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FROM THE EDITOR



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This is the third issue this year and has a number of interesting papers and topics. A paper from Qatar evaluated the quality of life instruments in a palliative care context through an integrative literature review. The author stressed that quality of life (QOL) research has been identified as a priority for nursing. A wide variety of QOL instruments have been developed to address a number of domains such as physical, functional, emotional, and social well-being. It has been proposed that meaning should also be included, as well as purpose, spirituality and grief. Evaluation of QOL instruments in palliative care is an important research priority. Considerable research has addressed the QOL and quality of care aspects for palliative patients, but there has been limited evaluation of the measurement technique for both in the Middle East. To the authors' knowledge no studies have been conducted to explore this issue in the Middle East, and

certainly not in Qatar. Therefore, this project promises to develop a new insight into the importance of evaluating the QOL measurement instruments that could potentially be used in the palliative care unit in Qatar. The overall objective of this paper was to examine the findings of an integrative for the purpose of determining cultural adaptations and validations of instruments needed to evaluate the QOL of patients in palliative care, and to discuss the use of these instruments in the Middle East context.

A research thesis paper from Sweden dealt with the rapid response team in a hospital setting. The rapid response team (RRT) decreases rates of mortality and morbidity in hospital and decreases the number of patient readmissions to the intensive care unit. The aim of the author was to describe current knowledge about medical-surgical nurses' experiences when they call an RRT to save patients' lives. The method used by the author was a literature review. The PubMed search database was used and 15 articles were selected, all of which were primary academic studies. Articles were analysed and classified according to specified guidelines; only articles of grades I and II were included. The results revealed that years of experience and qualifications characterise the ability of a medical-surgical nurse to decide whether or not to call the RRT. Knowledge and skills are also important; some hospitals provide education about RRTs, while others do not. Teamwork between bedside nurses and RRTs is effective in ensuring quality care. There are some challenges that might affect the outcome of patient care: The method of communication is particularly important in highlighting what nurses need RRTs to do in order to have fast intervention. The author concluded that medical-surgical nurses call RRTs to help save patients' lives, and depend on their experience when they call RRTs. Both medical-surgical nurses and RRTs need to collaborate during the delivery of care to the patient. Good knowledge and communication skills are important in delivering fast intervention to a critically ill patient, so that deteriorating clinical signs requiring intervention can be identified.

A paper from Jordan dealt with The Use of Seclusion in Psychiatric Settings. The aim of the author is to reduce psychiatric inpatient seclusion by improving nurses role and providing opponents and proponents legal overviews, this issue is one of the most controversial practices in psychiatric care according to legal perspective, the differences in legal supply make differences of using seclusion; patients who experiences psychosis need management and control challenging behavior to contain this behaviors seclusion is used in psychiatric setting significantly and the most important debatable issue in psychiatric field, nurses must balance the responsibility for protecting patient rights with the duty to protect patients from harming themselves especially in situations that escalated to the point of danger, there are suggests course of action and possible solutions to movement action in reduce of seclusion included for clinical practice, staff training and education, research, and staffing and policy change parts, which increase the quality of care and to choose the best decision.

MEDICAL-SURGICAL NURSES' EXPERIENCES OF CALLING A RAPID RESPONSE TEAM IN A HOSPITAL SETTING: A LITERATURE REVIEW

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Abstract

Background: The rapid response team (RRT) decreases rates of mortality and morbidity in hospital and decreases the number of patient readmissions to the intensive care unit. This team helps patients before they have any signs of deterioration related to cardiac or pulmonary arrest. The aim of the RRT is to accelerate recognition and treatment of a critically ill patient. In addition, in order to be ready to spring into action without delay, the RRT must be on site and accessible, with good skills and training for emergency cases. It has been reported that many hospitals are familiar with the concept of RRTs. There is a difference between this team and a cardiac arrest team, since the RRT intervenes before a patient experiences cardiac or respiratory arrest.

Aim: To describe current knowledge about medical-surgical nurses' experiences when they call an RRT to save patients' lives.

Method: The method used by the author was a literature review. The PubMed search database was used and 15 articles were selected, all of which were primary academic studies. Articles were analysed and classified according to specified guidelines; only articles of grades I and II were included.

Results: Years of experience and qualifications characterise the ability of a medical-surgical nurse to decide whether or not to call the RRT. Knowledge and skills are also important; some hospitals provide education about RRTs, while others do not. Teamwork between bedside nurses and RRTs is effective in ensuring quality care. There are some challenges that might affect the outcome of patient care: The method of communication is particularly important in highlighting what nurses need RRTs to do in order to have fast intervention.

Conclusion: Medical-surgical nurses call RRTs to help save patients' lives, and depend on their experience when they call RRTs. Both medical-surgical nurses and RRTs need to collaborate during the delivery of care to the patient. Good knowledge and communication skills are important in delivering fast intervention to a critically ill patient, so that deteriorating clinical signs requiring intervention can be identified.

Key words: Medical-surgical nurse, rapid response team, experiences, challenges, hospital.

Introduction

There are some hospitals that apply plans to prevent mortality and morbidity for patients who are critically ill, by using guidelines to protect patients when a staff nurse notices signs of instability before undergoing cardiac arrest (Chan, Jain, Nallmothu, Berg, & Sasson, 2010; Butner, 2011). A nurse who is assigned to a critically ill patient will have the chance to help the patient to survive. Not all nurses expect that their patient is experiencing an arrest (Dwyer & Mosel, 2002). However, many studies have reported that the hospital staff's failure to recognise the early signs of deterioration in patients, such as decreasing systolic pressure and abnormal breathing, can lead to serious concerns, such as some cases like post surgical infection, cardiac arrest code and even death (Abella et al, 2005; Peberdy et al., 2003).

A patient has the right to receive good quality of care (Burkhardt & Nathaniel, 2008). Good quality of care means improving the available health services for individuals to achieve their desired outcomes (Vincent, 2010). Furthermore, good quality of care, from a hospital administration's point of view, means the prevention of illness, infection, and decreases the Intensive Care Unit (ICU) re-admissions. It has been suggested that, in order to improve patient outcomes, surveillance to identify problems should be linked to effective responses (Green & Allison, 2006). To tackle this issue, a system termed 'the Rapid Response Team' has been initiated (Institute for Health Improvement [IHI], 2013). The Rapid Response Team helps to decrease mortality and morbidity rates, and also allows nurses to intervene when a patient has signs of deterioration before they experience a cardiopulmonary arrest (Jenkins & Lindsey, 2010).

Background

Around 60 per cent of hospitals in the US have experiences with patients who undergo cardiopulmonary arrest (Winter et al., 2007). Other studies show that most of the clinical deterioration signs for patients are exhibited before they reach cardiopulmonary arrest (Azzopardi, Kinney, Moulden & Tibballs, 2011). Health care professionals have a responsibility to know the signs of deterioration for critically ill patients and to have responses to prevent it. Not all professional health care workers recognise the signs that lead to death (National Patient Safety Agency, 2007; National Confidential Enquiry into Patient Outcome And Death, 2005). There are some challenges that hospitals face, such as managing healthcare workers and providing available resources, in achieving and managing patient care and outcomes of patient services (Rogers et al , 2004).

The Institute of Healthcare Improvement ([IHI], 2013) established in 1980 by Dr Don Berwick, works with a group of committed individuals to re-design healthcare into a system without delay, time consuming tasks, errors and unsustainable costs. The IHI focuses on key aspects, including person- and family-centred care, improvement

capability, patient safety, and quality, cost and value. The goal of the IHI is to improve the lives of the patients and health communication. They concentrate on safety, effectiveness, time lines, efficiency, and equity.

Rapid Response Team: Strategies for Saving Lives

The Institute of Health Care Improvement (2001) undertook the initiative of the 100,000 Lives Campaign in 2004, intended to reduce mortality and morbidity rates. This initiative's strategies is to implement the best practice and also to prevent pressure ulcers, reduce methicillin-resistant *Staphylococcus aureus* (MRSA) infection through control processes and policy, reduce infection through basic changes in infection control processes, reduce surgical complications by implementing changes in care, and prevent harm caused by high-alert medications, beginning with a focus on anticoagulants, sedatives, narcotics and insulin. They achieved this goal, partly by recommending the implementation of a Rapid Response Team (RRT).

The goal of this campaign was to save 100,000 lives during the time from its launch in December 2004 until June 2006. Since then they have launched a successor, the Save 5 Million Lives Campaign. In December 2006, the Institute of Healthcare Improvement recommended implementing the RRT as one of six strategies used to identify patients who were experiencing pre-arrest in unplanned ICU admission. The strategies behind the implementation of the RRT were to bring ICU-level patient care to the bedside of critically ill patients, to work together, and to assess and intervene in order to save patients' lives (Institute of Healthcare Improvement, 2013).

Currently, more than 25 per cent of US hospitals use RRTs to decrease the incidence of cardiopulmonary arrest, re-admissions to the ICU and deaths by providing early intervention for patients whose conditions are acute and progressively deteriorating (Donaldson, Shapiro, & Scott, 2009).

Different Terms for the Rapid Response Team

It is important to understand the terminology of the Rapid Response Teams. In the past, they were called Medical Emergency Teams (METs) or Medical Emergency Response Teams (MERT), and other terms including Patient at Risk Team (PART) and Critical Care Outreach Team (CCOT) have also been used. Some of these terms are interchangeable in places such as Australia, where RRT and MET have the same meaning (DeVita, Hillman, & Bellomo, 2011).

The similarity between the RRT and the MET is that they help critically ill patients from the emergence of any signs that could lead to cardiac or respiratory arrest. Both maintain the two key features of an afferent limb, such as how the team is activated, and an efferent limb, such as the response of the team. There are, however,

some differences between them: RRT is generally used to mean a nurse-led team, and the MET is generally a physician-led team. In this thesis, the author will use the term 'Rapid Response Team' to cover all of these terms, as it is the most commonly used variant in the literature (DeVita, Bellomo, Hillman, et al, 2006).

Definition of the Rapid Response Team and its Purpose

DeVita et al. (2011) defined a Rapid Response Team (RRT) as a group of healthcare professionals who are trained for critical cases and deliver quick critical care. A RRT's members come from multiple disciplines, including an intensivist, a physician's assistant, a critical care nurse and a respiratory therapist.

The purpose of this team is to be ready to spring into action without delay, and they must be onsite and accessible; they must have good skills and be trained well for emergency cases (Moldenhaure, Sabel, Chu, & Mehler, 2009).

An RRT is able to respond rapidly to a deteriorating patient with an average response time of less than five minutes (range: 2-10 minutes), and the duration of RRT calls averages between 20 and 35 minutes (range: 5-98 minutes). A RRT is intended to prevent hospital deaths caused by medical error in medical-surgical wards or wherever they occur, such as in an intensive care unit (Hatler et al., 2009; Chamberlain & Donley, 2008).

Hospital Mortality and Morbidity

Numerous studies have shown the numbers of patient lives saved when RRTs have been activated. A study in one hospital indicated that the RRT was called 344 times over a period of 18 months. The same study reported 7.6 cardiac arrests per 1,000 discharges each month over a five-month period before the RRT was implemented. However, with the introduction of the RRT, the number of cardiac arrests over a 13-month period subsequently decreased to three episodes of cardiac arrest per 1,000 discharges each month. Prior to the implementation of the RRT, the mortality rate was 2.82 per cent; after the RRT implementation, it decreased to 2.35 per cent. Additionally, the percentage of ICU re-admissions decreased from 45 per cent to 29 per cent (Dacey et al., 2007).

According to Bellomo et al. (2004), the implementation of RRTs reduced adverse events in postoperative patients, such as severe sepsis, respiratory failure, stroke, and acute renal failure. It also reduced the duration of hospital stays. There were 1,369 operations for 1,116 patients during the control period and 1,313 for 1,067 patients after the intervention of the rapid response team (RRT). The result was a decrease in the rate of respiratory failure incidents to 57 per cent, while the relative stroke risk reduction was 78 per cent; severe sepsis had a relative reduction of 74.3 per cent; acute renal failure requiring

renal replacement therapy relative reduction had a relative reduction of 88.5 per cent; and emergency intensive care admissions were reduced to 66.4 per cent. Furthermore, the rate of postoperative death dropped to 36.6 per cent, and the average duration of hospital stays decreased from 23.8 days to 19.8 days.

DeVita et al. (2006)'s findings supported the conclusion that the use of RRTs indeed decreases adverse outcomes and unplanned ICU admissions, and stated that hospitals should implement RRTs.

A recent study compared mortality rates before and after the implementation of RRTs. It was indicated that the initial mortality rate was 22.5 individuals per 1,000 hospital admissions. After the RRTs were implemented, the mortality rate dropped to 20.2 per 1,000 hospital admissions. The utilisation of RRTs decreased the mortality rate, as well as decreased ICU re-admission (Alqahtani et al., 2013).

Another hospital indicated that the number of cardiopulmonary arrests before implementing a RRT was 75 per 1,000 admissions in 2006; after implementing the RRT, the number of cardiopulmonary arrests decreased from 59 to 37 per 1,000 admissions during 2007 and 2008 (Hijazi, Sinno, & Alansar, 2012).

Another study found that, from 378 calls for a RRT during a time period spanning from 9 months before until 27 months after implementing a RRT, cardiac arrests were reduced by 57 percent, amounting to a reduction of 5.6 cardiac arrests per 1000 hospital discharges. Around 51 arrests were prevented (Geoffrey, Parast, Rapoport, & Wagner, 2010).

Konrad et al. (2009) found that, in a hospital where the number of RRT calls was 9.3 per 1,000 hospital admissions, the MET implementation was associated with a 10 per cent reduction in total hospital mortality. The number of cardiac arrests per 1,000 admissions decreased from 1.12 to 0.83; mortality was also reduced for medical patients by 12 per cent, and for surgical patients not operated upon by 28 per cent. The 30-day mortality pre-MET was 25 per cent versus 7.9 per cent following the MET implementation compared with historical controls. Similarly, the 180-day mortality was 37.5 per cent versus 15.8 per cent, respectively.

The study by Scott and Elliot (2009) showed that before implementing RRTs, 22 cardiac codes were called per month. After implementing RRTs, this number decreased to 14 per month. Before the implementation, the cardiac codes were mostly called for patients who required intubation; afterwards, the cardiac codes were seldom used for intubated patients because the RRT had been called before the patient's condition deteriorated.

The Criteria for and Purpose of Calling RRTs

When the medical-surgical nurse calls the RRT, there are certain criteria involved in the decision. When a medical-surgical nurse notices that their patient is almost at the point of requiring intervention, the staff nurse will review the criteria to assess a patient before calling the RRT. Each hospital must use certain criteria when it comes to calling RRT. The following will help to determine who should call RRT; using the proper protocol will help to reduce the incidence of mortality and morbidity due to unexpected cardiac arrests in the hospital (Buist, 2002). A study found that, through implementing RRTs, the number of calls for RRTs increased through an understanding of their outcome in saving patients' lives (Hillman, et al., 2005).

Each member of the team has a role to play during an intervention. The role of the RRT nurses is to assist the bedside nurses and to assess patients alongside them. The role of the physician is to assess the patient, evaluate the clinical findings in relation to the patient's history, and to determine the appropriate intervention with the other team members. Calling the RRT is commonly done for surgical patients, emergency department patients, elderly patients with multiple comorbidities, and critically ill patients with a longer length of stay at the hospital (Young, Donald, Parr, & Hillman, 2008). The criteria that a nurse in a medical or surgical ward should follow in deciding whether to call an RRT are shown in Table 1.

The impact of implementing a RRT is to maximise the climate of safety for a medical-surgical patient. Promoting a more cohesive clinical approach hospital-wide, such teams augment expertise and communication with the skills of the nurses throughout the facility (Sharek et al., 2007).

Process for Calling a Rapid Response Team

Each hospital uses a framework for RRTs, with plans and the mechanisms in place for a deteriorating patient. When

a nurse notices that a patient's condition is declining, after applying the criteria, the nurse will call the RRT by pager or telephone extension per the hospital's protocol (Institute for Clinical System Improvement, [ICSI], 2013). The nurse will then give a verbal report of relevant information using the communication tool of SBAR: 'Situation' refers to the room, the ward and a brief about the patient, including the name, age, admission date and the reasons for admission; 'Background' covers information about the patient's history and conditions, a list of medications, lab results and other clinical information; 'Assessment' is the nurse's assessment of the situation; and 'Recommendation' is what the nurse recommends, such as whether a patient needs to be seen immediately or needs an X-ray (Ray et al., 2009; Cretikos et al., 2006).

According to the Institute of Health Care Improvement (2013), SBAR is an easy and effective tool for communication about a patient between staff members.

Definition of Nursing and Nurses' Responsibilities

Nursing is defined as protecting, promoting and optimising health care while preventing illness and alleviating suffering through diagnosis and treatment. Nursing is primarily concerned with providing care to the physically ill, mentally ill and disabled. Nursing includes collaborative care for individuals of all ages, regardless of family, group or community, sick or well, in all settings (International Council of Nurses, 2012).

Nurses are responsible for patient care, where each nurse is accountable for his or her individual nursing practice, performing assigned tasks and providing optimum care. In all their other responsibilities, such as administration, teaching and research, each nurse is responsible for the quality of practice within their standard of care (American Nurse Association, 2011).

Table 1: The clinical criteria for calling a RRT

The clinical criteria for calling a rapid response team (RRT):
Any staff member (nurse, physical therapist, respiratory therapist, physician) is worried about the patient
Change in heart rate to <40 or >130 beats per minute (bpm)
Change in systolic blood pressure to <90 mmHg
Change in respiratory rate to <8 or >28 breaths per minute
Change in oxygen saturation to <90 % , despite O ₂
Change in the level of consciousness state
Change in urine output to <100 ml in four hours

(Institute of Health Care Improvement, 2011)

Nurses' Experience and Practice

Nurses' experience can be defined as their acquisition of knowledge and skills from feeling, seeing and doing. Another definition of nurses' experience is the achievement of a high level of knowledge, work and experience relating to healthcare from mind-body practices. Nurses' levels of understanding evolve through their experiences of practice in clinical settings (Kemper et al., 2011). In practice, nursing requires special skills and knowledge, as well as independent decision-making. Nurses must deal with different settings, types of patients, diseases and ways of giving treatment. Nurses protect those who need care (National Council of State Boards of Nursing, 2013).

Medical-Surgical Nurses

Nurses who work in medical and surgical wards are registered nurses who have been professionally registered after passing an examination to have the licence certification in order to be qualified to perform nursing care, as well as being equipped with the skills required to assess patients physically. Furthermore, they have the ability to make clinical decisions about the appropriate treatment and nursing intervention for a patient by performing an assessment, developing a plan of care and predicting patient outcomes (Keller, Edstrom, Parker, Gabriele, & Kriewald, 2012).

Problem Statement

It has been reported that many hospitals are familiar with the concept of the Rapid Response Team. The difference between the RRT and a cardiac arrest team is that the RRT intervenes before a patient experiences cardiac or respiratory arrest. The RRT is a system recommended by the Institute of Healthcare Improvement (IHI, 2010).

Significant evidence has shown that RRTs save patients' lives by mitigating medical errors, decreasing ICU admissions, and reducing the number of days spent in hospital (IHI, 2013). Because of this, the author focuses on medical-surgical nurses who are assigned to critically ill patients, who have complex responsibilities, may struggle with lacking confidence, or experience other challenges during RRT calls due to medical errors. The author also seeks responses from bedside nurses when they notice that their patient needs RRT intervention (Thomas et al., 2007).

Aim

To describe the current knowledge about medical-surgical nurses' experiences when they call Rapid Response Teams to save patients' lives.

Research Questions

- How do nurses describe their experiences of calling RRTs?

- What are the common challenges for nurses when calling RRTs?

Method

Study Design

A literature review is the gathering, analysis, and critical summary of information for a particular topic of study. The literature review is a helpful method for the researcher to collect and condense information (Polit & Beck, 2012). The fundamental aim of a literature review is to provide a comprehensive picture of the existing knowledge relating to a specific topic (Coughlan, Cronin, & Ryan, 2013). Moreover, the use of this method helps to inspire and generate new ideas by highlighting any inconsistencies in current knowledge, from among studies published in some search database such as PubMed, considered the most significant database in medicine, and including the entire field. PubMed primarily accesses the MEDLINE database, which includes references and abstracts. PubMed also involves a full articles database from different countries (Aveyard, 2010). In this study the PubMed database was used to retrieve all articles. The vocabulary and terminology used to search the PubMed database were found using MeSh (Medical subject Headings), a dictionary used for indexing articles.

Data Collection

Data collection is a formal research procedure used to help a researcher. This study performed a search to find articles relevant to nurses' experiences during calls to RRTs. PubMed is considered as the most significant database for this purpose and has been used in this study (Polit & Beck, 2012).

All 15 articles retrieved from PubMed answered the study's aim. MeSH terms were used to find some of terminology, which was then used in a free search in PubMed. However, there were no articles found in MeSh database related to this topic (Polit & Beck, 2012). The terms used in MeSh were: 'nursing' AND 'Rapid Response Team'; 'nurses' AND 'Rapid Response Team'; 'nursing' AND 'Rapid Response Team' AND 'experience' and 'nurses'; and 'challenges' AND 'Rapid Response Team' (see Table 2). The following inclusion and exclusion criteria were applied during search in selecting articles for this review.

Selection Criteria

Inclusion criteria

The inclusion criteria was to include articles, then analyse them for use in the result (Polit & Beck, 2012). This criteria used for each article included had to be written in English, with a publication date no earlier than ten years ago, and also filed under publications involving the nursing field. These were then used as the primary source texts, original studies and primary sources.

Exclusion criteria

The exclusion criteria was to exclude articles not to be used in the result, because they did not meet with criteria used in research (Polit & Beck, 2012). The criteria for each article excluded were those that were not written in English, those that were not relevant to nurses' experience in calling for RRTs, articles relating to the medical rather than nursing area, and literature reviews about RRTs. Other excluded articles were in report form and were not complete articles, while other articles were more than ten years old.

Data Analysis

Data analysis is an organisation and synthesis for a study (Polit & Beck, 2012). All 15 articles were read several times and then analysed. Each article was analysed separately and independently. The main findings were highlighted in different colours and documented on a separate piece of paper divided into two columns. The words describing nurse experiences were highlighted in green and words relating to challenges were highlighted in orange. This documentation was written up using Microsoft Word under titles and a sub title (Curtis, 2008). All of the articles were then evaluated in order to check their validity and reliability by looking at the qualifications of the authors and the study design and process (Background, Aim, Method, Results, Discussion, Ethical Considerations, and References), the number of participants in each study and the environment. Then each article was graded and classified using the guidelines for the quality of an academic article. The grade scale used was: high (I), moderate (II), or low (III) quality (see Appendix II).

Classification of Included Articles

The quality of each article and the types of methods used were classified based on the criteria of Berg, Dencker, and Skärsäter (1999) and Willman, Stoltz, and Bahtsevani (2006), and modified by Sophiahemmet University (see Appendix II). All the results relating to the article were collected and were written into the matrix table (see Appendix I). Each article used different methods ranging

between qualitative and quantitative methods. Some articles used interviews or focus groups, some used descriptive correlational design, some used qualitative ethnographic methods, and some provided quantitative numerical data examining the implementation of RRTs. Of the 15 articles used, there were 10 articles that scored grade I and the remaining articles were grade II. In addition, all articles were appraised according to the qualifications of each researcher and whether there were any ethical considerations noted, aiming to determine whether the research had received support from any company, advertisement or commercial purpose. All the articles were checked to see whether the researcher considered the environment of the study when collecting the data. Furthermore, the author checked to see if the topic was appropriate to the aim of the study. (Polit & Beck, 2012).

Ethical Considerations

Permission to do this study was obtained from Sophiahemmet University for thesis project of a bachelor degree. The author dealt with each study using equitably all articles being read and using all the results in this study, and used trustworthy data collection, analysis and interpretation to avoid any desired finding. Paraphrasing was done after the analysis of all articles. There was no adding of any personal information or comments to the articles, in the strictest effort to avoid plagiarism, falsification and fabrication while conducting data analysis. Each study was conducted in an ethical way during data collection and interpretation. References for each article have been stated in order to make it easy for the reader to locate the necessary information (Polit & Beck, 2012).

Results

The findings in this study were based on 15 articles. These articles focussed on nurses' experiences and challenges in calling RRTs. The results are presented in accordance with the research questions.

Table 2: Searches in PubMed

Search words	Number of hits	Read abstract	Read article	Chosen articles	Date
'Nurses' AND 'rapid response team'	84	56	40	5	17 SEP 2013
'Nursing' AND 'rapid response team'	130	60	60	9	01 OCT 2013
'Nursing' AND 'rapid response team' AND 'experience'	4	4	4	0	17 OCT 2013
'Nurses challenges' AND 'rapid response team'	3	3	3	1	17 OCT 2013

Nurses Describe Their Experiences of Calling RRTs

Nurses' Experiences and Qualifications

Most medical-surgical nurses were familiar with calling an RRT as part of improving patient care. Calling RRTs has increased nurses' experiences of preparedness. However, other medical-surgical nurses had been hesitant to call RRTs because the physician discouraged them to call. The decision to call an RRT depended on the years of experience of ward nurses when there was a critically ill patient requiring intervention from an RRT. Nurses who had 0-5 years of experience were less likely to call an RRT, while nurses with 11 years or more of experience called RRTs without asking other nurses (charge nurse) or the primary team. (Salamonson, Van-Heere, Everett, & Davidson, 2006)

The qualifications of nurses relate to their experiences when calling an RRT for an urgent case; those with an associate's degree in nursing (AND; who study nursing for two years) with less than or equal to three years of experience called at the request of another nurse (i.e. the nurse in charge) or a physician. Comparing this response to that of staff nurses with a bachelor of science in nursing (BSN), who have more than three years of experience and who study nursing for four years; they called the RRT following the criteria provided (Pussateri, Prior, & Kiely, 2011).

Some experienced ward nurses independently called for a RRT without waiting for any decision from the other nurses or physicians. The decision whether or not to call a RRT was based on the nurses' judgment on whether immediate assistance was needed. Some bedside nurses, who often ask for advice and consult with other nurses when unsure about whether or not to call a RRT, were encouraged to trust their own judgment before calling RRTs, in order to get the support and the affirmation that they needed (Wynn, Engelke, & Swanson, 2009).

Medical-surgical nurses perform a synergetic role when they receive support during a call for RRTs, where the bedside nurse brought the patient information to the situation. The RN in a RRT team provides the knowledge and the skills for the consultation to medical surgical nurse, and achieves role synergy characterised by RN-RN consultation where what is achieved from interaction is greater than that achieved from the individual efforts. The role of synergy between RNs is to prevent adverse events from occurring during the rescuing process. A synergic role is an effective and an educational tool for both nurses and patient that supports junior and new graduate nurses, and to have the full picture about a patient who needs support and intervention. (Leach, Mayo, O'Rourke, 2010).

According to Wehbe-Janek et al.,(2012) simulation experiences for bedside nurses have been used to increase their awareness of cases when a patient needs help. A

high fidelity simulator with realistic settings was used to identify valuable components for the nurse. The simulation program showed the relationship of the RRT associated with the patient outcomes. An increased familiarity with the equipment successfully increased their effective communication skills and gave them a sense of familiarity with the role along with its responsibility. Debriefing and reflective learning was used, and suggested a key future for such simulations for effective learning.

In medical-surgical nurses' experiences, the decision to call an RRT when they became worried for their patient was related to self-confidence. They would increase their awareness of the patient's condition in order to decide whether intervention from the RRT was needed (Jones et al., 2006).

Feelings experienced when calling an RRT differed from one nurse to another. Bedside nurses sometimes experienced a positive interaction with the RRT during the call, but while some of the nurses had positive views, others did not. A few nurses indicated that they felt afraid when they received criticism from an RRT after calling them. However, some nurses indicated that RRT calls were required because the medical management by doctors had been inadequate; many ascribed this to junior doctors and a lack of knowledge and experience. Some bedside nurses indicated that they would call the RRT if they were unable to call the covering doctor; however, a minority of medical-surgical nurses preferred to call the doctor if there was a critically ill patient before calling an RRT. (Williams, Newman, Jones, 2011).

According to Jones et al (2006) the majority of ward nurses indicated that calling RRTs prevents cardiac arrest, and 97 per cent said that the RRT intervention was intended to help and manage an unwell patient. On the other hand, a few nurses restricted their RRT calls because they were afraid of criticism about their patient care.

Nurses' views concerning the benefits of calling RRTs

According to Wynn et al. (2009), there were three main reasons to call RRTs from the bedside nurses' point of view. Around 78 per cent of the nurses surveyed (n=75) indicated that the primary reason they call a RRT is when there is a sudden change in the patient's vital signs. The second reason, indicated by 56 per cent of respondents, was when there was a steady decline in the patient's condition. The third reason, 35 per cent, was that no adequate response had come from the physician's side.

Some studies have shown that in most nurses' view, in their experiences, RRT helps critically ill patients when they have any early signs of deterioration (Astroth et al., 2013; Leach et al , 2013; Benin et al., 2012; Bagshaw et al., 2010).

An RRT promotes the assessment and treatment by providing a high level of knowledge and experience, as well as helping the nurse to prevent calling code blue to their medical-surgical ward. An RRT also transfers an ICU level of care to the patient in order to secure their safety. The participating nurses, from their own experiences, believed that RRTs could prevent critically ill patients from having a cardiac or respiratory arrest, and that they could prevent minor issues from becoming major and potentially life-threatening problems (Astroth et al., 2013).

Nurses thought that RRTs could help patients who were deteriorating fast, and cited this as the greatest advantage of RRTs. The participants described the RRT as a pair of eyes to assess the situation (Williams et al., 2011).

Bedside nurses receive immediate assistance and help for any patient in a life-threatening situation, with early intervention for critically ill patients to prevent cardiac or respiratory arrest. Furthermore, RRTs provide backup support for ward nurses when they are concerned or dissatisfied with their current medical management, or when the ward doctor is unavailable. This backup system gives them peace of mind in a clinical setting, and a sense of security in knowing that there is always a backup, providing the ward nurse with access to a medical expert who knows how to manage emergency situations (Salamonson et al., 2006).

The majority of medical-surgical nurse participants reported that they call the RRT if there is a complex medical-surgical issue. They also believed that calling the RRT would help to prevent a critically ill patient from having cardiac and respiratory arrest. A few nurses believed that they call the RRT because nurses have inadequate management (Bagshaw et al., 2010).

Knowledge and Skills of Bedside Nurses

A medical-surgical nurse identified that the RRT is a supportive team that provides guidance, education and continued follow-up for the patient's condition. None of the nurses noticed any discouragement from this team during calls. Furthermore, the unit culture of teamwork and the willingness to care for each other's patients during an RRT event gave them confidence, knowing that they would receive the needed assistance (Astroth et al., 2012).

The help from RRT and the improved skills through working as a team was immediately available through a single phone call for nurses, who were able to obtain additional help without having to request permission. The RRTs were the facilities' method of redistributing the workload for nurses (Astroth et al., 2012; Benin et al., 2012).

The support provided in calls to RRTs from medical-surgical nurses enhanced their skills and increased their knowledge and awareness in the processes of nursing

when they had critically ill patients. This especially benefitted new graduate nurses, allowing them to learn from the role of the RRTs. Some new nurses believed that calling the RRT represented a positive and collaborative experience that reinforces the use of teamwork. Patients also benefit from this team when intervention occurs quickly, and as some nurses noted, it helps them to practice their skills every day (Williams et al., 2010).

According to Wehbe-Janek et al. (2012), the simulation-training programme enhanced nurses' knowledge and skills relating to medical emergency situations. An RRT allowed them to identify their weaknesses and to learn from their mistakes or lack of knowledge, particularly in regards to the uncomfortable issues that they have to become familiar with during some proper procedures, such as using an algorithm and a crash cart. Other nurses felt that sharing ideas and tasks expedited the assessment process and ultimately improved the patient's condition at a faster rate.

Bedside nurses were satisfied with the collaboration with the RN RRTs, and noted that the outcome of the RRTs was often an improvement in skills and experiences. However, bedside nurses also wanted to be engaged with the team in order to provide better care for their patients, especially when the RRT call was over and they had to care for the patient remaining in the unit. Nurses noted that the RRTs brought about a greater sense of appreciation for the nurses after an RRT call, where some family members of a patient made positive comments about their support and how they helped to save lives. The opinion of the nurses in this study proved that they valued RRTs, and demonstrated the positive effects that the RRTs bring to their everyday practice. The implied positive effect is support and empowerment for nurses (Williams et al., 2010).

Some participants amongst medical-surgical nurses found that understanding the criteria for calling the RRT and knowledge were important to meet the patients' needs and to identify unstable patients. Education is important in providing skills that will help patients (Brown, Anderson, Hill, 2012).

Nurses' familiarity with using the criteria for calling the RRT

When a bedside nurse calls the RRT for a critically ill patient, he or she uses the criteria for calling the RRT based on his or her knowledge. Critical knowledge experiences are important in managing the crisis, and this is based on nurses' experiences (Galhotra et al., 2006).

According to Leach & Mayo (2013) medical-surgical nurses described that familiarity with the team leads to trusting behaviour between them when there is an urgent case.

The majority of participants expressed familiarity with the RRT criteria. Around 90 per cent of nurses thought that the RRT programme improved patient care, and around 84 per cent felt that the service improved the nursing work environment. Nurses who had called an RRT on more than one occasion were more likely to value their ability to do this (Pusateri et al., 2011).

The other nurses expressed that in their experience, the RRTs improved their practice, since they are supported by the RRTs when they know the criteria. Furthermore, they stated that they receive encouragement from the nursing leader and other co-workers. Participants in this study noted that they felt confident when they called an RRT. Medical-surgical nurses indicated that they received their education about RRTs during their annual competency review. A few noted that they did not receive any education on the RRT, other than when the RRT was developed. Participants believed that newly graduated nurses needed to be educated about RRTs in order to gain more awareness about when they should call this team and for what reasons (Astroth et al., 2012).

Communication Skills for Calling an RRT

Nurses enhance their communication skills as another valuable component of simulation training. Several participants described the RRT members' communication skills as being professional and caring. Both bedside nurses and the RRT members used the communication tool SBAR to collect information during the event, since this tool provides information both quickly and accurately. The participants noted that many of the RRT nurses provided emotional support. Others commented that they provide encouragement to bedside nurses, and use humour to defuse a tense situation. (Astroth et al., 2012).

In the case of an inadequately experienced bedside nurse, he or she is required to call the RRT in an emergency case, whereas other nurses would call the physician first when they have a sick patient. It was noted that 55.9 per cent from the total of 351 participants that they would call the RRT even if they were worried about any changes in the vital signs, in order to increase their knowledge through interaction with the RRT (Jones et al., 2006).

Common Challenges for Nurses When Calling RRTs

Knowledge and Experiences

A lack of knowledge and experience can lead to a lack of confidence and feelings of discomfort. Being faced with a need to exercise judgment and decide whether or not to call the RRT is a challenge for some bedside nurses when a medical-surgical nurse has noticed that a patient meets the criteria for calling an RRT. Furthermore, a lack of knowledge will lead to low quality of patient care (Schmid, Hoffman, Wolf, Happ, & Devita, 2013).

A few medical-surgical nurses were reluctant to call an RRT for fear of criticism from the RRT team when they responded to the call. (Jones et al 2006)

Conflict Between the Bedside Nurse and the Rapid Response Team

Working as a team is a major part of delivering good care to a patient and saving patients' lives. However, in the case of a conflict between the primary team and the nurses, or between the primary team and the RRTs, the bedside nurses attending felt that their plans for the patients were disrupted, resulting in disjointed care for the patient. This is a challenge concerning which team the bedside nurse will follow. As another study shows, these challenges are listed under the following two categories: direct challenge, when it is difficult to know when to call the RRT or not, and indirect challenge, when the RRT has been called and the question is who should take care of the patient during the RRT's call out (Shapiro et al., 2010).

Level of Education

Professionals who are to join RRTs need more education, training and understanding about the philosophy behind RRTs. Other challenges include the attitudes of RRT staff when they respond to calls from the bedside nurses. One nurse participant noticed that their individual's voice and communication style had a frustrated tone, which was not encouraging during the call out (Salamonson et al., 2006).

Traditional hierarchies and their relation to the physicians and supervisors impede some of the components of RN decision-making during rescue (Leach et al., 2010).

Other nurse participants identified that they were worried about calling RRTs because they felt afraid of criticism from them. Other nurses feared calling RRTs without the knowledge of the responsible nurses and physicians; nurses observed the reaction of the team, and this made them reluctant to call the RRT the next time. Other nurses described situations where they wanted to call RRTs, but were reluctant that they would be perceived as having neglected to give care to patients (Astroth et al., 2012).

Three different studies found that communication was a challenge when calling RRT members who did not exhibit a communication style that the nurses perceived as being supportive. According to the participants, their body language and method of questioning were perceived as negative and condescending. Moreover, their tone of voice was not encouraging to the bedside nurse. Furthermore, the lack of knowledge regarding the institution's policy on calling RRTs added a confusing barrier, making the nurse reluctant to make the call (Astroth et al., 2012; Jones et al., 2006; Baldwin et al., 2006).

According to Bagshaw et al. (2010) and Wehbe-Janek et al. (2012), there are other challenges facing nurses who want to call RRTs: they become frustrated with the delay in care when physicians are not present to assess their patients, and they have to resist calling the RRTs. Unavailability of assistance from co-workers created a demand for nurses to work around the clock, losing precious time when they should be providing care for their patient. Some nurses identified enhanced communication as another value of simulation training, since they were unaware of clear communication procedures. The lack of confidence and comfort flowed in the simulation where feelings were concerned.

Many nurses indicated that they would not call an RRT without calling a physician first, and some nurses feared that some doctors would shout at them when they called the RRT. 84 per cent disagreed or strongly disagreed that using an RRT system would increase their workload when caring for their patients. The poor attitude from some RRTs seems to require more education in order to deliver good communication between the team and the staff member who is taking care of the patient (Salamonson et al., 2006).

Discussion

Method

The literature review method was used in this study to compile and summarise findings; each article was read and critiqued separately and critically appraised starting with the title, year of publication, and abstract. Next, the whole article was analysed, including the background, aim, sampling method, data collection, data analysis, results, discussion and ethical approval. References were also checked for validity, credibility and reliability. The classification of each article was assigned following the guidelines of the quality grade (see Appendix II). This helped the author to choose the articles that best supported the aim. Most articles were grade I and the rest were grade II. Graded I articles included clear abstracts and clear processes of research, while grade II articles were less clear in some respects.

Ethical principles were used in the search process, including honesty, copyright for publication and avoiding any plagiarism or misconduct such as falsification and fabrication.

Some difficulties were faced when searching for articles in the PubMed database. Some articles provided more information but their year of publication was more than 10 years ago; other articles would not open. MeSh terms were used to find more articles relating to the topic and to address the aim of the study. The 15 articles represented research in different countries, but most focussed on US hospitals, while a few were conducted in Australia.

Other challenges during the time of this study included a lack of search results from the MeSh database; consequently, the free search in PubMed was used. All articles were published between the years 2005 and 2013. Some of the articles were randomised controlled trials (RCTs), whereas others were qualitative and prospective studies. (Poilt & Beck, 2012).

Results

This review looked at nurses' experiences and the challenges that medical-surgical nurses face when they call an RRT for an urgent patient case. During the analysis of all 15 articles, the results were categorised under the headings of 'experiences' and 'challenges'. All of these articles addressed the research questions and explored bedside nurses' experiences when calling RRTs. They found that the RRT is a helpful system for patients, and that bedside nurses felt supported by RRTs. However, there were some challenges that needed to be overcome in order to have a successful team delivering a good quality of care to the patient from the points of view of both medical-surgical nurses and the RRTs.

The themes of level of experience and qualifications largely reflected what the nurses experienced when calling RRTs. The findings emphasise that RRTs are an effective tool for patient care that saves patients' lives by preventing medical error and other adverse events (Winters et al., 2006; Brindley et al., 2007). However, there are many factors that can affect the performance of the system, including human error, poor communication, and deficiency in leadership, all of which could apply to the nursing team or the RRT (Raynard, Reynolds, & Stevenson, 2009).

The nurses' experiences with decision-making in trying to give quick and helpful intervention for patients focussed on the RRT for urgent and critical cases. Nurses are faced with the need to make a decision that requires years of experience combined with a high level of education. Nurses at the baccalaureate level with more than five years of experience had self-initiated calls to an RRT for urgent cases. Thus, education and experience are important when it comes to independent calling. Nurses who have more experience tend to have expertise in recognising and interpreting a situation, and are therefore better able to manage it. All hospitals have the responsibility to educate all healthcare professionals in order to improve the outcome for each patient. It is important to educate nurses about the RRT system, especially when it comes to new graduates (Wynn et al., 2009). Feelings of worry were major reasons for a bedside nurse to call the RRT, along with degree of empowerment and independent action by the nursing staff. Nurses need to know when and how to call an RRT in serious situations (White, Pichert, Bledsoe, Irwin, & Entman, 2005; Santiano et al., 2009).

Nurses' experiences when activating the RRT protocol differed according to their use of the RRT criteria,

different levels of education and diverse experiences. Some hospitals have their own protocol for calling the RRT, and this may be different from one hospital to another (Moldenhaure et al., 2009; Santiano et al., 2009). Decisions to call the RRT for critically ill patients by the bedside nurse are based on knowledge and the skills that come with years of experience and satisfaction with RRTs. This helps them to identify the best decision and when to call the RRT, but their qualifications also play a role in this (Metcalf et al., 2008).

Medical-surgical nurses stated that RRTs provide important assistance when the early signs of deterioration are identified in order to prevent an adverse event so as to save patients' lives. RRTs also create a teamwork situation that generates communication among professionals, and this communication becomes more effective when a bedside nurse uses SBAR when reporting on the arrival of other team members (Beebe, Brinkley, & Kelley, 2012).

Poor communication between a bedside nurse and the RRT leads to an improper response. This indicates that poor communication is a barrier to engaging in effective action when a patient is critically ill, and that it is necessary to enhance nurse-physician communication to ensure that when a nurse calls an RRT, the response is appropriate. (White et al., 2005).

Medical-surgical nurses did not believe that RRTs are overused in hospitals, and other participants believed that interaction with the RRT did not increase their workload or decrease their skills when they gave care to a patient, but rather provided an opportunity for education (Jolly, Bendyk, Holaday, Lombardozzi, & Harmon, 2007). It was also considered that RRTs increase the knowledge of the bedside nurses indirectly through the following of simulation training, enhancing skills and awareness preparedness for emergency team events. This was amplified by the strong response that nurses have a better understanding of the roles of the RRT following training (Potter & Perry, 2008). RNs in RRTs have a synergetic role when it comes to both patients and bedside nurses. The American Association for Critical Care Nursing developed the synergy model, which defines some common characteristics for patients and nurses. (Hardin, Kaplow, 2005)

The patient characteristics are vulnerability, stability, complexity and predictability. Keeping these in mind, the nurse will be able to provide the best care according to patients' needs. In terms of vulnerability, nurses look for actual and potential stressors, whether physiological or psychological, which might affect patient outcomes. Highly vulnerable patients are susceptible to further deterioration and poor outcomes. Stability involves maintaining a steady equilibrium and assessing this characteristic means evaluating a patient's ability to respond to the treatment. Meanwhile, complexity involves the interaction of two or more systems, and is found when patients are treated for complicated diagnoses. Here, the nurse will

assess patients for their response to treatment and other unknown factors. Predictability is important when it comes to nurses' identification of a predictable path based on the disease progress and potential complications. Here, the nurse must synthesise patient data with disease management guidelines to ensure favourable outcomes.

The nurse characteristics are clinical judgment, advocacy and moral agency, caring practice and collaboration. Clinical judgment is clinical reasoning which includes decision making, critical thinking and the global grasp of a situation according to experiential knowledge and evidence-based guidelines. When registered nurses are not part of an RRT, this team educates bedside nurses' in relation to their clinical judgment through physical and data assessment techniques that are anticipated to be helpful for the patient. Such tools are useful for critical care nurses when they are unfamiliar with these techniques. In terms of advocacy and moral agency, a nurse will demonstrate moral agency by working on the behalf and representing the concerns of the patient. As an advocate, the RRT nurse will be able to direct patient-centred care and ensure that patients' wishes, dignity and rights are preserved. Moreover, in this way, the team will provide support to patients and family by offering clear information about the patient's condition. The RRT also helps bedside nurses to promote decision-making. The team acts as a conduit to exchange information amongst the nurse, family and patient. Collaboration involves working with others such as physicians, families and healthcare providers in a way that promotes and encourages effective care. Each team must respect the other teams and the role they play in ensuring that their patient has a positive outcome (Hardin & Kaplow, 2005).

The implementation of the RRT in a hospital to save patients' lives distributes the work across a team of bedside nurses, physicians and RRT members. The RRT increases the sense of security among medical-surgical nurses when managing an unwell patient and this may translate into more confidence and empowerment for the nurse (Jolly et al., 2007).

Some bedside nurses noted that they learn new skills from interactions with RRTs, while some observed that they want to have a special programme concerning the RRT in order to understand when to make a call (Brown et al., 2012). Team communication and information sharing is a critical part of team behaviour; the Joint Commission report indicated that communication failure is a root cause of essential events (The Joint Commission, 2007). Communication is thus important in delivering good care. The following three main factors are associated with communication failure: (i) Physicians and nurses are trained to communicate differently; (ii) the hierarchies within the health care systems frequently inhibit people from speaking up; and (iii) the communication and the providers in health care (Leonard, Graham, & Bonacum, 2004).

Medical-surgical nurses and physicians need to work as a team and accept each other's ideas. Teamwork results in the delivery of good care to patients, as the patient is the main concern for nurses, physicians and the RRT. Some nurses stated that when faced with a patient who meets the criteria for an RRT, they should call a responsible physician before calling the RRT itself. This result suggests that the nurse would prefer to use diplomacy instead of calling the RRT. However, if there were no physician available, the participants indicated that they would call the RRT (DeVita et al., 2006).

Some physicians believe that the RRTs interfere with their plans, and this finding suggests that more education for both nurses and physicians is needed regarding the role of RRTs (Jolly et al., 2007). On the other hand, delays in quick intervention relating to the lack of a clear understanding about roles of RRTs have been a problem when it comes to taking responsibility for whether or not an RRT should be called. It has been suggested that simulation training clarifies this role and increases awareness and preparedness (Villamaria et al., 2008).

Education and teaching for bedside nurses will improve their skills when it comes to calling the RRT for their patients without the feeling of criticism. More extensive education is needed in order to remove the feeling of hesitation in calling the RRT (Pustateri, Prior, & Kiely, 2011).

Conclusion

Medical-surgical nurses call RRTs to help save patients' lives, and their decisions depend on their prior experience. Medical-surgical nurses and RRTs need to collaborate during the delivery of care to patients. Both need to have knowledge and good communication skills in order to identify the deteriorating clinical signs that require intervention and to deliver fast intervention to a critically ill patient.

The experiences of bedside nurses who have become familiar with the signs of a deteriorating patient and who know the criteria for calling RRT play a major role. Years of experience and levels of qualification are crucial in a nurse's decision to call the RRTs or to refrain from doing so. Furthermore, the communication and attitude of the bedside nurse and the RRT member play a large role in delivering clear information. Finally, the patient needs help and protection from any adverse event which could occur while receiving care in hospital. An RRT is a helpful tool for hospitals to apply, and can be used to educate staff. When a patient stays in the hospital because of a medical error, this team is needed.

Clinical Implications

The author found that, when employing RRTs in a hospital setting, it is important to focus on educating new staff alongside all nurses and physicians who have prior

experiences with RRTs. They should be given strategies on what their role will be when they are faced with the need for emergency care. Education about RRTs is important in order to avoid miscommunication and misunderstanding between the staff that take care of patients' wellbeing.

Recommendations for Further Studies

The author found that more studies regarding medical-surgical nurses' perspectives on education are required in order to address the challenges facing new staff when they call RRTs to save their patient's life. Additional studies should also focus on the area of improving communication among the members of the medical-surgical team and on communication attitudes.

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Appendix 1

Author(s) Year Country	Title	Aim/Objective	Method	Participants (attrition rate)	Results	Design Quality
Shapiro, S., Donaldson, N., & Scott, M. (2010) San Francisco, USA	Rapid Response Teams as seen through the eyes of the nurse	To explore the impact of the Rapid Response Teams from the perspective of the nurses who use them to give voice to the nurses' experiences	Mixed methods; qualitative & quantitative	N=56 From 18 hospitals, 13 states (0)	Experiences: —The participants call this team when they notice that a patient has clinical changes to his/her condition that needs an intervention from the RRT. —Some nurses noted that the RRT is the extra eyes, hands, and bodies that are used to help the patient meet the patient's immediate needs. —Staff nurses noted that calling the RRTs is a solution to expediting care for patients with urgent call. Challenges: —Direct challenges: difficult to know when to call the RRT, and when a nurse is going to call or not. —Indirect challenges: medical-surgical nurses who call the RRT are concerned about who would take care of their patient from RRT.	I
Salamonson, Y., Ven Heere, B., Everett, B., & Davidson, P. (2006) Australia	Voices from the floor: nurses' perception of the medical emergency team	To explore the nurses' satisfaction with the MET, the perceived benefits of having a MET system and suggestions for improving the system; to examine the characteristics of nurses who were more likely to activate the MET	Quantitative study using open-ended survey questions	N=92(73)	Experiences: —From 10 percent–16 percent of bedside nurses who have 0–5 years were less experienced calling RRT. —Around 9 percent–21 percent of nurses who have more than 11 years have experiences of calling RRT. —Participants noticed that the benefit of calling the RTT is that they intervene quickly, offer backup, support, and access to medical experts. Challenges: Bedside nurses were satisfied with the MET but they suggested more education for junior staff on the MET; some suggested improving the team by changing their poor attitude.	I Quantitative
Benin, A. L., Brogstrom, C. P., Jenq, G. Y., Roumanis, S. A., Horwitz, L. (2012) Australia	Defining the impact of a rapid response team: a qualitative study with nurses, physicians and hospital	To describe the experiences of the attitudes held by the nurses, physicians, administrators and staff regarding the RRTs	Qualitative study, open-ended interviews	Qualitative study, open-ended interviews	Experiences: There are positive and negative implications: the positive from the moral and teamwork support and empowerment of the bedside nurses, where both nurses and physicians used the RRT if there are any changes in vital signs in the patients that need an intervention from the RRT. The learning tool could support junior nurses. Challenges: —Workload, the redistribution of nurses' workload during emergent care, giving a process that might affect patient care. —Conflicts between the primary team and the nurses and between the primary team and the RRT. Negative impact for the education of house staff, burden of work for the RRT, error and delay due to the lack of continuity.	II

Author(s) Year Country	Title	Aim/Objective	Method	Participants (attrition rate)	Results	Design Quality
Leach, L., Mayo, A., & O'Rourke (2010) California, USA	How RNs rescue a patient: a qualitative study of the RNs' perceived involvement in Rapid Response Teams	To investigate how the RNs rescue patients in hospitals where RRTs are in place	Qualitative study, semi-structured interview	N=30 (0) 14 bedside nurse staff RN, 16 RRT staff RN, 18 nurse supervisors who had observed RRT	Experiences: —RN viewed the RRTs as being helpful, supportive and effective safety interventions; they prevent adverse events during the rescue process. —The decision-making of the RN involvement as a part of the rescuing process. —The rescuing process carried out by RN engaged in the RRT intervention. —RN-RN consultation was a source of role synergy, where role synergy increased the gain achieved from the interaction and the cooperative focus on need. The urgency of the circumstance is greater than those achieved through individual efforts. —The RN-RN role synergy was a value added that contributed to preventing adverse events. —The RN uses their knowledge of the RRT trigger protocol to make a thought decision-making process the RN uses in rescuing patients. Challenges: The RRT intervention was not always smooth in terms of the RN decision-making, minor conflict and barriers which emerged while there were different types of decision making happening.	I Q
Brown, S., Anderson, M., Hill, P. (2012)	Rapid Response Team in a rural hospital	To explore the nurses' knowledge and perceptions of the Rapid Response Team	Quantitative, prospective, descriptive design	N=57(0)	Experiences: 23 per cent of nurses known to call RRT and follow the criteria. Bedside nurses call RRT without involving the physician's opinion, and nurses can call if they are worried about their patient, or if patients meet the criteria. Challenges: There are some barriers to calling RRT, including physician opinion that RRTs were not particularly important to the nurse, and RRTs demanding to the person calling, and they give impetration to nurses not to call again.	II Quantitative
Astbroth, K., Woith, W., Stapleton, S., Degitz, R., & Jenkins, S. (2013) USA	Qualitative exploration of the nurses' decision to activate rapid response teams	To identify the barriers and facilitators of the nurses' decisions regarding the activation of the Rapid Response Teams in hospital	Qualitative study, semi-structured	N=81(0)	Experiences: —The participants believed that the RRTs are experienced and training enables them to manage seriously ill patients more effectively. —Participants indicate that the RRTs are supportive, provide immediate assistance. —The communication with the RRT is professional, use of SBAR tool which provides information quickly and accurately. —Participants said that the RRT nurses provided help and emotional support, there is no one who discourages them when they call, and they feel confident in calling. The education of the RRT is contradictory according to participant experience. Challenges: —Some of participants noted that RRT members did not exhibit a communication style that was perceived as supportive;	I Q

Author(s) Year Country	Title	Aim/Objective	Method	Participants (attrition rate)	Results	Design Quality
					<p>participants felt that the communication style of some individuals in the team were abrupt and disconcerting to the unit nurses.</p> <p>—Some participants noted that some of the RRT members sought out the necessary information from staff, but their body language was negative.</p> <p>—Some participants noted the tone of voice of RRT nurses did not give the impression of help, and the participants did not always feel that supported. The communication of body and voice becomes a challenge to the bedside nurses with the attitude of the RRT members; when they call they ask why are they calling.</p> <p>—Some of the participants believe that they should call an attending physician first, because some physicians will be unhappy if the RRT is called and they were not; some physicians reprimanded bedside nurses when they called the RRT.</p>	
<p>Bagshaw, S. M., Mondor, E. E., Scoutten, C., Montgomery, C., Slater-MacLean, L., Jones, D. A., Bellomo, R., Gibner, R. T. (2010) Canada</p>	<p>A survey of nurses' beliefs about the medical emergency team system in a Canadian tertiary hospital</p>	<p>To evaluate the nurses' beliefs and behaviours about the Medical Emergency Team system in Canadian tertiary hospital</p>	<p>Qualitative study</p>	<p>N=614 ()</p>	<p>Experiences:</p> <p>—Medical surgical nurses believed that MET provides benefit that could prevent critically ill patients from having cardiac arrest or respiratory arrest, and that could prevent minor issues from becoming major or potentially life-threatening problems.</p> <p>—94 percent of nurses thought that the MET obtained help for their patients when they were worried about them.</p> <p>—Several nurses indicated that the MET was supportive in the promotion of an enhanced level of patient care, also providing education and management of care to nurses outside of the ICU.</p> <p>Challenges:</p> <p>Some nurses were reluctant to call MET because of their fear of criticism. Most who responded felt afraid to call MET because of their knowledge, and they prefer to call the physician first.</p>	<p>I Q</p>
<p>Williams, D. J., Newman, A., Jones, C., Woodard, B. (2011) North Carolina, USA</p>	<p>Nurses' perceptions of how Rapid Response teams affect the nurses, team, and system.</p>	<p>To describe the perceptions of nurses who use an RRT at community hospitals.</p>	<p>Qualitative phenomenological study; focus group</p>	<p>3 medical-surgical nurses, 28-bed cardiac care unit, 42-bed medical-surgical unit, 12 observation unit.</p>	<p>Experiences:</p> <p>—Participants who were medical-surgical nurses showed that the RRT is an effective tool in patient care, a supportive and helpful team to patients.</p> <p>—RRTs developed nurses knowledge; RRTs benefit patients; they experience autonomy and use intuition.</p> <p>—Nurses perceive that RRT solves problems collaboratively, and praises the team. This team helps nurses to do systematic work for patients and processes advocating patient safety.</p> <p>Challenges:</p> <p>When the nurses saw the reaction during RRT calls, this made the nurses reluctant to call this team next time.</p>	<p>I Q</p>

Author(s) Year Country	Title	Aim/Objective	Method	Participants (attrition rate)	Results	Design Quality
Galhotra, S., Scholle, C., Dew, M., Mininni, N., Clermont, G., & DeVita, M. (2006) Pennsylvania, USA	Medical emergency teams: a strategy for improving patient care and nursing work	To understand nursing perceptions about medical emergency teams and their impact on patient care and the nursing work environment at an acute care teaching hospital in the USA	Questionnaire, survey	N=300 (52)	Experiences: —Participants had positive attitudes toward MET. —98 per cent of nurses familiar with MET activating criteria. However, 60 per cent had low awareness of the availability of MET information. —93 per cent of nurses say the MET improves patient care. 84 per cent of nurses say the MET response improves the nursing work environment. 98 per cent feel value when they call a MET.	I Quantitative
Wynn, J., Engelke, M., & Swanson, M. (2009) North Carolina, USA	The frontline of patient safety: staff nurses and Rapid Response Team calls	To examine the relationships between nurses' educational preparation, years of experience, degree of engagement, and the RRT call status (independent vs. dependent)	A descriptive, cross-sectional, correlational design	N=75 (0)	Experiences: —The participants noted that they called the RRT when they noted some critical changes. —Different experiences with three years' experience or more and BSN nurses compared to others with less experience. Challenges: Communication is become a barrier to effective action upon the clinical signs.	I Quantitative
Jones, D., Baldwin, I., McIntyre, T., Story, D., Mercer, I., Miglic, A., Goldsmith, D., Bellomo, R (2006). Victoria, Australia	Nurses' attitudes to a medical emergency team service in a teaching hospital.	To assess whether nurses value the MET service and to determine whether barriers to calling the MET exist in a 400-bed teaching hospital.	Qualitative, focus group.	N=331(0)	Experiences: —91 per cent responded that they understand the benefit of MET. —93 per cent agree that the MET prevents escalating minor to major issues. —7 per cent agreed that the MET is required in hospitals because they provide management for critical ill patients. —86 per cent disagree that the MET is overused in management in hospitals. —93 per cent disagree that they don't like to call MET because of criticism for not looking after their patient. —72 per cent agreed that they would call the physician before calling MET. Challenges: One of the barriers is the reluctance for nurses to call the MET for a critically ill patient. They fear criticism that the patient was not looked after well enough.	I Q
Puzateri, M. E., Prior, M. M., Kiely, S. C. (2011) USA	The role of the non-ICU staff nurse on a medical emergency team: perceptions and	To understand the role of nurses, and possibly to increase the effectiveness of these teams, we sought to determine the nursing staff's familiarity with and perceptions of the MET at one hospital.	Quantitative study	N=388 (131)	Experiences: —97 percent are familiar with the MET; 17 percent aware about this team at hire. —76 percent had been hired before the hospital had implemented the MET. —31 percent hesitated to call MET because physicians discourage them. —92 percent agreed that MET improves patient care. —83 percent agreed that MET improves their work. —Educational effort is needed as the Rapid Response system has yet to be fully understood and integrated into hospital culture.	II

Author(s) Year Country	Title	Aim/Objective	Method	Participants (attrition rate)	Results	Design Quality
Pusateri, M. E., Prior, M. M., Kiely, S. C (continued)					Challenges: The communication and relationship between bedside nurse and RRT needs to improve; there is some frustration.	
Leach, L. S., Mayo, A. M. (2013) USA	Rapid response team: qualitative analysis of their	To describe effectiveness of rapid response team	Qualitative	N=17(0)	Experience: RRT is an effective team, their performance include organisational structure, team work, managing the crisis, and improve communication Challenges: Lack of confidence and comfort when calling RRT.	I Q
Wehbe- Janke, H., Lenzmerire, C., Ogden, P., Lambden, M., Sanford, P., Herrick, J., Song, J., Pliego, J., & Colbert, C. (2011) Texas, USA	Nurses' perception of simulation- based inter- professional training program for Rapid Response and code blue events	Explore nurses' perceptions of simulations-based inter-professional training program for the Rapid Response team	Mixed methods of study between qualitative and quantitative	N=360 (0)	Experiences: —32 per cent agree with increased awareness and preparedness. —27 per cent of nurses had enhanced understanding of the responsibility for each role during RRT. —27 per cent agreed with improved team work. —21 per cent increased their knowledge and skills. —15 per cent increased their confidence and comfort. —14 per cent improved simulation of experiences. —13 per cent debriefing and reflective learning. —Debriefing and reflection in learning occurred when following the simulation training. The nurses called the code and received feedback on the positives and negatives of the codes, taking the time to review what they learnt. —The simulation program showed the relationship of the RRT to the associated patient outcome. The nurses' response was that the simulation of their experiences helped to increase their familiarity with the equipment used during resuscitation. —Clinical simulation experiences gave them the opportunity to increase communication skills and perform teaching skills.	I Qualitative and quantitative
Schmid, M., Hoffman, L. A., Wolf, G. A., Happ, M. B., & Devita, M. A. (2013) USA	The use of medical emergency teams in medical and surgical patients: impact of patient, nurse, and organisation	Examine differences in patient, nurse and organizational response	Quantitative study	N=108(0)	Lack of familiarity with patient problem could influence low of patient outcome	II Quantitative

Appendix 2 (Next page)

The classification guide for academic articles and studies regarding the quality in both quantitative and qualitative research, modified from Berg, Dencker, and Skärsäter (1999) and Willman, Stoltz, and Bahtsevani (2006).

CLASSIFICATION	GRADING OF ACADEMIC QUALITY		
	I = High quality	II = Moderate quality	III = Low quality
Randomised controlled trial (RCT) is a prospective study that entails a comparison between a control group and one or more experiment groups.	Large, well-planned and well-executed multicentre study with an adequate description of protocol, materials and methods, including treatment techniques. The number of patients/participants is large enough to answer the research question. Adequate statistical methods.	•	Randomised study with few patients/participants and/or too many partial studies with insufficient statistical strength. Insufficient number of patients/participants, inadequately described method or large attrition rate (participant dropout rate).
Clinical controlled trial (CCT) is a prospective study that entails a comparison between a control group and one or more experiment groups. Not randomised.	Large, well planned and well executed study with an adequate description of protocol, materials and methods including treatment techniques. The number of patients/participants is large enough to answer the research question. Adequate statistical methods.	•	Limited number of patients/participants, methods inadequately described, faults or lacking in protocol and insufficient statistical strength.
Non-controlled study (P) is a prospective study, but without a control group.	Well-defined research questions, sufficient number of patients/participants and adequate statistical methods.	•	Limited number of patients/participants, method inadequately described, faults or lacking in protocol and insufficient statistical strength.
Retrospective study (R) is an analysis of a historical material relating to something that has already happened, such as patient charts.	Number or patients/participants sufficient to answer the research question. Well-planned and well-executed study with an adequate description of protocol, materials and methods.	•	Limited number of patients/participants, method inadequately described, faults or lacking in protocol and insufficient statistical strength.
Qualitative study (Q) often is an investigation where the aim is to study phenomena or interpret meaning, perceptions and experiences from the perspectives of the participants. The aim can also be to develop concepts, theories and models.	Context clearly described. Selection of participants motivated. Clearly described selection criteria, data collection, transcription process and method of analysis. Credibility and reliability described. Relation between data and interpretation evident. Critique of method.	•	Poorly formulated research questions. Patient/participant group inadequately described. Method and analysis not sufficiently described. Presentation of incomplete results.

EVALUATION OF QUALITY OF LIFE INSTRUMENTS IN A PALLIATIVE CARE CONTEXT: AN INTEGRATIVE LITERATURE REVIEW

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Abstract

Quality of life (QOL) research has been identified as a priority for nursing. A wide variety of QOL instruments have been developed to address a number of domains such as physical, functional, emotional, and social well-being (Corner & Baliey, 2008, & Stewart). It has been proposed that meaning should also be included, as well as purpose, spirituality and grief (Sepúlveda, Marlin, Yoshida, & Ullrich, 2002). Evaluation of QOL instruments in palliative care is an important research priority. Considerable research has addressed the QOL and quality of care aspects for palliative patients, but there has been limited evaluation of the measurement technique for both in the Middle East. To the authors' knowledge no studies have been conducted to explore this issue in the Middle East, and certainly not in Qatar. Therefore, this project promises to develop a new insight into the importance of evaluating the QOL measurement instruments that could potentially be used in the palliative care unit in Qatar. The overall objective of this paper was to examine the findings of an integrative literature review for the purpose of determining cultural adaptations and validations of instruments needed to evaluate the QOL of patients in palliative care, and to discuss the use of these instruments in the Middle East context.

Introduction

The known lifestyle changes required for health, and the scientific advancements made in the health care system to date, have increased life expectancy among cancer patients in developed countries (Bingley, & Clark, 2009, Jassim, & Whitford, 2013). The incidence of people living longer with a diagnosis of cancer has increased, and as a result, there is a greater need for cancer care (Bingley, & Clark, 2009, Jassim, & Whitford, 2013). Palliative care is a very important part of this cancer care.

Palliative care is a philosophy of care whose efforts improve the QOL of patients and their family members. This is done in the process of coping with death through early identification, prevention and relief of suffering, evaluation of treatment appropriate to physical, psychosocial and spiritual problems (Corner & Baliey, 2008). Palliative care is defined as an approach that improves QOL for patients and their families who face the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychosocial and spiritual (Sepúlveda, Marlin, Yoshida, & Ullrich, 2002). The goal of palliative care is recognized to include health related quality of life (HRQOL), as well as spirituality, loss and grief, family involvement and coping.

In palliative care QOL is an important concept and a center of focus in the identification of the overall patient condition, and is an outcome measurement process (Kaasa, & Loge, 2003). The quality of care that is provided to patients in the last few months of life has a significant influence on both patients and their families (Stewart, Teno, Patrick, & Lynn, 1999). QOL has a wide range of different complex concepts that fall under it. These have led to the development of different measurements instruments (O'Boyle, & Waldron, 1997). Because of this, it is important to document the QOL experiences of dying patients and their families. As such, this information could help in the assessment of quality of care outcomes across the setting. It could also evaluate efforts to improve quality of care, which would in turn improve QOL (Kaasa, & Loge, 2003).

Despite the widespread use of the QOL concept, no standardized or precise definition exists (Kaasa, & Loge, 2003). The concept of QOL has been defined as an individual's perception of his/her position in life, in the context of a culture system value, where the individual lives in relation to his/her goals, expectations, concerns and standards. It is also connected to the individual's physical health, psychological state, and level of independence, social relationships, environmental factors and personal beliefs (World Health Organization, 1997). In the health care system QOL is a concept that is related to symptoms, functioning, psychological and social wellbeing,

and not fully related to meaning and fulfillment (Kaasa, & Loge, 2003). This definition is a multidimensional health-oriented concept which has been named HRQOL (Kaasa, & Loge, 2003).

Despite a lack of consensus for a definition of the term QOL, there are various instruments intended to measure such a construct from different perspectives. In this context, studies have been developed to validate instruments to evaluate QOL in the field of palliative care. The purpose of this study is to explore these various instruments that have been tested to measure QOL, and to determine the adequate QOL instruments in the palliative context. This information will then be used to facilitate the decision making process about the most appropriate instruments to be used in clinical practice and research in Qatar.

Palliative care in the Middle East

Palliative care is a new philosophical understanding or concept in health care within the Middle East. It was in Saudi Arabia where the notion of palliative care was pioneered, and where palliative care as a concept, was first introduced into the health care system in 1992 (Zeinah, Al-Kindi & Hassan, 2013b). The concept of palliative care was only recently introduced into the health care systems of the majority of countries in the Middle East including Qatar, United Arab Emirates, Bahrain, Palestine and Iraq, Oman and Lebanon. These countries are establishing a localized provision, or are in the building phase of introducing palliative care (Zeinah, Al-Kindi & Hassan, 2013b). As such, the integration of palliative care services in most of the Middle East countries has been shown to improve QOL for both the patients and their families. (Zeinah, Al-Kindi & Hassan, 2013b). In knowing this, assessment of QOL at the end of life is an important aspect to measure; however, researchers continue to struggle with the best way to measure QOL (Bentur, & Resnizky, 2005). This may be related to the unique characteristics of patients treated in palliative care making QOL a subjective concept.

Palliative Care in the State of Qatar

The State of Qatar is a wealthy country and is making tremendous strides in health and research innovation, yet it is considered to be in the developing phase in relation to palliative care (Zeinah, Al-Kindi, & Hassan, 2013A). The National Center for Cancer Care and Research (NCCCR) was established in Qatar in 2004, with a forty six bed capacity that provides cancer care. It is the only advanced cancer center in Qatar, and it is treating more than six hundred cancer patients each year from various nationalities and cultural backgrounds (Zeinah, Al-Kindi & Hassan, 2013b). The NCCCR offers advanced medical oncology care, radiotherapy, chemotherapy and pain management, as well as specialized laboratory services. The vision and mission of the NCCCR is incorporated within the Qatar National Cancer Strategy. For example, excellent standards, patient centered care and promotion of collaborative multidisciplinary team work are the key for the achievement of the best outcomes for patients.

The concept of palliative care was established in the State of Qatar in July 2008 with a ten bed unit specialized in caring for patients within the philosophy of palliative care. The objectives of the care provided within this unit are to improve the QOL for cancer patients and their families, and to achieve the best QOL outcomes by relieving suffering, controlling unrelieved distressing symptoms associated with cancer such as pain, and restoring physical and functional abilities.

The information on QOL in the Middle East region is extremely specific in characteristics because of the unique cultural norms and values of the people living in this region (Jassim, & Whitford, 2013). Therefore it is essential that both researchers and practitioners ensure that whatever tool is used, it is measuring the goals of the services offered, and is valid for the country, culture and target population (Bentur, & Resnizky, 2005). Most of the QOL measurement tools were developed or designed for the English language, and because of this, evaluating the QOL in terminally ill patients in the Middle East may be difficult as there is a need to adopt and translate these tools, and test the reliability and validity of the intended tool. However, to date, little information of this nature is available in the Middle East.

Objective of the project

The overall objective of this project was to complete an integrative literature review to analyze International studies for the purpose of determining cultural adaptations and validations of instruments needed to evaluate the QOL of patients in palliative care. The project then explored the use of these instruments in the Middle East context.

Research Question

To achieve the main objective the following research question will be addressed.

- 1) Which instruments used to evaluate the QOL for patients in Palliative Care have been validated and published?
- 2) Which instruments, if any, have been used to evaluate the QOL for patients in Palliative Care units in the Middle East?
- 3) Which instruments could potentially be used to evaluate QOL for patients in the Palliative Care unit in Qatar?

Method

To address the questions as stated above, a complete analysis of the literature was conducted. The literature review stages for problem formulation, data collection methods, data evaluation, data analysis and interpretation and data presentation were compiled for research synthesis (Cooper, 1998). These Cooper Stages (Cooper, 1998) for research synthesis were adapted to interpret and analyze the selected papers in order to extract the needed information to answer the research questions. To determine the sample, scientific papers published

in periodicals electronic databases were searched, such as CINAHL, Medline, Family & Society Studies Worldwide; Health Source: Nursing/Academic Edition; Middle Eastern & Central Asian Studies; Psychology and Behavioral Sciences Collection; SocINDEX with Full Text and PubMed from 1995-2014. The descriptors and search terms were identified with the University of Calgary in Qatar public services librarian. The descriptors which included hospice care, palliative care and terminal care were associated through the Boolean connector "AND", with QOL in English. The search was restricted to validation studies and to studies whose full text was available online. Literature was reviewed from the Western World as well as from the Middle East in the English language. The guiding questions of the study were taken into consideration during the search process. A total of 297 papers were found from the identified databases. The titles and abstracts were screened, and as a result, twelve articles were identified to be duplicated under more than one descriptor. The duplication articles were identified by using the RefWorks process. In the end, 271 articles were excluded as irrelevant according to inclusion and exclusion criteria as described in the method section. Twenty-one (21) articles met the inclusion criteria for this study.

All of the selected papers were quantitative validity studies which were conducted to validate various QOL instruments in the palliative care context. The studies were conducted in different countries; three studies were conducted in the United Kingdom, three in South Korea, two in Canada, two in Spain, one in German, one in Poland, one in Greece, one in India, one in France, one in Mexico, one in Taiwan, one in Israel, one in Italy, one in Sweden, and one in Norway. Thirteen different instruments were translated into various languages and validated in these different cultural contexts. A total of 13 different QOL instruments used in the area of palliative care were obtained for the purpose of this project.

Quality of Life Assessment Instruments

Studies have shown that many QOL instruments have been developed and are used to assess the QOL for cancer patients in the palliative care context (Catania, Costantini, Beccaro, Bagnasco, & Sasso, 2013, O'Boyle, & Waldron, 1997, Singh, 2010). The purpose of these QOL instruments are defined for research purposes, to assess cancer patients' QOL, support clinical practice, measure care outcome and improve patient's QOL at the end of life (Catania et al., 2013, Salisbury et al., 1999). Multidimensionality and subjectivity are the main standards for the QOL measurement tool in the health care system (O'Boyle, & Waldron, 1997, Salisbury et al., 1999). Most of QOL instruments cover the following main domains: physical, psychological, social, body image and sexual functioning (O'Boyle, & Waldron, 1997). Cancer patients' QOL measurement in palliative care need to be covered by different domains which help to determine the type of instruments required (Patrick, & Deyo, 1989, Wiebe, Guyatt, Weaver, Matijevic, & Sidwell, 2003). There are two different types of

QOL instruments; generic and disease specific QOL instruments (Patrick, & Deyo, 1989, Wiebe et al., 2003).

Generic QOL instruments are applicable for a wide range of diseases and across different medical interventions (Coons, et al., 2000). These identified instruments are multidimensional that include different QOL domains like physical, psychological and social aspects (Patrick, & Deyo, 1989, Wiebe, et al., 2003). The instruments measure the concept of the QOL in a broad way across various health condition types and severities, therefore these instruments are applicable to patients with more than one medical condition but often lack to responsiveness to change (Patrick, & Deyo, 1989, Wiebe, & et al., 2003, Kaasa, & Loge, 2003). An example of the generic measure is the Sickness Impact Profile (SIP). The SIP measures sickness impact on the physical, psychological and social aspects of patient life (Patrick, & Deyo, 1989).

Disease Specific QOL instruments are designed to measure the QOL of patients with specific disease categories and are focused to evaluate clinically important changes (Patrick, & Deyo, 1989, Garratt, Schmidt, Mackintosh, & Fitzpatrick, 2002). These instruments provide great details about the impact of illness on patients' QOL (Patrick, & Deyo, 1989, Wiebe, & et al., 2003, Garratt, & et al., 2002).

Disease specific QOL instruments focus on health aspects which are important to specific health problems in regard to cancer (Patrick, & Deyo, 1989, Wiebe, & et al., 2003, Garratt, & et al., 2002). The items in these instruments are designed to use various wording for items and instructions that are tailored to specific diseases. For example, cancer specific instruments items are focused on nausea, vomiting and cancer treatment related side effects (Patrick, & Deyo, 1989, Wiebe, & et al., 2003, Garratt, & et al., 2002). Disease specific instruments are multidimensional as they evaluate physical, social, and psychological aspects. These instruments are based on the nature of subjectivity to report symptoms and feelings of wellbeing (Kaasa, & Loge, 2003). Domain specific instruments evaluate specific health related QOL domains such as fatigue, pain or psychological distress and are sensitive to detect changes in the QOL related to the specified domain (Kaasa, & Loge, 2003). Assessments of the QOL often require a combination of generic, disease specific and domain specific instruments based on the study aim and purpose (Kaasa, & Loge, 2003).

Through this integrated literature review, the following QOL instruments used in the palliative care context have been selected for a closer review. They include:

1. The EORTC QLQ-C15-PAL (The European Organization for Research and Treatment of Cancer)
2. The Palliative Care Outcome Scale (POS)
3. The Support Team Assessment Schedule (STAS)
4. MC Master Quality of Life Scale (MQLS)

5. The McGill Quality of Life Questionnaire (MQOL)
6. Hospice Quality of Life Scale
7. Quality of Life at the End of Life (QUAL-E)
8. Palliative Care Quality of Life Instrument (PQLI)
9. Functional Assessment of Chronic Illness Therapy (FACIT)
10. MVQOLI (Missoula Vitas Quality Of Life Index)
11. Edmonton Symptom Assessment Scale (ESAS)
12. European Organization for Research and Treatment of Cancer Quality of Life Questionnaire-Core 30 (EORTC QLQ-C30)
13. European Organization for Research and Treatment of Cancer - Lung Cancer (LC13) questionnaire

Discussion

Multidimensional Aspect of QOL Instruments

Thirteen different QOL instruments were identified and thoroughly reviewed for this integrated literature review, and were acknowledged for their ability to measure various aspects of QOL. The number of various instruments could be related to the concept of QOL itself, as it is a difficult concept to be defined. Because of this, different QOL instruments exist to measure various aspects of QOL (O'Boyle, & Waldron, 1997, Salisbury et al., 1999). All of the instruments examined captured the physical, psychological, and social aspects of the QOL. However, measurements of suffering and the meaning of life were not acknowledged. Failure to recognize these important aspects of QOL is therefore recognized as a limitation to the use of most of the tools described (Moro, & et al., 2006).

The meaning of life is considered to be an important determinate for QOL measurement in the palliative care context. However, only 2 QOL instruments, the McGill QOL questionnaire and the Palliative Care Outcome Scale (POS), captured or addressed this aspect in their measurements. For instance, the McGill QOL questionnaire captured 4 domains of QOL: physical, psychological, existential well-being and support. The existential well-being domain included meaningful existence, control over own life, feeling good about oneself and feeling that every day is a gift/burden (Cohen, Mount, Strobel, & Bui, 1995). The support domain included achieving one's goals, feeling that life is worthwhile, feeling that the world is caring and feeling supported (O'Boyle, & Waldron, 1997, Cohen et al., 1995). The authors acknowledge that the failure to address the patient's meaning of life is a limitation to the use of their instruments. In the current review four studies addressed the validity of the McGill QOL instrument.

First, the McGill Quality of Life questionnaire (MQOL-Taiwan version) validated the instrument on a sample of 64 Taiwanese patients with terminal cancer. The study validated the (MQOL-Taiwan version) for clinical and research use in Taiwan. The second study validated the

McGill Quality of Life Questionnaire in hospice settings in Israel on a sample of 160 advanced cancer patients. The study concluded that the instrument is appropriate, reliable, and valid for the culture and Language of the Hebrew patient population. The third study validated the McGill Quality of Life Questionnaire in the palliative care setting in Canada on 143 patients with advanced cancer patients. The study findings suggest the tool is valid for the palliative care context in Canada. The fourth study validated the Korean version of the McGill Quality of Life Questionnaire on a sample of 140 palliative cancer patients. The study findings demonstrate strong reliable and validity scores for the instrument.

The Palliative Care Outcome Scale (POS) captures the meaning of life, life worthwhile and self worth aspects, however, it did not assess suffering (McMillan, & Mahon, 1994, Eischens, Elliott, & Elliott, 1998, Stevens, Gwilliam, A'hern, Broadley, & Hardy, 2005). One study that tested the POS reported some limitations in capturing the spiritual aspect for terminally ill cancer patients. It recommended the instrument to be expanded in certain areas to capture the spiritual domains and assess the patients' spiritual needs (Bausewein, & et al., 2005). In the review of four studies identified, the POS instrument proved to be a valid and reliable instrument to be used in the palliative care context. The first study validated the German version of the instrument on a sample of 118 advanced cancer patients. The authors concluded the instrument is valid and well accepted by the patients and staff. The second study validated the instrument in the United Kingdom on a sample of 262 cancer patients in the palliative care context. In this study the authors concluded the validity of the tool. A third study validated the scale in Argentina on a sample of 65 patients with cancer as well as 20 professionals. This study indicated that the Argentine POS is a valid and reliable measure of palliative care outcomes with advanced cancer patients. The fourth study validated the instrument in Spain on a sample size of 117 patients with advanced cancer. The results of the study proved a strong validity of instrument for use in the palliative context.

The Edmonton symptom assessment scale (ESAS) has identified that failure to address the meaning of life is a limitation in the use of this tool. In this study, authors reported that the ESAS has a limitation as it does not measure the suffering in cancer patients at the end of life (Moro, & et al., 2006, Nekolaichuk et al., 2008, Chang et al., 2000). The instrument measures the symptoms only in certain measurement levels and lacks the individual patient's experiences and expression (Moro, & et al., 2006, Nekolaichuk et al., 2008, Chang et al., 2000). In an additional study examining a review of the Italian version of the ESAS, a sample size of 83 in-patients and 153 home care cancer palliative patients were tested. The instrument was considered to be valid and reliable for physical symptoms assessment in the palliative context. The authors recommended the need for internal validity testing to be completed (Moro, & et al., 2006).

The Quality of Life at the End of Life (QUAL-E) instrument evaluates various important QOL domains at the end of life. These include the life completion aspect which explores the relationship with others, interpersonal connections, and the ability to help others (McAdams, & De St Aubin, 1992). The ability to help others is related to the generativity in the life span context theory of personality development (McAdams, & De St Aubin, 1992). The generativity has been identified as a concern in establishing and guiding the next generation, and it is considered as a key element in adulthood and in the end of life (McAdams, & De St Aubin, 1992, Steinhauer, & et al., 2004). Only one study in this author's review validated an instrument in Canada. This was completed on a sample of 464 patients with advanced cancer and concluded that the tool is valid to assess QOL for patients with advanced cancer.

Subjective Aspect of QOL Instrument

Thirteen QOL instruments identified the subjectivity of the QOL concept in that each patient has different values, needs and priorities in regard to QOL (Moinpour, Feigl, Metch, Hayden, Meyskens, & Crowley, 1989, Salisbury et al., 1999, O'Boyle, & Waldron, 1997). This is an important point for consideration in the palliative care context as it places patient value and autonomy as core to the concept of QOL (Salisbury et al., 1999). The use of subject language allows for the measurement of individual patient's experiences. With this understanding, care can be designed according to the patient's needs and preferences (Byock, & Merriman, 1998). Many QOL instruments have been used to measure the QOL for cancer patients who are not in terminal stages (Salisbury et al., 1999). It is important to understand the differences in QOL at the end of life, and that these differences will change for the same patient during the last days of life (Salisbury et al., 1999). Patient ratings for the symptoms assessment is considered to be the gold standard. However, in the current review, 6 studies acknowledged subjectivity a limitation of the study due to the often sudden deterioration in patient conditions at end of life (Salisbury et al., 1999, Nikolaichuk et al., 2008, Nicklasson, & Bergman, 2007, Bentur, & Resnizky, 2005, Kim et al., 2009, Kim et al., 2006 Hearn, & Higginson, 1999). Measuring the QOL for terminally ill cancer patients is a challenge as with this stage of the disease, it can be difficult to get data from the patients themselves. This is often related to the dramatic changes in cancer patients' health status at the end of life (Catania, Costantini, et al., 2013, Salisbury et al., 1999). Measuring changes in the patients' health conditions over time will help health care providers to assess care and measure outcomes. However, the Palliative Care Outcome Scale (POS) instrument acknowledged this challenge of rapid changes in the health status of terminally ill patients and viewed this as an opportunity to assess patients at different time points. Therefore, health care professionals can tailor care according to patient and family needs (Hearn, & Higginson, 1999, Arraras, & et al., 1994).

Each research article in this review has been evaluated based on the instrument evaluation criteria. If an article recommended the combination of using two instruments to evaluate QOL for cancer patients at the end of life, this was credited as fulfilling a need to measure QOL from a different perspective or from a holistic approach (Gill, & Feinstein, 1994, Arraras, et al., 2014, Higginson, & McCarthy, 1994). In this current review, an examination of a study by Arraras, et al (2014) found a recommendation for using a combination of the EORTC QLQ-C15-PAL with another QOL instrument to ensure a comprehensive QOL assessment. Also, Higginson, & McCarthy (1994) recommended the combination of the STAS instrument with the Rotterdam Symptom Checklist and SF-36 in order to facilitate the inclusion of more appropriate measures to assess patients with advanced cancer. In an attempt to find a comprehensive instrument to measure QOL, authors recommend the EORTC QLQ-C30 instrument in certain aspects for comprehensive QOL assessment (Bausewein, et al., 2005, Fredheim, et al., 2007). Others recommended the development of a new QOL instrument to assess spiritual and social aspects in depth (Kim et al., 2007, Leppert & Majkovicz, 2013).

Recommendation from the Review

The availability and advancement of a well developed validated QOL instrument for use in the palliative care context in Qatar is a critical step to improve the QOL for cancer patients in end of life. This review identified the validated QOL instruments that are used in the palliative care context, and identified the lack of QOL instruments use in the palliative care context in the Middle East and in Qatar. This review will assist researchers in the Middle East and in Qatar to choose a preferred QOL instrument that could be trialed to assess palliative patients' QOL. The review concludes that there is no uniformly best QOL instrument and the decision to choose one over another, or combination of two QOL instruments, is based on the aim and purpose of QOL measurement. The review suggests every QOL instrument has its own strengths and weaknesses or limitation. As well, selecting QOL instruments for the palliative care context needs to be based on rigorous criteria rather than consensus (Simon et al., 2012). In order to adopt a validated tool to evaluate cancer patients' QOL in the palliative care context in Qatar, it would be crucial to take into consideration the instrument's evaluation criteria including the validity, reliability, psychometric properties of the instruments, responsiveness to change and respondent and administrative burden (Gill, & Feinstein, 1994, Kirkova, et al., 2006, Nikolaichuk et al., 2008, Simon et al., 2012). From this perspective, a result of this review recommends that health care professionals adopt and validate the palliative outcome scale (POS) in the palliative care context in Qatar, because of the multidimensional and the psychometric properties of the scale.

Conclusion

To conclude, QOL measurement research in the palliative care context helps to improve care outcome and enhance palliative patients' QOL. This review identified different validated QOL instruments in the palliative care context and highlighted the need to measure QOL in the palliative care context in the Middle East and in Qatar. The ideal instrument can be determined by the psychometric properties and the aim of the QOL measurement. Moreover, validity, reliability, responsiveness to change and respondent and administrative burden are the main instrument properties which need to be taken into consideration. The review also identified ideal instrument evaluation criteria and based on these criteria recommended the need to adopt and validate the POS instrument in the palliative care context in Qatar. POS is a useful multidimensional scale in the palliative care context in research and in clinical setting. The advancement of POS in Qatar may considerably advance and improve cancer patients' QOL measurement in Qatar.

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POSITION STATEMENT: THE USE OF SECLUSION IN PSYCHIATRIC SETTINGS

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Introduction

There are many issues in debate that need more studies and analysis to meet an appropriate position on these issues. A position statement is defined as standing on a topic or a debate to let people know where they are standing in this topic; also it can be used in policy, literature, ethics, and legislation (Education Portal, 2013). According to American Nurses Association, a position statement is defined as showing your opinion of action by explanation, justification or recommendation for this action (American Nurses Association [ANA], 2014).

In the psychiatric field there are many issues that need a position statement to increase the quality of care and to choose the best decision. Mental disorders account for a significant and growing proportion of the global burden of disease, yet remain a low priority in many low and middle income countries (Chan, 2010).

The diagnostically acute psychiatric patients are the most disturbed (Happell & Harrow, 2010). Patients who experience psychosis need management and control challenging behavior to contain this behavior (Whittington, Bowers, Nolan, Simpson, & Lindsay, 2009). These behaviors of psychiatric inpatients cause severe complications during treatment (Ketelsen, Zechert, Driessen, & Schulz, 2007). There are several interventions used to control agitation or disorientation behaviors (Keski-Valkama et al., 2010); such behaviors include violent behavior or threatening violence which commonly lead to the use of many interventions (Whittington et al., 2009). The aggressive behavior is defined as the behavior in which the patient harms self or other, physically or emotionally (Siever, 2008).

The aggressive and violent behaviors could be controlled by several interventions including: seclusion, physical restraints, time out and chemical restraints (Migon et al., 2008). Seclusion has more than one definition but all definitions mean the same, seclusion means isolating psychiatric inpatients in locked rooms which are specially prepared and safely separated from other patients. This method is used internationally to manage and control disturbed behavior by psychiatric inpatients (Bowers et al., 2010; Bowers et al., 2011). Seclusion involves placing the service user in a locked room; it also involves isolation and reduction of sensory stimuli (Mayers, Keet, Winkler, & Flisher, 2010).

Abstract

This position statement is aimed to reduce psychiatric inpatient seclusion by improving nurses role and providing opponents and proponents legal overviews; this issue is one of the most controversial practices in psychiatric care according to legal perspective; the differences in legal supply make differences of using seclusion; patients who experience psychosis need management and control challenging behavior to contain this behavior; seclusion is used in psychiatric setting significantly and is the most important debatable issue in the psychiatric field; nurses must balance the responsibility for protecting patient rights with the duty to protect patients from harming themselves especially in situations that have escalated to the point of danger; there are suggestions for a course of action and possible solutions to movement action in reduction of seclusion included for clinical practice, staff training and education, research, and staffing and policy change parts, which increase the quality of care and to choose the best decision.

Key words: Position statement, Seclusion, Psychiatric setting, Legal, Policy.

There are several reasons causing the isolation of psychiatric inpatients in seclusion, such as: violence to property, verbal aggression or threats, threats of self harm or actual self harm, physical aggression to others, and severe psychiatric symptoms or disturbed behavior (Bowers et al., 2011). However, the prevalence of seclusion is lacking (Stewart, Van der Merwe, Bowers, Simpson & Jones, 2010); although many studies have investigated the intervention, the methods of calculation and reported prevalence rates vary widely (Janssen et al., 2008).

Therefore, many studies showed this topic in dilemmas of using seclusion with aggressive psychiatric patients. Many studies expound that authors advocated against its use in the psychiatric field, conversely others consider as necessary the use of seclusion to manage these aggressive behaviors.

The purpose of the current position statement paper is to reduce the use of patient seclusion by improving registered nurses' role in this issue.

Background

While reading what the articles have concluded and discussed, most of the discussion was about reducing seclusion among psychiatric inpatients which is related to more than one reason. There is some debate about this topic; however, the author will be touching on views regarding this topic and will look at more than one point of view.

During searching about the benefits and drawbacks of seclusion, the author was faced with a lack of evidence based knowledge, although, there are a bulk of studies that recommend using this method of intervention to prevent self or other harming (Keski-Valkama et al., 2010). But still the use of seclusion in the inpatients psychiatric setting is debatable. However, the American Psychiatric Association determined the indications of the usage of seclusion by the following: the prevention of harm to self and others, the prevention of damage to the physical environment, the prevention of serious disruption of the treatment program, a contingency in the behavior therapy of dangerous behaviors, a decrease of stimulation, and the patient's request (American Psychiatric Association [APA], 2006).

The differences in legal supply make differences of using seclusion. This was shown by the Netherlands, who had a high rate of violence in Europe related to restrictive use of involuntary medication. In Canada, their 2-year retrospective trial showed that 23.2 % were secluded with or without restraints and 17.5 % were secluded with restraints (Dumais, Larue, Drapeau, Ménard, & Giguère Allard, 2011).

The purpose of the background is to highlight opponents and proponents of using seclusion from policies and

governmental perspectives and the structure of the background will first explain the opponents then proponents of using seclusion.

Opponents of Using Seclusion

In various countries, there are policies and guidelines that are established by governmental authorities and social consensus supported an adoption to reduce and even eliminate seclusion (Larue, Piat, Racine, Ménard, & Goulet, 2010). Seclusion is used in the management of risky and disturbed behavior on psychiatric wards, and can't be eliminated completely from psychiatric units and the topics under discussion (Bowers et al., 2011). Also, Bowers et al. (2010) reported that some hospitals in UK work on without using seclusion in their psychiatric setting whether in acute psychiatric ward or psychiatric intensive care units, and in these hospitals the aggressive behavior is not that high. Although, several hospitals in several countries have a high level system of action to reduce seclusion use, however; hospitals in the UK use to have a low usage of seclusion (Bowers et al., 2011).

Bowers et al. (2011) and Whittington et al. (2009) explained that with the physically aggressive there are more tendencies to use seclusion and other methods for other types of aggressive behavior. Also, may be there will be repetition in the aggressive behavior while the patient is still in the hospital when using seclusion more than using other methods. Thus in this case seclusion is not acceptable for patient and staff nurse. In addition, the use of seclusion that is linked with the availability of a seclusion room increases the rate of seclusion use, and that does not show any connection with reducing aggressive behavior, self harm and medication related conflict (Bowers et al., 2009; Baker, Bowers, & Owiti, 2009). Thus, the removing of a seclusion room will not affect the staff and patient safety, but will cause the reduction of using it (Bowers et al., 2010).

Most likely, using seclusion will prevent injury for both patients and staff. However, the brawl with patients may produce injuries to both, in addition, when using effective ways these injuries can be avoided by managing without using seclusion (Knox & Holloman, 2012). There are several management ways other than seclusion used to contain patients. Vruwink et al. (2012) stated that there are nursing practices which should be focused on how to prevent seclusion such as de-escalation. In acute psychiatry cases, there is an effective management way other than seclusion, which is time out (Bowers et al., 2011). However, early prediction of aggressive behaviors and initiation of medication for newly admitted patients are related with the reduction of seclusion usage (Goldbloom, Mojtabei, & Serby, 2010).

Moreover, Lloyd, King, and Machingura (2014) conducted a study, using sensory modulation; which is the neurological regulation of response to sensory stimuli. The aims of study were to determine, firstly if sensory modulation can

reduce the level of distress experienced for patients in an acute psychiatric unit, and secondly if sensory modulation can reduce the usage of seclusion. The result for the first aim was effective therapeutic response to patient distress, for the second aim frequency of seclusion episodes was reduced after introducing the sensory modulation but there was no evidence that sensory modulation reduced the duration of seclusion.

The practices of secluding in the psychiatric setting are high risk practices, so there is a program built upon the public health prevention model called crisis prevention management which focuses on changing the culture of patient care, by changing the philosophy of care to reduce the usage of seclusion (Lewis, Taylor, & Parks, 2009).

Furthermore, seclusion may affect on quality of life of patients. Pitkänen, Hätönen, Kollanen, Kuosmanen, and Välimäki (2010) concluded that quality of life of patients is affected by use of seclusion and patients considered seclusion as punishment, not treatment and unnecessary to be used, and patients like the medication which shows a high rate of quality of life. In addition, seclusion shows factors that impact and affect on patient's quality of life such as holistic care, rehabilitation, therapeutic relationship, and long hospitalization (Soininen et al., 2013).

Nursing emotions and feelings toward seclusion

Secluding patients are dilemmas and conflicts for nurse. There are policies that lead to reduction of seclusion, for example, the Australian government policy identified a safety priority by reduction or possible elimination of seclusion and facilitates to explore the indications and intervention to reduce seclusion (Happell & Harrow, 2010). The staff nurse who experiences large numbers of secluded patients felt negative emotions; conversely staff nurses who experienced lower levels felt less negative emotions (Gelkopf et al., 2009). Moran et al. (2009) reported that nurses experienced distressing emotions in response to seclusion as well as the nurse who tries to suppress emotions going in interventions.

Moreover, Happell and Koehn (2011) concluded after examining the relationship between burnout, job satisfaction and therapeutic optimism justification of the use of seclusion according to use self-report questionnaire. The Elsom Therapeutic Optimism Scale (ETOS) which is designed to measure clinicians' level of optimism in conjunction with treatment outcome. The researchers report that the nurses who have less support for the use of seclusion are those who have a higher score on the ETOS and lower on emotional exhaustion, that may affect their negative attitudes on seclusion.

Seclusion affects emotionally stress on the therapeutic nurse patient relationship, increasing patient aggression (Ashcraft & Anthony, 2008; Moran et al., 2009). Furthermore, Kontio et al. (2010) reported that previous

studies of seclusion and relationship with emotional describe the physical and emotional damage that can be present to nurses and patients.

Gelkopf et al. (2009) found that there are variables that affect on the nurse goals of seclusion such as level of qualification, gender of the nurse, the department where he or she works, the set of instruments available to the staff to cope with violence, and environmental conditions.

Many patients placed in seclusion are left with negative views of the event. During work in psychiatric settings nurses may be exposed to aggressive behaviors from patients that affect on the physical and psychological health of nurses and may produce increased absence of nurses related to illness (De Benedictis, 2011). Seclusion may affect on psychiatric patients by developing negative perceptions of the center of mental health, hence will affect on treatment (Steinert, Bergbauer, Schmid, & Gebhardt, 2007).

Ethical issues facing seclusion

There are studies showing the ethical and moral dilemma of using seclusion with psychiatric patients. Kontio et al. (2011) reported the requirements required to change the culture of seclusion to nurses about the attitudes of negligence of basic needs like access to the toilet and washing. Furthermore, ethical issues divided autonomy of free self control, human dignity by affecting violation to dignity, and experiences of patients showing negative perception, although, there are differences in perception of benefits of seclusion between patients and staff (Prinsen & van Delden, 2009).

Proponents of Using Seclusion

As mentioned previously, the usage of seclusion in the inpatient psychiatric setting remains controversial. Prinsen and van Delden (2009) stated that seclusion is not a form of treatment but considered as an intervention to facilitate the treatment. Maintaining safety and avoiding injury to both patient and staff is associated with favorable use of seclusion (Stewart et al., 2010). Keski-Valkama et al. (2010) stated that there is no problem to use seclusion but a humanitarian manner should be taken into consideration when using it.

Happell and Koehn (2011) conducted a survey of nurses' attitudes to seclusion on 123 nurses from eight mental health services from Queensland, Australia. Despite the negative impact of seclusion in patients there was continued support of the use of seclusion by staff to the management of some behaviors such as violence and aggression. Although, in most circumstances where seclusion is considered justified appears to be the patient is hitting a staff member (80%) and the patient hitting another patient (70%).

Furthermore, the responses of patients to seclusion were different, they showed anger. Nurses' attitudes, affected by use of seclusion, reported that most responses were relief, that the problems have been resolved and there is satisfaction with helping the patient. Moreover; the seclusion rooms have a good impact on patients and help them to calm down, make them behave better, disempower, control their behavior, and allow them to express angry feelings in a way that's not destructive to the rest of the ward (Happell & Harrow, 2010).

Prinsen and van Delden (2009) stated that seclusion can be used as an intervention for reaching autonomy instead of violating autonomy which is the last reason for eliminating seclusion and there are not sufficient reasons in autonomy and the violation of human dignity to eliminate seclusion. Moreover, Knox and Holloman (2012) reported the seclusion is necessary in case of ineffective verbal and behavioral techniques to prevent harming of the patient and staff. On other hand, the quality of the patients' life may be enhanced by isolating them from the ward (Pitkänen et al., 2010).

The current author found a policy from the Jordanian nursing council for National Center for Mental Health about the use of seclusion. It includes: the purpose, reasons of action, and the guideline of action. This policy takes into consideration patient's safety, safety of others, and patient's right, in addition to observation patients, renewal order of seclusion by doctor, and meets the needs of patients (National Center for Mental Health [NCMH], 2011).

Summary and Conclusions

The purpose of the background was to highlight opponents and proponents of using seclusion, from policies and governmental perspectives. Most previous literature reviews of seclusion that was used among psychiatric inpatients setting work to reduce it and know the factors of aggressive behaviors to move away from using it. The author searched updated articles and the studies that were found talked about reducing these methods and using other methods. Seclusion is used in the psychiatric setting significantly and for many reasons which were mentioned. However, there are other methods used to manage aggressive behavior and reduce seclusion. The seclusion may negatively affect on staff and patients and ethically affect on autonomy and dignity. However, the priority in mental health hospitals is safety, and there is no effective treatment without safety.

Position Statement

The position statement of the current author is to reduce seclusion; nurses must balance the responsibility for protecting patient rights with the duty to protect patients from harming themselves especially in situations that escalate to the point of danger. However, improving this position through points and success to reduce seclusion

from view of authors which included for clinical practice, staff training and education, research, and staffing and policy change.

Clinical Practice

Developed clinical practices recommendations is the goal of reducing the usage of seclusion, such practices which include:-

- Work as multidisciplinary team in seclusion process.
- Met the needs of staff by individual support for team members with stress
- Observe regarding patients considered at high risk of seclusion.
- Supportive observation and reassurance, debriefing sessions post seclusion and explaining procedures.
- Creating appropriate environment that may help to reduce use of seclusion by reducing the behaviors that affect on patient, one-self and others.
- Good communication and contact between nursing staff and patients.

Staff Training and Education

- Train staff that seclusion is intervention which may be used only as a last resort; when all other intervention attempts have been made.
- Train staff nurse to cope and deal with aggressive behaviors and to know when and how to use seclusion.
- Encourage the use of inter professional education to develop processes of a decision making ethically and integrated on higher level.
- Give staff nurse program of clinical supervision to assist in managing distressing emotions.
- Train staff, about communication and skills of dialogue which may also be effective in reducing and containing aggressive behaviors, and train in de-escalation techniques.
- Make daily stimulation sessions for staff and define a recovery approach to caring for patients.
- Explore patient and staff perceptions and improvement suggestions regarding seclusion in psychiatric inpatient settings.
- Train for post seclusion debriefings with staff and patients, promoting attitudinal change among staff; support the development of skills in crisis management, and implementation of new models of care.

Research

- Conducting of future research should focus on staff patient interaction, reasons for patient aggressiveness, how to meet patients' needs to avoid aggressive reactions and interventions to reduce the use of seclusion in mental health care.

Staffing and Policy Change

- Changes required in policy change, organizational and cultural change, staff culture, coaching and group support, staffing structures, and environmental and regulatory unit changes.

Summary and Conclusions

This position statement of the present position of the current author toward seclusion used in psychiatric hospitals, is to reduce the usage of seclusion. Dilemmas and conflicts through caring for patients produce nursing accountability and responsibilities which are inevitable. The duty is to prevent harm to patients and staff which produces the nurse's conflict to balance their responsibility to protect patients' rights of freedom. Safety is priority in mental health hospitals and without safety there is no effective treatment.

This position is supported by discussion through using articles which show background derived from two parts, proponents' and opponents' opinions of using seclusion. Opponents stated the reasons to reduce seclusion from more than one side through using other interventions; seclusion affect on emotion of nurses or patients, and the ethical side has a role in this part. Although, there are proponents that recommend using seclusion, included articles show nurses may favour to use seclusion from other interventions. Suggested course of action and possible solution is mentioned finally to movement of action to reduce seclusion and deal with these changes and involve the user in this action.

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