

## Combating Disruptive Behaviors: Strategies to Promote a Healthy Work Environment



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### Abstract

Disruptive behaviors among healthcare workers threaten the safety and well being of both patients and staff. The Joint Commission now charges healthcare organizations seeking accreditation to address these behaviors. All members of the healthcare team need to be knowledgeable about disruptive behaviors. In this article the author reviews the [causes](#) and [consequences of disruptive behavior](#) for both patients and healthcare workers, discusses initiatives for [addressing disruptive behaviors](#), and provides specific [steps for nurse managers and staff nurses to combat disruptive behaviors](#).

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Disruptive behaviors among healthcare workers threaten the safety and well being of both patients and staff. Although disruptive behaviors have long been a concern among healthcare workers, they have often gone unchecked, or even worse, accepted as part of the system. By not addressing these behaviors, organizations silently supported and reinforced them. The good news is that these disruptive behaviors among healthcare workers have recently come under increased scrutiny. The American Medical Association (AMA) ([2002](#)) has stated: "Personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively constitutes disruptive behaviors" (para. 1). The American Association of Critical Care Nurses (AACN) ([2005](#)) has noted that collaboration among healthcare providers, which is paramount to establishing and sustaining a healthy work environment, is lost in the presence of disruptive behaviors. In 2008 a sentinel event alert was issued by the Joint Commission (TJC) to warn organizations of the safety risks posed by disruptive behaviors and to increase awareness of this risk for both individual workers and healthcare organizations.

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Those exposed to disruptive behaviors can experience stress, frustration, and physical and psychological disorders. Nurses have been reported to leave a particular place of employment due to disruptive behaviors ([Veltman, 2007](#)), and this drain on resources can further compromise care. In order to address this threat the Joint Commission, in January of 2009, instituted a leadership standard mandating that facilities seeking accreditation institute policies to address disruptive behaviors among healthcare workers.

Now all workers are charged with understanding and addressing this necessary culture change within healthcare. In this article the author will review the causes and consequences of disruptive behavior for both patients and healthcare workers. Initiatives to address disruptive behaviors will be discussed, and specific steps nurse managers and staff nurses can take to combat these behaviors will be provided.

### The Nature of Disruptive Behavior

Disruptive behaviors include overt and covert actions that are displayed by any healthcare worker and that threaten the performance of the healthcare team ([TJC, 2008](#)). The most frequently reported type of behaviors includes emotional-verbal abuse ([Anderson, 2002](#); [Anderson & Parish, 2003](#); [Hader, 2008](#); [Hesketh et al., 2003](#)). For nurses this verbal abuse is frequently reported as coming from other nurses ([Hegney, Plank, & Parker, 2003](#); [Hesketh et al., 2003](#); [Rowe & Sherlock, 2005](#)). Examples of these behaviors include using threatening or abusive language; making demeaning or degrading comments; humiliating someone in front of others, including staff and patients; rolling eyes in disgust; sending nasty emails; refusing to mentor; refusing to help others; ignoring attempts at conversations; throwing items; physically assaulting team members; and intimidating others ([Capitulo, 2009](#); [Hader, 2008](#); [North Carolina Physicians Health Program, 2009](#); [Porto & Lauve, 2006](#); [Rocker, 2008](#)). In a survey of 1,565 nurses, intimidation by physicians was found to have a negative impact on patient care ([Institute for Safe Medication Practices, 2009](#)). In this survey 39% of the nurses reported that they sometimes encountered reluctance or refusal to answer questions or return phone calls or pages; 40% reported condescending language or voice intonation; and 42% reported impatience with questions on the part of physicians.

Other terms in the literature that describe emotional, verbal, and/or physical disruptive behaviors between workers include bullying, horizontal or lateral violence, and mobbing. Generally the term bullying is used to describe situations of repetitive harassment that occur between one person who has some type of authority over another, such as a manager to a staff member ([Bray, 2001](#)). Horizontal or lateral violence has been associated with displays of aggression towards someone on the same hierarchical level, such as staff nurse to staff nurse ([Longo & Sherman, 2007](#)). When these same behaviors stem from a group and impact one individual, this behavior is termed mobbing ([Zapf, 1999](#)). All of these phenomena share one common theme, namely that they can cause a breakdown in the relationships among healthcare personnel thereby threatening patient and staff well being.

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Disruptive behaviors threaten patient well being due to a breakdown in communication and collaboration.

All behaviors that are potentially disruptive need to be examined. Stories are told of surgeons who throw instruments in the operating room or physicians who yell at the nurse for calling in the middle of the night. These actions exemplify overt behaviors displayed as physical or verbal aggression. However, there are also covert or subtle behaviors that can be just as detrimental to staff and patients. Nurses have often been associated with the phenomenon of "eating their young," which occurs when new nurses are not supported by experienced nurses, but rather are thrown into a situation to learn via 'trial by fire.' All of these behaviors discourage the teamwork which is essential to a healthy work environment.

Because of their status within the healthcare system, physicians are often the main focus of attention when it comes to disruptive behaviors. However, all groups of healthcare workers can be involved in these acts, including nurses. Rosenstein and O'Daniel ([2008](#)) studied hospital workers, including medical and nursing staff members, administrators, and other healthcare disciplines. Seventy seven percent of the participants reported witnessing disruptive behaviors in physicians, and 65% of the participants identified disruptive behaviors in nurses. Hader ([2008](#)) reported a study in which nurses were recognized as displaying disruptive behaviors more frequently than physicians (51.9% vs. 49%). Unlicensed assistive personnel have also been reported to display these behaviors ([Stanley, Martin, Michel, Welton, & Nemeth, 2007](#)). Rather than blaming one group of healthcare professionals, all healthcare workers need to claim accountability for these behaviors.

### Causes of Disruptive Behaviors

It is important to consider the concepts of power and authority in examining possible causes of disruptive behaviors. The perceptions of possessing power and/or yielding to power contribute to the longstanding acceptance of disruptive behaviors. Because physicians have long been in positions of power within healthcare

systems, due to their being seen as revenue generators for the hospital ([Porto & Lauve, 2006](#)), their disruptive behaviors may be ignored or the physician may be treated more leniently than other staff members ([Rosenstein, 2002](#); [Weber, 2004](#)). In addition, disruptive physicians may be very clinically competent, if not the most skilled physician in their specialty ([Lapenta, 2004](#); [Piper, 2003](#), [Weber, 2004](#)). This results in hospital administrators reinforcing the continuation of these behaviors by giving in to the demands of the physician ([Porto & Lauve](#)). Although this process was accepted in the past, these physician behaviors are now regarded as disruptive behaviors ([Sataloff, 2008](#)). This power shift in healthcare, due to the recognition of the value of teamwork and individual accountability ([American Organization of Nurse Executives, 2006](#)), is resulting in physician frustration and loss of autonomy which can lead to further disruptive behaviors ([Porto & Lauve](#)).

Unlike physicians, nurses historically have lacked power in the healthcare setting; this lack of power has been theorized to play a role in disruptive behavior among nurses. Traditionally, horizontal violence has been associated with oppressed group behavior ([McCall, 1996](#); [Roberts, 1983](#); [Skillings, 1992](#)). Nursing has been described as an oppressed group because the profession is primarily female and has been under the dominance of a patriarchal system headed by physicians, male administrators, and marginalized nurse managers for many years ([Farrell, 1997](#)). Displaced frustration resulting from oppression is often manifested as conflict within one's ranks, i.e., conflict from co-worker to co-worker ([Farrell, 2001](#)). Gender also plays a significant role in this cycle. Strauss ([2008](#)) reported that in a survey of Minnesota nurses looking at gender-based harassment (which is defined as unequal treatment due to gender) male registered nurses believed that they were treated better by male physicians than were female nurses, and that a camaraderie existed between them and male physicians that did not exist between female nurses and male physicians. Kramer and Schmalenberg ([2003](#)) have noted that the establishment of equal power relationships could lead to valuing and rewarding of positive nurse-physician relationships. In addition, simply acknowledging these power struggles could contribute to reversing disruptive behaviors.

Ford ([2009](#)) suggested that one of the underlying reasons for disruptive behaviors is conflict, which he defined as "differences about how expected needs will be met, usually manifesting in emotional tension and relational separation or combative behavior" (para. 10). Weber ([2004](#)) reported that conflict between physicians and nurses has been identified by physician executives as the most common cause for disruptive behaviors. Conflict exists in any healthcare situation in which expectations are not met, for example when equipment or staff is not available or orders are not carried out in a timely and correct manner ([Rosenstein, 2002](#)).

### Consequences of Disruptive Behaviors

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One of the reasons that disruptive behaviors have been allowed to flourish is that often employees are reluctant to report these behaviors.

Disruptive behaviors threaten patient well being due to a breakdown in communication and collaboration. In a study of 4,539 healthcare workers, 67% felt there was a linkage between disruptive behaviors and adverse events, 71% felt there was such a linkage with medication errors, and 27% felt there was a linkage with patient mortality ([Rosenstein & O'Daniel, 2008](#)). In this same study 18% of the participants reported being aware of an adverse event that was related to disruptive behaviors. In a study by Veltman ([2007](#)) 53% of the 32 respondents felt that disruptive behaviors contributed to near misses in a labor and delivery unit, and 41.9% (13 of 31) could identify specific adverse outcomes resulting from the disruptive behavior. In one study 64% of the pharmacists surveyed reported that they had assumed a medication order was correct rather than interacting with a particular physician to confirm the order ([Institute for Safe Medication Practices, 2009](#)). Due to the potential of the widespread influence that disruptive behavior can have on the healthcare system, all groups of

healthcare workers need to be cognizant of this issue.

The impact of disruptive behaviors threatens not only patient safety, but also the well being of healthcare workers and their ability to perform competently in their job ([O'Connor, 2007](#)). Yildirim and Yildirim ([2007](#)) have noted physical symptoms that can result from being a victim of disruptive behaviors include tiredness, headaches, gastro-intestinal complaints, and feelings of sadness. Home life may also be negatively impacted. Disruptive behaviors of physicians have been found to influence nurse retention, nurse satisfaction, and morale ([Rosenstein, 2002](#); [Veltman, 2007](#)). Psychological and behavioral disturbances, such as stress and frustration, can compromise nurse-physician relationships resulting in decreased concentration, collaboration, communication, and information transfer ([Rosenstein & O'Daniel, 2008](#)). However, the physician - nurse relationship is not the only one that is threatened by these behaviors. Farrell ([1999](#)) reported that disruptive behaviors on the part of nursing colleagues led to even more stress for nurses than did acts of aggression from physicians or patients. In addition Johnson and Rea ([2009](#)) reported that nurses bullied by other nurses are twice as likely as non-bullied nurses to report they are "very likely" or "definitely" intending to leave a position in the next two years, and are three times more likely to report that they are "somewhat likely" to leave the profession in the next two years. This increased likelihood to leave a given job, or even nursing itself threatens

to limit healthcare services and the ability of those who deliver the services.

One of the reasons that disruptive behaviors have been allowed to flourish is that often employees are reluctant to report these behaviors. Reasons for this reluctance include concern for their job, fear, lack of confidentiality around the report, lack of managerial follow-through on complaints of disruptive behaviors, and lack of information regarding where to get help ([Barnsteiner, Madiqan, & Spray, 2001](#); [Rosenstein, 2002](#); [Strauss, 2008](#)). Intimidation also plays a role especially when the physician engages in the disruptive behavior ([Porto & Lauve, 2006](#)). Disruptive behaviors have gone unchecked for so long that they have often become ingrained into the culture of an organization. Physicians who are disruptive may not even be aware of their behaviors ([Rosenstein](#)). Unless the behavior is brought to the attention of the physician, the behavior will not change.

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### Addressing Disruptive Behaviors

Given the current awareness of the detrimental effects of disruptive behaviors, these behaviors can no longer be ignored. Accreditation of healthcare facilities now depends on an organization's ability to effectively address disruptive behaviors. A strong commitment on the part of healthcare agencies to eliminate disruptive behaviors, along with cooperation from everyone in the organization, will be imperative. This commitment and cooperation can be achieved by developing sound policies and by providing education that will help to combat disruptive behaviors. Both approaches will be discussed below. [Table 1](#) describes steps to combat disruptive behavior.

#### *Developing Sound Policies and Procedures to Eliminate Disruptive Behavior*

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Accreditation of healthcare facilities now depends on an organization's ability to effectively address disruptive behaviors.

Administrators need to demonstrate a concern for the frequency of disruptive behaviors and implement a clearly outlined plan to address them ([Grenny, 2009](#)). Individual staff members also need to play a role in this process. The initial step in this process is to take a zero-tolerance stance towards disruptive behaviors ([Center for American Nurses, 2008](#); [Christmas, 2007](#); [Rosenstein, 2002](#); [TJC, 2008](#)). In order to effectively implement a plan of change, specific policies must be in place and followed in all circumstances. The Joint Commission leadership standard relating to disruptive behaviors (LD.03.01.01) addresses two elements of performance which can be used to formulate a plan to combat these behaviors, namely the existence of a code of conduct that defines acceptable and unacceptable behaviors and a process to manage such

behaviors ([TJC, 2008](#)).

First, it is important to develop a code of conduct describing the types of behavior that are considered disruptive ([AMA, 2002](#)). The code needs to address all workers in an organization, including employees, such as nurses, and nonemployees, such as physicians ([Barnsteiner, Madiqan, & Spray, 2001](#)). In order for a code of conduct to be effective, it must be applied in all circumstances where there is a possible breach. Without this enforcement, the code is meaningless. All team members, including hospital administrators, chief nursing officers, and other nursing leaders, need to be accountable for modeling and enforcing the code ([Christmas, 2007](#); [TJC, 2008](#)). [Table 2](#) provides guidance for drafting a code of conduct and [Table 3](#) offers online resources for developing this code.

Next, successful implementation of the code depends upon a clearly delineated channel through which breaches in the code are reported ([AMA, 2002](#); [Weber, 2004](#)). Once a breach has been reported, a review process needs to occur where the facts of the story are verified. Designated members of management or an independent review team can meet separately with the person reporting the breach and the perpetrator of the breach to listen carefully to both sides and evaluate if a breach has occurred ([Capitulo, 2009](#)). Based on this determination, further action may be needed.

If there is a true infraction of the code, an intervention, in which the emphasis for corrective action needs to be placed on the behavior and not the person, may be warranted. During this process it is imperative that privacy and confidentiality are maintained ([AMA, 2002](#)). Sometimes people are not aware of how their behaviors are affecting others or how they appear to others, so a designated person in management needs to discuss their behaviors with them. In this conversation an important link must be made between the disruptive behavior(s)

and the potential breach in patient safety ([Capitulo, 2009](#)). Providing actual data and relating this data to patient outcomes may serve as a wake-up call for necessary behavior change ([Keough & Martin, 2004](#)). If change does not occur, additional steps may need to be explored. Outside referrals to employee assistance programs, anger management classes, or individual executive coaching/mentoring may be appropriate ([Capitulo, 2009](#)). In some instances there may be an underlying pathological or psychological entity, such as stress or substance abuse, causing the behaviors. In these circumstances, appropriate referrals to mental health professionals may be needed ([Keough & Martin, 2004](#)).

Coaching and mentoring are ways by which an intervention can be implemented ([Porto & Lauve, 2006](#)). In coaching, behaviors are addressed by communicating the need to change and by having the person commit to the change. During coaching the fact that future behavior will be monitored for appropriateness should be conveyed, and the consequences of another breach outlined ([Keough & Martin, 2004](#)). A mentor can provide encouragement during this time and give feedback on the progress in attaining new skills ([Thornby, 2006](#)).

In instances where the disruptive behavior is clearly the result of a conflict, steps need to be taken to address the underlying issue. One way to address conflict management is through mediation which is used when both parties involved in the conflict seek to have a neutral third party guide them to reaching a neutrally satisfying agreement in resolving a particular issue ([Keough & Martin, 2004](#)). In these situations, an experienced mediator can be employed to establish a safe space for the individuals to discuss the situation and assist in guiding them towards a workable solution ([Gerardi, 2004](#)).

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Those reporting an incident of disruptive behavior(s) need to be backed by the organization in order to convey the message that an organization truly supports a zero-tolerance policy against disruptive behaviors.

If despite the exploration of all possible avenues of intervention, a problem with behavior still exists, disciplinary action may be warranted. Although generally in this corrective process the focus should be on education and rehabilitation rather than punishment ([Freeman, 2008](#)), there are instances when disciplinary actions cannot be avoided. Proper steps must be followed before this occurs ([TJC, 2008](#)). One way to ensure that proper steps are taken is through documentation that includes the dates and times of the incident(s), a description of the incident, witnesses, consequences that resulted in relation to patient care and hospital operation, and any action that was taken to interrupt or remedy the behavior ([Lapenta, 2004](#)). When discipline results in termination, there may be a concern about legal action being brought against the hospital. In the past case reports have indicated that the courts have conceded to the authority of the hospital to take action against a disruptive physician ([North Carolina Physicians Health Program, 2009](#)).

If an action is taken against a physician that results in loss of privileges, the physician may use the whistleblower defense. In such situations the defendant states that the alleged disruptive behavior and dismissal was retaliation for voicing concern about a quality care or patient safety issue ([Lapenta, 2004](#)). Protection for the person making the complaint needs to be clearly outlined in advance in the procedure addressing the management of disruptive behavior. In instances where a potential patient issue does exist, hospitals must assume responsibility for follow-up to determine the legitimacy of the complaint ([Lapenta](#)).

Fear of retaliation is a concern for anyone reporting a breach in the code. It is important to develop a compact to protect reporting employees against retaliation and establish penalties for those that do retaliate ([Porto & Lauve, 2006](#)). Another way to protect against retaliation is by addressing retaliation in the code of conduct. Those reporting an incident of disruptive behavior(s) need to be backed by the organization in order to convey the message that an organization truly supports a zero-tolerance policy against disruptive behaviors.

### ***Educational Initiatives to Combat Disruptive Behavior***

To date, few evidence-based interventions for addressing disruptive behaviors have been reported. Most research relating to these behaviors and associated activities, such as bullying, focus on the incidence and consequences of the behavior ([Johnson & Rea, 2009](#); [Rosenstein & O'Daniel, 2005, 2008](#); [Strauss, 2008](#); [Veltman, 2007](#)). The one area in which evidence-based interventions are being developed is that of education. In a study by Rosenstein ([2002](#)) 24% of the nurses, 21.3% of the physicians, and 20.8% of the executives stated that a needed strategy to decrease disruptive behaviors was that of teaching nurses and physicians to improve their working relationships. Griffin ([2004](#)) reported that newly licensed nurses who had been taught about the use of cognitive rehearsal techniques to address disruptive behaviors were better able to confront nurses who displayed lateral violence. MacIntosh ([2006](#)) reported 21 workers in a qualitative study of bullying suggested that increasing knowledge about terms and available services related to bullying would be a way to combat bullying. These early studies have suggested that education and practice can serve as power tools in addressing these disruptive behaviors. The following sections will discuss educational initiatives related to: (a) improving general communication skills, (b) increasing the desire to communicate effectively, (c) introducing policies regarding disruptive behaviors, and (d) interacting appropriately with those who are demonstrating disruptive behaviors. For those nurses wishing to learn more about disruptive behaviors, the Center for

American Nurses (CAN) has a free webinar titled *10 Tips for Addressing Disruptive Behavior at Work* that can be accessed at [www.centerforamericannurses.org/displaycommon.cfm?an=1&subarticlenbr=195](http://www.centerforamericannurses.org/displaycommon.cfm?an=1&subarticlenbr=195). The Center <http://centerforamericannurses.org/> also periodically offers other webinars related to workplace issues.

**General communication skills.** Skilled communication, a recognized standard in creating a healthy workplace, facilitates collaboration and assists in creating positive outcomes (AACN, 2005). Grover (2005) has listed eight skills that are essential for effective communication. These skills include: (a) listening to the other person; (b) asking open ended questions to gain more in-depth information; (c) asking closed questions to gain facts; (d) clarifying in-order-to get more details; (e) paraphrasing so that meaning can be interpreted; (f) using facilitators to encourage continuing dialogue; (g) assessing non-verbals; and (h) using silence to promote thinking. Though many of these skills are learned from an early age, when facing a challenging or confrontational situation the most fundamental approaches may be forgotten.

So as to keep these skills at an 'always ready' level, it is important to periodically conduct a self-evaluation as to how successful one has been as a communicator (Thornby, 2006). During this assessment an evaluation of past and current communication patterns can be made to look for behaviors that might be impeding the proper exchange of information. Such behaviors might include, among others, being timid and shy, emotional, overly aggressive, or too sensitive to how behaviors affect others (Thornby). Becoming aware of ineffective styles of communication may assist in recognizing areas for improvement.

**The desire to communicate.** A desire and a willingness to communicate are essential for maintaining safety in healthcare settings. In a study titled *Silence Kills*, conducted by VitalSmarts and the AACN (2005), two important workplace behaviors, namely teamwork and respect, were identified as factors that impede safety but are difficult to address with others (Maxfield, Grenny, McMillian, Patterson, Switzler, 2005). In this study 75% of the participants noted concern with a peer's poor teamwork and 77% were concerned about experiencing disrespect (Maxfield, et al.) Most of the participants stated that it was between difficult and impossible to confront providers demonstrating these behaviors. In contrast, the ability to talk with providers who were respectful team players did lead to positive outcomes. Those who were confident in confronting others concerning lack of teamwork experienced higher moral and intended to stay in their unit and hospital longer compared to those who were not confident in this behavior; those confident in confronting others concerning disrespect or abuse also had higher intentions regarding keeping their job (Maxfield, et al.). Managers may need to take steps to help staff learn to confront employees who show a lack of respect for and/or a lack of teamwork with other providers.

**Introducing zero-tolerance policies.** Education can serve to introduce all workers to a zero-tolerance policy, the organizational code of conduct, and related policies so as to change the organization culture to one that does not tolerate these behaviors (Keough & Martin 2004). This education should be included in orientation classes, continuing education classes, and institutional updates so that all members become aware of organizational expectations. The dangers of disruptive behaviors, the identification of these behaviors, and preparation for confronting these behaviors (Center for American Nurses, 2007) can be presented in these educational sessions.

**Confronting disruptive behaviors.** Education can also serve to teach employees how to confront a person displaying disruptive behaviors. This confrontation should occur as soon as possible after the incident (Briles, 2009; Namie & Namie, 2009). To avoid coming across as defensive, practice may be needed (Namie & Namie, 2009). This can be accomplished by rehearsing with a supportive peer. Patterson, Grenny, Mc Millian, and Switzler (2003) have provided the following helpful strategies for confronting fellow workers who use disruptive behaviors. They have noted that when the dialogue does take place, respect and privacy must be maintained. In order to initiate the conversation, the motives of the communication need to be clear and the conversation needs to stay focused on the topic at hand, with both parties being able to tell their stories. It is also imperative that a feeling of safety be maintained throughout the conversation so that relevant information is brought out into the open. A lack of safety can lead to silence where there is withholding of information, or to violence where undesired meanings are added to the conversation. Briles (2009) has explained that when addressing disruptive behaviors, a mutual understanding of what occurred needs to be reached, and confronters need to describe their feelings that resulted from the behavior as well as the impact the behavior had on them. The final step is coming to a mutual agreement as to how the situation will be resolved (Patterson et al.) This agreement should include a description of the desired behavior and the consequences if the behavior continues (Briles). Though at first the prospect of having this dialogue may be daunting, the results can be very positive and empowering. The more often these conversations occur, the more skilled and confident one becomes in holding these crucial conversations.

### Steps for Nurse Managers and Staff Nurses to Combat Disruptive Behaviors

All nurse managers and staff nurses have a responsibility in establishing a culture in which there is zero tolerance for disruptive behaviors. A discussion of the important roles both managers and staff nurses can play

in combating disruptive behaviors follows.

Nurse managers can play an important role in changing the work environments on their units by examining their areas for disruptive behaviors. One way in which to do this is through a strategy called 'rounding for outcomes' (Studer, 2008). Similar to physician rounds, managers can do daily rounds on their unit to determine employees' needs and concerns. The focus of these rounds should be on promoting a healthy work environment (Osborne, 2004). Rounding can provide a means both for recognizing employees and their contributions to patient care and for establishing development opportunities that address deficits in the care provided. In addition, rounding can also be a time to assess the potential for and/or presence of disruptive behaviors.

Because nurses who display disruptive behaviors may not be aware of how their behaviors are perceived by others, it is often up to the nurse manager to meet with these nurses, discuss other's perceptions of the nurse's behavior, and offer help as needed to address underlying issues that may be contributing to these behaviors. Most importantly managers, as representatives of the organization, need to enforce the code of conduct and provide follow through on code breaches. One source of frustration for victims is the feeling that there is nothing being done to address a reported occurrence of disruptive behavior. To maintain confidentiality the manager cannot share details about the follow up to a situation, but can support staff members who are victims by letting them know that the issue is being addressed through the proper channels. This serves to validate staff concerns and reinforces the organization's stance on disruptive behaviors.

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Staff nurses need to develop the skills required to confront disruptive behaviors and to report any breaches in the code of conduct. Knowing that an organization is seriously committed to changing the culture through action and follow up will make the nurse more responsive to these duties.

Staff nurses can also support fellow workers who are victims. Listening to the stories of fellow workers will allow those who have experienced disruptive behaviors to express their emotions and possibly rethink the situation so that they are prepared to confront it through conversation. One strategy that has been used by nurses to show support for other nurses is by calling a "Code Bully" or a "Code Pink" (Childers, 2004; Namie & Namie, 2009). If a nurse is being yelled at by another healthcare worker, a code can be called by word of mouth or by a more formal method, and the nurses can unify by physically standing behind the nurse so as to let the disrupter know that the disruptive behavior is unacceptable (Childers, 2004). When this happens, disruptive individuals realize they are not facing one person but rather facing a group of people, and a power shift occurs. This power shift is sometimes enough to stop the episode of disruptive behavior. Namie and Namie (2009) have offered an operating room example to illustrate this strategy. They have pictured a disruptive surgeon being encircled by a group of staff members informing the surgeon they are not going to assist the surgeon further if an apology is not given. Such a show of support empowers the group to stop disruptive behaviors from interfering with patient care and/or employee well being (Macintosh, 2006).

Additionally staff nurses need to be cognizant of their own behaviors. Familiarity with the acceptable and unacceptable behaviors outlined by the code of conduct can raise one's consciousness about one's own performance. Stress is inherent in nursing. Often this stress is compounded by uncontrollable circumstances in the environment that lead to frustration and disruptive behaviors. Rather than acting out these frustrations, self-awareness allows the recognition and identification of emotions so that they can be redirected in a more positive manner (Reeves, 2005). Changing a culture that supports or accepts disruptive behaviors to one that does not do so takes the commitment of the entire organization. All individuals need to assume their responsibility for making this happen.

## Conclusion

Disruptive behaviors that are acted out by any healthcare worker can be dangerous to both the patient and the healthcare workforce. It is no longer acceptable to tolerate disruptive behaviors. Adopting a zero-tolerance stance towards these behaviors is one step towards ending these behaviors. However, improving general communication skills, increasing the desire to communicate effectively, introducing policies regarding disruptive behaviors, and interacting appropriately with other healthcare workers are also important. All members of the healthcare team have the responsibility to act in a professional manner and have the right to expect fair and equal treatment from colleagues. A safe and healthy work environment depends on it.

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**Table 1. Steps to Combat Disruptive Behaviors**

1. Adopt a zero tolerance stance
2. Develop a code of conduct that defines acceptable and unacceptable behaviors and that clearly identifies the actions to be taken when there is a breach of the code. These must be enforced uniformly throughout the organization
3. Provide education regarding communication skills, the willingness to communicate, the code of conduct, the process to report a breach in the code, and skills to use in confronting disruptive behavior
4. Provide coaching and mentoring as needed to help improve behaviors
5. Provide mediation services in instances of unresolved disputes between parties
6. If well-documented efforts at changing the behaviors are not adequate, take disciplinary action.

**Table 2. Drafting a Code of Conduct**

**Purpose Statement:**

Develop a purpose statement that includes a definition of the term disruptive behaviors and describes the safety risks associated with disruptive behaviors.

**Policy:**

- Describe acceptable and unacceptable behaviors
- Provide examples of unacceptable behaviors such as those suggested by Porto & Lauve (2006) that may include: profane or disrespectful language, demeaning behavior, inappropriate touching, throwing objects, criticizing caregivers in front of others, undermining trust or confidence, retaliation against anyone who reports a breach in the code of conduct
- Refer to policies or procedures that outline the steps taken when there is a breach in the code

**Table 3. Online Resources for Developing a Code of Conduct.**

1. American Medical Association: [www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/organized-medical-staff-section/helpful-resources/disruptive-behavior.shtml](http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/organized-medical-staff-section/helpful-resources/disruptive-behavior.shtml)
2. HC Pro: [www.strategiesfornursemanagers.com/ce\\_detail/225618.cfm](http://www.strategiesfornursemanagers.com/ce_detail/225618.cfm)

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