Received: 16 March 2022 | Revised: 28 May 2022 | Accepted: 14 June 2022

DOI: 10.1111/jan.15336

ORIGINAL RESEARCH:
EMPIRICAL RESEARCH – QUANTITATIVE

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Contextual factors influencing patients' experiences of acute deterioration and medical emergency team (MET) encounter: A grounded theory study

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Abstract

Aim: This paper explores the personal, social and structural factors that influence patients' experiences of acute deterioration and medical emergency team (MET) encounter.

Background: Patient experience is recognized as a means of assessing healthcare delivery with a positive experience being linked to high-quality healthcare, improved patient safety and reduced length of stay. The experience of acute deterioration is unique, extensive and complex. However, little is known about this experience from the patient's perspective.

Design: Constructivist grounded theory, informed by Kathy Charmaz, was used to explore the personal, social and structural factors that influence patients' experiences of acute deterioration and MET encounter.

Methods: Using a semi-structured interview guide, in-depth individual interviews were conducted with 27 patients from three healthcare services in Victoria, Australia. Data were collected over a 12-month period from 2018 to 2019. Interview data were analysed using grounded theory processes.

Findings: Contextual factors exert a powerful influence on patients' experiences of acute deterioration and MET encounter. The most significant factors identified include patients' expectations and illness perception, relationship with healthcare professionals during MET call and past experiences of acute illness. The expectations and perceptions patients had about their disease can condition their overall experience. Healthcare professional–patient interactions can significantly impact quality of care, patient experience and recovery. Patients' experiences of illness and healthcare can impact a person's future health-seeking behaviour and health status.

Conclusion: Patients' actions and processes about their experiences of acute deterioration and MET encounter are the result of the complex interface of contextual factors.

Impact: The findings from this study have highlighted the need for revised protocols for screening and management of patients who experience acute deterioration.

KEYWORDS
acute deterioration, grounded theory, medical emergency team, patient safety, patients' experiences, rapid response teams

1 | INTRODUCTION

Patient experience is recognized as a means of assessing healthcare delivery with a positive experience being linked to high-quality healthcare, improved patient safety and reduced length of stay (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2020). The experience of acute deterioration has been described as unique, extensive and complex (Chung et al., 2020), however, little is known about this experience from the perspective of the patient. Studies exploring the contextual factors that influence patients' experiences of healthcare have gathered momentum over recent years, however, the contextual factors that influence patients' experiences of critical illness, including acute deterioration and MET encounter have received little attention (Chung et al., 2020). An in-depth understanding of these contextual factors creates opportunities for healthcare services to implement strategies to improve patient experiences.

2 | BACKGROUND

Healthcare services are treating increasing numbers of patients with complex medical conditions who are vulnerable to rapid physiological deterioration (Buykx et al., 2012; Chung et al., 2020; Guinane et al., 2017; Schoen et al., 2009). Clinical deterioration is defined as "a serious physiological disturbance or a sudden worsening of patient physiological condition" (Al-Moteri et al., 2019, p.1). Over the past decade, patient safety and ensuring patients who experience acute deterioration receive appropriate and timely care, has been a global concern (Australian Commission of Safety and Quality in Health Care [ACSQHC], 2017; Chung et al., 2020). As defined by the World Health Organization (WHO), patient safety is 'the prevention of errors and adverse effects to patients with healthcare' (WHO, 2015). Despite growing evidence suggesting healthcare professionals are well equipped to address the needs of deteriorating patients, major gaps remain in our understanding of patients' experiences of acute deterioration and MET encounter. Research suggests that patients are sensitive to, and able to, recognize a range of issues in healthcare delivery (Ricci-Cabello et al., 2016; Schwappach, 2010; Strickland et al., 2019) that may not be identified by other systems of healthcare monitoring (Levtzion-Korach et al., 2010; Ricci-Cabello et al., 2016). In the current literature, the absence of the patient's voice is particularly pertinent in the current rhetoric of quality improvement and safety (Chung et al., 2020; Guinane et al., 2017; Kenward et al., 2017).

The role that contextual factors play in shaping patients' experiences of acute deterioration and MET encounter has begun to receive some attention from researchers (Guinane et al., 2017; Sosnowski et al., 2018 & Strickland et al., 2019). For example, Strickland et al., 2019) identified a link between patients' experiences of acute deterioration and their knowledge of their illness and symptom recognition. Yet, despite their ideological connection, factors such as patents' expectations and illness perception, relationship with healthcare professionals during MET and past experiences of acute illness all moderate patients' behaviour towards conceptualizing their experiences. While contextual factors do not determine behaviours and attitudes, they do have a significant impact on patients' experiences (Birks & Mills, 2015; Hall et al., 2013).

2.1 | Aim

As part of a larger study designed to understand patients' experiences of acute deterioration and MET encounter, this paper specifically explores the contextual factors that influence patients' behaviour and attitudes when experiencing acute deterioration and MET encounter.

2.2 | Design

The consolidated criteria for reporting qualitative research (COREQ) checklist was applied to enhance the quality and transparency of this study (Tong et al., 2007). Constructivist grounded theory (CGT) was chosen to explore patients' experiences of acute deterioration and MET encounter. The research was underpinned by the theoretical assumptions of symbolic interactionism, which assumes individuals construct selves, society and reality through interaction (Charmaz, 2014; Hall et al., 2013). CGT places emphasis on processes and actions relating to particular situations, constructed between participants and researcher to generate new theories through inductive analysis of the data (Charmaz, 2014). Therefore, the findings became a co-construction of the researcher's interpretation of the data and participants' experiences (Charmaz, 2014).

2.3 | Data collection and participants

Purposive sampling was used to recruit participants and theoretical sampling was employed to focus on important concepts. Demographical characteristics of participants are presented in Table 1. Hospital patients over 18 years of age who experienced acute deterioration resulting in a MET review were invited to participate in the study. The exclusion criteria were patients who were confused and/or unable to provide informed consent, assessed as clinically unstable by a hospital clinician, obstetric

TABLE 1 Participant demographical information

Number of participants	N = 27
Gender	
Male	10
Female	17
Age (years)	
30–39	3
40–49	3
50+	21
Country of birth	
Australia	23
China	2
England	2
Reason(s) for MET review	
Decreased Glasgow Coma Scale (GCS)	3
Decreased blood pressure (BP)	15
Increased respiratory rate (RR)	4
Decreased heart rate (HR)	3
Increased temperature (Temp)	1
Low oxygen saturations (SaO2)	1
Facial and throat swelling	1
Bedside nurse was concerned	1
Day of admission	
0	6
1–5	15
11–19	2
20+	1
Location at time of MET	
Medical ward	11
Surgical ward	6
Emergency department	6
Critical care unit	1
Theatre recovery	2
Rehabilitation ward	1

patients, patients who had an active complaint against the hospital and patients admitted to a mental health unit or under a mental health team. An explanatory statement and consent form were distributed and interested participants were followed up by the researcher and consented to be interviewed. Twenty-seven patients were interviewed until emerging categories were saturated. Theoretical saturation was determined when gathering new data did not provide any new insights into the emerging categories (Birks & Mills, 2015). Participants were interviewed one-on-one while in hospital, at a mutually agreed time of approximately 30 min, using a semi-structured format with some guiding questions, informed by Charmaz (2014), as shown in Table 2. Interviews were audio-recorded, with permission from participants, and subsequently transcribed.

TABLE 2 Interview guide

Introduction
• Introduce Researcher • Provide participant with a brief explanation of the study and reiterate the aim of the study • Ensure the participant has read and understands the participant's explanatory statement • Ensure the participant consent form has been signed
Body of the Interview
I am interested to understand your experience of becoming unwell and needing to be cared for by the hospital's medical emergency response team. Can you describe to me your experience? • What were the events leading up to the MET review? • What were your thoughts and feelings before, during and after the event? • What was the communication like between you and the healthcare professionals? • Did you have any insight into your own condition? • Did you feel supported during and after the event? • Do you have any advice for healthcare professionals who are caring for a patient during a medical emergency review? • Do you have any advice for a patient being cared for during a medical emergency review? • Is there something else you think I should know to understand your experience better?
Conclusion
Is there anything you would like to ask me? May I have your permission to contact you again should I require further clarification of the data? Would you like a summary of the study when it is completed?
Thank you for your participation.

2.4 | Ethical considerations

Permission to conduct this study was granted by the human ethics committees of Monash University (12571), Federation University Australia (E18-003) and the relevant healthcare services (1347, HREC/19/BHSSJOG/20, 2018–05). Potential participants were approached in accordance with hospital ethical requirements and written consent was obtained. All participants were assigned a pseudonym to protect their identity.

2.5 | Data analysis

In keeping with the tenets of grounded theory, data collection and analysis occurred concurrently (Malik, 2017; Birks & Mills, 2015). Data generated from interviews were analysed by the first author using initial, focused and theoretical coding (Charmaz, 2006; 2014). Codes and emerging categories were discussed and agreed on by the research team. Preliminary subcategories and categories were constructed from the coding process and were constantly compared with codes, and emerging concepts to reveal actions, processes and events (Charmaz, 2014). Theoretical sampling and memoing supported concept development to establish properties of categories and relationships between each (Birks & Mills, 2015). By engaging with an iterative and interactive method, the advanced stage of

coding resulted in three categories and a core category. Contextual factors identified within categories included: *patients' expectations and illness perception*, *relationship with healthcare professionals during MET call* and *past experiences of acute illness*, which are the focus of this paper.

2.6 | Rigour and trustworthiness

The evaluation criteria of credibility, originality, resonance and usefulness proposed by Charmaz (2006; 2014) were used to ensure the trustworthiness of this study. Methodological rigour was enhanced by constant comparative analysis of the data, engaging in extensive memo writing, maintaining a reflective diary, writing field notes and any preconceived ideas or assumptions the researchers had were acknowledged and not imposed on the findings (Charmaz, 2014). Interview transcripts were read and analysed repeatedly and some were subject to member checking. Additionally, two participants were contacted to verify that the theory reflected a true interpretation of their meanings and interpretations of the findings was supported by the research team.

2.7 | Findings

A number of contextual factors mediated patients' experiences of acute deterioration and MET encounters. The factors that were found to be important are categorized into three broad areas: (i) patients' expectations and illness perception, (ii) relationship with healthcare professionals during MET call and (iii) past experiences of acute illness.

2.8 | Patients' expectations and illness perception

Data generated from interviews revealed that patients' illness expectations played an important part in their attitudes, beliefs and understanding of what occurred. Many participants identified that their acute deterioration and subsequent MET encounter was unexpected. One patient discussed being surprised by the event:

> *… I don't know how to describe it… it was just really quick. I mean didn't feel uncomfortable or anything. They were all asking, "Are you okay? Do you feel well?"…They were obviously making sure I was alright so… But to start with I was a little bit not stressed but surprised. I just didn't expect it …*
>
> (June)

Being 'surprised' when experiencing acute deterioration and a MET encounter is an interpretation of a range of behaviours that patients often struggled to describe. Kelly talked about being scared, uncertain and shocked by her sudden clinical instability because she was admitted to hospital for what she described as a 'simple procedure':

> *… I was quite shocked because I was coming in for a simple procedure… I didn't know what the consequences were for my blood pressure dropping down. I think it dropped down to about 70 something which is very low and can be life threatening… I was a bit scared and uncertain about what was going to happen.*
>
> *(Kelly)*

Tara also described being shocked by her unexpected acute deterioration and MET encounter "*…when I woke up I couldn't figure out what all the fuss was about … I was a bit shocked, I couldn't understand what had gone wrong.*" She qualified this by explaining "*… I can remember there was no sense coming out of me … and I couldn't work out what the heck was going on…" (Tara)*

In contrast, some participants were not surprised or shocked by their episode of acute deterioration and subsequent MET encounter. One participant, diagnosed with a terminal illness stated: "*I'm dying anyway*" (Anna) and although she was not surprised by her acute deterioration, Anna described being tired and feeling emotional while discussing her resuscitation status with the MET:

> *When they talk about your own death, you do get a little emotional. But I'm not going to burst out crying or anything else like that because I've faced this three times. It's just sometimes saying it out loud…*
>
> (Anna)

Another participant, George, also talked about not being surprised by his acute deterioration and MET encounter because of the nature of his illness: "*…I've been through dozens of medical things … but I wasn't surprised when my blood pressure dropped, death doesn't worry me…*" On reflection, George did not realize how unwell he was at the time of his acute deterioration: "*I started to realise only after I started to improve is when I realised how unwell I really was. I couldn't get out of bed I just was bedridden basically I didn't realise it at the time …*" (George).

Some participants perceived the nature of their illness, before their experience of acute deterioration, as stable based on what they had been told by medical staff and their discharge plan, for instance:

> *…the doctor said that I would be okay in one day, so they sent me to short stay. I had been there one day and then I felt a bit better but when they checked my blood pressure, it was going down, settled at 50 something and then at that time, they changed me to the ICU (MET call) … I am usually a healthy person and*

sporty person … I also had been worried about my health because so many doctors came around me, asking lots of questions (David). I was about to go home. I was ready to walk out the door and they told me that I had funny blood test results. So they kept me and I started to slowly feel worse …

(Amber)

Additionally, some participants did not raise an issue with their symptoms of acute deterioration as they associated it with their illness expectations:

*I felt a bit flat. I was a little bit dizzy but I thought that was because of the morphine, because I had morphine for the pain half an hour or an hour before … I didn't think anything of it. It was just when they did my obs [vital signs], they realised that my blood pressure was really really low, which should not be that low… (Kelly).*But they said, "No, this is really quite common after heart surgery or a surgery" … So once I told myself it's common, I just laid back and relaxed, there was nothing I could do about it …

(Rose)

2.9 | Relationship with healthcare professionals during MET call

From the perspective of the participants in this study, many acknowledged that their experience depended on the healthcare professionals who were caring for them at the time of their acute deterioration and MET encounter. A number of participants identified members of the MET who they had valued during their review:

The nurse was being very forceful in what she was saying about my blood pressure being so high, she was making sure because she felt the doctor wasn't taking that into consideration. I know she reiterated that several times…I was grateful that she was doing that. I knew she was on my side. I don't know what I would have done without her. I really don't

(Sarah)

I thought they were marvellous, I wasn't up to doing anything much and they just took over, and I felt quite safe in their hands…they don't mess around, they've got your welfare at the back of their minds. You know, what's not to like about that?

(Rose)

Given the dependent and intimate nature of the MET–patient relationship, all participants noted that the personality and competence of the MET members were of significant importance as mediators of good and bad MET experiences. Participants often characterized the MET along the dimensions of good and bad. A variety of descriptors were used to characterize a 'good' MET: 'knowledgeable', 'good', 'were there is a hurry', 'efficient', 'provided comfort and reassuring' and 'took the time to explain.' The features of a 'bad' MET included: 'detached', 'rushed', 'delayed in arriving', 'disorganized' and 'did not explain.' Not all participants placed the same importance on each of these characteristics. For some participants, importance was placed on therapeutic communication rather than clinical competence. Joan described the MET as being: *"a beautifully structured team"* that *"even if you think you are on your last breath, you think, thank God you are in really good hands."* But for Joan this was not enough, she recalled the MET being: *"caught up in their stuff"* which caused her to be scared and overwhelmed.

Sarah and Tara both experienced acute deterioration and MET review due to medication errors administered by healthcare professionals. Both Sarah and Tara had negative experiences with their respective METs, relating to pain. Tara said, "*It was hurting my arm. I kept saying, 'Please don't do it anymore', but they kept on doing it…I suppose they had to but I didn't want them to touch me…" (Tara).*

Sarah also explained:

You can't do that. You're hurting me, you're hurting me. You have to take it out! I want you to take it out! He took it out and comes at me with another one and he says 'I have to put another one in'. I said, 'Do not come near me.

(Sarah)

For some participants, a negative experience had a lasting effect. It caused a spectrum of feelings such as worry, helplessness, hopelessness and vulnerability:

I was frightened it would happen again and it made me question everything…I'd keep apologising, saying to the nurses, 'Look it's not you. It's just that I've had that bad experience'. I had to keep finding out what they were giving me, why and how much

(Tara)

2.10 | Past experiences of acute illness

Data generated from interviews highlighted that participants' past experiences of illness and hospitalization played an important role in their abilities to conceptualize their experiences of acute deterioration and MET encounters. For example, George's ailing chronic condition and previous near-death experiences led to a commitment to get better and live life to the fullest despite his condition:

> *I am determined to get better. I spent over two weeks or whatever in the hospital with a bacterial infection. I was sent home thinking I was alright but I never felt 100%, the next thing I was back in hospital with the same thing and I went through probably more because I had lost weight and my conditioning was right down. I was very vulnerable so I knew I wasn't in a good place when I had the MET call but I just accepted, yep I will get better.*
>
> *(George)*

Tara's previous experience of acute deterioration and MET review was due to a medication error by healthcare professionals. This previous experience influenced the trust she had for the current MET. Tara described how the development and maintenance of trust in healthcare professionals was ongoing, qualifying this by explaining:

> I think the fact that I'd been overdosed in the past… I thought if they've got that wrong, what else could they get wrong?
>
> (Tara)

Some participants who had a previous experience of hospitalization measured the seriousness of their condition by the number of healthcare professionals present. Julie said, "*Something was going on, I knew something was badly wrong with me for so many people to be in the room.*" This was similar to Alex who stated, "*Usually when I come there's a couple of people but this time I reckon there was eight or ten people.*" Additionally, some patients who experienced acute deterioration and MET encounter more than once emphasized the fear that remained. Tim explained, "*It's still a bit scary, the second time. The number of doctors I had means I'm in trouble, if I have one or two, okay that'll be fine. But maybe it was like five or six nurses and doctors.*" James said: "*The first time [MET review] is a bit scary, you don't know exactly what's going to happen…actually it doesn't get less scary.*"

Overall, the interplay between expectations and illness perception, relationship with the MET and past experiences was evident. These factors played important roles in patients' abilities to conceptualize their experiences of acute deterioration and MET encounters.

3 | DISCUSSION

The study findings offer insights into contextual factors affecting patients' experiences of acute deterioration and MET encounters in Australia. The aim was to providevaluable insights into the influences of contextual factors on patients' experiences of acute deterioration and MET encounter, which may be transferable across other clinical settings..

The expectations and perceptions of patients had about their illness trajectory had a significant impact on their experience. Patients' perceptions of their disease and expectations can condition their overall experience (Mazzotti et al., 2012). Health psychology research suggests that under certain conditions, health behaviours are influenced by patient-perceived severity and are considered as a substitute for beliefs about the objective controllability of disease (Albarracin et al., 2005; Mazzotti et al., 2012). According to the health belief model (Hochbaum, 1958), patients' perceptions and actions will change when disease severity and perceived vulnerability combine to form a 'threat'. The extended parallel process model (Witte, 1992) suggests, that healthy behaviours occur if there is a balance between threat and efficacy beliefs (Mazzotti et al., 2012).

The relationship patients had with members of the MET in this study had a significant impact on their experience. Our results are consistent with other research that suggest the healthcare professional–patient interaction can have a significant impact on quality of care, patient experience and recovery (Alpers et al., 2012; Cypress, 2011; Mylen et al., 2016; Strickland et al., 2019). A recently published Norwegian study found that the quality of the nurse–patient relationship, for example, strengthens not only health but also the patient's own resources for health and well-being (Standas & Bondas, 2017). We found that 'relationships' were raised as important aspects of personal meaning for participants and exerted a significant influence. All participants were affected by the interaction they had with members of the MET to some extent. Our findings are consistent with international research that suggests the nurse–patient relationship/healthcare professional–patient relationship is one of the most important aspects of positive patient outcomes (Molin et al., 2016; Peplau, 2004; Strandas and Bondas, 2017; Strickland et al., 2019).

Patient-reported outcomes measures (PROMs) and patient-reported experience measures (PREMs) provide a means of exploring relationships between patient safety, clinical effectiveness and patient experience when being cared for in hospital (Kingsley & Patel, 2017; Black et al., 2014). Some studies have explored the relationship between PROMs and PREMs with hospital patients and found that patients admitted following an acute event reported good communication by clinicians was associated with better post-discharge health-related quality of life (HRQL) and better physical health (Black et al., 2014; Fremont et al., 2001; Larson et al., 1996). Whereas, patients who were admitted with a chronic conditions, such as chronic obstructive pulmonary disease and diabetes, reported better health outcomes if they had a positive experience and better mental health associated with greater trust in the doctor and support for self-management (Black et al., 2014; Slatore et al., 2010). No studies were found that specifically explored the relationship between PROMs and PREMS with hospital patients who had experienced acute clinical deterioration and MET encounter suggesting further research is necessary.

In this study, we found that patients' experiences of illness and hospitalization formed an important part of the contextual factors. It is well documented in the literature that experiences in healthcare can impact a person's future health-seeking behaviour and health status (Bankauskaite & Saarelma, 2003; Eriksson & Svedlund, 2007; Schwei et al., 2015). For example, a negative experience can result in the avoidance of or delays in seeking further healthcare

(Schwei et al., 2015; Eriksson & Svedlund, 2007) and distrust or suspicion of the healthcare system (Martins, 2003; Nickasch & Marnocha, 2009; Schwei et al., 2015; Suurmond et al., 2011). In a Swedish study, Eriksson and Svedlund (2007) explored hospital patients' experiences of dissatisfaction with care. The authors found that patients who were dissatisfied by the care they received during a previous healthcare experience were more likely to wait too long before consulting a healthcare professional and feel guilty for partly causing the issue themselves. These findings are in accordance with our study that suggests patients' behaviours and expectations vary depending on their experiences of healthcare.

3.1 | Practical implications

Patient experience data is recognized globally as a means of assessing healthcare delivery with many countries now gathering patient experience or satisfaction data (Chung et al., 2020; Edwards et al., 2014). Our findings highlighted the need for revised protocols for screening and management of patients who experience acute deterioration. It is concerning that survivors of acute deterioration may experience perceptual, emotional and physical distress that could go unnoticed by healthcare providers. By being informed, clinicians will be better equipped to meet patients' needs and expectations which is an integral part of person-centred care and high-quality healthcare.

3.2 | Limitations

While this study offers an in-depth analysis, the theory has been constructed from data derived from a group of patients from Australian hospitals and therefore may not be directly transferable to different settings. Also, the experiences of family members, nursing staff, medical staff or members of the MET team were not explored which may add richness to the study findings.

4 | CONCLUSION

Patient experience is a pivotal component in measuring healthcare quality. While patients were often accepting of what occurred, contextual conditions play an important role in mediating their actions and understanding. Patients' experiences are the result of the interface between expectations and illness perception, relationship with heatlhcare professionals during the MET and past experiences of acute illness. The findings invite healthcare services to adopt screening policies and practical management for patients who experience acute deterioration and a MET review..

FUNDING INFORMATION

This research did not receive any specific grants from funding agencies in the public, commercial, or not-for-profit sectors.

ACKNOWLEDGEMENT

Open access publishing facilitated by Federation University Australia, as part of the Wiley - Federation University Australia agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST

None.

PEER REVIEW

The peer review history for this article is available at https://publons.com/publon/10.1111/jan.15336.

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How to cite this article: Chung, C., McKenna, L., & Cooper, S. J. (2022). Contextual factors influencing patients' experiences of acute deterioration and medical emergency team (MET) encounter: A grounded theory study. *Journal of Advanced Nursing*, *78*, 4062–4070. https://doi.org/10.1111/jan.15336