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## ORIGINAL ARTICLE

### THIRST IN SURGICAL PATIENTS: PERCEPTIONS OF THE NURSING TEAM IN INPATIENT UNITS

#### SEDE DO PACIENTE CIRÚRGICO: PERCEPÇÕES DA EQUIPE DE ENFERMAGEM NAS UNIDADES DE INTERNAÇÃO

#### SED DEL PACIENTE QUIRÚRGICO: PERCEPCIONES DEL PERSONAL DE ENFERMERÍA EN LAS UNIDADES DE INTERNACIÓN

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#### ABSTRACT

**Objective:** to assess the perception of the nursing team in inpatient units with respect to thirst in surgical patients and the factors that interfere with the implementation of management strategies. **Method:** Qualitative descriptive study with 12 nursing technicians of a university hospital. The Discourse of the Collective Subject method was used for the analysis. **Results:** the following categories were established: thirst - a little valued discomfort; perceiving patients' thirst; and performing in the face of thirst. **Conclusion:** the nursing technicians did not regard thirst as a primordial discomfort, making it an undervalued, underreported and unsystematically assessed symptom. For the management of thirst, they did not use evidence-based strategies due to the lack of knowledge about the topic and fear of possible complications. There is a need of continuing education actions aimed at sensitizing the professionals for intentional assessment and intervention in surgical patients who suffer from thirst without being cared. **Descriptors:** Thirst; Nursing staff; Perioperative Care.

#### RESUMO

**Objetivo:** explorar a percepção que a equipe de enfermagem que atua na unidade de internação tem em relação à sede no paciente cirúrgico e os fatores que interferem na condução de estratégias de manejo. **Método:** estudo qualitativo descritivo com 12 técnicos de enfermagem de um hospital universitário. Para análise, utilizou-se o método do Discurso do Sujeito Coletivo. **Resultados:** construíram-se as seguintes categorias: sede - um desconforto pouco valorizado; percebendo o paciente com sede; e agindo diante da sede. **Conclusão:** os técnicos de enfermagem não percebiam a sede como um desconforto primordial, tornando-a um sintoma subvalorizado, subnotificado e não avaliado de forma sistematizada. Para o manejo da sede, utilizavam estratégias não baseadas em evidência pelo desconhecimento quanto ao tema e receio de possíveis complicações. Há necessidade de ações de educação permanente visando sensibilizar os profissionais para uma avaliação e intervenção intencionais junto ao paciente cirúrgico que sofre sede sem ser atendido. **Descritores:** Sede; Equipe de enfermagem; Assistência Perioperatória.

#### RESUMEN

**Objetivo:** evaluar la percepción que el personal de enfermería en la unidad de hospitalización tiene sobre la sed en pacientes quirúrgicos y los factores que interfieren en la implementación de estrategias para su manejo. **Método:** estudio cualitativo descriptivo con 12 técnicos de enfermería de un hospital universitario. Para el análisis se utilizó el método del Discurso del Sujeto Colectivo. **Resultados:** Se establecieron las siguientes categorías: sed - un malestar poco valorado; percibiendo al paciente con sed; y actuación frente a la sed. **Conclusión:** los técnicos de enfermería no percibían la sed como un malestar primordial, haciendo de ella un síntoma infravalorado, subdeclarado y no evaluado sistemáticamente. Para el manejo de la sed, utilizaban estrategias no basadas en evidencia debido a la falta de conocimiento sobre el tema y el miedo de posibles complicaciones. Hay necesidad de acciones de educación permanente dirigidas a sensibilizar a los profesionales para una evaluación e intervención intencional del paciente quirúrgico que sufre sed sin ser atendido. **Descriptor:** Sed; Personal de enfermería; Asistencia Perioperatoria.

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## INTRODUCTION

Numerous discomforts are experienced during the perioperative period. Some of them, which are easily identifiable, such as pain, nausea, vomiting, and hypothermia during the anesthesia recovery period, have been extensively studied. Perioperative thirst, in turn, is a real and stressful discomfort with high incidence; however, it has been little investigated.<sup>1-3</sup>

During the perioperative period, confluent factors trigger and worsen the thirst, such as perioperative anxiety, fasting, intubation, blood loss, and anesthetic drugs.<sup>4</sup> Preoperative fasting contributes to the increased incidence and intensity of thirst, because, while it is recommended patients forego clear liquids for two hours, fasting may be extended for up to 37 hours.<sup>5</sup>

Thirst is a symptom and can be assessed by the Symptom Management Theory developed by Symptom Management Faculty Group at the University of California, United States. A symptom is described as a subjective experience that produces changes in biopsychosocial behavior or individual cognition.<sup>6,7</sup>

Since it is a subjective experience, perioperative thirst requires assessing the meaning of symptom and its impact on the patients. Unfortunately, it is observed that thirst has been undervalued, underestimated, undermeasured, underrecorded, and undertreated. Management strategies are still incipient; however, there is evidence that small amounts of water or ice can be used. On the other hand, ice chips and popsicles have been more effective than water at room temperature for the relief of thirst.<sup>2-4,8,9</sup>

The nursing team represents the link between the discomfort experienced by patients and the possible use of intervention measures. Often, this discomfort is decoded when characteristic signs and symptoms are detected and measured. Therefore, the humanization of care in inpatient units is closely linked to the performance of this team in the face of stressing factors. The goal is to relieve the stress-generating sources.<sup>10</sup>

Valuing the symptoms, understanding the physiological mechanisms, and knowing effective strategies for relief is essential for providing care to patients. Regarding thirst, the institutional culture—such as prolonged fasting and myths passed on by word of mouth: "fasting is fasting, it cannot be discontinued"—ends up influencing the nursing team's perception and evaluation.<sup>11</sup> What is observed in practice is an unprepared nursing

team to deal with thirst during the perioperative period and perform appropriately, since nurses often ignore thirst when patients ask for water.<sup>2,11</sup>

With respect to thirst during the perioperative period, the role and the perception of the nursing team have not been assessed. In the face of this issue, the following question arises: How does the nursing team of an inpatient unit perceive and treat patient's thirst in the perioperative period?

The goal of the present study was to assess the perception of the nursing team working in an inpatient unit with respect to surgical patients' thirst and the factors that interfere with the implementation of strategies to deal with it.

## METHOD

This is a qualitative descriptive study conducted in a large university hospital in southern Brazil, which is a reference institution for trauma, burns, bone marrow transplants, and risky pregnancy. The hospital provides care exclusively to Unified Health System patients, has 313 beds, a surgical center with seven operating rooms (with an average of 500 surgeries per month), 58 beds in the male medical-surgical unit and 47 in the female unit.

The study population was composed of nursing technicians who worked in the male and female medical-surgical units. The selection of the sample considered participants' willingness to participate in the survey and the data saturation in the discourses collected. Data collection was performed using a semistructured interview with the following guiding questions: What are the greatest discomforts that the patients feel during the pre-and postoperative period? How do you detect that the patients are thirsty? What makes surgical patients feel thirsty? What is your behavior in the face of the discomfort caused by thirst reported by the patients? and How do you feel about providing care to surgical patients who are thirsty?

The Discourse of the Collective Subject method was used for the analysis of the information. This method is described as a single discourse that allows expressing the opinion of a community about a particular topic as if it were a single individual, making it possible to add statements without reducing them to quantities. The discourses were analyzed by means of three methodological figures: key expressions; central idea; and discourse of the collective subject, resulting in a synthetic statement that discursively

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represented the perception of the nursing team about thirst in surgical patients.<sup>12</sup>

This study was drawn from the project "Thirst in surgical patients: understanding the issue and strategies for the management of thirst during the postoperative period", approved by the Ethics Committee of the institution studied (CAAE No. 02299412.6.0000.5231). The interviewees who agreed to participate in the study signed an informed consent form.

## RESULTS AND DISCUSSION

The participants of the study were 12 nursing technicians—of which 10 were women—aged from 27 to 48 years, and their working time in the institution ranged from six months to 22 years. The subjects were identified by the letters F (female) and M (male), followed by the number of the order in which the interviews were carried out.

The following categories were established from the analysis of the discourses: thirst - a little valued discomfort; perceiving patients' thirst; and performing in the face of thirst. The first category depicted how nursing technicians identified the discomfort experienced by patients in the perioperative period, and thirst was a discomfort little valued by the respondents.

When the interviewees were asked about the main discomforts experienced by the surgical patients during the perioperative period, they were unanimous in mentioning pain and anxiety. Thirst in the perioperative period, however, is a real discomfort and, despite its high incidence (75%),<sup>2</sup> it only emerged in the discourses of the respondents due to the questioning conducted by the researcher:

*Yes [...] it's true, you reminded me about that! Sometimes they complain about dry mouth, isn't it? Both before and after surgery. I had forgotten that. I think it occurs before, right? Also because there is that given time, in which, according to the patients' surgeries, they can't drink water. (F2, F5, F12).*

A study of patients admitted to an intensive care unit found a similar result. Half of the nursing professionals interviewed had not perceived thirst as a problem in patients receiving mechanical ventilation. Some of those interviewees had even claimed that sedated patients did not feel thirst.<sup>13</sup>

One of the nursing technicians interviewed in the present study recognized thirst as a symptom of extreme discomfort in the perioperative period, because this technician had had such an experience. That fact had

become of fundamental importance for valuing thirst when providing care to surgical patients:

*I underwent a postoperative period in which I couldn't drink water and you get really anxious to quench your thirst. I think it's one of the worst discomforts. The food not so much, but thirst, I think that, in any sense, is the worst thing ever. I underwent reduction of the stomach, hence I couldn't drink water and that was the worst thing that I suffered from. You want to drink and then your thirst increases, because you know you can't drink. Then, they give you a small piece of ice or wet a little bit your mouth, but you think about water all the time, do you understand? And I see that patients also think about that. You see that their lips sometimes dry out, which gives bad breath, because they remain there without drinking water for a long time. (F6).*

The non-valuation of thirst may be associated with the institutional culture reflected in the actions performed by the nursing team. These actions derive from knowledge without evidence that disseminate the need of maintaining a prolonged and "unbreakable" fasting, in addition to avoiding the use of strategies for the relief of thirst that will confront the medical prescriptions. Sometimes, the patients do not mention they are thirsty and the nursing technicians, even decoding the signs, decide not to perform any procedure.<sup>6,7</sup>

The second category, i.e., perceiving the patients' thirst, depicted how and when the signs of thirsty exhibited by the patients were identified by the nursing technicians of the unit. According to the Symptom Management Theory, the perception of a symptom is defined as a change in the way individuals feel or behave. Its evaluation involves the analysis of the causes, gravity, treatability and the impact it brings to their lives, suffering influence of environmental, physical, and emotional factors.<sup>6,7</sup> There is a process that must be better understood from the moment that the patients identify that they are thirsty until the moment in which the nursing team can decode that perceptions.

Perioperative thirst is triggered by a complex neurohormonal mechanism, whose goal is to restore water-electrolyte and volumetric balance.<sup>14</sup> Thirst may even be influenced by external factors, such as the fact that the patients know the necessity of fasting for a good surgical procedure, which often lead them to avoid reporting this discomfort. Therefore, the correct and intentional decoding of the signs of this symptom is necessary so that the nursing team

can proceed adequately.<sup>6,7</sup> Initially, the professionals stated that they only perceived the occurrence of thirst when the patients mentioned this discomfort:

*It is when they say that they are thirsty. There isn't anything that I usually observe. In our work, we can identify pain through the expression and everything, but thirst and some other discomforts, we can't identify them if the patients don't mention them. So we expect the patient to complain. (F1, F2, M3, F8).*

According to the Symptom Management Theory, the gold standard for studying a symptom is based on the perception of the individuals who experience it and their self-report, emphasizing that all the discomforts suffered by the patients should be managed.<sup>6,7</sup> The purpose of the intentional look at thirst is that the patients should not be afraid of mentioning their discomfort and trust that their symptom will be evaluated as something important. The premise that they need to fast—incessantly stated by the team—many times lead the patients to avoid reporting that discomfort.

In this way, the question is: What cultural and internal factors motivate the patients to inform about their thirst? Further investigations are needed to elucidate to what extent culture interferes with the perception that the patients have about thirst and their willingness to communicate it to the nursing team. If the perception of the professionals is not congruent with the assessment performed by the patients or their companions, there is a deadlock in the management of this symptom.<sup>6,7</sup>

In order to elucidate the factors that interfere with water intake in hospitalized patients, a study demonstrated that 52% of the respondents had reported that they were more thirsty than usual since their admission to hospital. Of the patients with a high degree of dependency, 94% hesitated before asking for water, and 91% had not ingested liquids because they did not want to disrupt the work of the nursing team by asking for help.<sup>15</sup> In addition to being detected by the verbalization of patients, the nursing technicians recognized thirst by the signs:

*Sometimes they are that way, with very dry mouth, it seems that the mouth is glued, it is more whitish, the saliva is thicker, you can see it by the skin [...] it dehydrates, it is flaky, it gets more sticky. When you fold the skin, it takes long to unfold again. And when the patients undergo a long fasting period, you observe that they are really dehydrating. Also the pallor, we realize that the patients are thirsty, they are really dehydrating. (F4, F5, F6, F7, M9, F10, F11).*

Some of the signs of thirst described in the literature are: dry mouth, tongue and lips; appearance of the skin of the tongue; halitosis; easy bleeding of the oral mucosa; low diuresis production; and dry eyes and skin, as well as high levels of hemoglobin and sodium in blood samples.<sup>13</sup> Signs identified, such as decreased skin turgor caused by dehydration, however, are late. This fact means that the patients may suffer from this discomfort until the professionals perceive it. In this way, there is a discussion on the need of establishing protocols for active and early assessment of thirst in surgical patients. The nursing technicians pointed out to physiological and emotional issues, and time of fasting as causes of perioperative thirst:

*In the preoperative period, it is usually due to fasting, for the long time they remain [without drinking anything], right? 12 to 24 hours. Sometimes, it takes longer, because, for some reason, the surgery delays. (F2, F5)*

*And I think the anxiety also helps cause thirst, helps make everything worse, pain, everything. If the person is anxious, it seems that the pain increases, the thirst increases. The psychological aspect also helps, anxiety [...] "Wow, I'm fasting, I can't eat anything, I feel like drinking water, but I can't, but I want" (F5, F10, F12).*

Among the physiological causes of thirst, the main ones are hyperosmolality and hypovolemia.<sup>13</sup> Anxiety and fear—particularly during the preoperative period—contribute to increase the thirst due to the activation of the sympathetic system and reduction of salivary secretion. Other causes may trigger thirst: dryness of the oral cavity; intubation; and also drugs such as opioids and anticholinergics, since one of the side effects is the reduction of salivary secretion.<sup>13-4</sup>

One discomfort readily identified by the respondents was the time of prolonged fasting, almost always due to the great surgical demand and the peculiar characteristics of teaching hospitals, with frequent surgical delays:

*Sometimes, a discomfort is also undergoing long fasting, huh? Sometimes, it takes long to be sent to the operating room, I think that's the main patients' complaint. For example, for orthopedic surgery, the patients fast for 24 hours. (M3, F6, M9, F10).*

The recommendation of the American Society of Anesthesiologists is eight hours for fatty food, six hours for solids, and two hours for clear liquids.<sup>5</sup> However, it turns out that the time observed for fasting of liquids and solids is the same, despite contrary indications found in the literature. This fact

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denotes that the nursing technicians' actions are based on the myth that fasting can not be interrupted under any hypothesis and an institutional routine that makes patients undergo fasting for an extended time and indiscriminately:

*It has always been that way here: fasting is fasting and that's it! What I remember of the course that I attended, at that time I was a nursing assistant, is that, when fasting, everything is discontinued. One day, the doctor said that the patients can run the risk of bronchoaspiration and such things. Sometimes, the patients are even afraid of discontinuing fasting. I also don't know whether this is true or a myth in which everyone believes. I've never seen it proven, nobody ever showed me that it's scientifically proven. I'm not sure whether drinking some water may interfere. Nobody ever explained anything scientifically, I don't know whether we ever questioned, or anybody ever bothered to find whether that's really true. I think it's the same as a myth, superstition, passing to each other, and that's it. (F1, F2, M3, F4, F5, F7, M9, F10, F11, F12).*

Despite admitting not knowing about scientific theories relating to the procedures performed, the nursing technicians were interested in new evidence that govern healthcare:

*It would be interesting to know whether there is anything proven about this. If one day there is something proven, you tell us, because some things have already changed, but we don't even know. It's like dressing, in the past we used povidine and there are patients who ask if we don't use it anymore, because now it changed, only catheter and such things. And if no one inform us about these changes, it gets [...] (F10).*

Another item pointed out as cause of thirst in the perioperative period was hypovolemia during surgery:

*Hypovolemia, huh? Because during surgery the patients lose much liquid, right? Blood, they lose considerable volume. Thus they are going to have postoperative thirst due to the loss of volume. (F1, F7).*

Thirst is activated by compensation mechanisms to face hypernatremia or hypovolemia in the surgical patient. Then, the renin-angiotensin-aldosterone system is activated to restore homeostasis.<sup>14</sup>

The third category to face thirst is related to the feelings and actions of nursing technicians when they provide care to patients who feel thirsty. Even when they detected the thirst through patients' verbalization or signs, they did not consider it important enough to be evaluated and recorded in the patients' medical records:

*No, we rarely record it, it isn't always. We talk about it when the teams change. And then we end up not recording it. That's the routine here, we aren't used to recording it. (F5, F6, F7, F8, F10, F12).*

A study that assessed the perception of nurses about thirst in patients undergoing mechanical ventilation observed that thirst was not usually recorded in nursing records, even though it is a discomfort worthy of attention.<sup>13</sup>

The procedures used by the nursing technicians for the management of thirst in surgical patients at the infirmary reflect a little flexible performance, since fasting was rigorously indicated according to medical prescriptions. Basically, they used moistened gauze and performed mouthwash to relieve patients' discomfort:

*I can't do anything, because I follow the medical prescription. At the most, wetting a little the mouth and that's all [...] Because we follow the medical prescriptions; you can't avoid that, do you understand? The tongue gets thick, uncomfortable, then we wet it a little, because that is not going to hurt the patients, with some gauze, sometimes, right? Just the mucosa, they wash their mouth at least to remove dryness, but they can't swallow. I've already seen wet cotton or gauze to be sucked by the patients. A piece of cotton not very wet, just to relieve, which gives the feeling that they're drinking water, but it doesn't solve their problem, it is only palliative. After a few minutes, they complain again about being thirsty, but this procedure relieves a little. Because if you keep giving as much water as they want, we are afraid that the patients may vomit and even bronchoaspirate, and nobody sees that. (F1, F2, M3, F5, F7, F8, M9, F11, F12).*

In order to provide the nursing team with resources to assess the safety of managing methods to relieve thirst, a Safety Protocol for the Management of Thirst was developed as part of the Study and Research Group on Thirst at the State University of Londrina, State of Paraná, Brazil. The selected safety criteria (level of consciousness, airways protection, and absence of nausea and vomiting) were grouped in a graphic algorithm that assess in a systematical, standardized and intentional way the safety for the implementation of the method for relieving thirst.<sup>16,17</sup>

The use of wet gauze or cotton for relieving thirst has no proven efficacy and, when compared with cold water gargling, the latter has significant effect in reducing the intensity of thirst, in addition to improving the oral conditions.<sup>18-9</sup>



The respondents also mentioned the strategy of offering ice or small doses of water as possible alternatives for relief, making it clear, however, that there is not a standardized amount of water or ice to be offered safely to the patients in the perioperative period:

*Oh, I give a glass of water, 50 ml, 20 ml, a few mL to humidify the mouth and relieve the feeling of thirst [...] There isn't a right amount, it's kind of empirical, until about two hours before surgery. And when you have to give a pill, then there's water too. A little bit of water, the patients eliminate it quickly. But there are surgeries according to which you can't give anything, you only wet the oral mucosa, mainly at stomach level, those things, you can't give, just wet. And after surgery, through the clinical assessment we see whether we really need to maintain total fasting or if you can, at least, offer water. I follow the prescription, depending on the patients' surgeries. Sometimes I offer water, but it is more difficult. Oh, depending on the clinical assessments, urology, cardiology, providing water is complicated. Now, orthopedics, I usually provide a little water until fasting is discontinued. And from the moment the diet is indicated, we provide water, not much, just a glass, because the patient returned to the room at that time, then we give a little, then a little more. (F1, F2, F7, F8, F10, F11).*

*And we also put ice in the patients' mouth [...] the regular size, a little piece of ice. (F1).*

There are indications that the use of ice has greater efficacy in relieving thirst, because it stimulates oropharyngeal receptors called transient receptor potential melastatin 8 (TRPM8), which are sensitive to low temperatures and also menthol-related substances.<sup>2,3,20</sup> Studies have shown that the risk of bronchoaspiration is reduced in a gastric volume less than 50 mL, allowing, therefore, the use of ice and water up to this limit.<sup>21</sup>

Ice in small volumes and menthol-related substances can decrease the intensity of thirst, in addition to enabling the improvement of oral conditions, such as dry mouth and lips.<sup>8,9</sup> Therefore, there is a new horizon of effective strategies for the management of thirst in patients during the perioperative period.

The absence of protocols adopted by the institutions in inpatient units for the management of thirst paves the way so that technicians can make random decisions about the best strategy and the volume used, without adequately recording or assessing the result of these actions. When the nursing

technicians of the present study were asked about perioperative thirst, they agreed that the feeling seemed to be intense and uncomfortable and perceived that the patients requested actions in the face of that discomfort:

*When you are leaving the patients' rooms you say: "I'm going to see when I can give you water." Then when you come back to the rooms, the patients ask: "Did you ask whether I can drink some water?" "Eating, not so much, but water, did you ask whether I can drink?" They ask their companions to look for us and ask whether the patients can drink water. (F6).*

Most of the respondents promptly reported a feeling of compassion toward the patients. At the same time that they recognized the thirst as a major discomfort, they understood that not satisfying it was necessary for patients' safety in the face of the risk of bronchoaspiration during surgery. Since they were powerless because they did not know how to proceed, they perpetuated the actions and procedures culturally established in the institution. They were not aware of the studies that were being conducted to address this issue:

*There aren't many resources, you see? What am I going to do? There isn't much we can do. You feel sorry for the patients, you want to provide water, but you can't, this is why I wet their mouths. It's hard to deal with it, because we know that it is a basic need, right?, drinking water. I feel sorry for older adults, because we tell them that they can't, but they don't understand. That's it [...] We're sorry, but it's better for them. (F1, F4, F7, M3).*

Feelings of empathy have always been present in the history of nursing and have been a part of its basis to present day encouraging the care provided to others. Assuming the myths and rites of nursing and demystifying them by means of scientific knowledge is, however, of great importance for improving care quality.<sup>22</sup>

The fear that offering water—even in limited amounts—could be a potential danger, and for being protected by medical prescriptions, nursing professionals were not worried when they dealt with this situation, even recognizing that it was not a humanized behavior:

*It's bad because thirst, right? As it's said, you tolerate hunger, but thirst is horrible. Oh, it's hard, but anyway [...] I feel ok, because we do what we can. So, it's not us who are letting them to be thirsty: it's a necessity that they have at that moment, they have to undergo the surgery, so this is for their safety. It isn't nice to deal with*

*this, I think for anybody. It's a matter of humanization that they say, right? (F1,F5, M3, M9).*

Even though the nursing technicians put themselves in the place of the patients, they regarded pain as an intense discomfort; however, they did not attach the same importance to thirst:

*It's normal, it's not something that will let me with a heavy heart. If it is pain, yes, I would not let the patients that way. It's harder for the patients, right? Because they're feeling the lack of water. I think that everyone is bothered when they see the patients that way [...] It's bad, you know you can't do it, but you want to go there and provide some water. I'm touched, there aren't children here, but they are admitted from the age of 12 years, they are children, right? But this is something we have to live with every day [...] If you take all the patient's problem for you, you can't live and work. (F5, F11).*

Another factor found in the interviewees' feelings was the difficulty in dealing with the lack of understanding on the part of the patients regarding the restriction of water intake:

*It's hard to explain to them that they can't. [...] it's annoying, especially when the patients don't understand, right? that need. [...] they look with that face, but they can't. Then, we wet their mouths. If the patients are using probes, we give a little bit of water, because the probes eliminate it. [...] older adults think that you're deceiving them, they even curse you. They don't understand that fasting is necessary, that the amount of water has to be controlled. [...] every time you enter the room they ask, they say that they're thirsty. It bothers me a little, because it's not that you don't want to do it, which is what they sometimes say to you. When they have companions, it's even worse, because the companions give water when we don't see it. (F7, F8).*

This misunderstanding was also a stressing factor for patients undergoing cardiac surgery.<sup>1</sup> Therefore, it is essential that the nursing team provides a more detailed and clear preoperative information to the patients. At the same time, the nursing team should take into consideration viable strategies that can meet the safety criteria for surgical patients, such as the use of ice popsicles and menthol-related substances.<sup>3,4,8,9,20</sup>

CONCLUSION

Thirst is an important discomfort usually undervalued from the perspective of nursing care. Within the work routine, the nursing

technicians identified visible and objective discomforts in the surgical patients, such as pain, hypothermia and nausea. However, subjective discomforts, such as thirst, were often unnoticed.

Thirst was regarded as a common suffering that the patients had to undergo within an institutional routine strongly characterized by the culture of prolonged and total fasting, whose causes, as described by the respondents, were considered correct. Although they recognized the severity of this discomfort in the patients, they did not record nor assessed thirst in a systematic manner. The identification of thirst did not occur actively, thus requiring that the patients had the courage to break their own barriers and report something that was causing their suffering.

The nursing technicians used management strategies in an empirical manner and there was no updating of the professionals with respect to the topic assessed in the present study. As well as pain, thirst produced compassion in the nursing technicians; however, it was less valued. Continuing education actions are necessary for these professionals, so that they can take into consideration this important discomfort that causes so much suffering to the patients and adopt safe and effective management measures to deal with patients' thirst.

REFERENCES

1. Lisboa Gois CF, Maimoni Aguillar O, Dos Santos V, Llapa-Rodriguez EO. Fatores estressantes para o paciente submetido a cirurgia cardíaca. Invest Educ Enferm [Internet]. 2012 Aug [cited 2014 Apr 05];30(3):312-9. Available from: <http://portal.estacio.br/media/3828547/312-319-fatores-estressante-para-paciente.pdf>

2. Aroni P, Nascimento LA, Fonseca LF. Avaliação de estratégias no manejo da sede na sala de recuperação pós anestésica. Acta Paul Enferm [Internet]. 2012 [cited 2013 Aug 20];25(4):530-6. Available from: <http://www.scielo.br/pdf/ape/v25n4/08.pdf>.

3. Cho EA, Kim KH, Park JY. Effects of frozen gauze with normal saline and ice on thirst and oral condition of laparoscopic cholecystectomy patients: pilot study. J Korean Acad Nurs [Internet]. 2010 Oct [cited 2013 Jul 10]; 40(5):714-23. Available from: <http://synapse.koreamed.org/Synapse/Data/PDFData/0006JKAN/jkan-40-714.pdf>

4. Arai SR, Butzlaff A, Stotts NA, Puntillo KA. Quench the thirst: lessons from clinical thirst trials. Biol Res Nurs. 2014 Oct [cited 2015 Jan 08];16(4):456-66. Available from:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3989478/pdf/nihms-512007.pdf>

5. American Society of Anesthesiologists (ASA). Practice guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures-a report by the American Society of Anesthesiologists Task Force on Preoperative Fasting. *Anesthesiology*. 2011 Mar [cited 2014 Jun 10];114:495-511. Available from:

<http://www.asahq.org/~media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/practice-guidelines-for-preoperative-fasting.pdf>

6. Dodd M, Janson S, Facione N, Faucett J, Froelicher ES, Humphreys J, et al. Advancing the science of symptom management. *J Adv Nurs*. 2001 Mar [cited 2014 Aug 22];33(5):668-76. Available from:

<http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.2001.01697.x/>

7. Conchon MF, Nascimento LA, Fonseca LF, Aroni P. Sede perioperatória: uma análise sob a perspectiva da Teoria de Manejo de Sintomas. *Rev Esc Enferm USP* [Internet]. 2015 Feb [cited 2015 April 03]; 49(1):122-28. Available from:

[http://www.scielo.php?script=sci\\_arttext&pid=S0080-62342015000100122&lng=pt](http://www.scielo.php?script=sci_arttext&pid=S0080-62342015000100122&lng=pt)<http://dx.doi.org/10.1590/S0080-623420150000100016>.

8. Conchon MF, Fonseca LF. Eficácia de gelo e água no manejo da sede no pós-operatório imediato: ensaio clínico randomizado. *J Nurs UFPE on line* [Internet]. 2014 [cited 2014 June 16];8(5): 1435-40. Available from:

[http://www.revista.ufpe.br/revistaenfermage/index.php/revista/article/view/5839/pdf\\_5167](http://www.revista.ufpe.br/revistaenfermage/index.php/revista/article/view/5839/pdf_5167)

9. Puntillo KA, Arai SR, Cooper BA, Stotts NA, Nelson JE. A randomized clinical trial of an intervention to relieve thirst and dry mouth in intensive care unit patients. *Intensive Care Med* [Internet]. 2014 Sept [cited 2014 Dec 08];40(9):1295-302. Available from:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4149585/#!po=1.42857>

10. Gois CFL, Dantas RAS. Stressors in care at a thoracic surgery postoperative unit:

11. nursing evaluation. *Rev Latino Am Enferm* [Internet]. 2004 Jan/Feb [cited 2013 Oct 02]; 12(1):22-7. Available from:

<http://www.scielo.br/pdf/rlae/v12n1/v12n1a04.pdf>

12. Madsen M, Brosnan J, Nagy VT. Perioperative thirst: a patient perspective. *Perianesth Nurs* [Internet]. 1998 Aug [cited

2014 Oct 25];13(4):225-8. Available from: <http://www.ncbi.nlm.nih.gov/m/pubmed/9814292/>

13. Lefevre F, Lefevre AMC. Depoimentos e discursos: uma proposta de análise em pesquisa social. Brasília (DF):Liber Livro; 2005.

14. Landström M, Rehn IM, Frisman GH. Perceptions of registered and enrolled nurses on thirst in mechanically ventilated adult patients in intensive care units-a phenomenographic study. *Intensive Crit Care Nurs* [Internet]. 2009 June [cited 2014 Jan 16];25(3):133-9. Available from:

<http://www.sciencedirect.com/science/article/pii/S0964339709000238>

15. Arai S, Stotts N, Puntillo K. Thirst in critically ill patients: from physiology to sensation. *Am J Crit Care*. 2013 Jul [cited 2014 Nov 04];22(4):328-35. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3718499/pdf/nihms487008.pdf>

16. Blower AC. Is thirst associated with disability in hospital inpatients? *J Hum Nutr Diet*. 1997 [cited 2014 Oct 22];10(5):289-93. Available from:

<http://onlinelibrary.wiley.com/doi/10.1046/j.1365-277X.1997.00061.x/pdf>

17. Nascimento LA, Fonseca LF. Sede do paciente cirúrgico: elaboração e validação de um protocolo de manejo seguro da sede. *Rev Enferm UFPE on line* [Internet]. 2013 [cited 2014 March 18];7(n. spec 3):1055-8. Available from:

<http://www.revista.ufpe.br/revistaenfermage/index.php/revista/article/view/3920>.

18. Nascimento LA, Fonseca LF, Rossetto EG, Santos CB. Development of a Safety Protocol for Thirst Management in the Immediate postoperative period. *Rev Esc Enferm USP* [Internet]. 2014 Oct [cited 2015 Apr 03];48(5):834-43. Available from:

[http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S0080-62342014000500834&lng=pt](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342014000500834&lng=pt)

19. Hur YS, Shin KA, Lee WJ, Lee JO, Im HJ, Kim YM. The Comparison of moisturizing effect of cold water gargling, wet gauze application and humidification in reducing thirst and mouth dryness after nasal surgery. *J Korean Clin Nurs Res* [Internet]. 2009 Apr [cited 2014 July 10];15(1):43-53. Available from:

[http://m.riss.kr/search/detail/DetailView.do?p\\_mat\\_type=1a0202e37d52c72d&control\\_no=71ccff8e6f7f0810ffe0bdc3ef48d419](http://m.riss.kr/search/detail/DetailView.do?p_mat_type=1a0202e37d52c72d&control_no=71ccff8e6f7f0810ffe0bdc3ef48d419)

20. Yoon SY, Min HS. The effects of cold water gargling on thirst, oral cavity condition, and sore throat in orthopedics surgery patients. *Korean J Rehabil Nurs* [Internet]. 2011 Dec [cited 2014 Dec 21];14(2):136-44.



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Thirst in surgical patients: perceptions...

Available from:  
[http://www.koreascience.or.kr/search/articlepdf\\_ocean.jsp?url=http://ocean.kisti.re.kr/download/volume/kasrn/HKJHBX/2011/v14n2/HKJHBX\\_2011\\_v14n2\\_136.pdf](http://www.koreascience.or.kr/search/articlepdf_ocean.jsp?url=http://ocean.kisti.re.kr/download/volume/kasrn/HKJHBX/2011/v14n2/HKJHBX_2011_v14n2_136.pdf)

21. Patel T, Ishiuiji Y, Yosipovitch G. Menthol. A refreshing look at this ancient compound. J Am Acad Dermatol. 2007 Nov [cited 2015 Jan 06];57(5):873-8. Available from:

[http://www.jaad.org/article/S0190-9622\(07\)00755-4/](http://www.jaad.org/article/S0190-9622(07)00755-4/)

22. Perlas A, Davis L, Khan M, Mitsakakis N, Chan VWS. Gastric sonography in the fasted surgical patient: a prospective descriptive study. Anesth Analg. 2011 July [cited 2015 feb 16];113(1):93-7. Available from:

<http://www.ncbi.nlm.nih.gov/m/pubmed/21596885/>

23. Siles González J, Solano Ruiz MC. Cultural history and aesthetics of nursing care. Rev Latino Am Enferm [Internet]. 2011 Oct [cited 2014 Sept 15];19(5):[about 5 screens]. Available from:

[http://www.scielo.br/pdf/rlae/v19n5/pt\\_06.pdf](http://www.scielo.br/pdf/rlae/v19n5/pt_06.pdf)

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