

INTERACTING WITH FAMILY MEMBERS OF HOSPITALIZED PATIENTS: A NURSING TECHNICIAN'S EXPERIENCE¹

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ABSTRACT

This study aimed to understand the meaning attributed by nursing technicians to the experience of interacting with the family of hospitalized patients. It is a qualitative research supported by the Symbolic Interactionism theoretical framework, and the Qualitative Content Analysis methodological framework. It had the participation of nine nursing technicians that worked at the medical clinic units of two public hospitals. Data were collected through semi-structured interview and participant observation. They revealed the difficulties, ambiguities and unpreparedness experienced by the professionals in the interaction with the family, although they recognize their importance, and the absence of their interaction with content on the subject, both in the technical course and in their professional lives. It was found that, in their experience with relatives, the nurse technicians lack knowledge and skills to deal with the care of the family; thus, they need theoretical and practical support to face such a situation.

Keywords: Family. Nursing. Nursing Technical Education.

INTRODUCTION

The National Policy on Hospital Care [*Política Nacional de Atenção Hospitalar*] (PNHOSP) proposes guidelines for the organization of the hospital component, which contribute to the effective humanization of health services, in agreement with the National Humanization Policy. The publishing of several booklets on humanization, and the approval of laws, including the “Patient’s right to companion and open visiting”, have shed a new light on the humanization of care, as the inclusion of family members in the care space promotes the valuation of subjective and social factors⁽¹⁾. Concerning the family, in order to effect humanization, it is not enough to open the institution for the permanence of companions. Health professionals should be sensitized and trained to interact with them, recognizing them as units of care.

Patient and Family-Centered Care (PFCC) is a

partnership-based planning, provision and assessment process of care that brings mutual benefits to patients, families and providers. In the philosophical conceptions of the PFCC, the family is not restricted to physical presence, but to the emotional and social support offered to the patient, deemed fundamental in health care⁽²⁾. Thus, the family plays a major role in patient care, whose absence may be a risk, especially for the most dependent ones. This conception began in children’s care, extended to the elderly, and currently includes those with chronic diseases⁽²⁾.

It is a care intended for patients of all ages, and it is the professionals’ duty to favor the continuity of the natural connection between most patients and their families, facilitating and stimulating the permanence of one of their relatives during hospitalization, in the sense of preserving the ties and strengthening their support network⁽²⁾.

Although there is evidence in the literature on the importance and benefits of PFCC⁽²⁾, no specific

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publications related to nursing technicians were identified on electronic databases as to the theme of hospitalized adult patients' relatives, revealing a gap in this knowledge.

In our reality, concerning nursing, it is the nursing professional's responsibility to provide a dignified and humanized assistance, treating families with respect, encouraging and supporting their participation in the patient's care.

However, for this to occur, it is fundamental that, during the formation of the Nursing Technician (NT) and in his or her professional trajectory, the family is included. Thus, it should be extended to technicians because, at health services, they are in significant number and are in the front line of the assistance.

As nurses and professors, including of technical courses, it is possible to identify difficulties faced by the TNs as they interact with families, bringing concerns as to the interaction experienced by professionals with the hospitalized patient's family. Thus, this study was carried out with the aim of understanding the meaning attributed by nursing technicians to the experience of interacting with the family of a hospitalized patient.

METHODOLOGY

This is a qualitative study, an approach that is expressed by common language in daily life, dealing with the universe of meanings, motives, beliefs, values and attitudes that correspond to the deepest space of relationships⁽³⁾. The theoretical framework was the Symbolic Interactionism (SI), a perspective of analysis of human experiences focused on both the nature of the interaction and in social dynamics, influencing perception and action within interactions between people⁽⁴⁾. The methodological framework was the Qualitative Content Analysis (QCA), which describes and promotes the knowledge of a phenomenon, when the literature about it is scarce, for being an analytical, flexible and interpretive method that maintains scientific rigor⁽⁵⁾.

Data were collected between February 2013 and April 2014 at the medical clinic units of two general public hospitals with different organizational characteristics: the first one, located in a city of Greater São Paulo, which is not classified as a teaching hospital. It has two medical clinic units with 48 beds distributed on two floors, without a humanization program; the second one is a university hospital in the south of the city of São Paulo, with

two medical clinics and 41 beds distributed in two wings. The choice of the second hospital was due to the fact it had an established humanization program. Both hospitals have standardized visiting hours and the entrance of two visitors at a time during this period. Patients over 60 years of age are entitled to a companion; other patients only with a nurse's authorization.

The option for the medical clinic unit is justified by the characteristics of the patients hospitalized there; most have chronic and incapacitating diseases that require a lot of care, which is why companions were present.

The study counted with nine nursing technicians, of which seven were female, with training time between 5 and 16 years, professional practice between 4 and 12 years and time working at the researched institutions between 2 years and 4 months, and 12 years. The selection criteria were part of the staff of a medical clinic and had professional experience superior to 2 years. The number of participants was defined by the saturation criterion, that is, when no new data were found and were sufficiently dense for the understanding of the phenomenon studied⁽⁶⁾. The schedule of the nursing professionals of the hospitals was divided in morning and night shifts. The first hospital had three NTs and one nurse on each shift; in the second hospital, there were four NTs and one nurse per shift.

Data from both institutions were collected by one of the researchers, on each shift, as per the NTs' availability. Data collection strategies were semi-structured interview and participant observation⁽³⁾. The interviews were individual, held privately at the hospitals, recorded and based on the following guiding question: *How is it for you to interact with the hospitalized patient's family?*

The observation was done considering the purpose of the study, observing how the NTs interacted with the patients' companions, that is, how they behaved, what dialogues they had with them in the different situations in which the families participated in the hospital routine, as well as what conversations they had with colleagues about it, which are recorded in a field diary.

Data analysis was carried out together with collection, after transcription, reading and re-reading of the data that were systematically analyzed, following the steps of codification, categorization, integration and description of categories⁽⁵⁾.

The study project was authorized by the

institutions where data were collected, approved by the Ethics and Research Committee of the Federal University of São Paulo (UNIFESP), Protocol No. 517.749/14, and complied with all guidelines of Resolution 466/2012 of the National Council of Health. The Free and Informed Consent Form was signed by the participants after clarification on the research objective, possible risks and benefits.

RESULTS AND DISCUSSION

Data analysis allowed understanding the difficulties and lack of preparation experienced by the NTs in the interaction with families. They are expressed in the thematic categories that, will be described and illustrated with examples extracted from the observations and interviews, identified by the letters NT (Nursing Technician) and followed by the number corresponding to the order of performance, and ON for Observation Notes.

Recognizing the importance of family

Despite difficulties in interaction, the NTs recognize the importance of family, both to patients and themselves. They see that, when accompanied by a family member, the patient is more willing to perform daily activities, calmer, collaborating with his or her recovery. They also perceive that the unaccompanied patient happens to be more restless, downhearted and less collaborative.

In addition, the NT considers that, for being closer to the patient, the family member can observe earlier any changes in his or her state, calling the professionals after perceiving some intercurrent that requires nursing intervention and assisting in procedures such as showering and feeding.

The patient is calmer with a companion; this even helps in recovery (NT9).

The patient who has a companion is more inclined to collaborate, to do daily activities. Those who do not have it are more discouraged, less collaborative (NT7).

Some patients sometimes get restless without the family, so the family helps keeping company, talking. Most families who come end up helping. They help with the feeding, with the shower, changing diapers (NT6).

The family member, in this daily care, observes more any aspect that changes in the level of consciousness, of anxiety. The closer person who can observe this earlier (NT8).

The nursing team sees the family as an important partner in the essential care to the patient's recovery. In addition to being able to perform technical procedures of low complexity, there is a need for reflecting on the use of family members as substitutes for the nursing workforce⁽⁷⁾.

Having trouble in the interaction with family members

NTs define the interaction with the patients' relatives as very difficult or complicated. Even when they report that the interaction is good, they do not recognize it as constant, claiming it is good when the family member knows how to assist the patient and do not ask much for professional help, and bad when they request it.

Most of the time, it is very difficult [...] (NT1).

It is very, a little complicated (NT6).

Sometimes it is good, sometimes it is not (NT2).

The good families are those that already know how to deal with the patient, which do not call us that much. Demanding ones are bad, those that do not have much preparation (NT3).

In this sense, the inclusion of the family member in the care of the patient represents a positive presence when he or she helps take care of the client. However, when companions interfere with the assistance, the nursing team sees their presence at the institution as negative⁽⁷⁾.

In addition, the NT reports that the companions complain that they are not served well; do not receive the necessary attention and information, that their relative is being neglected. They pressure, complain, make a mess, curse, but when the patient is discharged, they do not want to take him/her home, claiming they have no conditions to care for him/her.

The relatives say: you do not give information, we are on our own! [...] You say: wait a minute, I am medicating someone else. Then the mess begins! They say you are not helping, do not pay attention, and trouble begins! They start cursing. When the doctor discharges the patient, it is a riot; they do not want to take the patient home because they cannot take care of them there (NT1).

Regarding the request for information, nursing should provide clear and coherent information⁽⁸⁾, using appropriate terms and body expressions, with a stable and firm tone of voice, thus favoring interaction and creation of a bond between professionals and

companions⁽⁹⁾. In addition, when family members obtain information about the condition of their loved one, their distress and suffering decrease⁽¹⁰⁾.

The NT believes that the presence of relatives makes the service harder, because they need help all the time, even if he/she is assisting another patient. Thus, he/she defines them not as companions, but as “hellish” and “very annoying”; they are “unnecessarily” solicited so many times that they just decide not to answer them. He/she also analyzes that if the family members were not so demanding, he/she would provide a better care to all patients.

Because the relatives, instead of helping, they get in the way. They think, like, that their patient is the only one there, [...] so, you are medicating another patient, they call, they say: please, you have to help me change the diapers now. They are here to give us hell. They are not companions, they are annoyances! (NT1)

They do not help at all. Some patients have annoying relatives. [...] they want us all the time for unnecessary reasons. When they call for a need, we do not even go (NT2).

Whatever happens to the patient, they are always calling us. I could give a better assistance but, with the demanding relative, I have to give more attention to him or her (NT3).

For the NT, family members should be aware that they are there to help and not to supervise the service, noting that many do not help because they believe that nursing has the obligation to perform all the care.

They are here to help, a little help. However, that is not how they understand it. They understand that they are here to supervise us [...] (NT1).

[...] family members should be aware that they are there to help: take the patients to the bathroom, feed. They think these things are the duty of nursing only (NT2).

In this way, the nursing team does not see the companion as a collaborator and a partner of the patients, but as a supervisor of the care provided by the professionals, who, for being very demanding, makes the hospitalization process difficult for the patient⁽¹¹⁾. Possibly, the team does not realize that when relatives intervene, they believe they are showing affection towards their loved ones⁽⁷⁾.

Realizing the difference in the interaction with family members who always stay and those who come just to visit

The NT reports differences in the interaction with family members who stay at the hospital all the time

from those who only come at the visiting time. He/she thinks it is better to interact with those who stay at the hospital because they see everything that is being done, so they pressure less. Now, with the relatives who only come at the visiting time, the interaction is more difficult, because they do not know what has been done. When they arrive, they come with demands and want to know what is happening to the patient; they cannot give the latter much attention and affection, nor establish a bond with the team, and end up seeing only what happens at that moment, that is, only the bad things.

There is a difference: relatives who stay 24 hours, they happen to be more attentive, following closely the evolution of the patient, [...]. Those who come only to visit do not have as much attention to and affection for the patient (NT6).

Because the companion who is there all the time, he/she sees the patient's need, sees our rushing, sees what is being done and sometimes pressures less (NT2).

When the relative shows up and wants us to do many things, they have not seen: shower, dressing, everything is done. Then they pick small things to demand from us (NT4).

Those who do not see much do not have that bond. They will only see what happens in that period; often, they will only see the bad things (NT9).

It is possible to perceive that the professional does not recognize the access of companions into the hospitalization units out of the schedule, as the companions' entitlement to open visiting establishes⁽¹⁾. In general, relatives can stay with the patients after negotiation and, oftentimes, this is exhausting, as the needs of the hospitalized individual are not seen as priority⁽¹²⁾. In this sense, institutions should consider open visiting as a right, reorganize services and sensitize professionals to welcome them into an interaction of warmth and respect.

Perceiving himself/herself disrespected and unsupported

The NT perceives himself/herself disrespected and mistreated by family members. They do not thank them, they are not polite with the professional, judging that, if he/she is not in the room, he/she is not busy; and if he/she makes any mistakes, they are the first to accuse him/her, even if he/she is doing everything to help.

If the relatives do not see you in the room, they think we are lazing around; but we are in another room, doing

other things. [...] They say they distrust nursing. [...] What about thanking or at least being a little polite! You do everything to help, but a slip and they are the first to accuse you (NT1).

The professional also considers himself/herself disrespected when relatives pressure him/her for information on the patient, which he/she thinks is not his/her role, or when they perceive that they are not receiving any support in the service, including from the nurses, who, instead of defending him/her, instruct him/her to not create problems.

We cannot give information that only the doctor could give. We inform about the doctor's schedule. They find it absurd to have to leave their homes to come at 6 in the morning (NT3).

Some nurse do not want to get into trouble, so they say: "We won't lose our minds. You've got to find a way." There is no one to defend us (NT1).

In this way, the professionals reveal a great dissatisfaction and disappointment with their work, as they perceive themselves mistreated and disrespected by patients and their relatives⁽¹³⁾. In this sense, health institutions should aim at such a situation and promote actions that respect and value them as humans and workers.

Because they consider themselves so disrespected, the NTs analyze that, when the patient is admitted, family members should receive training and be oriented as to their duties as companions, such as not calling the professionals constantly, not complaining and cursing, since they are there to help. They believe that there should be someone to give this training, someone to "put them in their place".

Family members should be trained when patients are hospitalized, be instructed as to their role: you are a companion, do not call us all the time, complaining and cursing. You are here to help [...] they should have someone that put them in their "place" (NT1).

Although the NTs think they are mistreated and disrespected, observing the way they interact with relatives, the opposite also seems to happen, because they do not always treat them respectfully, even blaming sometimes the companions for what happened or might happen to the patient.

The NT enters the room to install the patient serum. The patient's wife says he is very calm. The NT looks at her and says: that is because you are here now; the night shift said that he removed the serum, got very agitated, and had to be restricted. All this happened because you disappeared from here, and now you show

up only to eat the afternoon snack (ON-TN1).

Going, in this way, against the PFCC principles, which call for respect for the choices and perspectives of families, so that their members are treated with dignity and respect⁽²⁾.

The NT also establishes rules to be complied with by relatives, assigning responsibilities, especially regarding procedures to be performed. If the companions claim they do not have the skills, he/she guides without assisting them or observing how the procedure is being performed.

Two NTs are called by the companion to change a patient's diapers and check that the sheet is all wet. They shake their heads negatively, look at the companion and say they do not change diapers all the time, that there is a schedule in the morning and at night, because the priority is medication. They say they will change this time (ON-NT1 and TE4).

The NT asks the patient's daughter: do you know how to give her a shower? The daughter replies: no! The NT tells her: Take your mother out of the bed and put her in the shower chair. The daughter's expression shows she does not know how to do that. The NT instructs her to put her mother under the shower and, with the plastic bottle, wet and soap her. The NT leaves and goes to the room to clean the bed (ON-NT2).

Thus, the nursing professionals, by means of instructions, establish norms and rules to the companion, as they consider it to be their attribution. After the instructions, the family member will fully take on the care for the hospitalized patient, including physical, emotional and social aspects⁽⁷⁾. Contrarily to this attitude, by assigning tasks, he/she will be passing on his/her responsibility to someone else, who may not agree to or feel unprepared for such a situation.

Relatives unable to help

Although he/she thinks that, the relatives are at the hospital to help in the care and recognizes their importance to provide support to the patient the NT analyzes that they do not always have the psychological conditions to do so. there are some who deem themselves unprepared, who, instead of encouraging, argue with the patients, stressing out the nursing staff. On the other hand, relatives are not always supported by the professional and, therefore, often end up crying.

There are somemuch-unprepared family members, emotionally weak; if their father or mother coughs or breathes differently, they run, start to cry. Then, we try to find some balance (NT3).

A 92-year-old patient is being admitted to the clinic, coming from the ICU. The facial expression of her companion, her granddaughter, is of shock: she observes the infrastructure and furnishings, which are in poor conditions of conservation, but says nothing; she just stops and stands there. The patient next to her points to a plastic chair for her to sit and, in doing so, she looks at her grandmother and starts to cry. No professional approaches her (ON - NT1 and NT2).

It is known that hospitalization can traumatize families because the latter encounters a different and dreadful reality in which their loved ones are involved, and during this process the companion feels some malaise, emotional imbalance, despair and impotence⁽⁸⁾. In this way, the services must provide professionals with training on humanization and how to welcome families.

The NT also realizes that, as a result of the hospitalization, some relatives become tired, because in the beginning they come every day, but, seeing that the treatment is taking longer, they abandon the patient. Others just sit, nap and sleep in the chair, as if they were indifferent to the patient's routine.

Family members get tired. In the beginning, they come every day, [...] If it is taking some time, they stop coming, abandon the patient here (NT1).

Instead of helping the patient, some relatives just sit in the armchair and nap, sleeping and being indifferent to the patient's routine (NT7).

Families have been facing difficulties to perform the role of companion, sleeping uncomfortably, interacting with restricted physical space, noise and equipment alarms, which causes physical fatigue⁽¹⁴⁾. In this way, institutions must provide adequate infrastructure so companions are respected in their basic needs.

Not perceiving himself/herself able to interact with the family

In addition to experiencing numerous difficulties to interact with family members, the NT does not perceive himself/herself capable of doing so, claiming that they have not received any content regarding it, whether in the training course and in the hospital, learning to deal with it in his/her professional practice. He/she clarifies that they have participated in trainings at the hospital, but are aimed at the humanization of the patient rather than the family.

Theory, no! I started to have contact with the family at work (NT3).

I had humanization training, aimed at the patient, not the family (NT7).

In addition, the NT does not relate humanization to the concepts of family care, defining them as bringing some of the home environment to the hospital, that is, computer, television. He/she analyzes that the world of humanization is not real in his/her everyday life, as this would mean providing a satisfactory patient care, which is not possible due to the insufficient number of employees and because many patients are bedridden.

Humanization for the patient is bringing their computer, television, video game, to lessen the stress in the hospital (NT4).

What is humanization? It is not real; it does not work in the everyday routine. We do not have enough employees to pay attention to what he/she really needs. Humanization is you assist the patients, at least enough [...] (NT2).

Recently, there has been a movement in nursing care in an attempt to find the best way to welcome and include the family as a unit of care⁽¹⁵⁾. However, for this to happen, nursing professionals need to be able to receive and assist it, which, as seen in the results of this research, is not happening when it comes to the NT.

Searching ways to interact smoothly with family members

Interacting amidst difficulties, the NT reflects, defines the situation and decides how to act, developing strategies and looking for ways to relate to the family, avoiding conflicts and discussions. One of these strategies is to recognize the characteristics of family members and to identify those who, in their definition, are the "worst" and the "best" and, to facilitate the interaction, to serve first the "most annoying" and "demanding" ones. In this movement of interaction with himself/herself, he/she defines as "nice" those who understand the professional, when the latter has a lot to do.

You need to be flexible. What are you going to do? You cannot talk, you can't do anything, you have to know how to deal with the situation and "swallow" it, stay quiet, trying to bear it as best as possible (NT5).

I say: mam, you refuse; I let the nurse know and keep going! I learned to deal with them, [...]. I try to learn about them, help the most annoying and demanding ones first, so they do not start a discussion, and the nicest ones understand, they already know, no, honey, you are so busy (NT1).

Trying to prevent greater conflicts, the NT tries to be polite with the companions, seeking to treat them with respect, helping them when they want information and preserving their privacy. He/she believes that the work of nursing is not only for the patient, but also involves family members in the care, as the latter must be aware of the patient's health condition.

Oh! Just as we interact with the patient we do it with the family, it is similar. We have to treat everyone with respect (NT7).

I think nursing work is not only about working with the patient directly, but it is about involving the family in that care. [...] the family should be well aware of his/her health condition and help us in this sense (NT8).

Understanding the family as part of care and allowing it to participate in caring processes are actions that promote the creation of a well-being environment between professionals and relatives⁽⁷⁾. Thus, the inclusion of companions in the care will only take place through interaction and dialogue, which will happen when the nursing professional acquires a broader view of the role of companions during the hospitalization of the patient⁽¹¹⁾.

FINAL CONSIDERATIONS

The data analysis, guided by the lenses of the SI and the steps of the QCA made it possible to comprehend the meaning attributed by the NT to the interactions established with the patient's family as being very difficult and even complicated. It is patent the lack of training during the technical course and in

his/her professional trajectory, in addition to highlighting the lack of knowledge about the PFCC and PNHOSP on the part of the NT, who cannot define the companion as a client who, just as the patient, needs care.

Considering the difficulties and unpreparedness of the NT in the interaction with the hospitalized patients' relatives, it is the responsibility of professional training schools to make changes in their curricula. They should ensure the insertion not only of theoretical contents related to the theme, but also the practice of ethical and humanized attitudes, since he/she has learned to interact with the family in his/her professional practice, developing strategies without scientific foundation, in an attempt to avoid conflicts with it.

Likewise, it is the duty of health institutions to be concerned about NT's ongoing education, by means of training aimed at understanding and developing family care actions, because, although public policies propose changes in the professionals' attitudes, through humanized conducts towards patients and their family members, there is still a long way to go until it is implemented.

It is worth emphasizing the importance of the experience herein revealed being expanded with data from other researches to deepen the understanding of the interaction of the NT with families, since this investigation studied only family companions of patients hospitalized at a medical clinic unit. The results are expected to contribute as an encouragement for a reflection on the central assumptions of the FPCC at schools and health institutions.

INTERAGINDO COM A FAMÍLIA DO PACIENTE HOSPITALIZADO: VIVÊNCIA DO TÉCNICO EM ENFERMAGEM

RESUMO

Este estudo teve como objetivo compreender o significado atribuído pelo técnico em enfermagem à vivência de interagir com a família do paciente hospitalizado. Trata-se de uma pesquisa qualitativa, que utilizou como referencial teórico o Interacionismo Simbólico, e o metodológico, a Análise Qualitativa de Conteúdo. Participaram nove técnicos em enfermagem que atuavam nas unidades de clínica médica de dois hospitais públicos, sendo os dados coletados por entrevista semiestruturada e observação participante. Revelaram as dificuldades, ambiguidade e despreparo vivenciados pelos profissionais na interação com a família, embora reconheça sua importância, e a ausência de sua interação com conteúdo a respeito da temática, tanto no curso técnico como na vida profissional. Constatou-se que, na vivência com familiares, faltam-lhes conhecimento e habilidade para lidar com o cuidado da família, assim, necessitam de suporte teórico e prático para enfrentamento de tal situação.

Keywords: Família. Enfermagem. Educação técnica em enfermagem.

INTERACTUANDO CON LA FAMILIA DEL PACIENTE HOSPITALIZADO: EXPERIENCIA DEL TÉCNICO EN ENFERMERÍA

RESUMEN

Este estudio tuvo como objetivo comprender el significado atribuido por el técnico en enfermería a la experiencia de interactuar con la familia del paciente hospitalizado. Se trata de una investigación cualitativa, que utilizó como referencial teórico el Interaccionismo Simbólico, y para el metodológico, el Análisis Cualitativo de Contenido. Participaron nueve técnicos en enfermería que actuaban en las unidades de clínica médica de dos hospitales públicos, siendo los datos recolectados por entrevista semiestructurada y observación participante. Revelaron las dificultades, ambigüedad y falta de preparación vividas por los profesionales en la interacción con la familia, aunque reconozca su importancia, y la ausencia de su interacción con el contenido a respecto del tema, tanto en el curso técnico como en la vida profesional. Se constató que, en la experiencia con familiares, les faltan conocimiento y habilidad para lidiar con el cuidado de la familia, así, necesitan de soporte teórico y práctico para el enfrentamiento de tal situación.

Palabras clave: Familia. Enfermería. Educación técnica en enfermería.

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