RESEARCH | PESQUISA

Family centered care in emergency departments: perception of brazilian nurses and doctors

Cuidado centrado na família em unidades emergenciais: percepção de enfermeiros e médicos brasileiros

Cuidado centrado en la familia en unidades de urgencias: percepción de enfermeros y médicos brasileños

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Abstract

Objective: To know the perception of doctors and nurses working in Emergency Care Units (ECU, in Brazil known as "UPA") on Family Centered Care (FCC). **Methods:** Descriptive study with qualitative approach conducted in two emergency units in Southern Brazil. Participated 32 health professionals, whose speeches were recorded, transcribed and subjected to content analysis. **Results:** The majority of respondents was unaware of the FCC, however, perceived it as a practice which values the family presence and allows its insertion in care. Many believed to be difficult to implement the FCC in Brazilian UPA, due to professional unpreparedness on the subject, high numbers and turnover of patients, the small physical space and socio-cultural profile of the population served. **Conclusion:** There is an urge for discussion of this care reference with managers and professionals, so that gradually, and to the extent of its possibilities, care to families in emergency units is expanded.

Keywords: Family; Emergency Medical Services; Health Personnel; Professional-family relations.

Resumo

Objetivo: Conhecer a percepção de médicos e enfermeiros atuantes em Unidades de Pronto Atendimento (UPA) sobre o Cuidado Centrado na Família (CCF). **Métodos:** Estudo descritivo de abordagem qualitativa realizado em duas unidades emergenciais no Sul do Brasil. Participaram 32 profissionais de saúde, cujas falas foram gravadas, transcritas e submetidas à Análise de Conteúdo, modalidade temática. **Resultados:** A maioria dos entrevistados desconhecia o CCF, entretanto, percebia-o como uma prática que valoriza a presença da família e permite sua inserção no cuidado. Muitos acreditavam ser difícil a implementação do CCF nas UPA brasileiras, em decorrência do despreparo profissional sobre o tema, do alto fluxo e da rotatividade dos pacientes, do diminuto espaço físico e do perfil sociocultural da população atendida. **Conclusão:** É premente a discussão deste referencial de cuidado junto a gestores e profissionais, a fim de que, paulatinamente, e na medida de suas possibilidades, se amplie o cuidado às famílias nas unidades emergenciais.

Palavras-chave: Família; Serviços Médicos de Emergência; Pessoal de Saúde; Relações profissional-família.

Resumen

Objetivo: Conocer la percepción de médicos y enfermeros que trabajan en Unidades de Cuidados de Urgencia (UCU) sobre el Cuidado Centrado en la Familia (CCF). **Métodos:** Estudio descriptivo con abordaje cualitativo realizado en dos UCU en Brasil. Participaron 32 profesionales, cuyos discursos fueron grabados y transcritos para posteriormente ser analizados a través de análisis de contenido. **Resultados:** La mayoría de los participantes desconocía el CCF, pero lo percibía como una práctica que valora la presencia de la familia y permite su inserción en el cuidado. Muchos expresaron la dificultad de implementar el CCF en las UCU de Brasil, debido a la falta de preparación profesional, el alto flujo de pacientes, falta de estructura física y el perfil socio-cultural de la población. **Conclusiones:** Se considera necesario que tanto los gerentes como los profesionales conozcan el marco conceptual del CCF para promover la implantación de prácticas centradas en la familia en UCU.

Palabras clave: Familia; Servicios Médicos de Urgencia; Personal de Salud; Relaciones Profesional-Familia.

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INTRODUCTION

The Family Centered Care (FCC) is an innovative approach to the planning, implementation and evaluation of health care, whose mainstay is the partnership that mutually benefits patients, families and health care providers.[1] Its application is intended for patients of all ages and can be practiced in any health care setting, including in emergency units.[2,3] By recognizing the importance of family in the life of the patient, it is allowed for it to assist in the modulation of government policies and health programs, to develop institutional projects, norms and routines; to assess the health care; and how the everyday interaction between professionals, patients and families is directed.[1]

Health professionals who perform in their practice care centered in the family, recognize the vital role of the family core in maintaining the health and well-being of its members. By using this approach, the socio-cultural values, innate strengths and the strengths of families are respected. So, the experience of care is understood as an opportunity to build trust relationships between professional-family, and to support it in care and decision-making, even in adverse situations in which the patient is severely sick.[4]

In Brazil, for the care of acute and/or serious clinical cases, the access to the Unified Health System (UHS) is the Emergency Care Units (ECU, in Brazil known as "UPA"). Such units do not have as a reference for the assistance the FCC, even though studies have pointed out that this approach converges for greater patient safety[5] and decrease of the permanence period in the health unit and the risk of complications during their stay.[6] For the family, with these actions, it is enhanced the offer and receiving of information in a timely manner[7] and the reducing of chances of developing post-traumatic stress disorder in those who follow invasive procedures and cardiopulmonary resuscitation maneuvers.[8]

Most of the scientific evidence and the reports of the implementation of the FCC is related to child health[4-9] and hospitalization scheme,[6] especially as a result of the planning and implementation of the FCC have being started in pediatric units. The recent consideration of the FCC for the adult and elderly population, particularly in critical situations and emergency, began with the increasing spread of the understanding that the family is the basic social interaction unit and, therefore, is the primary educator and support, regardless of the age of the patient and the local of provision of assistance,[5] making inconceivable the non-recognition of the familiar context in the treatment instituted.

Studies conducted in different countries - France,[8] Canada,[10] Ireland[11] and the United States[12] - showed that professionals working in emergency units, although they recognized the existence of many challenges for the implementation of the FCC, perceived it as a driver of qualification of care of grave patients and humanized the assistance.[8,10-12] In the Brazilian context, FCC is still incipient, has not been implemented in the health services nor discussed in vocational training. This brings up the following question: What is the perception that Brazilian doctors and nurses working in emergency units have about the FCC?

In this perspective, it is believed that identifying the perception and the level of understanding of Brazilian doctors and nurses on the FCC enables the development of institutional policies that establish criteria, guidelines and standards for inclusion of the family during the emergency care in this country, which would facilitate its applicability to offer greater security to professional practice. Given the above, the objective of this study was to understand the perception of doctors and nurses working in Emergency Care Units ("UPA") on Family Centered Care (FCC).

METHODS

Descriptive research with qualitative approach. The two emergency units, headquarters for this study, located in southern Brazil, work uninterruptedly. Each unit has 24 nurses and 16 doctors to daily attend an average of 400 patients. All professionals were potential participants in research.

The criteria for inclusion was: to be a doctor or nurse who work in the "UPA"; and the exclusion criteria: those who were on maternity leave (one nurse), vacation (two nurses and two doctors) or being on sick leave in the period of data collection (a doctor and a nurse). It is noteworthy that four professional addressed (one nurse and three doctors) refused to participate in the study.

Data collection occurred in January 2015. The open interviews, conducted with 11 doctors and 21 nurses, including professionals from different shifts, were audio-recorded. The place used for the interview was the own institution, held in a private room in order to allow participants to express themselves freely. The data were collected through support questions related to the topic of the interview, which were especially useful when respondents, by different reasons, rambled and distanced the following guiding questions of the study: *Do you know the Family Centered Care?* In the affirmative case, questioned: *What do you think about that?* And for negative answers: *What you think that the Family Centered Care is?* As support questions were used, for example: *Do you believe to be possible to carry out Family Centered Care in Emergency Care Units? Do you realize, in your healthcare practice, care focused on the family of patients?*

The interviews were conducted during the work shift of the participants, had an average duration of 35 minutes, ranging from 17 to 45 minutes and took place until new information were not reported, having achieved the objective.

The data were submitted to content analysis, thematic modality,[13] following pre-established steps by the reference that included the pre-analysis, material exploration and processing of data. In the pre-analysis was made the organization, transcription and separation of the data set. Then, there was the initial reading of the empirical material with initial identification of relevant aspects from the purpose of the study. On the exploration of the

material, was done the classification and aggregating of data from a thorough process of reading, with identification, through colors, common and more specific terms, giving rise to the previous categories. Finally, the processing of the data, deepened the categories by the articulation of the empirical findings with the theoretical material, constantly, the purpose of the investigation and the emerging themes of the analytical process.

This thorough and exhaustive data analysis process generated two thematic categories: (Un)knowledge of health professionals about the FCC; and Possibilities and limitations for the implementation of the FCC in the UPA.

To print methodological rigor in this study, interviews were audio-recorded and performed by two experienced researchers in qualitative data collection, providing non-biased polarization of the information obtained.[14] Then, the analysis and interpretation of data were also conducted by two researchers independently, which were based on the exercise of reflexivity, where prior assumptions have been recognized and left in suspension.[15] This was necessary mainly because researchers have already worked in emergency units. During the analysis, when there were inconsistencies, the team of researchers gathered and discussed the analytical and interpretive process data, reaching a consensus. Finally, reliability and confirmability were assured by maintaining an audit trail, ensuring that all relevant and supporting documentation (field, reflective and analytical notes) were available for future reference.[15]

The study was developed in consonance with the guidelines regulated by the National Health Council Resolution 466/12. The project was assessed and approved by the Permanent Training Centre in Health ("CECAPS") of the Municipal Department of Health and approved by the institutional Permanent Ethics Committee in Research with Human Beings ("COPEP"), under CAAE: 37231414.4.0000.0104, and Opinion No. 879783.

RESULTS

Participated in this study 11 doctors and 21 nurses, with age ranging from 25 to 57 years (average of 34.4 years). The majority were female (21), white (22), postgraduate (24) and worked for more than a year in the emergency unit (23), with professional experience ranging from six months to 15 years (average of 38.5 months of working).

(Un)knowledge of health professionals about the FCC

In this category it can be observed that most professionals do not know the FCC. Those who reported knowing that name demonstrated a very superficial understanding of the subject. Thus, the speeches, mostly, limited to associate the FCC with the humanization of assistance:

> *No, I've never heard of this FCC, but I think it may be a form of humanization in this moment of emergency assistance (Nurse 01).*

> *I don't know this FCC, but it must be something about giving attention and valuing the patient's family to provide a more humanized assistance (Doctor 06).*

Other professionals, however, believed that the FCC is one way to think about and include the family in direct technical care of the patient.

> *To tell the truth, I've never heard about the FCC, but I think it is something to think about and insert the family member to be part of the patient's care (Nurse 09).*

> *Must be the family participating in the care, techniques, these things [speaks with contempt] (Doctor 05).*

Other interviewees, even not knowing this philosophy of care, revealed a more expanded perception of the subject, highlighting the information shared with the family, psychological support, and mentioning the family's presence in moments of emergency procedures, such as elements or ways of FCC:

> *About FCC, I have heard, but only in college. It is a very distant thing from us, of our reality. I don't remember much, I can say that one must consider the opinions of family members. The conducts that you have to take, have to be informed to the family, things like that. Even the presence of the family in the proceedings, from a simple venipuncture [peripheral] until the resuscitation maneuvers (Doctor 01).*

> *I understand that in the FCC, we, as health professionals, offer emotional support, try to understand the context in which the family lives, those things (Nurse 06).*

There were respondents who believed that this was an approach that considers the constancy of the family in the life of its members and that, therefore, it is necessary to receive it and support it in different levels of care, including assistance in the final moments of the life of a loved one, because for the different beliefs that can be valuable.

> *I don't know the FCC. I think it's something that involves the provision of support in the final moments of the loved one, some family members would like to know how were the final minutes of the patient because it is important for his religious belief (Doctor 11).*

> *I think it would be you looking at the patient as a whole, in the sense that he has a family and this family needs to participate in the service, because it is part of the patient's life and the more the family is present, the better the service. Not only in a serious condition at the time of an emergency, but also before, the basic unit of health care, because when the family is participatory and informed, it becomes easier for the professional work with her (Nurse 10).*

The perception and understanding of the professional, although limited philosophical and practical aspects regarding the FCC, makes room for possibilities of implementation of this approach in various health institutions and types of care, and the health professionals point out the possibilities, although there are also contrary positions.

Possibilities and limitations for the implementation of the FCC in the UPA

Even without in-depth knowledge about the FCC, some professionals have revealed that this care philosophy could be used in the Brazilian "UPA", preferably starting by less complex cares and, gradually, evolving into the attendances of more severe cases.

> *I think this FCC can complement the "UPA" assistance. You start with a lower degree of complexity in procedures and gradually inserting the family more and more. Of course it's possible (Nurse 01).*
>
> *It is always possible to improve customer service, even in emergency units. If we know that the presence of the family members collaborate in the treatment, why not try to establish it in "UPA"? (Nurse 10).*

It is important to note that some nurses reported that the FCC, if deployed as a philosophy of care in the "UPA", would face resistance from doctors.

> *I think it's actually a lack of habit, you invite the family to participate in the proceedings. And another thing is that here, the medical team is resistant. Nursing would be easier to convince to have that kind of attitude; now, the medical staff is hard! Doctors tell us to "take the audience away" (Nurse 17).*
>
> *Theoretically it may even be that the FCC can be instituted in the "UPA", but it would be hard to implement in reality, because health professionals will present much resistance. Doctors would say you have to think first of the patient, and the family often can hinder, rather than assist (Nurse 02).*

In fact, most of the professionals who revealed the impossibility of implementation of the FCC in the "UPA" was composed of doctors. Among the reasons cited were: low socio-cultural level of population assisted; little understanding of the family members about the routines of the unit, the need to focus attention only on the patient, high demand of patients in the service and lack of time to be with family, becoming clear that for some professionals the FCC is open to application only on primary health care in cases of patients with chronic diseases.

> *This FCC works better abroad. In Brazil, and especially in the "UPA", is very complicated, because the social, economic and cultural level of our patients is very low (Nurse 11).*
>
> *There is no time to be giving explanations. The focus is on the patient, in saving that life. Thinking on family should be more restricted in the area of public health, the family doctor, where he has time to care with more tranquility, make domiciliary visit, look all around and consider the family in the treatment of individuals with chronic disease (Doctor 03).*
>
> *Here at "UPA" there is no way to implement FCC, here it's all very fast, there's a lot of people, the flow of patients is very intense, crowded. [...] Family should be waiting outside (Doctor 05).*

Even believing that the FCC could not be deployed in Brazilian "UPA", or at least it's something far from our reality, some respondents expressed concern about improvements that could be employed to facilitate the presence of the family in emergency care, for example, increase of the visiting hours to the patient in the emergency room.

> *The visit to the emergency room is only once a day, for a period of 30 minutes and I believe the family could come more often! So, I think this routine to allow entry only once a day is little. It is flawed (Nurse 08).*

Have also been reported strategies that need to be discussed and implemented for improving the physical structure in order to receive the family. And, yet, the qualification of professionals to act and intervene with the family in order to meet their main demands, because the current structural, organizational and training conditions do not allow for the FCC to be done properly.

> *We would have to promote a meeting between professionals and the direction of the unit, and discuss this type of care, including the question of space, because the patients should not stay for a long time in the "UPA". Therefore, we have no infrastructure to receive the family. Also a better preparation of health professionals for this new way to bring the family, to interact with it. Because this, at least for me, is very new, I believe we would need a retraining, to learn to deal with the family in a different way than is done today (Nurse 10).*
>
> *I think it's something that will happen at some point, even for reasons of evolution of care. Increasingly family participating more of the attendance of its members. But I think we will need more professional training (Nurse 13).*

In summary, although some respondents believed to be difficult to implement the FCC in the "UPA", there were many reports that pointed aspects to be improved. Respondents recognized the emerging need to adapt the physical space, the health team and the service organization to better welcome and integrate families to care in emergency units.

DISCUSSION

Front of the detection of unfamiliarity about FCC on the part of the professionals interviewed, it should be noted that, in fact, this is a recent health care philosophy, drawn up in the reality of a developed country, with innovative character, and still insufficiently addressed and discussed in the training of doctors and nurses in Brazil. Moreover, it is relevant to point out that the scenario of Brazilian research, especially in relation to the adult population met in emergency units, this subject is still emerging. It is believed that these are the main reasons for the respondents'' perceptions being deductive and superficial.

In other international contexts, the FCC in emergency units, for over fifteen years, has been discussed, implemented and evaluated systematically, as is the case of the United States of America.[2,3] In that reality, the evidences suggest that the units are integrated to the principles of the FCC, although the level of professional knowledge can vary according to the specific competencies of each service or even with the presence of continuing education programs.[2] Also, point out the relevance of the evaluation of services that practice FCC to maintain this care philosophy in the units. The aim is to identify the strengths and weaknesses, allowing improvements in assistance from the suggestions made by patients and their families.[3]

In this sense, it should be emphasized, based on the speeches of the professionals interviewed, or even in the literature on the subject,[16] that the initial training of health professionals contributes in a small way for them to know the FCC and even less to develop care guided by this philosophy. In addition, barriers imposed by the own professional work routine end up wearing one that could be a health care quality, based on comprehensiveness and active participation of the family.

Despite the lack of knowledge by the professionals, it is emphasized that to indicate humanized care as a synonym, or even a result of the FCC, is establish an important relationship and that may be the awakening for an initial understanding of what constitutes the FCC and how this philosophy can be contributory to health care, including the practice in emergency.[17] This contribution would occur fundamentally to disclose the possibility of creating a working environment more conducive to the appreciation of everyone involved in the care process, including family.

According to the perception of respondents, even if deductively, ways of developing the FCC in the emergency context - for example, emotional support, appreciation of religious precepts related to the moment of death and the attitude of availability regarding sharing information -, in fact constitute integrating principles of FCC[1] and, therefore, should be valued. Thus, while the professionals report the lack of knowledge about the FCC, some were able to point out the central elements of care philosophy. This indicates that in a greater or lesser degree, professionals are aware of the minimum requirements that must be met when the there is presence of the family in health service.

Moreover, considering that the FCC should be guided by principles, including respect for individuality, diversity and family development needs,[1] it is noted that the family invitation to be present for a service does not induce any requirement in order to testify or act in that care. There are many factors that predispose or not a family to feel prepared and comfortable to live such an experience. It is up to the health professional to identify such circumstances and respect them.[18]

It was observed in the present study, that the nurses declared themselves more welcoming to the practice of the FCC. The most favorable direction of the nursing team compared to the medical staff in relation of FCC in the emergency units, was also demonstrated in research carried out in Israel.[19] This attitude can be attributed to the fact that the nurse is the professional who usually remains for more time with the patient's family and is willing to be closer during the provision of the service. So, recognizes more easily the advantages to include the family in patient care, even in critical situations.[20]

In this sense, it was still possible to notice that some nurses interviewed, although to consider the FCC difficult to be implemented in the current situation of infrastructure and professional training in the Brazilian "UPA", are anxious to improve the care to the families. They suggested, in addition to physical restructuring and professional qualification, increase of the number of family visits to the emergency room because, in their perceptions, one visit a day was insufficient to meet the needs of families and patients, which has been appointed by families in other research.[21] This finding draws attention because the evidences show that nurses, even considering beneficial the family visits to critically ill patients, believe that flexible schedules hinder the development of its procedures and would entail greater workload for professionals.[22]

Certainly, is necessary a systematized work along the entire health care team so that the family is properly valued and incorporated into the emergency care process. A study conducted in the United States showed that, in general, the professionals working in emergency rooms felt that family members should be allowed to stay at the bedside during the service, but there are challenges, including the need for education and theoretical preparation of all health staff to facilitate practical attitudinal changes that promote family stay during the service.[12]

In addition to the theoretical preparation, as scored by professionals in this research, it is necessary to adjust the physical structure and work routine in emergency services to enable a suitable hosting of families. These seem to be indispensable elements for the paradigm shift and to overcome the barriers

that hinder the implementation of the FCC, for example, the resistance of the practitioners who believe to be restricted to primary health care services this philosophy of care.[23]

It is possible to check findings in literature that point convincingly the benefits of FCC in emergency assistance. For example, studies conducted in France showed that family members, when accompanying the cardiopulmonary resuscitation maneuvers had positive psychological outcomes and little negative interference in professional activities,[8] as well as lower frequency of complicated grief processes over a year.[24] So, it is important to discuss these issues with health professionals and managers to translate the available knowledge to clinical practice[25] and seek restructuring of services to facilitate the implementation of this type of care in the "UPA" in Brazil, in order to allow a development jump of assistance and test their viability for Brazilian culture.

Limitations

This study has limitations. The first refers to the fact that the interviews were conducted in the workplace and during the workdays of the participants, who were concerned to return to theirs activities. Second, the opinions of professionals who participated in the study may differ from those who refused to participate, enabling the introduction of information bias. The third limitation is related to the greater number of nurses compared to doctors. This may characterize more consistent with the perceptions of nurses findings, although during the analysis it has considered this aspect. However, the fact that in health services, the number of nurses is greater than doctors meant this limitation was not overcome. Finally, it is reiterated that the findings presented here are consistent with the perception of health professionals from the two "UPAs" of a municipally of the South of Brazil and that, as expected results of qualitative studies, even pointing to a certain direction, cannot be generalized to other contexts. Thus, it is suggested caution in the application and comparison of these results.

CONCLUSION

The results of this study have identified that, for Brazilian doctors and nurses, active in "UPA", FCC is still little known formally, which led to deductive and superficial perceptions of the subject. In general, respondents believed that the FCC was related to involving the presence of the family in the space of patient care, allowing greater humanization of assistance. Furthermore, it was possible to verify that professionals consider it difficult to implement the FCC in the "UPA", when reporting that the current physical space, professional unpreparedness on the subject, the high flow and turnover of patients and the socio-cultural profile of the population served constituted factors that hindered its application. However, some reports denoted the importance of maintaining contact between patient and family in these contexts, with suggestions for the expansion of visit opportunities and times.

These findings emphasize that the FCC is still little discussed, taught, researched and disseminated among Brazilian doctors and nurses. This has direct implications for the undergraduate and graduate courses, in the sense of making possible for professional training to contain the valuing of family in different areas of care for human beings. In addition, it is evident the considerable gap in knowledge about the FCC in emergency assistance to adults. This situation raises the need for pilot studies which include families in the emergency services from the FCC perspective and investigate the impact for patients, families and health professionals. It contributes, thus, with this study, for the possibility of discussing the implementation of this type of assistance in emergency care services located in different regions of the country, taking into account the local and regional characteristics of each service.

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