Patients experiences of their relationships with relatives and their collaboration with nurses during contact in non-COVID-19 hospital wards – A qualitative study

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Abstract
COVID-19 restrictions prevented relatives from visiting and accompanying patients to hospital and required that nurses wore personal protective equipment. These changes affected patients’ relationships with relatives and challenged their ability to connect with nurses. Individual, semi-structured interviews with 15 patients were carried out to explore patients’ experiences of their relationships with relatives and their collaboration with nurses during in- and outpatient contacts in non-COVID-19 hospital wards. The analysis of data was guided by phenomenological hermeneutic frame of reference and the study was reported according to the COREQ checklist. The findings illustrated that patients felt lonely and insecure when separated from relatives, caught between relatives and professionals during information exchange, and experienced the absence of relatives as both beneficial and burdening. Visitor restrictions provided patients with time to heal but prevented provision of informal care. Patients had to take responsibility for maintaining contact with relatives independent of their health condition. COVID-19 restrictions created distance with nurses, which potentially led to insufficient physical and psychosocial care.

Keywords
Collaboration, COVID-19, hermeneutic, nurse–patient relationship, patient perspective, phenomenology, relatives

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Introduction
With coronavirus disease (COVID-19), the context for, and the provision of, nursing care changed in the pandemic wards established to assess and treat patients with COVID-19. Likewise, the context changed for the remaining hospital wards that continued to provide care and treatment for other patients. In this paper, we refer to these wards as non-COVID-19 wards.

The COVID-19 pandemic restricted relatives from visiting patients in and accompanying them to hospital unless they were relatives of critically ill patients. This affected the possibility and benefit of involving the relatives in the patients’ pathway for both patients and nurses.7 Research shows that collaboration with relatives during in- or outpatient hospital contact is essential for the patients5 as the relatives provide emotional support6,7 and advocate for the patient through supportive mediation.6,8 In addition, they help patients to understand information and make decisions9 as well as sometimes serve as an extended arm of the healthcare professionals (HCPs).2,5,7
Internationally, family is perceived as a unit of care that plays an important role in nursing and much suggests that this role becomes even more important during pandemics such as COVID-19. According to Griffin, the family-centered approach is understood as a way of planning, delivering, and evaluating healthcare based on a collaboration between HCPs and families of patients. Even though Griffin focuses on family in neonatal settings, the family-centered approach is highly relevant for adults as well as it involves the core concepts of dignity and reciprocal respect, information sharing, and family participation and collaboration. Additionally, involving patients and relatives in care is expected to improve patient safety, quality of care, coherence, and geographical equality in healthcare. Thus, high-quality nursing care relies on a triad consisting of patients, relatives, and HCPs, and involves a collaborative dialogue between these parties.

The Fundamentals of Care (FoC) framework emphasizes how the delivery of high-quality nursing care rests on a nurse–patient relationship built upon mutual commitment. Furthermore, the FoC addresses how contextual factors within the healthcare system, as well as the skills, commitments, and abilities of the individual nurse, affect the ability to establish and maintain a relationship. To minimize transmission of the virus during the COVID-19 pandemic, wearing personal protective equipment (PPE) such as masks and shields and enforcing physical distancing were required. This physical barrier in the patient–nurse relationship may influence the patients’ and nurses’ ability to connect with one another, thus potentially affecting the quality of the nursing care provided. In addition, the relocation of experienced nurses to the pandemic wards may put an additional strain on the patients’ experience of receiving a timely, adequate, and high-quality standard of nursing care.

Consequently, the opportunities for providing and receiving individual and family-centered nursing care may be limited. However, how patients’ have experienced their collaboration with nurses and what it means to be without physical interaction with their relatives while they are in contact with hospitals and in vulnerable situations is unknown.

The aim of the present study was to explore patients’ experiences of relationships with relatives and collaboration with nurses during in- and outpatient contacts to non-COVID-19 hospital wards in a university hospital.

**Method**

The study was designed as a qualitative explorative study and guided by a phenomenological hermeneutic frame of reference, which is a mode of understanding in qualitative interviewing that aims to reveal patients’ perspective. The consolidated criteria for reporting qualitative research checklist were used as a guideline for facilitating and securing a complete reporting of the study.

**Setting**

Data were collected among patients in contact with non-COVID-19 in- and outpatient wards at a university hospital in Denmark during the first wave of the COVID-19 pandemic. During spring 2020, visitation opportunities were excessively restricted as no relatives were allowed to accompany patients unless they suffered from critical illness.

**Recruitment**

In total, 15 individuals were purposively recruited to participate in the study. The participants contacted the principal investigator by email after information about the study was displayed on the hospital’s Facebook page.

All participants had been in contact with the hospital due to acute or sub-acute health conditions (Table 1). Five of the participants were diagnosed with co-morbid physical illnesses. Four had more than one contact (admissions, examinations) with the hospital during the time of the pandemic-related restrictions.

| Patient | Age (years) | Sex | Contact reason | Type of contact | Relatives* |
|---------|-------------|-----|----------------|----------------|------------|
| 1       | 74          | Female | Respiratory distress | Acute | Spouse |
| 2       | 65          | Male   | Hyperglycemia, fever, pneumonia | Acute | Spouse |
| 3       | 28          | Male   | Diagnostic examinations | Sub-acute | Parents, spouse |
| 4       | 50          | Female | Specific illness, low hemoglobin count, renal stress | Acute | Spouse, two children |
| 5       | 28          | Male   | Accident | Acute | Spouse, two children |
| 6       | 30          | Female | Complication during pregnancy | Acute | Parents |
| 7       | 36          | Female | Toxic shock syndrome, sepsis, erysipelas, pneumonia, influenza | Acute | Spouse |
| 8       | 38          | Female | Diagnostic examination | Sub-acute | Mother |
| 9       | 29          | Female | Complication during pregnancy | Acute | Spouse |
| 10      | 38          | Female | Hypertension and tachycardia | Acute | Spouse |
| 11      | 46          | Female | Surgery | Sub-acute | Spouse |
| 12      | 42          | Female | Surgery | Sub-acute | No one specific Spouse |
| 13      | 27          | Female | Observation after trauma – late pregnancy | Acute | Spouse |
| 14      | 28          | Female | Complications during early pregnancy | Acute | Spouse |
| 15      | 30          | Female | Complications during late pregnancy | Acute | Spouse |

*Relative mentioned by the participant as relevant in the situation.
**Data collection**

A semi-structured interview guide was used to explore the patients’ individual experiences providing detailed information based on the respondents’ own words. The interview guide contained a starting question and additional exploratory questions that facilitated the participants’ perspectives on their experiences of relationships with relatives and collaboration with nurses during in- and outpatient contacts in non-COVID-19 hospital wards.

The 15 interviews were conducted by six researchers. The interviewers were five researchers with a PhD and one PhD student, who all had experience of interviewing. The duration of the interviews was 18–90 minutes (mean 35.41 minutes). Based on the patients’ preferences, two interviews were conducted on the telephone and 13 were conducted face-to-face. The latter took place in the patients’ homes or in a convenient office at the hospital. All the interviews were conducted during June and July 2020. All interviews were digitally recorded and transcribed verbatim. The patients are identified by numbers (patients 1–15) and in the citation’s blocks, capitals are added to denote emphasis or intense distress.

**Data analysis**

According to Brinkman and Kvale, using a phenomenological hermeneutic approach aims to describe the manifest meaning of the transcribed text. Subsequently, through interpretation the latent meaning is extracted, which goes beyond what is said and thus reflects a deeper understanding. After an initial reading and re-reading of the interviews to get a sense of the whole, the analysis proceeded by means of content analytical steps where essential meaning units were identified, and then coded. In this process, the analysis moved from the manifest to the latent content. After coding, three of the interviewers combined and arranged data in themes and sub-themes (Table 2). To take the researchers' preunderstanding into consideration, the interviewers questioned each other’s interpretations until consensus was reached. All researchers discussed and approved the final analysis.

**Ethical considerations**

The Regional Danish Data Protection Agency (ID 2020-072) was notified of the study and the regulations regarding research.

| Table 2. Extract of the analysis. |
|-----------------------------------|
| **Quotes from the text**          |
| **Condensed meaning units: manifest content** | **Condensed meaning units: latent content** | **Codes** | **Themes** |
| It was LONELY [trembling in her voice] a loneliness I have never felt before, feeling UNSAFE, AFRAID. My husband could have held my hand and given me a feeling of physical safety (patient 4) | The patient felt lonely and insecure and missed the support of her husband who helped her to feel safe | When patients enter the hospital without their relatives it left them with feelings of being unwillingly separated from their relatives | Loneliness and broken bonds | Feeling lonely and insecure |
| I got the answers and results and then I phoned my husband. Then, he asked me questions I was unable to answer ... When the professionals came back, I asked them and subsequently I phoned my husband again to inform him. I felt I was in-between, which I didn’t need in my condition (patient 14) | Being without physical contact with the relatives meant that the patient had to ask and needed to be informed more than once and that she became caught between her husband and the HCPs | The patients were expected to take responsibility for being a conduit of information and were caught between their relatives and the HCPs | The role as mediator | Remembering and comprehending information – caught between relatives and professionals |
| I was simply feeling so sick, so it was actually a bit of a relief that no one came. And I had no surplus at all for anything else than myself (patient 13) (...) | Lacking surplus energy, the patients expressed feeling relieved that the restrictions set the framework for visits. Furthermore, at the same time, they stated that they were aware of their need for a close relative to be present | The restrictions proved to have both advantages and disadvantages. The patients often lacked surplus energy to interact with relatives but at the same time found them indispensable for their informal care | Benefits of restrictions | Absence of relatives – benefit or burden? |

HCP, healthcare professional.
ethics and data management were followed. According to Danish legislation, no further ethical approval was needed. The participants received information about the study in written and oral form and provided informed, written consent when agreeing to participate.

Findings

The analysis resulted in three themes covering the patients’ experience of relationships and collaboration with relatives and nurses. The first theme described how loneliness and insecurity emerged when patients were separated from the relatives. The second theme revealed how patients felt caught between relatives and nurses when they were required to remember and comprehend information. The third theme showed how the absence of relatives during the patients’ hospital contact was experienced as both a benefit and a burden.

Feeling lonely and insecure

Irrespective of whether the patients attended the hospital for an acute illness, to give birth, or to undergo an examination, the relatives were asked not to come to the hospital to control the spread of the virus. The separation from one’s relatives started as soon as the patients entered hospital grounds when relatives had to say their goodbyes outside, as if there was an invisible gate that signaled “No relatives are allowed in.” This restriction was enforced despite patients reporting extreme tiredness, pain, or being in labor.

We drove to the hospital, and I was dropped off. My husband was not allowed to support me although I was barely able to crawl through the door (patient 13).

Although the relatives could attend during active labor, they were excluded in the process up to the birth regardless of whether it lasted a few or many hours. This exclusion prevented a husband from supporting his wife during their child’s birth and kept the couple from sharing the full experience of becoming parents.

Suddenly it became MY project, but it is not only MY child. It is OUR child. Although it is me who bears the child, he is as much a part of it as I am. He was excluded unwillingly because he wanted to take part in it all (patient 9).

The requirement of entering the hospital without a relative left the patients seeking alternative solutions. They described how relatives stayed in their cars outside the hospital or drove around in the neighborhood waiting to be allowed to enter the hospital in case of an imminent birth or other critical conditions. In this way, the patients managed to keep their relatives nearby—though at a distance.

Being separated from one’s relative in a vulnerable situation caused feelings of loneliness, anxiety, and insecurity. This was expressed by a patient in his late 20s who was controlled for relapse of his cancer: “My dad has ALWAYS been involved in ALL scans since I was 15 years old. It is a ritual that provides safety” (patient 3). Another patient was on the verge of crying when she recalled her feelings at admission:

It was LONELY [trembling in her voice], a loneliness I have never felt before, feeling UNSAFE, AFRAID. My husband could have held my hand and given me a feeling of physical safety (patient 4).

Thus, the presence of relatives seemed crucial for safeguarding the patients because they knew them mentally, physically, and offered care and attention. The relatives also provided data of the patient’s normal condition and habitual appearance. A woman suffering from severe high blood pressure after giving birth (undiagnosed pre-eclampsia) was nearly discharged. However, when her mother came to bring her home, she noticed that something was very wrong:

My mom knows me in and out … she noticed that my body looked wrong, and she said it several times. She couldn’t explain what it was, but she noticed I wasn’t as I was supposed to be (patient 6).

The mother’s observation and persistence served as indispensable contributions to keeping the patient safe as she was subsequently transferred to the intensive care unit for treatment.

In addition, the relatives could help patients with fundamental care needs. After having a surgery, the patient was informed of the importance of eating and drinking. However, she was only offered food and beverages at the three main meals.

We can benefit from relatives because often you would like them to help, and they want to help. They notice it is a while since you had something to eat and drink (patient 15).

Thus, the absence of the relatives potentially influenced the patients’ ability to be sufficiently nourished and hydrated during the day. Besides being unwillingly separated from one’s relatives and the risk of feeling lonely and exposed to insufficient nursing care, the COVID-19 restrictions put an additional burden on the patients to understand and remember information.

Remembering and comprehending information: Caught between relatives and nurses

Patients were aware that vulnerable situations affected them mentally and emotionally. The absence of their relatives required them on their own to remember and comprehend information, ask the right questions, and keep an overview of the situation. This was difficult due to emotional constraints, and due to medication-induced sedation.

I was very dazed because I got morphine and I was totally unable to remember anything. In this situation, it would have been great if my relatives were there when the professionals gave information (patient 5).
This quote shows how an extra pair of ears could have helped patients remember and process information. In addition, the presence of relatives could lessen anxiety and worries as they possessed knowledge and understood the patients’ symptoms, sometimes better than the patients themselves. A patient diagnosed with lung and kidney cancer was treated for his lung cancer. He worried about his rapidly deteriorating condition.

It would have meant a lot to me if I could have brought my wife and shared my worries with her because she knows more about my illness and the situation. I was afraid that my cancer exploded. I could have asked questions myself and angled for more information, but I belong to the generation who will not strain the nurses when they are busy (patient 2).

The situation was overwhelming, and the patient was unable to comprehend all that happened. His wife, who worked in the healthcare sector, could have provided an indispensable support in this situation. Her absence contributed to an increased anxiety because the patient was unable to understand that his symptoms were side-effects from the treatment and not generated by his cancer. For this patient, it seemed essential that the nurses were able to read his needs and offered him help to evaluate and adapt the information that he did not demand for himself. However, irrespective of their condition, the patients were expected to take on the role as information mediators between relatives and nurses: “I was asked ‘have you brought your telephone to call your relative?’” (patient 15).

Although the patients felt exhausted and had a delimited ability to remember and process information, they displayed concerns about how to share the information properly. Consequently, some called their relatives repeatedly because they did not ask the questions the relatives needed answering.

I got the answers and results and then I phoned my husband. Then, he asked me questions I was unable to answer … When the professionals came back, I asked them and subsequently I phoned my husband again to inform him (patient 14).

Given the responsibility of sharing information and securing collaboration with the nurses and relatives, the informants acquired the role of a person that was “in between,” a dyad facing the relatives on one side and the nurses on the other. As one patient noted: “I felt I was in between, which I didn’t need in my condition” (patient 14). The responsibility of being the mediator of information sharing triggered an additional burden on the patients and influenced the relationship with the relatives. Being in a serious condition and lacking surplus energy, a patient said: “I became short-tempered because I was feeling so sick. I just wanted to be on my own” (patient 13). In such situations there was a risk that patients had to cease telephone communication with the relatives to protect themselves. This diminished the relatives’ ability to be involved in the patients’ course of illness as well as the patients access to emotional support from their relatives.

**Absence of relatives: Benefit or burden?**

Although acknowledging the need for a present relative for support, it appeared evident that the COVID-19 restrictions also benefitted the patients when they felt seriously ill and without the surplus energy to relate to visitors.

I was so sick and did not have the strength to think about anything else. The HCPs worked like horses, and they did everything for me. So, (no) I did not miss my husband (patient 1).

When the patients were most affected by their disease, their need for professional assistance was at the forefront and their need for a close relative being present became secondary. In such acute situations, the patients’ focus was on getting cured or simply staying alive, and for this the support from the professionals was indispensable.

In addition, the visitation restrictions on the hospital resulted in a calm environment, where the patients found time and space to recover without being disturbed.

I really think it depends on what you are there for. I was simply feeling so sick, so it was actually a bit of a relief that no one came. And I had no surplus at all for anything else than myself (patient 13).

Another said, “It was a benefit because I didn’t have to decide myself whether I wanted visitors or not” (patient 11). Thus, on the one hand, the patients had a lack of surplus energy and felt relieved that the restrictions set the framework for visits. On the other hand, the patients were aware of their need for a close relative to be present, as illustrated in the following quote: “It would have been nice to have had my husband present, but I did not need him to be (at that point of time)” (patient 9). Accordingly, it appeared to be the patients’ condition that was the main determinant of their need to have a relative present. However, the absence of relatives appeared to emphasize the patients’ need of person-centered care provided by the nurses and revealed a need that the nurses acted as a substitute for their missing relatives.

I respect the nurses very much, but in the case where the relatives were excluded, I needed the nurses to understand my situation in another way. Sometimes they did, and sometimes they did not, and this was tough (patient 4).

According to this quote, the patient experienced a lack of emotional support. This was underlined by another patient who sought a relationship with the nurses where personal issues could be discussed:

I think the nurses had the best intentions. However, it seemed they lacked resources. They were running around like [they were] in a chicken yard trying to put out a fire … Anyway, I got my three meals, my medicine, I got my surgery, and I am alive, but no one was sitting at my bedside acknowledging my sorrow at losing an embryo and having been afraid of dying (patient 15).
Busyness and lack of resources seemed to inhibit “good nursing care” when the nurses had to prioritize tasks. This involved the provision of a minimum of care that meant to keep the patients safe physically. In this respect, the patients’ emotional contact with the nurses was not maintained adequately. The perception of missing emotional support was further increased as the patients perceived a fundamental change in the nurses’ behavior regarding proximity. Physical distance was exercised in the encounters unless nurses were measuring blood pressure, giving medicine, helping with personal hygiene, breastfeeding, and so on, as this patient described: “They were not shaking hands or giving hugs although I could see they wanted to do so because I cried and was unhappy” (patient 6). Another said:

I think the nurses kept a distance more than normally. They did not put a hand on a shoulder or contribute to close and warm contact … I felt they were restricting themselves (patient 10).

Hence, the patients noticed how the nurses restricted themselves and limited physical contact in their endeavor to conform to the requirements of using PPE and distance. Although the patients acknowledged the nurses “were constrained due to the coronavirus” (patient 2), the patients clearly requested recognition of how the restricted physical contact affected their experience of comfort and care.

Discussion
The aim of the study was to explore patients’ experiences of their relationships with relatives and collaboration with nurses during in- and outpatient contact in non-COVID-19 hospital wards.

Our study demonstrated that the COVID-19 restrictions induced separation from relatives made the patients feel lonely. Furthermore, it increased their vulnerability and anxiety, which ultimately left patients with feelings of being unsafe. This is in line with the study by Meide et al., where busyness of HCPs and their focus on technical aspects of care negatively impacted on older patients’ participation and left them feeling lonely during hospitalization. However, our findings underlined that loneliness was not reserved for older patients, as younger patients equally experienced distress from being separated from their family. Comparable findings are revealed by Gonzales et al., as visitors to patients in intensive care offered the patients moderate levels of reassurance, comfort, and calming. In our study, the patients experienced separation from their relatives as an unwilling exclusion. As dignity and respect are central concepts in family-centered care and core values in nursing ethics, this could be interpreted as they were deprived of their right to self-determination and the exercise of their personal values on how to involve their relatives.

Our patients expected becoming parents to be a shared experience. However, the restrictions resulted in separation of the couple, which clearly affected the women giving birth as their partners were deprived of getting “the full experience.” This indicated an underlying distressing feeling of being forced to take responsibility for healthcare decisions for themselves and their unborn child. Corbet et al. showed health anxiety among pregnant women during the COVID-19 pandemic; they worried about their unborn child and themselves, which is congruent with our findings. In our study, health anxiety was seen in women in labor but also in patients experiencing acute illness. As described by Jarvis et al., COVID-19 is a family-unfriendly virus. A family structure, such as the father being the only constant for his son during his cancer trajectory, was required to be put on hold. Our study pointed out that patients often became solely responsible for their own health and for finding ways to involve the relatives. In this case, the patient was denied the opportunity to involve the family as a resource, which is claimed to be important for family and person-centered care. Thus, the impact of COVID-19 on usual family structure and collaboration is considered extensive as the emotional ties, sense of belonging, and passion for being involved in one another’s lives was severely affected.

The exclusion of relatives required the patients to be information mediators between relatives and HCPs, which put an additional burden on them. An example was the mother in our study who persistently communicated her observation to the nurses, which subsequently influenced her daughter’s safety and recovery. This is in line with Zani et al. and Conn et al., where the representation of relatives at the hospital supported the patients’ safety and recovery as relatives contributed with observations and could warn HCPs of changes in the patients’ habitual condition. However, being left alone and positioned between relatives and HCPs caused a breakdown in the collaborative triad between the parties, which is essential for family-centered care. The ultimate consequence could be a fragmented nursing care, which compromises feelings of safety and prolongs recovery for the patients.

Our study evidently displayed how patients, young or old, and regardless of their condition, became responsible for information sharing as they were asked to phone and update their relatives. This finding was also displayed in the study by Krewulak et al., which underlined the difficulties patients experience when being expected to take responsibility for information sharing. Our study revealed the importance of finding alternative ways to bridge the distance between HCPs and the relatives to free the patients from an unnecessary burden. According to the FoC framework, the responsibility for establishing and maintaining a relationship relies on the nurses. Goldfarb et al. and Hart et al. suggested different ways of structuring and scheduling communication between the family and HCPs as well as facilitating phone or videoconferencing between patients and their families. This was shown to relieve patients of being solely responsible for the exchange of information.

The patients’ experienced their most vital care needs being met, but to a lesser degree their psychosocial needs; for example, the patient who was encouraged to eat frequently, yet was only offered three meals a day. Consequently, having to ask for extra food, drinks, or help was perceived as uncaring and transgressive for the patient. The absence of relatives who could help with fundamental care needs such as nutrition, induced the patient’s responsibility for self-care. However, our findings revealed conflicting feelings regarding excluding relatives since the patients openly stated how they...
Conclusion

This study revealed how patients’ collaboration with the nurses and their ability to maintain a relation with relatives became extensively affected during the COVID-19 pandemic. The restrictions imposed an additional distancing from the nurses unless they were performing instrumental tasks, which resulted in an insufficient physical and psychosocial care. This clearly burdened the patients as it required them to be responsible for self-care in a situation characterized by acute illness, vulnerability, and insecurity. In addition, the unwilling exclusion of relatives could compromise the patients right to self-determination and affect their dignity.

Visitor restrictions were experienced to be both positive and negative. They provided patients with time to heal but prevented them from receiving informal care that appeared essential because of the COVID-19 induced restrictions with distancing and an increased business of the nurses.

Furthermore, the COVID-19 restrictions resulted in an increased demand for patients to mediate between relatives and HCPs and take responsibility for maintaining contact with relatives irrespective of their health condition. These demands further overloaded the patients in their situation of acute illness, vulnerability, and insecurity.

The implications of this study during future pandemics highlights how a pandemic affects the nursing care of patients on non-pandemic wards. The preventive measures for further transmission of the virus severely challenge the physical and psychosocial wellbeing of the patients. To accommodate this, nurses and other HCPs must be ready to create new ways of ensuring collaboration between themselves and relatives to alleviate the patients’ burden of being responsible for their own care and information mediation. One way of involving all relevant parties could be through scheduled communication sessions (videoconferencing) between the family, nurses, and other HCPs. This has the potential of supporting family-centered care. In addition, the study points to the need to consider a controlled, yet still flexible and individualized, visiting policy to ensure the patients’ time to rest and heal.

Methodological considerations

In this qualitative study, 15 interviewees contributed information power, as suggested by Malterud et al. Volunteering was a strength of this study because the patients’ participation was based on a desire to contribute with their perspective. However, seeking participants on the hospital website and Facebook may have appealed to a younger population as this group is often more comfortable using these technologies. This is reflected in our sample, with three participants aged over 50 years and with a mean age of 37.4 years (range, 27–74 years). Trustworthiness of this study was secured through a transparent and systematic data collection and analysis including the patients’ quotations to verify the findings. The researchers continuously discussed data until consensus was reached, which supported consistency and trustworthiness. All interviewers were experienced in interviewing which may counterbalance the fact that every researcher performed a limited number of interviews.

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Authors contributions

The study was designed and conducted in collaboration with researchers affiliated to the Clinical Nursing Research Unit, Aalborg University Hospital, Denmark. BP, BL, LJ, CBT, HH, and KB conducted the interviews. BP, KB, and BL primarily analyzed the data and drafted the paper. All authors contributed to revising and approving the paper that presents the original results of the research.

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