Chapter 21
Well-Being, Patient Safety and Organizational Change: Quo Vadis?

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This book grew out of the WELLMED Network. WELLMED is devoted to examining the connection between well-being and performance in clinical practice. The WELLMED network conducts research aimed at exploring how burnout and wellbeing are related to different aspects of quality of care and patient safety, in terms of clinical decision making, communication in clinical practice, medical errors, civility at the workplace, and patient neglect. To date, WELLMED has held three international conferences, and this book evolved out of the many conversations between the participants over the three conferences. The aim of the book was to take stock of where the field stands, and signpost future areas for research. To this end, the book has provided comprehensive coverage of the myriad factors that influence the nexus between healthcare worker well-being, patient safety and organizational change. Each chapter provides key messages for researchers and healthcare delivery. Analysis of these recommendations provides us with an appropriate way to delineate the future directions for the field, and answer the call of *Quo Vadis*.

Part I was concerned with linking organizational factors to healthcare worker well-being and patient outcomes. The combined messages for future researchers are to work harder to define constructs more clearly and by doing so allow us to understand the relationship among the key variables. More specifically, the authors in this part identify areas for improvement. O'Connor, Hall and Johnson (2020) note that it is possible burnout is only associated with perceived safety, whereas wellbeing may be more strongly associated with actual safety behaviours. Teoh and Hassard (2020) warn us that there are differences in how these commonly understood constructs (i.e., organisational factors, workers' well-being, patient care) are defined and operationalised, and recommend that researchers should be clearer on how this is done and recognise any corresponding implications. Equally,

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Kirwan and Matthews (2020) argue that observation methods are needed to examine more deeply if the rationing of nursing care is always a result of lack of time or resources or if other explanations are also possible. Finally, Zhou, Panagioti, and Esmail (2020) remind us that whatever interventions we develop there is still a need to undertake international evaluations that will provide evidence regarding their feasibility, acceptability and cost-effectiveness. The authors in this part remind us that while the problems are well established and accepted, there is significant room for improvement in terms of being able to outline a definitive evidence base. The messages regarding healthcare delivery include; a greater emphasis on prevention, the need to acknowledge the links between staffing levels and missed care, an avoidance of locating worker health and occupational safety in different silos, and a greater need to link worker health and patient safety to workforce planning policies.

Part II took a finer grained look at the healthcare context across the globe. The key messages for researchers concerned a more systemic look at work practices and work design. Byrne et al. (2020) advised us that future research should look at work-life boundaries and the relationship between the intensification and extensification of temporal experiences for hospital doctors and the impact this has on their working lives. Isaksson Rø, Rosta, Tyssen, and Bååthe (2020) advocated the use of interactive collaborative research, where researchers could over a prolonged time-horizon collaborate with clinicians and managers, and study how system changes (co-created by clinicians and managers) impact clinician well-being and quality of care, over time. Equally, Van Stolk and Hafner (2020) note that more research is required to identify what human resource management practices are associated with better staff engagement. Governance is considered to be a distal aspect of work design, but as noted by Bringedal, Bærøe, and Teig (2020) future research should explore more closely the scope of how non-clinical factors, such as governing instruments, impact on health care provision. Finally, Jones and Blake (2020) who reviewed the impact of a UK "Freedom to Speak Up Guardian" (FTSUG) role discovered that the UK health system is a need on considerable research on training and guidance related to dealing with bullying and harassment concerns. In terms of healthcare delivery, the aforementioned authors recommend; making work schedules less porous, the need for clinicians and managers need to engage in local system changes, understanding variability in staff engagement scores across departments, acknowledging that accountability can undermine quality of care and more joined-up thinking concerning connections between interpersonal problems and quality/safety failures.

Part III explored how cultural factors are important levers of organizational change. The chapters in this part discussed how the organization of work drives the cultures that we find in different healthcare settings. In terms of key messages for researchers, Rus, Vâjâean, Oțoiu, and Băban (2020) argue that it is important to examine when (i.e., during work and after work) and how (i.e., the mechanisms) different work recovery experiences lead to individual, team and organizational positive outcomes and reduce the negative ones in healthcare settings. Moreover, Van Bogaert, Timmermans, Slootmans, Goossens, and Franck (2020) suggests that studies are needed to understand clinical microsystems' capacity to use feedback

mechanisms in order to learn, adapt and improve their work system. This is similar to the recommendation of West (2020) who suggests there is a need to develop and evaluate primary interventions focused on improving the workplace factors that influence staff stress and wellbeing. De Chant and Shannon (2020) highlight the need for researchers to develop more effective approaches to measuring the cost of burnout beyond turnover, and the return on investment of burnout reduction interventions. Congruently, Krasner and Epstein (2020) note that Mindfulness-Based Interventions vary in so many aspects. Therefore, for them to be compared, a research agenda for assessing efficacy should include a number of standard individual, team and systemic measures. In terms of healthcare delivery, the aforementioned authors recommend; supporting the use of replenishing activities to boost recovery, piloting approaches to enable mentoring styles of leadership, initiate compassionate care approaches from the top down, linking health worker health to population health policies, and designing work practices that increase the opportunities of social connectivity. Overall, the authors in this part advocate for formalizing the informal aspects of work that contribute to better well-being.

Part IV reviewed the potential for individual and organizational interventions to resolve the triple challenge of the book. The key messages for researchers concern the way that interventions are conducted. Gregory, Rothwell, and McAlearney (2020) recommend that we evaluate training programs at multiple levels (e.g., learners' reactions, learning, transfer of training, outcomes/results) and invest in assessing the impact of training on organizational and patient outcomes. Maben and Taylor (2020) suggest that future research could focus on evaluating the impact of rounds on any changes to practice and organisational culture (e.g. annual surveys of ripple effects to capture these often elusive and unreported changes). Adair, Rehder, and Sexton (2020) argue for more rigours measurement in the form of regular assessments (e.g. every 18 months) of well-being using psychometrically valid measures (e.g., emotional exhaustion, burnout climate, work-life balance) that can identify work settings at higher risk for lower engagement and professionalism (e.g., intentions to leave, turnover, disruptive behavior), as well as higher patient safety risks (e.g., infections, medication errors). Equally, Montgomery, Georganta, Gilbeth, Subramaniam, and Morgan (2020) in a review of mindfulness based interventions note that there is a significant lack of follow-up studies concerning the impact of mindfulness based interventions, which represents a significant gap in the knowledge base. Doherty (2020) reminds us that while acts of incivility in the workplace are a key element of stress and lack of engagement for health care workers, the evidence that skills training leads to a significant reduction in these behaviors is yet to be demonstrated. All authors agree on the need for better and valid research, and research designs that allow us to be more confident of recommending policies. In terms of healthcare delivery, the aforementioned authors recommend; training approaches that fits with needs of learners, providing formal and informal spaces for healthcare professionals to share stories, employing methods that allow us to identify and target struggling work units, assessing interventions for acceptability should be mandatory and correctly done, and building on what already works.

The appropriate conclusion to this review is to bring our focus back to the patient. We have accumulated enough evidence to suggest that expecting health professionals to deliver safe, efficient and patient-centered care, while they are getting more and more burnt-out, is not only ineffective but also costly and dangerous (Panagopoulou, Montgomery, & Tsiga, 2015). The authors in the book have provided recommendations as to how we can better integrate the perspective of patients into healthcare delivery and design. Zhou et al. (2020) argue that multicomponent interventions that will monitor and improve the organisational function of primary care and effectively engage health professionals and patients have the most realistic potential for improving workforce wellness. Isaksson Rø et al. (2020) suggest that the only long-term sustainable way to handle budgetary dilemmas is to improve the clinical care processes, i.e. the way people in healthcare work together, to meet the needs of patients. De Chant and Shannon (2020) put the patient experience as central and behooves us to prioritize efforts to design workflows that provide clinicians more time to directly engage with patients and less time engaged with administrative work. West (2020) reminds us that there us a symbiosis between compassionate care for patients and staff in terms of enhancing quality of care. Congruently, Maben & Taylor (2020) remind us that Schwartz rounds has the potential to share stories that can results staff feeling more connected to both colleagues and patients.

As noted by Richards (2019) health systems need to get better at collecting the experience of wide communities of patients and carers and to use this information to inform their decision making. In particular, there is a need to collect information from those who have the worst outcomes, rather than the 'typical' patient (i.e., white, educated, middle class) which the system is skewed towards. The perspective of patients and carers has the potential to be an indicator of organisational wellbeing, in terms of the organisational problems and burnout among healthcare staff. Finally, to paraphrase Nelson Mandela, healthcare (or a Nation) should not be judged by how it treats its highest citizens, but its lowest ones.

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