Evaluation of the welcoming strategies in the Intensive Care Unit*

AVALIAÇÃO DAS ESTRATÉGIAS DE ACOLHIMENTO NA UNIDADE DE TERAPIA INTENSIVA

EVALUACIÓN DE LAS ESTRATEGIAS DE RECEPCIÓN EN LA UNIDAD DE TERAPIA INTENSIVA

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ABSTRACT

This qualitative study was performed at the adult Intensive Care Unit (ICU) of a public hospital in Southern Brazil with the objective to evaluate the implemented welcoming strategies. Participants included 13 patients and 23 relatives. Data collection was performed from July to October 2008, utilizing semi-structured interviews. All interviews were recorded. Data analysis was performed using the Collective Subject Discourse. The collected information yielded two discourses: the family recognized the welcoming strategies and the patients found the ICU team to be considerate. By including the family as a client of nursing care, relatives felt safe and confident. Results show that by committing to the responsibility of making changes in heath care practices, nurses experience a novel outlook towards ICU care, focused on human beings and associating the welcoming to the health care model that promotes the objectivity of care.

DESCRIPTORS
Intensive Care Units
User embracement
Strategies
Nursing care
Professional-family relations

RESUMO

Trata-se de uma pesquisa qualitativa, realizada na Unidade de Terapia Intensiva (UTI) adulto de um hospital público no Sul do Brasil, que teve como objetivo avaliar as estratégias de acolhimento implementadas. Participaram 13 pacientes e 23 familiares. A coleta foi realizada de julho a outubro de 2008, com entrevistas semiestruturadas e gravadas. Para análise dos dados, utilizou-se o Discurso do Sujeito Coletivo. As informações deram origem a dois discursos: a família percebe o acolhimento e o paciente considera a equipe da UTI atenciosa. Ao incluir a família no cuidado como cliente da enfermagem, os familiares sentiram-se seguros e confiantes. Ao avaliar os resultados alcançados, destaca-se que, ao assumirem o compromisso e a responsabilidade de transformações da prática assistencial, os enfermeiros experienciaram um novo olhar para o cuidado em UTI, com enfoque no ser humano, aliando o acolhimento ao modelo assistencial que privilegia a objetividade do cuidado.

DESCRITORES
Unidades de Terapia Intensiva
Acolhimento
Estratégias
Cuidados de enfermagem
Relações profissional-família

RESUMEN

Investigación cualitativa realizada en Unidad de Terapia Intensiva (UTI) de adultos de hospital público del Sur de Brasil, que objetivó evaluar las estrategias de recepción implementadas. Participaron 13 pacientes y 23 familiares. La recolección de datos se realizó entre julio y octubre de 2008, con entrevistas semiestructuradas y grabadas. Para análisis de datos, se usó Discurso del Sujeto Colectivo. Las informaciones originaron dos discursos: la familia percibe la recepción y el paciente considera al equipo de UTI atento. Al incluir a la familia en el cuidado como pacientes de enfermería, los familiares se sintieron seguros y confiados. Al evaluar los resultados alcanzados, se destaca que al asumir el compromiso y responsabilidad de transformaciones de la práctica de atención, los enfermeros experimentaron nueva visión para el cuidado en UTI, con enfoque en el ser humano, aliando la recepción al modelo de atención que privilegia la objetividad del cuidado.

DESCRIPTORES
Unidades de Terapia Intensiva
Acogimiento
Estrategias
Atención de enfermería
Relaciones profesional-familia

INTRODUCTION

Welcoming means receiving and accepting the other as a subject with rights and desires and as a co-responsible for health production, from an individual as well as from a group perspective[1].

When we are open to involvement with the patient and family, various difficulties are overcome, make it easier to dose emotional needs and the use of hard technologies in a balanced way. Over time, it is perceived that welcoming experiences are intensely gratifying, mainly when the family manifests trust in the nurse and other health team members. Through the trust relation and welcoming, the professional turns into a reference point for support to these users.

Through the contact at an Intensive Care Unit (ICU), in severe situations of imminent death, sometimes, the researchers, who are experienced in this area, turned into reference professionals, whom the family trusts and to whom patient information requests are directed. It is perceived that, to the extent that involvement happens, we understand these intimate and noble relations bursting with gratitude. On the one hand, there is the relative grateful for the care received and, on the other, the professional who is satisfied with the accomplishment, not only because of institutional routines, but mainly because of the professional satisfaction welcoming entails.

When defining the competences nurses should develop, reflection is due about the instrumental, cognitive, affective, social and cultural skills in the care process for patients and relatives at health services and in the home context. Nurses should develop skills and attitudes to construct a therapeutic nurse-patient and nurse-family relation.

ICU care practice shows us that users' welcoming needs are unquestionable, in view of their fragilities. As nurses manage nursing care, other nursing team workers see them as models and references for technical care. It is concerning that, in most cases, these professionals address welcoming in a subtle way. In this sense, the premise is adopted that, if they have the opportunity to deepen their knowledge about welcoming at the ICU, their care practice will rest on respect and the subjectivity of the users involved, and they will feel that the care offered is comprehensive and effective.

In view of this context, the following guiding question was proposed for this research: How do relatives and patients identify the welcoming strategies in an intensive care environment?

To answer this question and in the attempt to minimize the existing gap in this area, the research aim was outlined as follows: to assess the welcoming strategies put in practice at the ICU according to family members and patients.

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METHOD

A qualitative, exploratory and descriptive research was developed, involving family members and patients hospitalized at the general adult ICU of a large public referral hospital in the South of Brazil.

The ICU offers ten beds, two of which are reserved for isolation, with a glass panel to facilitate visualization. The remaining beds are separated from one another with blackout curtains. At this unit, a waiting room with chairs and a bathroom are available for visitors.

The nursing team consists of six nurses and 26 nursing technicians. Since 2007, each technician has delivered comprehensive nursing care to two patients and, six months before the research, the ICU nurses, together with their team, put in practice welcoming strategies for patients and relatives at the unit.

Visits are distributed between two times, one in the morning, from 12h30 till 13h, and another in the afternoon, from 17h30 till 18h. At each time, only two relatives per patients can enter together. Family members constantly ask permission for more visitors to ender. Some nurses, mainly at weekends, consider this request feasible and permit the entry.

At the preset time for the visit, the hospital reception employee forwards the relatives to wait at the ICU waiting room. In the morning, the clerk and, in the afternoon, the nursing technician responsible for beds 1 and 2 receive the visitors. The family members receive information from the nurse and physician about the patient's health situation after the visit.

In this research, the actors were 13 patients who remained lucid for at least 48 hours during the data collection period and 23 relatives over 18 years of age who visited them at the ICU. How many patients and relatives would participate in the study was not determined in advance, as qualitative research uses expressive information sampling instead of the number of participants[2].

The relatives and patients were invited to participate in the study at the hospitalization unit, after discharge from the ICU. Some family members were invited at the unit waiting room, when their relative had been hospitalized for more than two weeks.

Data collection involved family members and patients separately, through a semistructured interview. The interview script addressed the perception and assessment of

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the welcoming strategies the ICU nurses adopted. The interviews were held between July and October 2008. The mean duration was 30 minutes. The interviews were tape-recorded and then transcribed. To preserve the study subjects' anonymity, identification codes were used, according to the order in which the interviews were held, for example: Family member 1 (F1) and Patient 1 (P1).

Information secrecy and anonymity were guaranteed to all actors. After the initial contact, they received the Informed Consent Term in compliance with National Health Council Resolution No 196/96 on research involving human beings. These procedures only took place after Institutional Review Board approval at *Universidade Federal de Santa Catarina*, under protocol No 342/07.

Three methodological figures from the Collective Subject Discourse (CSD) were used for data treatment: Key Expressions (KE); Central Ideas (CI) and the Collective Subject Discourse (CSD)[3].

KE are pieces, excerpts or continuous or discontinuous transcriptions of speech that reveal the essential contents of a given discourse fragment. They should be highlighted by the researcher and reveal the essence of the testimony or, to be more exact, of the discourse contents of the segments the testimony is divided in. CI are linguistic expressions that reveal and describe the meaning, or the meaning and theme, of each homogenous set of KE as synthetically and precisely as possible, and which will give origin to the CSD.

To construct the CSD, a classical start-middle-end scheme is followed, moving from the most general to the most particular. The discourse parts or paragraphs are linked through connectors that grant cohesion to the discourse, eliminating individualizing data like gender, age, particular events, specific illnesses and repeated ideas[3].

Thus, the CSD is an aggregate or non-mathematical sum of isolated pieces of testimonies, so as to constitute a coherent discursive whole, in which each of the parts recognizes itself as a constituent of this whole; it is a summary discourse written in the first person singular and sticks together the KE with the same CI[3].

RESULTS

The welcoming strategies the ICU nurses had put in practice six months earlier were used through the perceptions of 13 patients and 23 family members who spent time in this environment after the implementation. These include: welcoming, receptiveness, nurse-patient-family relation, distribution of ICU information material in print; telephone contact if the patient is discharged and worsens; standardized conduct in case of death and establishment of a dialogic relation during visiting hours.

Central Idea (CI): The family perceives the welcoming

Key expressions (KE):

They are always taking care with the right medication time, controls and are always around and tell how he's doing and that we can call if we need to, telephone at established times, and call him by the name and not by the number like in other places (F1).

When we got in for the visit, that old lady started to feel bad, we hadn't even noticed and you already started to deliver care. That nurse asked us to leave, said why, and we understood. You know how to talk, you're always around, you don't flee and are polite, and offer more time during the next visit (F6).

As laypersons, we have to respect and know that there are internal standards. But what's important is that you always explain everything, but know that we forget a lot, because we're nervous, but everything is written and drawn out on that folder, which we receive before the visit and which helps a lot, it even contains the telephone numbers. And, when we need to and cannot arrive at the right time, you understand and let us get in beyond normal times (F7).

I don't want mom to get out of here while she's not really well, we are not in a hurry. We know that she is very well taken care of here, you are attentive to everything, you noticed it soon when she started to feel bad. That comforts us, makes us feel calmer, and that day she got worse, you called at home and let us get in, I'll never forget that (F8).

Everyone is very kind to us and our relative, you understand what we are going through, despite the rush, you stop to explain when we ask, a lot of devices are connected, and you can explain in such a way that we manage to understand, and that helps to accept this entire situation in a calmer way (F12).

My daughter is very well taken care of here, you are there the whole time, the physician too, that calms me down and, when I ask something, I get an answer. When she got worse, you even called for us to come and visit (F20).

On the first day we got here, when I talked to the nurse, I already felt how dedicated you are. I had a lot of faith, although she said that my husband's condition was severe. I know that they'd do everything for him to get well. When we call you explain how he's doing, but the most important call I received was when you called and said he was being discharged from the ICU, that he was being moved to room X and that visiting times were different from the ICU there, it was great (F22).

Collective Subject Discourse (CSD) 1:

On the first day, when I talked to the nurse, I already felt the extent of your dedication. I had a lot of faith, even though she was saying that the case was severe. I knew that he was well taken care of and that they would do everything for his recovery. As laypersons, we have to re-

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spect and know that there are internal standards. But sometimes you let relatives get in beyond visiting hours. What's important is that everyone is very considerate and that you always explain everything, we are not left without an answer and you know how to talk. The folder you give us before the visit helps a lot. You understand what we are going through. You are always around and say that we can call and telephone if necessary. You even called when she got worse for us to come and visit, and also when the discharge from the ICU came, it's great.

Central Idea (CI): The patient considers the ICU team thoughtful

Key Expressions (KE):

> I cannot complain, people are very thoughtful, they call me by my name, they explain everything they're gonna do in a simple way for me to understand (P1).

> You're very sweet there, very kind, attentive despite so much to do and all of those beeps, you still had time to call my wife to bring my slippers when I was discharged (P3).

> At the ICU, there are some very good-humored and enjoyable kids, whenever they can they come and play with use and that helps a lot, we don't feel so alone in that bed. I didn't even want to get out of there, but you're serious and competent during work, although you can't see much, because you close the curtain, when things get tough, you're very fast and have good equipment (P4).

> All of the girls are very kind, attention was very good, better would be to much, I remember almost everyone's name, because they always mentioned their name, said hello, and when I couldn't sleep and was afraid of dying, that chat was my best medicine (P6).

> Today I was saying to my son: at the ICU care is much better! Doing what they do here, it's not easy, there's no time for the rush, medicines and devices are up-to-date, I've learned a lot here, because they explain everything, what everything serves for, and now that I'm on the room I do everything by myself, I can go home already, and there's my wife there and the grandchildren to help (P9).

> The staff is always smiling, and cheering us up, because it's not easy to go through what I've been, I even thought I was going to die, but there's no such thing at the ICU, they don't give up on us, I neither felt alone nor just one more, I felt like a person, and I also cried when I saw that woman being taken out on a stretcher covered with a cloth (P12).

> The whole time there's somebody near helping and asking if it's good, they inform about everything, even the time, and treated my family very well too, I've been to another ICU already and there was no such things, I was simply number 3 (P13).

Collective Subject Discourse (CSD) 2:

> Care at the ICU is very good! There's always someone near the bed, I don't feel alone. People are thoughtful, well-humored, loved, and inform us about everything, what those devices tell about us, they don't forget anything, they even remembered about my slippers upon discharge. They're very sweet, I remember almost all of their names, because they used to present themselves. They are always smiling and cheering patients up, but there's no time for the rush, there is no lost case, the drugs and devices are the most modern. They cheer us up, because it's not easy, I thought I was going to die and I also cried when I saw that stretcher leave covered with a cloth. ICU care is better than on the room here, we're not just a number and our relatives are also very well treated.

DISCUSSION

Existing welcoming strategies at the ICU were assessed through the perceptions of 13 patients and 23 relatives, who spent time in this environment and had direct contact with the entire unit team.

CSD 1 reflects the perception that almost all welcoming strategies adopted at the ICU were identified, as the analysis of this first collective discourse clearly reveals the family members' satisfaction with the care patients received while in the ICU, as well as the strategies oriented towards themselves.

Unfortunately, this satisfaction identified here does not appear in other studies, which report that, in view of the ICU hospitalization, the family members feel abandoned, and what is perceived is little willingness or welcoming towards the family. Concern focuses on receiving and taking care of the patient, while little importance is attributed to the awaiting relative. These attitudes indicate the extent to which family care is left aside[4].

The nurse also practices welcoming when she identifies herself to the family members and patients upon ICU admission. This act is acknowledged as additional dedication and, even if the contents of her statement contains the information that the health condition of their loved one is severe, family members still value this moment and this technicist environment as safe.

This dialectics reflects that welcoming for severe patients cannot be dissociated from existing care technologies at the ICU and the fact that state-of-the-art care, dialogue, information and attention to family members can coexist in this critical environment, as they will neither cease to exist at any time, not to be important for the patient's recovery.

During hospitalization, the family experiences a period of uncertainties and perceives welcoming as essential and extremely important, enhancing a bond of trust, and is confident that their relative is in good hands. When family members receive information about the patient's health condition adequately, they show their relief and security about the care received. At this moment, the family exposes its doubts and concerns, creating a bond of trust between team and family[5].

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Thus, the common sense that spans companions' social imaginary raises an interesting question about the complexity the ICU hospitalization process represents to them. The feeling of grief about the possibility of death mixes with the negative view the number of devices that keep patients alive at the unit creates. This situation is a reality health professionals at the sector observe day by day, which should be reconsidered and then addressed in these spaces[6].

It is also highlighted that, no matter how much the nurses study and work to put in practice welcoming strategies at the ICU under analysis, the patient and relative's life story also need to be valued and heard, so that other improvements can be added, even if this involves the welcoming of faith, which he expresses and acknowledges in his imaginary, which is real, which is possible and which is the only thing he, layperson, can offer towards all of those sophisticated devices and all specialized professionals he met at this unit.

The family members often conceive than, when they enter the ICU, no more hope of life exists for their loved on, so their last hope is faith. Nevertheless, fear of the patient's condition and the scene they will witness when they enter makes the family members feel lost because they do not know the rituals at the sector and afflicted to talk to a team member to get further information about the patient. Therefore, the idea of seeing family members not only as relentless inspectors who are bothering the whole time, but also as important for the patient's recovery and who also need care according to their needs[7].

Thus, the family members positively assessed the adopted welcoming strategy of distributing and presenting an explanatory folder about the ICU at the waiting room (including short information, in simple language, large fond, using colored pictures, mentioning ICU and the social worker's telephone numbers to consult the daily information bulletins about their relative's health status, the times and conducts for visitors), granting them more security at this time of separation, uncertainties, expectations, when their emotional condition can display important changes.

The family acknowledges that a relative's hospitalization is a difficult time and that, often, they feel helpless, with little information about the patient's health condition, and also frightened about the situation, in which fear and anguish are confronted with the unknown. When facing the hospitalization situation, the family needs a team member to provide information or simply listen. When assuming this commitment, the nurses can decrease the anguish family members feel[8-9].

The possible flexibility in the visiting hours and number of visitors at the ICU also emerges as a good welcoming strategy, because the relatives feel supported, helped, understood and comforted. Hence, at least part of their affected needs are attended through this strategy. At this moment of great anguish and anxiety, these additional minutes besides their loved on represent respect for affective bonds.

Welcoming family members is considered a nursing responsibility, because these strategies significantly contributed to the success of care quality improvements at this ICU, as they solve the main needs relatives going through the hospitalization of a loved one at a critical care unit generally appoint.

CSD 2 pictures patients' satisfaction with the care received at the ICU, related with the care the team delivers and with the loving and good-humored way in which the team relates with and welcomes their family members.

The patients perceived the ICU as a place to receive patients in severe conditions and at imminent risk of death. They describe that being an ICU patient represents being very ill but that, through care inside the unit, they have the opportunity to recover and leave better than when they arrived. Although they indicate some unpleasant aspects, they patients mention a feeling of wellbeing, satisfaction, security and confidence, regarding treatment as well as the team's fast action.

Patients' assessment in this study is similar to another assessment, in which the patients perceive that, during ICU hospitalization, although this is marked as a difficult experience, trained professionals are available, who deliver care all the time, granting them security and protection, and also transmitting confidence because they provide attention, kindness and affection, offering them with pleasant moments of joy[9].

Despite valuing this whole aspect of welcoming received from the nursing team, patients also felt the need to refer to existing ICU technologies as an essential part of their care and recovery, emphasizing the use of state-of-the-art equipment and medication.

In view of this result and the consequent literature review, a description was found that opposes this equipment valuation, in which small *details* are more important than high technology according to the patients. The needs they felt were mainly related to knowledge about what was happening to them, the certainty of received adequate care from qualified professionals, the continuing silence in the critical environment and valuation of the family's presence at the ICU[10].

It is observed, however, that according to the CSD 2, the patients positively add the valuation of the welcoming they received from the thoughtful and competent team, without excluding the need to use existing technologies experienced in this ICU environment. Thus, based on this assessment, in which the results were considered as very successful complementary needs, the recommendation is for other nurses to experience this strategy.

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The patients' expressions about the suffering experienced in the ICU context and the fear of death should be highlighted. The identification of these negative feelings is also met frequently as a result of other studies[6,11]. Therefore, it is noteworthy that this theme, although difficult to address and put in practice, needs to be present in the planning of welcoming for these individuals and family members, using strategies that progressively inform about the aggravation of the patient's health condition, combined with awareness about the importance of teamwork, as well as the use of any available technology for adequate care delivery to critical patients.

In general, the nursing team also sees death at the ICU as a professional loss and, sometimes, through this new experience, almost as personal, justified as a result of greater affective approximation, as a result of welcoming techniques for nursing in this environment. Hence, this is still a new situation, which needs to be addressed and planned better, so that it does not result in yet another factor that can arouse stress for professionals in a critical environment where, consequently, this burden could be attributed to the new welcoming strategies nursing has implanted.

Although stress is a theme that has been discussed for long, its presence is still verified among ICU nurses, due to their great proximity with suffering patients at risk of death. The need for direct and intensive care aggravates this fact, as well as the fact that institutions still do not offer special care to these professionals to enhance their health in a comprehensive way, through new investments in search of healthy environments, better work conditions and emotional support groups[12].

Despite considering that various factors exist which can interfere in patients' perception when assessing existing welcoming strategies at this ICU, it can be affirmed that historically disease-centered care improved, towards a reorganization of care practice based on humanized care promotion, justified here by the actions the nursing team accomplished to attend to the patients' needs, calling them by their names instead of a number, giving them a bedside chat as the best remedy against the fear of death, offering a pair of slippers at the moment of discharge despite so many things to do and, finally, telling him with a smile that not everything is lost and that they are not alone.

The idea of good nursing care seems to be more associated with the way professionals interact with the patient than with actual care issues, like the mastery of techniques, skills and scientific knowledge. In addition, the patients themselves indicate that dialogue with the team provides tranquility and security, contributing to mitigate anxiety and fear[13].

Thus, it is believed that the patients' impressions of care essentially depend on how professionals interact with them. At the ICU, dialogue needs to be enhanced with a view to the construction of welcoming in this critical situation, thus furthering shared needs and emotions.

CONCLUSION

The assessment the patients and relatives who experienced ICU hospitalization and care practice during the research period performed appointed that the welcoming strategies put in practice were perceived positively. This grants the ICU nurses the certainty and commitment that periodical evaluations are fundamental, as only continuous surveillance will validate the effective welcoming proposal.

Besides, it should be reminded that all new members who arrive at the unit need to be welcome and need to learn how to welcome, because it cannot be forgotten that the professional team can also change over time, as well as patients and family members' welcoming needs.

The results achieved in this research positively led to changes in nursing care at the ICU. The researchers believe this proposal can be applied in different health contexts for welcoming purposes, and not only in the critical environment, as this reality was only modified through the nurses' initiative, who assumed the commitment and responsibility for care practice transformations, and through the patients and family members who had the opportunity to manifest their perceptions with a view to care improvements.

It is highlighted that, through this important assessment of the welcoming strategies applied, new gaps could also be identified at this ICU, including: unattended spiritual needs, of family members as well as patients; welcoming when the news of death is given, which did not happen, and the possibility of having the relative stay at the bedside of their loved one longer, sensitively and coherently surpassing the continuing physical and cold barrier for them to be together beyond the 30 minutes of visiting hours.

This research, however, did not intend to exhaust all possible welcoming strategies at the ICU but, through its results, to permit reflection and even action, by daring to recommend to health professionals the importance of attention with a view to intervening in existing gaps in interrelations, within the scenarios in which care practices are developed.

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