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Rocky Road Ahead Of Nursing Presence in the Oncology Care Unit: A Qualitative Study

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Abstract

BACKGROUND: Cancer patients need not only well-planned treatment, but also comprehensive nursing care provided with compassion, competence, and conscience. Nursing presence is an essential part of the care process in all nursing interventions.

AIM: This study aimed to identify the barriers to the nursing presence in oncology care units.

MATERIALS AND METHODS: A qualitative content analysis study was carried out with the participation of 27 nurses who were chosen by purposive sampling. The data collection instruments were semi-structured interviews and observation. The interviews were recorded and transcribed, and then coded and analysed by the Graneheim and Lundman's content analysis methodology. The criteria proposed by Guba and Lincoln were used to ensure the validity of the research.

RESULTS: From the data analysis, the researchers were able to obtain a primary theme labelled "Rocky road ahead of nursing presence" and two subthemes labelled "Difficult and stressful work environment" and "Dysfunctional rules and regulations" with several subcategories including "exposure to violence", "shortage of nursing staff", "inattention to the needs of nurses", "organizational unfairness", "excessive paperwork", and "need for detailed documentation".

CONCLUSION: There are numerous challenges ahead of achieving satisfactory nursing presence and quality care in the oncology care units. The findings highlight the key role of organisational conditions in the nursing presence and the dire need to pay further attention to the motivational factors.

Introduction

Cancer is one of the most common causes of death and health problems in the world. Cancer is the third common cause of death after cardiovascular disease and accidents in Iran [1]. Cancer patients have to endure intense therapies and also may suffer long-term sequelae after their illness and its treatment. Fatigue, lack of energy, exhaustion, and impaired physical performance are among the most common symptoms in cancer patients and can have severe physical, emotional, and social effects [1] [2]. In addition to therapy, cancer patients need comprehensive nursing care provided with compassion, competence and conscience. Such care is a fundamental right of cancer patients and their families. Nurses are the members of the healthcare team who spend the most time with patients and act as the main caregivers or active companions of patients in their life-threatening experiences. Thus, in the case of cancer patients, nurses have to overcome many obstacles to provide a quality care [3] [4]. Nurses are the members of the healthcare team who spend the most time with patients and act as the main caregivers or active companions of patients in their life-threatening experiences. Thus, in the case of cancer patients, nurses have to overcome many obstacles to provide quality care [5]. The provision of humanistic care can be impeded by factors such as technological advancement, nurse understaffing, and the replacement of nursing staff with non-nurses, which undermine the ability of nurses to attend to the patient and thus the quality of patient care [6]. One of the quality indicators of nursing care is the nursing

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presence [7]. Nursing presence is an essential component of care and all nursing interventions [8] and has been described as a deliberate nursing activity that is indispensable for patient safety and the success of nursing process [9].

Paterson and Zderad have considered real presence, being or doing, cultivating goodness and more-being and experience, thinking, conceptualisation as nursing action. Presence is a conscious act grounded in the distinct personality of the nurse. This presence is a chosen human response that is freely given and can never be assigned [10]. Watson argues that there is a caring moment that forms a spiritual link between the nurse and the patient, becomes an existential turning point, and a focal point for honouring human integrity [11]. Nursing presence was first introduced to nursing texts in 1964 by Madeleine ClémenceVaillot. Nursing presence can be defined as being with the patient or being available in a reciprocal way [12]. In a study with a concept analysis approach, "nursing presence" was identified as a constructive interaction with voluntary concentration, patient-centred/task-oriented communication, responsiveness, transparency, and comprehensive engagement. This study argued that nursing presence requires clinical competence, self-actualisation, mutual cordiality, and desirable work environment, and will result in effective communication, balance/recovery, and growth and development. The nursing presence depends on a combination of personal characteristics of nurses and patients, their shared characteristics, a favourable environment for communication, and nursing decisions [13]. In a study carried out by Zamanzadeh et al., nurses of an oncology care unit stated that they give a higher priority to "monitoring and follow up" and "availability of nurses" in the care process [14].

To successfully perform professional duties regarding assuaging the physical and mental problems of patients, nurses need to have a presence when attending to their patients. Previous studies in this area are mainly focused on understanding the nature of this presentation from the nurses' viewpoint. Although nurses face many great challenges in their career, this does absolve them from their professional and moral duty toward cancer patients, who because of their pain and delicate condition, deserve more attention, monitoring, and follow up from their nurses. No study has so far investigated the barriers of nursing presence in oncology care units. Since nurses' perceptions are influenced by their care experience, one of the ways to explore this area and devising solutions at personal and professional levels is to study the experiences of nurses who work in oncology care units.

This study aimed to explore the experiences of nurses about the barriers to the nursing presence in oncology care units.

Methods

This qualitative content analysis study was carried out in 2017. As a research method, the qualitative content analysis is the subjective interpretation of the content of textual data through a systematic categorisation process to identify the meaningful pieces of content or latent and apparent patterns in the text. This process aims to produce new cognitive knowledge, enhance the researcher's perceptions of the studied phenomenon, and reveal a path toward operational solutions [15].

The research environment was the oncology care units of two teaching hospitals (in two adjacent provinces in the north of Iran). Using a purposive sampling approach, nurses with at least one year experience of working in the oncology care units were invited to participate.

Given the data saturation, 27 participants entered in this study. Data collection instrument was semi-structured and interactive interviews. In all interviews, a few primary questions such as "_Please describe a day of your work_?" and "_What prevents you from being present at the patient's bedside_?" were repeated. When needed, exploratory questions such as "_Please elaborate_", "_Please explain what you mean_", and "_Please give an example to help me better understand your experience_" were asked to deepen the interview. The average duration of interviews was 75 minutes, but they could take between 30 and 120 minutes depending on the participant.

All interviews were conducted by one researcher. The word-for-word transcript of each interview was prepared and coded within 48 hours after the interview. Data analysis was carried out simultaneously and continuously with data collection. The OneNote software was used to sort and organise the data. Data analysis was performed with the qualitative content analysis method of Graneheim and Lundman [16].

For this purpose, the transcripts of interviews were read through several times to obtain a sense of their contents. Then all interviews were considered as one analysis unit, that is, as a single text document that is intended to be analysed and coded. Paragraphs, sentences, or words were considered as meaning units, that is, the set of words and sentences that contain aspects related to each other through their content and context. Meaning units were abstracted according to their latent concepts and were coded accordingly. The codes were compared with each other based on their similarities and differences and then assigned to more abstract categories with specific labels. After a comparison of the categories and a deep reflection on their contents, the latest contents of the categories were formulated into themes.

The validity and robustness of the study were

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strengthened according to the criteria proposed by Guba and Lincoln [17]. For this purpose, the researcher attempted to improve the credibility by remaining engaged with the participants and data collection process for a prolonged duration and rechecking the validity of information with percipients. The dependability of data was improved by stepwise replication as well as inquiry audit by the supervising and advising professors and other experts. The confirmability was achieved through the confirmation of university professors and with the help of their critical comments. To ensure the transferability of the study, the researcher attempted to provide an accurate report of the statements made by participants as well as a detailed description of the research process in order to facilitate future evaluation and use of findings in other contexts, so that other researchers would be able to understand the experience of interviewed nurses about the subject.

This study was approved by the ethics committee of the university as a part of larger research. To protect the rights of participants, they were asked to give written consent and received assurance that interviews will remain confidential and transcripts or comments will be published without divulging any identity.

Results

Of the 27 participants, 3 were men and the rest were women. Participants had an age range of 26-58 years and a work experience of 1-30 years. Of the 27 participants, 20 were clinical nurses, 4 were nursing managers, 1 was a head nurse, and 2 were quality improvement experts.

After deep reflection on the transcripts of interviews, 610 initial codes were extracted.

These codes were read several times, abstracted, and categorised based on their similarities and differences. After analysis and comparison, the latent meanings were identified and formulated into four themes, which were given conceptual and abstract labels according to their contents. After analysing the data regarding the experience of nurses about the barriers to the nursing presence in the oncology care units, the researchers formulated primary theme labelled "Rocky road ahead of nursing presence" and two subthemes labelled "Difficult and stressful work environment" and "Dysfunctional rules and regulations". Each of these subthemes consists of several subcategories, which are presented in Table 1.

The oncology nurses faced numerous challenges in maintaining a presence in the patients' bedside and fulfilling their professional care responsibilities.

Table 1: Themes, subthemes, and subcategories of barriers to the nursing presence in the oncology care units

Theme	Subtheme	Code
Rocky road ahead of nursing presence	The difficult and stressful work environment	Exposure to violence Shortage of nursing staff Inattention to the needs of nurses Organisational unfairness
	Dysfunctional rules and regulations	Excessive paperwork Need for detailed documentation

The findings suggest a work environment that is very difficult and stressful and severely undermines the prospects of achieving a nursing presence. Nurses may be exposed to violence as a result of high level of stress and negative emotions among patients and families, their poor skills (e.g. in finding patient's veins), and their poor responsiveness to patients and their families because of understaffing an overwhelming number of patients. Some of the nurses believed they have a difficult work environment because they are constantly overworked and understaffed. In their view, the organisation views them as a tool and ignores their motivational needs (in term of wages, facilities, etc.) and expects them to work more than they are paid. This theme consists of four subcategories: "Exposure to violence", "Shortage of nursing staff", "Inattention to the basic needs of nurses", and "Organizational unfairness".

Nurses are exposed to various forms of occupational violence while attending to the patients. Physical violence is less frequent than other forms of violence and most violent acts are committed by the families of patients. Interviewed nurses stated that sometimes violence and aggression occur because of physicians giving false hope to the patient family, which result in high expectations. Nurses are less likely to stay at the patient's bedside when they sense exposed to aggression and violence. In these cases, they attend the patient's bedside as less often as possible or ask another nurse to do their tasks to avoid the patients or their families. Often, they end their shift with unhappiness about their job and take this feeling home to their family. One of the nurses stated:

"... We had a patient who suddenly went into arrest and expired. We did all we could for the patient. When I was coming back from the patient's room, someone threw something toward me; it was patient's father throwing a tea flask toward me; he then walked to me and slapped me in the face" (M.6, Male. 34, Married, Bachelor's degree, Nurse).

Another nurse provided an example of the aggressive behaviour of patient families:

"I was in charge of the shift. A family member of a patient came to me and said that the patient is bleeding in the mouth and you must come. I sent a nurse to the patient and started calling the doctor. The same person returned and started yelling at me that why don't you come? He is in bad shape, why are you still here?"(M.2, female. 27, Married, bachelor's

degree).

Nurses repeatedly mentioned their physical and emotional fatigue because of working with a tight schedule and overwhelming numbers of patients, because of which they remain completely occupied for the entirety of the shift and cannot have even a short break.

One of the nurses said:

"This is the central oncology department of the province; most of the patients coming here are extremely sick or at end stages; here we have 23 patients and only three nurses; we have to work hard really" (M.15, female, 33, married, bachelor's degree).

According to the participants, the other obstacles in the way of nursing presence were the shortage of support and service staff in the care unit one of the participants said:

"... I have only two assistant nurses, and this is just enough for taking the patients to sonography, CT scan, tests... When there's no assistant, nurses have more work to do... This is the time that you should dedicate to the patients, to be with them, and you lose it doing other works" (M.3, female, 48, married, bachelor's degree, head nurse).

Some nurses believed that the lack of motivation is an obstacle to staying at the patient's side. They stated that reasons such as lack of interest in the profession, poor management, low salaries and benefits, and high mortality rates all affect nursing presence.

"Our salary is low, and there's no support to compensate for it. They say that you're an outsourced nurse. So there is little motive to put much effort for the patient since there's no money, no respect, there is practically nothing..." (M. 16, female, 29, single, bachelor's degree, nurse).

Some nurses believed there is absolutely no attention to the welfare of the staff, such as the facilities of break rooms, vacation time or fund, etc. Therefore, nurses suffer from mental and emotional fatigue, which affects the nursing presence, because they are never in the right mood and psychological state to stay with the patients.

"The system should also pay attention to the welfare of personnel. We proposed that personnel should have periodic vacations to avoid fatigue, but .....the organisation does not pay any attention" (M.26, 44, married, bachelor's degree, quality improvement expert).

Some of the participants stated that the organisation expects more work than it pays and does not understand them.

"They won't understand, they can't understand until they work here in these units. They don't see the effects of drugs on nurses; they don't see the emotional and physical problems of the guys.

If you bother to look, you'll see that guys are on their feet from morning to noon" (M.22, female, 28, married, bachelor's degree, nurse)

The following is the comment of one of the head nurses about the transfer of the workforce from the oncology care unit and the organisation's negligence to retain specialist staff:

"Several times I went to the nursing office to make them retransfer a previous staff member to the oncology. I told them that I know this nurse, she's good, I approve of her work, and she has the right mentality to work with our patients. They didn't allow it and said that the other department is understaffed" (M.3, female. 48, married, bachelor's degree, head nurse).

Another theme observed in the comments of interviewees was the "dysfunctional laws and regulations" with two subcategories labelled "excessive paperwork" and "need for detailed documentation". Nurses believed the hospital accreditation program, as long as it is compulsory and poorly implemented, undermines the nursing quality. They stated that the managers of the organisation give a higher priority to the proper filling of documents than the actual results.

In Iran, the compulsory implementation of accreditation programs a method of hospital services quality assessment started in 2012. This program significantly increased the amount of paperwork that nurses have to do, as it added several hospital assessment forms to the routine forms that nurses have to complete during their work.

"There's an initial assessment form that takes all the patient information; for example, you write the entire information in one place, but you must write the entire thing again in the nursing report. ...... It's duplicate work. There's no time for the nurse to remain with the patient. In practice, the nurse starts ignoring the clinical work" (M.20, female, 43, married, bachelor's degree, nurse).

Most nurses were critical of accreditation program because of the time they had to spend on documentation. Interviewees stated that they were more interested in being with the patients than filling up forms.

"I don't like accreditation at all, because it's just paperwork" (M.24, female. 39, married, bachelor's degree, head nurse)

Nurses stated that patients expect nurses to completely focus on clinical work, but the size of non-clinical tasks practically undermines their presence beside the patient bed.

"Patients don't know what I'm writing on my papers, and won't understand; the work I'm doing on my workstation, all the paperwork, all the medication logs I put in the computer...." (M.9, female, 37, married, bachelor's degree, shift manager).

Some of the interviewed nurses stated that since the hospital evaluation system is based on the accreditation program, failing to get a good score means a reduction in the hospital credibility and grade, which results in reduced hospital income and therefore reduced income of the personnel; thus, they have to implement the hospital accreditation with great care.

"We have to do the accreditation stuff because the organisation wants us to do it. If it weren't for the mandatory accreditation, I wouldn't fill these forms" (M.24, female, 39, married, bachelor's degree, head nurse).

Participants also stated that in the event of a legal problem, the competent authorities would only accept the documents, because, from their perspective, anything that remains undocumented has not happened.

"You can find notifications one very wall and door about the complaint process and the way it'll be handled step by step; this makes you take care of your documentation because this is what saves you in the court" (M.24, male, 58, married, bachelor's degree, nurse).

Discussion

The findings of this study revealed the real perceptions and experiences of nurses about the barriers to the nursing presence in the oncology care unit. The analysis of the experiences of participants confirmed that nursing presence faces obstacles such as difficult work environment and dysfunctional laws and regulations.

One of the barriers to the nursing presence in the oncology care unit is the difficult and stressful work environment. Nurses were exposed to verbal abuse while on the patients' bedside, mostly as a result of poor technical skills of less experienced nurses. Given that nurses are the most easily accessible personnel in the hospital, the main cause of the high rate of violence and aggression against nurses is their close contact with patients and their families while they experience a stressful life-threatening situation [18]. The results of a study showed that nurses in the oncology care unit were 2.7 times more likely to be exposed to non-physical violence than those in the emergency department. This finding was attributed to the fact that oncology nurses are more prone to fatigue, reduced physical and mental health, and experiencing negative emotions.

Most interviewed nurses viewed the shortage of human resources (nurses and assistant nurses) and the intensive work shifts and consequent fatigue as a barrier to nursing presence. Nurses stated that as if a shortage of nurses is not enough, shortage of assistant nurses forces the trained nurses to do non-specialized work such as transportation of patients, and this leaves them no time to spend with patients. Various studies, including Elaraby et al., in Malaysia [19], Shinjo et al., in Japan [20], and Eygelaar et al., [21], investigated the impact of human resource imbalances and shortages on the quality of hospital services. Enforcing a minimum nurse-to-patient ratio not only improves outcomes such as patient safety [22] [23], length of stay [24], and readmission rate [25] it also increases the appeal of nursing as a career and decreases the rate of burnout among nurses [26]. The shortage of nursing staff creates overworked nurses who are unable to realise their full potential in providing quality patient care and have to spend most of their time doing basic and rudimentary tasks instead of communicating with the patients and paying attention to their needs as is theorised in the nursing presence concept. This ultimately results in job dissatisfaction, a stressful work environment, increased rate of medication error, and decreased quality of care provided to patients [27]. Most nurses believed that the organisation's lack of attention to salaries, benefits, and timely payment had crushed any motivation for effective presentations. Failure to pay attention to motivational factors in nurses can lead to low job satisfaction, and motivation reduced service quality and ultimately patient dissatisfaction with the health care services provided [28]. In a study income and benefits were found to significantly increase motivation, and discriminations in payments and the feeling of unfairness in the payment system were among the leading causes of decreased motivation and resignations [29].

The findings suggested that because of the fatigue caused by understaffing and overcrowding of the oncology care unit and its high mortality rates, nurses were inclined to be rotated out of the care unit. Job rotation, which is a labour-management technique where employees learn the skills of different care units, is known to reduce the fatigue caused by repetitive tasks. The recovery of staff motivation is one of the main tasks of care unit managers [30]. Nurses stated that the organisation asks them to be constantly available or present on the patient bedside to provide care services, but considering the amount of work that must be done in each shift, they often feel overworked and tired. Mazdaki et al. stated that there is "increasing the income gap between physicians and nurses, the crucial differences between physicians' and nurses' salaries" in Iran [31].

According to the study dysfunctional laws and regulation, and most notably the accreditation program, acted as a barrier to nursing presence. In a study by Walker, it was found that when a nurse prioritises paperwork over care services and does not converse with the patient during care, this leads to patient dissatisfaction [32]. Hospital accreditation is a

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standardisation program consisting of a set of rules that hospital are required to implement, but it says nothing about how these rules should be implemented [33]. Developing policies and procedures for every activity in the hospital will only increase the volume of paperwork and reduce the actual performance by keeping the clinical staff busy with preparing documents that they believe to be inconsequential [34]. Several studies have shown that the accreditation program has had an impact on the performance and quality of services. The accreditation program is a time-consuming administrative bureaucracy and increases the workload and creates stress in employees [33] [35]. Also, no significant relationship has been found between hospital accreditation and patient satisfaction [36]. Participant of this study believed that while increasing the awareness of nurses about patient safety, the accreditation program has not been helpful overall. They argue that most of the standards required by this program have always been fulfilled even before its implementation, so the program only emphasises the documentation, which reduces the clinical presence of nurses. It was found that nurses implement this bureaucracy solely to maintain accountability toward the organisation because insufficient documentation is the first critique that is raised in academic and managerial inspections.

Another issue that interviewees identified as barriers to nursing presence were the importance of documentation for safety against organisational inquiries and legal actions, which encourage nurses to spend time on filling paperwork meticulously instead of being present for the patient to provide direct care. The provision of direct care in the study of Harrison et al. was 24%, and in the study by Kiekkas et al., 35.2%, and 32.8% in the study by Des Jardins et al., [37] [38] [39]. It is clear that complete, accurate, and on time preparation of reports is imperative for verifying that patients have received the necessary care as instructed. From the legal standpoint, the medical team has to document its activities to ensure verifiability, as only the well-documented actions will be acknowledged. Hence, given the importance of nursing reports, many nurses spend a lot of time logging events and actions and thus have little time to spend on direct interaction with patients [40]. In the present study, nurses stated that since patients and families are aware of the patient rights and thus supervisors emphasise on the meticulous documentation, they spend a lot of time and effort to fill out all documents to ensure accountability toward legal authorities as well as their employer.

In conclusion, this study found that there are several challenges and a rocky road ahead of achieving satisfactory nursing presence and providing quality care. An honest conversation with nurses is the best strategy for managers to improve their insight and ability to deal with the problems of nurses and identify the barriers to the nursing presence in

oncology care units. The findings highlight the central role of the organizational conditions and the importance of attention to the motivational factors and the efficiency of laws and regulations in the nursing presence. Based on the findings of this study, it is recommended to pay further attention to the education of nursing students about the nursing presence, its association with the quality of nursing care, and how they can rely on this practice to enhance the care service provided to patients.

Acknowledgements

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