INTERNATIONAL COLUMN

Reflections by a Canadian oncology nurse regarding her international experience in India

by Zahra Lalani

What did you do?

I went to India and worked with pediatric oncology nurses and implemented safer chemotherapy administration processes and a safer sharps disposal process at the point of use.

I was asked by the head pediatric oncologist at a government hospital for people living below the poverty line to help raise the standards of care. The request came with a forewarning, “It will not be easy.” The oncology unit not only provided inpatient and outpatient chemotherapy, but it also doubled as the palliative ward.

The last nurse from abroad apparently burst into tears on her first day and was not able to bear witness to the suffering; I was told she booked her flight back home a few days later. They did not expect me to stay if it was too difficult for me, but I knew at that point, that no matter what I saw, that I would not run away.

What did you learn during your time there?

I was bursting at the seams to share what I knew and make things better, but what I learned very quickly was that I was the student. I had to step back, observe, and understand the lived experiences of the people I was going to work with. Quietly observing was not easy. I needed to keep from projecting what I knew and was cognizant that any changes would have to be meaningful and sustainable. I also realized that, in the small changes, there might be a big impact.

I had to reconcile the standards I wanted to project with the reality that existed for the nurses. I also had to be deliberate and sensitive in the way that I interacted with the team to establish rapport and trust.

What I learned was that I had to approach things with patience and tolerance, as well as respect for the team. I had to stop, to be still, and understand the psychosocial, financial and cultural differences. I had to stop myself from trying to fix things, criticize or judge. I had to learn to empathize with the colleagues who were working in less-than-ideal circumstances and, despite the vast differences in practice, I had to acknowledge that they were doing their very best with what they knew and what they had.

What were you concerned about (if anything)?

On my first day, I had a tour of the single room with 15 beds with two to three kids per bed. In addition, there was a long line-up of people waiting outside that same room for their outpatient chemo. The room was chaotic, and the noise and congestion provided little comfort and fed my anxiety. The average number of patients to be treated by four to five nurses was 45–60 per day. The numbers were daunting.

There was no pharmacy to prepare the meds; the nurse did this on the ward. There was no laminar flow hood for mixing chemo, no chemo gowns, no masks, no chemo gloves, and no space to mix chemotherapy medicines. What I observed next was distressing. The nurses had to mix chemo at the bedside without personal protective equipment (PPE); the syringes were filled with chemo that was then squirted into the air. I witnessed violent aggressive breaking of vials with scissors. The chemo and glass shards were airborne and landing on uniforms, bed surfaces and the floor, where kids were walking around without any footwear. All the chemotherapy had to be given by the end of shift change at 2 p.m. Needless to say, there were multiple opportunities for error and no checks in place to prevent them.

English was not spoken fluently, but enough people spoke it well enough for me to be able to communicate with the team. I had read in my preparation for the visit that this state in India had one of the highest rates of HIV transmission through non-sexual transmission. There were no IVADs, so IVs needed to be initiated on all children. I witnessed IVs being started on all the kids and the needles being left at the bedside for the kids to handle and play with. No sharps disposal bins and no safety systems in place created angst and despair inside me. I had no idea where to start. I felt overwhelmed. What could I possibly do and where would I begin?

How did you handle the concern... or what you would like other Canadian nurses to know about the environment and the setting where you were?

My initial reaction was fear. I was concerned initially about my own safety because I was in the space where all this was happening. I did not want to put myself in danger. Yes, I wanted to run, but I had to stay.

I started by observing. I kept a safe distance from all the chemo and the needles, but I showed up every day. I had to be there and be present but, at the same time, not be intrusive. I

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reported my observations to the oncology leader and then asked for some time to meet with the nurses on a regular basis.

I met with the nurses daily for a few days. I provided snacks and started the sessions by getting to know the team. I was able to ascertain quickly that the nurses were working with complex chemotherapy protocols, but had not received any specialized education. They were thrown into a role and learned from one another. Their nursing program did not prepare them to our western standards. There was a gap in knowledge about blood and body fluid precautions and there was no specialized education related to chemotherapy administration. There were no chemotherapy safety standards and no access to PPE. While my initial response was disbelief and judgment, learning about their backgrounds made me empathize with them in a way that compelled me to ‘stick it out’.

I started with the basics. I reviewed basic safety standards for starting IVs, and for blood and body fluid precautions. I had to be realistic and didn’t know if they could implement these standards without access to PPE and no access to sharps disposal containers.

I built on the basics by sharing chemotherapy safety standards and procedures that we would employ in the west and I also provided the rationale for these. I asked the nurses how they might use these principles to more safely mix and deliver chemotherapy and I encouraged them to think creatively about ways to do this. I had to acknowledge that there was a lack of resources that we were working with and that within their limitations there were still ways to minimize the risks through small changes.

When I came to the ward a few days later, I was pleasantly surprised. The team had really gained some insight. They had taken a metal cart that was used for storage, cleaned it up, used a fabric divider, and created a separate corner for chemotherapy mixing. They would not mix chemotherapy at the bedside anymore. They had access to basic regular gloves and they asked for chemo gowns. We went all over town in all the medical stores and could not find these.

After much searching and discussion, the team decided they would buy thick fabric and create aprons that would be used during chemotherapy mixing to avoid getting the chemo on their clothing. These would be reusable and would prevent the nurses from getting chemotherapy on their uniforms. This, coupled with safer technique to minimize airborne shards and chemo, was initiated. I found the nurses more mindful of their technique and there was an obvious effort to ensure that the chemo mixing was done at the cart (chemo mixing zone).

We also set out on a trip to the local bazaar to find ways to improve the IV disposal system. The team found square Tupperware basins for the supplies needed to start IVs to take to the bedside and identified small Tupperware disposal containers to dispose the sharps at the point of use. The small Tupperware containers were to be reused. While there was no ideal way to ensure the public was not harmed, this small step led towards disposal of needles out of reach of children. I designed visuals and posters that identified and reminded them that their unit was a needle-free zone and they were on a mission to sustain a needle-free zone within their ward.

The practice was continued the following two years that I was there. I believe this was possible because the team initiated the ideas and changes. The biggest lesson I learned was that knowledge is empowering and that changes need to come from the people who are doing the work.

Photos from top: Photo with the nursing team (I am wearing black and sitting down). Second photo - I am painting the face of a child on the peds ward. Third photo is of me with an adolescent child on the peds ward. Last photo is of me with the nurses on the peds ward.