Management of Disruptive Behaviour within Nursing Work Environments, A Systematic Review of the Evidence.

Reviewers

Professor Cath Rogers-Clark RN, BA, MN, PhD
Director
Australian Centre for Rural and Remote Evidence Based Practice
Contact: Phone +61 (07) 46 99 8313 Fax: + 61 (07) 46 99 8314
E-mail: rogerscl@usq.edu.au

Susanne Pearce RN, BN (with distinction), MN, PhD candidate
Nurse Manager (Research)
Australian Centre for Rural and Remote Evidence Based Practice
Contact: Phone: +61 (07) 46 99 8312 Fax: + 61 (07) 46 99 8940
E-mail: susanne_pearce@health.qld.gov.au

Michelle Cameron BN, MEd,
Nurse Educator
Australian Centre for Rural Remote Evidence Based Practice
Contact: Phone: +61 (07)46 16 6126…Fax: +61 (07) 46166669
E-mail: michelle_cameron@health.qld.gov.au

Disruptive Clinician Behaviour

Background

Safety and quality thrive in an environment that supports working in teams and respecting other people, regardless of their position in the organization. Disruptive behaviours that intimidate staff, decrease morale, or increase staff turnover can threaten the safety and quality of care[1] Disruptive clinician behaviour is defined as:

> '…..anything a clinician does that interferes with the orderly conduct of hospital business, from patient care to committee work. This includes behaviour that interferes with the ability of others to effectively carry out their duties or that undermine the patient's confidence in the hospital or another member of the health care team'. [2]

Unprofessional staff behaviour was identified as one of the most common causes of staff and family conflict in a 2001 study conducted in the United States.[3] Nursing morale has also been correlated with autonomy, workplace equipment, workplace safety, teamwork, work stress, the physical demand of nursing work, workload, rewards for skills and experience, career prospects, status of nursing and remuneration.[3-4]

The 2005 Queensland Health Systems Review identified that "dysfunctional behaviours including bullying, intimidation and a reluctance to share information were frequently reported and confirmed amongst clinical staff in 18 of the then 37 Health Service Districts reviewed within the Queensland Health service. [5] The report states that these negative behaviours interfered with the delivery of patient care in a resource constrained environment.

Simons (2006) identified belittling, punishing, excessive surveillance and exclusion as victimising behaviours amongst 511 randomly selected registered nurses in the USA[6]. The main finding by Simons was that as these types of behaviours increase, so does the individuals intent to leave the current nursing position.

Disruptive clinician behaviours have been highlighted as a risk to patient safety by the Joint Commission on Accreditation of Healthcare Organisations (JCAHO) in the United States. Standard LD. 3.15 (Leaders create and maintain a culture of safety and quality throughout the hospital) means that American Health organisations are now required to demonstrate second yearly completion of assessment of culture using valid and reliable tools and to provide working interventions[7]. This standard specifically requires that organisations address disruptive behaviours in the clinical environment.

Queensland Health Foster Review recommendation 4.1 articulates that:

"Surveys of workplace culture and staff satisfaction be undertaken regularly across the organisation so that all districts can monitor their progress with cultural change through time."[5]

Emotional outbursts play a negative part in organisational society and a human resource perspective recognises that people work for social and emotional benefits as well as for money.[3] Understanding of how people communicate and how people are motivated is often based upon an understanding of emotion, as are the behaviours of people. These emotions are the products of socialization and manipulation and can be termed the emotional climate of an organisation. [8-10]

The Office of Public Service Merit and Equity (State of Queensland) [11] refers to the organisational climate as being the "shared perception of what an organisation is like in terms of organisational policies practices, procedures, routines and expected behaviours". The Office of Public Service has identified that surveys can be employed to measure employee perceptions of a variety of management and leadership practices including working relationships with co-workers and workgroup distress[12].

Organisational culture and climate have particular significance in health care because:

- Organisational climate has a strong association with organisational performance (NHS studies demonstrate a strong association between advanced human resource practices, including staff appraisal, teamwork and training & development with lower patient mortality)[1]
- Staff satisfaction has a very strong positive correlation (0.89) with patient satisfaction[1]
- Staff satisfaction impacts strongly on absenteeism and turnover [1]

This systematic review protocol was developed to guide a systematic review on the strategies and recommendations available to address disruptive clinician behaviours within the nursing workforce environment. Although a number of strategies and recommendations are already available to assess and provide solutions for disruptive behaviour in nursing. , there is a lack of summarised accessible information detailing which of these strategies and recommendations actually work.

Included in this protocol, is the identification of interventions that may enhance positive nurse behaviours. Researchers have attempted to identify interventions and processes that might mitigate negative or dysfunctional behaviours. Within the healthcare profession generally, strategies such as professional supervision, performance review and education (audit and feedback)[13] have been proposed as a means of addressing all types of clinician behaviours. Various approaches have also been taken to measure emotional and behavioural quotients within organisations. Effective interventions need to be implemented in education, practice and policy to prevent or decrease dysfunctional behaviours amongst employees[14].

Fellowes et al (2003) critically evaluated all studies that have investigated the effectiveness of different communication skills training techniques for cancer care health care professionals. It was found that there was some evidence that labour–intensive training can have a beneficial impact on health care professional behaviour change.[13]

As early as the year 2000 the National Summit on Medical Errors and Patient Safety identified that 'bringing about the necessary cultural changes that support team work, acceptance and integration of decision support systems and clinical practice guidelines into health care practices, and avoidance of a "name and blame" response when errors occur is vital for positive patient outcomes.[1] The ability to detect the presence of disruptive behaviours amongst nursing staff and to address these may therefore have an impact on positive patient outcomes. Patient outcomes are not a focus for this review. The potential for improved patient outcomes as a result of improved staff behaviours should be acknowledged as a potential benefit however.

A comprehensive systematic review of the literature is yet to be completed that clarifies or synthesises what specific interventions can enhance supportive clinical behaviours.

Review question

Objectives

What interventions are effective in successfully managing disruptive clinician behaviours?

Inclusion Criteria

Types of Participants

This review will consider all qualitative and quantitative research that focuses on the management of disruptive clinician behaviours within a nursing workforce environment. Studies involving nurses and other members of the health care team including health administrators, medical practitioners, allied health workers will be included.

Types of intervention

Interventions of interest are:

- Quantitative and Qualitative nursing studies that address behavioural/educational/managerial or organisational interventions associated with positive nursing clinical behaviours

Types of outcome measures

Outcome measures will include measures (quantitative studies) or descriptions (qualitative studies) of the success or otherwise of interventions to manage disruptive clinician behaviour. Outcomes to be assessed will include the effect of interventions on patient safety and quality of care, quality of teamwork, levels of job satisfaction, retention rates of staff and staff perceptions of the quality of their work environment.

Types of studies

Studies that describe successful behavioural, educational or other types of management interventions for disruptive clinician behaviours will be included.

Opinion-based papers will also be explored to extract the opinions of respected authorities based upon consensus or experience in the absence of rigorous quantitative and qualitative research studies. Non –English language articles will be excluded.

Search Strategy

The Search Strategy is designed to access published and unpublished material in the English language, including ‘grey data’ found within research theses and conference proceedings. and will comprise of three stages:

1) A search of CINAHL, Medline, Medline-In Process, PsychINFO, Emerald and TRIP to identify any relevant keywords contained in the title, abstract and subject descriptors, including MeSH terms. Medline–In process will be used to search articles which have not had the cataloguing process completed.

2) Terms identified and the synonyms used by respective databases, will be used in an extensive search of the literature.

3) Reference lists and bibliographies of the articles collected from those identified in stage two will be searched.

The initial search terms will be adapted to suit the requirements of each database and terms/descriptors will include:

- Disruptive
- Clinician
- Bully*
- Mobbing
- Nurs*
- Behav*
- Behavio?r
- Strateg*
- Interventions
- Communication
- morale
- Patient safety
- Team work
- Retention
- Job satisfaction

Articles published in the last 10 years (1999-2009) in English and indexed in the following databases will be searched in order to enhance currency of any recommendations found form the search:

CINAHL
Medline
Cochrane Library
psycINFO
Emerald
Embase
Dissertation Abstracts
ERIC

Grey Literature Search

- Scirus
- OpenSIGLE
- Google Scholar
- BCEOHRN

Full copies of articles identified by the search, and considered to meet the inclusion criteria, based on their title, abstract and subject descriptors, will be obtained for data synthesis/analysis. Articles identified through reference lists and bibliographic searches will also be considered for data collection based on their title. Two reviewers will independently select articles against the inclusion criteria. Discrepancies in reviewer selections will be resolved at a meeting between reviewers prior to selected articles being retrieved.

Critical appraisal

Papers selected for retrieval will be assessed by two independent reviewers for methodological validity prior to inclusion in the review using the standardised critical appraisal instruments from the Joanna Briggs Institute System for the Unified Management, Assessment and Review of Information package (SUMARI). Any disagreements that arise between the reviewers will be resolved through discussion with a third reviewer.

Identified qualitative studies that meet the publication criteria will be grouped into one of the following categories: phenomenological, ethnographic, histographic and grounded theory methodology.

Quantitative studies will be grouped into one of the following categories: experimental studies; quasi-experimental studies; descriptive studies; descriptive-correlational studies.

The studies will then be assessed independently for methodological quality by two reviewers, prior to inclusion in the review using the corresponding checklist from the SUMARI suite developed by the Joanna Briggs Institute. Validity criteria used by the Joanna Briggs Institute (Qari Software, Appendix I) will be used to determine validity of qualitative studies relating to the outcomes. Opinion-based papers will be assessed for inclusion using the JBI Notari tool (Appendix II). Quantitative studies will be assessed for validity using the JBI Mastari tools for experimental and descriptive studies (Appendix III).

Disagreements between reviewers will be resolved through discussion and with the assistance of a third reviewer where required. Data extraction tools appear as Appendices IV to VI.

Data Collection

Following methodological assessment, the papers will be grouped according to whether they are quantitative, qualitative or opinion-based. Data extraction tools developed by JBI will be used to extract salient information from papers for the SUMARI software suite. Two reviewers will independently perform data extraction.

Date Synthesis

For qualitative data, where meta-synthesis is possible, qualitative research findings will be pooled using the Qualitative Assessment and Review Instrument (QARI). This will involve the aggregation or synthesis of findings to generate a set of statements that represent that aggregation, through assembling the findings (Level 1 findings) rated according to their quality, and categorising these findings on the basis of similarity in meaning (Level 2 findings). These categories are then subjected to a meta-synthesis in order to produce a single comprehensive set of synthesised findings (Level 3 findings) that can be used as a basis for evidence-based practice. Where textual pooling is not possible the findings will be presented in narrative form.

Data from quantitative studies will be pooled, where possible, in statistical meta-analysis using the Meta-Analysis of Statistics Assessment and Review Instrument (JBI-MAStARI). All results will be double entered to minimise risk of data entry error. Narrative form will be used to present findings if statistical pooling is not possible.

References

1. Queensland Health 2007 *Workplace Culture and Leadership Centre* http://qheps.health.qld.gov.au/betterworkplaces/culture/home.htm

2. Porto, G. and Lauve, R, 2006, A persistent threat to patient safety, *Patient Safety & Quality Healthcare*, July/August 2006, p.2 http://www.psqh.com/julaug06/disruptive.html.

3. Nursing & Nursing Education Taskforce (2006) *Priorities for Nursing and Midwifery Research*. Prepared by Emeritus Professor Margaret Bennett for the National Nursing and Nursing Education Taskforce.

4.Hegney, D Eley,R, Plank, A. Buikstra, E.
Parker, V. 2006 Workforce issues in nursing in Queensland:2001 and 2004, *journal if Clinical Nursing* 15 pp1521-1530

5. Queensland Health 2005 *Queensland Health Systems Review-Final Report.* *http://qheps.health.qld.gov.au/health_sys_review/final/qhsr_final_report.pdf*

6. Simons, S R 2006 Workplace bullying experienced by nurses newly licensed in Massachusetts, *Dissertation Abstracts International: Section B: The Sciences and Engineering* 67(6-B), pp3065

7. Joint Commission on Accreditation of Healthcare Organisations, 2007 PROPOSED Standard for Disruptive Behaviour -Hospital http://www.jointcommission.org/NR/rdonlyres/2BF44E9F-6EE0-4856-83EF-778FAF47723B/0/Disruptive_Behavior_cah_stds.pdf

8.Brown RB, Brooks I., 2002 Emotion at Work Identifying the emotional climate of night nursing, *Journal of Management in Medicine,* 16(5) pp.327-344

9. Fineman S.(ed) 1993,*Emotion in Organisations,* Sage Publications, London

10. Rime B, Mesquite B, Philpott P, Boca S. 1991, Beyond the emotional event: six studies on the social sharing of emotion, *Journal of Cognition and Emotion,* 5(5/6) pp.435-65

11. Office of Public Service Merit and Equity (State of Queensland) 2006 Organisational health, Quality public service workplaces-Information Paper 8

12. Office of the Public Service 1997 'A Focus on People: A Workforce Management Strategy for the Queensland Public Sector', Brisbane, Queensland.

13. Fellowes, D Wilkinson S, Moore P 2003 Communication skills training for health care professionals working with cancer patients, their families and /or carers *The Cochrane Database of Systematic Reviews 2007 1*

14. McGee, D., Shigemitsu, H, Henig, N and Raffin, T 2001, Conflict over communication and unprofessional staff behaviour: A common source of dissatisfaction during the withdrawal of care? *Critical Care Medicine* 28(1) pp217-219.

Appendices
Appendix I

Critical appraisal of qualitative research

QARI Critical Appraisal Instrument

Criteria	Yes	No	Unclear
1) There is congruity between the stated philosophical perspective and the research methodology.			
2) There is congruity between the research methodology and the research question or objectives.			
3) There is congruity between the research methodology and the methods used to collect data.			
4) There is congruity between the research methodology and the representation and analysis of data.			
5) There is congruity between the research methodology and the interpretation of results.			
6) There is a statement locating the researcher culturally or theoretically.			
7) The influence of the researcher on the research, and vice-versa, is addressed.			
8) Participants, and their voices, are adequately represented.			
9) The research is ethical according to current criteria or, for recent studies, there is evidence of ethical approval by an appropriate body.			
10) Conclusions drawn in the research report do appear to flow from the analysis, or interpretation, of the data.			
TOTAL			

Reviewers Comments:

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Appendix II

Critical appraisal of Evidence arising from Text, Expert Opinion and Discourse

NOTARI TEXTUAL CRITICAL APPRAISAL INSTRUMENT

Criteria	Yes	No	Unclear
1) Is the source of the opinion clearly identified?			
2) Does the source of the opinion have standing in the field of expertise?			
3) Are the interests of patients/clients the central focus of the opinion?			
4) Is the opinion's basis in logic/experience clearly argued?			
5) Is the argument developed analytically?			
6) Is there reference to the extant literature/evidence and any incongruence with it logically defended?			
7) Is the opinion supported by peers?			
TOTAL			

Reviewers Comments:

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Appendix III

JBI Critical Appraisal Checklist for Experimental Studies

R

eviewer ___________________ Date __________

Author _____________________ Year __________ Record Number ______

	Yes	No	Unclear
1. Was the assignment to treatment groups truly random?	☐	☐	☐
2. Were participants blinded to treatment allocation?	☐	☐	☐
3. Was allocation to treatment groups concealed from the allocator?	☐	☐	☐
4. Were the outcomes of people who withdrew described and included in the analysis?	☐	☐	☐
5. Were those assessing outcomes blind to the treatment allocation?	☐	☐	☐
6. Were the control and treatment groups comparable at entry?	☐	☐	☐
7. Were groups treated identically other than for the named interventions?	☐	☐	☐
8. Were outcomes measured in the same way for all groups?	☐	☐	☐
9. Were outcomes measured in a reliable way?	☐	☐	☐
10. Was appropriate statistical analysis used?	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info. ☐

Comments (Including reasons for exclusion)

JBI Critical Appraisal Checklist for Comparable Cohort/ Case Control

Reviewer ____________________ Date ___________
Author ______________________ Year ___________ Record Number _______

	Yes	No	Unclear
1. Is sample representative of patients in the population as a whole?	☐	☐	☐
2. Are the patients at a similar point in the course of their condition/illness?	☐	☐	☐
3. Has bias been minimised in relation to selection of cases and of controls?	☐	☐	☐
4. Are confounding factors identified and strategies to deal with them stated?	☐	☐	☐
5. Are outcomes assessed using objective criteria?	☐	☐	☐
6. Was follow up carried out over a sufficient time period?	☐	☐	☐
7. Were the outcomes of people who withdrew described and included in the analysis?	☐	☐	☐
8. Were outcomes measured in a reliable way?	☐	☐	☐
9. Was appropriate statistical analysis used?	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

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JBI Critical Appraisal Checklist for Descriptive/ Case Series

Reviewer ____________________ Date ___________
Author ______________________ Year ___________ Record Number _______

	Yes	No	Unclear
1. Was study based on a random or pseudo-random sample?	☐	☐	☐
2. Were the criteria for inclusion in the sample clearly defined?	☐	☐	☐
3. Were confounding factors identified and strategies to deal with them stated?	☐	☐	☐
4. Were outcomes assessed using objective criteria?	☐	☐	☐
5. If comparisons are being made, was there sufficient descriptions of the groups?	☐	☐	☐
6. Was follow up carried out over a sufficient time period?	☐	☐	☐
7. Were the outcomes of people who withdrew described and included in the analysis?	☐	☐	☐
8. Were outcomes measured in a reliable way?	☐	☐	☐
9. Was appropriate statistical analysis used?	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

Appendix IV
Qualitative Data Extraction Instrument

Reviewer	Date
Author	Year
Journal	Record Number

Method
Methodology
Data Analysis

Setting & Context

Geographical Context

Cultural Context

Participants: *Number:* *Description:*

Interventions

Findings	**Narrative Description**	**Qual of Evid. Rating 1,2,3**

Authors conclusion
Reviewers conclusion

Appendix V

JBI Data Extraction for Narrative, Expert opinion & text

Reviewer ____________________ Date ___________
Author ______________________ Year ___________ Record Number ______

Study Description

Type of Text: ____

Those Represented: ____

Stated Allegiance/ Position: ____

Setting: ____

Geographical: ____

Cultural: ____

Logic of Argument: ____

Authors Conclusion:

____

Reviewers Comments:

____

Conclusions	Illustration from Publication (page number)	Evidence		
		Unequivocal	Credible	Unsupported

Extraction of findings complete YES ☐

Appendix VI

JBI Data Extraction Form for Experimental/Observational Studies

Reviewer ______________________________ Date ________________

Author ______________________________ Year __________

Journal ______________________________ Record Number _______

Study Method RCT ☐ Quasi-RCT ☐ Longitudinal ☐

Retrospective ☐ Observational ☐ Other ☐

Participants

Setting

____

Population

____

Sample size

Intervention 1 _______ Intervention 2 _______ Intervention 3 _______

Interventions

Intervention 1 ____

____

Intervention 2 ____

____

Intervention 3 ____

____

Clinical outcome measures

Outcome Description	Scale/measure

Study results

Dichotomous data

Outcome	Intervention ( ) number / total number	Intervention ( ) number / total number

Continuous data

Outcome	Intervention ( ) number / total number	Intervention ( ) number / total number

Authors conclusions

Comments