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HUMANIZED CARE: PERCEPTION OF INTENSIVE CARE NURSES

ASSISTÊNCIA HUMANIZADA: PERCEPÇÃO DO ENFERMEIRO INTENSIVISTA

ATENCIÓN HUMANIZADA: PERCEPCIÓN DEL ENFERMERO INTENSIVISTA

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Objective: analyze the perception of intensive care nurses have about humanized care. Method: this is a qualitative analytical study conducted in a public hospital in the state of Alagoas, Brazil, in September and October 2016. Data were collected through a semi-structured interview applied to ten nurses, and submitted to a thematic content analysis. Results: three categories were defined from the answers provided by the interviewees addressing aspects of humanization as a work tool in intensive care units, associated with the use of technology and its influence on the recovery of critically ill patients. Conclusion: in the perception of intensive care nurses, offering humanized care is important, since it influences the treatment and recovery of patients.

Descriptors: Care humanization. Intensive care unit. Nursing care.

Objetivo: analisar a percepção do enfermeiro intensiva sobre a assistência humanizada. Método: estudo qualitativo de cunho analítico realizado em um hospital público do estado de Alagoas, Brasil, nos meses de setembro e outubro de 2016. O instrumento de coleta de dados foi a entrevista semiestruturada aplicada junto a dez enfermeiros. Os dados foram trabalhados mediante análise de conteúdo na modalidade temática. Resultados: as três categorias que emergiram das falas tratam de aspectos da humanização como ferramenta de trabalho, associada ao uso da tecnologia e sua influência na recuperação do paciente crítico. Conclusão: na percepção dos enfermeiros intensivistas, ofertar uma assistência agregada à humanização é importante, por influenciar no tratamento e na recuperação do paciente.

Descritores: *Humanização da assistência. Unidade de Terapia Intensiva. Cuidados de enfermagem.*

Objetivo: analizar la percepción del enfermero intensivista acerca de la atención humanizada. Método: estudio cualitativo de cuño analítico, realizado en un hospital público del estado de Alagoas, Brasil, en los meses de setiembre y octubre de 2016. El instrumento de recolección de datos fue la entrevista semiestructurada aplicada a diez enfermeros. Los datos fueron trabajados a través de análisis de contenido, en su modalidad temática. Resultados:

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las tres categorías que surgieron de las conversaciones tratan sobre aspectos de la humanización como herramienta de trabajo, asociada al uso de la tecnología y su influencia en la recuperación del paciente crítico. Conclusión: en la percepción de los enfermeros intensivistas, ofrecer una atención con agregación de la humanización es importante, por el hecho de influir en el tratamiento y en la recuperación del paciente.

Descriptores*: Humanización de la atención; Unidades de cuidados intensivos; Atención de enfermería.*

Introduction

Humanization is associated with different meanings. Literally, it means the act of making more human, more benevolent. Humanization can also be considered as something inherent to human beings; which is born with them and helps them guide their relationships in society based on charity, compassion, and goodness[1].

Over the years, humanization has received more attention, and not only in health care; other areas of social life have also been benefited. In health care, it generally refers to ethical issues related to caring for patients to improve relationships between all parties involved in this process and healthcare work condition[2].

Regarding the humanization context in Brazil, being a developing country, it has daily life problems that make it difficult to enforce the guidelines of the Unified Health System (SUS, as per its acronym in Portuguese). Then, strategies should be created to reorganize the current healthcare model, prioritizing the provision of care based on human values and quality of care. Given the above, humanization initiatives of health services in Brazil are an alternative to drive transformation[3].

However, the human aspect of care is one of the most difficult to implement, especially when it involves intensive care units (ICUs), where daily routine and complexity of physical and functional environments surround health professionals with paradoxes, such as the duel between life and death, success and failure, the decision-making process, and ethical issues, thus hindering the provision of humanized care[4].

The ICU is a distinct sector of the hospital, because it has specific organization and modern technology aiming to provide better care to critically ill patients. Due to the clinical conditions of these patients, the treatment is often invasive and aggressive due to required interventions. This makes the ICU a highly complex environment. In addition, the ICU causes depersonalization of patients, who are far from family and friends in an unfamiliar and uninviting place, surrounded by professionals and uncertainty about what will happen[2].

In this sense, addressing humanization in ICU is relevant as it allows a better understanding of nursing care singularities in the hospital sector and shows that humanized care involves different types of knowledge, practices, and decisions for the recovery of hospitalized patients[5].

This study attempted to answer the following guiding question: How do intensive care nurses perceive humanized care? And it aimed to analyze the perception intensive care nurses have of humanized care.

Method

This is a qualitative study conducted in a public hospital in the state of Alagoas, Brazil, which is a reference to high complexity care. During the data collection period, the general ICU had 12 nurses in its staff.

The following inclusion criteria were considered in this study: nurses of any sex and age, who have worked in the sector for more than 2 years and with experience in situations that favored discussions on humanization. Exclusion criteria were: nurses working in other sectors of the hospital, nurses on vacation and/or medical leave. The total number of participants in this

study was ten, because two did not meet the inclusion criteria.

The nurses who participated in this study signed an informed consent form to confirm their voluntary participation. To ensure participant anonymity and confidentiality of information, the letter "N" followed by a number from 1 to 10 was used to identify the nurses, according to the order of interviews.

Data were collected in September and October 2016. A semi-structured interview based on open-ended questions was applied. The answers were recorded and later transcribed by the researcher. Thematic content analysis was used to analyze the speeches of the interviewees, presenting the following steps: pre-analysis (thorough reading); exploration of the material (data are encoded in recording units); result analysis and interpretation (categorization and later regrouping according to common characteristics)[6].

This study followed the ethical concepts of Resolution no. 466/12 of the National Health Council[7]. It was approved by the Research Ethics Committee of the Universidade Estadual de Ciências da Saúde de Alagoas, under protocol no. 1.673.632 and CAEE 53338716.7.0000.5011.

Results and discussion

This study had 9 female and 1 male participants, aged between 40 and 49 years, with an average experience of 15 years in the nursing area and 10 years in ICU.

Three categories were identified, based on the National Humanization Policy, as follows: Humanization as a work tool in ICU; Interference of technology in the implementation of humanized care; Impact of humanized care on the recovery of critically ill patients.

Humanization as a work tool in ICU

Humanization has become a broad topic of discussion with the creation of the National Humanization Policy. It is proposed as a cross-sectional policy, a group of principles and guidelines applied to healthcare practices, services and in the instances of the system, characterizing a collective development. The policy was created to promote the debate about humanization in the SUS, and help consolidate its principles and guidelines, and it can be used as a work tool[8].

Providing humanized care is a current need, as care often involves the application of a nursing technique. However, in order to be humanized, it is important to understand that patients receiving the technique are biopsychosocial agents requiring comprehensive care, not only to address their pathological condition[5].

In the ICU where this study was conducted, when asked about the humanizing actions developed, the professionals described them as follows:

> *I provide humanized care, ensuring a more careful look. And when we begin to see that we can improve our care procedures, we begin to make greater progress in care. Because it's not just speaking or talking. I think that patient care itself improves the service and the issue of humanization.* (N2).

> *I provide humanized care, since I take into account the patient's needs. I think it is important to see patients as human beings and try to act for their well-being and recovery.* (N3).

> *When you go beyond the care provided, you can hear, look, touch the patient, see him or her as a complete human being, who has beliefs, principles, family. This is the start of humanized care, and it makes the difference.* (N8).

These statements show that nurses recognize the importance of having a holistic view when providing care and supporting patients comprehensively. They understand that humanizing is more than talking, using a soft voice, having kind and caring attitudes; it is something much broader because it is a complex, comprehensive and dynamic process that involves the different agents inserted in the context, such as professionals, patients, and family members. Humanization is mainly a change in behavior and attitudes of professionals with patients and their families. Health professionals who directly or indirectly provide care to patients are responsible for humanization, since awareness of the subject allows health professionals to

apply humanized care in the best possible way, and achieve the proposed goals[9].

Humanization is not a technique or a device; it is a process that involves the whole environment and the subjects inserted in it. The professionals working in this environment, in turn, provide patients with dignified care based on respect for human values, considering the circumstances of every patient at ICU admission.

For effective humanization in nursing practice, interaction between professionals and patients should happen, along with support from all those involved in the process, such as administrators, workers and service users. Humanization only happens if they work together, making it a positive and high-quality practice, when the person performing it adds values and meaning to what is being performed[10].

In this sense, when discussing about humanization in the ICU, a challenge is observed as it is an environment that provides care to critically ill patients. Today, the reality of humanization in ICUs has still many aspects to be reformulated and improved, particularly in public hospitals, where poor working conditions for professionals are observed, without proper ergonomics, remuneration and physical structure to satisfactorily perform their work. The lack of good working conditions has a negative impact on the provision of high quality humanized care.

Interference of technology in the implementation of humanized care

The world is currently characterized by technological innovations, and the ICU is an environment with new equipment and devices that help improve the quality of patient care. These innovations require better qualification of health professionals, allowing them to use technology in an efficient and safe manner, without forgetting the ethical principles that guide their profession[11]. The ICU is an environment of high complexity, and technology is a key factor in this sector, raising many questions about its benefits or risks to the provision of humanized care. Regarding this fact, the nurses participating in this study reported the following:

> *In some moments, you realize that some professionals value equipment much more than the practice. In the past, clinical practice was above everything; you needed few things to obtain a diagnosis. Today, unfortunately, some professionals don't value clinical findings, don't give importance to anamnesis and only worry about requesting high-tech exams.* (N1).

> *Sometimes some professionals just want to perform procedures, a diagnosis, if all exams are available, a CT exam, a magnetic resonance exam, among other things. Before, the physical examination was crucial to evaluate the patient along with anamnesis.* (N3).

> *Technological advancements are a very important ally in patient recovery. On the other hand, there are many devices, they provide everything ready, it is much easier, and it affects patient touch and observation of other signals that are not linked to the devices.* (N4).

Considering the above, since the ICU is an environment of high complexity and surrounded by technological innovations, regarding the influence of technology on humanized care, the participants of this study reported that some professionals often overestimate technology over the nurse/patient relationship. Then, they end up providing fragmented care, based on the corrective model that aims to heal the pathology and where patients are seen as an object of study. The provision of humanized care thus becomes a challenge, the fact that care is provided to human beings is forgotten and technology becomes the main focus of attention.

Technological advancements help provide immediate care to patients and ensure security to the care team, contributing to patient recovery. However, they also make human relationships more distant, creating some dependence among professionals, who become more concerned about the information produced by the devices. It contributes to increase distance between professionals and patients, affecting the subjective data and comprehensiveness of care.

In the ICU, nurses should always have technical and scientific knowledge to perform procedures and interventions of this hospital sector. However, technological devices should not be overestimated, so that caring, listening, and putting oneself in the place of the other

are not forgotten. It is crucial, for good care, to combine technology and care[5].

The nurses of this study also recognized that technology was important in the ICU environment, provided that patients were the main focus, since critically ill patients require continuous monitoring and complex care that helps improve or stabilize their clinical condition. However, they also highlighted the importance of proper use of technology, emphasizing that it should be an ally in humanized care, and not the main object in care provision, as noted in the following statements:

> *It will depend on the perspective of each professional. Because, ideally, you have to use technology as an accessory, and not as the main focus. The perception of health professionals does not fail as often as the equipment or technology. It requires health professionals to be prepared and know how to look at the patient, the clinical practice, and not just technology.* (N4).

> *Patients recover much faster with a well-equipped ICU, with technology available, invasive and non-invasive monitoring, and with the necessary procedures performed effectively and fast.* (N7).

Regarding the ICU environment, the impact of technology is easily observed, since these sectors provide care to critically ill patients. There, practice becomes mechanized and specialized, forcing reflections on the real meaning of care, which should be associated with humanization. Health professionals need to strengthen communication and contact and value patients, because, when talking and listening to their complaints, they may help resolve issues and provide comprehensive care[10].

Impact of humanized care on the recovery of critically ill patients

The National Humanization Policy emphasizes that humanization should not be seen as a program, but as a policy that covers different actions and management bodies of the SUS, so that it can effectively build solidary exchanges committed to the dual task of production of health and production of subjects, considering that humanization seeks to value different subjects involved in the process of health production[8].

The hospital context, regarding the actions of health professionals in this environment and care itself, has a fragmented view of humans, in which body functioning is associated with a machine. In this environment, care is provided individually and mechanically; health professionals are pressured so that technical tasks are performed in high quantity and in a short time. Therefore, humanization comes as an alternative to change this reality, since it proposes to understand the sensations and subjective impressions of intensive care professionals, considering that no matter how necessary technical excellence may be, it is not enough for the recovery of critically ill patients in biopsychosocial terms[5].

Regarding the influence of humanized care on the recovery of critically ill patients, nurses recognize that it contributes positively by offering care directed to every patient's real needs, listening attentively, solving problems, and providing comfort during the ICU admission process, as noted below:

> *In humanized care, patients have a better reception; their needs are taken into account. This way, they have a better response in their recovery process.* (N3).

> *Patients who are in an ICU, far from the family, in bed, depending on people for everything, in a routine that is completely different from their daily life, will consequently be stressed. So if you don't provide good humanized care, their recovery will be even more difficult.* (N7).

Nursing care with humanization in each technique to be performed, from handling a monitor to body hygiene, allows the practice of listening, valuing individual complaints and needs, besides the attention to psychological, emotional and affective aspects of patients. As reported by N7, the hospitalization process has a direct impact on the patient's life, causing feelings of anguish, doubt and fear, often turning the patient into an actor in this process.

Humanized care increases the chances of survival and recovery of critically ill patients, but as the ICU is an environment where the unexpected is always present in the daily routine with aggravations and other events, health professionals should understand the importance of humanized care, so that it can be inserted in their work behavior[12].

The production of knowledge about humanized care in the ICU environment allows nurses to think of a topic that is often unexplored in their work routine, due to the daily routine of this sector and these professionals. This reflection may cause nurses to rethink their behaviors when providing care to critically ill patients so they can offer quality care based on humanization.

A limitation of this study is that it was conducted in only one hospital. Thus, further studies are required in other hospitals and scenarios to analyze different realities and broaden the perceptions on this theme, seeking to enrich the results obtained.

Conclusion

This study showed that nurses recognize the importance of having a holistic view when providing care and supporting patients comprehensively.

The participants realized that providing quality care based on human values and humanization in the ICU environment enables positive results in the treatment and recovery of critically ill patients in biopsychosocial terms. They understand humanization is not a technique, a device, but a complex, comprehensive and dynamic process that involves the whole environment and the subjects inserted in it.

Finally, it should be noted that health professionals should think of their conduct and actions performed during the care process, and start incorporating attitudes based on humanized care, considering the guidelines of embracement and adaptation, and protection of human rights, as defined in the National Humanization Policy.

Collaborations:

1. conception, design, analysis and interpretation of data: Savia Nobre de Araújo Dórea and Maria da Piedade Gomes de Souza Maciel;

2. writing of the article and relevant critical review of the intellectual content: Emilenny Lessa dos Santos, Leila Karoline Ferreira dos Santos, Mariana Barbosa da Silva and Maria Goretti Lins Moraes;

3. final approval of the version to be published: Emilenny Lessa dos Santos, Savia Nobre de Araújo Dórea and Maria da Piedade Gomes de Souza Maciel.

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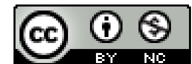

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