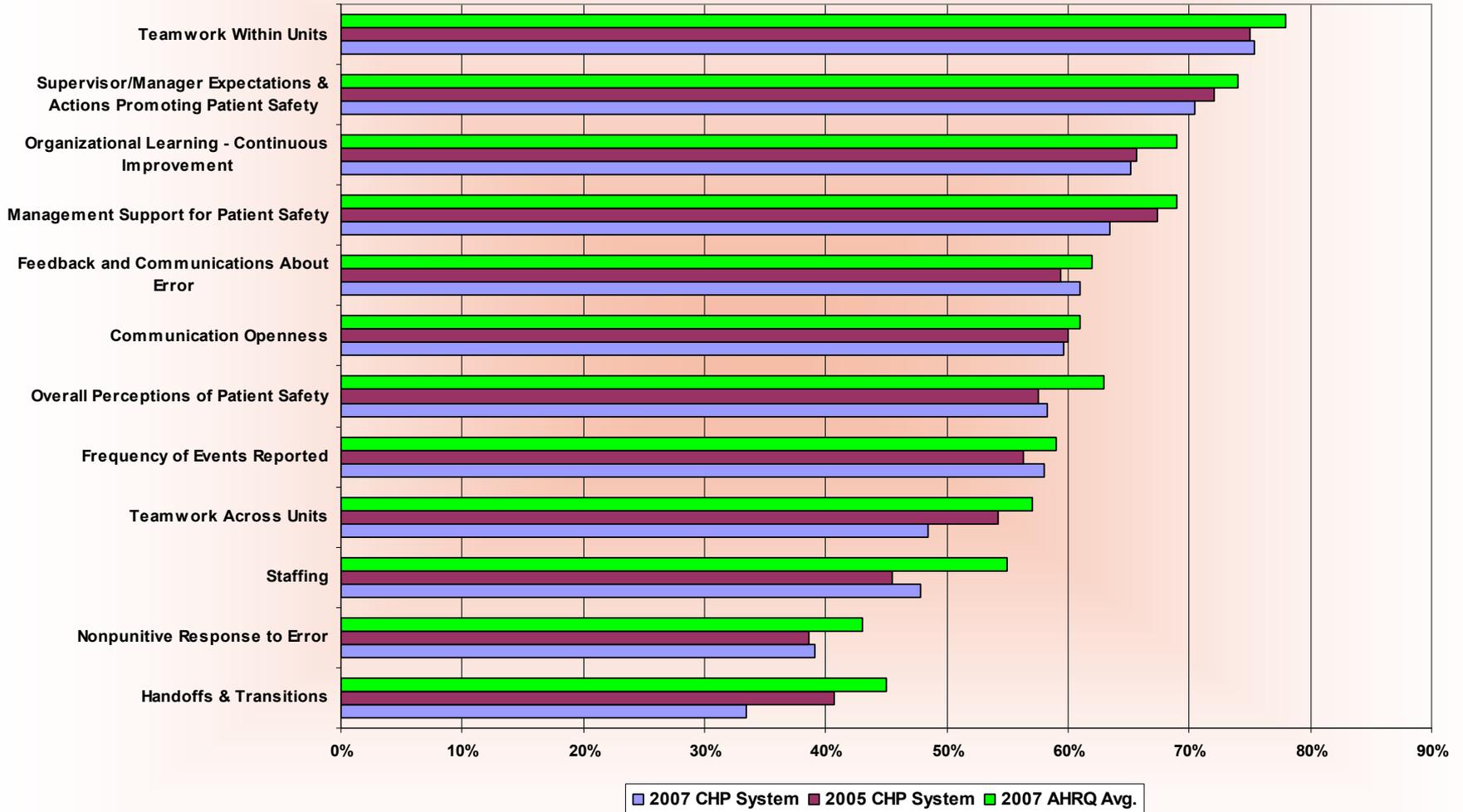
Task Force Recommendations

- **Build awareness and alignment with key constituents.**
- **Develop educational materials including a video to be viewed by all medical staff and employees.**
- **Incorporate expectations and monitoring into credentialing and performance appraisal process.**

Action Steps and Timeline – Early 2007

- **Research and literature review.**
- **Provide to Task Force and develop work plan and talking points.**
- **Presentation to EMT.**
- **Joint meeting with Chief Medical Officers and Nurse Executives facilitated by Dr. Rosenstein.**
- **Governance Retreat education and training session with Dr. Gerald Hickson.**

2007 AHRQ CHP System



Action Steps and Timeline – Mid 2007

- **Site teams attend Vanderbilt - “The Why and How of Dealing with ‘Special Colleagues: Discouraging Disruptive Behavior’” presented by Drs. Hickson and Pichert.**
- **Presentation by early adopters at the Executive Management Team.**
- **Development of motivational/instructional video and tool kit.**

Action Steps and Timeline – Late 2007

- **Video release at the Annual Management Conference in conjunction with David Marx's presentation on "Creating a Just and Healing Environment in Healthcare."**
- **Distribution of high quality Tool Kits to over 500 managers.**
- **Action Plans due by year end:**
 - ***Regional/Divisional CEO Accountability***

CHP's "Setting the Standard" Tool Kit

- **Setting the Stage:**

- **Mission, Values, Ethical & Religious Directives**

- **Setting the Stage:**

- **Patient Safety and Associate Morale**

- **Code of Conduct**

- **Definition of Disruptive Behavior**

- **Survey Templates**

- **TeamSTEPPS Pocket Guide**

- **Crucial Conversations**

- **Call to Action**

2008

System Objective (CEO Part 3):

- **Each Facility will complete a Professional Behavior Survey using the “Rosenstein/Institute for Safe Medication Practices Template by end of 2nd quarter.**
- **Action plans will be revised based upon survey findings by end of 3rd quarter.**

Joint Commission Standards

•Leadership Standards (eff. 2009):

- **LD.03.01.01- “Leaders create and maintain a culture of safety and quality throughout the hospital.”**
- **(Some) Elements of performance for LD 3.01.01:**
 - *Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.*
 - *The hospital has a code of conduct that defines acceptable, disruptive and inappropriate behaviors.*
 - *Leaders create and implement a process for managing disruptive and inappropriate behaviors.*

Sentinel Event Alert (7/9/08)

- Education on the code of conduct.**
- Hold all team members accountable by enforcing the code consistently and equitably.**
- Develop policies/procedures that address “zero tolerance,” non-retaliation, responding to patients/families who witness, disciplinary actions.**
- Accompanying medical staff policies.**
- Detection systems – reporting, surveys, rounding.**
- Training & coaching, tiered approach.**

Going Forward – 2009

- **Implementation of action plans – CEO Part 3 System Objective**
- **Surveillance – electronic event reporting module**
- **AHRQ Patient Safety Culture Survey – 3rd round**

Obstacles & Challenges

- **Denial**
- **“Normalization of Deviance”**
- **Avoidance**
- **Fear**
- **Inexperience**

Best Practices & Lessons Learned

CHP experience:

- **Leadership engagement and oversight critical.**
- **Equip leaders and staff with tools to handle disruptive behavior and conflict.**
- **Incremental and flexible approach is more likely to succeed.**
- **Relationship to mission/vision/values and patient safety resonates with staff and leaders.**
- **Culture change takes time, planning and commitment at all levels.**

Some Closing Thoughts

- **This is a (long) journey.**
- **It's mostly about culture change.**
- **The "soft stuff" is hard.**
- **Stay the course.**
- **(Almost) everyone wants to do the right thing.**



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