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How can unprofessional behaviours between healthcare staff be reduced? A realist review

Justin Avery Aunger[1,2*], Ruth Abrams[1], Mark Pearson[3], Judy M Wright[4], Johanna I Westbrook[5], Russell Mannion[6], Aled Jones[7], Jill Maben[1]

[1]University of Surrey; [2]Midlands Patient Safety Research Collaboration, University of Birmingham; [3]University of Hull; [4]University of Leeds, [5]Macquarie University; [6]Health Services Management Centre, University of Birmingham; [7]University of Plymouth

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Unprofessional behaviours (UBs) have been defined as "any interpersonal behaviour causing distress or harm to other healthcare staff".

Such behaviours encompass incivility, bullying, harassment and microaggressions.

Despite repeated scandals in the UK NHS and internationally, there is limited knowledge about what can be done to address UB in healthcare organisations.

We conducted a realist review [1] to understand how, why, and in what contexts interventions to reduce UBs between healthcare staff work, and whom they may benefit.

Background

Unprofessional behaviours affect :

Staff by damaging psychological and physical health. This is true not only for those on the receiving end of the behaviours, but for colleagues who witness the behaviours.

Organisations by reducing staff morale, resulting in problems with retention, reducing patient safety, and loss of reputation.

Patients by affecting staff confidence to report clinical errors, poor patient experiences, and concerns around care quality and safety. Staff who do not feel psychologically safe are less likely to share their mistakes.

The proportion of UK NHS Staff Reporting experiencing harassment, bullying, and abuse each year is approximately:

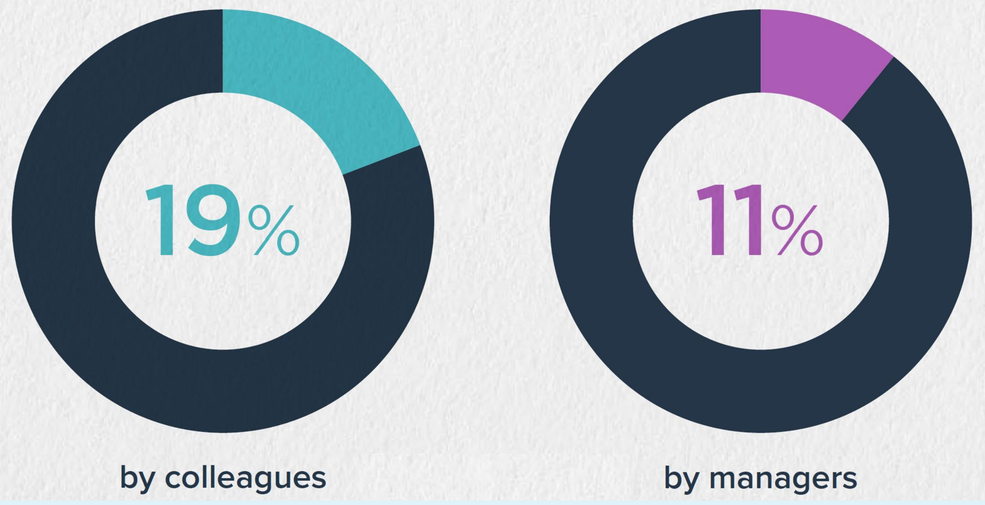

Figure 1. Impacts and prevalence of unprofessional behaviours. Reproduced with permission from Maben et al. (2023b) [2].

Methodology

Our realist review followed this six-step methodology [3] :

(1) Formulating initial programme theories drawing on informal literature searches.

(2) Performing systematic and purposive searches for grey and peer-reviewed literature on Embase, CINAHL and MEDLINE databases as well as Google and Google Scholar.

(3) Selecting appropriate documents while considering rigour and relevance.

(4) Extracting and synthesising data.

(5) Refining the programme theories by testing the theories against identified literature and with stakeholders.

(6) Developing resources based on programme theories.

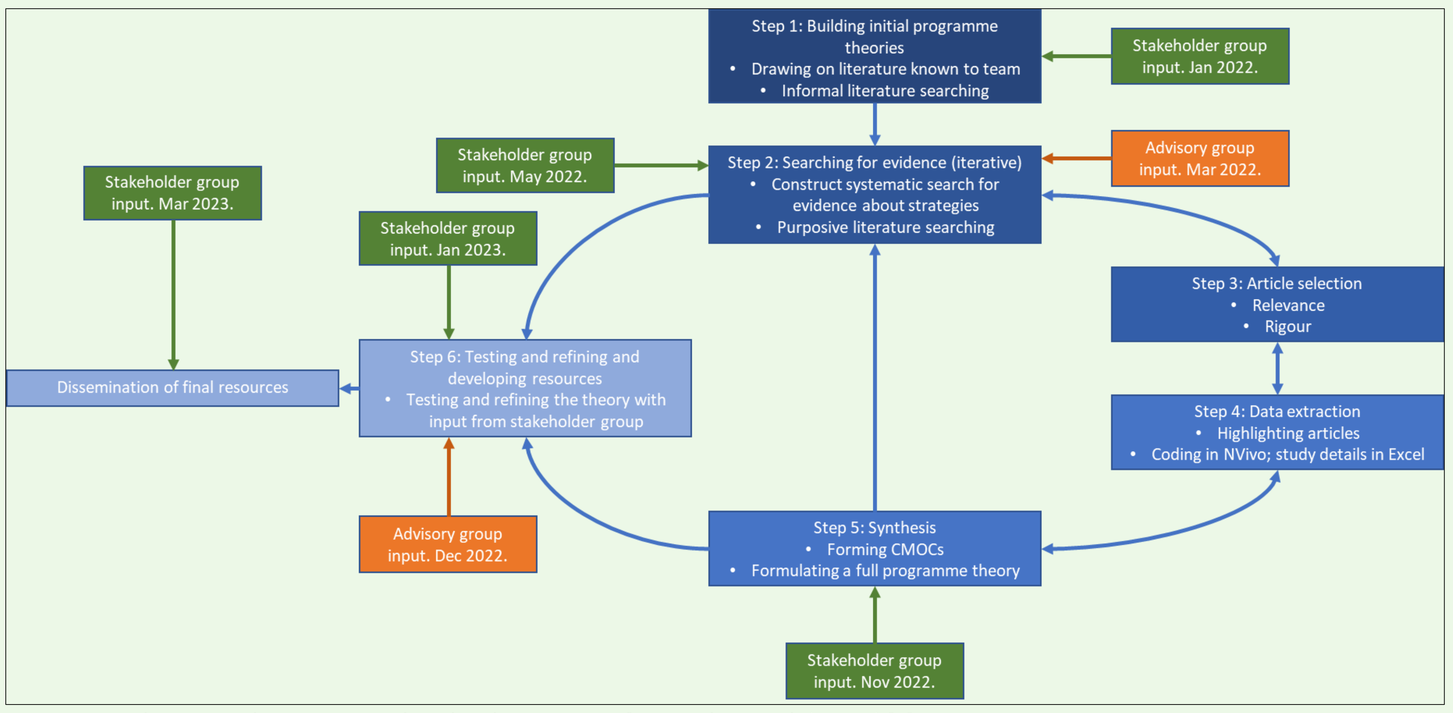

Figure 2. Study process diagram. Reproduced with permission from Maben et al. (2023a) [1].

Results

- **Search results:** from n=2977 records, n=148 full text sources were included with n=42 sources describing interventions.
- **Countries:** thirty were conducted in the USA; five in Australia; two each in Canada and South Korea; and one in Turkey, Ireland, and Iran.
- **Evaluations**: twenty-nine out of 42 studies assessed intervention effectiveness.
- **Effectiveness (reducing UB)**: of these 29, the majority (n = 23) reported some positive results, three reported no significant change and three reported a negative result.
- **Outcome measures:** the most common outcome measure was the change in the prevalence of UB following implementation of the intervention (n = 23).
- Seven studies assessed staff wellbeing or proxies such as turnover intention or burnout
- No studies assessed improvements to patient safety or economic factors.

We identified five major intervention designs:

- Single session (n=13)
- Multi session (n=11)
- Combined sessions with other activities (n=6)
- Professional accountability programmes (n=8)
- Structured culture change programmes (n=4)

And 13 types of behaviour change strategies used across interventions:

- Improving awareness and knowledge
- Improving ability to cope
- Improving confidence to come forward
- Direct approach to instigator
- Social norm-setting
- Improving teamwork
- Workplace redesign
- Improving leadership competence and empathy
- Changing recruitment processes
- Reporting and escalation systems
- Understanding prevalence of UB
- Implementation-aiding strategies
- External pressure on organisations

We found 12 key dynamics that affect intervention success:

1. Address actual systemic contributors to UB
2. Ensure an open culture where staff can address issues informally
3. Ensure how and why an intervention will lead to desired outcomes is clear
4. Enhance psychological safety to improve patient safety
5. Encourage bystander intervention only when safe
6. When adopting an anonymous reporting system, ensure messages are triaged
7. Improve intervention authenticity by ensuring staff believe it can work
8. Reach all staff by using multiple strategies, sustained over a long period of time
9. Include managers in interventions and ensure their behaviour is addressed
10. Ensure no groups of staff feel left behind or singled out
11. Decide between improved fidelity of evaluation, or flexibility of implementation
12. Do something quickly when issues arise, but also draw on theory and best practice

If an intervention is successful

If these dynamics are properly navigated, interventions can have positive outcomes:

Positive Outcomes

- UB is mitigated, reduced, or prevented

LEADING TO:

- Improved patient safety
- Improved staff wellbeing
- Improved resource efficiency
- Improved trust in management

If an intervention is unsuccessful

Negative Outcomes

- UB is not mitigated, reduced, or prevented

LEADING TO:

- Reduced patient safety
- Poor staff wellbeing
- Increased staff turnover
- Reduced resource efficiency
- Further loss of trust in management

Figure 3. Programme theory diagram. Reproduced with permission from Maben et al. (2023a) [1].

Implications

- Most interventions do not address systemic contributors to UB and rely on education or training workshops.
- Interventions that focus on both individual and systemic contributors are required to effectively reduce UB [4].
- It is unclear whether these interventions positively impact organisational culture, patient safety or staff psychological wellbeing.
- Future research should (1) draw on modern behavioural and implementation science principles (2) incorporate economic analyses, (3) focus on systemic issues that produce UB and (4) address the additional burden of UB experienced by women and minoritised staff.

Download our **free evidence-based** guide for addressing unprofessional behaviours

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References:

1. Maben J, Aunger JA, Abrams R, Wright JM, Pearson M, Westbrook JI, et al. Interventions to address unprofessional behaviours between staff in acute care: What works for whom and why? A realist review. BMC Med [Internet]. 2023a;21(403). Available from: https://doi.org/10.1186/s12916-023-03102-3
2. Maben J, Aunger, Justin. A. Abrams, Ruth. Mannion R, Pearson M, Wright JM, Jones, Aled. Westbrook J. Addressing unprofessional behaviours between healthcare staff: A guide. [Internet]. Guildford: University of Surrey; 2023b. p. 1–38. Available from: workforceresearchsurrey.health
3. Pawson R, Greenhalgh T, Harvey G, Walshe K. Realist review - A new method of systematic review designed for complex policy interventions. J Heal Serv Res Policy. 2005;10(SUPPL. 1):21–34.
4. Aunger JA, Abrams R, Mannion R, Westbrook JI, Jones A, Wright JM, et al. How can interventions more directly address drivers of unprofessional behaviour between healthcare staff? BMJ Open Qual [Internet]. 2024 Jul 1;13(3):e002830. Available from: http://bmjopenquality.bmj.com/content/13/3/e002830.abstract