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HUMANIZATION OF NURSING CARE TO THE PATIENT IN THE PERIOPERATIVE PERIOD: A NURSE'S VISION

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Abstract: Objective: To identify factors that act as a barrier, so that humanized nursing care does not occur in its legitimate form in the Surgical Center and to contribute to the improvement of the quality of care provided to the client/patient. Method: Field research was carried out through semi-structured interviews with 32 nurses from two hospitals, one philanthropic/private and the other public, from June to July 2017. Results: Difficulties were identified in providing humanized care in the Surgical Center, such as: Negligence in the application of humanized practices, work overload, lack of knowledge of the attributions of the humanization program, deficit in the dimensioning of personnel and investment in continuing education. Final considerations: The study reinforces that despite the difficulties, there must be no barriers that make it impossible to provide humanized care, with the guidance and qualification of nurses being essential to ensure humane and quality care.
Keywords: Surgical Center. Humanization of Assistance. Nurses.

INTRODUCTION

Due to the increase in specializations in different areas, some health professionals have lost direct contact with the patient, leaving their emotions, beliefs and values in the background. Scientific knowledge became the center, transforming health care into just providing a mechanized service. With that, the need arose to seek a more humane care that goes beyond the scientific technique, in favor of a more humanized care, after all, to humanize is to have a different look, it is to see the client/patient as a whole in a biopsychosocial way, also looking at their family and community, as it was noted that this was the appropriate way to intertwine care with technological advances (BRASIL,2001; BRASIL, 2012).

Humanization in the hospital environment becomes important since, nowadays, it has been the subject of debate, as care is not being faithful to what the National Humanization Policy (PNH) recommends (GIRON; BERARDINELLI; SANTO, 2013).

In Brazil, the Unified Health System (SUS) was the forerunner in the implementation of humanization in health through the creation, in 2001, of the National Program for the Humanization of Hospital Assistance (PNHAH), which served as the basis for the creation, in 2003, of the HNP. Such measures are aimed at rescuing humanitarian values, especially empathy between health professionals and patients (BRASIL,2001; BRASIL, 2012).

The composition of the Surgical Center (SC) is elaborate and bureaucratic, becoming more dehumanized and technical. The nursing team, especially the nurse, must be careful so that the patient/client is seen as a whole, without labels, without nomenclature, as a bearer of feelings and not just as another pathology, another procedure, more a treatment or even a medical record number, devaluing their own identity and individuality (MARQUES; MORAES; OLIVEIRA, 2012).

The perioperative period comprises the moment the patient/client enters the SC until the moment he is referred to the Post Anesthesia Care Unit (PACU). When the patient/client is submitted to a surgical procedure, he is taken by desires that act negatively in the restoration of his state of health, showing that these feelings are not only related to the environment, equipment and unknown people, but also that one must consider the way that each patient/client individually lives the experience of being in the SC (STUMM *et al,* 2009).

Therefore, the nurse has a great responsibility in making the assistance humanized from the reception of the patient

throughout his/her stay in the SC, even with the supposed existence of barriers that make the act difficult, and that often prevent welcoming occurs in a humane way, ensuring that the culture of the place does not change (GIRON; BERARDINELLI; SANTO, 2013).

The present study stems from the need for SC nurses to have an individualized look that encourages communication between patient/client and professional so that this happens based on qualified listening, culminating in the construction of a humanized care process of nursing, which preserves the autonomy of the patient/client by establishing a bond of trust capable of significantly reducing the anxiety and negative psychological responses that are routinely present in this surgical event, generating credibility, trust in the professional and in the service provided (ROCHA; IVO, 2015).

In view of the above, the following research question arises: What factors hinder the execution of humanized nursing practices in the perioperative period for the patient/client in the Surgical Center according to the nurse's perception?

Therefore, the present study aims to identify factors that act as barriers, so that humanized nursing care does not occur in its legitimate form in the SC and contribute to the improvement of the quality of care provided to the client/patient.

METHODOLOGY

This is a cross-sectional, descriptive, quantitative and qualitative study, which aims to collect primary data from a given population, or previously specified sample, using technical variables to demonstrate a hypothesis, seeking to analyze the effectiveness of the humanization of nursing care based on theoretical references already addressed and published, where a systematic review of the literature of choice was performed (LAKTOS; MARCONI, 2010; GIL, 2010).

The primary data collection was carried out in a public hospital in the State of Bahia, which offers urgent, emergency, hospitalization, small, medium and large elective surgeries, and another teaching hospital, from the private and philanthropic network, which operates in the day hospital model, both located in the city of Salvador, in the state of Bahia, Brazil. The samples were of the simple random type and had as inclusion criteria nurses who work with patients/clients in the CC of the respective institutions with a minimum admission time of 02 months and a maximum time of 30 years of service. As exclusion criteria: nurses who do not maintain contact with SC patients/clients. Therefore, totaling a sample of 32 nurses who participated in the study.

After approval by the Ethics Committee for Research with Human Beings, opinion nº. 2,078,427 of May 23, 2017, the semi-structured interviews were carried out in June and July 2017, taking place only through the face-to-face application of the research questionnaire composed of simple, multiple-choice and optionally justifiable subjective questions.

The compilation of quantitative data and statistical analysis of the results obtained through a sample study were carried out in Microsoft Excel and subsequently transformed into graphs and tables with sociodemographic and labor information. After the separate analysis of each hospital, the data in question were unified and transformed into unique graphs for each applied question. Some justifications considered relevant were selected and used to support the discussion of the statistical results obtained in the research.

To support the proposed study, scientific articles from the following databases were used: Latin American and Caribbean

Literature in Health Sciences (LILACS), Virtual Health Library (BVS) and SciELO Scientific Electronic Library Online (SciELO).

49 studies were found available in electronic scientific databases. For the selection of articles, scientific articles available in Portuguese from 2001 to 2017, which converged with the theme and objectives of the research, were used as inclusion criteria. It was noted that some of them were repeated in the different databases, were incomplete and others did not meet the inclusion criteria of the study, being excluded. Thus, 22 articles remained, whose titles and abstracts were read in detail to identify those appropriate for the basis of the discussion of the results of this research, as well as manuals and protocols.

The research project was carried out in compliance with the requirements of the Ethics Committee for research involving human beings, Resolution nº. 466/2012 of the National Health Council, which deals with regulatory guidelines and standards for research involving human beings. The Informed Consent Form (TCLE) was used, which after explaining the research project was signed and a copy left with all those involved at the end of each interview (NOVOA, 2014).

RESULTS

In this section, the results obtained after compiling primary data through biostatistical analysis are presented.

Public Hospital of Salvador BA			
	Variable	**n(25)**	**%**
Age	20 to 30 years	4	16
	31 to 40 years	14	56
	41 to 50 years	3	12
	51 to 60 years	4	16
Gender	Feminine	24	96
	Masculine	1	4
Service time	0 to 1 year	11	44
	1 to 2 years	7	28
	2 to 6 years	4	16
	6 to 20 years	1	4
	20 to 30 years	2	8
Bond Type	CLT	10	40
	Contract	6	24
	Statutory	9	36
Position	Nurse (a)CC	25	100
	Total	25	100

Philanthropic / Private Hospital of Salvador BA			
	Variable	**n(25)**	**%**
Age	20 to 30 years	5	71,43
	31 to 40 years	2	28,57
Gender	Feminine	5	71,43
	Masculine	2	28,57
Service time	0 to 2 year	2	28,57
	3 to 6 years	5	71,43
Bond Type	CLT	7	100
Position	Nurse (a)CC	7	100
	Total	7	100

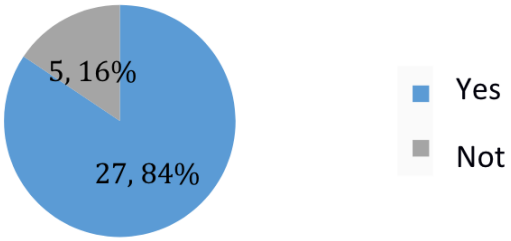
*N= Sample Size *% = Percentile.

Table 01 - Social, demographic and labor characteristics of 25 nurses from a public hospital and 07 nurses from a philanthropic/ private hospital, according to age, gender, length of service, type of job and position, Salvador, Bahia, Brazil, 2017. (N=32).

Source: Own elaboration.

Table 1 shows the number and characterization of the nurses interviewed. The results present data collected during the interviews, which, in turn, were separated by research hospital, which is philanthropic/ private, with a population of 07 nurses with a prevalent age of 20 to 30 to years of age equivalent to 71, 43%, equivalent to females 71.43%, length of service 03 to 06 years

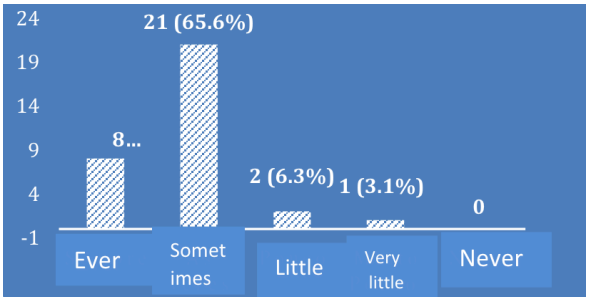
equivalent to 71.43%, type of CLT bond equivalent to 100% and position of nurses who work with surgical patients 100%. In the public hospital in Salvador, Bahia, with a population of 25 nurses with a prevalent age of 31 to 40 years equivalent to 56%, female 96%, length of service 02 to 12 months 44%, type of CLT bond equivalent to 40 % and position of surgical center nurses 100% by analyzing the collected data, we can trace the profile of nurses working in the CC.



Graph 01: Knowledge of the nurse regarding the PHN.

Source: Own elaboration

Graph 01, on the other hand, shows the total of 27 (84.4%) nurses who claimed to have knowledge about PNH, and 5 (15.6%) who denied having knowledge about the program.



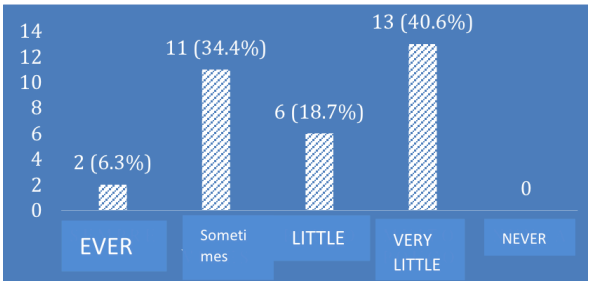
Graph 02: Time for carrying out humanized and individualized care for each patient/client.

Source: Own elaboration.

Graph 02 shows that 21 (65.6%) nurses stated that sometimes there is time available to provide humanized and individual assistance to each patient/client.

According to nurses from the philanthropic/ private Hospital, none of the interviewees gave any justification.

According to nurses at the Public Hospital of Salvador, Bahia: Due to the high demand for surgical procedures on weekends and the reduced number of professionals, it is impossible to protect all clients (E08) and the attempt to idealize processes to maintain humanization it is frequent, but the short time is indeed a factor that makes it difficult to always answer (E02).



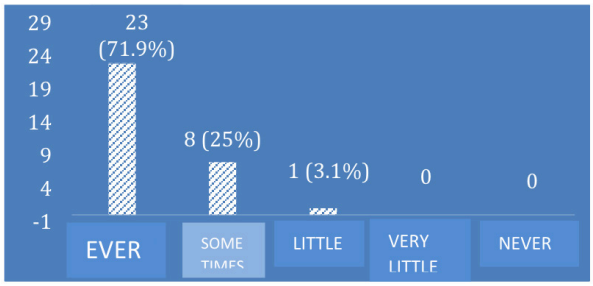
Graph 03: Frequency with which the SC nurse observes that nursing care is not being humanized.

Source: Own elaboration.

Graph 03 shows that from the point of view of the nurses who work in the SC, 13 (40.6%) believe that the frequency of non-humanized assistance in the SC is very low and 11 (34.4%) say that sometimes times this happens.

According to nurses from the philanthropic/ private Hospital: *When there is a very large flow of patients it is not always possible. Even because it is usually a nurse for all patients* (E07).

According to nurses from the Public Hospital of Salvador Bahia: *Mainly with emergency care when the patient does not respond and the criterion "saving life" is placed first. Or in the multi-specialized care of a service such as a surgical center, which the protocols sometimes impair the client's autonomy* (E16) *and Assistance is offered so that the work develops in the best possible way* (E08).

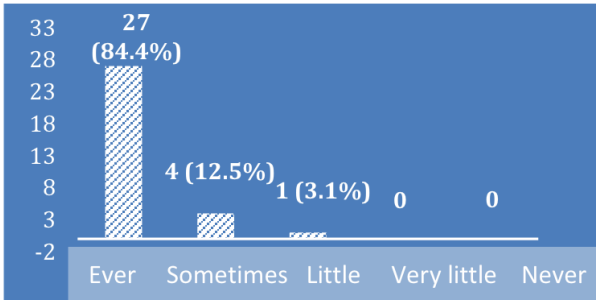


Graph 04: Nurse's perception of the difference in nursing care when it is provided in a humanized way.

Source: Own elaboration.

Graph 04 shows that 23 (71.9%) nurses answered that assistance is always provided in a humanized way and they perceive that there is a difference in the care provided.

> According to nurses from the philanthropic/ private Hospital: *It interferes with the patient's emotional well-being and recovery during the postoperative period* (E06).
>
> According to nurses from the Public Hospital of Salvador Bahia: *It improves the quality of the service provided and recognition by the patient* (E11); *The patient is much calmer and more collaborative* (E16) *and Greater Collaboration of patients* (E01).

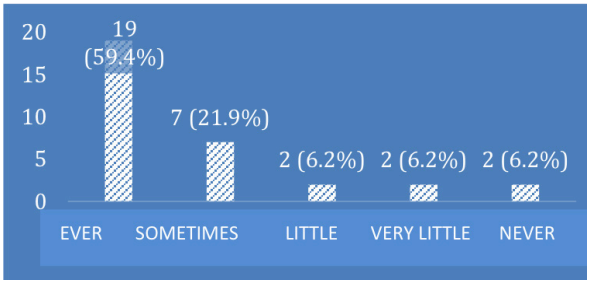


Graph 05: Need to improve humanized nursing care according to the nurses' point of view.

Source: Own elaboration.

Graph 05 shows that 27 (84.4%) nurses answered that, given their experiences, they agree that the humanization of nursing care always needs to be improved.

> According to nurses from the philanthropic/ private Hospital: *Individualized and humanized care always modifies and improves, it is always necessary to update and improve* (E01).
>
> According to nurses from the Public Hospital of Salvador Bahia: *A lot, every day, we need to provide humanized assistance* (E02); *There is always a need for new training* (E10); *The Surgical Center professional is responsible for the reception of the patient, has to treat them well, answer questions and minimize anxiety and* with *updating, working conditions and resources that favor this improvement* (E01).

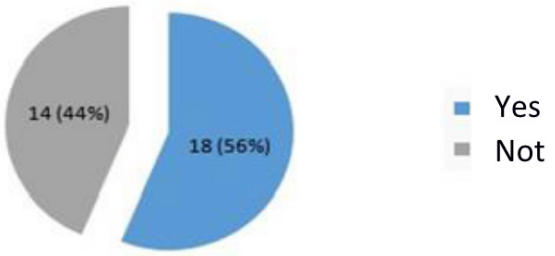


Graph 06: Interferences in the number of nursing professionals to provide humanized care when compared to the sector's demand.

Source: Own elaboration.

In Graph 06, it can be seen that 19 (59.4%) nurses responded that the number of nursing professionals always interferes with the performance of humanized care, when compared with the demand of the sector, and, 07 (21.9%) answered that sometimes there is interference.

> According to nurses from the philanthropic/ private Hospital: *In larger demands, care control is lost when a large enough team is not offered to maintain care and service quality* (02).
>
> According to nurses at the Public Hospital of Salvador Bahia: *This is a key factor, as it contributes to a more complete and calm assistance, avoiding failures, being more holistic* (E08) and *when there is a great demand and a reduced staff and Demand big with small frame, leads to professional demotivation and dissatisfaction* (E02).



Graph 07: Opinion of the nursing professional regarding the interference on the negligence of humanization when there is a need to return care to the bureaucratic service.

Source: Own elaboration

In Graph 07, it is observed that 18 (56.25%) professionals agree that when the nurse turns to the bureaucratic service, humanized nursing care is left aside or neglected.

> According to nurses from the philanthropic/ private Hospital: *From the moment the nurse needs to make reports, and emails, the patient ends up being left out* (E01).
>
> According to nurses from the public hospital in Salvador – Bahia: *Often in the wards, the number of forms is very large, the professionals end up providing more time in the bureaucratic service, resulting in quality care* (E06); *Nursing is indeed very bureaucratic. There are several reasons why processes need to be improved, including legal issues that increase the demand for documentation. However, the dimension itself and the correct distribution of daily functions can ensure that assistance is not neglected. Misguidance, lack of training, poor academic education are more serious processes for negligence of care than the bureaucracy itself* (E16) and *The shorter the time, the lower the quality of the service provided* (E15).

DISCUSSIONS

The humanization of health care is observed in the current scenario as a change that integrates health ties, bringing improvements in the area of care, through excellent service and an environment capable of promoting the progress of care, thus generating quality of life for patients. clients/ patients (BARBOSA; CARVALHO; TERRA, 2014).

One of the principles that guide health practice highlights the importance of: "Valuing the subjective and social dimension in all care and management practices, strengthening/ stimulating integrative processes and promoting commitment/accountability" (BRASIL, 2004).

Based on this view, it is understood that, more relevant than a set of idealistic principles, the term humanization brings a complex set of postures and activities that comprises relevant changes to all those involved, directly or indirectly with health relations seeking extinction of the biomedical model that has been weakening the patient/ client relationship with the nursing team (BARBOSA; CARVALHO; TERRA, 2014).

Humanization is a proposal that associates the subjective side of care with the objective side of the human being, in prevention, promotion and health rehabilitation actions (GALVÃO; MENDES, 2015). When we recognize the supremacy of the psychological, emotional, social and spiritual aspects, linking scientific technical practices with the physiological, it is possible to establish some practical actions, such as: qualified listening, a good relationship with the patient/client, managerial restructuring of processes of work that simplifies so as not to negatively influence working methods. These principles are based on the holistic practice that is conceived after a set of actions that start from the premise that, it is believed that the nurse does not need to be well paid to practice human actions, these actions must first be part of of its personal nature (MONGIOVI *et al,* 2014).

Studies state that most nursing professionals believe that assistance must always be improved and practiced in order

to be offered in the model of the holistic concept, in which the individualized look and kindness towards the patient are indispensable practices for valuing the individual, which aims to establish this way, a bond based on help, qualified listening and empathy, bringing humanization as the basis for any assistance in the CC (STUMM; MALÇALAI; KIRCHNER, 2006). The present study confirms the author's justification when it reveals in graph 5 that 27 (84.4%) nurses reveal that, given their experiences, they believe that the humanization of nursing care always needs to be improved.

The surgical environment is a closed unit full of risks, norms and routines, where a significant number of highly complex procedures are carried out. combined with a good interpersonal relationship that favors the management of internal and external conflicts (LEMOS *et al,* 2010; STUMM; MALÇALAI; KIRCHNER, 2006).

Since the CC is a highly complex technological unit focused on techniques, routines and procedures that affect the privacy of patients, it is necessary that nursing professionals in the sector become aware of the importance of returning individualized attention to the client, keeping in mind that the objective of his work is his recovery, being concerned with detecting signs of anxiety, stress and/or other factors that may interfere with the smooth running of the surgical act, as safety and tranquility favor the treatment and recovery (DAIAN *et al,* 2012).

However, it is understood that the SC environment can become a welcoming and humanized environment for the patient, so that the ideal reception can happen that will directly contribute to the positive evolution of their clinical condition (MARQUES; MORAES; OLIVEIRA, 2012).

It is noteworthy that, when the patient/client needs to undergo an invasive procedure, he is taken by a very high level of stress, which can generate specific behaviors in each individual, which consequently affect the physiology of this client (GIORDANI et al, 2015; BARBOSA; CARVALHO; TERRA, 2014).

Thus, the patient/client is subject to trigger feelings that will act unfavorably on their emotional state, making them fragile and dependent (CHRISTOFORO; CARVALHO, 2009; SILVA, CHERNICHARO; FERREIRA, 2011).

Based on these statements, studies show that the quality of humanized nursing care in the SC depends on practices aimed at welcoming that offer the necessary support to surgical patients and provide clarification of doubts, thus promoting patient/client satisfaction, quality and trust. in nursing care and the service provided (FONSECA; PENICHE, 2016; BARBOSA; CARVALHO; TERRA, 2014).

Therefore, it is notorious and expected that patients/clients about to undergo invasive procedures are hemodynamically and psychologically unstable. (SILVA; SOUZA; MARCELINO, 2008; ARAÚJO *et al,* 2016; STUMM *et al,* 2009). This study leans towards this statement as, in graph 4, 23 (71.9%) nurses responded that humanized care brings benefits to the health of patients/clients.

It is important to point out that the role of the nurse in the CC is proving to be more complex every day, due to the need to integrate the activities of the technical, administrative, assistance, teaching, research and management areas. All this demand ends up moving them away from direct patient care, where at times they are unable to offer humanized care to the client/patient (LEMOS *et al,* 2010; SILVA, CHERNICHARO; FERREIRA, 2011). The study reaffirms this justification when it reveals in Graph 2 that 21 (65.6%) of the nurses state that they only have

the necessary time to provide humanized and individualized assistance to each patient/client at certain times.

The professionals idealize about the humanization theme, but highlight the difficulties to provide a humanized care. The work routine in the sector implies a lack of time to promptly employ the means to engage in this activity. (ADAMI; BRASILEIRO, 2017).

Based on this, the SC nurse faces a dilemma in the performance of his duties, generating a conflict between his decisions in relation to what he is able to do and what is actually done. This difficulty persists as the administration of health institutions does not understand the importance of the nurse's role in direct assistance to surgical patients in the perioperative period, which causes a deviation from their care function (ARAÚJO et al, 2016; STUMM *et al,* 2009). This is proven in this study when it is observed in Graph 7 that 18 (56.5%) nurses respond that when turning to the bureaucratic service, nursing care and humanization are neglected.

It is noteworthy that some difficulties were encountered in carrying out this study. Firstly, due to the fact that it was not possible to affirm the veracity of the responses of the professionals involved, since the participants felt embarrassed when answering the questions that involved their individual practices and the low number of researches in Portuguese on the subject of humanization also contributed to the limitation of the study (STUMM; MALÇALAI; KIRCHNER, 2006).

FINAL CONSIDERATIONS

The results reveal that there is a significant number of SC nurses who demonstrate knowledge about the attributions of the PNH, revealing that they practice and believe in the effectiveness and benefits of humanized care.

However, barriers that nurses face in carrying out humanized care in the SC were still identified, such as: negligence of humanization in the SC by professionals of the nursing team, difficulty in carrying out humanized practices due to the high hospital demand, the pressure imposed by the bureaucratic service in the CC that ends up removing you from direct contact with the patient, work overload that directly affects the performance of the nurse, lack of knowledge of the duties of the NHP and deficit of investment in continuing education.

It was identified that humanization is a tool that does not bring financial costs of great potential, which can be used by any professional, acts directly in the assistance to the client/patient and its use can avoid potential complications to health, allowing the improvement in the biopsychosocial.

It was identified that it is essential to strengthen some existing measures in the PNH, such as: making the environment more welcoming by adapting it to the hotel model already used today by some hospitals, formation of Humanization Working Groups (GTH) with a work plan defined, offer humanized reception service with welcoming users, provide qualified listening mechanisms for patients/clients and workers, guarantee the existence of humanized mechanisms of dehospitalization, and invest in permanent education with themes that refer to the humanization of nursing care.

Therefore, the humanization of nursing care is shown differently in the two hospitals involved, since the philanthropic hospital, by working with a larger number of professionals in relation to the demand and absence of folds and attendance to a single specialty, ends up becoming shows within the evaluated vestments humanized when compared to the large public hospital where the workload can be higher due to recurrent folds and the greater patient demand compared to the number of professionals available on duty.

Therefore, it is concluded that nursing care must be seen as care, never dissociated from humanization, which in turn must be seen as a continuous and unfinished project and be present in all sectors of a hospital.

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