PATIENT SATISFACTION AND LEADERSHIP CHALLENGE IN THE HEALTHCARE INDUSTRY

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CASE DESCRIPTION

This case study describes the challenges faced by healthcare staff and leaders. The delivery of healthcare services is complex as a result of various payors for services and the requirements for each. The healthcare operates as a business framework to effectively manage the rising cost of services and the decreased reimbursement from third party payors. The impact of spiraling healthcare costs on government spending facilitated legislators to create the Patient Protection and Affordable Care Act, shortened to the Affordable Care Act (ACA)[1], in the USA. Health care is responding by catering to patients in order to receive the scores and revenue. The following scenario reveals one example of the struggle healthcare workers face when caring for patients and their family members who are unsatisfied and are aggressive for a multitude of reasons. The case reveals a situation occurring too often in healthcare that will have a significant impact on the workforce in the future unless organizations determine methods to stop unreasonable behavior toward professionals and demonstrate consistent support for staff members. The scenario can be used to discuss the causes of patient and family aggression in order to create action plans for future employees and leadership.

CASE SYNOPSIS

The case involves a nurse, Diane Kare, trying to care for a patient, Mr. Pen, who has been in the hospital for a month and is very ill. Mr. Pen is abusive both verbally and at times physically when Diane Kare attempts to administer medication, take vital signs or position him appropriately to prevent pressure sores. Some of the treatments are not comfortable but the nurse has orders to complete all procedures as deemed necessary by the physician to facilitate healing and prevent additional harm.

CASE BODY

Staff busily prepare for a new admission from another facility. The report received indicates the patient and family have been difficult but staff members are accustomed to such reporting and thus remain objective. Mr. Pen arrives with family members close. The patient is admitted and having difficulty getting settled into the new surroundings even with his wife close by. The night nurse has issues with the patient as he continues to struggle to get out of bed when he clearly is too weak to do so. The family demands the nurse assist the patient out of bed despite the nurse indicating the patient is too weak and it is not safe for the patient or staff member to try to move him. The wife is irate all night despite staff member attempts to keep her calm. The patient finally calms down to rest. The next day, the wife continues to verbally abuse all staff members stating how poor the care is at the hospital and states she has a neighbor who is a nurse and things should be going better for her husband. The wife has also seen recording staff

members with her iPhone as they are caring for her husband. The nurse discusses the case with the physician emphasizing the difficulties all staff members are encountering. The physician rounds later but the wife and patient are very nice to him and voice no complaints to the amazement of the staff members. The physician does not engage the wife to discuss the inappropriate behavior reported by the nurse as they are not aggressive toward him.

The Nurse

Diane Kare RN is a new employee and has been orienting with a nurse employed with the facility ten years. Diane is a service-oriented individual who has a genetic disposition for nursing as her Mother and Grandmother were both nurses. She is excited to assist others on their path to recovery demonstrating high energy and a positive attitude. She did not experience patients who were aggressive during her clinical rotations but is now in a facility with patients who have more extensive issues and remain in the facility for longer time periods. Her training has not prepared her to manage difficult patients and when she seeks assistance from other nurses, they indicate she should just do her work and ignore the continual negativity in the room. Diane is frustrated throughout the shift but does not say anything else about the patient. She finds herself distracted throughout the day leading to less focus on her appropriate patients. She leaves mentally and physically exhausted hoping she is not assigned the same patient the next day.

The Mentor

Sheila Fern RN has worked in the facility for ten years. She is immune to almost every situation as she has seen her share of disrespectful people. She continues to move through all of their complaints with very limited visible compassion. Although she is a highly skilled nurse, she admits to some job burnout but indicates it is not any different for all the others who work there and so does not really discuss any issues with Diane or give her specific guidance other than telling her "*you will get used to it, it is part of our job*". Sheila's method is to avoid any discussion with this family other than the bare minimum attempting not to incite them more. She does enter the room with Diane at one point when the wife is trying to film a procedure to stop the action. The wife then seeks the charge nurse to complain about both Diane and Sheila because they are not caring for her husband appropriately and no one is telling her what is going on.

TEACHING NOTE

This case is based on the authors' professional and consulting experiences and has been modified to be more applicable to a classroom setting. The names and specific details have been changed.

TEACHING METHODS

The following is a sample teaching for a 50-min discussion session in a leadership or healthcare administration course:

1. Distribution of case study & discussion questions-15 min.
2. Discussion on the unique characteristics, the trends, and the challenges of the healthcare industry issues-15 min.

3. Discussion Questions–15 min.
4. Summarize and discuss the answers-5 min.

UNIQUE CHARACTERISTICS OF THE HEALTHCARE INDUSTRY

The following Table 1 lists the aspects of healthcare vastly different compared to other organizations leading to some explanation as to why healthcare is very difficult to manage in the same manner as any other business and requires a synthesis of clinical and non-clinical leadership skills for success. Understanding the daily struggles of clinical staff and managers by all leaders is mandatory to effectively mitigate violence toward the workforce of our valuable life-saving systems (Carmel and Hunter, 1993).

Table 1
Healthcare *vs.* Other Service Industries

Differences
• Customer satisfaction not as valued as in the service industry.
• Inability to automate.
• Conducts business in a specific area.
• Increased labor cost/increased quality.
• Multiple specialized business units.
• Most regulated industry.
• Many involved in purchase, patient, payor, provider.
• Professional association/licensure needs for staff.
• Multiple payors for reimbursement of service.
• Payors passively impact rates of reimbursement.
• Service to those with no funding.

Source: Information for differences in healthcare from Gee (2016), Marcinko (2011), Rosen (2017).

Table 2
REGULATORY AGENCIES FOR HEALTHCARE

Formal	**Informal**
Center for Medicare Services.	HCAPs.
Food and Drug Administration.	No reimbursement for preventable events (Medicare).
Joint Commission.	No reimbursement for readmissions (Medicare).
Medical Societies.	
State Boards for Licensure of Professional Staff.	

Source: Information for regulatory agencies for health care from Gee (2016).

The Table 2 above refers to the myriad of agencies both formal and informal that regulate and direct reimbursement in healthcare compounding the barriers healthcare organizations face to succeed in balancing patient satisfaction, staff satisfaction, and regulatory needs.

DISCUSSION QUESTIONS

Questions

Q1. Why do you think patients and families become so frustrated and unreasonable?

Q2. How do you think leadership can support employees in facilities with patients who are physically and verbally abusive?

Q3. How does the presence of patient and family aggression influence the future of our healthcare workforce?

Discussion of Problems and Proposed Solutions

Q. 1. Patients' dissatisfaction with hospital services is a major indicator for the assessment of healthcare quality. Prior studies identified several factors directly influencing patients' dissatisfaction, including food service, nurses' criteria, and hospital facilities (Rasouli and Zarei, 2015). Iihara et al. (2014) also found that interpersonal relationships with medical staff are highly associated with patient dissatisfaction. In addition, patient expectations were also common in dissatisfied surgical patients (Noble et al., 2006).

The problems in the case are:

- The disconnect in the wife's perception of how care is provided and standard hospital practice.
- The wife's continued complaints throughout the six-week stay of the patient fatiguing all staff members.
- Lack of understanding of healthcare terms and need for procedures by the wife and patient.
- Inconsistent staff response to complaints.
- The lack of comprehensive managerial interaction to stop the behavior as it is not reported by all staff on the floor.

Q. 2. Leadership and clinical staff engagement

- Leaders and staff must collaborate to determine actions plans and procedures to implement to manage incendiary patients.
- Cross-functional agility teams are an option to study the issue in detail by determining why and how often the behavior is occurring, where it occurs in the service quality gap model, identify aspects within the control of the institution and develop specific consistent employee actions for each encounter based on a simple algorithm to train staff members.
- Leadership must support and encourage reporting of all events in order to gain a clear picture of the issue and firmly address immediately through an increased number of objective specialists trained in service recovery while supportive of hospital staff members. Stempniak (2017) reports Mission Health in Asheville, North Carolina developed a response that combines all aspects referred to as the Behavioral Emergency Response Team or Code BERT. The team is activated when staff cannot defuse situations and provides daily rounding by a team member after interventions. The example is a streamlined approach to management of the patients and families but cannot exist without a consistent definition of what is deemed inappropriate by all healthcare workers in order to develop specific actions. The inability to isolate "*inappropriate behavior*" is a direct result of all healthcare workers' handling of interactions differently based on experience, personality, title, level of apathy and tolerance for confrontation. The Table 3 below indicates the incidence of healthcare workplace violence and some typical behaviors.

Table 3
WORKPLACE VIOLENCE IN HEALTHCARE

Incidence 2017	Types
45% of the total reported occurs in Healthcare.	Physical-biting, spitting, scratching, hitting, pushing, throwing urinals other items.
40-75% or healthcare workers report abuse all areas.	Verbal-cursing, yelling.

Source: Cox (2017).

Q. 3. Future implications of patient aggression for the health care workforce

The top companies to work for in this country have a workforce satisfied with the job they provide and the leadership supporting them. Many books and articles have been written to support the notion that a happy workforce translates to happy consumers and overall success. In other industries, the companies are striving to provide the "*wow*" feel good, exceptional experience. However, many tests and procedures involved in the diagnostic and subsequent healing process of the body simply do not "*feel good*". But employees must still be able to enjoy

their job to fulfill their individual purpose and to demand a professional in healthcare to operate as customer service representatives does not support their profession or the overall purpose to heal people. The impact eventually will be increased burn out and an aversion to healthcare due to the difficulty encountered by patients when one is working to only help them.

CONCLUSION

Hospitals are a place for healing and recovery to move forward in one's life. Some patients choose where they go for service based on the need and others are in facilities due to a tragic, unforeseen illness or traumatic injury requiring emergent care. Hospital staff should be tasked to provide quality care but now are forced to operate in a different manner to please customers who have no idea of how the body functions or what is required to heal. Violence does not have a place in the health care system. Diagnoses of dementia, psychiatric conditions, brain injury or medication effects are managed differently and are not included in the violence as reviewed in this writing. We thus should gather data in our facilities based on categories of workplace violence and develop a team who will respond swiftly to issues. Not only will staff morale improve but they will be able to attend to other patients who are grateful for their services and reward them with high satisfaction scores leadership seeks.

ENDNOTE

1. The Affordable Care Act, nicknamed Obama care, went into effect in 2010. Patient satisfaction is included in the quality measures forcing hospitals to maximize patient satisfaction to receive full reimbursement for services

REFERENCES

Bing.com. (2018). *Service quality gap model*. Retrieved from https://www.bing.com/images/ search

Carmel, H., & Hunter, M. (1993). Staff injuries from patient attack: Five year's data. *Bulletin of The American Academy of Psychiatry & The Law, 21*(4), 485-493.

Cox, E. (2017). Violence in the healthcare workplace. *U.S. News Health*. Retrieved from https://health.Usnews .com/health-care/for-better/articles/2017-09-29/violence-in the-health-care-workplace

Gee, T. (2016). *4 ways health care is different from other industries.* Retrieved from https://www.health works collective.com/4-ways-health-care-different/

Iihara, N., Nishio, T., Okura, M., Anzai, H., Kagawa, M., Houchi, H., & Kirino, Y. (2014). Comparing patient dissatisfaction and rational judgment in intentional medication non-adherence versus unintentional non-adherence. *Journal of Clinical Pharmacy and Therapeutics. 39(1), 45-52.*

Marcinko, D.E. (2011). *Recognizing the difference between healthcare and other industries.* Retrieved from https://medicalexecutivepost.com/2011/01/19/recognizing-the-differences-between-healthcare-and-other-industries/

Noble, P.C., Conditt, M.A., Cook, K.F., Mathis, K.B. (2006). The John Insall Award: Patient expectations affect satisfaction with total knee arthroplasty. *Clinical Orthopaedics and Related Research, 452, 35-43.*

Rasouli, O., & Zarei, M.H. *(2015).* Monitoring and reducing patient dissatisfaction: A case study of an Iranian public hospital. *Total Quality Management and Business Excellence, 27(6), 1-29.*

Rosen, P. (2017). The patient as consumer and the measurement of bedside manner. *NEJM Catalyst.* Retrieved from https://catalyst.nejm.org/patient-satisfaction-consumer-measurement-bedside-manner/

Stempniak, M. (2017). Violence in the hospital. Preventing assaults using a clinical approach. *Hospitals and Health Networks.* Retrieved from https://www.hhnmag.com/articles/8306-violence-in-the-hospital-preventing-assaults- using-a-clinical-approach