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The Impact of COVID-19 Visitor Restrictions on Clinical Cancer Nurses

Amy O'Dea[a,*], Rebecca Caulfield[b,c], Michael A. Roche[d,e,f]

[a] Nursing Honours Candidate, School of Nursing and Midwifery, University of Canberra, Bruce ACT, Australia
[b] Lecturer, School of Nursing and Midwifery, University of Canberra, Bruce ACT
[c] Registered Nurse, Canberra Health Services, Canberra, ACT
[d] Professor of Mental Health Nursing, Faculty of Health, University of Canberra, Bruce ACT
[e] Clinical Chair in Mental Health Nursing, SYNERGY Nursing & Midwifery Research Centre, ACT Health
[f] Adjunct Professor, Faculty of Health, University of Technology Sydney, Ultimo NSW, Australia

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ABSTRACT

Objectives: To explore the impact of visitor restrictions on clinical cancer nurses, their roles and duties, and the coping strategies used to address the impact.
Data Sources: Semistructured qualitative interviews were conducted through purposive sampling with nurses working in a clinical role within cancer services at the study site for at least 1 year. Interviews were recorded and transcribed. Textual data transcribed from interviews were analyzed for themes using NVivo version 12 software, following Braun and Clarke's six phases of thematic analysis.
Conclusion: Visitor restrictions implemented due to COVID-19 had a significant impact on clinical cancer nurses. The study found evidence of moral injury and conflict—within the role of the nurse, the implementation of organizational policies, and nurses' professional identity and personal beliefs. Despite this adversity, nurses remained committed to their clinical practice.
Implications for Nursing Practice: Changes to nurses' roles and the practice environment have potentially significant impact on well-being and retention. To ensure that nurses can continue to provide high-quality nursing care in challenging environments, organizations must minimize this impact. Consistent communication and support activities, including recognizing and responding appropriately to situations, may be used in the reduction of potential moral injury and stress.

INTRODUCTION

Emergence of the novel coronavirus disease in 2019 (COVID-19) resulted in a global pandemic that significantly affected cancer care services worldwide.[1] Cancer patients have a potentially increased vulnerability to COVID-19 due to their immunosuppressive state caused by both their disease pathophysiology and the subsequent treatment they receive.[2,3] The awareness of cancer patients vulnerability as well as the overall impact of COVID-19 on health services led to delays or changes in cancer diagnostic procedures and treatment, postponement of preventative screening, cancellation of appointments, and the introduction of telehealth.[4] In the inpatient context, visitor policies mandated conditions on entry including COVID-19 testing, symptom monitoring, and the wearing of certain types of masks, together with restrictions on the number and duration of visits. This paper focuses on the ways restrictions to the number and duration of visitors (herein referred to as "visitor restrictions") affected cancer care nurses.

BACKGROUND

In June 2020, the World Health Organization made a number of recommendations for maintaining essential health services during COVID-19. One of the recommendations pertinent to cancer services was that "numbers of visitors and visiting periods should be highly restricted."[5p10] This resulted in healthcare services across the globe implementing visitor restrictions to limit the transmission of COVID-19.[6,7] Visitor restrictions varied both between countries and between different jurisdictions within a country.[7] Within Australia, health authorities in each state and territory provided recommendations, with health services within each jurisdiction then developing and implementing their own visitor policies informed by these recommendations. Hospitals, other healthcare settings, residential aged and disability care facilities, in-home care, and disability care were all classified by the Australian government as high-risk settings. In these settings, many people were considered at risk of severe illness from

* Address correspondence to: Amy O'Dea, School of Nursing and Midwifery, University of Canberra, 11 Kirinari St, Bruce ACT 2617, Australia.
E-mail address: amy.odea321@gmail.com (A. O'Dea).

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COVID-19.[8] Within these high-risk settings, some jurisdictions went further and recognized specific clinical areas as "high risk"; for example, wards with immunocompromised patients like those in cancer services.[9] The areas deemed as "high risk" by the health service often experienced stricter visitor restrictions than other areas of the health service.[9]

Visitor restrictions at the study site, an Australian metropolitan tertiary referral hospital cancer services department, changed frequently throughout the course of the pandemic, ranging from no visitors (except for compassionate exemptions), to no restrictions, with a plethora of variances in between.[9] As the study site was considered a "high-risk" area, at times it had different visitor restrictions to other areas—for example, when the health service was reopening to limited visitors at that same time visitors were still not allowed in high-risk areas without a prior approved exemption.[9]

The implementation of visitor restrictions had an impact on patients, healthcare workers, and the healthcare system as a whole. Visitors are known to be a crucial source of support and to have a positive impact on the health and well-being of the patient.[7,10] The pandemic, therefore, created dilemmas for healthcare services in trying to balance limiting the spread of COVID-19 and the individual well-being of patients and their family members.[7]

Previous research has highlighted that visitor restrictions implemented due to COVID-19 had an impact on patient, caregiver, and healthcare worker outcomes.[7] The integrative review by Hugelius et al[7] found that visitor restrictions were linked with moral injury and seen to add a burden to healthcare providers, in the form of ethical dilemmas, requirements for learning new means to facilitate social engagement, and increased demand for both communication and social support for families and patients.[11] However, the impact of visitor restrictions as a whole on clinical nurses in the specialty area of cancer services is presently unexplored.

Research Aims

The aims of this study were to explore the impact of visitor restrictions on clinical cancer nurses, their roles and duties, and the coping strategies used to address the impact. Two research questions were addressed:

1. What was the impact of visitor restrictions on the role and duties of clinical cancer nurses?
2. What strategies did clinical cancer nurses use to address the impact of visitor restrictions?

METHODS

Research Design

The study was conducted according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (see Appendix A). A qualitative narrative inquiry approach was taken to explore the experiences of clinical cancer nurses in relation visitor restrictions.[12] Narrative inquiry is defined by Clandinin and Connelly as "the study of the ways humans experience the world."[12p2] Narrative inquiry has a holistic quality, and the fundamental focus on human experience has made the methodology important in many disciplines.[12] Other researchers have found narrative inquiry to be effective in unveiling nuance and exploring past experiences within a nursing context.[13] The methodology of narrative inquiry often uses interviews to explore participants' experiences[13,14] and thematic analysis to make meaning of the data.[15] Therefore, narrative inquiry was considered the most appropriate approach for meeting the research aims.

Study Site

The study was conducted in cancer services in an Australian metropolitan tertiary referral hospital. Cancer services included both inpatient and outpatient oncology and hematology areas, radiation oncology, cancer specialist nurses and palliative care. As noted above, the service implemented a range of visitor restrictions that changed throughout the course of the COVID-19 pandemic depending on government and governance advice at the time.[9]

The study site had governance bodies for COVID-19 emergency response that provided recommendations for the jurisdiction spanning both public and private sectors. Across the duration of the pandemic, there were more than 150 alerts or advice statements provided by the clinical health response governance body.[9] These alerts or advice statements covered aspects of clinical response to COVID-19 including but not limited to personal protective equipment, physical distancing, infection prevention and control measures, management of COVID-19 patients, visitor restrictions, and exemption processes. The alerts or advice statements sometimes focused on just one clinical response area and at other times covered multiple areas in a single advice. At times there were alerts/advice statements exclusively on changes to visitor policy; however, visitor policy changes were also included among other, more general statements.

The study site was considered a "high-risk" area and therefore at times had different restrictions to other areas of the hospital, meaning that the general advice given in the clinical response statements was not always applicable to the study site. The visitor restrictions varied throughout the pandemic, ranging from no visitors (except for compassionate exemptions) to no restrictions. The change to visitor restrictions was not a linear process as the restrictions reflected the current government and health advice, which varied during different phases and waves of the pandemic.

Participants

Participants were registered nurses or enrolled nurses (LPN/LVN equivalents) working in a clinical role within cancer services at the study site for at least one year. Nurses working in primarily nonclinical roles such as training or management were excluded from the study. Participants may have worked under varying types of visitor restrictions depending on their specific work context during different phases of the pandemic. As the purpose of the study was to explore the impact of COVID-19 visitor restrictions as a whole on clinical cancer nurses, rather than to examine the impact of specific types of visitor restrictions, participants were not required to have worked during specific types of restrictions. All eligible nurses across cancer services were invited to participate in the study. The study was advertised by displaying posters across cancer services and briefings that were held in each area to describe the purpose and procedures for the study.

Purposive sampling was undertaken to permit selection of a participant sample who had knowledge of the phenomena under study and who were willing and available to communicate their experiences in a detailed manner. Sample size was determined by data saturation, with interim analysis conducted concurrently with data collection to review when this occurred. A combination of Glaser and Strauss'[16] foundational understanding of saturation (that no additional data are being found) and Grady's[17] perspective (the same comments are being heard again and again in the interviews) was used to determine the point of data saturation.

Data Collection

Data were collected between August and October 2022 while visitor restrictions were ongoing. A semistructured interview guide was developed by the research team that used open-ended questions and

prompts (see Appendix B). Individual semistructured interviews ranging from 22 to 55 minutes (average 33 minutes) were conducted by the chief investigator (AO), a female registered nurse with cancer services experience. The chief investigator had previous experience conducting semistructured qualitative interviews and conducted a pilot interview to test the interview guide and received feedback from other members of the research team with expertise in qualitative interviews. Participants were given the option of face-to-face or online interviews to provide flexibility; all participants chose face-to-face interviews. Face-to-face interviews were conducted in a private room within the service. Interviews were recorded then transcribed by the chief investigator (AO). Demographic data, including age, years in nursing profession, years in cancer nursing specialty, job title, and whether they were employed at the health service prior to the COVID-19 outbreak commencing, were also collected.

Data Analysis

Textual data transcribed from interviews was analyzed for themes (thematic analysis) using NVivo version 12 software, following Braun and Clarke's six phases of thematic analysis.[18] The first author familiarized themselves with the data by transcribing all of the interviews, relistening to the interviews for quality checking, and rereading all of the completed transcripts. To ensure reliability, the second and third authors quality checked the transcriptions by listening to a random sample of the interviews and confirming the accuracy of the transcriptions. Initial coding was completed in NVivo whereby the first author selected sections of text that were relevant to the research questions and labeled them, with quality checking completed by the second and third authors to ensure consistency and reliability. Through discussion within the research team initial codes were collated into potential themes by identifying consistent patterns in codes. The themes were then reviewed, defined, and named. Participants did not provide initial feedback on findings; however, those who had expressed interest were provided with a summary of findings at completion of the study. Participants were randomly allocated an identification number to protect their privacy and uphold anonymity.

Ethics Approval

Ethics approval was granted by ACT Health Human Research Ethics Committee's Low Risk Sub-Committee (2022.LRE.00098) and University of Canberra Human Research Ethics Committee (11849).

RESULTS

Semistructured interviews were conducted with 14 participants (Table 1) who met the inclusion criteria. Data saturation was found to be reached at this point through interim analysis. The highest proportion of participants were aged 25–34 (n =6), with over 10 years' experience in both nursing in general (n =7) and cancer nursing specifically (n =7), were registered nurses (n =12), and were employed in cancer services prior to the COVID-19 outbreak commencing (n =10).

Table 1
Characteristics of respondents (N = 14)

Descriptor	n
Age, y	
25–34	6 (43%)
35–44	1 (7%)
45–54	4 (29%)
55–64	3(21%)
Years in nursing profession	
1–2	2 (14%)
2–5	3 (21%)
6–10	2 (14%)
>10	7 (50%)
Years in cancer nursing	
1–2	3 (21%)
2–5	3 (21%)
6–10	1 (7%)
>10	7 (50%)
Job title	
Registered nurse	12 (86%)
Endorsed enrolled nurse/enrolled nurse	2 (14%)
Employed in cancer services at study site prior to COVID-19	
Yes	10 (71%)
No	4 (29%)

Three common themes, with associated subthemes, were developed across the range of participants (Fig 1). The first theme focused on the *impact on clinical cancer nurses*, with the subthemes of: being the "bad guy," experience of workplace violence and inability to provide holistic care. The second theme looked at the *individual responses* of nurses, with the subthemes of duality in reflection, and supportive relationships. The final theme centered on the *organizational response*, with the subthemes of organizational support, and organizational communication and consistency.

Impact on Clinical Cancer Nurses

Visitor restrictions were seen to have several impacts on clinical cancer nurses at an individual level. This affected them personally, their role and work, and the care that they were able to provide.

Being the "bad guy"

Nurses consistently expressed a role conflict highlighted by the struggle of being forced into the role of implementing the visitor restrictions, feeling that this should not have been the role of the clinical nurse.

> "That's not our job as a nurse you know, we don't do the job to be the bad guy, and to do that, we do it to be the opposite." (Nurse 3)

Some nurses highlighted the damage to rapport and intimate nurse–patient relationship that being the bad guy resulted in, particularly in the specialized area of cancer services.

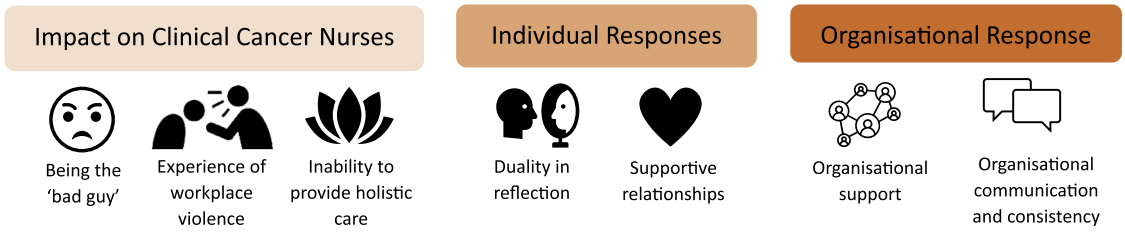

Fig 1. Themes and subthemes.

"I don't think that's fair, ... it's quite an intimate relationship when you are looking after a patient and their families, especially in cancer services and, it's quite a unique journey that these patients and their families are going through. I feel that it's really unfair at any time that nursing staff should have to be the ones to implement that [visitor restriction] because it can change the dynamics of that relationship and that patient care and the relationship you have with the family as well." (Nurse 9)

The emotional distress of nursing staff was evident, with moral injury reported by some of the nurses interviewed. The role conflict of being the bad guy also led to emotional distress for some of the nurses interviewed.

"It was horrible you feel like the worst person in the world." (Nurse 3)

Experience of workplace violence

A few nurses highlighted that some patients and families were understanding of the visitor restrictions.

"I think on the whole people were very understanding because COVID was such a big thing and it was so advertised everywhere and it was all about keeping safe and staying away from crowds and wearing masks and stuff so people on the whole were very understanding." (Nurse 7)

In contrast, several nurses reported experiencing workplace violence in relation to the visitor restrictions.

"I think it was also really hard because being the ones that were telling patients "no you're not allowed visitors" and telling the visitors "no you have to go home" apart from it being heartbreaking, we coped a lot of abuse. We coped a lot of people yelling, swearing like saying lots of nasty things from both patients and family members over the phone and in person. Which was really awful." (Nurse 1)

One nurse highlighted that workplace violence was present in the specialty of cancer services prior to implementation of visitor restrictions but that the visitor restrictions were an additional aspect for families to be frustrated about.

"I would say most of the verbal abuse nurses and medical staff get from people is from families and not being able to meet whatever their expectations are ... I think a lot of families would hear that their family member was in hospital with cancer, they think end of life care but it wasn't necessarily end of life care, so I think that elevated the probably verbal aggression and the expectation that they could come and visit." (Nurse 13)

Inability to provide holistic care

The nurses interviewed recognized the important and irreplaceable role that visitors have in holistic care for patients within the cancer care environment.

"It's really hard to practice holistic care when you can't meet the social or the spiritual needs of someone because their support system isn't allowed to come up with them." (Nurse 11)

Some participants found that their time and ability to provide care for patients was influenced by the visitor restrictions impacting their workload, both due to the absence of family and the process of facilitating visitor exemptions.

"Family members often help out with things like ... helping the patient have a shower, setting up their meals ... family members can be very valuable in helping out with a lot of things." (Nurse 9)

While other participants felt that their workload was easier without the presence of visitors, was different (not explicitly increased or decreased) or experienced no changes in workload due to visitor restrictions.

"I didn't see it as being a hugely impactful extra workload." (Nurse 7)

Individual Responses

Clinical cancer nurses responded to the challenges they encountered due to the visitor restrictions in numerous way; some implemented new strategies, others reinforced existing strategies and some felt that they did not need to implement anything additional in order to cope.

Duality in reflection

Some participants highlighted different reflective approaches that encompassed the duality of looking at positives and negatives or what they did well and what could be improved, as one way to cope with the challenges they experienced due to the visitor restrictions.

"For a time I even started a little journal, a reflective journal cause this was one of the strategies that was brought up 20 years ago when I did my nursing that if you do a reflective journal and then read it over at the end of the week and see what you could do better and what you did do well, and that helped me to cope." (Nurse 14)

Some participants highlighted the duality of reflection while emphasizing the importance of separation. These participants recognized the value in being able to separate their work life from their personal life as a way to cope with the visitor restrictions.

"I try, when I get to my car, think about my day, think about all the good things and the bad things, and all my feelings about it and then I can think about it on the way home and call my sister or whatever on the way home. Then when I get out of my car, I don't think about it again until the next day. Because my home time is my home time, not for work." (Nurse 1)

Supportive relationships

A coping strategy that the participants identified for responding to their challenges with visitor restrictions was informal debriefing which took place in an atmosphere of collegiality. Nurses were seen to be supporting their colleagues. Some nurses found that the exceptional support they received from their colleagues during work hours was enough and therefore they did not need to do anything additional outside of work hours to cope.

"I think if anything the staff that were in it together, like if we were on a shift together we'd debrief more so at lunch and things like that, so it was more a work change but we do debrief anyway. But I think if someone had had a particularly rough time with a family member, I think other nurses can also recognize that and will check on them and I think we're already quite a tight knit team, so I think that was just kind of just amplified if anything" (Nurse 13)

Participants also highlighted that they had informal debriefs with friends and family as a way of coping.

"Debriefed with family and friends and colleagues and yeah just sort of a good old whinge." (Nurse 12)

It is important to acknowledge that there were a variety of responses with a small number of participants reporting that visitor restrictions did not have a significant impact and therefore did not feel they needed to employ any specific strategies to cope.

"It didn't impact me in the respect that I felt that I had to cope in any way." (Nurse 7)

Organizational Response

The third theme examines organizational approaches and responses to visitor restrictions and the flow on affect this had on clinical cancer nurse.

Organizational support

Participants expressed a continuum of opinions regarding the level of support they felt they received from the organization in response to the visitor restrictions and the subsequent impact on nurses. The continuum included some nurses being unaware of support services, others feeling that no support was offered while a further group felt well supported.

"No it wasn't something that I investigated, it wasn't advertised that there was support services available." (Nurse 7)

"I found myself really feeling really frustrated and really angry at the hospital as a whole for not supporting us during this time." (Nurse 1)

"I spoke to my CNC about it who was incredibly supportive, and she put me through to the EAP" (Nurse 8)

However, regardless of the support or lack thereof participants experienced, when asked if visitor restrictions impacted their overall intention to stay, participants consistently indicated that their intention was not affected.

"No not at all, no, because this is what I set out to do and this is what I'll keep doing regardless of what's going on." (Nurse 14)

Organizational communication and consistency

Clarity and consistency of communication in addition to the rapidity of change were identified by participants as being uniquely challenging in their practice environment. It is noted that these organizational communications affected staff, patients, and visitors.

"It was the frequency of . . . changing. Changing day by day means that nobody really knows what the policy is. The rules were always changing and it just and it made the staff confused, and if the staff were confused how are we meant to explain it to the patients?" (Nurse 11)

There was inconsistency in participant responses regarding the source of information through which nurses were informed about the visitor restrictions. Nurses highlighted receiving the information via email, through management, social media, news, staff meetings, daily briefings, signage while entering the hospital, hospital intranet and the radio.

Over time, the participants noted the decreasing effectiveness of the communication as they 'tuned out' due to the overwhelming rate of change of information.

"But I think the updates were just happening too fast, too frequent and eventually you just, tuned out of it." (Nurse 4)

Issues with communication consistency were climaxed within the cancer care environment due to its classification as a high-risk area.

"This was when, because we are a vulnerable ward, our visitor policies have always been a bit stricter than the rest of the hospital. So like on the radio and everything, it was saying, at all health services now they are allowed visitors. But we weren't." (Nurse 1)

The unclear messages the community was receiving about the visitor restrictions led to many visitors turning up at the cancer care environments and having to be turned away by nursing staff.

"When the hospital was saying that visitors can come back then no one mentioned to them [visitors] that they couldn't come into our department. So that started a lot of friction almost immediately." (Nurse 8)

DISCUSSION

The COVID-19 pandemic saw numerous, rapidly initiated changes that led to significant impact on the health workforce and cancer care provision globally. One change that was implemented was the introduction of visitor restrictions. This study sought to evaluate the specific impact of visitor restrictions in the specialized area of cancer care. This study highlighted three key themes of: 1) impact on clinical cancer nurses, 2) individual responses and 3) organizational response. Embedded throughout all of these themes was a common underlying thread of undeniable emotion; nurses were emotionally affected by the visitor restrictions. The emotional impact felt by the nurses was influenced by role conflict associated with implementing a policy they did not create, workload, and repetitive change.

Nurses were required to implement policies that sought the protection of their patients and the healthcare system as a whole from the spread of COVID-19 while also understanding the potential negative impact that isolation and separation could have on a patients' holistic well-being. Nurses at times felt sad, guilty, like they were the "bad guy," like "the worst person in the world," angry, frustrated, helpless, powerless, and confused, although they did not describe doing harm as has been noted in other studies.[19] The emotions expressed in the present study highlight a role conflict where there was an internal tension between their required role and their desired nursing role, moral beliefs or expectations. Nurses experiencing this tension are at risk of moral injury, which is caused by "failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations."[7,20p697] Other research has recognized that the COVID-19 pandemic has led to healthcare providers experiencing moral injury[7,21] and has highlighted that visitor restrictions can be a factor that may not only be a cause but subsequently amplify moral injury.[7] A study that evaluated dilemmas with visitor restrictions from the perspective of elderly care physicians (ECPs) in nursing homes, similarly, found that ECPs felt responsible for implementing a policy that was not their decision, and this led to a profound emotional impact on the ECPs, which illustrated moral distress.[22] This is also consistent with Marmo et al's[19] study of critical care nurses and with our findings that visitor restrictions has led to a risk for moral injury for clinical cancer nurses. Moral injury can have a devastating impact on healthcare providers' mental health[21] and therefore organizations need to be aware of the lasting impact that visitor restrictions can have on nurses' well-being. In particular, the potential

impact on nursing staff of implementing such a policy in the future must be carefully considered.

The effects of implementing the visitor policy on clinical cancer nurses extended to an experience of workplace violence. Workplace violence is an ongoing issue for nurses, with healthcare being considered one of the most violent workplaces, and nurses at the highest risk.[23] Participants in this study expressed that while some patients and families were understanding, verbal violence was a frequent response to visitor restrictions. Some research has not linked workplace violence to visitor restrictions,[19] but a study of registered nurses from the United States during the COVID-19 pandemic highlighted that around 20% of nurses experienced an increase in workplace violence and attributed this to a number of factors, one of which was restriction of visitors.[24] The impact on nursing staff safety and well-being must be considered when assigning nurses to the role of implementing policies around visitor restrictions.

To maintain nurses' overall health during stressful occupational times such as a pandemic, a layered approach to support is considered optimal.[25] The level of support nurses felt they received throughout the changes to visitor policy varied depending on the participant and whether they were speaking of supportive relationships or organizational support systems. Nurses had a strong sense of collegiality and benefited from informal debriefing with their colleagues, family, and friends. The importance of collegiality is noted by Utriainen et al,[26] who highlighted that collegial support was a critical element for the well-being of nurses in the hospital context. Indeed, in other specialty settings (mental health) the lack of collegial support has been identified as a major workplace stressor.[27] The majority of participants answered in the negative about the role of formal debriefing but did recall being told they could contact the Employee Assistance Program if required. To best support well-being, nurses may benefit from more structured support across all levels; from individual/peer support, to team support, and then support from management.[25] Quality clinical supervision programs have been studied in many clinical settings including acute medical and surgical services, and shown to be associated with improved nurse outcomes including improved well-being and lower rates of burnout.[28] Although research focused on the cancer care setting was not located, there is potential for clinical supervision to be used in this context as a strategy to enhance nurses' well-being in the postpandemic era.[29]

Participants discussed varying perspectives on the impact changes to visitor policy had on their overall workload. One participant found their workload was easier due to not having visitors physically present, while others found their absence increased workload as nurses had to undertake additional personal care. The perceived decrease in workload is similar to the findings of a New Zealand study[30] that linked reduced visitation in ICUs to decreased workload, and open visitation to increased workload. The increase in personal care requirements noted in the present study may be a consequence of differences between the ICU and cancer care settings, suggesting the need for additional research in different clinical settings.

In this study, an increased workload was also linked to nurses' responsibilities in implementing policy, in particular organizing and processing visitor exemptions. It is known from literature that the experience of a high administrative and documentation burden for nurses is ongoing issue.[31,32] Administrative tasks are often considered by clinicians as less meaningful and therefore the addition of administration tasks has been linked with an increased risk of burnout.[33] The administrative burden discussed in this study while not stated by nurses to be less meaningful, was linked with a heightened emotional impact on staff. Nurses spent significant time processing, making decisions about, and allaying the outcomes of visitor exemption applications to patients and their families. The increased workload related to the distressing nature of this role and the witnessed impact on patients and families was linked with nurses being the "bad guy" and related negative emotional impacts.

This study highlighted the negative impact that rapid changes to policy had on participants personally and their ability to both understand and effectively implement visitor policy changes. This is consistent with other work that noted challenges regarding the communication of policy changes made externally.[19] There is the potential that rapid change can be associated with uncertainty, which is known to be closely linked with stress.[34] Current literature reports that stress can have negative outcomes for nurses including burnout, psychological distress, depression, and anxiety. The effect of rapid change in policy on nurses is not currently explored among published COVID-19 literature and therefore provides a key area for future research.[35]

While nurses recognized the significant impact that the visitor restrictions had on them, participants consistently stated that this did not affect their intention to stay within their current role. This may highlight the strong sense of duty nurses feel to their patients and work even in the face of adversity. A systematic review exploring nurses' perceptions of working during a pandemic highlighted that nurses felt both duty to work and commitment to quality patient care during the pandemic.[36]

Limitations

The study provided in-depth analysis of the experiences of clinical cancer nurses at one study site. The design and size of the study preclude generalizability, and further research would be required to explore this area in other clinical or geographical settings. The research team recognizes that while the focus of this study was on the impact of visitor restrictions, the COVID-19 pandemic in general had a significant impact on clinical cancer nurses. While the interview guide was comprised of questions specifically focused on changes in visitor policy, general COVID-19 impact may have influenced participant responses. Additionally, although visitor restrictions were still ongoing, the study was not conducted during the height of the pandemic so the authors recognize that recall bias around the impact of earlier visitor restrictions may impact participant responses. Finally, this study focuses solely on the impact of visitor policy changes from the perspective of clinical cancer nurses. It is recognized that experiences from other healthcare workers, patients and families would add value and key insights into the overall impact that visitor restrictions had on the healthcare system. Further research into this area is needed.

CONCLUSION

Visitor restrictions implemented due to COVID-19 had a significant impact on clinical cancer nurses. The study found evidence of moral injury and of confliction—within the role of the nurse, the implementation of organizational policies and their professional identity, values, attitudes, and personal beliefs. Despite this adversity, nurses remained committed to their clinical practice. The impact that changes make to nurses' role and work environment must be appreciated to enable nurses to be supported, ensure their well-being is cared for, and that they are able to remain in practice.

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Credit Author Statement

Amy O'Dea is responsible for conceptualization, methodology, formal analysis, investigation, writing – original draft, writing –reviewing and editing, visualization, and project administration. Michael Roche is responsible for conceptualization, methodology, formal analysis, interpretation, writing – reviewing and editing, and supervision. Rebecca Caulfield is responsible for conceptualization, methodology, formal analysis, writing – reviewing and editing, and supervision.

Declaration of Competing Interest

The authors have no conflicts of interest to disclose.

Supplementary materials

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.soncn.2023.151530.

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