Clinical Governance

Clinical Governance: An assessment of New Zealand’s approach and performance

Clinical governance policy initiatives have been introduced in many countries and health systems. How to assess development is an important question. This article describes and reflects upon the approach taken in New Zealand.

New Zealand’s clinical governance policy of 2009 and its implementation through its public health care system are outlined. The authors’ assessments, in 2010 and 2012, of this policy are described and key findings summarised.

The implementation of the policy was swift, with considerable commitment across the public health care system to this. The authors quantitative assessments found reasonable developmental progress between 2010 and 2012. Case studies undertaken in 2012 indicated various areas that policy makers should attend to or build upon in order to better support clinical governance development.

Key lessons from New Zealand’s clinical governance experience, based on these assessments: include the need for: a well-defined definition of clinical governance; resource materials that can be used by those involved in clinical governance development; recognition that clinical governance development is complicated and takes time; and commitment to new leadership and organisational arrangements.

Clinical Governance – Volume 20 no 1 (2015): 2-12

R Gauld & S Horsburgh
2 The role of information governance within English clinical governance: Observations based upon the interim report from the NIGC of the Care Quality Commission:

This article is designed to explore the relationship between information and clinical governance in the English NHS. It is a personal reflection based upon the interim report of the National Information Governance Committee (NIGC) of the Care Quality Commission.

The contribution of the NIGC to clinical governance in England has been significant for a number of reasons. Most notably, it has been embedded at the heart of an organisation concerned with the whole spectrum of health and social care, with a role where information is seen predominately as a means to deliver better care rather than an end in itself. The recommendation to establish a specific and mandatory information governance element of the inspection regime reflects the fact that without validation of the evidence base, the whole inspection regime may be seen as resting on insecure foundations, and provides reassurance in the integrity of the whole inspection process, well beyond the scope of information governance.

The article provides an insight into policy making at the heart of clinical governance, and its relationship with information governance. It highlights the fact that the work of the NIGC has placed validation of information at the heart of the new CQC inspection regime, providing increased confidence in the information on which the rest of the inspection process is based.

Electronic Health Records

3 Electronic health records improve clinical note quality

The clinical note documents the clinician's information collection, problem assessment, clinical management, and its used for administrative purposes. Electronic health records (EHRs) are being implemented in clinical practices throughout the USA yet it is not known whether they improve the quality of clinical notes. The goal in this study was to determine if EHRs improve the quality of outpatient clinical notes.

A five and a half year longitudinal retrospective multicenter quantitative study comparing the quality of handwritten and electronic outpatient clinical visit notes for 100 patients with type 2 diabetes at three time points: 6 months prior to the introduction of the EHR (before-EHR), 6 months after the introduction of the EHR (after-EHR), and 5 years after the introduction of the EHR (5-year-EHR). QNOTE, a validated quantitative instrument, was used to assess the quality of outpatient clinical notes. Its scores can range from a low of 0 to a high of 100. Sixteen primary care physicians with active practices used QNOTE to determine the quality of the 300 patient notes. All the element and grand mean quality scores significantly improved over the 5-year time interval.

The EHR significantly improved the overall quality of the outpatient clinical note and the quality of all its elements, including the core and non-core elements. The authors believe this is the first study to demonstrate that the EHR significantly improves the quality of clinical notes.


HB Burke et al.

4 Organizational strategies for promoting patient and provider uptake of personal health records

Using semi-structured interviews and a web-based survey, the authors sampled US health delivery organizations which had implemented PHRs for at least 12 months, were recognized as PHR innovators, and had scored highly in national patient satisfaction surveys. Respondents had lead positions for clinical information systems or high-risk population management. Using grounded theory approach, thematic categories were derived from interviews and coupled with data from the survey.

Interviews were conducted with 30 informants from 16 identified organizations. Organizational strategies were directed towards raising patient awareness via multimedia communications, and provider acceptance and uptake. Strategies for providers were grouped into six main themes: organizational vision, governance and policies, work process redesign, staff training, information technology (IT) support, and monitoring and incentives. Successful organizations actively communicated their vision, engaged leaders at all levels, had clear governance, planning, and protocols, set targets, and celebrated achievement. The most
A successful strategy for patient uptake was through health professional encouragement. No specific outreach efforts targeted patients with chronic disease. Registration and PHR activity was routinely measured but without reference to a denominator population or high risk subpopulations.

Successful PHR implementation represents a social change and operational project catalyzed by a technical solution. The key to clinician acceptance is making their work easier. However, organizations will likely not achieve the value they want from PHRs unless they target specific populations and monitor their uptake.

5 Physicians’ acceptance of electronic medical records exchange: An extension of the decomposed TPB model with institutional trust and perceived risk

Electronic medical records (EMRs) exchange improves clinical quality and reduces medical costs. However, few studies address the antecedent factors of physicians’ intentions to use EMR exchange. Based on institutional trust and perceived risk integrated with the decomposed theory of planned behavior (TPB) model, we propose a theoretical model to explain the intention of physicians to use an EMR exchange system.

The authors conducted a field survey in Taiwan to collect data from physicians who had experience using the EMR exchange systems. A valid sample of 191 responses was collected for data analysis. To test the proposed research model, we employed structural equation modeling using the partial least squares method.

The study findings show that the following five factors have a significant influence on the physicians’ intentions to use EMR exchange systems: (a) attitude; (b) subjective norm; (c) perceived behaviour control; (d) institutional trust; and (e) perceived risk. These five factors are predictable by perceived usefulness, perceived ease of use, and compatibility, interperson and governmental influence, facilitating conditions and self-efficacy, situational normality and structural assurance, and institutional trust, respectively. The results also indicate that institutional trust and perceived risk integrated with the decomposed TPB model improve the prediction of physician’s intentions to use EMR exchange.

The results of this study indicate that our research model effectively predicts the intention of physicians to use EMR exchange, and provides valuable implications for academics and practitioners.

6 Managing ethical issues in patient care and the need for clinical ethics support

The objective of this study was to investigate the range, frequency and management of ethical issues encountered by clinicians working in hospitals in New South Wales (NSW), Australia.

A cross-sectional survey was conducted of a convenience sample of 104 medical, nursing and allied health professionals in two NSW hospitals. Results Some respondents did not provide data for some questions, therefore the denominator is less than 105 for some items. Sixty-two (62/104; 60%) respondents reported occasionally to often having ethical concerns. Forty-six (46/105; 44%) reported often to occasionally having legal concerns. The three most common responses to concerns were: talking to colleagues (96/105; 91%); raising the issue in a group forum (68/105; 65%); and consulting a relevant guideline (64/105; 61%). Most respondents were highly (65/99; 66%) or moderately (33/99; 33%) satisfied with the ethical environment of the hospital. Twenty-two (22/98; 22%) were highly satisfied with the ethical environment of their department and 74 (74/98; 76%) were moderately satisfied. Most (72/105; 69%) respondents indicated that additional support in dealing with ethical issues would be helpful.

Clinicians reported frequently experiencing ethical and legal uncertainty and concern. They usually managed this by talking with colleagues. Although this approach was considered adequate, the ethics of their hospital was reported to be satisfactory, most respondents indicated that additional assistance with ethical and legal concerns would be helpful. Clinical ethics support should be a priority of public hospitals in NSW and elsewhere in Australia. What is known about the topic?
Clinicians working in hospitals in the US, Canada and UK have access to ethics expertise to help them manage ethical issues that arise in patient care. How Australian clinicians currently manage the ethical issues they face has not been investigated.

What does this paper add? This paper describes the types of ethical issues faced by Australian clinicians, how they manage these issues and whether they think ethics support would be helpful. What are the implications for practitioners? Clinicians frequently encounter ethically and legally difficult decisions and want additional ethics support. Helping clinicians to provide ethically sound patient care should be a priority of public hospitals in NSW and elsewhere in Australia.


E Doran et al

Health Care Priority Setting

7 Value congruence in health care priority setting: social values, institutions and decisions in three countries.

Most developed democracies have faced the challenge of priority setting in health care by setting up specialized agencies to take decisions on which medical services to include in public health baskets. Under the influence of Daniels and Sabin's seminal work on the topic, agencies increasingly aim to fulfil criteria of procedural justice, such as accountability and transparency. We assume, however, that the institutional design of agencies also and necessarily reflects substantial value judgments on the respective weight of distributive principles such as efficiency, need and equality. The public acceptance of prioritization decisions, and eventually of the health care system at large, will ultimately depend not only on considerations of procedural fairness, but also on the congruence between a society's values and its institutions. We study social values, institutions and decisions in three countries (France, Germany and the United Kingdom) in order to assess such congruence and formulate expectations on its effects.


C Landwehr and D Klinnert

8 Social values and health priority setting in Australia: an analysis applied to the context of health technology assessment.

This study set out to describe the role of social values in priority setting related to health technology assessment processes and decision-making in Australia.

The processes and decision criteria of the Pharmaceutical and Medical Benefits Advisory Committees are described based on literature and policy sources, and analysed using a framework for identifying social values in priority-setting.

Transparency and accountability of processes are apparent. Participation balances inclusiveness and effectiveness of decision-making, but presents an opportunity to enhance priority setting processes. Clinical and cost-effectiveness are important content considerations. Social values related to justice/equity are considered, without quantification of criteria weights for equity relative to other factors. HTA processes support solidarity through subsidising approved technologies for all Australians, whilst retaining autonomy by permitting non-subsidised technologies to be accessed privately, leading to possible tension between the values of solidarity, autonomy and equity.

Priority setting related to health technology subsidy incorporates a range of inter-related social values in the processes and content of decision-making. Participation in decision-making could arguably be improved if a patient and public engagement policy were to be formulated alongside more widespread changes across processes to assess social values using approaches such as the Citizens' Jury.


J Whitty and P Littlejohn
Hospitals - Admissions/ Discharges

9 Who gets admitted to the Chest Pain Unit (CPU) and how do we manage them? Improving the use of the CPU in Waikato DHB, New Zealand

Chest pain is a commonly encountered presentation in the emergency department (ED). The chest pain unit at Waikato DHB is designed for patients with likely stable angina, who are at low risk of acute coronary syndrome (ACS), with a normal ECG and Troponin T, who have a history which is highly suggestive of coronary artery disease (CAD). Two issues were identified with patient care on the unit (1) the number of inappropriate admissions and (2) the number of inappropriate exercise tolerance tests.

A baseline study showed that 73% of admissions did not fulfil the criteria and the majority of patients (72%) had an exercise tolerance test (ETT) irrespective of clinical picture. We delivered educational presentations to key stakeholders and the implementation of a new fast track chest pain pathway for discharging patients directly from the ED. There was an improvement in the number of patients inappropriately admitted, which fell to 61%. However, the number of inappropriate ETTs did not decrease, and were still performed on 76.9% of patients.

BMJ Quality Improvement Reports - 2015 doi:10.1136/bmjquality.u206670.w2735
J Jade, P Huggan and D Stephenson

10 Development and evaluation of an electronic health record–based best-practice discharge checklist for hospital patients

Checklists may help reduce discharge errors; however, current paper checklists have limited functionality. In 2013 a best-practice discharge checklist using the electronic health record (EHR) was developed and evaluated at Stanford University Medical Center (Stanford, California) in a cluster randomized trial to evaluate its usage, user satisfaction, and impact on physicians’ work flow. The study was divided into four phases.

In Phase I, on the survey (N = 76), most of the participants (54.0%) reported using memory to remember discharge tasks. On a 0–100 scale, perception of checklists as being useful was strong (mean, 66.4; standard deviation [SD], 21.2), as was interest in EHR checklists (64.5, 26.6).

In Phase II, the checklist consisted of 15 tasks categorized by admission, hospitalization, and discharge-planning. In Phase III, the checklist was implemented as an EHR “smart-phrase” allowing for automatic insertion

In Phase IV, in a trial with 60 participating physicians, 23 EHR checklist users reported higher usage than 12 paper users (28.5 versus 7.67), as well as higher checklist integration with work flow (22.6 versus 1.67), usefulness of checklist (33.7 versus 8.92), discharge confidence (30.8 versus 5.00), and discharge efficiency (25.5 versus 6.67). Increasing EHR checklist use was correlated with usefulness.

The EHR checklist reminded physicians to complete discharge tasks, improved confidence, and increased process efficiency. This is the first study to show that medicine residents use “memory” as the most common method for remembering discharge tasks. These data reinforce the need for a formalized tool, such as a checklist, that residents can rely on to complete important discharge tasks.

T Grig et al.

11 A multidisciplinary care pathway significantly increases the number of early morning discharges in a large academic medical center.

In an environment where there is increased demand for hospital beds, it is important that inpatient flow from admission to treatment to discharge is optimized. Among the many drivers that impact efficient patient throughput is an effective and timely discharge process. Early morning discharge helps align inpatient capacity with clinical demand, thereby avoiding gridlock that adversely affects scheduled surgical procedures, diagnostic procedures, and therapies.

At the authors large, academic medical center, they hypothesized that an interdisciplinary approach to scheduled discharge order entry would increase the percentage of discharges occurring before 11:00 AM and improve overall discharge time. The pilot study involved moving rate-limiting steps to earlier in the discharge process, specifically medication reconciliation to the
night before discharge and "discharge to home" order entry before 9:00 AM the morning of discharge.

The baseline rate of discharges before 11:00 AM was 8% and significantly increased to 11% after the intervention ($P = .02$). Moreover, in the subset of patients (21%) for whom early medication reconciliation and discharge to home order entry were both executed, the percentage of patient discharges occurring before 11:00 AM increased to 29.7%, with an associated average discharge time of more than 3 hours earlier. No patient harm events were associated with this pilot project. There was no significant change in length of stay, and 30-day readmission rate improved significantly from 13.8% to 10.3% ($P = .002$).

The study demonstrates that a multidisciplinary approach using prescribed order entry and medication reconciliation is a low cost, safe, and effective way to increase early morning discharges and improve patient flow for large hospitals with high volumes of scheduled patient admissions.


R Durvasula et al

12 Improving the quality of discharge summaries for elective surgical procedures at North Bristol NHS Trust

Following elective surgical procedures, hospital discharge summaries are essential in the handover to primary care. The information provided varies between institutions and is highly user-dependent. Various interventions have focused on improving information transfer to patients and primary care physicians including the development of electronic templates, electronic transmission to primary care, and training initiatives for junior doctors.

An evaluation of the urological patient’s journey at Southmead Hospital revealed a need for improved discharge summary advice. Urology specialists developed "gold standard" templates for elective urological procedures. Following a new rotation of junior doctors, discharge summaries were audited for one week. The templates were then made available on the urology ward, a teaching session was employed to encourage compliance, and the hospital electronic discharge summary template was edited. Following each intervention, summaries for one week of urology procedures were audited to assess the quality of advice provided to patients.

At baseline, 18% of discharge summaries contained sufficient patient advice, this reduced to 10% after templates were made available on the wards, increasing to 45% following the education session and 84% once the electronic discharge summary proforma was edited. We conclude that discharge summaries are an effective time point for intervening to provide patients with specific post-operative information and this may be optimised for different elective procedures via the introduction of electronically-distributed standardised templates.


E Laddss et al.

13 Identifying risk factors and patterns for unplanned readmission to a general medical service

A retrospective observational study was conducted using an administrative database at a general medicine service in a tertiary public hospital between 1 January 2007 and 31 December 2011 to identify factors and patterns associated with 7- and 28-day readmission for general medicine patients at a tertiary public hospital.

Demographic and clinical factors, as well as readmission patterns, were evaluated for the association with 7- and 28-day readmission.

The study cohort included 13 802 patients and the 28-day readmission rate was 10.9%. In multivariate analysis, longer hospital stay of the index admission (adjusted relative risk (ARR) 1.34), Charlson index _3 (ARR 1.28), discharge against medical advice (ARR 1.87), active malignancy (ARR 1.83), cardiac failure (ARR 1.48) and incomplete discharge summaries (ARR 1.61) were independently associated with increased risk of 28-day readmission. Patients with diseases of the respiratory system, neurological or genitourinary disease, injury and unclassifiable conditions were likely to be readmitted within 7 days. Patients with circulatory and respiratory disease were likely to be readmitted with the same system diagnosis.

Readmission of general medicine patients within 28 days is relatively common and is associated with clinical factors and patterns. Identification of these risk factors and patterns will enable the interventions to reduce potentially preventable readmission.
JYZ Li et al

14 The relationship between timing of surgical complications and hospital readmission.

Readmissions after surgery are costly and may reflect quality of care in the index hospitalization. This research aimed to determine the timing of postoperative complications with respect to hospital discharge and the frequency of readmission stratified by predischarge and postdischarge occurrence of complications.

This is a retrospective cohort study of national Veterans Affairs Surgical Quality Improvement Program preoperative risk and outcome data on the Surgical Care Improvement Project cohort for operations performed from January 2005 to August 2009, including colorectal, arthroplasty, vascular, and gynecologic procedures. The association between timing of complication with respect to index hospitalization and 30-day readmission was modeled using generalized estimating.

All-cause readmission within 30 days of the index surgical hospitalization discharge. RESULTS Our study of 59,273 surgical procedures performed at 112 Department of Veterans Affairs (VA) hospitals found an overall complication rate of 22.6% (predischarge complications, 71.9%; postdischarge complications, 28.1%). The proportion of postdischarge complications varied significantly, from 8.7% for respiratory complications to 55.7% for surgical site infection (P < .001). The overall 30-day readmission rate was 11.9%, of which only 56.0% of readmissions were associated with a currently assessed complication. Readmission was predicted by patient comorbid conditions, procedure factors, and the occurrence of postoperative complications. Multivariable generalized estimating equation models of readmission adjusting for patient and procedure characteristics, hospital, and index length of stay found that the occurrence of postdischarge complications had the highest odds of readmission (odds ratio, 7.4-20.8) compared with predischarge complications (odds ratio, 0.9-1.48).

More than one-quarter of assessed complications are diagnosed after hospital discharge and strongly predict readmission. Hospital discharge is an insufficient end point for quality assessment. Although readmission is associated with complications, almost half of readmissions are not associated with a complication currently assessed by the Veterans Affairs Surgical Quality Improvement Program.


J Dimick and A Ghaferi

Back to top

Hospitals - Emergency Departments

15 Redesigning emergency patient flow with timely quality care at the Alfred

The 4 h National Emergency Access Target was introduced in 2011. The Alfred Hospital in Melbourne implemented a hospital-wide clinical service framework, Timely Quality Care (TQC), to enhance patient experience and care quality by improving timeliness of interventions and investigations through the emergency episode and admission to discharge in 2012. We evaluated TQC’s effect on achieving the National Emergency Access Target and associated safety and quality indicators.

The 4 h National Emergency Access Target was introduced in 2011. The Alfred Hospital in Melbourne implemented a hospital-wide clinical service framework, Timely Quality Care (TQC), to enhance patient experience and care quality by improving timeliness of interventions and investigations through the emergency episode and admission to discharge in 2012. We evaluated TQC’s effect on achieving the National Emergency Access Target and associated safety and quality indicators.

Retrospective analysis with piecewise regression of 215,125 ED attendances before/after implementation, November 2009 to August 2013; with comparison of proportions of patients discharged, admitted or transferred from ED within 4 h of arrival; left at risk; unplanned ED reattendances up to 28 days; ED length of stay; and in-hospital mortality. The percentage of patients admitted, discharged or transferred within 4 h rose from 60% in 2010, to 74% in 2013. Median ED length of stay decreased significantly. Rate of unplanned ED representations decreased by 27%, 22% and 17% within 24 h, 48 h and 7 days, respectively; and patient numbers leaving at risk halved from 8% to 4%. Mortality for admitted patients declined from 3.5% to 2.2%. All results were statistically significant.

TQC resulted in improvement in timeliness of care for emergency patients without compromising safety and quality. Success is attributed to effective engagement of stakeholders with a hospital-wide approach to redesigning the care pathway and
establishing a new set of principles that underpin care from the time of ED arrival.


J Lowthian, A Curtis, L Straney, A McKimm, M Keogh and A Stripp

16 Evaluation of a nurse practitioner-led extended hours mental health liaison nurse service based in the emergency department

To evaluate a nurse practitioner (NP)-led extended hours mental health liaison nurse (MHLN) service based in the emergency department (ED) of an inner city teaching hospital in Sydney and to explicate a model of care that is transferable across a broad range of ED settings, both in metropolitan and rural contexts.

This mixed-methods evaluation encompassed descriptive data on ED mental health presentations, quantifying waiting times for MHLN involvement and interviews with MHLN team members at the commencement of the evaluation and 12 months later. Interviews were also conducted with a snapshot of ED patients, and a sample of ED and psychiatry staff.

The expanded MHLN service was rapidly incorporated into the ED structure, enthusiastically endorsed by ED patients and highly valued by staff and the organisation. The MHLN team saw 55% of referred patients within the first hour of arrival (frequently before medical assessment), thereby initiating and expediting co-ordination of care at an early stage of the ED process.

An NP-led extended hours MHLN team based in the ED provides prompt and effective access to specialised mental health care for people with ‘undiifferentiated health problems’, and removes a significant workload from nursing and medical staff. Embedding the NP-led MHLN service within the ED structure was pivotal to the success and sustainability of this model of care.


T Wand, N D’Abrew, C Barnett, L Acret and K White

Management

17 Get the boss to buy in

The article looks at the frequent need for middle managers to bring particular issues to the attention of higher-level executives or to convince them to adopt certain changes. The authors outline obstacles mid-level managers often face and offer recommendations based on their research for communicating effectively in such situations, which they refer to as issue-selling. Topics include the decision over when to propose an idea, managing the emotions of both oneself and one’s audience, and framing the issue in a way that matches the goals and perspectives of the executives making the ultimate decision.


S Ashford and J Detert

18 Better safe than sorry

“For business owners there is no greater cause for sleepless nights than the possibility of their data being insecure. Thankfully “cloud-based” services mean they can now sleep easier over their data storage and back up.” NZBusiness talks to some of the major players in New Zealand’s online storage and backup market and offers their reflections on data storage. Whether a small company or a large corporation, data storage and protection, back up/disaster recovery, require best-practice solutions.

NZ Business - March 2015

G Baker
19 The art of giving and receiving advice
The article looks at giving and receiving advice as an element of organizational leadership and managerial ability. It suggests that the skills related to these actions, such as self-awareness and diplomacy, are not innate talents but can be learned. They list problems that research has shown often occur in the process of seeking or giving advice, including being over-confident about one's own perspective, failing to seek advice from those with different perspectives, and not defining the problem at hand in a clear manner. It offers recommendations for both those seeking and giving advice to make the process as effective as possible.

D Garvin and J Margolis

20 The truth about CSR
The article discusses corporate social responsibility (CSR) programs. In the authors' view many of these programs consist of disparate, uncoordinated initiatives that fail to maximize their impact. They recommend a more coherent strategy that divides CSR efforts into three categories including those related to philanthropy, operational effectiveness, and shaping the firm's business model to better create shared value. Consideration is also given to developing metrics for assessing CSR performance.

K Rangan, L Chase and S Karim

21 When senior managers won't collaborate
The article discusses the increasingly specialized nature of professional services firms due to the increasingly complex regulatory, economic, and technological environments they function in, and the necessity this creates for specialists within firms to collaborate with each other. Commentary is presented on how firms and employees benefit from collaboration, rivalry, compensation systems, and other aspects of corporate culture that impede collaboration, and strategies that can promote collaboration by helping professionals experience its benefits sooner.

H Gardner

22 Managing your mission-critical knowledge
The article looks at management of the knowledge resources of corporations. It notes that while much attention is currently paid to big data, it is only one of the many strategically important knowledge assets a company typically possesses, and suggests that companies can benefit from systematically inventorying all of such assets, including intellectual property and employee talent and expertise. It offers an approach to mapping knowledge assets along two dimensions--tacit versus explicit and proprietary versus widespread--to facilitate determining how to maximize their value. The use of the approach at aerospace company Boeing and at the European Organization for Nuclear Research (CERN).

M Ihrig and I Macmillan

23 A second chance to make the right impression
The article looks at interpersonal relations, focusing on the first impression one makes on others. It says how people perceive an individual on first acquaintance is shaped by various unconscious social and cognitive patterns, including patterns related to trust, power, and ego. It discusses how awareness of these patterns can be used to ensure that one creates a positive impression, citing behaviors including projecting a warm personality, describing oneself in terms of the other person's goals, and being modest. Other topics include prompting the other person to act fairly, the value of being helpful at moments of stress, and the impact of risk aversion on perceptions of others.

H Halvorson
24 What board games can teach business

The article looks at board games, focusing on the skills and lessons players can learn from them that are applicable in life and in business. It describes the game Monopoly, including the progressive economic views of Elizabeth Magie, creator of the Landlord's Game from which it was derived, and the importance of negotiating with others and making deals to winning. On the game Monopoly, it cites the book "The Monopolists: Obsession, Fury, and the Scandal Behind the World's Favorite Board Game" by Mary Pilon. It discusses other games including Pictionary, Morphology, the Extraordinaires, and Power Grid, describing how they can foster skills including empathy, creativity, and iterative thinking.


A Innes

25 Bridging psychological distance

The article describes different kinds of psychological distance including social, temporal, spatial, and experiential that can hinder one's job performance, and discusses a pair of strategies for dealing with them. One may choose to either close or widen the distance depending on the context, with closing more appropriate in negotiations and widening sometimes suitable in a managerial situation. Instead of altering the distance, a second approach would be to substitute one type of distance for another.


R Hamilton

Mental Health Services

26 Investigation into coordinating dependencies between care pathways within mental healthcare: A qualitative case study and pilot testing of a new theoretical framework

Aiming to improve quality of care and reduce costs, mental healthcare organizations implemented care pathways. These pathways have mostly been evaluated as single entities. However, evidence suggests that improvements in individual pathways do not necessarily lead to better performance within the whole care process due to dependencies between pathways. Limited empirical research has been devoted to this theme. The aim of this study was to examine how departments coordinate dependencies between pathways, to discern types of coordination used and to construct a theoretical framework.

In a comparative case study of three departments within two mental healthcare organizations, 27 employees were interviewed on the subject of coordination of pathways. A document review was performed to gain general insights into the departments and their pathways. Interviews were transcribed and analyzed using content analysis, based on criteria derived from the theoretical framework. The cases were compared through pattern analysis.

Findings indicate a lack of awareness among team members regarding the theoretical pathway structure within their department and that all departments deployed a function or system to monitor coordination practices. Within the departments, flow dependencies were found. Although departments coordinated pathways differently, these mostly were horizontal and programmed in nature. The findings suggest more explicit and structured communication about pathways can be helpful in organizations. Also, outcomes were better if coordination was monitored. Further research is warranted to verify and evaluate the preference for horizontal and programmed ways of coordinating pathway dependencies within mental healthcare.


M Sengers, I Bongers and D Roeg

27 Mental health care in hospitals and primary care: an unsustainable balance

Although austerity is now a major political and social driver, both to an increased disease burden and resource inertia, there may now be a case for saying that the wholesale closure of NHS psychiatric beds must be reversed. In addition to investment in effective primary care mental health services, we may also need more mental health beds. Evidence for this view might be strengthened by a national epidemiological study of mental health needs. If we, as a country, truly need a change of mental
health policy, is there a political appetite to make this necessary change before a public health disaster becomes inevitable?

B Green and B Gowans

28 Where to mental health reform in Australia: is anyone listening to our independent auditors?

Independent audits find consistent evidence of failure across Australia's mental health system.

There is widespread agreement that Australia's mental health system is in critical need of reform. In a move that has left many in the mental health sector wondering if they were trapped in a rerun of Groundhog day, the Australian Government recently charged the National Mental Health Commission with undertaking a mental health review to investigate the gaps and duplications in, and effectiveness of, Australia's mental health system.

This review followed in the wake of a long series of national and state inquiries and reviews of the mental health sector in Australia dating back to the Burdekin Report in 1993, which provided the impetus for a national mental health reform agenda.1 The findings of these reviews point to the continuing failure of successive governments to build the community-based model of care promised after the closure of stand-alone psychiatric institutions.

29 Enhancing social networks: a qualitative study of health and social care practice in UK mental health services

People with severe mental health problems such as psychosis have access to less social capital, defined as resources within social networks, than members of the general population. However, a lack of theoretically and empirically informed models hampers the development of social interventions which seek to enhance an individual's social networks. This paper reports the findings of a qualitative study, which used ethnographic field methods in six sites in England to investigate how workers helped people recovering from psychosis to enhance their social networks. This study drew upon practice wisdom and lived experience to provide data for intervention modelling. Data were collected from 73 practitioners and 51 people who used their services in two phases. Data were selected and coded using a grounded theory approach to depict the key themes that appeared to underpin the generation of social capital within networks. Findings are presented in four over-arching themes - worker skills, attitudes and roles; connecting people processes; role of the agency; and barriers to network development. The sub-themes which were identified included worker attitudes; person-centred approach; equality of worker-individual relationship; goal setting; creating new networks and relationships; engagement through activities; practical support; existing relationships; the individual taking responsibility; identifying and overcoming barriers; and moving on. Themes were consistent with recovery models used within mental health services and will provide the basis for the development of an intervention model to enhance individuals' access to social capital within networks.

30 What are incident reports telling us? A comparative study at two Australian hospitals of medication errors identified at audit, detected by staff and reported to an incident system

Objectives: To (i) compare medication errors identified at audit and observation with medication incident reports; (ii) identify differences between two hospitals in incident report frequency and medication error rates; (iii) identify prescribing error detection rates by staff.

Design: Audit of 3291 patient records at two hospitals to identify prescribing errors and evidence of their detection by staff. Medication administration errors were identified from a direct observational study of 180 nurses administering 7451
After gaining support of medical and nursing staff, a trial was undertaken and a further two weeks of data collected to see if reducing delays by improving documentation and communication of stat medication requirements between nursing and medical staff with the intention to reduce delays by improving communication.

While working on a geriatrics ward I noticed that there were often significant delays in administration of stat medications which occurred on a regular basis. I therefore investigated this by collecting data over a two week period to assess the situation. While working on a geriatrics ward I noticed that there were often significant delays in administration of stat medications which can lengthen patient recovery times, prolong admission, and can lead to avoidable patient harm and suffering.

Stat medications are regularly prescribed on hospital wards as part of the ongoing care for patients. Because they are prescribed at variable times that do not coincide with regular nursing drug administration times, they rely on good communication and vigilance on staff to ensure they are administered in a timely manner. Delays in drug administration can lengthen patient recovery times, prolong admission, and can lead to avoidable patient harm and suffering.

After gaining support of medical and nursing staff, a trial was undertaken and a further two weeks of data collected to see the
effect of the intervention. The results showed that there was an increase in the median time delay (1 hour 34 minutes to 2 hours 26 minutes, a 55% increase in median time delay) after the implementation of the my intervention, suggesting that it actually made communication worse, creating more delays. Subsequent feedback and analysis showed that this was due to a number of factors that led to worsened communication between staff and therefore an increase in medication delays. Early recognition allowed the intervention to be promptly withdrawn and a re-assessment of the nature of the initial problem.

This project highlights the importance of measurement in determining if an intervention actually works and is an improvement on current practice.


S Nagar and N Davey

33 Developing a ward round checklist to improve patient safety

Checklists have been shown to improve care and reduce morbidity and mortality in the healthcare setting.[1] Their application in safety-critical industries outside of medicine continues to offer a strong argument for their application to medicine.[2] The daily in-patient medical ward round is a complex process and includes multiple potential risks to patient safety. This project aims to evaluate the effectiveness of a ward round review checklist on one general medical ward in a district general hospital in the UK.

A baseline audit was performed, examining case-notes for a set of pre-defined outcome measures relevant to patient safety. Compliance with documentation of each outcome measure was assessed prior to the introduction of a ward round checklist. This was followed by a quality improvement project through the use of PDSA cycles, with the aim of introducing and developing a ward round checklist over a nine month period. Following the introduction of a checklist, overall compliance with documentation of each outcome measure improved from 45% to 89%.

In conclusion, a quality improvement project involving the introduction of a ward round checklist for daily use has resulted in improved documentation of outcome measures that are relevant to patient safety. Teamwork and leadership skills from clinicians committed to improving patient safety is essential to sustaining improvements in traditional ward round practice.

BMJ Quality Improvement Reports - (2015): doi:10.1136/bmjquality.u204775.w2440

G Hale and D McNab

34 Patient handover in orthopaedics, improving safety using Information Technology

Good inpatient handover ensures patient safety and continuity of care. An adjunct to this is the patient list which is routinely managed by junior doctors. These lists are routinely created and managed within Microsoft Excel or Word. Following the merger of two orthopaedic departments into a single service in a new hospital, it was felt that a number of safety issues within the handover process needed to be addressed. This quality improvement project addressed these issues through the creation and implementation of a new patient database which spanned the department, allowing trouble free, safe, and comprehensive handover. Feedback demonstrated an improved user experience, greater reliability, continuity within the lists and a subsequent improvement in patient safety.


T Pearkes

35 Improving junior doctor handover between jobs

Patient safety is one of the most important issues in healthcare. In recent years there has been much focus on “Black Wednesday”; the day that Foundation doctors start their first jobs. Great efforts have been made to ensure that patient safety on this day has improved, with the main example being that newly qualified doctors now use some of their free time between medical school and starting their first job to shadow their outgoing counterparts.

However, because Foundation doctors start a brand new job approximately every four months for two years, subsequent job changeovers were identified as a time of potential problems and increased patient risk. It is not practical to shadow prior to every job because junior doctors are needed in their current post right up until changeover day, so a simple way to smooth this transition was needed.

A handover lunch seemed to be a feasible solution. The day before Foundation doctors change jobs, an hour is dedicated for
Foundation Year 1 doctors (F1’s) to sit down together over lunch (provided by the mess) and take a formal handover of all relevant information about their forthcoming job and discuss current inpatients.

Results showed that 100% of those surveyed mentioned face to face handover as essential, 93.75% said it was either helpful or extremely helpful to have a dedicated time for F1’s to handover, and 12.5% said they would not have sought a face to face handover otherwise. Apart from being extremely simple and cheap, it was very popular with the F1’s in the trust. It enables effective working from day one and is a great team building activity.

BMJ Quality Improvement Reports - (2014): doi:10.1136/bmjquality.u201125.w713

L Hayes

36 The association between patient-reported incidents in hospitals and estimated rates of patient harm

Objective: The aim of this study was to test the association between the rates of patient-reported incidents and patient harm documented in the patient record.

Design: The study was a secondary analysis of two national hospital assessments conducted in 2011.

Setting: Hospital services in Norway.

Participants: The patient survey was a standard national patient-experience survey conducted at the hospital level for all 63 hospitals in Norway. The medical record review was performed by 47 Global Trigger Tools (GTTs) in all 19 hospital trusts and 4 private hospitals. The two data sets were matched at the unit level, yielding comparable patient experiences and GTT data for 7 departments, 16 hospitals and 11 hospital trusts.

Intervention: No intervention.

Main Outcome Measures: The correlation at the unit level between the patient-reported incident in hospital instrument (PRIH-I) and estimated rates of patient harm from the GTT.

Results: The PRIH-I index was significantly correlated with all patient-reported experience indicators at the individual level, with estimates for all patient harm events (Categories E–I) at the unit level ($r = 0.62, P < 0.01$), and with estimates of more serious harm events in Categories F–I ($r = 0.42, P < 0.05$).

Conclusions: Patient-reported incidents in hospitals, as measured by the PRIH-I, are strongly correlated with patient harm rates based on the GTT. This indicates that patient-reported incidents are related to patient safety, but more research is needed to confirm the usefulness of patient reporting in the evaluation of patient safety.


O Bjertnaes, E Tveter Deilkås, K Eeg Skudal, H Hestad Iversen and A Mette Bjerkan

37 Patient experiences of inpatient hospital care: a department matter and a hospital matter

Objective: To examine the added value of measuring and possibly presenting patient experiences at the department level, in addition to the hospital level, and to explore the possibility that patient experiences differ according to the ‘type’ of hospital department.

Design: Secondary analysis of data from a widely used survey on patient experiences of Dutch inpatient hospital care [Consumer Quality Index (CQI) Inpatient Hospital Care].

Setting: Inpatient hospital care experience survey of patients of 78 Dutch hospitals.

Participants: A total of 15 171 randomly selected inpatients from 78 Dutch hospitals, who had at least one night of hospitalization between October 2006 and October 2007.

Main outcome measures: Explained variance in patient experiences at the department level, compared with the explained variance at the hospital level. Significant differences in patient experiences between types of departments, expressed in regression coefficients. Patient experiences were measured using validated quality indicators, calculated from specific survey
Results: Adding the department level to the analyses of patient experiences is statistically worthwhile for a number of quality indicators of the CQI Inpatient Hospital Care, and will enable the presentation of more detailed results within hospitals. Furthermore, the results indicated that there are some systematic differences in patient experiences between specific types of hospital departments across hospitals. However, the proportion of variance in experiences explained by both department and hospital is limited (max. 14%).

Conclusions: Analyses of quality information on patient experiences of inpatient hospital care should not only take the hospital level, but also at the more specific department level into account.


M Krol, D De Boer, H Sixma, L Van Der Hoek, J Rademakers and D Delnoij

38 An integrative framework for sensor-based measurement of teamwork in healthcare

There is a strong link between teamwork and patient safety. Emerging evidence supports the efficacy of teamwork improvement interventions. However, the availability of reliable, valid, and practical measurement tools and strategies is commonly cited as a barrier to long-term sustainment and spread of these teamwork interventions. This article describes the potential value of sensor-based technology as a methodology to measure and evaluate teamwork in healthcare. The article summarizes the teamwork literature within healthcare, including team improvement interventions and measurement. Current applications of sensor-based measurement of teamwork are reviewed to assess the feasibility of employing this approach in healthcare. The article concludes with a discussion highlighting current application needs and gaps and relevant analytical techniques to overcome the challenges to implementation. Compelling studies exist documenting the feasibility of capturing a broad array of team input, process, and output variables with sensor-based methods. Implications of this research are summarized in a framework for development of multi-method team performance measurement systems. Sensor-based measurement within healthcare can unobtrusively capture information related to social networks, conversational patterns, physical activity, and an array of other meaningful information without having to directly observe or periodically survey clinicians. However, trust and privacy concerns present challenges that need to be overcome through engagement of end users in healthcare. Initial evidence exists to support the feasibility of sensor-based measurement to drive feedback and learning across individual, team, unit, and organizational levels. Future research is needed to refine methods, technologies, theory, and analytical strategies.


M Rosen, A Dietz, T Yang, C Priebe and P Pronovost

39 “Safe handover saves lives”: results from clinical audit

Purpose – The implementation of the European Working Time Directive and its subsequent impact on the hours worked by doctors in training has resulted in shift-working rotas being the norm and greater cross-cover between specialties. As such, the need for continuity of information and comprehensiveness of handover between shifts has become more important than ever. The purpose of this paper is to show how handover can be improved by the implementation of an electronic handover system and subsequent Quality Improvement Rapid Cycle Change Model of clinical audit.

Design/methodology/approach – Initial data were collected using a standardised questionnaire collected prospectively from all junior doctors within the surgical division. Following the first audit cycle, changes were implemented in a Quality Improvement Rapid Cycle Change Model of clinical audit and a Surgical Division Electronic Handover Shared Drive was developed. Three further prospective cycles of clinical audit were carried out over a period of 12 months.

Findings – The results show a more effective handover system to be in place. Effects of change measured as an 80 per cent standard was achieved in all categories and maintained throughout all cycles of re-audit. Practical implications – A surgical division shared electronic handover drive was developed and subsequent audits have shown improved handover practice in a foundation trust. This has positive benefits on patient safety and quality of care.

Originality/value – This work is of interest to those looking to set up an electronic handover system and additionally to all those working in specialties where cross-cover is required.


R Advani, N Stobbs, N Killick and B Kumar
40 The burden of disease and injury attributable to alcohol in New Zealanders under 80 years of age: marked disparities by ethnicity and sex

Aim. To update and improve estimates of morbidity and mortality due to alcohol consumption in New Zealand.

Method. We applied the comparative risk assessment methods of the Global Burden of Disease Study at country level, and separately for Māori and non-Māori where possible. Analysis was restricted to 0–79 year olds.

Results. We estimated 5.4% of all deaths under 80 years old were attributable to alcohol in 2007 (802 deaths) and these represented 13,769 years of life lost (YLLs). Injuries accounted for 43%, cancer for 30% and other diseases for 27% of deaths. We also calculated 351 deaths were averted by alcohol use, but only 3095 YLLs, resulting in a net annual loss of more than 10,000 years of life. Sex and ethnic disparities were marked, with twice as many deaths in men as women for both Māori and non-Māori, and the age-standardised death rate for Māori two and a half times the rate for non-Māori. Injury was the biggest cause of alcohol-related deaths and YLLs in the young and overall, but the leading cause of alcohol-related death in both Māori and non-Māori women was breast cancer. We estimated 6.5% of all healthy life lost among 0–79 year olds in 2004 was attributable to alcohol (28,403 DALYs lost), and 6538 DALYs were prevented. The sex disparity in DALYs lost mirrored the mortality analysis, but no disaggregation by ethnicity was possible.

Conclusion. Alcohol consumption results in substantial loss of good health across the life course in New Zealand. It makes an important contribution to Māori/non-Māori and male/female health disparities. High average consumption and heavy drinking occasions confer the greatest risk of harm to the drinker and others. At a population level there are no documented health benefits of drinking before middle-age and benefits in later life are increasingly uncertain.

J Connor, R Kydd, K Shield and J Rehm

41 What doctors should know about the Trans-Pacific Partnership Agreement

How this new breed of trade agreement could affect public health and access to medicines

Macroeconomic policy decisions can seem far removed from day-to-day medical practice; however, these high-level policy decisions about trade and economic policy have far-reaching consequences and can undermine effective health policy and practice.

A Thow, D Gleeson and S Friel

42 The Trans Pacific Partnership Agreement: Exacerbation of inequality for patients with serious mental illness

Negotiations for a treaty that is set to become one of the world's biggest trade agreements, the Trans Pacific Partnership Agreement (TPPA), have sparked considerable concern and debate about the possible impacts on health. The TPPA negotiations involve a diverse set of 12 countries from around the Pacific Rim. These include developed countries such as Australia, New Zealand, the United States and Canada, along with much lower-income countries such as Vietnam and Peru.

While few details about the negotiations are publicly available, the TPPA is said to comprise approximately 29 chapters, which include legal rules covering issues such as investor protections, intellectual property rules and regulatory coherence along with more traditional trade issues such as the removal of tariffs. A number of recent reviews based on leaked negotiating documents conclude that there are legitimate concerns about the potential impact of the TPPA in relation to ensuring equitable access to medicines and public health regulation, including tobacco, food and alcohol regulation (see, for example, Hirono et al., 2014; Wyber and Perry, 2013).

E Monasterio and D Gleeson
Research

43 Public involvement in research: making sense of the diversity

This paper presents a coherent framework for designing and evaluating public involvement in research by drawing on an extensive literature and the authors’ experience. The framework consists of three key interrelated dimensions: the drivers for involvement; the processes for involvement and the impact of involvement. The pivotal point in this framework is the opportunity for researchers and others to exchange ideas. This opportunity results from the processes which bring them together and which support their debates and decisions. It is also the point at which research that is in the public interest is open to public influence and the point at which the interaction can also influence anyone directly involved. Judicious choice of methods for bringing people together, and supporting their debate and decisions, depends upon the drivers of those involved; these vary with their characteristics, particularly their degree of enthusiasm and experience, and their motivation.

S Oliver, K Liabo, R Stewart and R Rees

Rural Health

44 Oncology service initiatives and research in regional Australia

Objective: This paper reflects on the recent growth of cancer research being conducted through some of Australia's rural centres. It encompasses work being done across the fields of clinical, translational and health services research.

Design: This is a collaborative piece with contributions from rural health researchers, clinical and cancer services staff from several different regions.

Conclusion: The past decade has seen an expansion in cancer research in rural and regional Australia driven in part by the recognition that cancer patients in remote areas experience poorer outcomes than their metropolitan counterparts. This work has led to the development of more effective cancer networks and new models of care designed to meet the particular needs of the rural cancer patient. It is hoped that the growth of cancer research in regional centres will, in time, reduce the disparity between rural and urban communities and improve outcomes for cancer patients across both populations.

C Murphy et al.

45 Specialist cancer care through Telehealth models

Objective: Disparities in outcomes are experienced between people who live in rural and remote areas and those who live in larger cities. This paper explores the ability to deliver specialist cancer care through the use of telehealth models.

Design: Review of telehealth models for cancer care.

Setting, participants and intervention: Cancer patients in rural, remote and Indigenous communities who receive their care through telehealth.

Outcome measures and results: Telehealth models seem to be applicable to all fields of oncology and all health professionals. These models not only facilitate the provision of specialist services closer to home in an acceptable, safe and cost-effective manner, but also help expand the rural scope of practice and enhance service capabilities at rural centres.

Conclusion: New models of telehealth are another avenue to help further decrease the disparity of access and survival outcomes between rural and urban patients. Implementation of these models requires health system wide approach for development key performance indicators and allocation of resources.

S Sabesan
The many benefits for the rural sector suggest it is time to integrate telehealth models into routine clinical practice.

The uptake of telehealth in Australia has been increasing steadily, but continued uptake relies on clinical champions. Australian telehealth models cover a wide range of medical specialties and subspecialties. However, most telehealth services in Australia are currently optional, which acts as a barrier to the growth and uptake of these models.

Many successful telehealth networks have been established by incorporating telehealth models of care as part of the core business of hospitals and health services, rather than as an academic activity or a pilot project. While some may argue the evidence base for telemedicine is “weak”, we assert there is sufficient evidence for these models to be integrated into routine clinical practice.

S Sabesan and J Kelly

Does Pūkawakawa (the regional-rural programme at the University of Auckland) influence workforce choice?

Aim: Relative shortages of rural doctors persist. In 2008 the University of Auckland medical programme introduced a Year 5 regional and rural immersion programme, Pūkawakawa, based in Northland, New Zealand (NZ). This study evaluates the early workforce outcomes of graduates of this programme.

Method: During 2013 we surveyed Auckland medical graduates who were in the 2008–2011 Pūkawakawa cohorts. Questions were asked regarding recent and current place of work, future intentions for place of work, and career preference with reasons why. Qualitative analysis was undertaken to analyse free text responses about experiences of Pūkawakawa on this choice.

Results: Of the 72 Pūkawakawa participants, 45 completed the survey, for a response rate of 63%. In 2013, 62% were working in rural or regional areas, with 31% in the Northland DHB. The great majority intend to work rurally or regionally, with 35.6% intending to return to Northland DHB. Of the respondents, 68% listed general practice in their top three future career intentions.

Conclusion: In the early postgraduate years, medical graduates who participated in Pūkawakawa are very likely to be working in rural and regional areas. These graduates also show an intention to work in general practice and rural medicine.

C Matthews, W Bagg, J Yielder, V Mogol and P Poole

The relationship between nurse staffing and inpatient complications

Aim: To compare characteristics of hospitalizations with and without complications and examine the impact of nurse staffing on inpatient complications across different unit types.

Background: Studies investigating the relationship between nurse staffing and inpatient complications have not shown consistent results. Methodological limitations have been cited as the basis for this lack of uniformity. Our study was designed to address some of these limitations.

Design: Retrospective longitudinal hospitalization-level study.

Method: Adult hospitalizations to high intensity, general medical and general surgical units at three metropolitan tertiary hospitals were included. Data were sourced from Western Australian Department of Health administrative data collections from 2004–2008.

We estimated the impact of nurse staffing on inpatient complications adjusted for patient and hospital characteristics and accounted for patients with multiple hospitalizations.

Results: The study included 256,984 hospitalizations across 58 inpatient units. Hospitalizations with complications had
significantly different demographic characteristics compared with those without. The direction of the association between nurse staffing and inpatient complications was not consistent for different inpatient complications, nurse skill mix groups or for hospitalizations with different unit movement patterns.

Conclusion: Our study design addressed limitations noted in the field, but our results did not support the widely held assumption that improved nurse staffing levels are associated with decreased patient complication rates. Despite a strong international focus on improving nurse staffing to reduce inpatient complications, our results suggest that adding more nurses is not a panacea for reducing inpatient complications to zero.

L Winton Schreuders, A Bremner, E Geelhoed and J Finn

Workplace Violence

49 The effect of bullying on burnout in nurses: the moderating role of psychological detachment

Aims: The aim of the study was to examine the relationship between bullying and burnout and the potential buffering effect psychological detachment might have on this relationship.

Background: There is evidence to suggest that bullying is relatively widespread in the nursing profession, with previous studies indicating that bullying is associated with higher levels of burnout. There is, however, limited research focusing on potential moderators of the relationship between bullying and burnout.

Design: A cross-sectional quantitative study conducted with self-completed, anonymous questionnaires.

Methods: The study was conducted in 2011 with 762 Registered Nurses in Australia. Two hypotheses were tested with validated measures of bullying, psychological detachment and burnout. The hypotheses were tested using hierarchical regression.

Results: Bullying is positively associated with burnout. Psychological detachment does not significantly moderate the relationship between bullying and burnout.

Conclusion: The results indicate that bullying exacts a strong negative toll on nurses. Ensuring there are workplace policies and practices in place in healthcare organizations to reduce the instances of bullying and proactively address it when it does occur would therefore seem crucial. Individuals may also lower their risk of burning out by psychologically detaching from work.

B Allen, P Holland and R Reynolds

50 Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports

Aim: To explore catalysts to, and circumstances surrounding, patient-to-worker violent incidents recorded by employees in a hospital system database.

Background: Violence by patients towards healthcare workers (Type II workplace violence) is a significant occupational hazard in hospitals worldwide. Studies to date have failed to investigate its root causes due to a lack of empirical research based on documented episodes of patient violence.

Design: Qualitative content analysis.

Methods: Content analysis was conducted on the total sample of 214 Type II incidents documented in 2011 by employees of an American hospital system with a centralized reporting system.

Findings: The majority of incidents were reported by nurses (39.8%), security staff (15.9%) and nurse assistants (14.4%). Three distinct themes were identified from the analysis: Patient Behaviour, Patient Care and Situational Events. Specific causes of violence related to Patient Behaviour were cognitive impairment and demanding to leave. Catalysts related to patient
care were the use of needles, patient pain/discomfort and physical transfers of patients. Situational factors included the use/presence of restraints; transitions in the care process; intervening to protect patients and/or staff; and redirecting patients.

Conclusions: Identifying catalysts and situations involved in patient violence in hospitals informs administrators about potential targets for intervention. Hospital staff can be trained to recognize these specific risk factors for patient violence and can be educated in how to best mitigate or prevent the most common forms of violent behaviour. A social–ecological model can be adapted to the hospital setting as a framework for prevention of patient violence towards staff.

J Arnetz, L Hamblin, L Essenmacher, M Upfal, J Ager and M Luborsky

Back to top