The Effect of Healthcare Professional Disruptive Behaviour on Patient Care: A Systematic Review

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No conflict of interest to declare and no funding received

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ABSTRACT

Background: Disruptive behaviour amongst healthcare professionals can adversely affect patient care. These behaviours undermine cultures of safety, exposing patients to preventable risk. Existing evidence associates disruptive behaviours with a negative effect at the organisational level and on healthcare professional but the effect on patient care has been less well documented.

Objectives: To identify and synthesize the empirical evidence of healthcare professional disruptive behaviours on the following outcome measures of patient care: clinical outcomes, patient safety, patient satisfaction or quality of care.

Methods: A systematic literature review was conducted. Between June 6th and July 23rd, 2019, six databases were searched for published empirical studies that examined disruptive behaviours and patient outcomes. Excluded from this pool were studies that did not make associations with patient care. Studies were analysed using thematic analysis.

Results: 25 studies met the inclusion/exclusion criteria and were included in the review. The prevalence and type of disruptive behaviour varied but it consistently contributed to a reduction in the quality and safety of patient care. The effect on patient care was manifested through adverse incidents, neglect of care-needs, never events and complaints. Disruptive behaviours significantly impaired the safety culture leading to reduced patient safety, evidenced by worse clinical outcomes.

Conclusions: Disruptive behaviours amongst healthcare professionals are a significant threat to patient safety and quality of care. Organisations must harness the benefits of awareness programmes, policy and interventions to generate a culture change where these behaviours are not accepted, thereby protecting patients from preventable harm.

INTRODUCTION

Concern about the effect of disruptive behaviours (DB) in healthcare has been gaining traction since the American accreditation body, The Joint Commission (TCJ), published in

2008 new standards aimed at addressing DB amongst healthcare professionals (HCP) [1]. Research shows DB to be a pervasive problem, with 92.5% of HCP having experienced or witnessed DB in the workplace [2]. DB effects

HCP's well-being [3] , it increases healthcare costs [4,5] and negatively affects staff retention and job satisfaction [2,6].

DB is an umbrella term that captures any inappropriate behaviour by HCP that has the potential to undermine a culture of safety or jeopardise quality healthcare delivery [1]. This encompasses a variety of behaviours or confrontations ranging from non-collaboration, verbal abuse to physical or sexual harassment. DB includes but is not limited to bullying, incivility and horizontal/lateral violence. Although the definitions of all these negative behaviours overlap, they do possess individual characteristics [7]. Previous literature states that persistent, low-level behaviours which are often normalised in everyday clinical settings are just as harmful as the higher intensity behaviours [8,9].

Regulatory bodies in Canada and the United States of America (USA) have developed system level frameworks for recognition and management of HCP DB [1,10]. Whilst no such frameworks were found for other developed healthcare systems, studies from Australia, New Zealand and the UK suggest that prevalence of DB is similar in other settings [11–13]. In the UK, the most recent NHS staff survey reported an increase in bullying from managers and other colleagues (13.2% and 19.1% respectively) [14]. A survey conducted by UNISON found 8% of healthcare workers had suffered workplace sexual harassment with the majority perpetrated by colleagues [15]. More than half the referrals received by the National Clinical Advisory Service (NCAS) are related to behavioural concerns, defined as erratic or aggressive behaviour towards others [12]. As a response to growing DB concerns, NHS has introduced a national whistleblowing policy to support HCP's speaking up about their concerns and the GMC has recently launched a pilot programme which trains doctors in tackling unprofessional behaviours from their colleagues [16].

While the consequences to the organisation and affected individual are well-documented, the direct association between DB and patient harm is less clear, but it is growing. A study in 2004 linked intimidation and preventable medication errors [17]. The report found intimidation contributed to 7% of drug errors, and 49% of participants felt pressured into

dispensing or administering medication despite concerns. Another study of 4530 HCPs found that 75% of participants associated DB with medication errors and 27% associated DB with increased risk of mortality [18]. A systematic literature review in 2009 identified 10 studies, all of which found links between HCP perceptions of DB and poor patient care [19]. However, all studies were of a descriptive, non-experimental design and the author concluded that improved research was needed to establish the true impact of HCP on the patient. It is now ten years since the review was published and an apt time to assess the empirical evidence collected over the last decade and whether the Joint Commission's Sentinel Event Alert about DB has had any effect.

Aims

The aim of this study is to identify and synthesize the empirical evidence on the effect of HCP DB on at least one of the following outcome measures of patient care; clinical outcomes, patient safety, patient satisfaction or quality of care.

METHODS

To address the aim of the study, a systematic literature review was conducted.

Eligibility Criteria

Studies were selected if they met the following inclusion criteria:

1. Empirical studies that examined the relationship between HCP DB and patient care.
2. HCP were defined as any registered or certified healthcare worker working in any healthcare setting globally
3. Studies that referred to DB, bullying, lateral or horizontal violence, verbal, physical or sexual assault, incivility, hostile, unprofessional or rude behaviours
4. Studies that linked DB with outcome measures of patient care including clinical outcomes, patient safety, patient satisfaction and quality of care.
5. Studies published from 01/01/2009 until 23/07/2019
6. Peer reviewed
7. Published in English

Excluded from this pool were studies that focused on the prevalence of DB but did not make associations with patient care. Studies that examined HCP DB aimed at patients or student HCPs were excluded. Studies examining DB perpetrated exclusively by patients, their families or student HCP's were excluded although studies that presented mixed group DB that included HCP were included. Studies that solely focused on organisational outcomes of DB and patient care (i.e. staff retention or financial impact) were excluded however studies that included both organisational and individual outcomes were included. Excluded were studies that examined the relationship between teamwork and/or interprofessional collaboration and patient outcomes as poor teamwork is not always attributable to DB.

Information Sources

Between June 6th, 2019 and July 23rd, 2019, six databases were searched (Allied and Complementary Medicine (AMED), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Embase, Health Policy Reference Center, Medline and PsychInfo) for published studies that examined healthcare professional DB and patient care. Databases were searched individually via the EBSCOhost portal and OVID online. Additional studies were also found by hand searching reference lists of previous systematic reviews.

Search Strategy

The search strategy was developed under the supervision of the Health Sciences librarian, at City, University of London [ES]. Key word searching and MeSH search terms were used. Titles and abstracts were screened by a sole reviewer. Full texts were screened blindly by two reviewers.

Risk of Bias

The studies were assessed for quality using the Mixed Methods Appraisal Tool (MMAT) [20]. This tool was chosen to cater for the heterogeneity of studies included in the review. Risk of bias assessment was completed by the first author. No studies were excluded on the result of the risk of bias assessment.

RESULTS

Study Selection

An initial search yielded 9016 results. Initial report characteristics exclusion criteria (date, peer review and English only) were applied leaving 5069 results. After title screening and removing duplicates, 279 abstracts were included for screening. 77 full texts were selected for screening of which 25 were included. [See Figure 1 for stages of the study selection using the PRISMA framework [21]].

Summary of study characteristics

The 25 studies identified were conducted in a wide range of healthcare settings and included a variety of HCP's (nurses, doctors, dentists, pharmacists and allied health professionals). The majority were conducted in USA (n=15), though in total studies came from 9 different countries. Most studies solely sampled nurses (n=14), others sampled solely doctors or patients of those doctors (n=2) and the rest sampled across professional groups (n=8). In the mixed samples, nurses usually formed the largest group of participants (n=7). Study design varied from quantitative descriptive (n=17), qualitative (n=5), non-randomised (n=2) and randomised (n=1). Three studies searched databases or hospital records [22–24]. Eight studies referred to DB, 7 to bullying, 5 to violence (including horizontal or lateral violence), 3 to intimidation, 2 to rudeness. The prevalence of DB varied hugely in the studies from 2% - 79% [25,26]. The type of DB ranged from a refusal to co-operate to emotional and verbal abuse with 12% of participants from one study having suffered physical abuse from colleagues [27]. One study reported sexual abuse [28]. Studies that reported DB amongst different professional groups saw an equal number of studies reporting a higher prevalence of DB amongst non-physician groups [26,29] and physician groups [23,30]. Outcome measures were wide ranging and included HCP/patient reported quality of care (n=7), adverse events (n=5), near misses (n=4), surgical and medical complications (n=3), medication errors (n=3), falls (n=2) and compliance with hand hygiene (n=1). [See table 1 for results table].

Studies included showed a mixed risk of bias. 6 studies had a low risk of bias, 18 studies had a medium risk of bias and 1 study had a high risk of bias. Low response rates were widespread, with non-response bias of up to 80% [25].

Main findings

There is an abundance of evidence that supports the hypothesis that DB has a direct negative effect on patient care (n=24). Four recurring themes were identified throughout the literature: adverse incidents, neglect of care needs, complication rates and patient safety.

Adverse incidents

Many studies provide evidence that DB contributes to adverse incidents. These behaviours were demonstrated to both cause and predict adverse incidents [25,31]. Descriptions of adverse incidents in the literature include mortality, patient harm, never events, falls, hand hygiene compliance and medication errors. Up to 94% of clinicians associated DB with mortality [22,26,30,32] and 13 – 45.5% were aware of a specific adverse incident that had occurred because of DB [26,30]. One study reported that DB had resulted in 189 incidences of harm to patient in the past year, 10% of which caused permanent harm and 12.7% required life sustaining interventions [33]. After controlling for variables, an increase in DB exposure led to a corresponding increase in adverse events [22,25,34] and the likelihood of near misses [25,27,30,32,35]. However, 2 out of 19 studies found no significant association between DB and adverse incidents and an analysis of serious events associated with bullying resulted in no direct patient harm [23,36]. This may be due to a widespread culture of underreporting and the absence of a bullying category in the patient safety report system. Underreporting of DB was a recurring theme, with study participants reporting fear of identification, despite guarantees of confidentiality [13].

Neglect of care needs

There was a positive correlation between exposure to physical violence and bullying and the omission of clinical tasks [13,22,37]. Tasks that were completed after the HCP had been exposed to violence took longer and were delayed more frequently [22]. DB resulted in HCP attention being diverted away from the patient and toward the perpetrator and resulted in staff being less willing or refusing to collaborate with other providers over patient management [13,38,39]. DB resulted in toxic working environments that led to staff leaving patients soiled for extended periods and relegating tasks that they considered 'non-essential' such as repositioning, mobilising and oral hygiene [28]. The disengagement of HCP from patients' emotional needs and the adoption of a mechanistic, task-orientated approach was a coping

mechanism for HCP who were near cognitive depletion, a state that is consistent with exposure to DB [28,36,40].

Clinical Outcomes

Medical teams attending to a deteriorating paediatric patient had a 12% reduction in diagnostic and procedural performance when exposed to rudeness, compared to teams not exposed to rudeness [41]. Individual procedural performance including resuscitation, ventilation and pericardiocentesis skills were reduced with exposure to rudeness as was overall team performance. There was a significant association between reduced diagnostic ability of shock, deterioration, bowel perforation, cardiac tamponade and rudeness [41]. Another study showed that patients whose surgeons had received any co-worker complaints about professionalism had a 11 – 14% higher risk of surgical and medical complications [24]. Those who had received four or more negative behavioural reports compared to those with zero reports had a 31.7% higher estimated mean complication risk. This is supported by other studies that suggest patient complaints about professionalism can be used to identify doctors with higher complication rates [42,43]. Complaints regarding professionalism outnumber complaints regarding medical issues, reflecting an intolerance of patients to be treated by unprofessional as well as potentially incompetent clinicians [43].

Patient Safety

In the studies identified, disruptive behaviours were found to interrupt existing patient safety mechanisms. Divergence from clinical protocols aimed at improving patient safety was reported to be both a manifestation and consequence of disruptive behaviour [38,44–46]. Refusal to follow protocol was described in neonatal resuscitation procedures, drug administration and standard operational procedures [36,38,44–46]. Rudeness was also shown to impact on infection control protocols with a significant association ($p=0.03$) found between rudeness and reduced compliance with hand hygiene [36]. Although no direct harm was reported by these studies, staff described a breakdown in the patient safety culture and the provision of standardised care [38,47]. Furthermore, widespread intimidation related to drug administration was reported, with nurses frequently being told to 'just give what I ordered' despite concerns about prescriptions, leading to potential drug errors [29,38,45]. Studies reported an association between disruptive behaviours and a reduction in help-seeking

behaviours (n=5). This was described in medications management, procedural and diagnostic performance, manual handling, when using unfamiliar equipment and when alerting medical staff to a deteriorating patient [28,29,38,41,45,46]. Timely sharing of quality information, vital for treatment was also reduced with exposure to rudeness [13,41].

DISCUSSION

The prevalence and severity of DB in all studies is alarming, with evidence suggesting that HCP face physical and sexual violence from colleagues. However, whilst these high-intensity but less frequent behaviours should trigger well-embedded disciplinary and support processes, low-level behaviours are more challenging to manage. The evidence suggests that most healthcare settings have normalised a low-level culture of DB in which HCP's have come to accept rude and aggressive behaviours as inevitable and justified by the stressful nature of the job [3,33]. DB is considered a rite of passage into seniority [28].

At a systemic level, the role of the organisation was paramount and was seen either as a protective or an enabling factor in DB [22,28,38,45–47]. Institutions that had codes of conducts, clinical protocols, higher levels of nurse autonomy and procedures in place to encourage junior staff to question senior staff had lower levels of perceived DB [22,45]. However, most studies reported substandard organisational response resulting in most HCP's preferring to seek advice from a colleague or learning to 'stay silent' [23,28,29,38,46,47]. Those that did report DB through the formal channels did not receive any feedback or follow up from the organisation [29]. There was a feeling that the organisation would not listen and always appease the hierarchy and protect the status quo [13,28,38,46,47]. A small proportion of HCP's did not report DB due to fear of retribution [29]. Research illustrates the essential role of leadership and education programmes in tackling HCP DB and that taking appropriate early action leads to reduced complaints and defers future conflict including lawsuits [8,48].

The increased research profile of DB is reflected in clinical practice in the USA, but to a lesser extent in the UK. Whilst serious individual concerns will be referred to NCAS, the GMC, NMC or other regulatory body, there are few safeguards in place for dealing with ingrained, low-level DB [8]. Whilst most NHS Trusts have codes of conduct that address bullying and harassment, the authors couldn't find any policies that address low-levels of DB

such as incivility. The GMC's 'Medical Professionalism Matters' workshop this year showed that 60% of doctors would still not feel supported by their organisation if they raised a concern [16]. However, steps are being made in the right direction with the pilot programme, 'Professional Behaviours and Patient Safety' launched by the GMC to educate doctors in how to manage HCP DB. 2 years ago the Royal College of Nursing published 'Managing Unacceptable Behaviour' guidelines [49]. Last year as a response to the high levels of bullying reported in the NHS staff survey, an alliance against bullying, undermining and harassment was created to support staff across the health sector [50]. Despite this progress, healthcare leaders must continue to utilise the evidence-based education and management programmes to protect patients from iatrogenesis.

CONCLUSION

This systematic review shows that HCP DB negatively effects patient care. DB ranged from low level, demeaning behaviours to verbal abuse and sexual assault. These behaviours occurred across healthcare settings and professional groups. The effect on the patient included medication errors, falls, surgical and medical complications and mortality. Help-seeking, information sharing and adherence to protocols are reduced, significantly impeding positive inter/intra-professional collaboration. The targeted HCP experienced poor job satisfaction and increased intent to leave and the organisation suffered culturally and financially. Covert bullying behaviours have been normalised in healthcare and are unrecognised and unreported meaning that HCP DB may be more prevalent than currently thought [23].

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