2-28-2025

Nursing Leaders' Perceptions of a Revised Patient Dismissal Policy

Judi L. Brendle
Walden University

Walden University

College of Nursing

This is to certify that the doctoral study by

Judi Brendle

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Margaret Harvey, Committee Chairperson, Nursing Faculty
Dr. Barbara Niedz, Committee Member, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2025

Executive Summary: Quality Improvement Initiative

Nursing Leaders' Perceptions of a Revised Patient Dismissal Policy

by

Judi L. Brendle

MS, University of Phoenix, 2005

BS, Immaculata University, 2003

Executive Summary Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2025

Summary

Patient aggression related to behavioral health and emotional issues is an ongoing concern in primary health care. Disruptive patient behaviors include a broad spectrum of outward conduct, from verbal violence to physical assault. The focus of the Doctor of Nursing Practice project was a quality improvement project. The purpose encompassed improving the perception of primary care nursing leaders and provider practice leadership by enhancing the current organizational policy on patient dismissal from practices. Analytical strategies included pre- and post-surveys to determine the perception of the nursing supervisors and provider practice leadership.

Survey questions encompassed an understanding of the original policy, risk management involvement, available resources, executive leadership support, and consistent administration across the practices. A two-tailed, homoscedastic *t* test of each question indicates no statistically significant difference between the pre-and postsurvey with *p* values ranging from .088 to .889, all greater than the benchmark *p* value of .05. Changes from the pre-and postsurvey included additional clarifications to the policy, modified exhibits, and new exhibits to provide guidance and resources.

Recommendations include separating the policy into three policies related to no-show appointments, disruptive behavior, and children's vaccinations. Positive social change may be fostered by increasing nursing practice goals to include providing all patients with the support they need, ensuring appropriate dismissal following state regulations, and appropriately using legal resources. Another goal includes promoting the mental health, well-being, and safety of all staff and providers.

Background

The practicum organization continues to experience disruptive behavior among its primary and specialty care practices, with providers and nursing supervisors escalating concerns to the chief quality officer. Addressing disruptive patients decreases the mental and physical health changes, that lead to burnout of employees and increasing safety concerns for all involved (Cannedy et al., 2024). Cannedy et al. (2024) noted that an impact at the organizational level includes decreased quality of healthcare delivery, compromised continuity of care, increased absenteeism of employees and turnover, and reduced job commitment.

In some practices at the organization, patients were dismissed due to foul language, whereas in other practices patients remained after physical contact with a staff member. Differences in how leaders administrated the policy had led to dissatisfaction among employees, nursing leaders, and providers. The evidence-based practice question was, Will standardizing the patient dismissal policy using evidence-based practice improve the satisfaction among the practice manager nursing leaders and managing providers?

I conducted a comprehensive literature review of academic, full-text articles on patient dismissal that were published between 2017 and 2024. The databases utilized were the Cumulative Index of Nursing and Allied Health Literature; the National Library of Medicine's premier bibliographic database, Medline; and Ovid Technologies' OVID. Keywords included *patient dismissal from practice*, *patient discharge from practice*, *disruptive patients*, *threatening patients*, and *adults*. The search yielded approximately 21 articles. After the removal of nine duplicates, 12 articles remained. I reviewed the content

and relevancy of the remaining articles (Barry et al., 2022; Bramer et al., 2018). I retained articles that concerned (a) the dismissals of patients with threatening or disruptive behaviors or (b) interventions that kept healthcare providers and employees safe in practice. I excluded articles whose content was not related to the project focus. The eight selected articles addressed threatening and disruptive behavior criteria, including patient dismissal or maintaining a professional relationship within the practice.

Two articles by Groisser et al. (2022) and O'Malley et al. (2017) rated as Level II evidence and as excellent and good quality by the Johns Hopkins evidence rating model. (Dang et al., 2022). Both researchers noted the number of patients dismissed from the practice related to disruptive and no-show appointments for the continuity of business and the safety of employees. Groisser et al. and O'Malley et al. described resources to assist practices, including security, police, and mental health resources. Three articles by the American Medical Association (2017), the American College of Obstetricians and Gynecologists' Committee on Ethics (2022), and the Council on Ethical and Judicial Affairs (2022) rated as Level IV evidence and of excellent quality. The focus of the articles was on agreeing to terminate the patient–physician relationship with disruptive patients due to the inability to maintain a trusting relationship with aligned health care goals. Level IV evidence articles by Jung and McDowell (2022), Lim et al. (2022), and TDIC Risk Management Staff (2022) rated as excellent or good and aligned with patient dismissal due to the inability to maintain or reestablish a trusting relationship with aligned health care goals. The authors of these articles discussed resources for mental and behavioral health support, grief support, security, law enforcement, and early intervention with risk management.

Project Development

The evaluation's outcome variable was the responses to six Likert survey questions (see Appendix A). Eighty-nine nursing leaders, including practice managers and providers, received an invitation through the REDCap web application survey system used at the organization, which provided de-identified data. Thirty-eight nurse leaders participated in the first survey and 28 in the second. The first survey occurred prior to the implementation of the policy in January 2024, and the second one occurred after approval of the policy and provision of education to all nursing leaders, including practice managers and providers, in July 2024. I performed two-tailed, homoscedastic *t* tests to compare the changes, if any, in nursing leaders' perceptions between Survey 1 (no changes) to Survey 2 (postchanges).

Results

Due to the number of complaints from nursing leadership/practice managers and providers, my project mentor and I found it surprising that so many understood the original policy despite a lack of guidance written within the policy. More surprising was the lack of significant difference in survey responses postimplementation (see Figures 1–6). Nursing leaders indicated that they felt supported by leadership and needed to know when to include risk management, although both elements were included in the policy and workflow (see Appendices B and C).

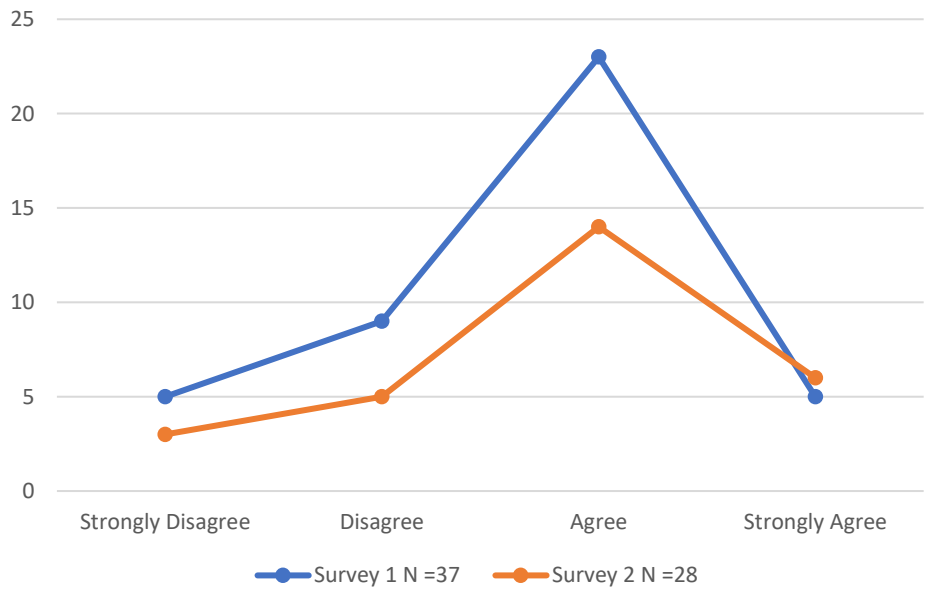
Since introducing the revised policy, the practice site's risk management unit noted a 35% increase in notifications of disruptive patient issues within primary practices. The impact on the organization remains to be seen at this time due to the low rate of disruptive patients and the need to further assess any differences in volume or

discharges. The importance of this project beyond the organization relates to the perceptions of leadership regarding using the policy and the outcomes associated with the policy, which include obtaining a trusting relationship with aligned health care goals. Enhancing or maintaining the process will involve understanding the reasons for the disruptive behavior and determining referrals to other services. The last step embraces dismissing the patient from a practice, which may lead to fragmented care and poor outcomes.

I used a two-tailed, homoscedastic *t* test to compare leaders' perceptions of their understanding of the policy on patient dismissal before the policy change (Survey 1) and after the change (Survey 2). No significant difference occurred between Survey 1 (M = 2.67, SD = 0.818) and Survey 2 (M = 2.73, SD = 0.874). The p value was .799. Figure 1 is a line graph comparing perceived understanding of the policy pre- and postchange.

Figure 1

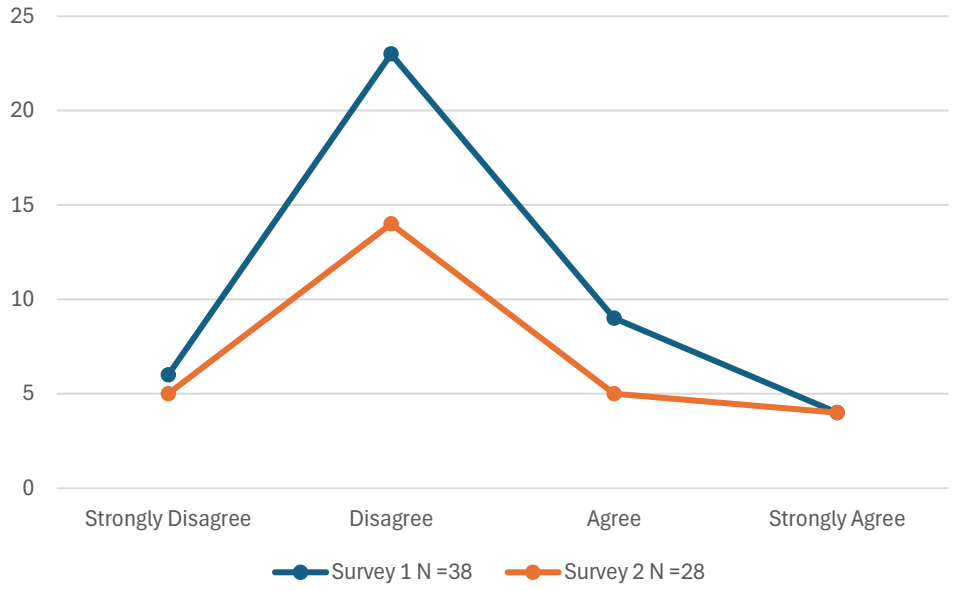
Perceived Understanding of the Patient Dismissal Policy, Pre- and Postchange



I also used a two-tailed, homoscedastic *t* test to compare changes, if any, in perceptions of whether assistance from Risk Management was needed when using the policy. No significant difference occurred in the perception of requiring assistance between Survey 1 (M = 2.31, SD = 0.809) and the new policy indicating when Risk Management is required (M = 2.29, SD = 0.937). The p value was .889. Figure 2 is a line graph comparing the perceived need for assistance pre- and postchange.

Figure 2

Agreement With the Need for Assistance to Apply the Policy, Pre- and Postchange

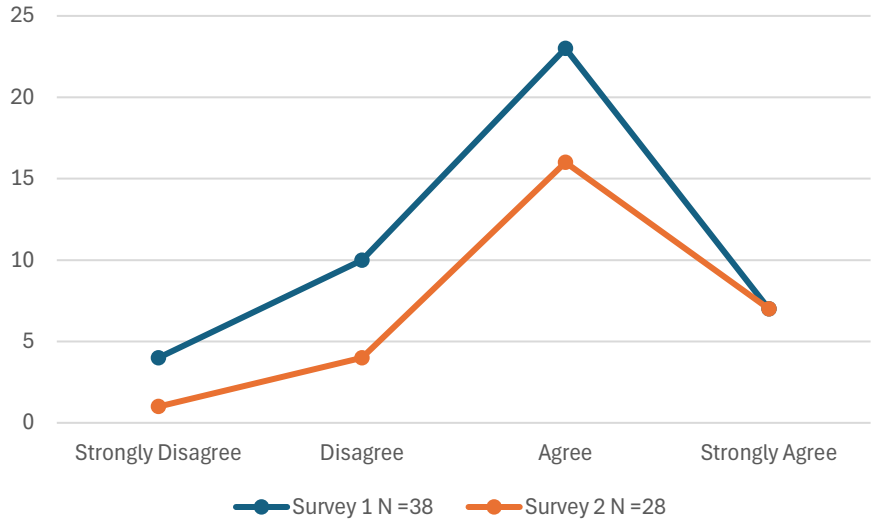


A two-tailed, homoscedastic *t* test was also used to compare any changes in perceived understanding of resources available to staff, leadership, and providers on threatening behaviors. No significant difference occurred in the perception of available resources between Survey 1 (M = 2.76, SD = 0.883) and Survey 2 (M = 3.03, SD =

0.744). The *p* value was .190. Figure 3 is a line graph comparing the perceived understanding of resources pre- and postchange.

Figure 3

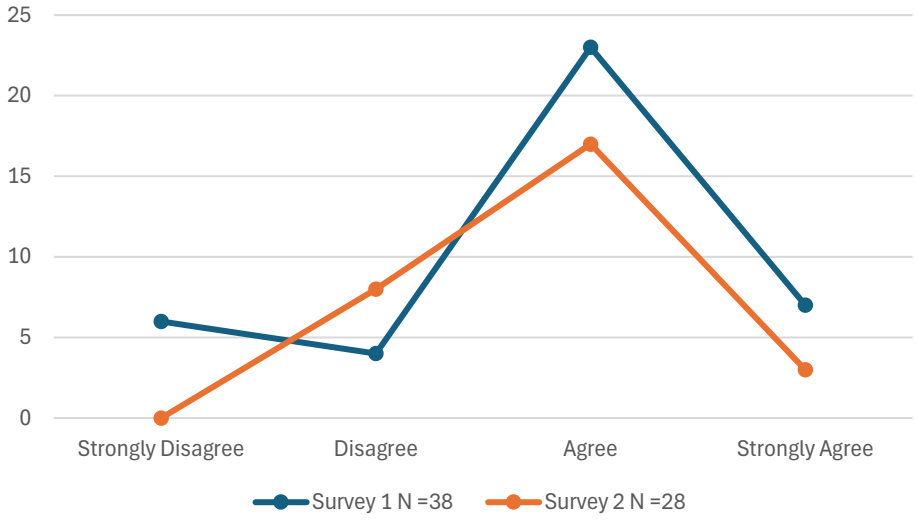
Knowledge of Available Resources for Managing Threatening Patient Behavior, Pre- and Postchange



There was also no significant difference in the perception of being supported by the executive leadership and risk management when using the policy, as shown in Survey 1 (M = 2.71, SD = 0.871) and Survey 2 (M = 3.04, SD = 0.744) data analysis. The *p* value was .118. Figure 4 is a line graph comparing perceived support pre- and postchange.

Figure 4

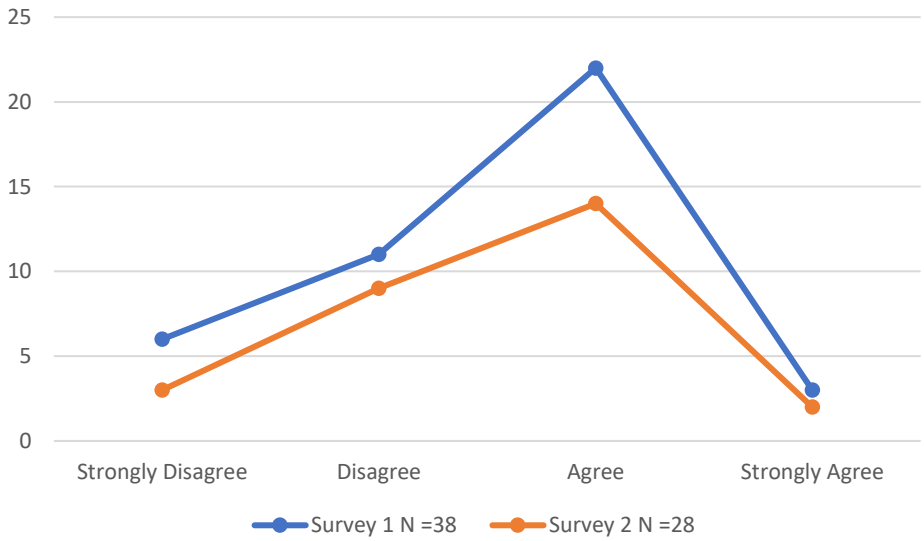
Feelings of Support When Using the Policy, Pre- and Postsurvey



No significant difference occurred in the perception of when to apply the policy, as shown in data analysis for Survey 1 (M = 2.78, SD = 0.802) and Survey 2 (M = 2.82, SD = 0.612); $t(11) = -2.244$, p = .088. Figure 5 is a line graph comparing perceptions of when to apply the policy pre- and postchange.

Figure 5

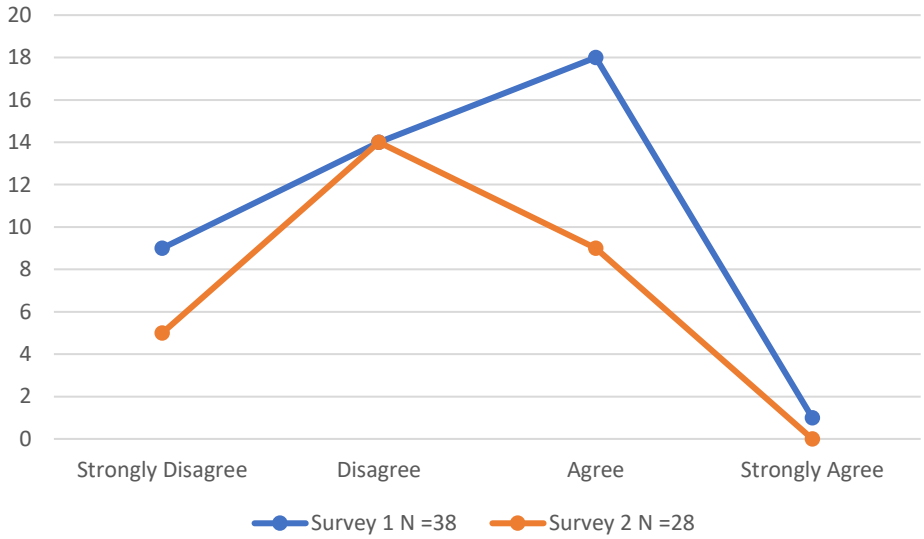
Understanding of When to Apply the Policy, Pre- and Postsurvey



I further sought to compare any changes in perceptions of leadership's consistency in applying the policy from Survey 1 (no changes) to Survey 2 (post changes). No significant difference occurred between Survey 1 (M = 2.48, SD = 0.835) and Survey 2 (M = 2.54, SD = 0.793). The p value was .231. Figure 6 is a line graph of the perceived consistency of leadership pre- and postchange.

Figure 6

Nurses' Perceptions of the Consistency of Policy Implementation, Pre- and Postsurvey



Conclusions

The project provides further clarity on the organization's policy and a workflow summary to assist leadership in administering the policy. The outcome included a revised, voted on, and approved policy. Organizational leaders implemented the policy in June 2024. The results did not significantly differ in the pre-and postsurvey data. Further recommendations include providing a more specific survey calling out the disruptive patient portion of the policy and potentially splitting the document into three separate policies covering dismissal for no-show appointments, disruptive behavior, and refusal to follow the recommended treatment plan. Another recommendation is to have broader case management support and referral use that includes first-time patients. The project has implications for nursing practice and positive social change, diversity, equity, and

inclusion. It highlights the need for health care nursing leaders to understand life events, socioeconomic concerns, and health literacy. With this knowledge, nursing leaders may be able to craft effective policies that prevent disruptive episodes from occurring in health care settings.

References

The American College of Obstetricians and Gynecologists' Committee on Ethics (with Arora, K. S., & Cass, I.). (2022, November 17). *Ethical approach for managing patient–physician conflict and ending the patient–physician relationship* (Committee Statement, No. 3). https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2022/12/ethical-approach-for-managing-patient-physician-conflict-and-ending-the-patient-physician-relationship#

American Medical Association. (2017). *AMA code of ethics.* https://code-medical-ethics.ama-assn.org/ethics-opinions/terminating-patient-physician-relationship

Cannedy, S., McCoy, M., Oishi, K., Canelo, I., Hamilton, A. B., & Olmos-Ochoa, T. T. (2024). Coping with disruptive patients: Perspectives of primary care employees. *Work, 77*(1), 307–315. https://doi.org/10.3233/WOR-230157

Council on Ethical and Judicial Affairs. (2020, November). *Amendment to Opinion 1.2.2: Disruptive Behavior and Discrimination by Patients* (Report 1). American Medical Association. https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/1.2.2%20Discrimination%20and%20Disruptive%20Behavior%20by%20Patients%20--%20background%20reports.pdf

Dang, D., Dearholt, S. L., Bissett, K., Ascenzi, J., & Whalen, M. (2022). *Johns Hopkins evidence-based practice for nurses and healthcare professionals: Models and guidelines* (4th ed.). Sigma Theta Tau International.

Groisser, A. R., Reyes Nieva, H., Ruan, E., Wright, A., & Schiff, G.D. (2022). Terminations in primary care: A retrospective observational study of 16 primary

care clinics. *Journal of General Internal Medicine*, *37*(3), 548–555. https://doi.org/10.1007/s11606-021-06793-7

Jung, S., & McDowell, R. H., (2022). *Abandonment* (PMID 33085432). National Library of Medicine, National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/books/NBK563285/

Lim, M. C., Jeffree, M. S., Saupin, S. S., Giloi, N., & Lukman, K.A. (2022). Workplace violence in healthcare settings: The risk factors, implications, and collaborative preventive measures. *Annals of Medicine and Surgery*, *78*, Article e103727. https://doi.org/10.1016/j.amsu.2022.103727

O'Malley, A. S., Swankoski, K., Peikes, D., Crosson, J., Duda, N., Day, T., & Heitkamp, S. (2017). Patient dismissal by primary care practices. *JAMA International Medicine*, *177*(7), 1048–1050. https://doi.org/10.1001/jamainternmed.2017.1309

TDIC Risk Management Staff. (2022). Patient dismissals: Why, when, and how. *Journal of the California Dental Association*, *50*(6), 371–373. https://doi.org/10.1080/19424396.2022.12220726

Appendix A: Likert Scale Questions

Survey: Involuntary Termination of the Patient/Provider Relationship

I understand the current policy related to patient dismissal.			
Strongly d**isagree** **1**	Disagree 2	Agree 3	Strongly agree 4

I require assistance from risk management when I apply the policy.			
Strongly d**isagree** **1**	Disagree 2	Agree 3	Strongly agree 4

I know what resources are available to me when I, employees or providers experience threatening behavior from a patient.			
Strongly d**isagree** **1**	Disagree 2	Agree 3	Strongly agree 4

When I implement the policy, I feel supported by LGHP Leadership and Risk Management.			
Strongly d**isagree** **1**	Disagree 2	Agree 3	Strongly agree 4

I understand when I should apply this policy, and so do other leaders within LGHP.			
Strongly d**isagree** **1**	Disagree 2	Agree 3	Strongly agree 4

The same way I apply this policy, so do other leaders within LGHP.			
Strongly d**isagree** **1**	Disagree 2	Agree 3	Strongly agree 4

Appendix B: Revised Policy

Disruption, Harassment, Verbal/Written Physical Abuse, Illegal Acts or Other Types of Inappropriate Behavior

1. In cases of theft, forgery, illegal misuse of prescription medications and unsafe, destructive, or disruptive behavior, public slander or misrepresentation, or physical, and verbal abuse of staff and providers, document the details of the instance(s) in the patient's electronic medical record and review (See Exhibit I: *"LGHP Patient Discharge Workflow for Disruptive, Verbal, Written, or Physical Behavior").*
2. Managing physicians (M)P), the practice manager (PM), and Risk Management (RM), should discuss the case particulars and decide jointly if termination of the relationship is justified prior to formal request to terminate from all LGHP primary care practice sites.
3. It is the responsibility of the discharging PM and/or MP to verbally discuss the circumstances with other involved practice leaders and ARM to clarify the potential ramifications if discharge is requested from all LGHP primary care prctice sites. All parties involved, including the Regional Director, must sign off that the patient's actions warrant discharge from all LGHP primary care practice sites.
4. If there are no objections to the patient being dismissed from all LGHP primary care practice sites, refer the case to the LGHP Medical Director for further review. Provide the patient's name, date of birth, gender, address, medical record

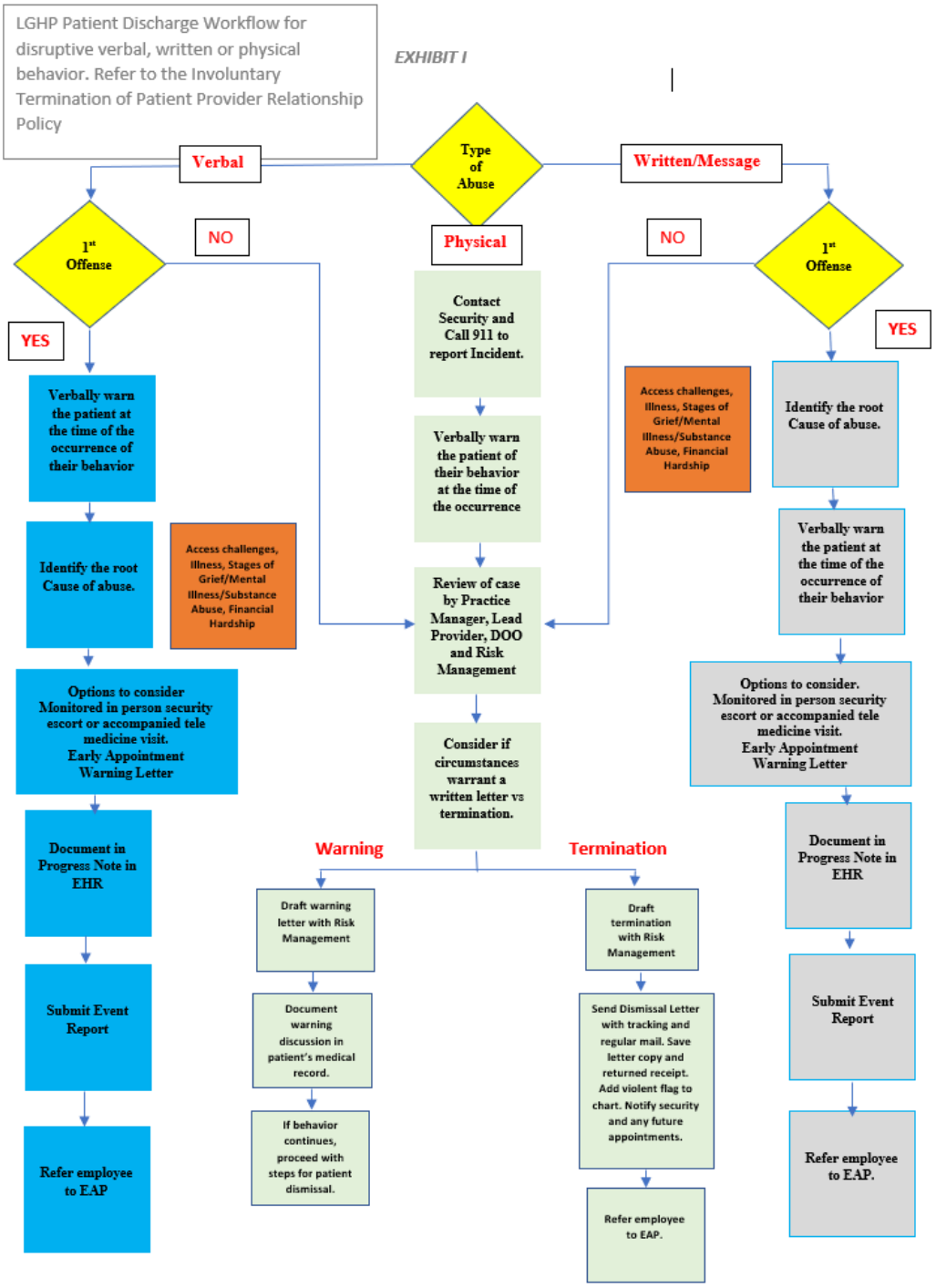
number, anticipated date of termination, and reason for termination using Exhibit D, *"Involuntary Terminating Patient Care Practice Manager Request Form".*

5. LGHP Administration will prepare the final letter, providing sufficient notice for the termination (not less than 45 days) and consider the medical education of the patient. The form letter is Exhibit G, *"Involuntarily Terminating Patient Care from ALL LGHP Primary Care Medicine Sites Patient Notification Letter".* The LGHP Medical Director will sign this letter. LCHP Administration shall send the letter and Primary Care Practice List enclosure to the PM for MP signature.
6. Once the letter is received by the PM, the PM will create an FYI in the patient's EMR advising that the patient is in the process of dismissal and there will be a 45-day period whereby only emergent care or medication renewal will be provided.
7. The discharging practice site will send the written notification to the patient by certified mail (returning receipt requested) and scan Exhibit D, *"Involuntary Terminating Patient Care Practice Manager Request Form"* and Exhibit E, *"Involuntary Terminating Patient Care from a Practice Site Patient Notification Letter"* into the patient's medical record. The discharging practice will cancel all future non-emergent appointments only for that site.
8. Discharge remains valid if a certified letter is returned for any reason. PM at the discharging practice will resend the letter via first class mail and attempt to notifiy the patient via telephone, if possible.
9. The discharging practice will send a letter to the patient's insurance carrier using Exhibit F, *"Insurance Company Notification Letter"*, and enclose a copy of the

patient discharge letter, for PCP reassignment when applicable. Exhibit F will be scanned into the patient's medical record.

10. LGHP Administration will notify appropriate E-Health personnel via Footprints to have discharge information entered into the patient's electronic medical record. Individual sites will be notified of the need to cancel any future non-emergent appointments.
11. Copies of the patient's medical records will be available to their new provider upon receipt of written authorization.

Appendix C: New Policy Exhibit I



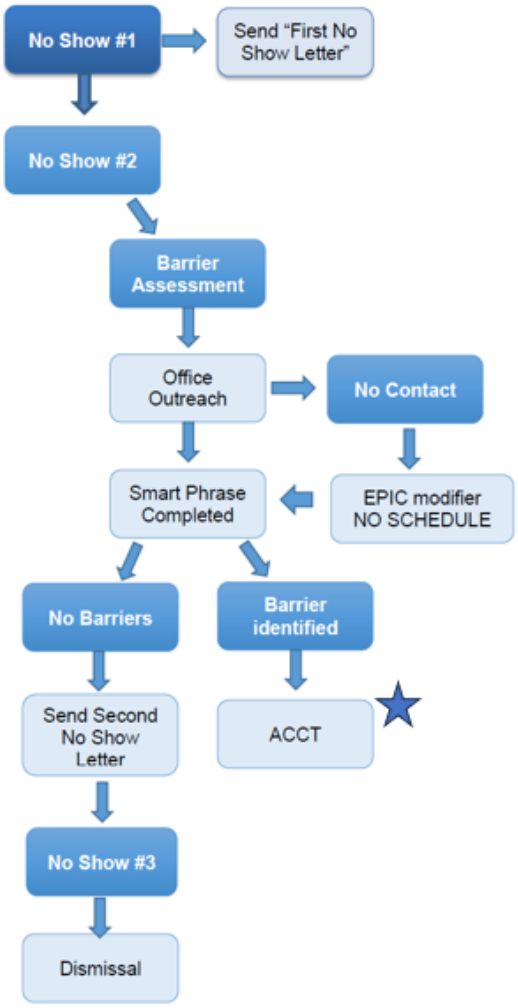
Appendix D: Revised Policy Exhibit J

POLICY TITLE: Involuntary Termination of the Physician/Patient Relationship
DOCUMENT NAME:

EXHIBIT J

Patient Care "No Show" Dismissal Flow Chart

Flexibility is provided to each practice to determine when to initiate and continue the process of dissmisal from the practice due to "No Show Appointments."



★ ACCT only sees patients if they are part of the organization system.