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ENVIRONMENT AND HUMANIZATION: RESUMPTION OF NIGHTINGALE'S DISCOURSE IN THE NATIONAL HUMANIZATION POLICY

Ambiente e humanização: retomada do discurso de nightingale na política nacional de humanização

Ambiente y humanización: la retomada del discurso de nightingale en la política nacional de humanización

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ABSTRACT

Objective: The objectives were to identify the constituent elements of the environment concept in the official documents of the Brazilian National Humanization Policy and to analyze the relations between these concepts and the promotion of the care environment recommended by nursing. **Methods:** In this qualitative and descriptive research, the eleven HumanizaSUS Brochures of the Brazilian Ministry of Health served as the sources. Lexical content analysis was applied, using the software ALCESTE®. **Results:** The specific lexical class about the environment as a humanization instrument revealed elements that approximate nursing knowledge about care for the physical space to promote comfort and wellbeing and the welcoming of users and their family members. **Conclusion:** The constituent elements of the environment concept in the National Humanization Policy are consistent with Nightingalean thinking, which underlies nursing, its science and its art.

Keywords: Nursing; Health facility environment; Humanization of assistance; Health policy.

RESUMO

Os objetivos deste estudo foram identificar os elementos constitutivos do conceito de ambiente nos documentos oficiais da Política Nacional de Humanização e analisar as relações entre eles e a promoção de ambiente de cuidado preconizada pela enfermagem. **Métodos:** Estudo qualitativo e descritivo, cujas fontes foram as onze Cartilhas HumanizaSUS do Ministério da Saúde. Realizou-se análise de conteúdo, tipo lexical, por meio do programa ALCESTE®. **Resultados:** A classe lexical específica sobre o ambiente como instrumento de humanização evidenciou elementos aproximados ao conhecimento da enfermagem sobre os cuidados com o espaço físico promotor de conforto e bem-estar e o acolhimento dos usuários e seus familiares. **Conclusão:** Concluiu-se que os elementos constitutivos do conceito de ambiente na Política Nacional de Humanização se coadunam com o pensamento Nightingaleano, que serve de base aos fundamentos da enfermagem, à sua ciência e à sua arte.

Palavras-chave: Enfermagem; Ambiente de instituições de saúde; Humanização da assistência; Política de saúde.

RESUMEN

Objetivo: El estudio objetivó identificar los elementos constitutivos del concepto de ambiente en los documentos oficiales de la Política Nacional de Humanización y analizar las relaciones entre ellos y la promoción de ambiente de atención preconizada por la enfermería. **Métodos:** Estudio cualitativo y descriptivo, cuyas fuentes fueron las once Cartillas Humaniza SUS del Ministerio de la Salud. Se realizó el análisis de contenido, tipo lexical, a través del programa ALCESTE®. **Resultados:** La clase lexical específica sobre el ambiente como instrumento de la humanización evidenció elementos aproximados al conocimiento de la enfermería sobre la atención con el espacio físico proveedor de conforto y bien estar y el acogimiento de los usuarios y sus familiares. **Conclusión:** Se concluyó que los elementos constitutivos del concepto de ambiente en la Política Nacional de Humanización se coaduna con el pensamiento Nightingaleano, que sirve de base a los fundamentos de la enfermería, a su ciencia y a su arte.

Palavras-clave: Enfermería; Ambiente de instituciones de salud; Humanización de la atención; Política de salud.

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INTRODUCTION

In 2003, the Brazilian Ministry of Health created the National Humanization Policy (NHP), focused on health care and management practices. The NHP is a public policy in the Unified Health System (SUS) that is aimed at contributing to the qualitative improvement of attendance in health services[1].

To achieve service quality, the NHP sets five specific targets, which are: the reduction of queues and waiting times through expanded access to attendance in a welcoming and problem-solving manner, based on risk criteria; information to all users; monitoring of people in the patient's social network; defense of health users' rights; as well as permanent education for health professionals[1].

In the light of this policy, the quality of health services is closely related with improvements in health practices, focused on the users and health professionals. Hence, the humanization of health is constructed with the participation, accountability and autonomy inherent in the subjects, who possess rights and duties in the health process, also entailing implications for management. For Humanization to take place, not only participation is required. This condition also needs to be put in practice as an ethical, legal and moral attitude[2]. It is guided by the subjects' autonomy and leading role, the co-accountability among them, the establishment of solidary bonds, the construction of cooperative networks and collective participation in the management process.

The NHP is based on three principles: mainstreaming, considered as the expansion and increase of the communication capacity among policies, programs and projects and between subjects and groups; the non-severability of health care and management, which should be understood as immanent elements of health practices: the leading role of subjects and groups, investing in transformation. These principles are core elements of the way the NHP understands the power of the public health policy[1].

Within a perspective of dialogic and collective construction among health professionals, managers and users of the Unified Health System (SUS), the NHP uses some directives to guide transformative action, which are: the expanded clinic, welcoming, co-management, valuation of work and workers and defense of users' rights[3].

Within this logic, various devices have been developed, which are material arrangements to enhance a process, which are put in practice to promote changes in the care and management models. Some of these devices are: welcoming with risk classification, management boards, ambience, education program in health and work, referral and matrix support teams, co-managed ambience projects, right to a companion and open visit and construction of collective monitoring and assessment processes of humanization activities[3].

The NHP reveals its strength through the understanding of the subjects' repositioning from the perspective of their leading roles, the power of the group, the importance of the construction of shared care networks, in contrast with the contemporary world characterized by individualism and competition as a source of disputes[3].

Concerning nursing, whose object of science and practice is care, it is important to understand the latter in the current context of health practices as a condition of right, as respect for people is a nursing premise. Nursing care implies the respectability and proper treatment of the other, and is therefore ethical[4].

Nursing care is not restricted to the accomplishment of tasks and techniques, summarizing the accomplishment of procedures by the nursing team. The nursing care act involves technical and sensitive actions, turning its practice complex. To perform nursing care, scientific knowledge is needed, in which technique and subjectivity interact[5].

As regards scientific nursing knowledge, its most abstract and general components are the metaparadigms, which identify the primary phenomena of interest to the discipline, including the main philosophical orientations or worldviews in nursing. These metaparadigms cover the individual, health, the environment and nursing.

The environment is a core concept in nursing, around which Nightingale organized her observations about what is nursing and what is not. The environment is understood as a set of elements external to individuals that influence them, as internal and external conditions that influence the organism and even as the individuals nearby whom people interact with.

In the NHP, the environment is an important element and the policy specifically dedicatees three devices to it, which present this concept at the heart of their proposals: welcoming with risk classification, ambience and co-managed ambience projects. The humanization discourse defends the environment as a space of interaction among subjects, and also as a tool that facilitates the work process, in which the right to privacy and respect for individuality should be guaranteed, permitting the production of subjectivities[6,7].

In that sense, the research question is: What elements constitute the environment concept in the official documents of the NHP? What is the link between these

elements and nursing knowledge? The aim is to identify the constituent elements of the environment concept in the official documents of the NHP and analyze the relations established between what the NHP recommends and the promotion of a care environment recommended by nursing.

METHOD

In this qualitative, descriptive and exploratory research, the primary sources were the 11 most recent HumanizaSUS brochures created by the Ministry of Health to support the NHP, which are: the baseline document, the guidelines and the devices. Hence, other documents the Ministry of Health published about the NHP but which contain no guidelines were excluded, as they go beyond the scope and objectives of this research.

Lexical content analysis was applied with the help of the software ALCESTE®, which aims to distinguish the word classes in different text forms about a given topic of interest through complementariness and contrast8, focusing on the most significant elements that represent the essential information contained in the texts under analysis. Then, the researcher interprets these elements, classifying and identifying the existing relations between the lexicons analyzed[9].

The texts of the sources were previously prepared for submission in the software through the correction of spelling mistakes and the use of the underline signal to connect words that require the use of the hyphen and/or words that need to be analyzed jointly. In the *corpus*, the documents were identified per command line, in accordance with the rules of ALCESTE®, to allow the researcher to contextualize the lexicons analyzed by the program. This command line included an identification code, indicating the document, type of document (baseline document, guidelines or devices) and the year of its publication.

ALCESTE® divided the *corpus* into 11 initial context units (i.c.u), corresponding to the texts of each document selected from the NHP, classified into 992 elementary context units (e.c.u), totaling 69% of use of the contents submitted to analysis, grouped into four lexical classes. The e.c.u represent the text analysis units, normally between three and five lines, dimensioned by the program in function of the size of the corpus or the program user's preference, respecting the punctuation and the order of appearance in the text. In this research, the e.c.u excerpts made by the software were used.

Each of the four classes deriving from the lexical analysis was named according to the interpretation of the words corresponding to the class, as well as their meanings and senses when included in the e.c.u. Class 3 joined the lexicons that alluded to the research problem, and was therefore focused on in this analysis and discussion. In the light of the meanings of the lexicons that shape it, it was called "The environment as a humanization instrument, with 180 e.c.u and corresponding to 18% of the total corpus and 188 words analyzed.

RESULTS

The environment as a humanization instrument

This class presents the environment as an instrument that can permit and enhance the humanization of health services, as one of the factors that influence the health-disease continuum and the users' socialization. Constituted based on the second division of the analysis corpus, the Khi^2 coefficient was based on the Descendant Hierarchical Classification (DHC) dendrogram, including words with a Khi^2 of 18 or higher.

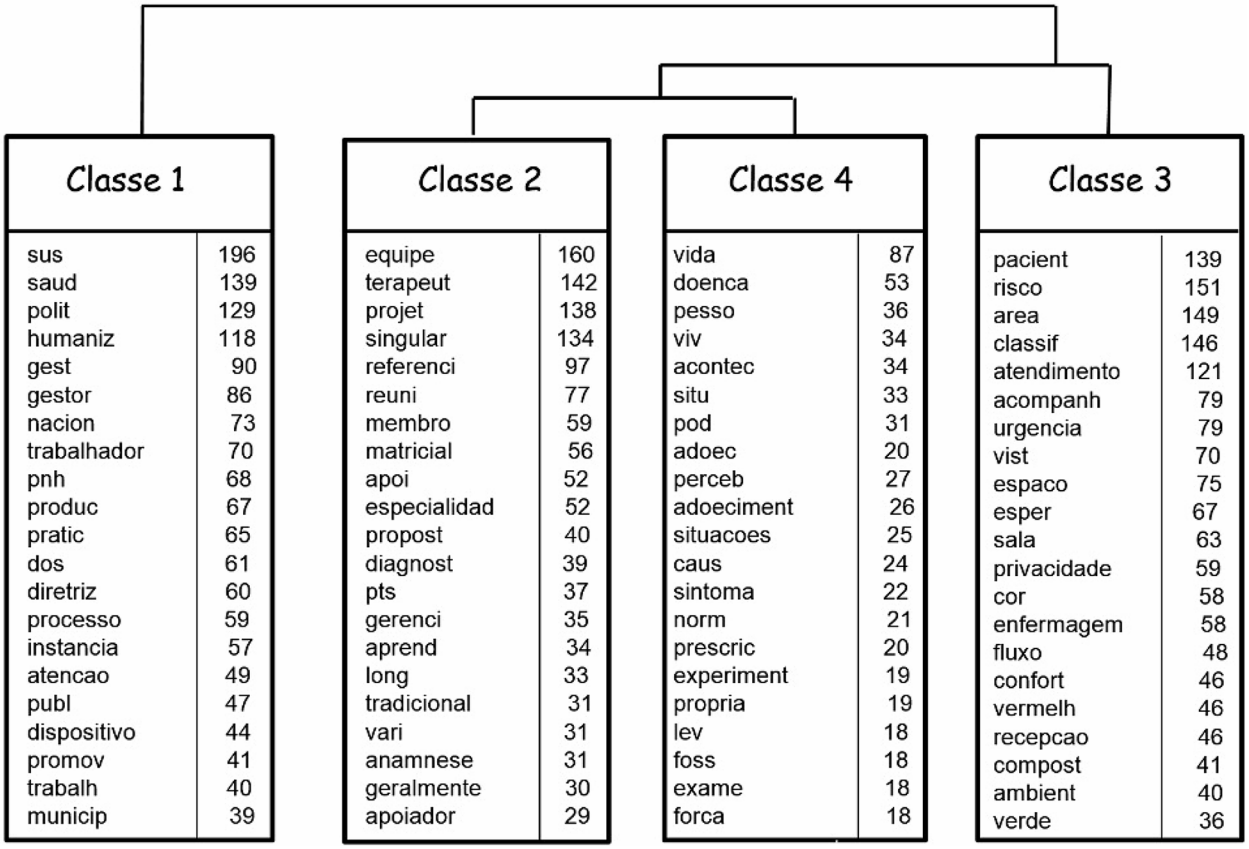
The analyzed words in the DHC dendrogram are considered as the most important elements that represent the classes, serving to describe them, in view of their higher chi-square coefficient (khi2). The khi2 calculates how frequently a word is present in the text, making it representative in the discourse context. The higher the khi2, the more relevant the word is for the construction of the class. Graph 1 displays the specificity of the classes: the higher the position of a class in the graph, the greater its specificity.

In the light of the results shown in Figure 1, the class profile is based on document number 4, a device document, specified as ambience, published in 2010.

This class characterizes the environment of the health services, evidenced by the words attendance (Khi^2 = 159), urgency (Khi^2 = 79), privacy (Khi^2 = 59) and nursing (Khi^2 = 58). It evidences the importance of the users' social context through the figure of the companions and visitors and highlights the role of the ambience in the provision of problem-solving and comforting attendance.

In the ascendant hierarchical classification, the relations are evidenced that are established between nursing and the attendance flow concerning risk classification in the emergency contexts, besides the subset that joins comfort, waiting, reception, the companion, the visit, the space and privacy.

Figure 1. Dendrogram of the Descendant Hierarchical Classification.



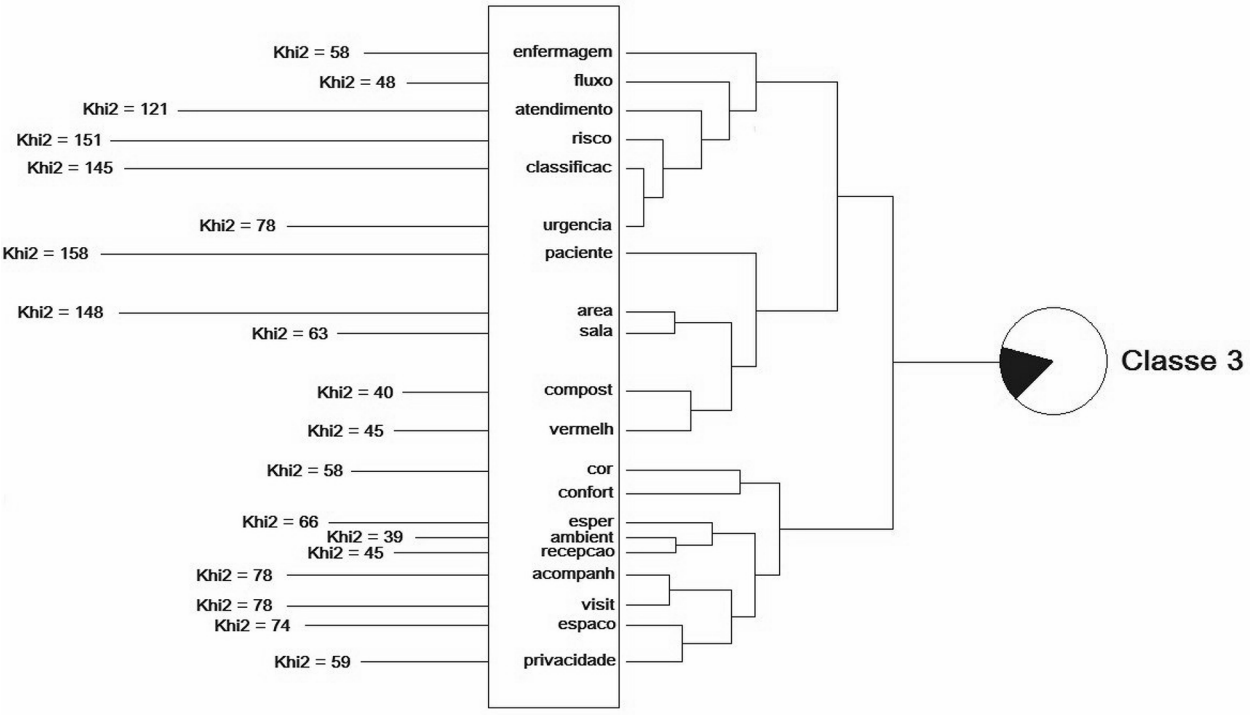
Classe 1	
sus	196
saud	139
polit	129
humaniz	118
gest	90
gestor	86
nacion	73
trabalhador	70
pnh	68
produc	67
pratic	65
dos	61
diretriz	60
processo	59
instancia	57
atencao	49
publ	47
dispositivo	44
promov	41
trabalh	40
municip	39

Classe 2	
equipe	160
terapeut	142
projet	138
singular	134
referenci	97
reuni	77
membro	59
matricial	56
apoi	52
especialidad	52
propost	40
diagnost	39
pts	37
gerenci	35
aprend	34
long	33
tradicional	31
vari	31
anamnese	31
geralmente	30
apoiador	29

Classe 4	
vida	87
doenca	53
pesso	36
viv	34
acontec	34
situ	33
pod	31
adoec	20
perceb	27
adoeciment	26
situacoes	25
caus	24
sintoma	22
norm	21
prescric	20
experiment	19
propria	19
lev	18
foss	18
exame	18
forca	18

Classe 3	
pacient	139
risco	151
area	149
classif	146
atendimento	121
acompanh	79
urgencia	79
vist	70
espaco	75
esper	67
sala	63
privacidade	59
cor	58
enfermagem	58
fluxo	48
confort	46
vermelh	46
recepcao	46
compost	41
ambient	40
verde	36

Figure 2. Ascendant hierarchical classification.



DISCUSSION

Florence Nightingale, the main global nursing icon and precursor of modern nursing, created a theory known as Environmental Theory, disseminated in her works *Notes on Nursing*: *What It Is and What It Is Not*, *Sick-Nursing and Health-Nursing* e *Notes on Hospitals*, all of which were published in England in the second half of the 19th century. Only the first of these was translated to Portuguese by the Brazilian Nursing Association to enhance the dissemination of her writings in Brazilian nursing[10,11]. In her works, Nightingale shows a distinguished look at the environment, considering it as an agent that directly influences the patient's health processes, focusing on the aspects that mainly involved cleaning and sanitation, in view of health institutions' precarious conditions in the 19th century. But these were not the only elements of the care environment in the light of Nightingale's notes. Care for the patients' environment involved other elements with a view to enhancing their conditions to let nature act and let the restoring process get established[10,11].

Since Nightingale until today, a consensus exists in nursing about the supply of a comfortable care environment for health, concerning appropriate lighting, noise, smell and ventilation[6]. Essential care elements involve the environment, including colors, lighting, sounds, clean air (ventilation/aeration), besides care regarding the flow of people and clean and dirty clothing/utensils. These notes are characteristic of Nightingale's discourse and are objectively evidenced in the documents of the NHP, which emphasize these elements, which were already essential for nursing care, but now, based on this policy, are considered essential for user health care, as observed in e.c.u 774:

> *In the yellow and green rooms [risk classification colors], besides the appropriateness of the spaces and furniture for functions that facilitate the work process, it is important to consider issues related to sound, smell, color, lighting (i.c.u 5).*

One of the lexicons analyzed relates to comfort, which also involves environmental issues, and it is observed that this is addressed in the NHP, and therefore important in the humanization of health care practices. This element is linked to care, in in Nightingale's writing as well as current literature, and is also addressed in a medium-range theory called the Theory of Comfort. That theory considers that nurses are responsible for identifying the users' needs for comfort, and that the comfort offered through nursing care can bring down the stress that is usually produced in the healthcare process, favoring the commitment of positive tensions. The results of this care further behaviors in search of health by users as well as their social support network[6,12]. Hence, comfort is fundamental for the promotion and recovery of people's health, emerging as a hub surrounded by several elements that are important for health care, such as: prejudice, religiosity, sexuality, culture, privacy, as evidenced in the NHP documents translated in e.c.u 81.

> *Urban violence is related to racial, religious, sexual prejudices of origin and others in the reception/welcoming and forwarding processes; adapting the services to the environment and to the users' culture, respecting the privacy and promoting a welcoming and comfortable ambience (i.c.u 1)*

One of the metaparadigms of nursing relates to the person, considering the individual, family and community spheres[6]. Therefore, according to nursing, with regard to care, the family also serves as a focus of attention. Nevertheless, Brazilian hospitalization units still face difficulties for the family's stay in the hospital environment when a relative is hospitalized. Issues related to the family's participation in care and the relation with professionals further enhance these difficulties. Health teams do not strengthen the idea yet that the family also comes with specific demands and needs in the hospital context, and often are not prepared to respond[13].

Given the importance of family participation, professionals should be formally prepared to adopt a welcoming posture, with a view to good relations with these subjects, who can serve as allies in the user health process, and are included in the process to share care, departing from a cooperative attitude[14]. The NHP is concerned with this demand and its documents demonstrate this relevance when defending the maintenance of good relations with the family and the supply of ambience appropriate to its needs, as evidenced in the contents of e.c.u 779 and 781, respectively:

> *Let us remind, then, an important guideline for these areas, to create spaces that enhance the right to a companion and to visits. It is important that users and visits are not received by a fenced door and strict and restricted visiting times, but that they have a reception, waiting rooms and spaces for listening. (i.c.u 5)*

> *It is not enough, therefore, to guarantee the right to a companion, but spaces need to exist to welcome and accommodate them, not only in the rooms referred to as yellow and green here, but in the different environments at the units. (i.c.u 5)*

In the light of the NHP, the environment should be welcoming, to the extent that respect for the companion and visitor as members of the users' social support network is carefully addressed. This discourse clearly approaches that of Nightingale, which defends that nursing care involves not only care for patients, but also for the people in contact with them, particularly informal caregivers[6].

Ambience is observed as an important tool to promote a welcoming care and to further value the subjects involved in care practice, as it permits offering a more comfortable space and greater social participation in the hospital area through the welcoming of visitors and companions at the hospitalization units[13].

In practice, the fact that the companions need to take care of the users uninterruptedly without the conditions needed for a satisfactory rest and that they are not entitled to the meals the health unit offers are factors that complicate this companion's health and that can generate conflicting relations with the professionals[13]. It is also highlighted that this situation does not comply with the premises in the NHP documents, and therefore go against the logic of this policy.

The inclusion of the user's social and family network in the hospital context makes it possible to maintain bonding and proximity with the social world/ socialization, and also evidences the users' valuation as social beings.

When the ambience offers good conditions for the family to stay at the hospitalization unit, this furthers treatment results, strengthens the bond between the health unit and the community and grants users and their social support network a leading role in health care, in line with the recommendations in the NHP guidelines[1]. Therefore, a care policy for companions and visitors that strengthens their participation in the health services is fundamental[13]. The spatial organization of the care environments needs to comply not only with the architectonic guidelines of service functionality, but should also take into account the people who give life to and justify the existence of those spaces, as evidenced in e.c.u 792.

> *Medical care area, a place where the consultation rooms should be planned to permit the presence of the companion and the patient's individuality. (i.c.u 5)*

In the meantime, welcoming with risk classification is highly relevant and ambience figures once again as an important factor for humanized care in health services through the use of colors based on this classification, facilitating identification, which can be observed in e.c.u 659:

> *Characterization using colors is adopted because this is an efficient tool for the sake of clarity and easy understanding in the organization of the space. Therefore, it is recommended to use colors that identify the respective areas and axes, based on the system adopted by the risk/vulnerability classification (i.c.u 4)*

To promote a good ambience, welcoming emerges as a health promotion instrument for the people who apply and use the service, as it speeds up care, organizes the management of users' needs, prioritizes the maintenance of these subjects' life and wellbeing and facilitates the user's connection with the service network. This permits harmonious relations among the subjects, leading to better work conditions for the professional and better healthcare conditions for the users[15].

Welcoming with risk classification is highlighted as yet another tool to break with a care model that is focused on the production of procedures that devalues subjects and their needs, with a view to prioritizing care for more emerging demands and articulating the reorganization of the physical area at health service units, especially urgency and emergency units, with a view to offering a welcoming environment to the users, companions and visitors, constituting a true care environment[15].

CONCLUSION

This research evidenced that the National Humanization Policy considers the best practices in health in direct user care as well as in health management. As a public policy of the Unified Health System (SUS), it is aligned with proposals for health care integrality, showing efforts towards a complete and holistic approach of human health needs.

Therefore, Humanization, in the light of policies, adopts a comprehensive focus that ranges from the supply of services and care and management technologies to the creation of environments that result in comfort, safety and wellbeing for users and their relatives.

The physical and social environment of health institutions emerges from the official NHP documents as promoters of users and family members' integration

in health care. In addition, the comfort resulting from high-quality care is closely related with aspects of the ambience the services provide.

These research results ratified that the environment is a core concept addressed in the NHP documents and, in that sense, it was evidenced that the constituent elements of this concept in the official documents of the NHP are intrinsically related with the recommendations in nursing discourse in the promotion of the care environment, adjusted to Nightingale's thinking, which serves as the base for the fundamentals of nursing, for its science and art.

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