



INTENSIVE CARE UNIT NURSES NEED USER EMBRACEMENT
O ENFERMEIRO DE UNIDADE DE TERAPIA INTENSIVA NECESSITA DE ACOLHIMENTO
EL ENFERMERO DE UNIDAD DE TERAPIA INTENSIVA NECESITA ACOGIMIENTO

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ABSTRACT

Objective: to understand how intensive care unit (ICU) nurses experience user embracement. **Method:** descriptive and exploratory study with qualitative approach. The research was held at the ICU of a public hospital in the south of Brazil with the participation of six nurses. Data collection was carried out from July to October 2008, using recorded semi-structured interviews, based on the following guiding question: How do you, nurse of the intensive care unit, experience user embracement? The collective subject's discourse was used for the analysis. The research project was approved by the Research Ethics Committee, Protocol No. 342/2007. **Results:** after the analysis, three discourses emerged: User embracement and receptivity; 2) User embracement is grounded in family values; and 3) Lack of user embracement for nurses. **Conclusion:** the nurses understood that user embracement in the environment of the ICU was directly influenced by the experiences of family, academic and professional life. **Descriptors:** Intensive Care Unit; User Embracement; Nursing.

RESUMO

Objetivo: entender como os enfermeiros de unidade de terapia intensiva (UTI) vivenciam o acolhimento. **Método:** estudo descritivo, exploratório, de abordagem qualitativa. A investigação foi realizada na UTI adulto de um hospital público no sul do Brasil com a participação de seis enfermeiros. A coleta dos dados foi realizada de julho a outubro de 2008, com entrevistas semiestruturadas gravadas, a partir da questão norteadora: Como você enfermeiro de unidade de terapia intensiva vivencia o acolhimento? Para análise, utilizou-se o discurso do sujeito coletivo. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, Protocolo nº 342/2007. **Resultados:** depois da análise foram originados três discursos: 1) Acolhimento é receptividade; 2) O acolhimento está ancorado em valores familiares; e 3) Falta acolhimento para o enfermeiro. **Conclusão:** os enfermeiros compreenderam que o acolhimento no ambiente de UTI era influenciado diretamente pelas experiências de vida familiar, acadêmica e profissional. **Descritores:** Unidade de terapia intensiva; Acolhimento; Enfermagem.

RESUMEN

Objetivo: comprender cómo los enfermeros de la unidad de cuidados intensivos (UCI) experimentan el acogimiento. **Método:** estudio descriptivo y exploratorio con enfoque cualitativo. La investigación se realizó en la UCI de adultos de un hospital público en el sur de Brasil con la participación de seis enfermeros. La recolección de datos se llevó a cabo de julio a octubre de 2008, con entrevistas semiestructuradas grabadas, con la siguiente pregunta guía: ¿Cómo, usted enfermero de la unidad de cuidados intensivos, experimenta el acogimiento? Para el análisis se utilizó el discurso del sujeto colectivo. El proyecto de investigación fue aprobado por el Comité de Ética de la Investigación, Protocolo N° 342/2007. **Resultados:** después del análisis se originaron tres discursos: 1) Acogimiento y receptividad; 2) El acogimiento está anclado en los valores familiares; y 3) Falta de acogimiento para el enfermero. **Conclusión:** los enfermeros comprendieron que el acogimiento en el ambiente de la UCI estaba influenciado directamente por las experiencias de la vida familiar, académica y profesional. **Descriptores:** Unidad de Cuidados Intensivos; Acogimiento; Enfermería.

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INTRODUCTION

User embracement (UE) means receptivity, welcoming and also accepting the 'other' as a subject of rights and co-responsible for the promotion of health, both from an individual perspective and the collective point of view.¹ UE and care humanization in intensive care units (ICUs) is a difficult task, because it sometimes requires individual attitudes against a dominant technological system. Even so, there is in practice a great effort on the part of nurses so that the humanization of the service occurs or starts. It is believed that when nurses are open to the relationship with the patients and families, various difficulties are overcome, facilitating the dosage of emotional needs and the use of technologies in a balanced way. With the passage of time, it can be noticed that UE experiences are intensely rewarding, especially when the families express confidence in the nurses and other health team members. With a relationship of trust and UE, nurses become the reference to support these users.

The hospital environment has connotation of pain, suffering and deprivation. In ICUs, particularly, patients face fear, loneliness and the prospect of permanent coexistence with the death. Usually, patients are isolated from their family members, they are forgotten and excluded and the nursing staff ends sometimes depersonalizing their actions by focusing on objectivity and technology. However, since nurses manage nursing care, they are seen as a model and reference for care. For this reason they have to be well enough to play their role.

ICU nurses have experienced that health care has become increasingly technological. However, a critical disease is not only a physiological change, but a psychosocial, developmental and spiritual process, representing a threat to the individuals and their families. This fact makes humanization requirements concurrent to technological advances increasingly essential. Nurses must also show interest, attention, empathy, desire and ability to make patients and their families in crisis to be embraced.¹

ICU nurses, particularly, have a high level of responsibility to perform more complex activities involving greater risk for patients, in addition to being responsible for the activities carried out by all the nursing staff. Health care practice has shown that nurses who care for critical patients present signs of physical and/or psychological suffering, which are characteristic of the resistance, need and help phase... or would it be UE?

Given this context, the following guiding research question was raised: How do intensive care unit nurses experience UE? In order to answer this question and seeking to minimize the gap that exists in this area, this study proposes the following goal:

- to understand how intensive care unit nurses experience UE.

METHOD

This is a descriptive exploratory study with a qualitative approach, carried out with the ICU nurses of a large public hospital, which is a reference institution of the southern region of Brazil. The ICU is comprised of 10 beds and two of them are insulated by glass panels for easy viewing. The nursing staff is constituted by six nurses and 26 nursing technicians. Since 2007, every technician provides nursing integral care for every two patients and, since six months ago, the ICU nurses, along with their teams, have implemented UE strategies for patients and family members in the unit.

The participants of this research were six nurses who accepted the invitation to participate in the study during the period of data collection. The number of nurses was not previously stipulated because a qualitative research uses expressive sampling information and not the number of participants.²

The data were collected with the nurses separately through a semi-structured interview with the following guiding question: How do you, nurse of the intensive care unit, experience UE? The interviews were conducted from July to October 2008. They had an average duration of 30 minutes and were recorded for being subsequently transcribed. In order to preserve the privacy of the subjects of the study, they were identified using codes for the order number of the interviews, for example: Nurse 1 (E1). Confidentiality and anonymity of the information was assured to all the participants and they signed an informed consent form after the first contact, in accordance with Resolution No. 196/96 of the National Health Council, which regulates research involving human beings.

For the processing of data, the following three methodological figures of the collective subject's discourse were used: key expressions (KEs); central ideas (CI); and the collective subject's discourse (CSD).³ The KEs are pieces, excerpts or continuous or discontinuous transcripts of discourses that reveal the essence of the content of a given fragment that makes up the discourse. They should be highlighted by the researcher since they

reveal the essence of the statement or, more precisely, the discursive content of segments into which the statement is divided. The CI is composed of linguistic expressions that reveal or describe in a more synthetic and as accurately as possible the meaning or sense and the theme of each homogenous set of KEs that will give rise to the CSD.

In order to build the CSD, a classical layout (beginning, middle and end) is followed, from the most general topic to the most specific detail. The parts of discourse or paragraphs are linked through linking words that provide discourse cohesion, eliminating specific data, such as sex, age, private events, specific diseases and the repetition of ideas.³ Therefore, the CSD is an aggregation, or non-mathematical sum of isolated pieces of statements, so as to form a whole coherent discourse, in which each part may be recognized as a constituent of that complete discourse. It is a synthesis discourse in the first person singular and comprising the "collage" of KEs that have the same CI.³ It is worth mentioning that the research project of this study was approved by the Research Ethics Committee of the Federal University of Santa Catarina (CEP/UFSC) with Protocol No. 342/07.

RESULTS

Key expressions refer to UE and the idea of receptivity mainly related to personal values and beliefs acquired in the family environment.

1. Central Idea (CI): UE and receptivity.

Key-Expressions (KEs):

I think that user embracement is receiving, welcoming. It must be in this sense that the word user embracement emerged. I think that it is linked to humanization. (E3)

It is receptivity. Receiving both the patients and the families in the sector, in the place where we work. (E4)

If a word should be said, I would say receptivity. User embracement, in fact, is how you receive the patients, the families. Not only how you receive them at the time that they are admitted, but throughout the process until patients' discharge. How you are going to treat the patients, how you are going to relate to the patients and the families. (E5)

Collective Subject's Discourse (CSD) 1:

User embracement is how you receive, treat and relates to the patients and the families. Not only how you receive them at the time that they are admitted, but throughout the process until patients' discharge. I think it is linked directly to humanization. (E3, E4, E5)

2. Central Idea (CI): User embracement is grounded in family values.

Key-Expressions (KEs):

I think there's a lot of what you are. The way you use to relate to other people, regardless of being or not in the workplace, it has to do with your way of being. (E2)

I think that user embracement has a lot to do with creation and things from home, family. (E3)

It's much more personal. My home education brought much more of this than graduation did. The way I deal with the patients and the families comes from family. (E5)

I believe it is the personal self that interferes in how I am at the workplace. You bring to the professional the way you are. (E6)

Collective Subject's Discourse (CSD) 2:

The way I deal with the patients and families comes from family, creation. It's much more personal. The way you use to relate to other people, regardless of being or not in the workplace have to do with your way of being. (E2, E3, E5, E6)

3. Central Idea (CI): Lack of UE for the nurses.

Key-Expressions (KEs):

User embracement depends a lot on how you are feeling at that moment. (E1)

Some people have a tendency to avoid getting involved, I don't know why, but the relationship with human beings, either patients or nurses, should have involvement. You do not have a relationship if you don't get involved somehow, but this is not easy, you also feel lack of user embracement. (E2)

We say that we are used to the environment of the ICU, with the service, but emotionally, the ICU will demand much more from you than any other sector. I felt that it is another kind of tiredness. I can't wait to go on vacation. I miss works on the humanization of the nurses and the ICU environment. (E3)

Sometimes, it is much easier to create a barrier in order not to get involved. If they are crying I won't even look, it is easier than going there and get involved, giving a handkerchief because I don't know how to act in this situation, and who's going to embrace me afterward? I think that emotionally, the ICU will demand much more from you than any other sector. (E6)

Collective Subject's Discourse (CSD) 3:

Some people have a tendency to avoid getting involved and create a barrier. If someone is crying, it's easier not to look than going there and give a handkerchief, because I don't know how to act in this situation. And who's going to embrace me

afterward? In a relationship with human beings, either patients or nurses, there should be involvement. You do not have a relationship if you don't get involved somehow. But, user embracement depends a lot on how you are feeling at that moment. We say that we are used to the environment of the ICU, with the service, but emotionally, the ICU will demand much more from you than any other sector. I felt that it is another kind of tiredness. I can't wait to go on vacation. I miss works on the humanization of the nurses and the ICU environment. (E1, E2, E3, E6)

DISCUSSION

CSD 1 shows that nurses' understanding about UE is related to the professionals' way of being during the relationship established with patients and families in the ICU. UE is a procedure for the reorganization of services that allows detecting gaps in the relationships nurse/patient and nurse/family, with a view to ensuring universal access, efficaciousness and humanization of health care.⁴ Thus, UE can be seen as an interference strategy in the work process, which consists of a change in attitude regarding health care and implies sharing knowledge, needs, possibilities, anxieties, and inventions. A UE attitude implies being aware and prepared to cultural, racial and ethnic diversity.^{5,6}

Those involved in this relationship with the other possess powers and knowledge suitable for communication. This communication requires a relationship of dialogue, respect for others and acceptance of differences, in order to establish a relationship of mutual trust.⁷ This respect and acceptance must occur at all times during the relationship between nursing professionals and patients in the ICU and their families, from the admission, including the period of stay, until hospital discharge, as observed in the discourses presented.

In the context of dialogical relationship in the ICU, UE must arise from a meeting in which patients and families share their anguish and the nurses are able to respond to this call in order to help them confront this new experience.⁸ The dialogue in that meeting has a goal, since this is a joint work built through sharing that relationship and it is not just a vehicle for reaching a set of agreements or consensus.⁹

However, the notion of UE in the field of health has been focused on the diseases and the procedures, and not on the subjects and their needs. Punctual, isolated and uncommitted actions are programmed, producing suffering and low quality of life not only for users, but also for health

professionals. The challenge of ethical alliances for the promotion of life arises, in which the singular commitment with users is the center of this process.⁵

The importance of recognizing the perspective of the users grows when the quality of health services is addressed. UE is one of the essential elements of health care, so that it is possible to focus effectively on the individuals and the collectivity's state of health.⁶ In this way, the actions focused on the patients and their families and not on the diseases involve UE, with feelings and respect for their personal and social history, their values, their beliefs and their feelings. UE must transform the perception that people have regarding hospitals as a hostile environment and make the period of stay as pleasant as possible.¹⁰

Generally speaking, UE should be implied in all the relationships established; however, in daily practice at ICUs, for different reasons, there is a tendency to be distant from meeting patients and family members. When performing UE, the existing model expands and it is almost exclusively directed to objectivity and nursing care subjectivity gains prominence.

In CSD 2, nurses state that in order to relate with the patients and families they retrieve their life experiences and interact according to their beliefs and values in the UE at ICUs. This finding was also found in another study.¹⁰ There is a close relationship between the meaning of UE and the essence of health care. Thus, while retrieving the definition of health care, many authors define it according to their life references and experience. To this end, UE is understood as: a way of being; health care being associated to feelings; related to another human being and a state in which subjects recognize themselves in the others and know the others and care about them; an interaction of personal, social and professional dimensions; and also defined as a moral phenomenon.¹¹

According to ICU nurses' perception, UE reflects personal experiences. This interpretation suggests that the way in which they relate within the professional environment can be similar to their family relationships or reflect beliefs as the one observed during health care practice, i.e., ideal nurses have a firm stance and avoid expressing feelings and exhibiting attitudes that somehow can depreciate their technical skills. From these ideas, UE is understood as an interactive attitude between two or more human beings that respect and value their life

experiences. Within this human intersubjectivity, a dialogical relationship of a genuine meeting between the professionals and the individuals being cared for takes place in a complementary process of feelings, actions and reactions.

Hospital institutions aggregate multiple sectors and professions. They become institutions composed of workers exposed to emotionally intense situations such as life, disease and death, which repeatedly triggers anxiety and physical and mental tension.¹² The CSD 3 seems to confirm the importance of subjectivity in nursing health care at ICUs. However, it points out the individual limitations of professionals as human beings to lead patients and relatives' anguish.

Daily routines can separate professionals under pressure and, sometimes cold and hardened by coping with the fear and pain, that closes themselves in face of their human limitations, from the patients and their families with fear, pain, anxieties, and doubts.⁷ Sometimes, the relationship between them is fragmented and distant, giving no response to calls, because for some health professionals subjective relationships with patients and family members in the ICU increase their exposure to feelings of pain, suffering and fear.

In certain situations involving the affection and suffering so present in the ICUs, there is difficulty affecting the nursing staff, because nurses did not receive emotional preparation for these experiences with patients and their families.¹³ The highlighted issue in the nursing schools has been the biomedical model, focused on the disease, with a fragmented curriculum in which the human being is seen as part of a machine. Thus, without proper preparation, most nursing workers present feelings of impotence, which obstructs the increment of humanization actions in the health care context. UE within health institutions—when it takes place—still emphasizes the patients and the families, showing little concern with respect to subject-worker's UE.¹⁴

Guided by these feelings, the professionals move away, avoiding emotional involvement because they believe that this is the best way to take care of themselves. It is therefore a challenge to make the relationship between nurses, patients and families a real meeting, characterized by a genuine presence in search of well-being and being better, essential for the production of health protection.

UE provided to professionals in the workplace is critical to the introspection of

subjectivity and love in professional and interpersonal relationships. During the relationship with the patients and the families, professionals take their cultural values, prejudices or attitudes, so that UE for those who provide health care is critical.¹⁵

With this emphatic relationship, the professionals put themselves in the place of the patients and family members in order to care for them with respect and dignity. While being valued, the professionals become more dynamic, especially regarding increased self-esteem that benefits both the occupation of a recognition and prestige position and professional autonomy.¹³

The humanization of work for nursing professionals points out that the fact that some institutions have a team of humanization facilitates meetings between the workers, with the aim of learning and intellectual growth. However, the actions are not always effective for the improvement of the relationship within the team and the manifestations of feelings associated with the devaluation of the professionals are persistent. In practice, the effects of activities proposed by the teams of humanization only appear after internalization of the proposal for humanization and UE at the institution by all professionals. Therefore, the constant evaluation of the activities proposed by the team of humanization in hospital institutions is relevant.¹⁴

Although there is a load of emotional distress, some professionals are kind and attentive to patients. They are able to maintain and demonstrate their emotions, with a commitment to offer health care based on the expression of love, tenderness, warmth and compassion.¹⁴ The Ministry of Health proposed the National Plan for Humanization aiming to meet the subjective demands of patients, family members and workers based on health care integrality.⁵

Based on the principles of integrity, fairness and users involvement, the UE should favor the creation of spaces for enjoying and stimulating the dignity of the patients, families and professionals.¹⁵ Nursing is a human experience and includes all the possible answers from people (those who provide health care and those who receive it) in each situation. Thus, it is worth noting that nurses and their nursing staffs, like any other human beings, possess potentialities, such as tenderness, confidence, joy, hope, and limitations such as frustration, impatience, aggressiveness and suffering.⁸

CONCLUSION

The nurses understood that UE in the ICU environment was directly influenced by the experiences of family, academic and professional life. It is understood that it is necessary to show the paths for a new way to understand and feel the reality, not only prioritizing technicality, but proposing warmth care, making the nurses turn their attention to the patients, being more present and responding to patients and their families' calls, as well as regarding themselves as individuals.

By recognizing the emotional limitations and difficulties that the ICU nurses revealed, this UE proposal suggests the help of the multiprofessional team that works in ICUs, particularly the psychologists who aim to unite their knowledge and actions to the other health care procedures, for promotion and an extensive support to life and health in a biopsychosocial dimension that can help meet nurses' needs. However, this study did not have the pretension of exhausting all discussions about the experience of nurses in ICUs, but to allow reflection and even the action of recommending to nurses the importance of being aware to intervene in gaps of interrelationships within the scenarios where social and nurses' practices are developed.

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