Original Article

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TEXT & CONTEXT NURSING TEXTO & CONTEXTO ENFERMERÍA

HUMANIZED NURSING CARE IN AN INTENSIVE CARE UNIT IN ANGOLA: FACILITATING AND HINDERING FACTORS REVEALED

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ABSTRACT

Objective: to describe the aspects that facilitate and hinder the work of nursing professionals regarding the humanized care in an intensive care unit in Angola.
Method: descriptive, qualitative research, conducted in an Intensive Care Unit of a general hospital in Huambo, Angola, Africa, with 15 nursing professionals, in 2020, through semi-structured interviews. The Collective Subject Discourse to analyze the data was used; and to organize the data, the QualiquantiSoft software was used.
Results: five central ideas emerged from the statements: two involving the facilitating factors; and three involving the difficulties in providing humanized care. The facilitating factors refer to the involvement of the multidisciplinary healthcare team and the interpersonal relationships of the nursing team. The hindering factors are linked to the lack of material resources, equipment, and supplies; the scarcity of human resources; and the poor specialized skills of the nursing team.
Conclusion: when referring to the humanization of nursing care, its facilitating factors are linked to behavior and professional relationships, while the difficulties, for the most part, involve management aspects that are not under the professionals' responsibility, thus requiring attention from the managers of the institution.

DESCRIPTORS: Humanization of the assistance provided. Intensive care units. Critical care. Patient care. Nursing care. Nursing. Critical care nursing.

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CUIDADO DE ENFERMAGEM HUMANIZADO EM TERAPIA INTENSIVA EM ANGOLA: FACILIDADES E DIFICULDADES DESVELADAS

RESUMO

Objetivo: descrever as facilidades e dificuldades dos profissionais de enfermagem no cuidado humanizado em terapia intensiva em Angola.
Método: pesquisa descritiva, qualitativa, realizada em Unidade de Terapia Intensiva de um hospital geral de Huambo, Angola, África, com 15 profissionais de enfermagem, no ano de 2020, por meio de entrevista semiestruturada. Utilizou-se o Discurso do Sujeito Coletivo para análise dos dados; e para a organização, o *software* QualiquantiSoft.
Resultados: emergiram dos depoimentos cinco ideias centrais: duas envolvendo as facilidades; e três, as dificuldades em oferecer um cuidado humanizado. As facilidades referem-se ao envolvimento da equipe multiprofissional no cuidado e às relações interpessoais da equipe de enfermagem. As dificuldades estão atreladas à falta de recursos materiais, equipamentos e insumos; recursos humanos escassos e pouco preparo especializado da equipe de enfermagem.
Conclusão: na humanização dos cuidados de enfermagem, as facilidades estão relacionadas ao comportamento e relações profissionais, enquanto as dificuldades, na sua maioria, envolvem aspectos de gestão que não estão sob a governabilidade dos profissionais, requerendo atenção dos gestores da instituição.

DESCRITORES: Humanização da assistência. Unidades de terapia intensiva. Cuidados críticos. Assistência ao paciente. Cuidados de enfermagem. Enfermagem. Enfermagem de cuidados críticos.

ATENCIÓN HUMANIZADA DE ENFERMERÍA EN CUIDADOS INTENSIVOS EN ANGOLA: FACILIDADES Y DIFICULTADES REVELADAS

RESUMEN

Objetivo: describir las facilidades y dificultades de los profesionales de enfermería en la atención humanizada en cuidados intensivos en Angola.
Métodos: investigación descriptiva, cualitativa, realizada en la Unidad de Cuidados Intensivos de un hospital general de Huambo, Angola, África, con 15 profesionales de enfermería en 2020, mediante entrevistas semiestructuradas. Se utilizó el Discurso Sujeto Colectivo para el análisis de los datos y el software QualiquantiSoft para su organización.
Resultados: de los enunciados se desprenden cinco ideas centrales: dos se refieren a las facilidades y tres a las dificultades para ofrecer cuidados humanizados. Las facilidades se refieren a la implicación del equipo multiprofesional en los cuidados y a las relaciones interpersonales del equipo de enfermería. Las dificultades están relacionadas con la falta de recursos materiales, equipos y suministros; los escasos recursos humanos; y la falta de formación especializada del equipo de enfermería.
Conclusión: en la humanización de los cuidados de enfermería, las facilidades están relacionadas con el comportamiento y las relaciones profesionales, mientras que las dificultades involucran, en su mayoría, aspectos de gestión que no están bajo el control de los profesionales, requiriendo la atención de los gestores de la institución.

DESCRIPTORES: Humanización de los cuidados. Unidades de cuidados intensivos. Cuidados críticos. Cuidados al paciente. Cuidados de enfermería. Enfermería. Enfermería de cuidados críticos.

INTRODUCTION

Intensive Care Units (ICUs) refer to hospital areas aimed at assisting critical patients who require complex and specialized care. They have specific characteristics and account for a high concentration of human, material and technological resources in the hospital environment. These elements are essential to provide care to critically ill patients who require continuous assistance, so that their vital conditions can be correctly observed and monitored, and rapid intervention can be carried out in situations of clinical imbalances[1].

ICUs are environments filled with high technological and nursing care complexity. Based on their historical-political-social development process, they are designed to be areas where technical aspects are a priority given the type of care provided and the dense technology arranged in these environments. Consequently, professionals who care for critically ill patients tend to prioritize these resources and put off humanized care practices, sparking debates about this type of care[2].

However, it is known that all healthcare professionals must comprehensively conduct nursing care practices in favor of the patient and their relatives[3]. The literature asserts that the main challenges for implementing humanization in the intensive care environment are related to the several meanings of the concept of humanization, the working conditions of the professionals, the quantity of human and structural resources, the training and updating of healthcare professionals, in addition to some management aspects related to the organization of the work process[4–5].

From this perspective, it is understood that nursing care is the essence of the work process and must be intricately linked to both the care management process and the administration of the practices performed by the healthcare team, as well as to health education activities[6–7]. In underdeveloped countries like Angola, the humanization of care is still a particularly important challenge, as this is a population with large inequalities in living and working conditions as a whole; and, consequently, these inequalities interfere with the humanization of care provided to patients[8].

Regarding the Angolan context, it is also important to highlight that their National Health System (Portuguese Acronym: SNS) was organized amid a scenario of great political vulnerability resulting from an internal conflict that led to the civil war. This situation has caused problems at all levels of health care in the country, such as insufficient funding, shortage of health units and services, high demands, and lack of human and material resources[9].

Furthermore, it is worth highlighting that the humanization of care in Angola is still a scarcely explored topic both in national and international literature. In a study that investigated the perception of nursing professionals in an Angolan ICU regarding humanized care and the resources necessary for its implementation, it was reported that, despite the advances in this area, the need for improvements is still seen mainly in the fields of infrastructure, human and material resources, in addition to the need for healthcare professional development and training[10].

In view of the above, considering the relevance and scarcity of publications on the topic in the Angolan context, the following guiding question was created: “what are the facilitating and hindering elements for providing humanized care in intensive care units in Angola?” In this sense, the present study aims to describe the facilitating aspects and the difficulties faced by nursing professionals regarding humanized care in an intensive care unit in Angola.

METHOD

This is a descriptive study with a qualitative approach developed in the Adult ICU of the *Hospital Geral* located in the province of Huambo, in Angola, Africa. It was written in accordance with the international guide known as Consolidated Criteria for Reporting Qualitative Research (COREQ)[11].

The above-mentioned ICU provides care for the population of 11 municipalities in the province of Huambo and its setup includes 7 intensive care beds for all clinical specialties. It has 26 nursing professionals, 9 of whom are nurses and 17 technicians. 15 professionals participated in the study, and the following inclusion criterion was considered: being an ICU nursing professional. Those professionals who were on vacation or leave of any kind were excluded. Therefore, 11 professionals were excluded: 6 for being on vacation and 5 for being on leave, as they belonged to the risk group for Covid-19 and were on sick leave. Sampling was intentional.

Data were collected from June to October 2020 through semi-structured interviews guided by a script prepared for this study. Professionals were asked to talk about the facilitating aspects and the difficulties encountered in the process of providing humanized care in the ICU; in addition, questions focused on the sociodemographic characteristics of the participants were asked.

The interviews were scheduled in advance according to the participants' availability and were conducted on a one-on-one basis, in person, in a secluded setting chosen by them. All were audio-recorded and fully transcribed by the main researcher into a text file in Microsoft Word®, complying with all transcription and transcreation reliability criteria; and they lasted an average of 30 minutes.

As the interviews were conducted during the Covid-19 pandemic, all protective measures such as necessary social distancing, use of face masks and hand hygiene with alcohol gel were duly respected. The strategy of returning the interview to the participants to get their validation was not applied. The termination of data collection occurred when all professionals who met the eligibility criteria were interviewed.

To analyze the data, the Collective Subject Discourse (CSD)[12] was used, which comprises four methodological figures: Key Expressions (KE); Central Ideas (CI); Anchoring (AC); and the Collective Subject Discourse (CSD) itself. KEs are the most significant and literal excerpts from the statements, and they depict the essential content of the discourse. As for the CIs, they describe the meaning of each homogeneous set of KEs present in the statements; in turn, AC occurs when the subjects, in order to make sense of their statement, rely on some pre-existing knowledge. Finally, the CSD is made up of KEs that have CIs or ACs with similar or complementary meaning, and it is written in the first-person singular[12]. In this study, no ACs were identified.

The data were organized using the Qualiquantisoft software, version 1.3c, based on the transcribed interviews. In the software, first the research was duly registered. Then each question was entered, and the content of each participant's answers was transferred. The following step consisted of identifying, in each response, the KEs and, based on these, identify and name the respective CIs. Then the CIs were grouped and named based on the fact of having equivalent or complementary meaning, thus creating categories. The last step was the construction of the CSD based on the KEs with the same CI and corresponding to each category. The software also made it possible to identify the number of participants represented in each discourse.

The study was approved by the Ethics Committee of the Caála/Huambo Polytechnic Institute. All the participants signed the Free and Informed Consent Form (FICF). To preserve their identity, the professionals were identified by the letter "P" for participant, followed by the number corresponding to the order of the interviews (P1, P2, P3…).

RESULTS

Of the 15 professionals participating in the study, 10 were nursing technicians (66.7%) and 5 were nurses (33.3%), mostly females (n = 11; 73.3%). The average age was 42 (ranging from 32 to 51 years old). The average time working in intensive care was nine years (ranging from 3 to 22 years). As for the work shift, eight professionals performed their activities at night, five in the morning and two in the afternoon.

Based on the statements given, five CIs emerged, and each originated one CSD. The summary of the CIs extracted from the individual statements can be found in Table 1.

Table 1 – Summary of the central ideas related to the facilitating and hindering factors faced by Angolan nursing professionals regarding humanized care in an intensive care unit, extracted from individual statements (n = 15). Huambo, Angola, Africa, 2020.

Central Ideas	n	%
CI: Interpersonal relationship of the nursing team as a facilitating factor of the humanization of care	7	46.6
CI: The performance of the multiprofessional team favors humanization	8	53.3
CI: Insufficient nursing staff sizing as a hindering factor for humanized care.	5	33.3
CI: Lack of material resources, equipment and supplies	13	86.6
CI: The lack of specialized nursing qualification hinders ICU care	5	33.3

CI: Interpersonal relationship of the nursing team as a facilitating factor of the humanization of care

CSD 1: *I consider that the following positive factors serve as facilitators for the humanization of care: the relationship of the nursing team, the interpersonal relationship between us, the mutual respect and collaboration between us. I think here in the ICU there is a sense of union. And it is this day-to-day team working dynamic that promotes an incredibly positive relationship; and the patients are the ones who benefit the most from it. Because we work together as a team, there may be work stress, but the personal relationship between us is great, we have no communication problems between us.* (P4, P6, P8, P9, P10, P12, P15)

CI: The performance of the multiprofessional team favors humanization

CSD 2: *I think when we work as a team – not only between the nursing team but also together with the medical team and the basic level staff – when we are all working together around a patient, we feel like the job is smoother, that there is a work of humanization there. A satisfactory performance has been delivered by the staff because both the nurses and the doctors form a multiprofessional team focused on fixing or providing solutions to the problems faced by our patients in the ICU.* (P1, P2, P4, P9, P10, P13, P14, P15)

CI: Insufficient nursing staff sizing as a hindering factor for humanized care

CSD 3: *We go through several difficulties in our ICU which include providing humanized care to patients, but above all, we lack human resources. The nursing staff is small, so all the goals we set, sometimes, end up being invalid as we cannot fully achieve them. Sometimes we have one nursing technician to care for three or four patients, which is very tiring. The nurse cannot perform or fulfill all their plans with the patient, because there are too many patients waiting to be cared for. Here we have seven patients; and sometimes there are just two nurses on duty, so we can't make better action plans if we are alone with two patients in mechanical ventilation; there are times when one patient in mechanical ventilation needs to be cared for two nurses, so we end up not being able to provide proper assistance.* (P1, P2, P4, P6, P10)

CI: Lack of material resources, equipment and supplies

CSD 4: *On a daily basis, what makes it difficult to provide humanized care to ICU patients is the fact that there are times when we want to do a certain type of care, we want to perform specific procedures but we find it difficult to use a certain device because it does not have the right equipment or because there is a lack of material resources, not enough cleaning staff, or even enough uniforms to provide the care. Sometimes there is a lack of medication, as the pharmacy does not always have the necessary meds required to treat the illnesses of patients here in the ICU. When the patient needs certain medications that are not available in the ICU, the doctor prescribes them so that the patient's relatives or companions can try and purchase them. There are times when we lack simple things, such as suction pumps, monitors, oxygen catheters, thus making it harder to provide proper ventilation to the patient.* (P1, P3, P5, P6, P7, P8, P9, P10, P11, P12, P13, P14, P15)

CI: The lack of specialized nursing qualification hinders ICU care

CSD 5: *In the ICU, we must be qualified to perform technical procedures, we need to know the necessary drugs and how to use the technological devices; and sometimes the work is hindered by a lack of specialized nursing technicians. Here in the ICU, 90% of the nurses who provide care are not experts, making it difficult to provide the best treatment for the patients as well as proper assistance to their companions or relatives.* (P2, P11, P12, P13, P14)

DISCUSSION

This study revealed the importance of having a well-integrated team, with positive effects on patients and professionals, thus serving as a facilitating element for the humanization of care. The appreciation of interpersonal relationships improves the quality of the work, considering that, if health professionals maintain a participatory relationship, the provision of nursing care will be more pleasant and enhanced[13]. Moreover, it is paramount that the care team recognizes the importance of building friendly interpersonal bonds developed through joint reorganization and focused on acting, conversing, and performing, since the intensity of these actions has direct influence on the patients' care[14].

An American study focused on intensive care investigated the relationship between team members and reported that interpersonal relationships are supported by the complexity of the healthcare environment in which the professionals are inserted. It is believed that an environment that promotes mutual confidence, collaboration, and employee engagement is essential to improve patients' outcomes at all care levels[15].

In nursing care, the whole team must perform their attributions in a humanized manner with the patients, carefully observing the situations that may alleviate or harm these practices. Every professional must practice empathy, caring for patients in a holistic way and respecting their particularities[16].

The present study also revealed that the performance of the multiprofessional team favors the humanization of care, as all professionals get involved in the process of solving the patient's problems. By concept, "multiprofessional team" refers to professionals from various healthcare areas who work together to provide global care according to patients' needs[17].

The benefits of this practice for the professionals who perform it are increased trust and job satisfaction, professional development motivation, promotion of patient safety, increased productivity, reduced professional turnover and employee absenteeism[18]. Multiprofessional performance also guarantees that the patient is well-received along with their relatives and companions, and also improves communication between the staff-relative-patient triad, thus contributing to data of great relevance such as reduced mortality and length of hospital stay[17].

It is important to highlight that, in the Angolan context, even after the country's independence in 1975, disparities can still be seen in relation to the supply of professionals due to their displacement to urban centers, as well as inequalities and low number of access opportunities for students who seek professional training across its territory[8,19]. This migration process of qualified professionals, added to the numerous uncovered public health demands, places Africa at the center of a global crisis linked to the scarcity of human resources in the health area, in a way that both the health care and the humanization of care turn out unsatisfactory[20]. Nevertheless, the performance of the multiprofessional team analyzed in the present study, considering the Angolan context, proved to be a facilitating factor regarding the humanization of care for adult ICU patients.

The statements given by the professionals in CSD 3 converge to the difficulties they experience in terms of implementing humanized care, especially due to nursing staff sizing. Based on this perspective, the literature shows that the lack of nursing professionals makes it difficult to provide humanized care, as it increases the team's workload, thus leading to poor results regarding healthcare and managerial quality indicators for nursing services[21–22].

In the ICU, care teams constantly deal with sensitive situations related to working condition such as work overload, insufficient human resources, lack of materials, among others. These situations negatively influence their emotions, generating stress and impacting the mental health of all professionals[23].

In this regard, considering the intensive care environment in the Brazilian context, the Nursing category is still quantitatively smaller than the one recommended to provide proper patient care[24]. In Angola, the National Association of Nurses gives the following guidance in terms of the number of nursing professionals required – one general or graduate nurse to care for two patients, or one auxiliary nurse to care for every six patients[25].

Regarding the lack of material resources and supplies for humanized care, an aspect evidenced in most statements given by the participants, in a study whose objective was to size the number of professionals working in the nursing category of an ICU by applying the Nursing Activities Score (NAS), it was found that the lack of these resources creates obstacles, in addition to being a source of wear and tear in the production of humanized assistance. Poor management of human and material resources results in inadequate care, affecting the team's availability faced with the demands of patients and relatives accompanying their hospitalization[24].

In the fifth statement (CSD 5), it was evident that the lack of professionals with specialized qualification working in the ICU was reported as a hindering factor in the production of humanized care. In this sense, the ICU is characterized as a complex workplace, as it demands advanced technical skills from professionals who care for critical patients, and these skills must be acquired through specialized professional training[26]. It is worth highlighting that, in Angola, health professionals, upon entering the SNS, develop their skills by taking permanent educational and postgraduate programs, of a professional nature, and restricted to licensed nurses[27].

Therefore, in Angola there is still a notable shortage of human resources in the health sector, but efforts have been made to alleviate this problem. The Ministry of Health of Angola (Portuguese Acronym: MINSA) works together with the Ministry of Higher Education to promote partnerships with institutes in order to train health professionals, especially doctors and nurses. By doing so, the aim is to train professionals so that they become duly qualified to provide health care to the entire population of the Angolan territory[28]. Furthermore, the Human Resources Development Plan (Portuguese Acronym: PDRH), focused on strengthening the institutional capacity of the SNS, highlighted the importance of training managers in different spheres of activity[27].

It is noteworthy that this study was limited to the perceptions of nursing professionals regarding the humanization of care in the ICU environment of a general hospital in Angola. However, the findings

of this study contribute to the promotion of new and more humanizing practices in the critical Angolan context, as they depict the difficulties in providing humanized care, which are viewed as challenges to be overcome. It is believed that this study has enabled professionals to reflect on the humanization of care; and further studies on the topic are suggested, which must include other professional categories and hospital institutions to deepen the understanding of the phenomenon reported in the country.

CONCLUSION

The study revealed factors that facilitate the humanization of nursing care and that are related to both individual and collective efforts involving the nursing and multidisciplinary teams; however, it was found that there are no initiatives either by the ICU or the hospital management to promote a more humanized and welcoming care in this scenario. Aspects that hinder the implementation of humanized care were also highlighted, represented herein by the lack of human resources, equipment, supplies, and more specialized nursing professionals. Although these negative factors are more intricately linked to the ICU management, they may put the quality of care provided by the intensive care nursing staff at risk. Therefore, a speedy resolution is necessary to provide humanized care for critically ill patients.

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NOTES

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CONFLICT OF INTEREST

There is no conflict of interest.

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