Middle East
Journal of Nursing

FROM THE EDITOR

Abdulrazak Abyad
MD, MPH, AGSF, AFCHS
(Chief Editor)

In this issue a number of papers from the region deal with various issue of interest to the nursing field and the community.

A Case Study looked at Pain Experience among Patients Receiving Cancer Treatment Pain
The author stressed that pain is the most feared symptom found in patients who have malignant tumor, and represents the most feared consequences for patients and their families.

Inadequate management of pain is the result of various issues that include: under treatment by clinicians with insufficient knowledge of pain assessment and therapy; inappropriate concerns about opioid side effects and addiction; a tendency to give lower priority to symptom control than to disease management; patients under-determined purposes of interventions and optimal use of limited in-patient resources. The authors concluded that the violence on mental health staff is prevalent and increasing in the

the psychiatric setting, there are alternative ways to reduce incidence of unsafe violent behavior.

A large group meeting of patients and health team widespread in the majority of Mental hospital is often called "community meetings". The community meeting occurs in inpatients setting as a part of the therapeutic action delivered to clients. The authors ask the question of What is The Purpose of Community Meeting in an Inpatients Psychiatric Unit? Community meeting is a part of milieu program, its a regular meeting in an inpatient unit for all staff and patients on the unit, the duration range from 45 to 60 minutes, it can be held once daily to once weekly. The member of the meeting includes nurses, social workers, occupational therapists and psychiatrics.

The meeting derived from work done in England during World War II. At that time, large number of patients needed care for the treatment of mental illnesses, the treatment are primary guided by psychoanalytic theory and clinical experience, the use of community meeting is classified as " milieu therapy".

A systematic search of the literature published between 2006 and 2012 was undertaken to identify research available on chemotherapy induced nausea and vomiting and quality of life.

This study is aimed at examining the impact of chemotherapy-induced nausea and vomiting on QoL of patients amon gcancer patient. The mixed methods review was conducted using critique quantitative studies prospective. The authors concluded that even if the number of the published studies specifically aimed to evaluate the impact of the chemotherapy-induced nausea and vomiting (CINV) on Quality of life (QL) can be considered high, those showing results that are reliable and helpful to orient the clinical decision are few. Also considering the improvement in antiemetic therapy obtained in the last few years, and the more frequent implementation of reliable antiemetic guidelines, as well as the recent increasing diffusion of lower emetogenic chemotherapies, more research should be performed to obtain results on the impact of CINV on QL useful to orient the choice of antiemetic therapy.

Nurses are communicating between each other and with other health care workers, in order to provide good nursing care for the patients. The authors attempt to describe nurses` experiences of communication during verbal hand-over reporting, on in-patient units. Qualitative, semi-structured open ended interviews carried out with ten participants. Content analysis method is used to analyse the data in this study. The study showed that the hand-over verbal communication experienced between the nurses had many advantages which can be connected with nurses´ satisfaction in providing high quality care and that this reflects positively in patient's satisfaction and safety. The points considered as challenges are related and connected to; miscommunication, misunderstanding, incomplete patient data and language issues. The advantages and challenges shown in the result section of this study are important factors to be taken into consideration, for further research in the area of communication in hand-over reporting. Further research in the field can lead to improved safety and quality of care for patients in hospitals in Saudi Arabia.

A policy analysis paper discussed the effect of smoking on public health. Jordan has a series of smoking control policies that have been established since 1971. However, apparently there are many factors that prevent the actual implementation of smoking control policies in Jordan. The authors reviewed the smoking control policies applied, to demonstrate the efforts that have been spent at the national and at international level to enforce these policies, and discussed the major factors that prevents the actual implementation of the smoking control policies, to assess and analyze the protect public health from smoking dangerous policy in Jordan regarding to (administrative ease, cost and benefit, effectiveness, equity, legality and the political acceptability). The author propose solutions that may enforce smoking control policies to protect Jordanian health from the risk of tobacco smoking.

KNOWLEDGE AND PERCEPTION REGARDING OBJECTIVE STRUCTURED CLINICAL EXAMINATION (OSCE) AND IMPACT OF OSCE WORKSHOP ON NURSE

Firdous Jahan (1)
Mark Norrish (2)
Gina Lim (3)
Othman Vicente (4)
Gracita Ignacio (5)
Aisha Al-Shibli (6)
Khadija Al-Marshudi (7)

(1) Dr Firdous Jahan, Associate Professor/ Head of the Department, Family Medicine Oman Medical College.
(2) Dr Mark Norrish, Associate Professor and Head of Department of Social and Behavioral Medicine, Oman Medical College Sohar
(3) Dr Gina Lim, Tutor, North Batinah Nursing institute Sohar Hospital
(4) Mr. Othman Vicente, Senior. Trainer, North Batinah Nursing institute Sohar Hospital
(5) Mrs. Gracita Ignacio ,Senior Trainer, North Batinah Nursing institute Sohar Hospital
(6) Mrs. Aisha Al-Shibli, Senior trainer, North Batinah Nursing institute Sohar Hospital
(7) Mrs. Khadija Al-Marshudi, Traine,r North Batinah Nursing institute Sohar Hospital

Correspondence:
Dr Firdous Jahan, Associate Professor/ Head of the Department,
Family Medicine Oman Medical College.
Email: firdous@omc.edu.om

Abstract

Objective: To evaluate the knowledge and perception of nurse educators regarding objective structured clinical examination (OSCE) construction and self-assessment of skills implementing OSCE in a workshop. Impact of OSCE workshop on Nurse educators.

Background: Assessment is a powerful driver of student learning: it gives a message to learners about what they should be learning, what the learning organization believes to be important, and how they should go about learning. OSCE is a practical test to assess specific clinical skills. It is a well established method of assessing clinical competence.

Method: A cross sectional descriptive study designed to evaluate the knowledge and perception of nursing educators regarding OSCE at OSCE workshop at North Batinah Nursing Institutes Sohar Hospital Oman. The participants were given reading material and participated in interactive hands-on exercises. Performance was determined by direct observation of participants performing a mock OSCE. Pretests and posttests were conducted to assess change in knowledge.

Result: The participants demonstrated a significant improvement in their mean score of the posttest in comparison to pretest. The participants highly evaluated the workshop and were positive in their future ability to conduct an OSCE.

Conclusion: Adopting an interactive hands-on workshop to train the nursing educators is feasible and appears to be effective. The feedback from participants in the workshop was overwhelmingly positive. This workshop has changed some of the perception of nurse educators regarding the uniformity of OSCE scenarios, teaching audit, demonstration of emergency skills and whether they are time consuming to construct and administer.

Key words: knowledge and perception, OSCE, Nursing educators, self-assessment

Background/Introduction:

Assessment is an integral part of the health care profession. Clinical examination skills are the bridge between the patient's history and the investigations required to make a diagnosis: an 'adjunct to careful, technology-led investigations'[1].

The objective structured clinical examination (OSCE) has become a standard method of assessment in both undergraduate and postgraduate students[2]. OSCE is a practical test to assess specific clinical skills, a well-established method of assessing clinical competence. The OSCE was first introduced in medical education in 1975 by Ronald Harden at the University of Dundee[3-4]. The aim of the OSCE was to assess clinical skills performance. Currently, the OSCE assessments, the administration, logistics and practicalities of running an OSCE are more expensive than traditional examinations[5]. However, this must be set against their reliability, which is far superior to the traditional short case, a versatile multipurpose evaluative tool that can be utilized to assess health care professionals in a clinical setting. It assesses competency, based on objective testing through direct observation[6].

The OSCE style of clinical assessment, given its obvious advantages, especially in terms of objectivity, uniformity and versatility of clinical scenarios that can be assessed, allows evaluation of clinical students at varying levels of training within a relatively short period, over a broad range of skills and issues[7-8].

It is critical to improve faculty and preceptor's ability to facilitate and assess learning and to apply instructional design principles when creating learning and assessment tools, help faculty to more objectively assess student performance by implementing objective structured clinical examinations (OSCE) and validated knowledge assessments[9-10].

This study was done on nursing educators who are participating in the OSCE workshop, to evaluate their knowledge and perception regarding OSCE and to assess pre and post work shop knowledge enhancement with self-assessment.

Method

A cross sectional survey designed to evaluate the knowledge and perception of nursing educators regarding OSCE at OSCE workshop in North Batinah Nursing Institute at Sohar Hospital Sultanate of Oman. All nurse educators from different regions of Oman participating in the workshop and giving consent to participate in study, were included in this study.

Data Collection: Data was collected through self-filled questionnaire by the participant which included demographic characteristics (age, gender, year of practice) and questions regarding knowledge and perception of OSCE construction as well as self-assessment of their own performance. Principal Investigator ensured uniformity, explained the questionnaire objectives to the participant and obtained written consent before collecting the data. Survey instrument was made after literature search was reviewed by and agreed on via several brain storming sessions. Validation of questionnaire on small group (pilot) was also done.

Ethical Considerations: This study proposal was approved by Internal Review Board for ethics of Oman Medical College as well as Ministry of Health Oman.

Workshop description

This workshop was design to train the trainer in OSCE organization and implementation. This workshop aimed to encourage constructive dialogue between health professional educators in the use of OSCE for student learning and assessment, creativity to develop OSCE, encourage a liberation of minds, to meet the challenges of developing and assessment of skills in health professional education and ensures that all the examiners have been prepared to the same standard and fully understand their role. The main objectives were to understand the structure of the OSCE, the roles of the supervisors and the students, list the logistics of setting an OSCE, demonstrate how to construct an OSCE station, and learn how to train a simulated standardized patient.

The workshop emphasized interactive sessions based on working out exercises and hands-on experience in addition to core lecture presentation on OSCE process; validity and reliability of the OSCE stations being used, length of each OSCE station, the range of advanced clinical skills being examined, clinical skills to discern whether the nurse practitioner student can independently assess and perform the task.

Workshop Structure:

The participants were given reading and an information website regarding OSCE and its construction. The program was conducted for a whole day.

After introducing the facilitators and providing a brief description regarding the workshop content, the participants took a pretest. The second activity for this day included Historical Background Application of OSCE in the Foundation Course of Nursing followed by an introduction to the structure, importance, validity and reliability of the OSCE with learners' understanding and importance in nursing education. The participants were given a few OSCE cases to study before they started constructing their own OSCE station of setting an OSCE, including the blueprint, inventory, and venue preparation.

The participants were divided into groups of two or three. Each group was asked to write a short case station that included the information for students (aim, data, and task/s), the scoring sheet for the supervisor

	Program Activities	Duration
1	Welcome note, orientation and pre-test	30 minutes
2	Overview of the Training Workshop and its Objectives	30 minutes
3	Historical Background Application of OSCE in the Foundation Course of Nursing	30 minutes
4	Learners understanding of OSCE	30 minutes
5	Importance of OSCE in Nursing education	30 minutes
6	Constructing stations and logistics	1 hour
7	Test the station: Preparation, training the simulator patient, being a candidate and supervisor	2 hours
8	Feedback on stations: Get feedback from learner and give feedback to candidate	30 minutes
9	Evaluation : Post -test and workshop evaluation	30 minutes

and materials required/ the scenario for the standardized patient. Each group shared the prepared case with the others. All the participants commented on the case and agreed on the final material. At the end of the session, the participants prepared the blueprint and inventory for the cases they constructed. These stations were used as the hands-on experience of the OSCE.

The last segment was the demonstrating of what had been learned and observed in previous sessions. The participants were involved in preparing the stage for five OSCE stations. The participants were divided into groups of two. Standardized patients were available for each group to train. Then a real OSCE was performed. Each member of the group acted alternatively as a supervisor and as a student.

After that, participants met to receive feedback from the standardized patients and to provide each other with feedback regarding the process of OSCE from the perspectives of students and supervisors as well as the possible amendments to be done to the station write-ups.

The final activity was evaluating the workshop and completing a posttest.

During the evaluation session, the participants were encouraged to report any development related to future implementation of the OSCE in their universities.

Evaluation

Participants were asked to complete an anonymous satisfaction survey. Participants elicited their opinion on a 5-point Likert scale (1=Poor, 5=Excellent) to assess the quality of teaching material, facilitators' knowledge and skills, value of hands-on experience, quality of syllabus/handout, overall course evaluation, and their ability to conduct an OSCE.

Data Analysis

Data were analyzed using the Statistical Package for Social Science (SPSS version 18). The obtained data were coded, analyzed, and tabulated. Descriptive analysis, including frequencies, was performed, and the paired sample t test with a 95% confidence interval was used to compare means and test for statistical significance.

Result

The response rate was 75%, out of 36 participants 28 completed the pre and posttest with feedback.

Paired sample t-tests were done on the 10 questions that were asked to participants before and after the workshop.

While all the responses are generally favorable, with average scores for all question (pre and post) being above the mid-likert point, there were significant pre-post differences for 3 of the questions.

It is clear that the views of participants on whether OSCE scenarios are uniform (q4), whether they allow for teaching audit and for demonstration of emergency skills (q5), and whether they are time consuming to construct and administer (q7) have changed as a result of this workshop. For all three of these items there a significant increase in the level of agreement following the workshop.

Feedback

The feedback from participants in the workshop was overwhelmingly positive. With all median value either 'agreeing' or 'strongly agreeing'. Figure 2 shows the average of the feedback for each question (with standard error displayed).

Result

Gender	n (%)
Male	7
Female	21
Age Mean	
34.57	
Years of practice	
0-5	4
5-10	8
>10	13
Designation	
Staff Nurse	9
Nurse Manager/Executive	1
Tutor/Lecturer	8
Clinical instructor	8
Other	2
Specialty	
trauma/emergency	3
critical care	1
adult medicine	10
pediatrics	3
surgery	2
other	9

Discussion

There is a growing international interest in teaching clinical skills in nursing education. OSCE is a form of performance-based testing used to measure candidates' clinical competence. It is designed to test clinical skill performance and competence in skills such as communication, clinical examination, medical procedures , prescription, and interpretation of results The workshop aimed to encourage the nurse educators to construct OSCE for student learning and assessment and to encourage creativity to develop OSCE. Expert-delivered workshops improves the ability to implement assessment approaches when compared to self-study alone[11].

Our study group in the workshop has shown great enthusiasm and improvement in knowledge. The context, educational tools, and collective motivation to learn and suggested the approach as a feasible and effective strategy for disseminating and incorporating medical teaching.

Our study has shown a significant improvement in posttest scores, signifying better knowledge about OSCE and its implementation.

Literature supports the utility of OSCE as a reliable tool for assessment and this should be used as choice for clinical skills assessment[12].

In the workshop trainers learnt how to construct the OSCE and few concepts were cleared after the workshop. It is evident that it should be applied carefully to get maximum benefit[13].

The participants exhibited a significant improvement in the mean score of the posttest delivered at the end of the workshop as compared to the mean of pretest. OSCE can be used as an assessment tool for formative and summative assessment, as a resource for learning, as a basis for abbreviated versions of physical examination assessments and to identify gaps and weaknesses in clinical skills [14-15]

There was significant knowledge improvement in posttest on the question about the scenarios are uniform for all candidates, OSCE allow for teaching audit and for demonstration of emergency skills and OSCE is time consuming to construct and administer. There are various evidence based information that multiple and emergency skills can be evaluated in OSCE [16-17]. Many studies have shown that trainer workshops are an effective training tool for continued medical education among health care professionals in several fields of education .This methodology allowed the participants to apply the learned material through discussion with the facilitators and granted them the opportunity to ask questions for any further clarifications [18-19]. Our workshop participants showed appropriate posttest knowledge, some of the theme was cleared after the workshop. It is imperative to train the trainer to get the maximum benefits and appropriate health care delivery[20-21].

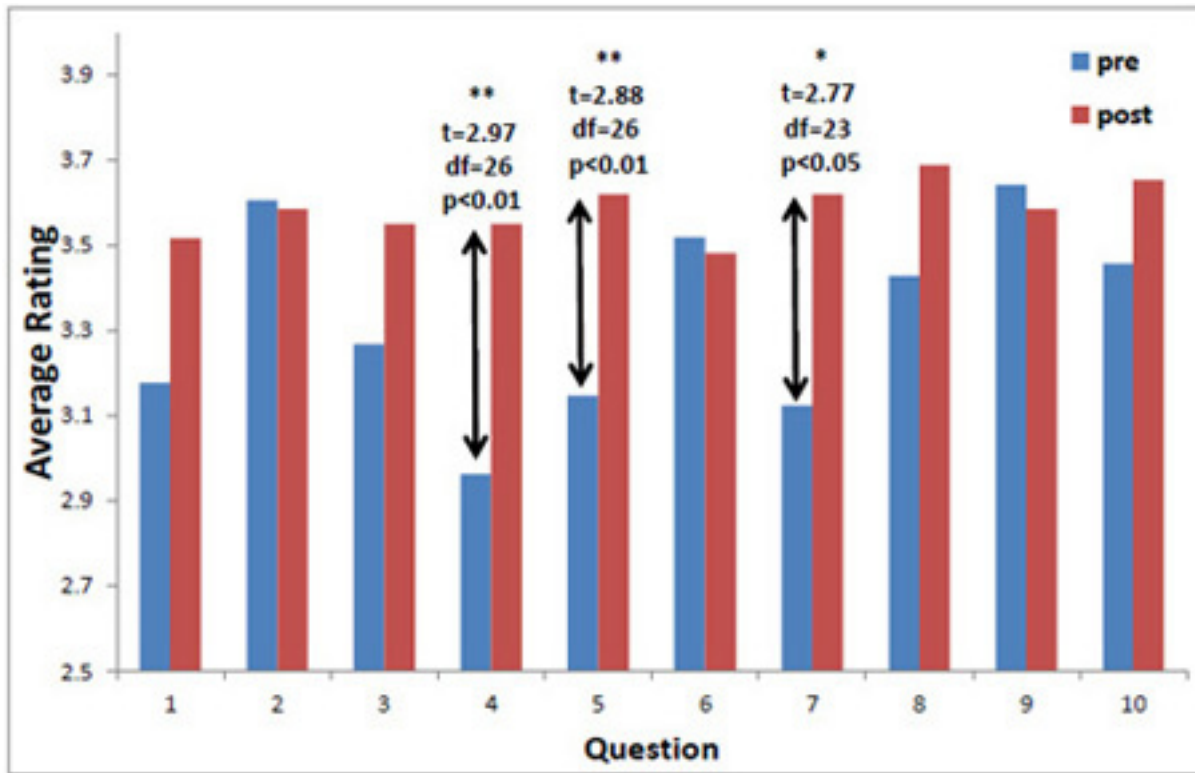The overall evaluation of the workshop was over whelming positive. The majority of participants

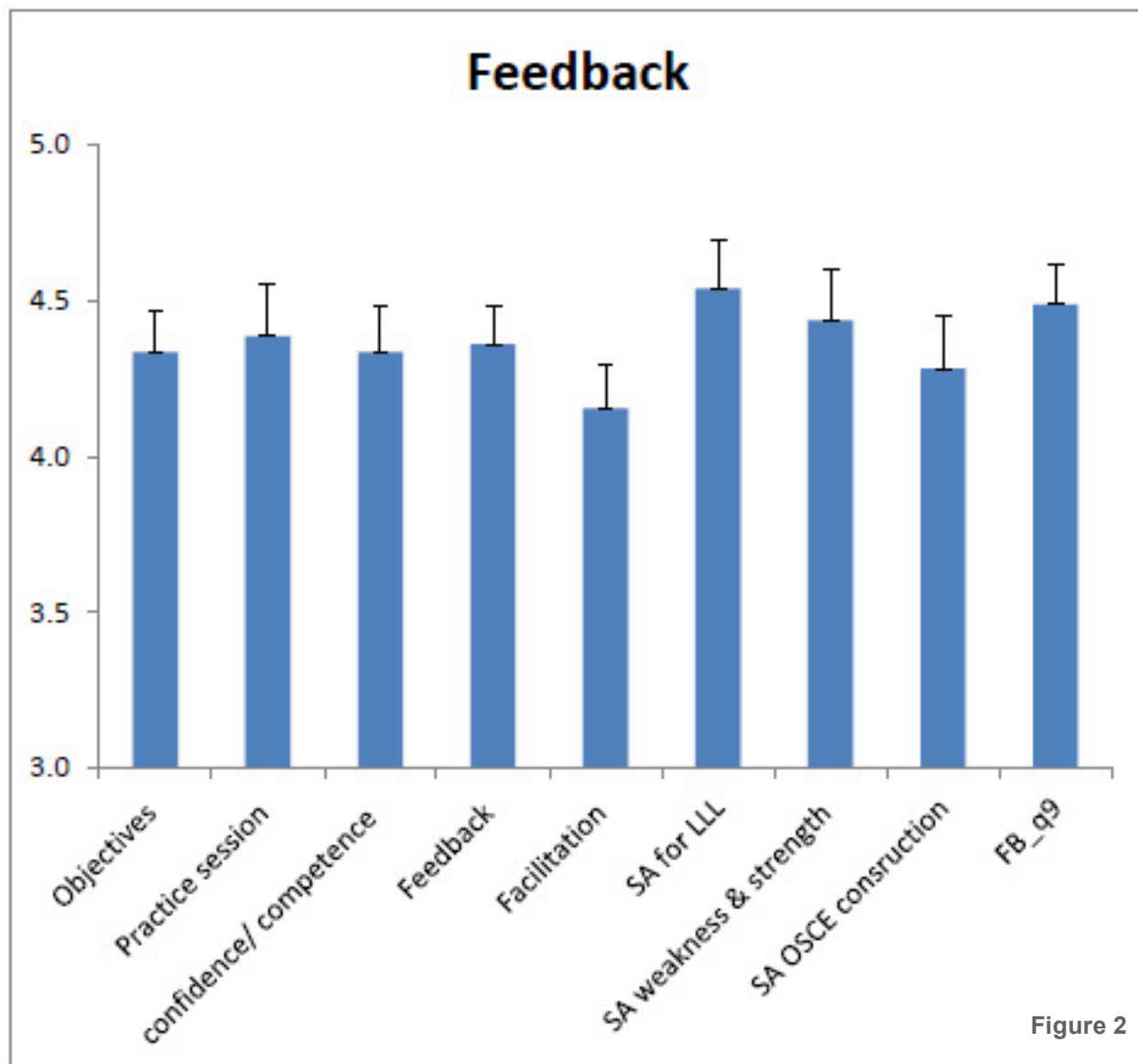**Figure 1: Distribution of Response Pre and Posttest**

Figure 2

Feedback	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	Mode
Objectives of this workshop was clear and achieved	0	2.5	7.5	42.5	45	Strongly Agree
Quality/Practice session with feedback helped in learning	0	7.5	5	27.5	57.5	Strongly Agree
This workshop increased your level of confidence/ competence in constructing OSCE	0	2.5	12.5	32.5	50	Strongly Agree
Feedback was constructive for each group presentation	0	2.5	2.5	50	42.5	Agree
Facilitation of work shop was appropriately done	0	5	7.5	52.5	32.5	Agree
Self-assessment is important mechanism for lifelong learning and self-improvement	2.5	2.5	0	27.5	65	Strongly Agree
Self-Assessment identifies your weakness and strength	2.5	2.5	2.5	32.5	57.5	Strongly Agree
Self-assessment of skills in constructing OSCE	2.5	2.5	7.5	37.5	47.5	Strongly Agree
OVERALL	0	0	10	30	57.5	Strongly Agree

rated all the items between agree and strongly agree. Most of the nurse educators were confident in quality and practice session which helped them learning, applicability of the OSCE test in terms of planning, organizing, and designing stations as a clinically useful new idea. In the simulation the trainers were very excited and felt how the simulators feel when they are examined by the students[22]. Their self-assessment was appropriate and honest and majority agreed this is important for lifelong learning which identify your strength and weaknesses[23].

In our workshop, the participants had the opportunity to demonstrate their knowledge and skills by conducting a real OSCE. Benefit was noted during the practical application of the training and the ability to apply theoretical principles acquired early on in the workshop. Workshop participants were positive concerning their ability to conduct an OSCE in the future[24].

Besides providing learning skills and principles, clinical educators need to develop sound evaluation of what they teach. This workshop was conducted to help participants become trainers who can effectively assess clinical skills of their students and consequently single out any gaps in education. The positive attitude toward adopting OSCE was observed and was reassuring as more than two thirds were inclined to conduct the OSCE in the future.

Conclusions

Implementing to train the nurse educators workshops may be a feasible and effective way to enhance one's knowledge and skills in conducting OSCE. It would be reasonable to adopt an interactive, hands-on, exercise-rich methodology to implement such workshops, and our study serves as a guide in this respect. We suggest conducting a follow-up workshop to explore barriers and feedback from the participants' implementation.

References

1. Miller G. The assessment of clinical skills/competence/performance. Academic Medicine 1990;65(Suppl. 9):S63–S67.

2. Ahuja, J. OSCE: A Guide for Students, Part 1. Practice Nurse2009, 37(1), 37 – 39.

3. Harden RM, Stevenson M, Downie WW, Wilson GM. Assessment of clinical competence using objective structured examination. Br Med J 1975 Feb;1(5955):447-451.

4. Harden RM, Gleeson FA. Assessment of clinical competence using an objective structured clinical examination (OSCE). Med Educ 1979 Jan;13(1):41-54.

5. Calman L, Watson R, Norman N, Redfern S, Murrels T. Assessing practice of student nurses: methods, preparation of assessors and student views. Journal of Advanced Nursing. 2002;38:516–523

6. Wass V, van der Vleuten C, Shatzer J, Jones R. Assessment of clinical competence. The Lancet 2001;357:945–949.

7. Bujack L, McMillan M, Dwyer J, Hazleton M. Assessing comprehensive nursing performance: the objective structured clinical assessment (OSCA). Part 1: development of the Assessment Strategy. Nurse Education Today 1991;11:179–184

8. Bujack L, McMillan M, Dwyer J, Hazleton M. Assessing comprehensive nursing performance: the objective structured clinical assessment (OSCA). Part 2: report of the Evaluation Project. Nurse Education Today 1991;11:248–255

9. Kurz, J.M., Mohoney, K., Plank, L.M., & Lidicker, J. Objective Structured Clinical Examination And advanced Practice Nursing Students. Journal of Professional Nursing 2009; 25(3):186-191.

10. Bell-Scriber MJ, Morton AM. Clinical instruction: train the trainer. Nurse Educ 2009; 34(2):84-7.

11. Harden RM. Twelve tips for organizing an Objective Structured Clinical Examination (OSCE). Med Teach 1990;12(3-4):259-264

12. Marliyya Zayyan. Objective Structured Clinical Examination: The Assessment of Choice. Oman Med J. 2011 July; 26(4): 219–222.

13. Helen E. Rushforth. Objective structured clinical examination (OSCE): Review of literature and implications for nursing education. Nurse Education Today July 2007 ; 27(5):481-490.

14. Khattab Ahamed D, Rawlings Barry. Assessing nurse practitioner students using a modified objective structured clinical examination (OSCE) Nurse Education Today October 2001; 21(7): 541-550.

15. Ross M, Carroll G, Knight J, Chamberlain M, Fothergill-Bourbonnais F, Linton J. Using the OSCE to measure clinical skills performance in nursing. Journal of Advanced Nursing. 1988;13:45–56.

16. Bartfay W, Rombough R, Howse E, Leblanc R. The OSCE approach in nursing education. Canadian Nurse. 2004;100(3):18–23

17. Borbasi S, Koop A. The objective structured clinical examination: its application in nursing education. The Australian Journal of Advanced Nursing 1993;11(2):33–40.

18. Lara H,El-Khoury, Basem S, Umayya M, Jumana A. Impact of a 3 days OSCE workshop on Iraqi Physicians. Family Medicine Oct 2012;44(9):627-632.

19. Tanabe P, Stevenson A, Decastro L, et al. Evaluation of a train-the-trainer workshop on sickle cell disease for ED providers. J Emerg Nurs 2011;Sept 19.

20. Newble D. Techniques for measuring clinical competence: objective structured clinical examinations. Medical Education. 2004;38:199–203

21. Levine SA, Brett B, Robinson BE, et al. Practicing physician education in geriatrics: lessons learned from a train-the-trainer model. J Am Geriatr Soc 2007;55(8):1281-6.

22. Alinier G. Nursing students' and lecturers' perspectives of objective structured clinical examination incorporating simulation. Nurse Education Today. 2003;23:419–426. Hodges B. OSCE! Variations on a theme by Harden. Med Educ 2003. Dec;37(12):1134-1140.

23. Eva KW, Regehr G. Knowing when to look it up: A new conception of self-assessment ability. Academic Medicine. 2007; 82(10 suppl):S81-S84.

24. Mattheos N, Nattestad A, Falk-Nilsson E, Attström R. The interactive examination: Assessing students' self-assessment ability. Medical Education. 2004;38(4):378-389.

25. Roberts J, Brown B. Testing the OSCE: a reliable measurement of clinical nursing skills. The Canadian Journal of Nursing Research 1990;22(1):51–59

26. Cazzell M, Rodriguez A. Qualitative analysis of student beliefs and attitudes after an objective structured clinical evaluation: implications for affective domain learning in undergraduate nursing education. J Nurs Educ. 2011 Dec;50(12):711-4.

27. Watson,R, Stimpson, Topping, A, Porock, D.. Clinical Competence assessment in Nursing: A System review of the literature. Integrative Literature Reviews and Meta-Analyses 2002; 39(5), 421 – 431

ADMISSION POLICY ANALYSIS IN PRINCESS BASMA HOSPITAL

Asem Ahmed Abdalrahim

Correspondence:
Asem Ahmed Abdalrahim, RN, MSN
Lecturer- Faculty of Nursing
Hashemite University
Phone: +962796328487
Email: asemalhmoud@yahoo.com

Admission Policy Analysis in Princess Basma Hospital

Being admitted to hospital may be a stressful, if not frightening experience for any individual (Protocol on Admission to Hospital in Shetland, 2004). The purpose of the current paper is to use a systematic method and analytical approach to analyze the admission policy in Princess Basma Hospital and to develop the best solutions for the problems that are identified in the policy based on a pre established criteria. The policy analysis will include six steps policy analysis criteria, as the following steps: Verifying, defining and detailing the problem, establishing evaluation criteria, identifying alternative policies, Assessing alternative policies, displaying and distinguishing among alternatives, and implementing, monitoring, and evaluating the policy.

1. Verifying, Defining and Detailing the Problem

The basic problem in the admission policy of Princess Basma Hospital is related to the patient's safety and feeling of being secure. Although the admission policy in the Princess Basma Hospital mentioned that its major purpose is to admit the patient in an easy and safe way, the safety precautions were not mentioned clearly. The extent of safety problems identified in the policy includes psychological and physical aspects.

Before explaining these aspects, it is important to mention that all admitted patients to Princess Basma Hospital must be provided with standard precautions and information to achieve feeling of being secure in the environment. However, some deficits in the current policy may hinder patients from feeling secure in the environment. For example, any newly admitted patients will be advised to report directly to the main reception. The patient will be directed by the receptionist to the relevant ward. If the patient is unfamiliar with the hospital or requires any other assistance, the receptionist will make arrangements to assist the patient to the relevant ward area (Protocol on Admission to Hospital in Shetland, 2004). Then, a member of the ward team will meet and greet the patient and take them to their allocated bed. The process on each ward will vary according to ward philosophy and workload, but the following principles will be always applied when admitting patients: such as introducing fellow patients; patient's doctor will be informed of his/her arrival on the ward, promoting prompt assessment, clinical examination and the ordering of any relevant tests; and orienting to the local environment, persons, and procedures including toilets, washing facilities, nurse call bell system, time of food, taking of details by health care professionals, routine observations, blood test, visiting times, introduce the patient to others in the ward, introducing to health care professionals by name and title

e.g. doctor, nurse (Protocol on Admission to Hospital in Shetland, 2004).

Therefore, applying these steps during admission will make the patient feel safe in the environment. In addition, hospitals are responsible for ensuring that appropriate procedures and records are maintained to facilitate accurate reporting, and to justify the admission (Victorian Hospital Admission Policy, 2011).

Patients may have fear from an unknown future because the policy did not mention an approximate length of time they can expect to stay in the hospital. Furthermore, patients are not involved in their plan of care or informed of their progress. Therefore, these may hinder patients from feeling secure in the hospital environment (Protocol on Admission to Hospital in Shetland, 2004).

In addition, the identification of the patient is not mentioned. Other admission policies for example, Peterborough and Stamford Hospitals (2008) mentioned that all admitted patients or those undergoing treatment must have 1 wrist band detailing the following: Full name, date of birth and patient number. Moreover, Protocol on Admission to Hospital in Shetland, (2004) specified that wrist bands must be in specific colors such as red, for example, if the patient was reported to have an allergy. However, the policy in the Princess Basma Hospital does not include that, and patients are still up till now without wrist band for identification. This will cause serious challenges in emergency situations especially if the health care professionals need to response quickly for an urgent situation such as patient loss of consciousness if the health care professional does not remember the name of the patient to follow instructions in patients file.

Protocol on Admission to Hospital in Shetland (2004) cited that patients need to understand that family and carers have the opportunity to interact and support the patient during admission and prior to discharge, inclusive of participation in the leave and discharge by planning processes with the consent of the patient to feel safe and secure in the environment. In addition, the clients and recognized carers should have the opportunity to discuss any issues encountered during admission and as part of the discharge. They can also share the planning process with their treating medical officer and members of the treating team. The admission policy in Princess Basma Hospital did not provide any data about that and focused mainly on the process of admission.

As identified by the previous discussion, our objectives in the following analysis will focus on admitting the patient in an easy and safe way by working to provide the least restrictive environment that supports patients to feel safe and secure during admission. This will be achieved by using a more client-centered approach in addition to providing the most effective inpatient treatment and care. These objectives are consistent with the general purposes of Princess Basma Hospital admission policy.

It is very important for patients to feel secure and safe during the admission into any .health facility. This will keep the patient calm, relaxed and decrease the risk of other harm such as violence toward health care professionals and other patients. However, our major concern is including actions that aim to enhance patients feeling of being secure. This concern is usually expected by patients and their families in addition to health care providers because they know that the patient will experience a lot of stressors during admission and need to feel secure and safe. This can be achieved by adding some aspects in the admission policy such as all patients are treated as individuals

and that their needs are met in a manner that recognizes this; all patients, and where appropriate their relatives and carers, are involved in planning their care from the moment they are admitted to hospital; the admission process is as quick and efficient as possible; the importance of early planning to facilitate a smooth discharge is recognized, therefore this process will begin as soon as practical after admission; an immediate explanation is offered for any delays that occur during the admission process, and that all possible steps will be taken to rectify the situation; and any concerns patients and, where appropriate relatives and carers have regarding the progress of their admission will be listened to where appropriate, and action will be taken to address these concerns (Protocol on Admission to Hospital in Shetland, 2004).

Patients and their families have less power than the health care providers to achieve the expected outcomes related to patients' feeling of safety and security during admission. This is because health care providers have some legal authority related to their position.

Estimation of resources needed to solve the problems that have been explained previously reveals that we mainly need human resources. The human resources include the chief nurse executive who is working on the policy to identify the limitations related to patient's safety and modifying or adding the new suggestions to the current policy, and the nurses who are responsible for applying the policy and evaluating the outcomes.

2. Establishing Evaluation Criteria
The major goal for the current policy is to admit the patient in an easy and safe way. The policy has not included explanations for the method in which outcomes will be measured and evaluated. However, the effectiveness of the current policy to achieve the expected outcomes was measured by two major criteria; the

content of the policy, and reports of patients, families, and health care providers.

The first criterion focused on the content of the policy. The content of the current admission policy didn't include many actions that are needed to admit patients safely and make patients feel secure in the environment, such as orientation to the local environment, persons and procedures, including toilets, washing facilities, nurse call bell system, time of food, taking of details by health care professionals, routine observations, blood test, visiting times, introducing the patient to others in the ward, introduction to health care professionals by name and title e.g. doctor, nurse, presence of identification band and mentioning to the patient an approximate length of time they can expect to stay in hospital.

The second criterion focused on the reports of patients, families, and health care providers. Most reports of patients, families, and health care providers either by their verbalization or objective assessment, mentioned that the patients aren't satisfied about the current policy for feeling safe and secure in the environment.

As the policy has a major goal to admit the patients in an easy and safe way, the desirable outcomes of applying the current policy are to provide safety for patients, satisfy feelings of being safe and secure in the environment, and using the least restrictive approaches to achieve these outcomes as reported by patients, families, and health care providers.

The most important criterion is the effectiveness of achieving the desired goals appropriately. Other important criteria include administrative ease of the policy. This can be measured by using solutions that do not require more new structures, staff, or other resources. Cost is another important criterion; this can be measured by identifying the cost of implementing solutions on taxpayers, such as the

cost of implementing solutions in the term of staff, equipment, operating expenses, benefits paid.

In addition to the previously mentioned criteria, other criteria include the net benefits, equity, legality, and political acceptability. Net benefit is the benefits that can be achieved if compared with the costs, equity refers to the distribution of the benefits equally on the service users, legality includes the presence of authority to implement the proposed solution, and political acceptability refers to being the proposed solution acceptable to political leaders or popular among general citizens.

3. Identify alternative policies

To identify alternative policies, brainstorming and obtaining solutions using alternative policies developed by experts, were used. However, considering the status quo or no-action alternative, was applied.

The first option to stay with the status quo or no-action alternative. This option includes leaving the current policy free from any additional instructions that enhance patients' ability to feel safe and secure in the environment.

The second option is including specific actions in the policy that enhance patients' ability to feel safe and secure in the environment. This option is derived from Protocol on Admission to Hospital in Shetland (2004) which included specific instructions, for example:

• Each patient arriving at the hospital must be greeted by a member of staff who must introduce themselves by name and title e.g. doctor, nurse. An outline of the admission process must be described. The name of the doctor under whom the patient has been admitted must be given and details of any routine procedures, i.e. taking of details, routine observations, blood test, must be explained.

• The patient must be orientated to the local environment including toilets, washing facilities and nurse call bell system.

• On arrival to the allocated bed, it must be considered if it is appropriate to introduce the patient to others in the bay.

• The ward routine must be explained. A copy of the generic hospital booklet 'Welcome to Princess Basma Hospital' must be made available to the patient and in addition local information relevant to the ward area should be shared and supported with a local booklet detailing, for example, ward round times, meal times and any other specific information.

• Visiting times must be explained clearly, highlighting the reasons for restrictions and these details should be highlighted to any accompanying person.

• The patients must be asked if they have any particular needs to be addressed during their hospital stay. At this point it is important to establish if the patients have any communication requirements.

• On admission each patient must be made aware of the approximate length of time they can expect to stay in hospital.

• Each patient must be involved in their plan of care and must be kept informed of their progress.

• Each patient must be informed that if they wish to raise concerns or are unhappy with any aspect of their care, they may raise the matter with any member of staff so their problem can be resolved quickly.

• All patients admitted or undergoing treatment must have 1 wrist band detailing the following:
  • Full name
  • Date of birth
  • Patient number

• The wrist bands must be red if the patient is reported to have an allergy. All details must be checked with the patient or accompanying person prior to application.

The third option is including general actions in the policy that enhance the patient's ability to feel safe and secure in the environment. This option is derived from admission to inpatient services policy by the Health Boards Executives in its Project Guideline (2003) which included general instructions, for example:

• Provide the best available evidence practice and treatment within a safe environment for consumer, staff, carers and visitors

• The consumer and recognized carers should have the opportunity to discuss any issues encountered during admission, during any period of leave and as part of the discharge planning process with their treating medical officer and members of the treating team.

• Extended access to rapid assessment clinics and outpatient radiology and pathology services.

• Rapid assessment and extended access to diagnostics (unnecessary delays in admitting and/or discharging patients from hospital may arise from avoidable delays in patient assessment by specialists, duplication of tests or the absence of high or low dependency beds).

• Early Senior Medical decision making available at the point of admission.

• Close multidisciplinary team work.

• National agreed standardized triage processes to ensure clinical prioritization of patients on their arrival in the Emergency Department and to ensure timely and appropriate care is delivered.

• Patients should be streamed into the following categories:
i. Resuscitation;
ii. Minor illness and injury stream (patients who are unlikely to be admitted);
iii. Pediatric cases;
iv. Specialized medical/surgical team assessment for patients who may require admission; psychiatric case assessment service.

• Care pathways to minimize delays in the Emergency Department if admission is definite.

- These pathways should be developed in consultation with the relevant professionals and stakeholders.
- Rapid access facilities such as Medical Assessment Units (MAU) requiring robust, specific and auditable operational policies.
- Protocols for transfer of patients within and between regional areas and tertiary units to continue to be developed and implemented with pre-hospital emergency care, trauma teams and other relevant parties.
- Short Stay observation wards or Clinical Decision Units (CDUs) are advocated in emergency patient care. Such units should be directly adjacent to the Emergency Department and should be supervised by Consultants in Emergency Medicine. The length of stay should not be greater than 24 hours.
- Chest Pain Clinics, geriatric, respiratory clinics and in-house specialist services should be used to fast track patient management where possible.
- Information Systems should be used to provide comprehensive comparable and reliable data on activity waiting times. While a least restrictive approach is used this must also be balanced against an emphasis on safety for consumers, staff, carers, visitors and that of the general public.
- An information sheet as to the consumers rights is to be provided to the consumer along with an explanation of the purpose of admission and an indication as to the plan of care that has been developed to respond to the consumers needs inclusive of an explanation about any prescribed medication.

The fourth option is providing handbooks for patients that describe all general and specific instructions and patients' rights that enhance patients to feel safe and secure in the environment. This option, however, was developed using brainstorming and includes some nurses' work in Princess Basma Hospital.

4. Assess alternative policies

Option 1:

The first option is the staying with the status quo or no-action alternative. This option includes leaving the current policy free from any instructions that enhance the patient to feel safe and secure in the environment. This policy is currently applied. The expected outcomes of applying this policy are that the patient will be admitted in an easy way. However, patients who are admitted according to the current policy do not feel completely safe. Patient usually feels "shocked" because of the new environment and many aggressive incidents occur.

This is a direct result of not being oriented to the surrounding environment. The expected outcomes for applying this option are not fully consistent with the desired policy goal which aims to admit patients easily and safely into the hospital.

This option however does not satisfy patients' needs for safety. It may need to be discarded, but we need it as a base line for comparison between the other options.

Option 2:

The second option is including specific actions in the policy that enhance patient's ability to feel safe and secure in the environment. This option aims at including many specific instructions that enhance patients' feelings of safety such as orientation to the local environment, persons, and procedures, including toilets, washing facilities, nurse call bell system, time of food, taking of details by health care professionals, routine observations, blood test, visiting times, introduce the patient to others in the ward, introducing to health care professionals by name and title e.g. doctor, nurse, presence of identification band and mentioning to the patient an approximate length of time they can expect to stay in hospital.

This option has an opportunity to be applied. The expected outcomes of applying this policy are that the patient will be admitted in an easy and safe way. Safety will not be limited to the physical aspect, but the patient will feel psychologically relaxed in the new environment.

This is a direct result of applying client centered policy within the new environment. The expected outcomes for applying this option are fully consistent with the desired policy goal which aims to admit patients easily and safely into the hospital.

Option 3:

The third option is including general actions in the policy that enhance the patient's ability to feel safe and secure in the environment. This option aims at including some general instructions that enhance patients' feelings of safety, such as mentioning that the care should be provided during admission within a safe environment for consumer, staff, carers and visitors and that the patient and recognized carers should have the opportunity to discuss any issues encountered during admission, any period of leave and as part of the discharge planning process with their treating medical officer and members of the treating team. Another example is that of an orientation to the physical layout of the unit and unit programs and routines, but without mentioning them specifically.

This option has an opportunity to be applied. The expected outcomes of applying this policy are that the patient will be admitted in an easy and safe way. Safety will not be limited to the physical aspect, but the patient can feel psychologically relaxed in the new environment. However, although this policy can be described as client centered, the application of the policy may differ according to the staff's general understanding of the policy because it has general statements. This can hinder some important actions needed to enhance the feeling of being safe and secure within the new environment. The expected outcomes for applying this option are

partially consistent with the desired policy goal which aims to admit patients easily and safely into the hospital.

Option 4:

The fourth option is providing handbooks for patients that describe all general and specific instructions in addition to patient's rights that enhance feeling safe and secure in the environment. Each patient must have a copy of this book. This option aims at including general and specific instructions that enhance patients' feelings of safety that are a compensation of instructions in option two and three. The hand book will be explained to the patient who cannot read by a staff nurse or a family member. This option has a difficulty in application because it will be costly. However, the expected outcomes of applying this policy are that the patient will be admitted in an easy and safe way. Safety will not be limited to the physical aspect, but the patient can feel psychologically relaxed in the new environment. The expected outcomes for applying this option are fully consistent with the desired policy goal which aims to admit patients easily and safely into the hospital.

5. Display and distinguish among alternative policies

After generating four policies, it is necessary to narrow the options to choose the policy that is most consistent with the evaluation criteria. To compare the alternative policies, a table of matrices will be applied. This table describes and compares the policies using scenario comparison and identifies strengths and weaknesses of each alternative according to the evaluation criteria.

The most important criterion for comparison between alternative policies is the effectiveness of policy and achieving the desired goals appropriately. As identified by this table, the most effective policy is policy option 2. However, the worst and least effective policy for achieving the desired goals is policy option 1. The policy options 3 and 4

can be effective but less than policy option 2. Other concerns for the policy options 3 and 4 is that policy option 3 is general and vague and policy option 4 can be costly.

As inferred from the previous discussion, the best option for making patients feel safe and secure in the environment is policy option 2 which aims at adding specific actions (described on page 7 and 8) to the current policy that enhance the patient's ability to feel safe and secure in the environment.

6. Implement, Monitor, and Evaluate the Policy

As there is a quality management office in Princess Basma Hospital, implementation of the current policy will be with coordination with the quality management office. Implementation will include adding specific instructions to the current policy to obtain client centered policy that enhances feelings of safety and security during admission. These instructions should be included in a separate section called safety insurance section. The following are specific instructions that will be added and include:

• Each patient arriving at the hospital must be greeted by a member of staff who must introduce themselves by name and title e.g. doctor, nurse. An outline of the admission process must be described. The name of the doctor under whom the patient has been admitted must be given and details of any routine procedures, i.e. taking of details, routine observations, blood test, must be explained.

• The patient must be orientated to the local environment including toilets, washing facilities and nurse call bell system.

• On arrival to the allocated bed, it must be considered if it is appropriate to introduce the patient to others in the bay.

• The ward routine must be explained. A copy of the generic hospital booklet 'Welcome to the Princess Basma Hospital must be

made available to the patient and in addition local information relevant to the ward area should be shared and supported with a local booklet detailing for example, ward round times, meal times and any other specific information.

• Visiting times must be explained clearly, highlighting the reasons for restrictions and these details should be highlighted to any accompanying person.

• The patient must be asked if they have any particular needs to be addressed during their hospital stay. At this point it is important to establish if the patient has any communication requirements.

• On admission, each patient must be made aware of the approximate length of time they can expect to stay in hospital.

• Each patient must be involved in their plan of care and must be kept informed of their progress.

• Each patient must be informed that if they wish to raise concerns or are unhappy with any aspect of their care, they may raise the matter with any member of staff so their problem can be resolved quickly.

• All patients admitted or undergoing treatments must have 1 wrist band detailing the following:

  • Full name

  • Date of birth

  • Patient number

• The wrist bands must be red if the patient is reported to have an allergy. All details must be checked with the patient or accompanying person prior to application.

After including these instructions in the current policy, the new policy will be announced and applied. Nurses will be trained to apply this policy. The monitoring system will include a check list including each of the new instructions. The check list will be filled in by the patient and saved in the patient's file. Patients will have the right to put a question mark on items that were not explained or applied for them.

Scenario table for admission policy in the Princess Basma Hospital focusing on the problem of safety				
	Policy option 1	**Policy option 2**	**Policy option 3**	**Policy option 4**
Attributes	Status quo (This option includes leaving the current policy free from any additional instructions that enhance the patient's ability to feel safe and secure in the environment).	This option includes adding specific actions to the current policy that enhance the patient's ability to feel safe and secure in the environment.	This option includes adding general actions to the current policy that enhance the patient's ability to feel safe and secure in the environment.	This option includes providing a handbook for patients that describes all general and specific instructions and patients' rights that enhance the patient's ability to feel safe and secure in the environment.
Evaluation Criteria **Effectiveness**	Patients report that they are not feeling safe in the environment.	Patients report that they are happy and feel safe in the environment.	Patients report that they somehow feel safe in the environment but they have some concerns about safety.	Patients who understand the handbook content report that they are happy and feel safe in the environment.

Scenario table for admission policy in the Princess Basma Hospital focusing on the problem of safety				
Continue	**Policy option 1**	**Policy option 2**	**Policy option 3**	**Policy option 4**
Administrative ease	This option includes not adding any new thing, so it is easy to administer.	This option includes adding new criteria on the current policy; this may need efforts and be time consuming	This option includes adding new criteria on the current policy; this may need efforts and be time consuming	This option includes developing a new handbook; this may need efforts and be time consuming
Costs	This option will not add a new cost.	This option may add little cost of developing new policy and training the staff to apply it.	This option may add little cost of developing new policy and training the staff to apply it	This option may add more costs related to developing and printing a new handbook, in addition to costs of training staff to apply it.

Scenario table for admission policy in the Princess Basma Hospital focusing on the problem of safety				
Continue	**Policy option 1**	**Policy option 2**	**Policy option 3**	**Policy option 4**
Equity	All patients are expected to receive low benefits regarding safety.	All patients are expected to receive the same benefits regarding safety if staff nurses worked according to the policy.	All patients are expected to receive the same benefits regarding safety if staff nurses worked according to the policy.	Patients may receive different benefits regarding safety especially if some patients did not read the hand book.
Legality	none	The proposed solution requires approval from the head nurse as there is no quality management department.	The proposed solution requires approval from the head nurse as there is no quality management department.	The proposed solution requires approval from the head nurse as there is no quality management department.

Scenario table for admission policy in the Princess Basma Hospital focusing on the problem of safety (Continued next page)

Scenario table for admission policy in the Princess Basma Hospital focusing on the problem of safety				
Continue	Policy option 1	Policy option 2	Policy option 3	Policy option 4
Political acceptability	This solution is not popular among general citizens and nurses' leaders.	This solution is popular among general citizens and nurses' leaders.	This solution is popular among general citizens and nurses leaders.	This solution is popular among general citizens and nurses' leaders.
Net benefits	No benefits regarding patients' safety. However, some staff may see this option as favorable because it decreases the workload.	Patients will feel safe and secure during their admission into Princess Basma Hospital.	Patients may feel safe and secure during their admission into Princess Basma Hospital.	Patients may feel safe and secure during their admission into Princess Basma Hospital.

Scenario table for admission policy in the Princess Basma Hospital focusing on the problem of safety

Evaluation of the policy will depend mainly on achieving the intended outcomes by making patients feel safe and secure within the environment. Achieving the intended outcomes will be measured using a semi structured interview with the patients and staff and comparing them with the base line data regarding safety. After that, the implementation of the new policy will be applied for the first six newly admitted patients. The result will measure the achieving the intended outcomes.

Conclusion

The policy remains a live document and will be refined, updated and expanded following implementation, evaluation and the introduction of any new alternative or legislation relating to admission policy. It is our aim to ensure that the patient's journey through the admission process and subsequent hospital stay and discharge, are as smooth and trouble free as possible.

References

Health Boards Executives in its Project Guideline: admission and discharge policy (2003).

Retrieved from http://www.dohc.ie/issues/health_strategy/action84.

pdf?direct=1

Peterborough and Stamford Hospitals Admission Policy (2008). Retrieved from

http://www.peterboroughandstamford.nhs.uk/_files/policies/1212020admissions20policy.pdf

Protocol on Admission to Hospital in Shetland (2004). Retrieved from

http://www.shb.scot.nhs.uk/documents/pphandbook/documents/

HospitalAdmission.pdf

Victorian Hospital Admission Policy (2011). Retrieved from

http://www.health.vic.gov.au/hdss/vaed/adm_policy_1_Jul2011.pdf

IMPACT OF LANGUAGE BARRIER ON QUALITY OF NURSING CARE AT ARMED FORCES HOSPITALS, TAIF, SAUDI ARABIA

Sameer Al-Harasis

Correspondence:
Sameer Al-Harasis, BSN, RN ,Diploma (Nurse Tutor)
Nursing Clinical Instructor, Armed Forces Hospitals,
Taif, Saudi Arabia
Email: shrasis1967@yahoo.com

Abstract

Since Saudi Arabia has a shortage of nursing staff and depends on expatriate nurses, difficulties in communication because of language barriers may affect patient satisfaction or at the worst may lead to healthcare errors. Objectives: To determine the effect of language barriers on quality of nursing care at Taif Armed Forces Hospitals and to suggest possible interventions to mitigate the effect of language barriers on quality of nursing care. Methods: This study was conducted in Armed Forces Hospitals, Taif Region. Two different questionnaires were applied (one for nurses in English and the other for admitted patients in Arabic). Total number of respondents was 343 nurses. Results: Forty-nine percent of the nurses reported they have difficulty in dealing with patients because of the language barrier. Healthcare outcomes that were affected because of language barriers include general nursing care, understanding patients' needs, communication with patients, healthcare errors, having trust in nursing care and feeling satisfaction). An equal percentage of nurses and patients (90% and 89.5%, respectively) suggested that attending an Arabic course during the orientation period is very essential. Conclusion: Future research is required to determine the effectiveness of suggested interventions (e.g., Arabic language courses, bilingual staff, common words dictionary, etc) and their impact on improving communication (i.e., access to care), change behaviors (i.e., health outcomes), and ultimately reduce diseases. Moreover, it is necessary to view the language barrier through a cultural competency model.

Key words: language, barriers, nurses

Introduction

Since Saudi Arabia has a shortage of nursing staff, it depends on expatriate nurses from foreign countries mainly the Philippines, India, Malaysia and South Africa. Nurses who came from these countries are non Arabic speaking resulting in difficulties in communication between nurses and patients as well as between nurses and medical staff from other nationalities. Consequently, these communication problems may affect patient satisfaction or at the worst may lead to medical errors.

A study conducted in the United Kingdom in 1999 (1) showed that language barriers may increase the likelihood that a patient would not return to the same institution for future care (1). In the United States in 2000, another study showed an association between language barriers and actual follow-up appointments (2). Patient compliance is another issue that emerges from the literature as affected by language access. Patients who have more difficulty understanding their physician or nurse would be less likely to follow treatment directions, and this is not only due to the obvious difficulties in obtaining accurate information, but also because good communication can be a source of motivation, reassurance and support, as well as an opportunity to clarify expectations (3).

Discussing the issue of language barriers is more important for nurses as they are the only personnel at the patients bedside twenty four hours a day, seven days a week.

A study in the United States covered eleven Boston area ambulatory clinics in 2000 showed that language barriers may play a role in outpatient drug complications, which in turn is related to lower patient satisfaction. Multiple regression analysis of the

same study revealed that having a primary language other than English or Spanish was an independent predictor of patient reported drug complications, along with the number of medical problems and failure to have side effects explained before treatment. The level of overall satisfaction was significantly lower among patients who reported problems related to medication use than among those who did not (4).

An interview study in an Australian children's Hospital of parents of Chinese immigrants presenting to the emergency department, where interviews arre conducted in English, language barriers and insufficiency of linguistic access services are significant barriers to care (5).

So it is very important for those working in the healthcare field and for the decision makers to conduct and support studies that reveal the impact of language barriers on nursing care and to look for solutions to overcome drawbacks of this problem on quality of healthcare and patient satisfaction.

Thus this study was conducted to assess the impact of language barriers on quality of nursing care at Armed Forces Hospitals, Taif, Saudi Arabia and to suggest possible interventions to overcome the effect of language barriers on quality of nursing care.

Materials and Methods

This study was conducted during the period from April - December 2009 in Armed Forces Hospitals, Taif, Saudi Arabia. These hospitals consist of 3 main hospitals (i.e., AlHada, Prince Mansour and Prince Sultan Hospital) in addition to the Rehabilitation center. They are serving military personnel and their families at Taif region.

The study included all nurses working at these hospitals with a total of 385 nurses distributed in different hospitals. All nurses who are working at Armed forces hospitals and have at least one year

experience of work in Saudi Arabia at the beginning of the study were invited to voluntary participate (n= 360).

A predestined self reporting questionnaire was applied to all participants. The questionnaire was provided in English language (the language used by all foreign nurses). It included socio-demographic information, work experience in and out of Saudi Arabia, level of reading, writing, speaking and understanding Arabic, English and other languages, training experiences in the Arabic language, their attitudes towards impact of language barrier on quality of healthcare, their experiences of problems associated with language barriers and their suggestions to solve the problem.

Another simple questionnaire was distributed to 227 inpatients already present during the study period. The questionnaire was in Arabic language and was administered through interview with the patients. It included questions about the age and level of education in addition to questions about their assessment of the magnitude of the language barrier and its relation to the communication difficulties with the nursing staff as well its relation to their satisfaction of the healthcare provided.

Approval of the Research and Ethics committee of the Armed Forces Hospitals, Taif, Saudi Arabia was obtained to conduct the study.

Results

This study included 343 nurses with a response rate of 96% and 227 patients with a response rate of 88%.

The majority of nurses were female (92.7%). There were 58.9% with nursing high school education, 37.9% bachelor degree in nursing and only 3.2% with master degree in nursing. The overall experience in nursing was almost equally distributed in the following groups: less than 5 years, 5-10 years and

more than 10 years of nursing. More than half of the participating nurses (56%) have 2-5 years of work in Saudi Arabia including their work at Taif Armed Forces Hospitals, however, about 20% either had 1-2 years or more than 5 years of work in Saudi Arabia (Table 1 - opposite page).

Regarding patients, there were 120 males out of 227 patients (55%) and there were 71% among them having less than university education.

Forty-nine percent of the nurses reported they have difficulty in dealing with patients because of the language barrier (Table 1).

Regarding Arabic language knowledge, self-report of the participating nurses revealed that they cannot read or write at all (68.8% or 70%, respectively). However, 98.5% were either completely (33.8%) or a little (64.7%) able to speak and 99.7% were either completely (39.1%) or little (60.6%) able to understand the Arabic language (Figure 1).

Almost one fifth of the participating nurses think that healthcare outcomes (i.e., nursing care, understanding patients' needs, communication, healthcare errors, having trust in nursing care and feeling satisfaction) are USUALLY or ALWAYS affected because of language barriers (median is 22.4%). However, more than half of the nurses think that the reported healthcare outcomes are SOMETIMES affected because of language barriers (median is 55.8%) (Table 2 - page 20).

Knowledge of participating nurses about the Arabic language was estimated using scores 0, 1, 2 for no, little and yes knowledge of reading, writing, speaking and understanding as reported by the nurses. It was found that 40.3% of those who have less than average Arabic language score have experienced questioning because of language barriers compared to 29.9% among those who have above average score (p=0.05) (Figure 2).

**Table 1: Socio-demographic characteristics
of the participating nurses**

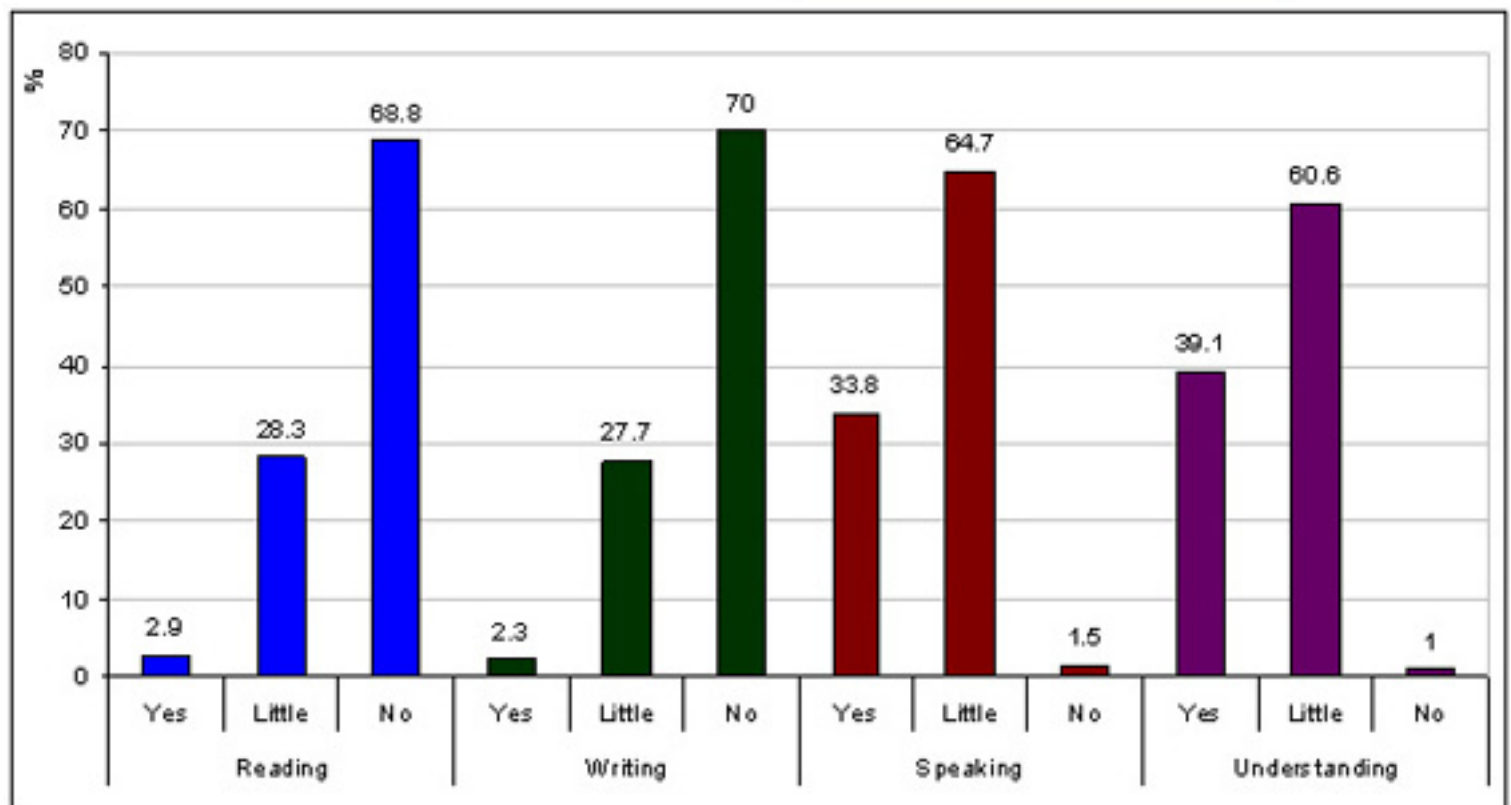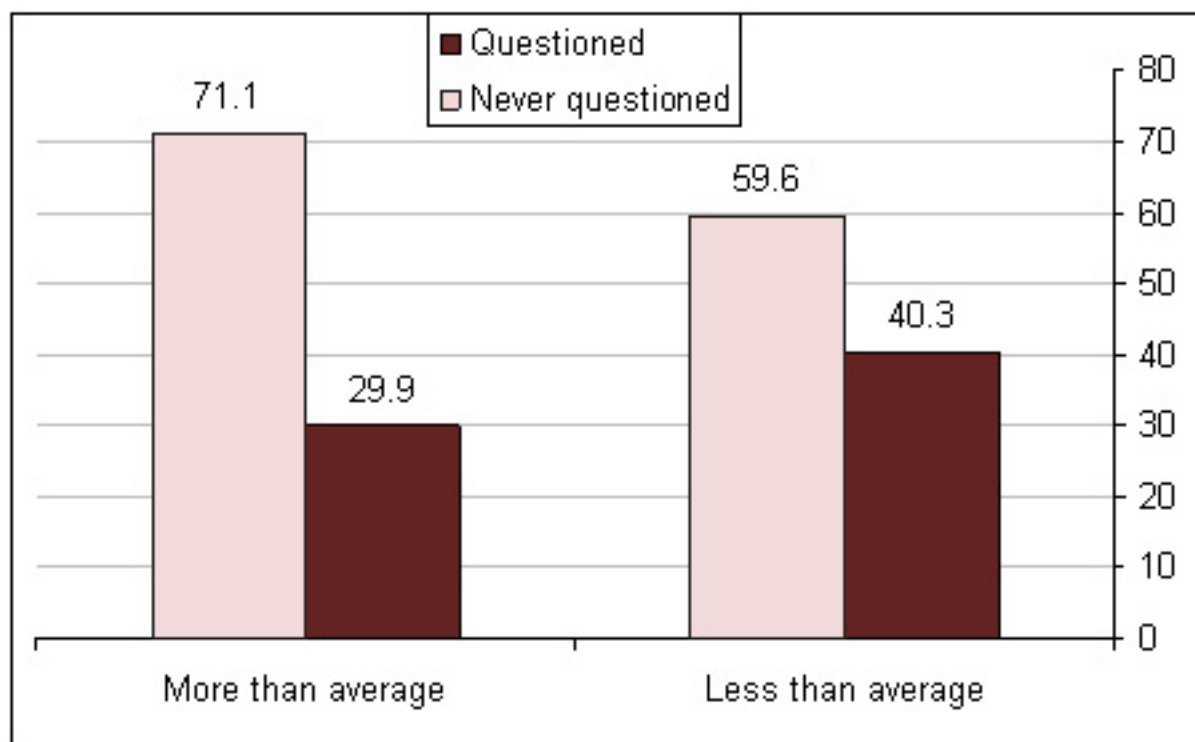| Variables	N (%)
Sex;	
Male	318 (92.7)
Female	25 (7.3)
Level of Education;	
High school nursing	202 (58.9)
Bachelor degree	130 (37.9)
Master degree	11 (3.2)
Overall years of experience;	
Less than 5 years	136 (39.7)
5 – 10 years	97 (28.3)
More than 10 years	110 (32.1)
Total years of work in Saudi Arabia;	
1 – less than 2 years	73 (21.3)
2 – 5 years	192 (56.0)
More than 5 years	78 (22.7)
Do you find difficulty in dealing with	
Arabic speaking patients;	
Yes	322 (94.0)
No	21 (6.0)

Figure 1. Level of reading, writing, speaking and understanding the Arabic language

Healthcare outcomes	Never N(%)	Rare N(%)	Sometimes N(%)	Usual/Always N(%)	P value
1. Nursing care	45 (13.1)	17 (5.0)	151 (44.0)	130 (37.9)	0.001
2. Delay in nursing care	52 (15.2)	14 (4.1)	182 (53.0)	95 (27.7)	0.001
3. Understanding of patient needs	27 (7.9)	13 (3.7)	226 (66.0)	77 (22.4)	0.001
4. Communication with patients	24 (7.0)	21 (6.1)	211 (61.5)	87 (25.4)	0.001
5. Healthcare errors	93 (27.0)	55 (16.0)	145 (42.2)	50 (14.8)	0.001
6. Trust with patients	58 (17.0)	20 (5.7)	191 (55.8)	74 (21.5)	0.001
6. Nurses' job satisfaction	75 (21.8)	24 (6.7)	194 (56.6)	50 (14.6)	0.001

Table 2: Do you think language barrier can affect / lead to the following healthcare outcomes?

More than average (n= 250) and less than average (n= 93); p value = 0.05

Figure 2: Previous experience of questioning because of problem / mistake related language barrier according to level of Arabic language knowledge

Among patients, there were 33.2 and 26% who reported communication difficulties and decreasing satisfaction, respectively, as usual or always experienced because of language barriers. Those who reported communication problems and decreasing satisfaction as sometimes experienced were 59.5% and 56.3%, respectively (Figure 3).

An exactly equal percentage of nurses and patients (90% and 89.5%, respectively) suggested that attending an Arabic course during the orientation period before starting work is essential. Similarly, 85% and 83.1%, respectively suggest translators in different wards to minimize language barriers. However, 94% of nurses compared

to 73.9% of patients prefer common words dictionary as a solution. About 83% of nurses compared to 64.4% of patients think that using the signal language can help in minimizing language communication difficulties. Most of the patients (87.7%) encourage having Arabic speaking nurses to overcome the problem (Figure 4).
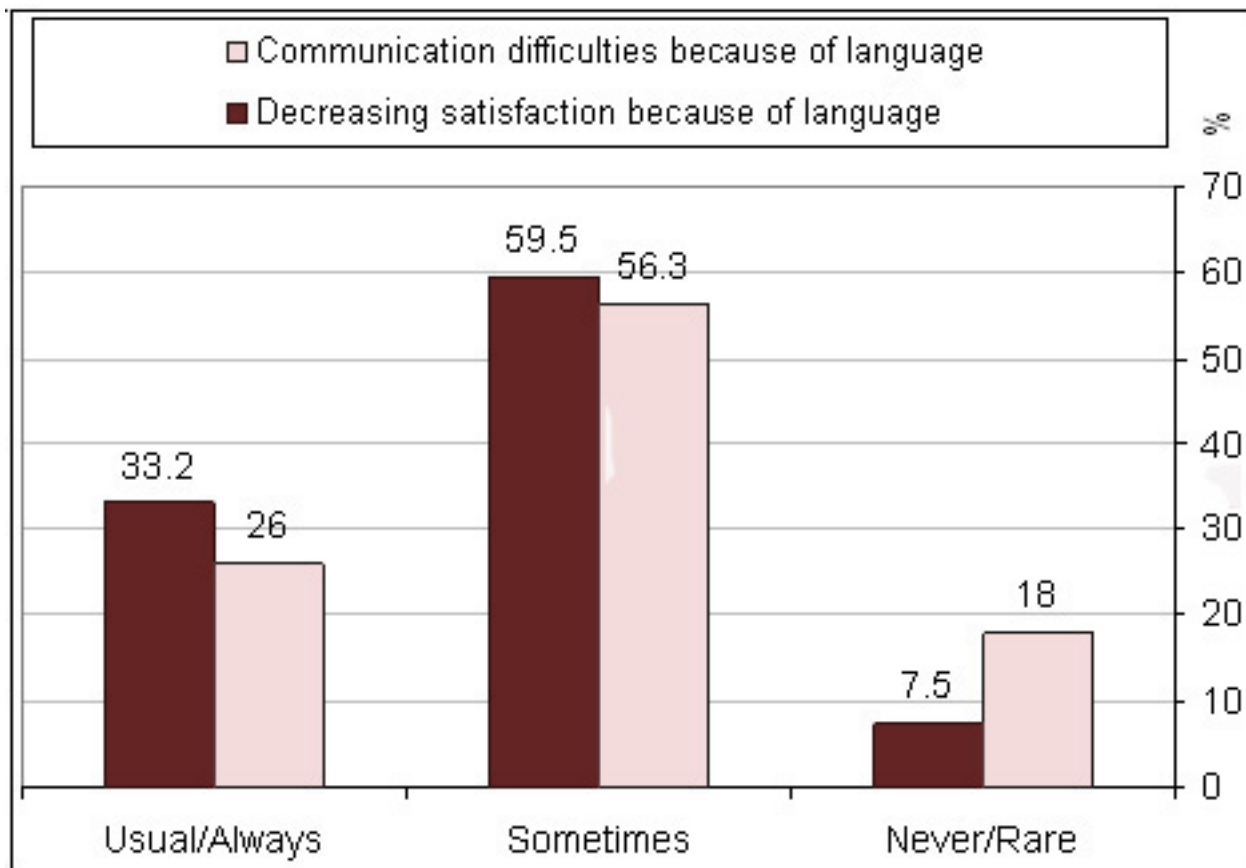
Figure 3: Communication problems and satisfaction of patients related to language barriers as reported by patients (n=227)
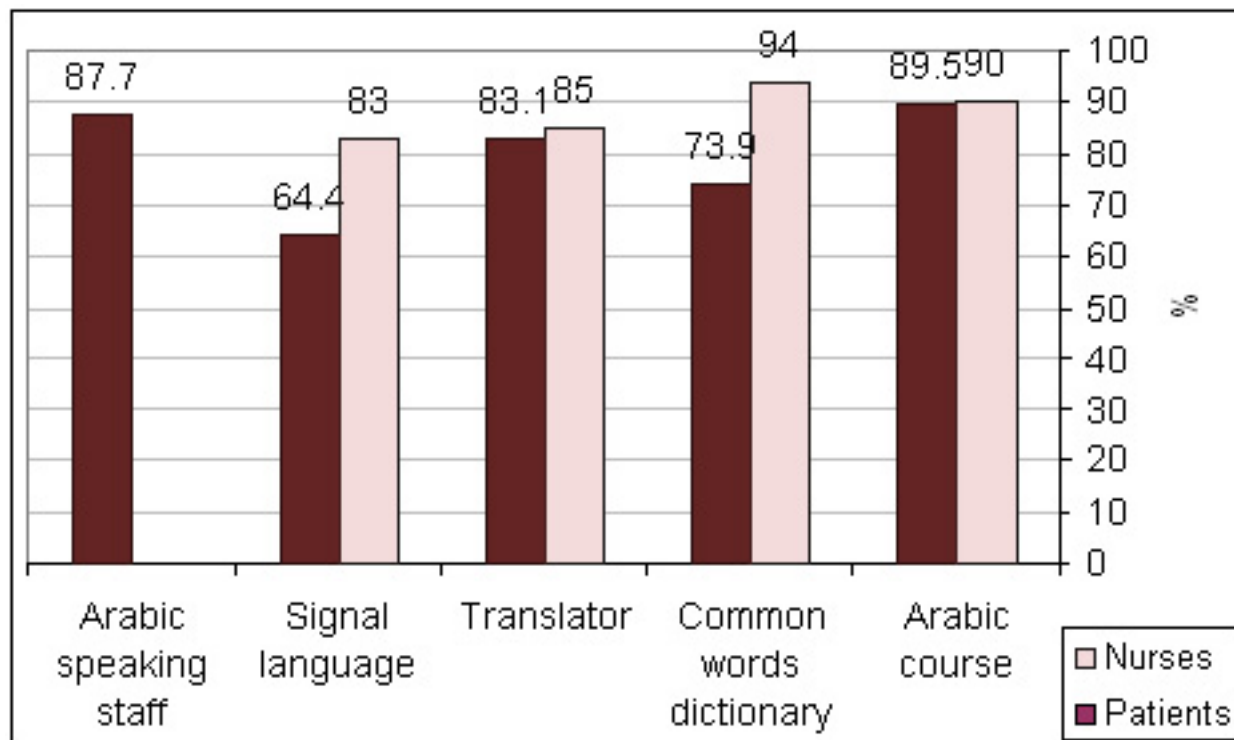

Figure 4: Suggestions of nurses and patients regarding solutions of language barriers problems

Discussion

Differences in language between healthcare providers and patients increasingly impose barriers to healthcare (5). The consequences of language barriers range from miscommunication with its drawbacks on health outcomes (6) to inefficient use or lack of access to health care services (7, 8). The current study may be the first that assesses the magnitude of language barrier as an obstacle to the healthcare system in the Arab world. Although the majority of nursing staff in the Arabic speaking gulf countries are from non-Arabic speaking countries, research that indulges this major problem are lacking. The current study revealed that the majority of working nurses find difficulty in dealing with Arabic speaking patients who represent all the patients in the facility. Moreover, most of the patients find difficulties in communication with non-Arabic speaking nurses and their overall satisfaction is affected.

The current study ranked the healthcare outcomes that may be affected because of language barriers according to nurses self-reporting. Understanding of patient needs (88.4%) was ranked first followed by general communication with patients (86.9%), quality of nursing care (81.9%), delay in nursing care (80.7%), building trust with patients (77.3%) and potential for healthcare errors (57%). Additionally, nurses reported that language barriers affect the nurses' overall job satisfaction.

A systematic review of 47 articles by Yeo (2004) (9) indicated that language barriers are associated with lack of awareness about health care benefits (such as Medicaid eligibility) (10), less insured status (7), longer visit time per clinic visit (8), less frequent clinic visits (11), less understanding of the physician's explanations (6, 12), more lab tests (7), more emergency room visits (7), less follow-up (8), and less satisfaction with health services (13, 14). As the reviewed studies were all observational causal relationship between language barriers and quality of care could not be established.

Several studies have reported negative associations between the presence of language barriers and the number of healthcare visits (10, 11, 15). David and Rhee (1998) (6) concluded that the language barriers are correlated negatively with patient satisfaction and medication compliance.

Another literature review by Timmins (2002) (16) showed that non-English speaking populations lack access to a therapeutic relationship with their health care provider because of the language barrier. The patients are at higher risk of health problems because they do not get benefit from the available health services. According to that review, language barriers can lead to poor patient outcomes, increased use of expensive diagnostic tests, increased use of emergency room services, poor patient satisfaction and poor or no patient follow-up when follow-up is indicated.

In research study by Dunn et al (2001), (17) it was concluded that lack of time and language affected whether a discussion about cancer screening was required. It was further mentioned that screening was avoided due to lack of resources for interpretation. A similar explanation was provided by Thompson and others (2002) (18) who reported that Hispanics were much less likely than non-Hispanic whites to ever have had cancer screening in addition to other socio-demographic factors.

Morales and colleagues (1999) (14) measured dissatisfaction of patients using five observations about medical staff: (1) they listen to what patients say; (2) they give answers to questions; (3) they explain about prescribed medications; (4) they explain about medical procedures and test results; and (5) they give reassurance and support. It is worthy of notice that all these observation require a high quality of communication and language is usually the core of good communication.

Several studies demonstrate that language barriers result in both inefficiency and potential increases in costs (7, 8). For instance, Hampers (7) indicates that patients with language barriers have significantly higher test costs ($145 vs. $105) and longer emergency department stays (165 minutes vs. 137 minutes) than their English-speaking counterparts. Kravitz (8) also demonstrated that Spanish- and Russian-speaking patients averaged 9.1 and 5.6 minutes longer for visits, respectively, than English-speaking patients.

Various interventions to mitigate the effect of language barriers on the quality of the provided healthcare have been suggested. Both nurses and patients in the current study agreed that administration of Arabic courses for nurses is essential (90% and 89.5%, respectively). In the US, as the problem is reversed where patients are non-English speaking, thus they suggested health education strategies for the patients who do not speak or read English at the elementary level (19). In such situations when there is a language barrier, nurses should use simple, everyday words rather than complex words or medical jargon (9).

Using nonverbal communication such as hand gestures and facial expressions has also been suggested by other researchers (6, 7, 8). The percentage of nurses who suggested nonverbal communication in the current study was higher compared to patients (83% among nurses vs. 64.4% among patients). Using a dictionary may be why that is preferred by the patients as it takes time and may not be suitable in day-to-day communication, however, for nurses they have it all the time with them and they can review commonly used words any time.

It is not only attending language classes or using non-verbal

communication; healthcare providers are encouraged to attend in-services that focus on cultural awareness, especially in Saudi Arabia where culture is different and affects health and lifestyle of the population in different ways.

As Saudi Arabia hires healthcare professionals with multicultural and multilingual backgrounds, assistance from specially trained interpreters or family members of the patients is essential to providing enhanced healthcare and culturally competent care. Having translators in different departments has been agreed upon by both nurses and patients in the current study (85% and 83.1%, respectively). The issue of who should be the interpreter, (whether that person should be a trained or untrained individual?) has been discussed by Timmins (2002) (16). An untrained interpreter (i.e., ad hoc interpreter), can lead to inaccurate communication and ethical breaches (including role conflicts and patient confidentiality). Using a family member as an interpreter may not be suitable, especially when the content is sensitive and disrupts the family relationship. Suitable interpreters as suggested by Timmins (2002) (16) include: hiring bilingual healthcare providers, hiring trained professional interpreters, training volunteer interpreters from the community and using phone interpreting.

The quality of interpretation depends on many factors including the accuracy and content of a competent medical interpretation (20). When untrained personnel are involved in iterpretation the content of medical advice is often not fully understood (12) and patients are less satisfied with the health service (21).

Hiring Arabic speaking staff as an alternative is highly recommended by the patients, which needs more efforts from healthcare institutions, decision making, and community leaders to establish institutions for nursing education and to raise awareness of the community towards importance and need for Arabic speaking nurses. This requires a long-term strategy and collaboration of different organizations.

Proper communication is essential for optimal patient care and to maintain health.

Future studies may focus on the causal relationship between language barriers and various health outcomes. Clinical trials need to be conducted to determine the effectiveness of interventions (e.g., Arabic language courses, bilingual staff, common words dictionary, etc) and their impact on improving communication (i.e., access to care), change behaviors (i.e., health outcomes), and ultimately reduce disease. Moreover, it is necessary to view the language barrier through a cultural competency model. Several conceptual models (22, 23, 24) have been developed; however, fitting these models to the Arab culture is essential or developing new fitted models.

References

1. Carrasquillo O,Ovray EJ, Brennan TA, Burstin HR. Impact of language barriers on Patient satisfaction in an emergency department. J Gen Internal Med.1999;14:82-87.

2. www.hc-sc.gc.ca/hcs-sss/pubs/acces/effe-eng.php Accessed 6/4/2008.

3. Betancourt JR, Carrillo JE, Green AR. Hypertension in multicultural and minority populations: linking communication to compliance. Curr Hypertens. 1999. Rep., 1, 482-488.

4. Ghandi TK, Burstin HR,Cook EF. Drug complications in outpatients. J Internal Med.2000;15:149-154.

5. Chak S, Nixonj, Dugdale A. Primary health care for Indo-Chinese children in Australia. Australian ped J.1984;20:57-58.

6. David RA, Rhee M. The impact of language as a barrier to effective healthcare in an underserved urban Hispanic community. Mount Sinai Journal of Medicine. 1998; 65, 393-397.

7. HampersLC, Cha S, Gutglass DJ, Binns HJ, Krug SE. Language barriers and resource utilization in a pediatric emergency department. Pediatrics. 1999, 03(6 Pt 1), 1253-1256.

8. Kravitz RL, Helms LJ, Azari R, Antonius D, Melnikow J. Comparing the use of physician time and health care resources among patients speaking English, Spanish, and Russian. Medical Care. 2000, 38, 728-738.

9. Yeo Seonae. Language Barriers and Access to Care. Annual Review of Nursing Research. 2004, 22 (1), 2004: 59-73(15)

10. Feinberg E, Swartz K, Zaslavsky AM, Gardner J, Walker DK. Language proficiency and the enrollment of Medicaid-eligible children in publicly funded health insurance programs. Maternal and Child Health J. 2000, 6(1), 5-18.

11. Derose KP, Baker DW. Limited English proficiency and Latinos' use of physician services. Medical Care Research and Review. 2000, 57(1), 76-91.

12. Gerrish K. The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carers. Journal of Advanced Nursing. 2001, 33, 566-574.

13. Meredith L, Stewart M, Brown JB. Patient-centered communication scoring method report on nine coded interviews [Comment]. Health Communication. 2001, 13(1), 19-31.

14. Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD. Are Latinos less satisfied with communication by health care providers? Journal of General Internal Medicine. 1999, 14, 409-417.

15. Jacobs EA, Lauderdale DS, Meltzer D, Shorey JM, Levinson W, Thisted RA. Impact of interpreter services on delivery of health care to limited-English-proficient patients. Journal of General Internal Medicine. 2001, 16, 468-474.

16. Timmins CL. The impact of language barriers on the health care of Latinos in the United States: A review of the literature and guidelines for practice. Journal of Midwifery and Women's Health. 2002, 47(2), 80-90.

17. Dunn AS, Shridharani KV, LouW, Bernstein J, Horowitz CR. (2001). Physician-patient discussions of controversial cancer screening tests. American J Prev Med. 2001, 20(2),130-133.

18. Thompson B, Coronado GD, Solomon CC, McClerran DF, Neuhouser ML, Feng Z. Cancer prevention behaviors and socioeconomic status among Hispanics and non Hispanic Whites in a rural population in the United States. Cancer Causes & Control. 2002, 13, 719-728.

19. Aboul-Enein FH, Ahmed F. How language barriers impact patient care: a commentary. Journal of Cultural Diversity. Fall 2006, 13 (3): 168-9.

20. Woloshin S, Schwartz LM, Katz SJ, Welch HG. Is language a barrier to the use of preventive services? Journal of General Internal Medicine. 1997,12, 472-477.

21. Lee LJ, Batal HA, Maselli JH, Kutner JS. Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. Journal of General Internal Medicine. 2002, 17, 641-645.

22. Brach C, Fraser I. Can cultural competency reduce racial and ethnic health isparities? A review and conceptual model. Medical Care Research and Review. 2000,57(Suppl 1), 181-217.

23. Andersen RM. Revisiting the behavioral model and access to medical care: Does it matter? J Health and Social Behavior. 1995, 36(1), 1-10.

24. Andersen RM, Rice TM, Kominski GF. Changing the U.S. health care system: Key issues in health services, policy, and management. San Francisco:

Jossey-Bass. 2001.

THE RELATIONSHIP BETWEEN CANCER CHEMOTHERAPY AND FATIGUE: A REVIEW

Bilal S. H. Badr Naga

**The Hashemite University
Department of Adult Health Nursing**

Correspondence:
Bilal S. H. Badr Naga., MSN, RN, BSN
The Hashemite University
Department of Adult Health Nursing
Amman-Jordan
Email: Bilal_badrnaga@yahoo.com

Abstract

Fatigue is a subjective experience that affects cancer patients who treated with chemotherapy. In healthy individuals, it can be considered a physiological response to physical or psychological stress. In people with cancer diseases; fatigue often represents one of the most significant problems. Fatigue can be caused by many factors, both intrinsic to the patient and extrinsic, such as therapeutic (chemotherapy). This review, based on published studies, has been conducted between 2005 and 2012 with the aim of presenting a critical analysis of the available information on the characteristics, causes and potential treatments of fatigue in cancer patients receiving chemotherapy. Furthermore, in the absence of a clear demonstration of the efficacy of some therapies, the management of cancer-related fatigue remains poorly defined (except for the treatment of anemia-related fatigue). New randomized clinical trials are necessary to indicate the best strategies for overcoming this problem among cancer patients.

Key words: chemotherapy, fatigue, exercise, and cancer.

Introduction

Fatigue is one of the most common side-effects of cancer and its treatments (Hofmana et al., 2007, Prue, Rankin, Allen & et al. 2006). Fatigue is a common problem in patients receiving treatment for cancer. This type of fatigue, defined as cancer- or therapy-related, is different from everyday tiredness, which can be reversed by rest or sleep. Results of a multi-centre patient survey revealed that cancer patients identify fatigue as an important problem which affects their daily activities for more of the time than either nausea/vomiting or cancer pain. CRF is usually characterized as an overall lack of energy, cognitive impairment, somnolence, mood disturbance, or muscle weakness (The National Comprehensive Cancer Network (NCCN), 2012). These symptoms occur with cancer and cancer therapy and are not relieved by rest or additional sleep and often interfere with daily activities.

Cancer-related fatigue that associated with chemotherapy has been associated with other symptoms, including pain, difficulty sleeping and muscle weakness (Cleeland, 2007). Cancer-related fatigue may interact with other common adverse effects of chemotherapy drugs, such as nausea and vomiting, by increasing their perceived severity. This could increase their impact on patient activity, and challenge patients' ability to complete their recommended treatment on the optimal schedule. In addition to having a significant influence on the quality of life (QOL) during chemotherapy, CRF may be present even before treatment begins; it can increase during the course chemotherapy; and it can persist at a higher-than-baseline rate, sometimes for years, after cancer treatment is finished (Nail & King (1987).

Cancer-related fatigue has been under-reported, under-diagnosed and under-treated (NCCN, 2012). Health care professionals have been challenged in their efforts to help patients manage this distressful symptom and to maintain the quality of patients' life.

Compared with other health care providers, nurses spend most of their time with patients and their families (Dickinson, Clark, & Sque, 2008).

Nurses play a major role in the care of individuals and their families in all stages of cancer, from diagnosis to death. Nurses deal frequently with cancer patients and trying to maintain high quality of care, alleviate suffering, decreases side effect and complications of cancer treatment (Dickinson, Clark, & Sque, 2008). Nurse's knowledge and experience about CRF can shape their attitudes toward care for cancer patients (William, Dale, Godley, & Neimeye, 2003). In addition, nurses are in the most immediate position to provide care, comfort and counseling for patients and families at the stage of cancer management (Dickinson, Clark, & Sque, 2008). Successful symptom management for patients can help maintain effective chemotherapy, physical/social wellbeing, and reduce emotional distress of patients. Thus, the purpose of this paper is to determine factors that have been associated with treatment of cancer and to identify the risk factors associated with methods of treatment of cancer with chemotherapy that causes fatigue.

Methodology

In order to review the body of knowledge related to fatigue among patients receiving cancer chemotherapy, a comprehensive literature review was conducted using the electronic databases of CINAHL, EBSECO, MEDLINE, and PUBMED, for articles published between 2006 and 2012. The following key terms were used to search the electronic databases: fatigue, cancer, exercise, and chemotherapy.

Many articles obtained and reviewed, only 18 research articles that achieved the inclusion criteria for the purpose of this study. The inclusion criteria were the following: (1) it is a research-based study; (2) written in the English language; (3) investigated the pain experience among patients receiving cancer treatment; and (4) recently published article. Each article will be read and analyzed, to identify the main themes/findings of the studies. Articles then will be systematically compared for common concepts to recognize similarities and differences in scope and findings across the studies. The articles that included in this study were quantitative and qualitative studies that published in peer reviewed nursing and medical journals. Countries within which the studies for this review were conducted include the United States, Australia, Japan, China, Greece, and Jordan.

The 18 studies composing this integrative research review were seven quantitative studies and seven qualitative studies. Although only 18 studies were included in this research review, a wide variety of instruments were used to measure concepts related to cancer pain experience. The most common questionnaires used in these studies are the piper fatigue scale. The sample sizes in the 18 studies in this review ranged from 11 to 360 adult cancer patients aged between 18 and 82 years.

Finding

More than half of the patients had suffered fatigue every day or almost every day. Nevertheless, even social activities, concentration and caring for the family were more difficult for >50% of patients on the days when they suffered from fatigue. An analysis of the financial impact of this syndrome revealed that 75% of patients had changed their employment status. Bed rest, exercise, and relaxation techniques were the treatments most widely advised by health care provider; nevertheless, 40% of patients were not provided with any advice or recommendation.

Cancer-related fatigue

Cancer-related fatigue (CRF) is a universal distressing symptom among cancer patients who are receiving cancer treatments (Gibson,et al.2005). The National Comprehensive Cancer Network (NCCN) defined CRF as: "distressing persistent, subjective sense of physical, emotional and/or cognitive tiredness or exhaustion related to cancer or cancer treatment that is not proportional to recent activity and interferes with usual functioning" (NCCN, 2012, p.FT1). Cancer-related fatigue has been reported as the most important symptom that impairs the quality of life and daily patients' activities (Rayan, et al. 2007). According to NCCN, 70% to 100% of cancer patients experience CRF and most cancer patients suffer from CRF while receiving chemotherapy, radiation, or bone marrow transplant (NCCN, 2012). Cancer patients experience CRF resulting from the disease process, treatment modalities, psychological burdens, and worsen during chemotherapy course and persists for months after completing the treatment (Mustian, Morrow & Carroll, 2007).

A study conducted by Erickson, et al. (2010) aimed to explore factors affecting fatigue. The researchers recruited 20 adolescents with cancer receiving chemotherapy. Twelve cancer patients in the study reported brief peaks of moderate to severe CRF that occurred one to four days after each week of chemotherapy administration. In addition, the researchers found that the factors that made CRF worse included "not being able to eat before procedures, going to the bathroom a lot, getting chemotherapy in the morning, and just getting chemotherapy".

Alison Richardson & Margeret Evison (2005) mentioned that patients with cancer have identified CRF as symptom that causes them major distress as they live with the disease and its treatment squeal. Many did experience physical, social, and psychological distress as a result of having fatigue.

Relationship between Chemotherapy and Fatigue

Wielgus, Berger, & Hertzog (2009) found that higher CRF is associated with chemotherapy treatment. Hofman and colleagues (2007) found that more than 80% of patients receiving chemotherapy report CRF as a significant side effect of treatment. At the same study they found that 88% of patients who had chemotherapy reported that CRF had affected their activities of daily living.

Lucia and colleagues (2003) explain the relation between cancer and CRF and found that 70% of people with cancer report feelings of CRF during and after adjuvant chemotherapy.

Hwang, et al. (2003) in their study proposed a conceptual model with three dimensions (situational, biological, and psychological dimensions) that predict cancer-related fatigue. The situational dimension represents demographic information including age, gender, stage of cancer, active cancer treatment, and caregiver status. The biological dimension can be described by serum chemistry profile to identify anemia caused by chemotherapy or radiotherapy (Berndt, et al. 2005). The impact of anemia on CRF may be different depending on onset time, patient age, and co-morbidity (Berndt, et al. 2005). Psychological factors, such as depression and anxiety, may contribute to the development of chronic CRF before and after chemotherapy among patients with solid tumors (Wasteson, et al. 2009). Distress after a diagnosis of cancer can be caused by the initial fatigue, and other side effects of upset, like insomnia which may also increase in patients undergoing chemotherapy (Wasteson, et al. 2009).

Furthermore, Yeh, et al. (2008) investigated the relationships between clinical factors (including hemoglobin value, chemotherapeutic agents, and corticosteroid use) and changing patterns of CRF before and for the next 10 days following the start of a new round of chemotherapy in children with cancer. The researchers found that CRF levels were changed significantly over time; patients have more problems with CRF in the first few days after the start of chemotherapy. Also, the researchers reported that Corticosteroid use and hemoglobin value were associated with significant increases in CRF that were sustained for several days and reached the highest level of CRF at day 5 for those receiving concurrent steroids. In addition, Yeh, et al. (2008) reported that the association of chemotherapeutic agents with CRF varied between patient self-report and parent report, but the type of chemotherapeutic agents used was not associated with most changes in fatigue.

This study supports that lower hemoglobin level as a significant contributor to fatigue, thus, frequent hemoglobin check might increase the nurses' understanding of CRF that accompanies chemotherapy treatment.

Berger, Lockhart, &Agrawal, (2009) examined the relationships among cancer-related fatigue, physical and mental quality of life (QOL) and different chemotherapy regimens in patients prior to, during, and after treatment. The researchers reported that CRF and mental (QOL) changed significantly over time for all regimens, but the patterns of change did not differ based on regimen. Physical (QOL) changed significantly over time for all regimens. Higher CRF was correlated with lower physical and mental (QOL) prior to and 30 days after the final treatment, regardless of regimen. The results of this study assure that higher CRF associated with lower (QOL) regardless of the chemotherapy regimens. Thus, study recommended that nurses should screen patients for CRF using a visual analog scale (VAS), assess for contributing factors and to integrate evidence-based CRF interventions as early as possible to reduce CRF and prevent lower quality of life during treatment.

Evidence-Based Treatment for Cancer-Related Fatigue

Despite the high prevalence of cancer-related fatigue and its documented negative effects on patients' quality of life, limited evidence is available to support interventions to prevent or treat cancer-related fatigue. Both pharmacologic and non-pharmacologic interventions have been tested, with aerobic exercise programs and anemia correction by erythropoietin demonstrating greatest effectiveness. This article reviews the available evidence and describes gaps in knowledge regarding cancer related fatigue.

Yurtsever (2007) studied the experience of CRF in patients receiving chemotherapy. The researcher focused on measures taken by patients to cope with fatigue. Cancer-related fatigue was found to be affected by patients' daily activities, age, gender, treatment, and symptoms related to the chemotherapy.

Yurtsever (2007) found that the majority of cancer patients receiving chemotherapy (86%) experienced fatigue; and73 % stated that they coped with CRF by decreasing their activities and resting more. In addition, taking care with their nutrition (12%), exercising (5%), reading a book or newspaper (3%), listening to music (3%), drinking lots of fluids (3%), watching television (3%), trying to cope with the pain (3%), and massage (3%). Additionally, when the patients used these measures, 26% stated that the measures were "partially effective" in decreasing their CRF and 37% stated that they were "ineffective." Age was not found to be a significant contributing factor that is affecting the level of fatigue. However, other related factors including gender, length of illness, number of chemotherapy courses, and patients' symptoms were found to have an effect on level of fatigue. The findings of Yurtsever may refer to the majority of patients experiencing CRF, coped with less activity and more resting.

On the contrary, Kuchinski, Reading, & Lash (2009) did a systematic review to determine the effect of exercise in decreasing CRF for patients receiving chemotherapy and radiation.The researchers found that eight out of ten studies showed regular committed exercise (walking, bicycling or swimming) resulted in less CRF among patients participating in exercise programs. Participants who walked at least 60 minutes per week in three or more sessions demonstrated an increased functional capacity and activity level, with minimal increase in CRF compared to the control group.

In another study done by Blaney, et al. (2010) who explored the barriers of using exercise among patients recently diagnosed with cancer and suffering of fatigue.

The researchers reported that Cancer-related fatigue was associated with barriers such as physical problem, social isolation, and difficulty of making a routine exercise.

Lee, Tsai, Lai, and Tsai (2008), explored the relationship between fatigue, hemoglobin, and the coping strategies used by cancer patients receiving chemotherapy. The researchers found that majority of patients had a baseline hemoglobin level of 12 g/dl and a significantly greater mean cancer-related fatigue score than patients with hemoglobin >12 g/dl. Cancer-related fatigue levels were significantly higher in patients receiving a third course of chemotherapy than in those receiving first course.

The most commonly used management strategy was energy conservation (sitting and lying down). However, participants rated exercise, sleep, going to bed early and walking as the most effective. Distraction techniques, such as listening to music, reading books and visiting with friends had low-to-moderate effectiveness. The most effective coping strategy was chatting with others; back massage and relaxation training which were found to be

moderately effective in reducing chemotherapy-induced fatigue. Thus, implementation of these coping strategies may prevent CRF and promote the quality of life.

Yesilbalkan, (2009) did a quasi-experimental, descriptive study to determine whether a nursing educational interventions decreased the perception of CRF among gastrointestinal (GI) cancer patients receiving chemotherapy for the first time. The researcher assessed cancer-related quality of life by using the Fatigue Inventory, Piper Fatigue Scale, and the European Organization for Research and Treatment of Cancer Quality of Life (EORTC QLQ C-30) scale before their first cycle of chemotherapy, on the 10th day after (T1), and again 10 days after the second cycle of chemotherapy (T2). Patients received an individual educational intervention at baseline, T1, and T2 based on the results of their CRF assessment. Patients were given an educational booklet on CRF prior to treatment and symptom specific booklets as required atT1 and T2. The researcher found that at baseline, patients generally reported moderate levels of fatigue for each subscale of the (PFS) (behavioral, affective, sensory, and cognitive), but the levels decreased with each subsequent intervention (i.e., at T1 and T2). Following the educational intervention, mean scores in the functional domain of the EORTC QLQC-30 (physical, role, cognitive, emotional, social, and global QOL) have been increased while symptoms (fatigue pain, lack of appetite) have been decreased at both T1 and T2, compared to baseline.

Recommendation

These findings emphasized the importance of developing a nursing educational program regarding CRF assessment. This is crucial for the provision of appropriate educational interventions to patients prior to chemotherapy in order to help in reducing severity of CRF and improve quality of patient's life. There is need to expanded nursing

educational programs regarding CRF assessment and possible management options to reduce severity of CRF and improve their quality of life. New randomized clinical trials are necessary to indicate the best strategies for overcoming this problem among cancer patients.

Summary and Conclusion

Cancer-related fatigue is the most commonly reported side effect of cancer and its associated treatment options, mainly chemotherapy. Cancer-related fatigue differs from that induced by other causes, such as sleep disturbance and exertion, as the latter are typically alleviated by a period of rest. This literature review considered the effect of several factors including exercise on CRF among patients treated with chemotherapy. Evidence from these studies supports the inclusion of scheduled exercise in the care plan of patients undergoing chemotherapy. Patients with cancer may be challenged to do exercise with nursing support.

This support can be made more effective if the recommended exercise program is regularly adjusted to the patients' health status with consideration to other factors such as level of hemoglobin, age, course of chemotherapy. Nurses' awareness of the role of exercise in managing related CRF can provide better education that benefits patients. Results of included studies indicated that exercise and psychological interventions provided reductions in cancer-related fatigue.

References

Andrykowski, M.A., Curran, S.L., Lightner, R. (1998). Off-Treatment Cancer-related fatigue in Breast Cancer Survivors: A controlled Comparison. Journal of Behavior Med, 21:1-18

Berger, A.M., Lockhart, M.K., and Agrawal, S. (2009). Variability of Patterns of Cancer related fatigue and Quality of LifeOver Time Based on Different Breast Cancer Adjuvant Chemotherapy Regimens. Oncology

Nursing Forum, Vol.36 (5), 563-570

Berndt, E., Kallich ,J., McDermot, A., Xu, X., Lee H., and Glaspy, J. (2005) Reductions in Anemia and Cancer-related fatigue are Associated with Improvements in Productivity in Cancer Patients Receiving Chemotherapy. Pharmacoeconomics; 23 (5), 505-514

Blaney J., Lowe-Strong A., Rankin J., Campbell A., Allen J., and Cracey J. (2010). The Cancer Rehabilitation Journey: Barriers to and Facilitators of Exercise Among Patients With Cancer-Related Fatigue. Physical therapy, 90 (8), 1135-1147

Carey M., Burish T.G. (1988). Etiology and Treatment of the Psychological Side Effects

Associated with Cancer Chemotherapy: A critical review and discussion. Psychological Bulletin, 104(3), 307-325.

Cleeland, C.S.(2007). Symptom Burden: Multiple Symptoms and Their Impact as Patient-Reported Outcome. Journal of the National Cancer Institute Monographs, No. 37: 16- 21

Dickinson, G. E., Clark, D. &Sque, M. (2008). Palliative Care and End of Life Issues in UK

Pre-registration, undergraduate nursing programs.Nurse Education Today, 28: 163-170

Erickson, J.M., Beck, S., Christian, B., Dudley, W., Hollen, P., Albritton, K.,(2010).Patterns of Cancer-related fatigue in Adolescents Receiving Chemotherapy.Oncology Nursing Forum, Vol.37, No.4, 444-455.

Gibson, F., Mulhall, A.B., Richardson A., Edwards J.L., Ream, E&Sepion, B.J. (2005). A

Phenomenologic Study of Cancer-related fatiguein Adolescents Receiving Treatment for Cancer. Oncology Nursing Forum, 32, 651-660.

Hofman, M., Ryan, J., Figueroa-Moseley, C., Jean-Pierre, P. Morrow, G. (2007). Cancer-Related Fatigue: The Scale of the Problem. The Oncologist, 12, 4-10.

Hwang, S., Chang, V., Rue, M., Kasimis, B. (2003). Multidimensional

Independent Predictors of Cancer-Related Fatigue. Journal of Pain Management. 26(1):604-614.

Kuchinski A-M., Reading M., and Lash, A.A. (2009).Treatment-Related Cancer-related fatigue and Exercise in Patients with Cancer: A Systematic Review. Journal of Medical Surgical Nursing, Vol. 18. NO.3, 174-180

Lee, Y-H., Tsai, Y-F., Lai, Y-H., & Tsai, C-M.(2008). Cancer-related fatigue: Experience and Coping Strategies in Taiwanese Lung Cancer Patients Receiving Chemotherapy .Journal of Clinical Nursing, 17, 876-883

Lucia A., Earnest C., & Perez M. (2003). Cancer-Related Fatigue: Can Exercise Physiology Assist Oncologists? The Lancet Oncology, 4, 616-625.

Miaskowski C., Dodd M., & Lee K. (2004). Symptom clusters: The New Frontier in ….Symptom Management Research. Journal of the National Cancer Institute. Monographs, 32, 17-21.

Mustian KM, Morrow GR, Carroll JK. (2007). Integrative Nonpharmacologic Behavioral Interventions for the Management of Cancer Related Fatigue. The oncologist,;12:52- 67

Nail, LM., King, KB. (1987) Cancer-related fatigue: A side Effect of Cancer Treatments. Semin Oncology 3:257-262

National Comprehensive Cancer Network (NCCN) (2012). NCCN clinical practice guide-lines in oncology: cancer-related fatigue; Available at: http://www.nccn.org/professionals/physician_gls/PDF/fatigue.pdf/. Accessed April 12, 2012.

Patrick D.L., Feketich S.L., Frame P.S., Harris J.J., Hendricks C.B & Levin B (2003). National Institutes of Health State of the Science Conference Statement: Symptom Management in Cancer: Pain, Depression, and Fatigue. Journal of the National Cancer Institute, 95(15), 1110-1117

Prue G., Rankin J., Allen, J. et al. (2006). Cancer-Related Fatigue: A critical Appraisal. ….European

Journal Cancer. 42 (7), 846-863

Rayan JL., Carroll JK., Rayan EP., Mustian KM., Fascella K., Morrow GR. (2007). Mechanisms of Cancer-Related Fatigue. The Oncologist Journal. 12 (1):22

Simon, A., Zittoun, R. (2000). Cancer-related fatigue in Cancer Patients. Current Opinion Oncology; 11:244-249

Wasteson E., Brenne E., Higginson I., Hotopf M., Loyd-Williams M & Kaasa S (2009). Depression Assessment and Classification in Palliative Cancer Patients: a systematic literature review. Journal of Palliative Medicine, 23(8) 739-75

Wielgus K.K., Berger A.M. and Hertzog M. (2009). Predictors of Fatigue30 Days after Completing Anthracycline Plus Taxan Adjuvant Chemotherapy for Breast Cancer. Oncology Nursing Forum. 36, (1), 37-48

William E., Dale G., Godley J. & Neimeye R. (2003). Roles for Psychologists in End-of-Life Care: Emerging Models of Practice. American Psychological Association, 34, (6), 626 - 633.

Yeh C.H., Chiang Y.C., Lin L., Yang C-P., Chien L-C., Weaver MA., and Chuang H-L. (2008). Clinical factors associated with cancer-related fatigue over time in pediatric oncology patients receiving chemotherapy. British Journal of Cancer, 99, 23-2

Yesilbalkan O.U. (2009).The Effectiveness of Nursing Education as an Intervention to Decrease Fatigue in Turkish Patients Receiving Chemotherapy. Oncology Nursing Forum Vol. 36, No. 4, E215-E222.

Youngmee Kim, PhD, Jane T. Hickok, MD, MPH, and Gary Morrow, PhD, MS(2006). Cancer-related fatigue and Depression in Cancer Patients Undergoing Chemotherapy: An Emotion Approach.Journal of Pain and Symptom Management Vol. 32.

Yurtsever S. (2007).The Experience of Cancer-related fatigue in Turkish Patients Receiving Chemotherapy. Oncology Nursing Forum, Vol.34, NO3, 721-728

STRESS AND COPING AMONG PSYCHIATRIC NURSES

Asem Ahmed Abdalrahim

Correspondence:
Asem Ahmed Abdalrahim, MSN, RN
Lecturer- Faculty of Nursing
Hashemite University
Phone:+962796328487
Email: asemalhmoud@yahoo.com

Abstract

Objective: This paper reviews current literature of stress and coping among psychiatric nurses to gain more information about psychiatric nursing job stress, coping strategies, and the relationship between job stress and coping strategies.

Method: Published research was systemically retrieved, interrogated, and analyzed.

Result: Twenty studies met the inclusion criteria. The present review of nursing literature has highlighted a dearth of studies addressing stress and coping in psychiatric nurses. This limits the ability to compare and synthesize findings. However, the published studies paint a picture of psychiatric nurses' experiences related to workplace stress and interpersonal relationships, particularly with patients and colleagues. These stressors can lead to poor health and daily functioning. Nurses also experience job dissatisfaction and report their intention to change profession as a result of work-related stress. Psychiatric nurses use mainly problem-focused strategies to deal with work stress. Commonly used problem-focused strategies include problem orientation and social support. Overall, psychiatric nurses perceive social support, particularly family support, as an essential component in their coping with stress. It is recommended that health organizations recognize the need to provide appropriate support to nurses, perhaps in line with western initiatives.

Discussion: There is no study that has been conducted on the topic in Jordan. Therefore, the research about this topic is a national and international priority. We hope, however, that the next few years will witness conducting some researches about this topic in Jordan in the light of current development in our national competencies that are qualified to conduct such research.

Key words: stress, coping, psychiatric, nurses, Jordan.

Introduction

Stress is a term often used by individuals in a variety of social, academic, and employment settings. However, nursing is a stressful profession that deals with intense human aspects of health and illness (Arafa et al., 2003). The presence of workplace stress among nurses is considered as a cost factor on the health care organization. According to the American Institute of Stress (AIS), stress is considered number one health problem in America. Recently it was estimated that the cost of stress is approximately $250 to $300 billion annually. This cost can involve absenteeism, diminished productivity, nursing turnover, short- and long term disabilities, workplace accidents, emotional problem, clinical incompetence, direct medical, legal, and insurance fees (ILO, 2000). Carson et al. (1995) concluded that the levels of work stress experienced by psychiatric nurses are unusually and especially high. While psychiatry nursing has similarities to other nursing specialties, it differs as staff have more intense relationships with their patients, engage in preventing self-harm, and often face higher levels of challenging behaviors in the environment (Dallender et al, 1999; Jenkins and Elliott, 2004). Many sources of stress in psychiatric nurses work have been identified, such as heavy workload, organizational structure, difficulties with patients, home/work conflict, and inter professional conflict , which lead to feelings of depression, helplessness and hopelessness. The link between work stress and somatic complaints, coronary heart disease, alcoholism and attempted suicide has also been well documented (McVicar, 2003 & Tully, 2004).

Although the stress in the psychiatric nurses' environment can affect the care provided and contribute to burnout (Currid, 2008), it is still

very prevalent. According to the Royal College of Nursing (2005), forty percent of nurses in acute mental health care show signs of psychological ill health, and fourteen percent of them are classified as in distress. Despite these significant and dangerous outcomes, studies into stress in mental health nursing are few, and studies specifically looking at acute mental health nurses are even fewer (Currid, 2008). So, the fact that there is little known about stress in acute mental health inpatient nurses, and its dangerous effects on the nurses' health and their profession, made it a very significant topic.

Few studies have been conducted in Jordan about stress and coping among Jordanian nurses. For example, Hamaideh, Mrayyan, Mudallal, Faouri and Khasawneh (2008) conducted a study about Jordanian nurse's job stressors and social support. However, there is not any study conducted in Jordan to explore psychiatric nurse's stressors and their coping methods to deal with the every day life difficulties present in their job.

When implementing strategies to improve acute wards, it is important that we also look at wellbeing of staff who deliver the care to the vulnerable patients in this specific area of nursing (Currid, 2008). Psychiatric nurses need to manage their stress and keep themselves well before they can provide care for the clients. To reduce nurse's job stress, first we need to recognize the impacts of job-related stress and make use of the most effective coping methods to manage it (Wang, Kong, & Chair, 2009).

The purpose of this literature review is to gain more information about psychiatric nursing job stress, coping strategies, and the relationship between job stress and coping strategies through identifying factors contributing to stress in psychiatric nurses, the effects of stressors on nurses' health and the various coping strategies employed by them.

Methods

The analysis was conducted in two parts. The first part focused on stressors and stress outcomes, whereas the second component reviewed research examining coping strategies.

Search strategies

Most popular were multiple databases searches, followed by individual database searches and online search engines. Multiple databases searches were conducted by searching EBSCOhost Web: Academic Search Complete, CINAHL, MEDLINE, Education Research Complete, Psychological and Behavioral Sciences Collection, Professional Development Collection, ERIC, Research Starters-Education. The individual database searches were conducted using each of the following databases alone, SpringerLink, Oxford University Press Journals, Pubmed database, BMJ, CMA, BMC, and Scopus using the following keywords in various combinations: "nurse", "stress", "coping", "ways of coping", "ways of coping with stress for psychiatric nurses", and "occupational stress".

Inclusion and exclusion criteria

The literature search was based on a theoretical rather than on a systematic review format. This search strategy resulted in 25 articles of potential relevance to this review and all were obtained in hard copy. Each article was read in full and assessed for relevance to the review with reference to the following inclusion criteria: English language publication; primary research paper; research that measured stress and/ or coping as outcomes; and psychiatric nurses. Seven studies were excluded from the final review. These included non-nursing participants and/or outcomes other than stress and/or coping.

Nursing Job Stress

Lazarus and Folkman (1984) defined stress as "any situation in which internal demands, external demands, or both, are appraised as taxing or exceeding the adaptive or coping resources of an individual or group".

In nursing, stress of working nurses is a worldwide issue and its prevalence is high. Gray-Toft (1981) investigated the causes and effects of nursing stress in the nursing workplace setting. It was hypothesized that the sources and frequency of stress experienced by nursing staff were functions of the type of unit on which they worked, levels of training, trait anxiety, and socio-demographic characteristics. It was also hypothesized that high level of stress would result in decreased job satisfaction and increased turnover among nursing staff.

Most studies on stress in nursing have focused on general nursing specialties, and relatively little awareness has been paid to psychiatric nurses. Psychiatry nursing has similarities to other nursing specialties, however, its difference is that psychiatric nurses have more deep relationships with their patients, engage in preventing self-harm and often face higher levels of challenging behaviors in the environment (Jenkins and Elliott, 2004), which cause excessive level of workplace stress to psychiatric nurses (Edwards & Burnard 2003). In addition mental health work is, in itself, inherently stressful and this has been documented; many studies provided a great deal of evidence to support the conclusion that the levels of work stress experienced by psychiatric nurses are unusually and especially high (Tully, 2004; Carson et al., 1995).

Research studies in psychiatry nursing identified several sources of stress; Sullivan (1993) found that violent incidents, potential suicide and observational practices are main sources in acute care staff. In contrast, Nolan (1995) identified heavy workload, organizational structure, difficulties with patients, home/work conflict, inter-professional conflict and professional self-doubt to be the most frequent. In addition Yada, Abe, Omori, Ishida, and Katoh (2009) identified

stressors for psychiatric department nurses, and compared the differing stress variables and levels of stress encountered in the acute ward and the recuperation ward. The results of this analysis found according to the correlations between demographics and nurses' stressors; that Nurses' stressors correlate significantly and positively with shift worked, level of education and model of nursing care provision.

Boey et al. (1997) examined work stress in 1043 nurses from three public hospitals and found that one-third of this population reported extreme work stress due to staff shortages and high demands from work resulting in work overload as the most stressful situation for nurses. In addition to these causes Lateef et al. (2001) in a sample of 80 emergency nurses reported more than half of their sample rated stress levels as "moderate to extreme" and almost one-fifth of nurses experienced stress daily resulting from aggressive patient behavior, which was the most stressful experience. Furthermore, work-family conflicts were ranked last as a stressful contributor to work-related situations (Chan et al., 2000). Staff in acute mental health care are frequently subjected to violent and aggressive behaviors from patients (Currid, 2009). In addition, psychiatric nurses who are working on locked units provide care for clients who require increased observation and complex treatment modalities. This exposes these psychiatric nurses to a variety of difficult work-related stressors (White, 2006). Moreover, Edwards and Burnard (2003) mentioned many sources of stress among psychiatric nurses as administration and organizational concerns, client-related issues, heavy workload, staffing levels, inter professional conflict, financial and resource issues, professional self-doubt, and home/work conflicts.

White (2006) classified occupational stressors among psychiatric nurses into two major sources, external and internal. He also divided external

stressors into major life events, hassles and uplifts, occupational stressors such as patient demands, organizational and managerial issues, staffing, future concerns, job satisfaction, and adverse physical conditions such as hot or cold temperatures and pain. In addition, he divided internal stressors into physical and psychological influences. Physical influences such as trauma, infections, and inflammation. Psychological influences such as fear, uncertainty, intense worry, and unfulfilled anticipation (White, 2006).

According to Currid (2008), the acute mental health wards are busy, challenging and much criticized environments. Stress experienced at work by the psychiatric nurse is related to many factors such as dealing with disturbed and unpredictable patients, having a lack of promotion prospects, having to deal with colleagues who do not do their share of the work, and having too little time to plan and evaluate treatment (White, 2006). Additional sources of stress for psychiatric nurses include feeling professionally isolated, particularly when required to respond to crises and suicidal clients, difficulties in communicating with one's colleagues and managers, lack of adequate communication and support from fellow professionals, and the lack of personal safety particularly when working with unpredictable and potentially violent clients (Leary et al., 1995).

White (2006) mentioned the most frequently reported stressors by psychiatric nurses include dealing with difficulties that occur when they try to take action against incompetent staff, inadequate staffing coverage in potentially dangerous situations, and having to deal with colleagues who do not do their share of the workload. He also mentioned some of the less frequently reported stressors include having to deal with potentially suicidal patients, feeling inadequately trained to deal with violent patients, having to deal with disturbed and unpredictable patients,

and having insufficient training to work with difficult patients.

In addition, Shen, Cheng, Tsai, Lee, and Guo (2005) reported that the occupational stress among psychiatric nurses in Taiwan was associated with young age, widowed, divorced, or separated marital status, high psychological demands, low work support, and threat assault at work. Moreover, Shen et al. (2005) stressed that the threat of being attacked has become the most important source of stress among psychiatric nurses.

Konstantinos and Christina (2008) identified the number of stressors for mental health nurses working in hospitals included the poor professional relationships as the lack of collaboration between doctors and mental health nurses, conflicts between nurses and doctors, and lack of doctors' respect for nurses' opinions and their participation in decision making about patients' care. Konstantinos and Christina (2008) also mentioned that mental health nurses are become stressed by difficulties in relationships and conflicts with other staff nurses they work with.

Happell (2004) proposed that the workload was the highest perceived stressor for psychiatric nurses, followed by inadequate preparation. In addition to organizational issues, lack of nursing staff was also found to be directly related to the mental health nurses' stress (Konstantinos & Christina, 2008).

As evidenced by the previous literature, the sources of stress for psychiatric nurses working in different settings are complex and not limited. However, most of the literature focused on the risk of violent and aggressive patients, the complex treatment modalities and therapies, organizational concerns, heavy workload, poor professional relationships, communication and collaboration, lack of staff, low work support, and inadequately trained staff.

Very few studies have been performed in Jordan addressing job stress. Hamaideh et al. (2008) in their study about Jordanian nurses' job stressors and social support examined the stressors that Jordanian nurses commonly face in their work setting, social support they received to decrease the influence of these stressors and the relationships between Jordanian nurses stressors and the sample's characteristics. The researchers used a descriptive co-relational research design; a convenience sample of 464 Jordanian nurses who were working in 13 Jordanian hospitals participated in this study. The analysis showed the workload, dealing with issues of death and dying, and conflict with physicians were the most prevalent stressors among Jordanian nurses. In a similar study, Mrayyan in 2009 explored differences between Intensive Care Units (ICUs) and wards in regard to Jordanian nurses' job stressors and social support behaviors as well as predictors of the two concepts. High job stressors and low social support behaviors were evidenced in Jordan. Job stressors were higher in ICUs than those in wards, thus more social support behaviors should be provided to nurses in ICUs. Nurses' stressors should be assessed and managed. In all settings in general and in ICUs in particular, nurse managers should use various social support behaviors to buffer the influence of job stressors on nurses. In contrast there is no study investigating job stress among psychiatric nurses.

Several studies showed that chronic stress might result in increased morbidity and mortality. As a result, nurses bear an increased risk of certain diseases (McNeely, 2005). In addition, the excessive and persistent stress result in deterioration in an employee's adequate adjustment with various dimensions of professional life and personal life (Kumari & Mishra, 2009). Signs and symptoms of stress, however, differ among individuals ("Help guide", 2007).

Help guide (2007) proposed the consequences of stress on psychiatric nurses' health. The negative symptoms consequent of workplace stress include cognitive, physical, emotional, and behavioral symptoms. The cognitive symptoms include memory problems, poor judgment, indecisiveness, inability to concentrate, seeing the negative side of an issues, loss of objectivity, anxiety, racing thoughts, constant worrying, trouble thinking clearly, and fearful anticipation that something will happen. The physical symptoms include headaches, muscle tension and stiffness, diarrhea or constipation, nausea, dizziness, insomnia, chest pain, rapid pulse, weight gain or loss, skin breakout, and frequent colds. Moreover, the emotional symptoms include moodiness, agitation, restlessness, short temper, irritability, impatience, inability to relax, feeling tense, feeling overwhelmed, sense of isolation, and depression. Finally, the behavioral symptoms include sleeping disturbance, eating pattern disturbance, neglecting responsibilities, procrastinating, overdoing activities, substance abuse, jaw clenching, and overreacting to unexpected problems, and picking fights with other.

In addition, Fagin, Brown, Bartlett, Leary, and Carson (1995) proposed the consequences of stress on psychiatric nurses' job performance through psychiatric nurses with high level of stress are more likely to have a higher number of days off sick, have lower self-esteem scores and feel unfulfilled in their work. This also affects their relationships with clients, especially in their ability to empathize with their problems. Furthermore, Kumari and Mishra (2009) cited that problems from stress are especially relevant to poor job performance, lowered level of self esteem resentment of supervision, inability to concentrate and make decisions, and job dissatisfaction. These outcomes of stress can have direct cost effects on the organization.

Coping

Coping is defined as the cognitive and behavioral efforts made to master, tolerate or reduce external and internal demands and conflicts (Folkman & Lazarus 1980). Studies on coping in nurses have revealed several significant findings.

Coping behaviors are generally classified as problem-oriented (long-term) or affective-oriented (short-term) methods. The problem-oriented strategies are those used to solve stress-producing problems, whereas the affective-oriented manage the emotional component involved. Short-term coping methods (eating, sleeping, and smoking) reduce tension temporarily but do not deal directly with the stressful situation. Drawing on past experience and talking it out with others are examples of long-term stress-reduction methods (White, 2006).

Most nurses engage in positive, problem-focused coping: the ability to develop a strategy that addresses the cause of the stress and is considered to be the most effective strategy to deal with stress (Bennett et al. 2001; Carson et al. 1999; Dallender et al. 1999). Folkman & Lazarus (1980) have also hypothesized that some people tend to use emotion-focused coping, a strategy considered to be less effective in reducing stressful demands. Emotion focused coping deals with the unpleasant emotional effects of stress rather than finding a way to upgrade its cause. Strategies include distancing from the problem, avoiding stressful situations and exercising self-control over feelings and behaviors (Lambert et al. 2004). However, focused coping strategies may have negative outcomes, some studies have indicated that using distancing and self-control may actually predict better mental health in nurses (Folkman et al. 1986; Lambert et al. 2004).

Stress outcomes can be either positive or negative depending on the effectiveness of coping. If the

individual copes effectively with the internal or external stressor, the individual will experience a positive outcome. If the individual is unable to cope with the stressor effectively, then a negative outcome will result (White, 2006).

Most people use a mixture of these coping styles and this is reflected in the literature. For example, Lateef et al. (2001) found that Singaporean nurses used a variety of coping strategies in stressful times. Five top coping strategies were identified: planning actions from past experiences; talking to friends and colleagues; going for a holiday; having adequate rest; and diversional therapy. Approximately three-quarters of nurses would approach a colleague or senior staff member for help if they needed someone to talk to, indicating that social support at work is an important strategy in dealing with work stress.

Problem orientation is similar to Folkman and Lazarus's (1988) Planful Problem Solving where efforts are aimed at resolving the problem situation. Problem-focused strategies among stress-resistant nurses mainly were used (Boey, 1998; 1999). These included scrutinizing the problem, managing time efficiently and adjusting workload. In addition, these resilient nurses were able to maintain good mental health by seeking and receiving greater support from family relationships than highly stressed nurses who did not have high levels of support from their families. In contrast, distressed nurses who exhibited more psychological symptoms used more negative strategies such as suppression of feelings and blaming others. Nurses who engaged in problem-focused strategies had a better mental health status as measured by the General Health Questionnaire (GHQ-30) and higher self-esteem and internal locus of control (Boey, 1999). These findings concur with Chan et al.'s (2000) study of work stress and family support in working professionals. They found nurses

who have above average scores for family support reported fewer negative health symptoms.

Tysona et al. (2002) described three types of coping strategies among hospital nurses. The first one is the problem-solving strategy, which includes defining goals, planning and searching for alternative solutions. The second strategy is the social support strategy, which is the tendency to turn to others for advice, communication, and comfort. The last one is the avoidance strategy, which involves physical or psychological withdrawal through distraction or fantasy.

Coping with Stress among Psychiatric Nurses

Addressing methods of coping among psychiatric nurses may help to increase an individual's ability to cope effectively and as a result, reduce experienced levels of stress and burnout (White, 2006). Therefore, how psychiatric nurses cope with job stress is an important concern. This concern is not only for the psychiatric nurses themselves but also for the organizations, since job stress leads to burnout, illness, absenteeism, poor morale of staff, and reduction in their efficacy and productivity (Coyle et al., 2000). In addition, psychiatric nurses utilizing effective coping methods frequently experienced less stress (White, 2006).

Wang et al. (2009) described three frequently used methods by nurses to cope with stress that are evasive (avoidant activities used in coping with a situation), confrontive (confront the situation, face up to the problem, constructive problem solving), and optimistic (positive thinking, positive outlook, positive comparisons).

White (2006) reported that psychiatric nurses favored informal approaches to coping with the occupational stress. These approaches include having pastimes and hobbies outside of work, knowing that life outside of work is

healthy, enjoyable and worthwhile, looking forward to going home at the end of the day, having a stable home life that is kept separate from their work life, and having confidence in one's abilities to do the job well.

White (2006) conducted a study on 46 psychiatric nurses, and reported that the most coping strategies often used by the psychiatric nurses working on locked units is having pastimes and hobbies outside work, and the second most often utilized coping strategy was knowing that life outside of work is healthy, enjoyable and worthwhile. On the other hand, the least utilized coping strategy was having confidential one-to-one supervision, and the second least utilized coping strategy was having team supervision.

Interestingly, Coyle et al. (2000) conducted a study on 640 community psychiatric nurses, and reported the same results. The study reported that most methods of coping with occupational related stress are knowing that life outside of work is healthy, enjoyable and worthwhile and having a stable home life that is kept separate from the work life. In addition, the least methods used are confidential one-to-one supervision, and the second least utilized coping strategy was having team supervision. The study stressed that there are some coping strategies built upon structures available within the psychiatric nurses' workplace such as supervision and staff support group.

Reininghaus, Craig, Gournay, Hopkinson, and Carson (2007) explored specific stress resistance resources utilized by psychiatric nurses subjected to physical assault and other related stressors. They found that self-esteem, self-con?dence, and coping met the criteria of general stress resistance resources. They also concluded that assaulted psychiatric nurses who have a supportive manager scored lower on psychological distress than non-assaulted nurses who have an unsupportive manager. This study indicates that psychiatric nurses can

cope with work stressors effectively using the supportive system in the area that they work with.

Edwards and Burnard (2003) conducted a systematic review to determine the effectiveness of stress management methods that mental health nurses utilize. They reported that the most frequently reported coping strategies utilized by mental health nurses were social support, having stable relationships, recognizing limitations, dealing with problems immediately they occur, fitness levels, peer support, personal strategies, supervision, good home life with family and partner and interests outside of work. The researchers also reported that the factors associated with increased use of coping skills are being female, particularly for social support and emotional comfort, more experience in the field, being older, jobs security and work setting.

One inadequate way of coping strategy utilized by psychiatric nurses to cope with stress is to consciously or unconsciously distance themselves from the source of stress. This coping mechanism has negative effects on the therapeutic relationship between the psychiatric nurse and the client if psychiatric nurses are still distant or indifferent to their patients (Fagin et al., 1995).

Fagin et al. (1995) explored the effects of six coping strategies utilized by psychiatric nurses to alleviate work stress, that are social support (help from peers), task strategies (ways of organizing work), logic (using a detached approach), time (awareness and management), involvement (identification with work aims), and home and work relationships (the balance between home and work). The study concluded that all of the six coping strategies were effective to alleviate work- related stress except the logic (using a detached approach).

Other study reported that the methods for coping with stress among psychiatric nurses include efficient management of time, planning for team meetings and the construction of support networks in addition to improvements in communications both within and between determent professional disciplines (Leary et al., 1995).

Tully (2004) focused his study on students of psychiatric nurses and mentioned that they experience stress as any other qualified nurses. In addition, he found that psychiatric nurse students owned limited coping skills such as: wishing things were different, comfort eating, drinking, smoking or taking medications, and by taking it out on others and/or trying to forget it.

Tully (2004) also reported that psychiatric nurse students who reported lower levels of distress on the General Health Questionnaire (GHQ-30) tended to use more appropriate problem-solving methods of coping such as; talking to others, getting help, seeking advice and following it, changing things so that the situations may improve and taking things one step at a time.

Fothergill, Edwards, & Burnard (2004) conducted a systematic review to find out the effectiveness of stress management interventions for those working in the psychiatric profession. They mentioned two coping strategies utilized by mental health staff that include support from colleagues and outside interests.

As evidenced by the literature about ways of coping with stress among psychiatric nurses, the mostly used methods of coping are informal methods such as pastimes and hobbies outside of work. This indicates that there is a gap in the health care organizations as they rarely help psychiatric nurses to cope with their stressors. On the other hand, the most formal coping strategy that is reported to be effective is the managerial and peer support although it is reported as one of the least frequently used coping methods.

Conclusion

Job stress and coping among psychiatric nurses are essential for both individuals and organizations. Although stress and coping are very significant topics, very little research about this topic is available throughout the world. The present review of nursing literature has highlighted a dearth of studies addressing stress and coping in psychiatric nurses. This limits the ability to compare and synthesize findings. However, the published studies paint a picture of psychiatric nurses' experiences related to workplace stress and interpersonal relationships, particularly with patients and colleagues. These stressors can lead to poor health and daily functioning. Nurses also experience job dissatisfaction and report their intention to change profession as a result of work-related stress. Psychiatric nurses use mainly problem-focused strategies to deal with work stress. Commonly used problem-focused strategies include problem orientation and social support. Problem orientation is directed at resolving work-related issues, whereas social support acts as a form of emotional coping for nurses. Overall, psychiatric nurses perceive social support, particularly family support, as an essential component in their coping with stress. It is recommended that health organizations recognize the need to provide appropriate support to nurses, perhaps in line with western initiatives.

In addition, no study has been conducted about it in Jordan. Therefore, research about this topic is a national and international priority. We hope, however, that the next few years will witness the conducting of some research about this topic in Jordan in the light of current development in our national competencies that are qualified to conduct such research.

References

Arafa MA et al. (2003). Predictors of psychological well-being of nurses in Alexandria, Egypt. International journal of nursing practice, 9:313-20.

Bennett, P., et al. (2001) Stress in nurses: coping, managerial support and work demand. Stress and Health, 17, 55-63.

Boey KW, Chan KB, Ko YC, Goh LG, Lim GC. (1997). Work stress and psychological well-being among the nursing profession. Singapore Med. J.; 38: 256-260.

Boey KW. (1998). Coping and family relationships in stress resistance: a study of job satisfaction of nurses in Singapore. Int. J. Nurs. Stud; 35: 353-361.

Boey KW. (1999). Distressed and stress resistant nurses. Issues Ment. Health Nurs. ; 19: 33-54.

Carson J., Fagin L. & Ritters S. (1995) Stress and Coping in Mental Health Nursing. Chapman & Hall, London.de

Carson, J., et al. (1999) Burnout in mental health nurses: much ado about nothing? Stress Medicine, 15, 127-134.

Chan EY, Morrison P.(2000). Factors influencing the retention and turnover intentions of registered nurses in a Singapore hospital. Nurs. Health Sci.; 2: 113-121.

Chan KB, Lai G, Ko YC, Boey KW. (2000). Work stress among six professional groups: the Singapore experience. Soc. Sci. Med.; 50: 1415-1432.

Coyle, D., Edwards, D., Hannigan, B., Burnard, P., & Fothergill, A. (2000). An explanation of the coping strategies used by community psychiatric nurses in Wales. Nursing and Health Sciences, 2, 59-67.

Currid, T. (2008). The lived experience and meaning of stress in acute mental health nurses. British Journal of Nursing, 17, 880-884.

Currid, T. (2009). Experiences of stress among nurses in acute mental health settings. Nursing Standard, 23 , 40-46.

Dallender J, Nolan P, Soares J, Thomsen S, Arnetz B (1999). A comparative study of the perceptions of British mental health nurses and psychiatrists of their work environment. J Adv Nurs 29(1): 36-43

Edwards D. & Burnard P. (2003). A systematic review of stress and stress management interventions for mental health nurses. Journal of Advanced Nursing 42, 169-200.

Fagin, L., Brown, D., Bartlett, H., Leary, J. & Carson, J. (1995). The Claybury community psychiatric nurse stress study: is it more stressful to work in hospital or the community? Journal of Advanced Nursing, 22, 347-358.

Folkman, S. & Lazarus, R.S. (1980) An analysis of coping in a middle-aged community sample. Journal of Health and Social Behavior, 21 (3), 219- 239.

Folkman, S., et al. (1986) Dynamics of a stressful encounter: cognitive appraisal, coping and encounter outcomes. Journal of Personality and Social Psychology, 50, 992-1003.

Folkman, S. & Lazarus, R.S. (1988) Ways of Coping Questionnaire: Sampler Set, Manual, Test Booklet, Scoring Key. Consulting Psychologists Press, Redwood City, CA.

Folkman, S. (n.d.). Ways of coping (revised). University Of California, San Francisco, USA. Retrieved 12 April 2011 from

http://www.caps.ucsf.edu/tools/surveys/pdf/Ways%20of%20coping.pdf

Fothergill, A., Edwards, D., & Burnard, P. (2004). Stress, burnout, coping and stress management in psychiatrists: Findings from a systematic review. International Journal of Social Psychiatry, 50, 54-65.

Gray-Toft, P., Anderson, J., (1981). The nursing stress scale: development of an instrument. Journal Behavioral Assessment 1, 11-23.

Hamaideh S, Mrayyan M, Mudallal R, Faouri I, & Khasawneh N. (2008). Jordanian nurses' job stressors and social support. International Nursing Review, 55, 40-47.

Happell, B. (2004). Stress, burnout, and job satisfaction in rural psychiatric nurses: A Victorian study. Australian Journal of Rural Health, 12, 120-125

Help Guide. (2007). Understanding stress: Sign, symptoms, causes and effects. Available from: http://www.helpguide.org/ mental/ stress_ signs. htm.

Jenkins R, Elliott P (2004) Stressors, burnout and social support: nurses in acute mental health settings. J Adv Nurse 48(6): 622-31

Konstantinos, N., & Christina, O. (2008). Factors influencing stress and job satisfaction of nurses working in psychiatric units: a research review. Health Science Journal, 2, 183-195.

Kumari, P., & Mishra, R. (2009). Effect of job stress and personal life stress on mental health and job outcomes of medical professionals. Available at http://poseidon01.ssrn.com/delivery.php

Lateef, F., Ng, A., and Anantharaman, V. (2001). Stress among nurses in the emergency department. Singapore Nurs. J. ; 28: 22-26.

Lambert, V., Lambert, C., & Itob, M. (2004).Workplace stressors, ways of coping and demographic characteristics as predictors of physical and mental health of Japanese

Lazarus, R. S., & Folkman, S. (1984). Stress, Appraisal and coping; Springer publishing Co, New York. Retrieved 12 April 2011 from

http://paracite.eprints.org/cgibin/openurl.cgi?sid=paracite&date=1984&aufirst=RS&aulast=Lazarus&genre=book&atitle

Leary, J., Gallagher, T., Carson, J., Fagin, L., Bartlett, H., & Brown, D. (1995). Stress and coping strategies in community psychiatric nurses: A Q-methodological study. Journal of Advanced Nursing, 21, 230-237.

McNeely, E. (2005). The consequences of job stress for nurses' health: Time for a check up. Nursing Outlook, 53, 291- 299.

McVicar, A. (2003). Workplace stress in nursing: a literature review. Journal of Advanced Nursing 44(6), 633-642.

Mrayyan, M. (2009). Job stressors and social support behaviors: Comparing intensive care units to wards in Jordan. A journal for the Australian nursing profession, 31, 163-75

Nolan, B. (1995). Sleep disturbances in Parkinson's disease. The comprehensive management of Parkinson's disease. New York.

Reininghaus, U., Craig, T., Gournay, k., Hopkinson, P., & Carson, J. (2007). The high secure psychiatric hospitals' nursing staff stress survey 3: identifying stress resistance resources in the stress process of physical assault. Personality and Individual Differences, 42, 397-408.

Royal College of Nursing. (2005). At breaking point? A survey of the wellbeing and working lives of nurses in 2005. Retrieved 12 April 2011 from http://www.rcn.org.uk/__data/assets/pdf_file/0003/78690/003021.pdf

Shen, H., Cheng, Y., Tsai, P., Lee, S., & Guo, Y. (2005). Occupational stress in nurses in psychiatric institutions in Taiwan. Journal of Occupational Health, 47, 218-225.

Sullivan, P. (1993). Communication skills training for interactive sports, The Sport Psychologist, 7(1), 79 - 91.

Tully A. (2004) Stress, sources of stress and ways of coping among psychiatric nursing students. Journal of Psychiatric and Mental Health Nursing 11, 43-47.

Tysona, P., Pongruengphant, R., & Aggarwal, B. (2002). Coping with organizational stress among hospital nurses in Southern Ontario. International Journal of Nursing Studies, 39, 453-459.

Wang, W., Kong, A., & Chair, S. (2009). Relationship between job stress level and coping strategies used by Hong Kong nurses working in an acute surgical unit. Applied Nursing Research, 101, 176 - 193.

White, R. (2006). Perceived Stressors, Coping Strategies, and Burnout Pertaining to Psychiatric Nurses Working on Locked Psychiatric Units (Unpublished master's thesis). Eastern Michigan University. Ypsilanti, Michigan.

Yada H, Abe H, Omori H, Ishida Y, Katoh T.(2009). Stressor among nurses in a psychiatric department--comparison between acute and recuperation wards, J UOEH. ;31(3):293-303.

EDUCATING NURSES FOR PERSON-CENTERED CARE

Lois Thornton

Correspondence:
Lois Thornton
University of Calgary, Qatar
P. O. Box 23133, Doha, Qatar
Telephone: 974 4406 5319
Fax: 974 4482 5608
Email: lethornt@ucalgary.edu.qa

Abstract

Background and Objectives: A person-centered model for long-term institutional care of elder persons is supportive of Arab societal values and Islamic beliefs. Four workshops were conducted for nurse leaders from long term care facilities in Qatar with the overall objective of initiating a practice culture change which would result in evidence of more person-centered care practices.

Methods: Workshops were held weekly for 4 weeks. Participants were 23 nurse managers and supervisors from 3 long term residential facilities in Doha, Qatar. Evaluation forms were completed by participants after each workshop and a focus group was conducted with the participants from one facility 12 weeks after the workshops.

Results: Participants reported increased person-centered care practices on their units. These practices began with staff coming together around shared values and philosophy and included: more attention to residents' personal preferences; inclusion of residents and family in decision-making and social activities; individualized care plans; therapeutic relationships.

Discussion: More research into the implementation of care models that support Arab religious and family values is essential to meet the growing need for high quality long term residential care in the Arab Gulf region.

Key Words: Person-centered care, education, elders, Arab society

Introduction

Long term institutionalized care for elderly persons is a relatively new phenomenon in the Arab Gulf countries. However, the Arab population, like the rest of the world, is aging and the need for residential long term care for older people is likely to increase. This need will be exacerbated by societal and family changes related to modernization that will challenge traditional expectations of the family to provide all care for its aging members (1,2). At present, residential long term care in the region tends to be clinically and task oriented (3, 4). In most instances, care is provided by expatriate nurses of diverse backgrounds and various levels of knowledge of Arab culture and society. Models of care that support Arab religious and family values are required for high quality long term care alternatives for Arab families.

A person-centered model of care ensures the dignity of the individual and encourages involvement of the family unit in care, in keeping with Arab societal values and Islamic belief. As well, a person-centered care framework could bring a diverse nursing workforce together around a common philosophy and consistent approach, leading to improved health outcomes and satisfaction of residents and their families (5). Person-centeredness is grounded in shared values and expressed through the workplace culture of care.

This paper describes an educational program provided to nurse leaders of long term care facilities in Qatar. Utilizing the person-centered care framework developed by McCormack & McCance (5), the intent of the program was to introduce nursing leaders to the concepts of person-centered care, investigate shared values that facilitate the development of a person-centered workplace culture,

and analyze how the shared values are operationalized in practice. By directing the education to nursing leaders, it was hoped that they would transfer their knowledge to front-line staff, encourage action learning by staff and begin a culture shift on their units.

Literature Review

Nursing has long identified person-centeredness, holism and individualized care as being integral to quality patient care. However, within the past decade the international focus on humanizing health and social services has precipitated extensive research and literature on the meaning of the term "person-centered" and its implications for nursing and other healthcare practice (5). Person centered care has been defined as "an approach to practice that is established through the formation and fostering of therapeutic relationships between all care providers, patients, and others significant to them" (6, p. 3) and is based on the values of respect for persons, self determination, mutual respect and understanding.

McCormack & McCance (5) purport that nurses often experience person-centered "moments" in their practice, but that sustained cultures of care where person-centeredness is commonly recognized as the "way of doing business" are infrequently encountered. Person-centered cultures of practice are cultivated through a commitment to change and careful attention to the care environment and care processes as well as the attributes and skills of the nurses providing care (5).

The framework developed by McCormack & McCance (5) places person-centered outcomes at the center of a care environment that is supportive of person-centered care processes and dependent on the person-centered skills and attributes of the care givers. The outcomes-satisfaction with care, involvement in care, feeling of well-being, creation of a therapeutic culture-are

achieved only when there is synergy between the care processes, the care environment and the attributes of the carers. Person-centered processes describe the approaches taken in completing the tasks of care: working with patients' beliefs and values; shared decision making; engagement of nurse and client; having sympathetic presence, and providing holistic care (5). The processes can happen only in an environment that supports shared decision-making, power sharing, and effective staff relationships, that attends to appropriate skill mix and that facilitates innovation and risk-taking. Both the care processes and the care environment are made possible by the pre-requisite attributes of the nurses: professional competence, developed interpersonal skills, commitment to the job, clarity of beliefs and values, and a good knowledge of self (5).

Procedure

The overall goal of the workshops was to begin a practice culture change which would result in evidence of more person-centered care practices. The objectives were (5):

- To promote an awareness and understanding of person-centered nursing

- To articulate explicit values and beliefs that inform the provision of nursing care

- To develop a shared vision that promotes person-centered nursing practice

- To collect information on the quality of resident and staff nurse experience in order to benchmark practice change

- To identify areas for practice change

The workshops were facilitated once a week over four consecutive weeks. Participants included head nurses and nursing supervisors of two long term care facilities and a newly opened community care facility for assisted living. There were 23 participants in all. Attendance at each workshop varied from 23 to 16. A focus group was conducted with

participants from one of the long term care facilities 12 weeks later to evaluate the outcomes in practice. Written consent was received from all participants in the focus group.

Nurse leaders were targeted as participants with the expectation that they would become facilitators of practice change on their units. The workshops utilized creative ways of unleashing the nurses' leadership potential. By co-creating a shared vision for care, and critically reflecting on care practices, they moved a step toward developing a culture of person-centered care. During the final workshop, they agreed on one priority area for change. They clearly identified the problem, and brainstormed on an action plan for change. The nurses were enabled to use the action learning cycle, to critically reflect on their work and work environment and to develop alternative ways of thinking and doing that would enhance quality of life and satisfaction for residents and families.

The first workshop introduced the participants to the concept of person-centeredness and the person-centered care framework. An activity called "Victorian Parlour Game" (7) was used to help participants recognize empathy for the residents under their care. In this activity, participants were asked to think about the question: "if I were one of my residents, how would I feel right now?" The answers of all the participants were then organized into an insightful poem that indicated that each participant was aware of the feelings of isolation, loneliness and hopelessness often felt by residents of elder long term care. (See "In Long Term Care")

In small groups, participants mapped aspects of a case study against the person-centered framework. After plenary discussion of this activity, participants discussed in pairs how these concepts could be used to change some practices on their units, and decided on three ways that they could use these ideas in their practice in the coming week.

Component	Description
Person-centered Outcomes	• Satisfaction with care • Feeling involved in care • Having a feeling of well-being • Creating a therapeutic culture
Care Processes	• Working with patients' values and beliefs • Engagement of nurses and clients • Shared decision-making • Having sympathetic presence • Providing holistic care
The Care Environment	• Appropriate skill mix • Shared decision-making systems • Effective staff relationships • Power sharing • Potential for innovation and risk taking • Homelike, welcoming physical environment
The Prerequisites	• Professional competence • Developed interpersonal skills • Commitment to the job • Clarity of beliefs and values • Knowing self

Components of the Person-Centered Nursing Framework (5)

In the second workshop, participants reflected on their individual values and shared these with one other person in the group. Then they worked with others from the same nursing unit to agree on a common set of values and write a shared vision of nursing care in their unit using the following headings:

• We believe the purpose of our nursing care is...

• We believe this purpose can be achieved by...

• The factors that will help us achieve this purpose are...

• Other values and beliefs about nursing in our unit are...

The groups then created a poster depicting their vision and developed a plan for sharing this with their staff in the coming week. As preparation for the next workshop, they were asked to observe care on their unit in the coming week and note one instance of care that was in keeping with the vision, and one that did not fit with the vision.

During the third workshop participants evaluated the quality of the patient-centered processes on their units by comparing their observations of care with the vision that they had developed and identifying sources of data for evaluating practice. Using a provided set of questions to guide their

reflection on each of the person-centered processes, unit groups were asked to evaluate the quality of care on their units. They then brainstormed how they could validate these evaluations by using sources of data available to them. Each group developed a plan for evaluating the use of person-centered processes on their unit and for identifying areas of practice that needed to change.

The final workshop examined the attributes of the nurse and the care environment that are essential for a person-centered culture of care. It also aimed to assist participants to plan for a continuous trend toward a person-centered culture of care. In their unit groups, participants evaluated the context of care in their facility and discussed how the care environment contributes to the areas of care that they had identified for change. Plenary discussion identified and prioritized common themes related to change to the care context.

The top priority theme was then analyzed by the group to clarify the problem, identify the evidence of the problem, suggest desired outcomes, develop possible solutions, and decide on how outcomes could be evaluated. The action learning cycle (plan, act, observe, reflect) was presented as a process for ensuring continuous change in the care culture.

By engaging nursing leaders in reflecting on their practice settings and comparing what they see with the visions that they have developed, these workshops initiated a process of change toward more person-centered care. Identification of one priority area of change, and employment of the action learning cycle created the opportunity for the change process to be sustained.

Evaluation

An evaluation form was completed by participants at the end of each workshop. Participants commented: "have started (a change process)

and will continue"; "very, very much excited (to initiate a change in care practices)". Responses to the evaluation questions indicated that participants understood the concepts from the workshop, and were able to identify significant sources of data for evaluating care practices on their units. Many participants identified incongruence between care being provided on the units and their shared vision: "care is task centered" and "nurses do not spend time talking with residents". They recognized methods for gathering data on the care processes on their units including: talk with the residents and let them tell their stories; patient satisfaction survey; observation; asking questions; random visits; interviews with the residents and families; getting feedback from staff. The participants' high level of engagement in the unit group work as well as the plenary discussion indicated that the workshops were relevant to them. They commented after each workshop that they had enjoyed and learned from each session.

In order to evaluate the usefulness of the workshops in starting a process of change, a focus group was conducted at one of the participating long term care facilities 12 weeks after the workshops were completed. The purpose was to ascertain if indeed practice change had occurred that would provide greater quality of life and satisfaction for residents and families.

Focus group comments indicated that practice change related to individualized care, inclusion of residents and families in care decisions, and improved services to residents and families had indeed occurred. Admission assessment forms had been modified to include more information about residents' likes and dislikes, preferred activities, hobbies, etc. and individualized care plans were developed based on these preferences. Copies of the care plans were shared with families as well as the interdisciplinary team. Interests of family members were being noted and families were included in activities on the

units. Recognizing the desire of one resident to be involved in meal preparation, opportunities to help prepare meals for her family were provided, and a weekly cooking activity was made available to all residents.

A committee had been established to plan activities for residents and more activities were offered in the afternoon and evening to accommodate family participation. A volunteer visitor program provided residents with greater variety in interaction as well as companionship.

Nurses noted that residents were "more cheerful" and more active participants in their care. One nurse commented that resident/staff relationships were stronger. Nurses said that family members, too, indicated that they appreciated the extra attention.

Change did not come without some challenges. Nurses noted that it had been difficult to readjust care routines to accommodate resident preferences. There were on-going efforts to educate all staff about the unit vision through making it visible on posters throughout the facility and communicating it consistently at monthly unit meetings. The vision had also been published in both Arabic and English in the form of a handbook, an information booklet and a poster at the bedside along with the resident bill of rights.

Nurses also commented that the atmosphere at work had become more positive and that staff felt informed and involved in the changes being instituted. They felt that the challenge now was to increase the momentum of the change and to gain a reputation as a superior place to work.

Conclusion

Focus group comments indicated that a culture change was happening in this long-term care facility and that resident care was becoming more person-centered as outcomes of

of the workshops. In this case, a work environment that allowed nurses the freedom to create a unified vision for care and to recognize and change practices that did not conform to the vision resulted in greater satisfaction and quality of life for both nurses and residents.

This paper has described an educational program for nurse leaders in long term care intended to generate a work culture change to support the practice of person centered care. More research into the implementation of care models that support Arab religious and family values is essential to meet the growing need for high quality long term residential care in the Arab Gulf region.

References

1. El-Haddad, Y. Major trends affecting families in the Gulf countries 2003. http://www.un.org/esa/socdev/family/Publications/mtelhaddad.pdf

2. Sinunu M., Yount K., El Afify N. Informal and formal long-term care for frail older adults in Cairo, Egypt: Family caregiving decisions in a context of social change. J Cross Cult Gerontol 2009; 24: 63-76.

3. Margolis S, Reed, R. Institutionalized older adults in a health district in the United Arab Emirates: Health status and utilization rate. Gerontology 2001; 47: 161-167.

4. Al-Shammari S, Felemban F, Jarallah J, El-Shabrawy A, Al-Bilali S, Hamad J. Culturally acceptable health care services for Saudi's elderly population: the decision-makers perception. Int J Health Plan Manage 1995; 10: 129-138.

5. McCormack B, McCance T. Person-centered nursing: Theory and practice. Oxford, U. K.: Wiley-Blackwell; 2010.

6. McCormack B, Dewing J, McCance T. Developing person-centered care: Addressing contextual challenges through practice development. Online J Issues in Nursing 2011;16(2):1-

7. Nisker, J. Narrative ethics in health care. In Storch J, Rodney P, Starzonski R. eds. Toward a moral horizon: Nursing ethics for leadership and practice. Toronto: Prentice-Hall; 2004.

In Long Term Care

Longing for compassion and loving care
For feelings of belonging
And the hugs and kisses that is sweet
Lonely and useless
Frustrated and sometimes afraid
They pity me
Such boredom, sadness and loneliness
But even though I am sick I am in safe hands
Anxious but
If my parents are around, beautiful the life is
Need for much attention and love
The time is too long: nothing to do
Bored and depressed
Rejected, alone, pitiful, powerless, depressed
I want to be with my family right now
The touch of their caress, the smile on their faces
Their voice saying how much they love me
Repulsed by wound exudates and smell
Pain but
Life here is better than at my house
Cannot express my feelings
Useless, wasted, a burden to society
They deal with me as an object not
A human being
Machine centered care
Upset and irritable
Lonely and irritable
Thank God for what and who I am
I will overcome and use the best of my abilities
To survive.