

Meaningful iterative process for the care of the person with cancer during the pandemic

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Abstract

Objective: To understand the experience of care provided by nurses to people with cancer in the context of a pandemic. **Method:** Constructivist qualitative study with descriptive design, conducted with hospital nurses in the Metropolitan Region of Chile between September 2020 and March 2021. Fifteen semi-structured interviews were conducted, which after transcription were subjected to content analysis according to Krippendorff. **Findings:** The pandemic became a challenge for oncology and palliative care nurses, who had to face this health crisis by reorganizing care through an iterative process, which made it possible to give meaning to the care provided. **Conclusions:** Oncology and palliative care nurses faced the pandemic with resilient leadership that led them to reorganize person-centered care within a framework of comprehensiveness, meaningful learning, innovation, engagement, and cohesion.

Keywords: Covid-19. Oncology. Palliative care. Nursing.

Introduction

In January 2020, the World Health Organization (WHO) declared the COVID-19 epidemic as a public health emergency of international concern, which seriously affected the prevention and treatment strategies of noncommunicable diseases (NCDs) in different countries.¹ Therefore, people with cancer were in a more vulnerable position, given the suspension of some screening programs, the postponement of diagnoses, and the interruption or postponement of oncological treatments due to the redistribution of personnel to units for patients with COVID-19 and less beds available for the safe care of these patients.^{2,3}

It is important to bear in mind that before the pandemic, cancer was the second leading cause of death worldwide, so the effect of postponing treatment and screening further aggravated this situation.⁴

For the oncology nurses and palliative care nursing teams, the pandemic was complex to address because of the implications it had on the morbimortality of people with cancer,⁵ when medical care, hospitalizations, follow-up controls and home visits were modified.⁶ These changes and their adaptations resulted in greater work and emotional overload, stress, and compassion fatigue, especially in nurses.^{7,8} Care became a

challenge for them to face because of a greater number of deaths of patients, both oncological and COVID-19 patients.

Therefore, the present study aims to understand the experience care provided by nurses to people with cancer in the context of pandemic.

Method

Design. A study was conducted with constructivist focus, using a qualitative descriptive design.⁹

Participants. Oncology nurses and oncology palliative care nurses from different hospitals in the Metropolitan Region of Santiago de Chile were recruited, invited through the social networks of the Scientific Societies of Oncology Nursing and Palliative Care of Chile, and by snowball method. The sample was purposive, considering professional nurses who had been working for more than one year in oncology or palliative care, who worked in private or public hospitals as inclusion criteria, and who voluntarily wanted to take part. Those interested were contacted via email with the principal investigator, who asked them, through the *Survey Monkey*[®] digital platform, to complete a sociodemographic questionnaire and register the digital informed consent.

Data collection. It was conducted between September 2020

and March 2021 through a semi-structured interview, audiotaped through the virtual platform Zoom®. The interviews were conducted by three of the researchers (XG, RL, PV), following a script of questions: How have you perceived the care given by you to patients in the context of the COVID-19 pandemic? What are the situations that you consider have made it difficult for you to perform care? What emotions have you experienced the most during the performance of your care? And what has it meant for you to supply care in the context of pandemic? The interviews had an average duration of 40 minutes and were stored according to the identifier code for each participant. Subsequently, each recording was transcribed verbatim avoiding the identification of the participants.

Data analysis. This analysis was done based on the analysis of thematic content according to the three stages of Krippendorff.¹⁰ For this purpose, the research team was separated into two groups; three researchers analyzed the oncology interviews (BZ, RG, PV), and the other three, analyzed the palliative care interviews (XG, RL, PV). In the first instance, each researcher performed the analysis individually. In second instance, each group met to triangulate the findings, developing a code book where the categories and dimensions were described according to the experience of the professionals by area, thus achieving the saturation of the data. Later the results were shared with the participants, who confirmed the results. It ended with triangulation of findings, which allowed to unveil the “core” category.

The sample size was defined according to the data saturation criterion. The sample size was defined according to the data saturation criterion.

Methodological rigor. The investigation meets the criteria of methodological rigor of Lincoln and Guba (1985)¹¹ and verification of COREQ reports.

Ethical aspects. This study was approved by the Scientific Ethical Committee of Salud UC of Pontificia Universidad Católica de Chile (ID:200625071).

Results

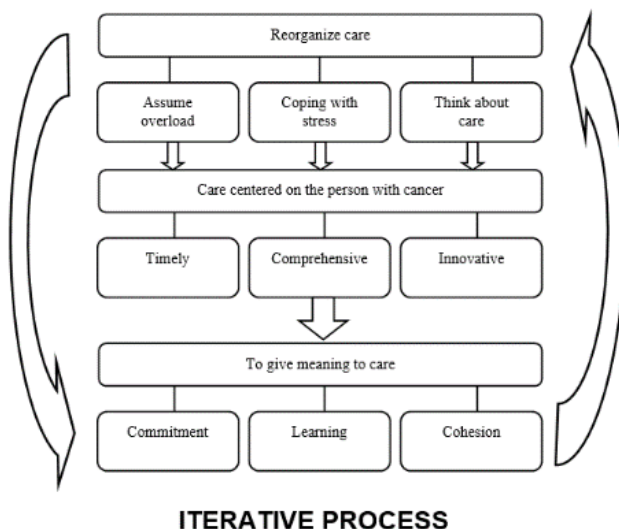
Fifteen nurses participated, nine worked in oncology (ON) and six worked in palliative oncological care (PCN). They had an average age of 36 years. Oncology nurses had worked in the area between one and eight years, while palliative care nurses had worked in the area between eight and twenty-one years. Thirteen of the nurses were redistributed to another unit during the pandemic, and only six received psychological support (Table 1).

The COVID-19 pandemic became a challenge for oncology nurses and palliative care nurses, who had to face this health crisis by reorganizing person-centered care through an iterative process, which made it possible to give meaning to the care provided (Figure 1).

Table 1. Sociodemographic Characteristics of the fifteen participants

Code	Age	Gender	Marital status	Children No.	Years since graduation	Years in the field	Postgraduate training	Health center	Change of unit due to pandemic	Psychological support in pandemic
PCN1	49	F	Married	3	25	21	No	Private	Yes	No
PCN2	53	F	Married	2	30	8	Yes	Private	Yes	Yes
PCN3	36	F	Divorcee	1	13	13	Yes	Private	Yes	Yes
PCN4	43	F	Married	3	16	9	Yes	Public	Yes	No
PCN5	32	F	Married	2	9	9	Yes	Private	Yes	Yes
PCN6	52	F	Divorcee	3	28	10	No	Public	No	Yes
ON1	32	F	Single	0	8	7	No	Private	Yes	No
ON2	29	F	Single	0	4	3	Yes	Private	Yes	No
ON3	27	F	Single	0	1	1	No	Private	No	Yes
ON2	32	F	Single	1	8	8	No	Private	Yes	No
ON5	31	F	Single	0	7	7	No	Private	Yes	Yes
ON6	30	F	Married	1	4	1	Yes	Private	Yes	No
ON7	31	F	Single	0	8	6	Yes	Public	Yes	No
ON8	27	F	Single	0	2	1	No	Private	Yes	No
ON9	28	F	Single	0	6	2	Yes	Private	Yes	No

Figure 1. Meaningful iterative process developed by oncology nurses and palliative care nurses for the care of the person with cancer during the pandemic



Reorganizing care. Faced with the pandemic health situation, the nurses had to reorganize care because of the conversion of beds, change of schedules, and redistribution of both staff and patients to other areas, which led them to assume the work overload in order to maintain quality care, having to cope with the stress of complex situations and maintain a constant reflection on the care provided: “They were very intense months, because it also involved developing protocols that we had not implemented, such as the use of personal protective equipment both in the outpatient and at home. It was quite a challenge! So, there was much work, such as reviewing literature, generating protocols, and reaching consensus with the institution. As the number of cases in homes decreased, they called the unit more, wrote more e-mails or asked us for things that we used to address in person at home”. (PCN5-32 years old). “There was a reflective process behind it. For me, it meant a substantial change in care. Like realizing the importance of the educational role, especially when you are faced with other needs of the person, and you realize that there is another priority of care” (ON6-30 years old).

Person-centered care for the person with cancer. Despite the overload and complex situations arising from care in times of pandemic, the nurses organized their care centered on the person with cancer and their families, prioritizing comprehensive, timely, and continuous care: “I became much more concerned about the details. You need to take care of these things and these other things. You can use this to take care of yourself at home, and call us, here we have nurses 24/7. There will always be someone who will respond and can help you; to value and look for ways to make patients always feel accompanied. For me, that has been important, like taking on the real weight of how important it is” (ON1-32 years old). “It was the strategy of learning to communicate with our patients [despite the protective equipment and the mask], and to show affection in a unique way: in the tone of voice, maybe in body language, and this hand-holding thing. We used to hug and sit next to the bed. Now we can't do it! But it was the strategy to recover even more the human when the human was so difficult to achieve” (PCN5-32 years old).

To give meaning to care. The care experiences lived by the nurses allowed them to give meaning to their daily work, by valuing the assumed commitments, the learning, and the cohesion achieved within the team, thus becoming the engine where the nurses themselves assumed the new challenges in the care of the person with cancer: “I think what I value the most is the commitment to our patients, the affection towards them and the concern that we had towards their welfare. In general, if we had things, it was with their welfare in mind” (ON5-31 years old). “The thing about optimizing time and resources is a learning process. You try to adapt and say: how can I do more with less time, less resources, less space? And that is where the art of nursing comes in and you come up with everything you can think of and what else can you do! Finally, it has been an important learning experience. That is why the issue of placing more emphasis on patient education in a more concentrated way, in trying to give all the tools that are available so that patients have the best at home (ON1-32 years old). “One of the important things, has to do with emotions. I think

that to work on this [palliative care] we need not only to be administratively efficient, but we must be efficient in the cerebral, in the spiritual, in the emotional, and be a whole. Humanization becomes more present in pandemic” (PCN2-53 years old). “It generated a greater closeness with co-workers, and it was like a “Let's go” feeling. The feeling of giving encouragement to each other and keeping people together. That was my feeling in doing it. I appreciated the team, and the commitment of the team gave me a lot of satisfaction” (ON7-31 years old).

Meaningful iterative process when caring. By giving meaning to care, nurses are aware that this motivates them to face the new situations that arise during the pandemic, which allows them to reorganize their interventions and to give rise to a virtuous spiral of care: “There was also a great process of satisfaction, of having been part of this! Of being able to help many patients who had a very, very bad time. Having been a part and having been internally helping each person's process, so they could endure this. I think satisfaction is the only thing it leaves” (ON2-29 years old). “For me it was also an opportunity. To work in palliative care has always been a gift, and I believe that even more during the pandemic. It was a gift to be there! Because in fact, their [social] networks were much more diminished, and it was much more difficult to access health care. It is the satisfaction of being able to be there, of knowing that those people were still able to live their illness process accompany, they were able to live it calmly” (PCN5-32 years old).

Discussion

Several investigations performed in the last three years have highlighted the changes and adaptations that had to be made by the health teams, facing the uncertainty and vulnerability in front of a complex, global situation, given by the shortage of personal protective equipment, distribution of beds in favor of COVID-19 patients, lower staff coverage by distribution or licenses, lack of preparation of health infrastructure and changes in oncology protocols that led to greater labor overload,^{12,13} which was also described by the study nurses. This situation exposed professional nurses to psychological distress, triggered mainly by factors related to work conditions and vulnerability situation of patients, and must face depressive symptoms, anxiety, and stress.^{14,15}

In spite of the above, nurses adopted a proactive approach within multidisciplinary teams to face a critical problem that required rapid and decisive actions in a short time, and must assume the planning and risk that the pandemic entailed within health centers.¹⁶ As described by Lewis (1985), the organizational change that this crisis generated, led nurses to “thaw” the situation produced by COVID-19, through the awareness of the workers and the mobilization for safe, timely and quality care, through structural changes and organizations.¹⁷ This allowed “changes” to reorganize new ways and stable intervention protocols based on evidence, which led them to “freeze” interventions at a different level, which is consistent with the subsequent learning that the pandemic brought.¹⁷ Thus, for the nurses in the study, this process occurs in an iterative way, where this behavioral advance must be performed in the way of the desired change and under the protection of a

reorganization of the care.

Some authors describe that it is these situations of uncertainty that forge leaders, for whom the challenge is to frame the nature and severity of the problem, address the concerns of patients and other staff, and provide a degree of clarity on interventions and answers that are required,¹⁸ so that the ingenuity of nursing in the application of innovative and timely interventions is revealed, in an environment of trust, honesty and commitment to the sick person, in the different scenes.¹⁹ This was described by participants, for whom leading timely, comprehensive and innovative care was key in the well-being of people with cancer.

In this way, oncology nurses around the world proved the ability to be effective leaders, by critically pursuing and providing timely evidence-based actions and “mobilizing” to achieve effective solutions for care and advocacy in all areas of practice.¹⁸

Assuming this leadership leads them to feel professional satisfaction, to increase positive emotions and professional commitment, to improve their productivity with innovative ideas, and to reduce stress, which contributes to supply more effective, humanized, holistic care despite the pandemic,^{20,21} as described by the interviewed nurses.

In the case of oncology nurses and palliative care nurses, the leadership assumed is resilient, being able to overcome problems through continuous learning and transforming it positively into flexible and organizational changes in favor of the person with cancer.^{15,22} They show strong leadership by manifesting a commitment to reorganize their care to provide it in a timely, comprehensive, innovative manner and to take on the challenges that these decisions bring within a process of continuous change.

This is the leadership that allowed nurses to give meaning, not only by giving the meaning of care in times of pandemic, but to guide their purpose and role in this health crisis, which requires personal creativity, discovery of themselves, and the development of self-realization, along with the ethical duty to care.^{20,23} Therefore, the care provided transcends and is at the disposal of the patient as a source of meaning for a group, as described by the participants. It is important to point out that the relationship between a resilient, creative, meaningful

leadership, has a helical structure, with ever-widening spikes, symbolizing growth, development, creativity and life,²⁴ similar to the iterative process with meaning described in the results.

Although this study is an advance in understanding the role of nursing, it is not exempt from limitations such as the lack of participation of male nurses and the low participation of public sector professionals, despite being invited through snowball. This could be explained by the overload of work, given the excuses received during recruitment.

Conclusions

The pandemic became a major challenge for nurses who care for people with cancer, both in oncology and palliative care, for whom it not only became a vital risk for their patients, but it also exposed them to a shift in care to help patients with COVID-19. However, they faced overload and stress, reinforcing their care through a resilient leadership that led them to supply a reflexive, integral, timely, innovative care, in a framework of trust, creativity and self-realization that was developed over time. This is how an iterative and helical process that allows nurses to give meaning to the care supplied is generated.

That is why this research opens up new aspects that must continue to be studied, regarding the changes implemented in favor of the person with cancer after the pandemic; the relevance of home care with active, continuous accompaniment; the incorporation of new technologies in the service of care, and the adaptation of the regulations in order to avoid lonely deaths, an aspect that significantly marked, not only people with cancer, but all who were in an end-of-life situation in time of pandemic.

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