

## HOSTING AIMED TO RELATIVES OF PEOPLE HOSPITALIZED IN PUBLIC INTENSIVE CARE UNITS OF BAHIA<sup>1</sup>

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### ABSTRACT

This is a qualitative study that aims to analyze how the hosting of relatives of people hospitalized in the Intensive Care Unit (ICU) is carried out by the workers of a public hospital of the state of Bahia. Fifteen subjects (seven workers and eight family members) participated in the study. For data collection, we used a semi-structured interview and collection was carried out from January to March 2014. The findings were submitted to thematic content analysis, and were organized into two categories: "hosting conceptions in the ICU by family members and workers" and "Strategies to promote the hosting to family members in the ICU: facilities, problems and prospects". This study has demonstrated that the actions aimed at welcoming the relatives of people hospitalized in ICUs are punctual and, when performed, take place according to the design and the availability of each employee. It is considered that hosting should not be seen only as an ethical position of workers, but mainly as an organizational guideline, in which care quality is a priority.

**Keywords:** Welcoming. Professional-family relationship. Intensive Care.

### INTRODUCTION

The hospitalization of a family member in the Intensive Care Unit (ICU) is usually an abrupt, unanticipated event that eventually disorganizes the family unit and causes significant disruption in people's lives, given that they have to deal with the imminent possibility of loss of their loved ones. Studies show that hospitalization is an event that puts families in different stressful situations and therefore causes suffering that unleashes psychological and physiological responses. Thus, the condition of a loved one cannot be reduced to a set of symptoms, but it means a situational event filled with representation of moral, social and psychological order<sup>(1)</sup>.

Due to new trends, settings and organizations of members, it is necessary to adopt a family

conception in this study. Therefore, it is understood that the family is not restricted to the emotional ties of consanguinity, but the coexistence and emotional exchange between the people who are involved through regular interaction<sup>(2,3,4)</sup>.

The term hosting, in turn, is often cited today, mainly in hospital settings, especially after the implementation of the *Política Nacional de Humanização* (PNH) (National Humanization Policy). This policy aims to improve the quality of care in health to citizens-users of the *Sistema Único de Saúde* (SUS) (Unified Health System). For its effectiveness, hosting is a technology that should be developed, as recommended by the meeting, listening, relationship, and respect for differences between health workers and citizens-users<sup>(5)</sup>.

In this sense, hosting means meeting all those who seek health services, assuming a posture that is capable of welcoming, listening, and

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condoning, and thus giving more appropriate responses to the needs of the people hospitalized and their families<sup>(6)</sup>. Therefore, this is not only related to acknowledging hospitalized patients' needs, but also their families', who have to deal with peculiar stressful situations in the hospital setting, particularly in ICU.

Welcoming to the ICU means an ethical posture that is visible from the clarification of doubts for family members (through qualified listening) to the construction of a bond with health workers, thus contributing to the production of care. And in this care production it is important to establish the link between the hospitalized person, the family, and the worker by means of a language that enables the understanding between those involved, whether in verbal or non-verbal communication.

However, in ICU care routine interferes with the production of care, since it is also understood as a relational action permeated by inter subjectivity of those who provide care and the ones who are cared for, not merely an action marked by the implementation of procedures. This routine is characterized by high technological complexity; by the focus on emergency and remedial taken on by this environment; by the shortage of material resources and workers; and by the complexity of the clinical condition of the hospitalized person, as well as the personal limitations of professionals to deal with the way family members express their feelings.

Given the above, the following questions arose: how are the hosting concepts prepared by family members and workers of the ICU in a public hospital? How does the hosting provided by employees of a state public hospital in Bahia to the family members of people hospitalized in the ICU occur? To answer such questions, the objectives aimed to analyze the hosting conceptions developed by family members and ICU workers of a public hospital and the way hosting is provided by employees of a state public hospital in Bahia to these people were established.

## METHODOLOGY

This is a study of exploratory and descriptive nature that uses a qualitative approach, developed in two intensive care units of a public

hospital in the state of Bahia, which covers the resident population (606,139 inhabitants) and the population of 127 surrounding municipalities. This is a large health unit (300 beds), considered a benchmark in terms of care in emergency care and specialized clinic that provides average and high complexity attendance<sup>(7)</sup>. The study covered the two ICUs (Adult I and II) of the hospital.

The recommendations of Resolution No. 466/12 of the National Health Council were respected at all stages of the study, and it was approved by the Ethics Research Committee of the State University of Feira de Santana (UEFS), under Opinion No. 550,947. Initially, the subjects were informed about the risks and benefits of the research beyond the scope of the study. By agreeing, they signed the Informed Consent (IC).

Participants were relatives of people hospitalized in ICU Adult I and II, as well as health workers of these units. The criteria for the inclusion of the family members were: being with hospitalized family member for over 48 hours in the ICU; being of age 18 or over; being the closest person to the hospitalized loved one; and having paid, at least, one visit to the hospitalized person during hospitalization. In relation to workers, the included ones were those with more than six months of work in the unit and who were on duty during the visiting hours. The excluded employees were those who were on vacation or leave of any kind in the period.

For data collection semi-structured interviews were used recorded and transcribed in full in the period from January to March 2014. In order to preserve the privacy of the study subjects, a numbered identification code was used as the order of interviews. The codes adopted for family members were Family Member 1 (F1) and Family Member 2 (F2); the codes used for workers were Trabalhador (Worker) 1 (T1) and Trabalhador (Worker) 2 (T2). Participants were 15 respondents. Of these, eight were family members and seven were workers. The criterion, saturation of the findings, was used to end the interview. It should be noted that the inclusion of workers of different categories was intended in order to meet the study object.

Seeking to respect the privacy of the participants, not to suffer harmful consequence in their free expression of words, the

interviews were conducted in private (psychology room), after visiting hours and with an average duration of 30 minutes.

For data analysis, we have adopted as a methodological strategy, the thematic content analysis which consists of seeking the interpretation of the qualitative material, emphasizing the regularities of speech, which can oscillate between the rigor of the supposed objectivity of numbers and subjectivity<sup>(8)</sup>.

## RESULTS AND DISCUSSION

Of the eight relatives interviewed, seven were female, aged from 26 to 33 years, three were spouses, three were children, there was a mother and a sister.

Two had incomplete primary education, three had completed high school and three others had finished higher education or were undergraduate students. Regarding marital status, five were married, two were singles and one was divorced.

Four participants lived in the city where the hospital is located and the others lived in surrounding towns. As for the family monthly income, six reported receiving less than three minimum wages; one earns a minimum wage and the other receives up to four minimum wages.

Among the workers, the study participants were nurses, nursing technicians, physical therapists, a janitor and an administrative assistant. There was a predominance of women, aged between 29 and 46 years.

The acting time in the ICU ranged from two to seven years and the hours worked per week varied between 30 and 40 hours, with a journey of 12 hours between high-school level workers and 24 hours for the higher-education-level workers. Most of the workers were employed under a statutory regime. Only one (01) of the interviewees reported receiving in-service training on hosting.

The speeches of the participants were grouped according to the units of meaning that were divided into two categories previously defined, "hosting conceptions in the ICU for family members and workers" and "strategies to promote hosting to family members in the ICU: facilities, difficulties and prospects".

## WELCOMING CONCEPTIONS FOR FAMILY AND WORKERS IN THE ICU

The hospitalization of a family member in the ICU usually occurs on an emergency and inadvertently, leaving little time for family adjustment. Faced with this stressful situation, relatives can feel disorganized, helpless and they may face difficulties to mobilize themselves; because of that different types of needs emerge<sup>(9)</sup>. In this perspective, hosting, as a relational technology, is a key device in that it provides qualified and resolute listening.

Hosting, in the technical dimension, involves the construction of tools that enable the qualified listening, identifying appropriate solutions to solve the problem of citizens looking for health services. This leads to the reorganization of the work process, which would cease to be directed to the complaining behavior to work in a broader perspective with a focus on health determinants. In addition, it incorporates work conception as an interaction of knowledge and practices<sup>(10)</sup>. The statements of the relatives reveal a hosting concept turned to help, that is, for a benefit received, a gift:

Hosting means some help, the care provided by a group or person to another (F1).

Helping, clarifying, listening, clearing doubts (F2).

Being welcome and well treated (F4).

It could be observed that the speeches concerning this concept focused on people with low education, who do not realize that quality care is a right expressed in the Federal Constitution and that hosting must be an ethical stance of the health team. In this direction, the hosting constitutes a device, a strategy, and a posture before users; a technological arrangement capable of expanding access to health services, reorganizing the work process in order to ensure humanized, resolute and quality services, focused on people's needs, with the potential to form new ways of producing care<sup>(10,11,12)</sup>.

Some rather sporadic testimonies portray a broader approach on hosting:

Care (F5).

It means being well served, well treated, having accessibility to the service (F7).

It means being monitored and receiving attention on the arrival, in the visitor identification and patient care (F8).

Humanization arises in workers' testimonials as a way to make the environment more welcoming, less gloomy and scary to family members, who face a difficult time and are susceptible to unpleasant feelings and experiences in the ICU, as it was revealed in the following lines:

It means making the environment more pleasant to decrease this cold feeling, and make it less hard. I think hosting is similar to humanizing the environment (T6).

Hosting means socialization between the team, the patient and the family. I say this in the sense of not being apart and making it a less scary environment (T7).

According to these testimonies, it is observed that, although workers expand their hosting concept at the expense of that elaborated by family members, they perceive humanization in a reductionist way, that is, focused on the organization of the environment.

Despite the fact that ICU is seen as a 'place of death' 'and that it causes a major impact on family structure, the approach of the team with the family who has a loved one hospitalized enables the creation of a bond and, therefore, qualifies care based on its humanization, being an important mechanism perceived in the speech of respondents.

Understanding the family, using empathy and putting yourself in the others' shoes (T1).

It is a humane treatment for the patient, family and staff, in order to have a good relationship (T4).

The workers interviewed stated that hosting is related to the professional attitude of support, inclusion, and information, allowing the family to express its feelings regarding their hospitalized family member, in order to provide

solution to their needs, as shown in the statements below:

To provide a quality service to patients, analyze the entry and arrival, observe the patient's needs and provide resolvability (T2).

It is a humane treatment for the patient, family and staff, in order to have a good relationship (T4).

It is to be well served and have service accessibility (T7).

In the case of a humanized perspective of health care, some testimonials indicate that hosting means serving all who enter/seek health services, listening and adopting a posture that is capable of welcoming, condoning, and giving more appropriate responses to the needs of the people hospitalized and their families, which are considered individuals who need health care in the hospital setting.

The PNH proposed by the Ministry of Health in 2003, constitutes a transversal and inclusive policy with a view to strengthening the SUS. The policy is structured by principles of inseparability between the management model of care, autonomy and leadership of individuals (manager, worker and user). In addition to providing transversal "devices and the triple inclusion method (subjects, their collective, and the conflicts arising from this approach) in order to promote changes in work processes<sup>(5)</sup>.

#### STRATEGIES TO PROMOTE HOSTING TO FAMILY MEMBERS IN THE ICU: FACILITIES, DIFFICULTIES AND PROSPECTS

In the admission process in the ICU, mechanisms that promote hosting to family members are important to include these in the care of hospitalized patients. Generally, the health care team is focused on meeting the needs of hospitalized patients<sup>(11)</sup>. It is noteworthy that, although the hospitalized patient suffers with the disease and hospitalization, the family also experiences anxiety, fear, insecurity and suffering.

Actions that aim to clarify, guide, and ease the family's suffering are essential during hospitalization in ICU. It was possible to perceive the actions taken by workers, aimed at

welcoming family members in the words that follow:

There is a psychology service; I don't know how it happened, but they welcome people (T1).

There is a physiotherapist activity in the waiting room, on Thursdays, that includes stretching, physical exercises, and guidance to family members to learn how to act at the bedside; and at the end there is a moment of prayer (T3).

Distribution of a medical report in order to direct and inform the clinical condition to the families, who are entitled to two visits per day (morning and afternoon) (T5).

I perform actions may let me get closer to the family. During hospital discharge I instruct family members on how to take care of their loved ones in the face of their new condition (T6).

It is noted by the speeches that, although actions aimed at hosting between different health professionals occur, these are localized and fragmented occasions<sup>(12)</sup>.

It is observed that some workers view hosting as a limited and specific moment of certain members of the multidisciplinary team, giving the impression of a certain distance and that the hosting actions are not included in their competence, as revealed in the speech below:

The social service is the one who does it directly (T7).

It is understood that hosting should be part of the conduct of health professionals, since it may happen in any place where there is a meeting between an employee and a client, through technological processes aimed at the production of listening relations and accountabilities; which is linked to the establishment of ties and commitments in intervention projects; which aims to act on needs regarding the search for the production of "something" that can represent the "achievement of suffering control (of a disease) and/or the production of health"<sup>(12)</sup>.

To establish a connection, it was identified that the team performs some strategies in the ICU to promote the hosting of family members of hospitalized people, either through a professional attitude of direct assistance to the family or by means of established routines in the service such as: admission, delivery of the

medical report and flexibility in terms of visit time.

The team works very well; the ICU is never left alone; and the service is really special for patients (T2).

I think that's good. There is a problem solving attitude and flexibility on the part of the staff (T3).

There is flexibility in terms of the schedule and time of visit; respect and understanding the suffering of family members (T4).

I see it in a satisfactory manner. We try not to do any procedure in the time of the visit, leaving that moment only for patients and their family members as it lasts only 30 minutes. We only interfere if necessary. As a nursing technician I can perceive signs of depression, for example, and signal the nurse (T7).

Hosting actions are part of the work process and are essential for the construction of a link between health professionals and people hospitalized/family<sup>(12)</sup>. The bond can be characterized as a complicity relation between users and professionals, becoming a reality within the hosting framework and it is a starting point for building trust among those involved, as evidenced in the following statement:

Those who are on the bedside always try to raise hopes, and end up creating a bond with them. Inside the ICU we have more contact, and we create a bond with the family members of older patients, leaving us more comfortable to accept (T1).

For there to be a bond, it is essential that there is empathy and respect. The elements that denote their training are based on mutual recognition between service and community, since it is not possible to establish a link without the condition of the subject, without the free expression of users through their speech, judgment, and desire<sup>(11)</sup>.

The family members stated that communication takes place in a timely manner with the workers, and it makes hosting more difficult. Importantly, the communication difficulty recorded in the speeches focuses on the medical professional figure. In the speeches it is possible to observe a complicity of family members around that professional, for, while they miss this communication, they reveal that whenever that professional appears to assist their

hospitalized loved one, he overcomes this lack of dialogue.

They take good care of him. I have nothing to criticize. The staff is present, watching and making examinations. [...] One day a doctor touched his belly, just said it had worsened and left; he ignored me and did not explain anything to me (F5).

When we arrived in the ICU I realized that there is also a great concern in terms of maintaining the health of the patient we are visiting. [...] I miss receiving more information, [...] I miss receiving news. [...] Many times we also seek a neurologist. When we came to visit, the bulletin was always read by a doctor. [...] I missed receiving more clear information for the family. Some questions remain unanswered. We always ask questions to the doctor and he always argues, "No, you should ask these questions to the neurologist". But when we find him we are very well received, and we clear all our doubts (F8).

Attitudes such as dialogue, listening, and presence, or co-responsibility, commitment, and appreciation of the other as well as sharing experiences are considered basic elements to make hosting effective. These are, however, still little present in the professional daily work in the various health services, especially in the ICU.

It is possible to perceive convergence in the statements regarding the need for more clarification, more information. Communication is a tool that would enable more confidence in family members in terms of the care provided by professionals, bringing more tranquility and, thus, alleviating the suffering of the family.

I would like to have more information in order to follow everything that happened during the day, especially in the early days. They must welcome relatives to transmit information more clearly to the family. The team should be integrated to pass accurate information about the condition of the patient; it should provide more effective communication between the team and ICU specialists (F8).

I would like to have more attention from professionals. They tell us little, and don't fully explain patients' situation, because they believe that another professional has already explained it (F5).

As we have nothing filed and directed, each professional makes it his own way. [...] If I had a protocol it would be easier to drive the service.

The staff is very accessible to the new routine (T5).

We try to be as human as possible. When we have a meeting, we always discuss about humanization, hosting, and conviviality of the team, because a disunited team affects customer service (T4).

Given the difficulty experienced by professionals regarding hosting, the need to design and implement a hosting protocol aimed to facilitate and direct actions in the ICU appears as perspective, contributing to a better integration of the staff and training for a greater bond between the multidisciplinary team, the hospitalized people, and the family.

## FINAL CONSIDERATIONS

Hosting is related to the ability to run the service through a professional act that promotes access opportunities to family members in the ICU in an inclusive and listening attitude, allowing changes in the service of everyday life around proximity relations between workers and family members. In this respect, the meaning of hosting can be considered an attribute of a professional practice that should be developed in the work process of the multidisciplinary ICU team.

In this context, according to the concepts discussed on hosting, a link must be established, respecting the differences between the triad family/hospitalized person/worker, thus constituting an essential tool that should be used by health professionals.

Communication is a difficulty faced by workers due to high demand and service routine, by the perception that the visit is a private family moment and for the removal of their own family members. Thus, identifying the needs of family members of ICU patients may contribute to the humanization of care in this environment, making it more welcoming and less impersonal, especially with regard to hosting.

The need for hosting, support, information and dialogue stems from the suffering and the real threat to life that the hospitalization of a person in the ICU represents for its family members. This situation leads professionals to adopt a qualified hearing to be able to identify the needs of family members and unfold into effective action.

Research has shown that the hosting to family members does not constitute an institutional policy, and it is carried out in a timely manner by some health workers. The study allowed the analysis that it is possible to implement hosting to family members who accompany the hospitalized people in an

intensive care unit; however, it is considered that it should not be only seen as an ethical attitude of health workers, but as an organizational guideline.

## ACOLHIMENTO AOS FAMILIARES DE PESSOAS HOSPITALIZADAS EM UNIDADES PÚBLICAS DE TERAPIA INTENSIVA DA BAHIA

### RESUMO

Estudo qualitativo com objetivo de analisar como ocorre o acolhimento pelos trabalhadores de um hospital público do estado da Bahia aos familiares de pessoas hospitalizadas na Unidade de Terapia Intensiva (UTI). Participaram deste estudo sete trabalhadores e oito familiares, totalizando quinze participantes. Para apreensão dos dados, utilizou-se a entrevista semiestruturada, sendo a coleta realizada no período de janeiro a março de 2014. Os achados foram submetidos à análise temática de conteúdo e organizados em categorias: Concepções do acolhimento na UTI por familiares e trabalhadores; Estratégias para promover o acolhimento aos familiares na UTI: facilidades, dificuldades e perspectivas. Este estudo demonstrou que as ações voltadas para o acolhimento aos familiares de pessoas hospitalizadas em UTI, pelos trabalhadores, são pontuais e quando realizadas, acontecem de acordo a concepção e a disponibilidade de cada trabalhador. Consideramos que é preciso que o acolhimento não seja visto somente como uma postura ética dos trabalhadores, mas sobretudo, como uma diretriz organizacional, em que se faça primordial a qualidade da assistência.

**Palavras-chave:** Acolhimento. Relações profissional-família. Terapia intensiva.

## ACOGIMIENTO A LOS FAMILIARES DE PERSONAS HOSPITALIZADAS EN UNIDADES PÚBLICAS DE CUIDADOS INTENSIVOS DE BAHIA

### RESUMEN

Estudio cualitativo que tuvo el objetivo de analizar cómo ocurre el acogimiento por los trabajadores de un hospital público del estado de Bahia-Brasil a los familiares de personas hospitalizadas en la Unidad de Cuidados Intensivos (UCI). Participaron de este estudio siete trabajadores y ocho familiares, totalizando quince participantes. Para la recopilación de los datos, se utilizó la entrevista semi estructurada, siendo la recolección realizada en el período de enero a marzo de 2014. Los hallazgos fueron sometidos al análisis temático de contenido y organizados en categorías: Concepciones del acogimiento en la UCI por familiares y trabajadores; Estrategias para promover el acogimiento a los familiares en la UCI: facilidades, dificultades y perspectivas. Este estudio demostró que las acciones hechas por los trabajadores, dirigidas para el acogimiento a los familiares de personas hospitalizadas en UCI, son puntuales y cuando realizadas, ocurren de acuerdo a la concepción y a la disponibilidad de cada trabajador. Consideramos que es necesario que el acogimiento no sea visto solamente como una postura ética de los trabajadores, sino, principalmente, como una directriz organizacional, en la que se haga primordial la calidad de la atención.

**Palabras clave:** Acogimiento. Relaciones profesional-familia. Cuidados intensivos.

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