Exploring the experience of a hospital care strategy during the COVID-19 pandemic: A qualitative study

Entendiendo la experiencia de una estrategia de cuidado hospitalario durante la pandemia COVID-19

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Abstract

Introduction: At the hospital level, the SARS-CoV-2 pandemic required biosafety measures which negatively affected person-centered care. **Objective:** Describe patients, relatives, and healthcare teams' experience with virtual and face-to-face accompaniment strategy in hospital care during the COVID-19 pandemic. **Methods:** A qualitative study with a phenomenological approach was carried out, where 32 semi-structured interviews were conducted (10 patients, 10 relatives and 12 professionals). The information was analyzed following Colaizzi's method, considering three moments: before, during and after the strategy. **Results:** It was found that the experience before the implementation was permeated by negative perceptions regarding the care process; during the implementation, the experience changed mostly as a positive and restorative experience; and after the implementation, the strategy was rated as useful and effective. **Discussion:** The findings obtained in this study are similar to those reported in the literature. The restriction of visits in hospital services produced psychological symptoms, stress and affectation in the family and social area in all people. In health personnel, there was evidence of workload and emotional affectation. Likewise, it confirms that the implementation of accompaniment strategies has a positive effect on the restoration of family-patient-health personnel communication and the care of psychosocial needs. **Conclusion:** In a pandemic situation, it is feasible to maintain the person-centered care in the hospital guaranteeing warmth, well-being, and effective communication between patients, relatives and healthcare teams.

Keywords: Patient-centered care; COVID-19; Pandemics; Hospitalization; Family; Patients; Health personnel; Colombia.

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Resumen

Introducción: a nivel hospitalario, la pandemia por SARS-CoV-2 requirió medidas de bioseguridad que incidieron negativamente en la atención centrada en la persona. **Objetivo:** describir la experiencia de pacientes, familiares y equipos de salud con la estrategia de acompañamiento virtual y presencial en la atención hospitalaria durante la pandemia por COVID-19. **Métodos:** se realizó un estudio cualitativo con enfoque fenomenológico. Se realizaron 32 entrevistas semiestructuradas (10 pacientes, 10 familiares y 12 profesionales). La información fue analizada siguiendo el método de Colaizzi, se consideraron tres momentos, antes, durante y después de la estrategia. **Resultados:** se constató que la experiencia previa a la implementación estuvo permeada por percepciones negativas sobre el proceso de atención; durante la implementación, la experiencia cambió mayormente como una experiencia positiva y reparadora; y luego de la implementación, la estrategia fue calificada como útil y efectiva. **Discusión:** los hallazgos obtenidos en este estudio son similares a los reportados en la literatura. La restricción de visitas en los servicios hospitalarios produjo síntomas psicológicos, estrés y afectación en el ámbito familiar y social en todas las personas. En el personal de salud se evidenció una sobrecarga y afectación emocional. Asimismo, confirma que la implementación de estrategias de acompañamiento tiene un efecto positivo en el restablecimiento de la comunicación familia-paciente-personal de salud y la atención de necesidades psicosociales. **Conclusión:** en situación de pandemia es factible mantener el cuidado centrado en la persona en la atención hospitalaria, garantizando calidez, bienestar y comunicación efectiva entre pacientes, familiares y equipos de salud.

Palabras clave: Atención dirigida al paciente; COVID-19; Pandemias; Hospitalización; Familia; Pacientes; Personal de salud; Colombia.

Introduction

The pandemic caused by the coronavirus 2019 (COVID-19) has affected more than 609,435,192 people and caused more than 6,517,027 deaths worldwide[1]. To control this situation, multiple strategies were introduced at the social level, such as the mandatory use of masks, hand washing, physical distancing, quarantine periods and mobility restrictions, causing changes in the provision of healthcare services[2]. In hospital care, biosafety measures were adopted, such as restriction of the entrance of the family members, isolation of the patients with confirmed or suspected COVID-19, limitation of the entry of electronic devices for personal use and use of elements for personal protection by the healthcare teams and patients. These measures were efficient in guaranteeing biosafety care, but they led to an increase in death in solitude, perception of loneliness and abandonment by the patients, limitation of the physical interaction and length of interaction between the healthcare teams and the patients, perception of exclusion of family members from the care process and breakdown of the information channels[3,4]; and in the healthcare teams, they have been related to increased levels of anxiety, depression, insomnia and stress[5].

The World Health Organization (WHO) has promoted the establishment of integrated people-centred health services through coordinated, safe, timely and efficient processes, with the potential to produce significant health benefits, including improved access to care, good health and clinical outcomes, and greater efficiency, which would reduce overall costs[6]. The person-centered care (PCC) seeks to understand and practice health care adopting the point of view of the patients, caregivers, relatives, and communities, respecting their preferences and promoting clear communication, participation in decision-making and self-management of their health[7]. This approach was affected by biosafe care established during pandemic.

A network of eight clinics in Colombia implemented a strategy to guarantee the accompaniment between patients-relatives and restore communication between teams-relatives-patients using virtual, digital, and face-to-face channels. As a result of this strategy, reports on its benefits were received from the relatives, patients and healthcare teams at the end of the care process, generating the expectation of maintaining it in the medium and long term within healthcare institutions to strengthen the PCC in hospital care. The foregoing motivated the need to explore the impact of this strategy on the experience of the people involved during the hospital care process. Thus, the objective of this study was to describe the experience of relatives, patients, and healthcare teams with the virtual, digital and face-to-face accompaniment strategy implemented in hospital care during the COVID-19 pandemic in eight healthcare institutions.

Methodology

A qualitative study with a phenomenological approach was conducted to describe a phenomenon based on the perception, knowledge or experience lived by the individuals[8]. The participants were selected with a simple random sampling with replacement of the base of hospital care provided in COVID areas (emergencies, hospitalization, and intensive care unit) from a network of eight clinics in Colombia, between August and October 2020. Patients ≥18 years of age hospitalized for a suspected/confirmed diagnosis of COVID-19, who received any of the modalities of the accompaniment strategy, their relatives and members of the healthcare teams who were involved in the strategy were included. Patients or relatives with cognitive limitations that prevented them from answering the interview, hospital readmission or discharged after 60 days were excluded. Health institutions with hospitalization and intensive care services that were part of the network were included.

To reduce the impact of isolation measures on patients, families, and the healthcare team, implemented by the COVID-19 health emergency, and attend the needs for accompaniment and information on the health status of patients with suspected or confirmed COVID-19 diagnosis, seven accompaniment modalities were created using virtual, digital, and face-to-face strategies. In all cases, the strategies were activated after hospital admission according to the preferences and wishes of the patients and family members. For the virtual information modality, three levels of information were established: level 1 was made up of health professionals from different areas, including nurses, bacteriologists, psychologists, and social workers; level 2 included non-treating physicians level 3, treating physicians or intensive care specialists. For the digital strategies, electronic devices were used to facilitate communication between patient-family and health team-family-patient. Face-to-face accompaniment was offered in the cases of patients with a greater probability of death in the short term, significant deterioration in their state of health, functional dependence or those who died alone. For more information on the strategy, it is published in the article by Erazo et al.[4].

The experience was understood as the individual perception of the patient, relatives, or members of the healthcare team in three moments before, during and after the implementation of the strategy to identify its impact during the care process. The exploration *before the implementation* sought to know the impact on the participants and on the PCC during hospital care with the restrictive biosafety measures; *during the implementation* sought to know the experience of the participants in the hospital care from the components defined by the policy of person-centered care of the participating healthcare institutions; and *after the implementation* sought to identify the impact and usefulness of the strategy identified by the participants.

Semi-structured interviews were conducted using a standardized question guide for each type of participants. The interviews were conducted by video call and recorded in audio for later transcription and analysis. The interviewer was a psychologist external to the researchers, who had prior training in the question guides through role play and was contextualized about the implemented accompaniment strategy and the objective of the research.

The interviews were transcribed into Microsoft Word® the day after they were conducted, by an external psychologist not associated with the study researchers and different from the person who conducted the interviews. The two people involved in this phase had close contact to resolve doubts or clarify situations that were not understandable in the recording of the interviews. Subsequently, they were analyzed in Microsoft Excel ®, using Colaizzi's phenomenological analysis of seven steps (1978): 1) Reading and rereading of the transcription; 2) Extraction of significant statements related to the phenomenon; 3) Formulation of meanings and senses based on the statements of the participants; 4) Identification of thematic groups and subthemes; 5) Exhaustively analyzing the structure of the phenomenon; 6) Generation of the description of the structure of the phenomenon; and 7) Validation of the results of the study through the feedback from the participants. For the last step, the validation was performed with the participants during the interview.

For the analysis, five pre-established categories were based on the components of the policy of the PCC of the participating healthcare institutions, and emerging categories were also generated. The definitions of the pre-established categories were: a) Haling environments: experience derived from or related to the physical facilities where care was given or received; b) Nurturing of the being: experience derived from or related to psychoemotional, spiritual aspects, or nutritional feeding; c) Family/friends participation: experience derived from or related to the involvement and active participation of relatives/friends during hospitalization; d) Coordinated care: experience derived from or related to the coordination from the organization to provide the strategy of accompaniment to the patient and family; and e) Education and communication: experience derived from or related to education, training, and communication between the healthcare teams, the family, and the patient. The data analysis was performed in a paired manner between a senior and junior researcher and it was subsequently reviewed by a senior researcher. For *validity* and *reliability*, the triangulation of the researchers and of the perspectives of the participants was performed.

Results

Thirty-two participants (10 patients, 10 relatives and 12 members of the healthcare teams) were interviewed. The median age of the patients, relatives and members of the healthcare teams was 62 years (SD ±15), 47 years (SD ±13) and 42 years (SD ±11), respectively. Table 1 shows demographic characteristics of the participants of the study. The interviews were analyzed from the five pre-established categories, from which 32 sub-themes and 361 textual quotations emerged. Appendix 1 shows the pre-established themes, emerging sub-themes and representative quotes of the participants. Based on the quotations, Figure 1 shows the triangulation of the information was performed to understand the experience of the patients, relatives and health personnel before, during and after the accompaniment strategy.

Experience before the strategy: Hospitalization without the family

It consisted of three themes of the PCC: Nurturing of the being, Healing environments and Participation of the person, family and friends, from which six sub-themes emerged: Suffering in patient-family due to lack of contact; Negative affectation of the healthcare team; Non-empathic hospital spaces; Teams as emotional support for the patient; Unsatisfied expectations and desires in the family; and Need of the teams to integrate the family.

Table 1. Demographic characteristics of the participants in the study.

Variable	Patients (n=10)	Relatives (n=10)	Health personnel (n=12)
Sex (n; %)			
Female	5 (50.0)	7 (70.0)	11 (91.7)
Male	5 (50.0)	3 (30.0)	1 (8.3)
Age, years (mean; SD)	62 ±15	47.3 ±13	42.5 ±11
Educational level (n; %)			
Middle education	1 (10.0)	1 (10.0)	n.a
Technical	3 (30.0)	3 (30.0)	n.a
University	4 (40.0)	4 (40.0)	n.a
Postgraduate	2 (20.0)	2 (20.0)	n.a
Marital status (n; %)			
Single	2 (20.0)	2 (20.0)	3 (25.0)
Married	5 (50.0)	3 (30.0)	6 (50.0)
Widower	3 (30.0)	1 (10.0)	0 (0.0)
Divorced	0 (0.0)	1 (10.0)	2 (16.7)
Cohabitation	0 (0.0)	3 (30.0)	1 (8.3)
Religion (n; %)			
Catholic	8 (80.0)	9 (90.0)	10 (83.3)
Christian	1 (10.0)	1 (10.0)	0 (0.0)
None	1 (10.0)	0 (0.0)	2 (16.7)
Kinship (n; %)			
Children	n.a	7 (70.0)	n.a
Grandchildren	n.a	1 (10.0)	n.a
Spouse	n.a	2 (20.0)	n.a
Profession (n; %)			
Nursing assistant	n.a	n.a	2 (16.7)
Head nurse	n.a	n.a	2 (16.7)
Physician	n.a	n.a	2 (16.7)
Nutritionist	n.a	n.a	1 (8.3)
Social Worker	n.a	n.a	4 (33.3)
Physiotherapist	n.a	n.a	1 (8.3)

Variable	Patients (n=10)	Relatives (n=10)	Health personnel (n=12)
Time of work experience (n; %)			
<10 years	n.a	n.a	5 (41.7%)
11 to 20 years	n.a	n.a	3 (25.0)
More than 20 years	n.a	n.a	4 (33.3)
Time working in the institution, years (median; IQR)			4 (2 – 20.5)

[a] n.a= not applicable
[b]IQR= Interquartile range
[c]SD= Standard deviation.

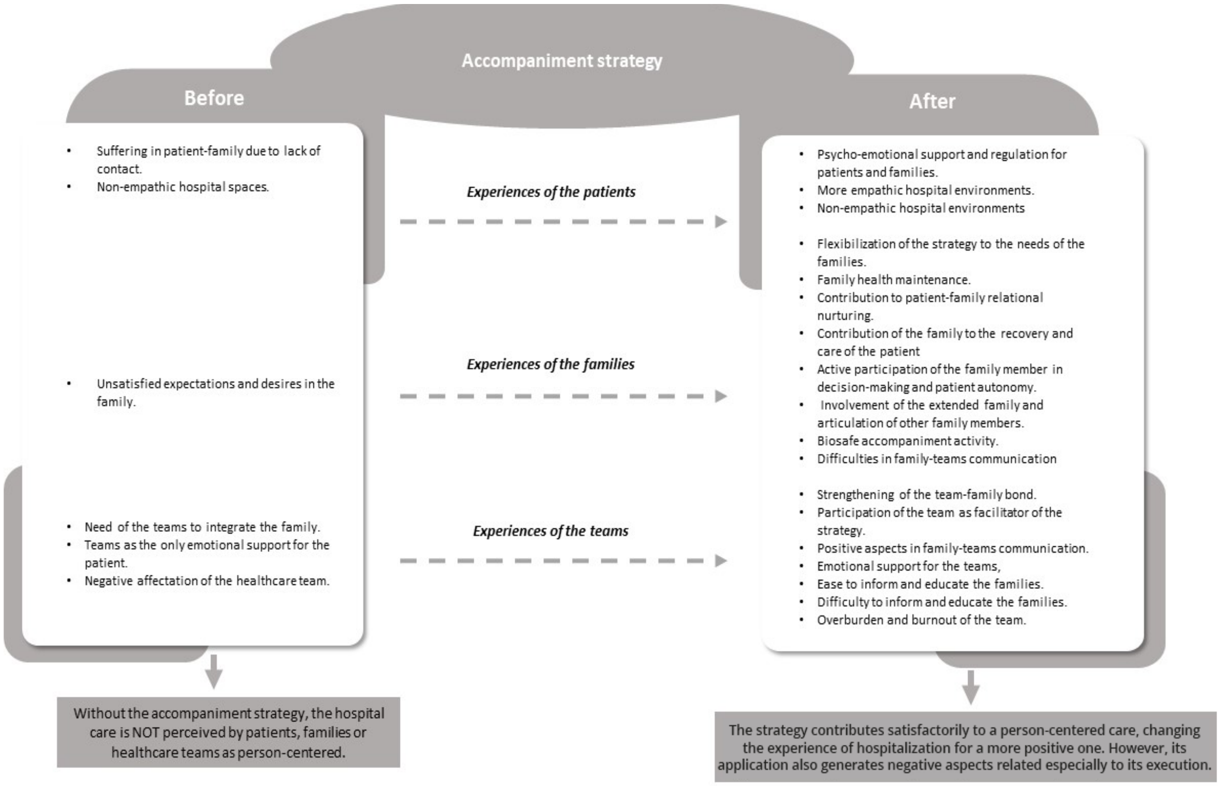


Figure 1. Triangulation of the experience of the patient, families and health personnel with the accompaniment strategy.

In general, hospitalization without the presence of a relative was experienced by patients as a moment of isolation and loneliness, which along with the perception of the hospital environment as not very empathic (because of the lights on, constant noises, sleep interruption) that did not contribute to their emotional balance and comfort. For the relatives, this stage was permeated by impotence, depressed mood, as well as high expectations and desires to participate in the care of the patient. Meanwhile, for the members of the healthcare teams, the negative state of mind of the patients, together with the death in solitude and the rupture of the close doctor-patient relationship due to the biosafety protocols, caused an emotional overflow generating in them a personal challenge and additional demand to assume with each patient the role of accompaniment and support due to the absence of their family, which in turn motivated the development of new forms of coping based on teamwork.

In addition, they perceived that the feeling of abandonment of the patients had a negative impact on the acceptance of their disease, their recovery and the compliance with the clinical recommendations. For this reason, the imminent need to involve the relatives through communication channels that are not traditionally used in hospital care, such as video calls and letters, was recognized.

Experience with the strategy: Person-Centered Hospitalization

It considered five PCC themes: Nurturing the being, Healing environments, Coordinated care, Communication and education, and Participation of the person, family, and friends, from which 18 sub-themes emerged: Contribution to patient-family relational nurturing; Strengthening of the team-family bond; Overburden and burnout of the team; Family health maintenance; Participation of the team as facilitator of the strategy; Psychoemotional support and regulation for patients and families; Positive aspects in family-teams communication; Difficulties in family-teams communication; Ease to inform and educate the families; Difficulty to inform and educate the families; Contribution of the family to the recovery and care of the patient; Active participation of the family member in decision-making and patient autonomy; Involvement of the extended family and articulation of other family members; Flexibilization of the strategy to the needs of the families; Biosafe accompaniment activity; More empathic hospital environments; Less empathic hospital environments; and Psychoemotional support to healthcare teams.

The introduction of the accompaniment strategy during hospitalization had a restorative effect of the nurturing of the being, since the patients and family members reported positive emotions, emotional balance and facilitating the grieving processes. Although it strengthened the bond between the members of the healthcare teams and the relatives, for some members of the healthcare teams it represented a work overload due to the personal commitment to carry out the strategy, which in some cases required additional time or increased work activities, and also emotional burnout due to family dynamics characterized by a lack of communication and exigencies to the members of the healthcare teams.

Regarding to coordinated care, it allowed to provide psychoemotional support to the patients and relatives through interventions directed by specialized professionals (psychologists, psychiatrists and social workers) from the healthcare institution, reducing emotional crises, uncertainty and insecurity. As a strength it was identified that the members of the healthcare teams, participated as facilitators and "bridges" for the successful operation of the accompaniment strategy, which required the development of coping skills based on teamwork. On the other hand, the insufficiency of contact channels to achieve effective communication and care was identified as a barrier, and the limitation of time to devote to their families.

Regarding the communication and education, for some relatives it was positive because the information received from the members of the healthcare teams met their expectations in terms of timeliness of delivery, content, and respectful treatment; while for others the experience was negative because the communication channels were perceived as unpunctual and of very short duration, generating uncertainty and concern. In addition, the information was considered insufficient and difficult to understand due to the use of technical language by some members of the healthcare teams.

For some members of the healthcare teams, the experience had positive impact similar to the relatives, especially the opportunity to educate the family; while the negative experience was related to the transmission of contradictory information to the family, misunderstanding of the instructions given and the commitment of some members of the teams with the pedagogical role. On the other hand, the strategy promoted the participation of the relatives in decision-making as guarantors of respect for the autonomy of the patient. Also, it offered the flexibility of the strategy according to the needs of each family contributing to the emotional support of the members of the healthcare teams for managing stress and job burnout.

Finally, regarding healing environments, some patients-relatives perceived the facilities warmer so that the experience of the hospital stay was less difficult; while for others the spaces were perceived as unfavorable due to the rude treatment of some members of the healthcare teams and the difficulties of elderly patients in the use of technological means, generating unpleasantness and discomfort. In addition, the strategy was experienced as a biosafe intrahospital activity due to the training given to the relative in the use of personal protection elements and seeing its strict compliance by the members of the healthcare teams.

Experience at the end of the strategy: Impact and aspects to be strengthened

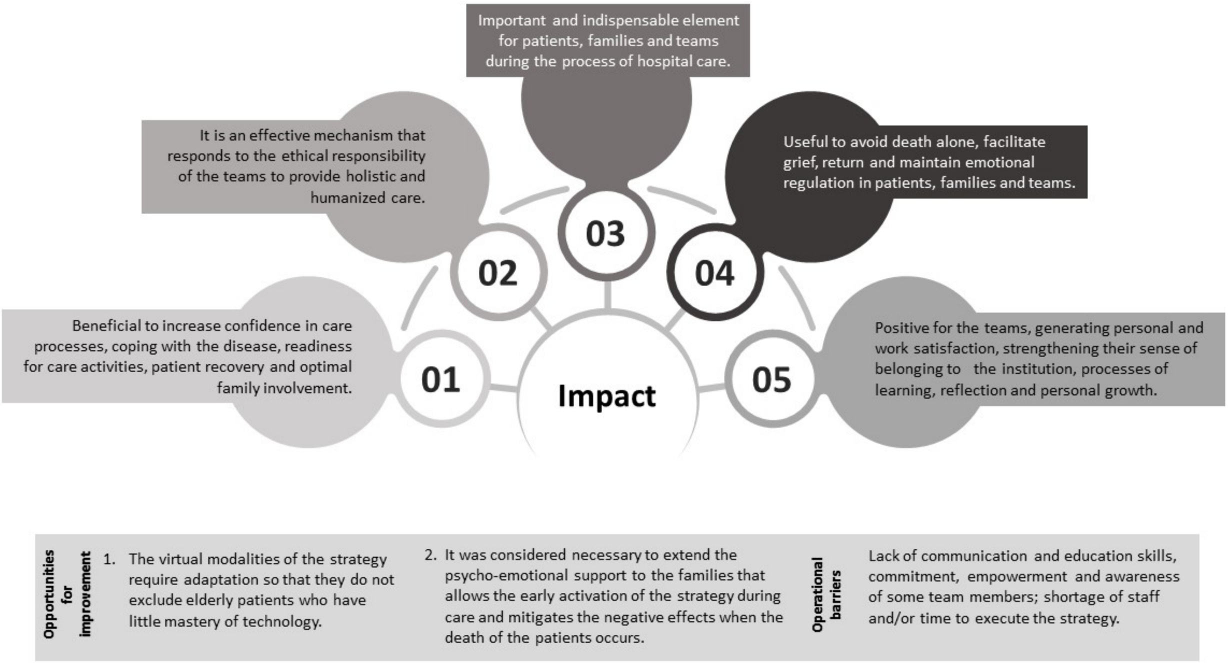
It consisted of four themes of the PCC: Nurturing of the being, Healing environments, Coordinated care and Participation of the person, family and friends, from which eight sub-themes emerged: Positive effects perceived in the psychosocial-emotional balance of patients and families, in the recovery and hospital stay; Strengthening of the individual and labor dimension of the healthcare teams; Need for comprehensive intervention for families; Shortcomings and difficulties perceived by the healthcare teams; Importance of holistic care; Effectiveness of family involvement; Importance of the virtual modalities of accompaniment; Positive effects of family involvement in care. Figure 2 shows the impact of the accompaniment strategy on the patient, families, and health personnel.

The accompaniment strategy was perceived by the patients, relatives and healthcare teams as an indispensable and useful element within the hospital care process, although it implied an additional effort by the members of the teams and relatives for its accomplishment. It also helped integrate the care and the identified psychosocial-emotional needs to provide holistic and humanized care, establishing itself as a differentiator axis of quality that facilitates hospital care despite the physical restrictions caused by the pandemic.

In general, the benefits perceived by everybody were avoiding death in solitude, facilitating grief, emotional balance, increasing confidence in care processes, improving in coping with the disease, recovery of the patient, and optimal involvement of the relatives. For the members of the healthcare teams, it was perceived as an opportunity to provide support that strengthened their personal and work satisfaction, personal growth and their sense of belonging to the institution. Among the identified opportunities for improvement, it was found that the virtual modalities of the strategy require adaptation so that they not exclude elderly patients who have little mastery of technology and early activation of the strategy during care to mitigate the immediate and short-term negative effects. The difficulties reported by some members of the healthcare teams were the lack of communication and education skills, commitment, empowerment and awareness, as well as the shortage of staff and time to execute the activities of the strategy.

Discussion

Person-centered care is a healthcare approach that has become more relevant in the last decades, positioning itself as a fundamental component in the high-quality health systems, due to its contribution to warm, safe, efficient, timely and equitable care[9]. As the COVID-19 pandemic progressed, the relevance of the PCC approach in the provision of health services became more evident by identifying a break in the relationship, communication and participation of patients, relatives, and healthcare teams in the care process[10,11]. The biosafety restrictions generated in patients, relatives, and healthcare team's sadness, loneliness, tiredness, overburden, pathological grief, limitation of active participation of people in care, personal isolation from the family for fear of contagion, guilt about the possibility of being a source of contagion for their relatives and obsessive/compulsive behaviors[11].



Important and indispensable element for patients, families and teams during the process of hospital care.

It is an effective mechanism that responds to the ethical responsibility of the teams to provide holistic and humanized care.

Useful to avoid death alone, facilitate grief, return and maintain emotional regulation in patients, families and teams.

Beneficial to increase confidence in care processes, coping with the disease, readiness for care activities, patient recovery and optimal family involvement.

Positive for the teams, generating personal and work satisfaction, strengthening their sense of belonging to the institution, processes of learning, reflection and personal growth.

1. The virtual modalities of the strategy require adaptation so that they do not exclude elderly patients who have little mastery of technology.
2. It was considered necessary to extend the psycho-emotional support to the families that allows the early activation of the strategy during care and mitigates the negative effects when the death of the patients occurs.

Lack of communication and education skills, commitment, empowerment and awareness of some team members; shortage of staff and/or time to execute the strategy.

Figure 2. Description of the impact of the accompaniment strategy on the patient, families and health personnel.

The results show that before the implementation, fear and uncertainty in the face of the unknown were stress generators; during the implementation of the accompaniment strategy, patients and relatives reported positive emotions and emotional balance given by tranquility, peace, stability, expression of spirituality, consolation and facilitation of grieving processes; and in the healthcare teams, an attitude of resistance to change was reported, as well as an increase in the workload due to the fact that they participated in the education of patients and relatives in biosafety measures and generated spaces for virtual communication. After the implementation of the strategy, the relatives and the members of the healthcare teams perceived a positive impact referred to as psychosocial-emotional balance, professional satisfaction, personal growth, family involvement in care, reduction of loneliness and strengthening of the family union.

When contrasting the results obtained with the literature, these were similar to those reported worldwide. An integrative review that sought to investigate the effects of visitor restrictions in the hospital services during the SARS-CoV-2 pandemic found in the patients depressive symptoms, agitation, reduced cognitive ability, dissatisfaction, and loneliness; in the relatives, psychological stress was identified in the social, work, personal and family areas; in addition, the relatives of the survivors had a greater demand for information about the condition of the patient[12]. Regarding the healthcare teams, ethical and emotional dilemmas were identified when trying to balance biosafety measures and the emotional well-being, and they reported an overload related to give information to relatives through alternative channels (video calls, virtual visits, etc.)[12]. Some studies identified that additional staff was integrated to manage the patient-family communication and the psychosocial needs of family members[13,14].

Another study conducted by Zante et al.[15], found a high prevalence of symptoms of acute stress in family members during the hospital stay and anguish due to the suppression of ICU visits. Also, it found a positive perception of the availability of video calls, ICU diaries and daily information, since they perceived communication as one of the most important aspects. Mohammadi et al.[3], explored the psychological challenges presented by the relatives of patients who died of COVID-19, such as: difficulties in the mourning process due to the emotional affectation generated by guilt, impossibility of a proper farewell, burial concern, fear of the future, difficult financial conditions, and social stigmatization.

In a study, the perception of the actors of care about the implementation of accompaniment strategies was positive, since both the family members and the healthcare personnel considered that virtual and face-to-face modalities are effective in achieving communication, preferring phone calls for a quick update and video calls for making important decisions, despite this, presentiality is still the communication mechanism of choice[16]. Also, the strategies of accompaniment and communication generated in the patients hope, motivation to participate and support in the care. Likewise, the relatives perceived these strategies as generators of tranquility and emotional support upon receiving information, appreciated to be connected with their loved ones and ensure how their relatives are being cared; although an increase in anxiety was evidenced in the main family member who must be in charge of transmitting the information to the rest of the family[17,18].

A qualitative study evaluated the impact of family visit restrictions on the work experience of ICU during the COVID-19 pandemic and found that the physicians reported negative changes in the workflow due to disruption in communication with the family members, the ability to provide medical care, in the degree of interpersonal connection, and an increase in work-related emotional distress and unsatisfaction; while the nurses reported favorable repercussions in the workflow related to the increase in time and space to provide greater attention to the patients care. In addition, both physicians and nurses perceived those visiting restrictions generated a negative impact on end-of-life care and increased family anguish[19]. Regarding the emotional impact on this population, anxiety and depression were reported in ICU professionals as a consequence of the fear of being infected, the inability to rest, the difficulty to care for their own family, struggling with difficult emotions, the disagreement with the institutional policies for visiting restrictions and witnessing hasty decisions at the end-of-life[20].

A qualitative systematic review examined the impact of family involvement in self-management of chronic diseases, highlighting their crucial role in reinforcing and facilitating self-care practices. Families underwent reorganization to support affected members in maintaining as normal a life as possible and in managing their condition independently. Notably, adaptations in family dynamics and the physical environment were observed, fostering ongoing unity among family members and integrating the condition into family life. Consequently, fostering an environment that promotes active family engagement is vital for achieving improved health outcomes[21].

During the COVID-19 pandemic, it was necessary to implement PCC strategies to lessen the impact and consequences of patient separation from family members and of patients dying alone in the care team. Person-centered care can be useful in any care setting (outpatient and inpatient) because it has become an essential approach to promote the integral well-being of patients, not only by working on patients but also on families and the care team involved in the care. Likewise, this strategy helps in the design of care at the personal level, in the continuous improvement at the organizational level of health services and in the definition of the outcomes that are most important to all. Some of the principles of this approach are providing people with dignity, compassion, and respect; offering coordinated and personalized care, support, or treatment; and supporting people to recognize and develop their own strengths and skills to enable them to live independent and satisfying lives[22].

The results of this study must be considered with caution according to the sociocultural, economic and health context in which it was developed. A limitation of this study was the difficult to focus the participants on the description of the experience of the accompaniment strategy during hospitalization because it was confused with the experience of threat and anxiety generated by the pandemic, which led to discarding information due to lack of clarity in the responses between these two situations experienced. Besides, the analysis of the emerging categories was carried out from an approach of presence/absence and not of frequency to use all the information available for each interview.

Conclusion

This study shows that the restrictive measures adopted for biosafety during the SARS-CoV-2 pandemic negatively affected the person-centered care during the hospitalization. It also identifies that the implementation of virtual and face-to-face accompaniment was perceived by patients, relatives, and healthcare teams as a necessary, viable, useful and an effective alternative to guarantee warmth, psychoemotional well-being, participation and effective communication in the care process during this pandemic. However, the sustainability of these strategies in the medium and long term requires an organizational commitment to manage resources (human, technological, economic) that avoids overloading healthcare teams and that involving all healthcare stakeholders (health team, family, and patient) is essential to achieve a coordinated and efficient process with good health outcomes.

Authors contribution

ME, FC, JB, AM, AA, and AC contributed to the idea of the research; FC and JB performed the protocol design; ME, JB, JH, MT and FC contributed to data collection. All authors contributed to the paired analysis of the information. ME, JH, JB and FC, contributed to the drafting of the manuscript. All authors reviewed and critically provided feedback to the draft of the manuscript.

Ethical considerations

This study had the approval of the ethics committee of the Fundación Universitaria Sanitas, Act CEIFUS N° 480-20. All participants gave their informed consent and authorized the recording of the interviews.

Conflict of interest

The authors declare that they have no conflict of interest in relation to this article.

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The authors report that they did not use Artificial Intelligence, language models, machine learning or similar technologies to create or assist with the elaboration or editing of any of the contents of this document.

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