Original Article

Reception of pediatric emergency room users from the perspective of nurses*

Acolhimento de usuários em um Pronto-Socorro Infantil na perspectiva dos enfermeiros

Acogida de usuarios en un servicio de emergencia Infantil en la perspectiva de los enfermeros

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ABSTRACT

Objective: To understand the meaning and experience of the nurse in respect to the quality of the reception of users / attendants in a Pediatric Emergency Room of a university hospital in São Paulo. **Methods:** A qualitative, exploratory descriptive study, with the participation of eight nurses. Data collection was conducted through semi-structured interviews with the transcripts subjected to content analysis. **Results:** categories emerged: the meaning of reception: concepts and professional attitudes; reception: the real to the ideal; experience in implementing changes; process of reception: factors affecting. **Conclusion:** The reception process was modified throughout the work process, characterized by interpersonal relationships, professional behavior, communication and questions related to infrastructure.
Keywords: Emergency nursing, User embracement; Quality of health care; Child health services

RESUMO

Objetivo: Compreender o significado e a experiência do enfermeiro a respeito da qualidade envolvida no acolhimento de usuários/acompanhantes em um Pronto-Socorro Infantil de um hospital universitário do Município de São Paulo. **Métodos**: Estudo qualitativo do tipo exploratório descritivo, com participação de oito enfermeiros. A coleta de dados foi realizada por intermédio de entrevistas semiestruturadas e as falas foram submetidas à análise de conteúdo. **Resultados:** Emergiram as categorias: significado do acolhimento: concepções e atitudes profissionais; acolhimento: do real ao ideal; vivência na implantação das mudanças; processo de acolher: fatores intervenientes.**Conclusão:** O processo de acolher foi modificado ao longo do trabalho, caracterizado pelo relacionamento interpessoal, postura profissional, comunicação e questões relativas à infraestrutura.
Descritores: Enfermagem em emergência; Acolhimento; Qualidade da assistência à saúde; Serviços de saúde infantil

RESUMEN

Objetivo: Comprender el significado y la experiencia del enfermero respecto a la calidad involucrada en la acogida de usuarios/acompañantes en un servicio de emergecia Infantil de un hospital universitario del Municipio de Sao Paulo. **Métodos**: Estudio cualitativo de tipo exploratorio descriptivo, con la participación de ocho enfermeros. La recolección de datos fue realizada por medio de entrevistas semi estructuradas y los discursos fueron sometidos al análisis de contenido. **Resultados:** Emergieron las categorías: significado de la acogida: concepciones y actitudes profesionales; acogida: de lo real a lo ideal; vivencia en la implantación de los cambios; proceso de acoger: factores intervinientes. **Conclusión:** El proceso de acoger fue modificado a lo largo del trabajo, caracterizado por la relación interpersonal, postura profesional, comunicación y cuestiones relativas a la infraestructura.
Descriptores: Enfermería de urgencia, Acogimiento; Calidad de la atención a la salud; Servicios de salud del niño

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** Research developed at the Child Emergency Care Unit of a Teaching Hospital in São Paulo City.*

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INTRODUCTION

User embracement has been analyzed through different approaches and mainly considers the relations between health professionals and service users, so that these are focused on.

Regarding professionals' relations with users, user embracement is understood as a conversation-dialogue network, which consists in a special type of conversation that occurs or should occur inside health services, occupying all places and serving to receive and interconnect one conversation with the other, joining the spaces that involve workers and users during any meeting[1].

In work organization, user embracement is seen as a strategy to change the health work process, in the attempt to modify relations between professionals and users, among professionals, as well as to humanize care, establish teams' bonding with/accountability to users, enhance the ability to listen to users' demands and rescue the health team's technical knowledge, broadening their interventions[2].

User embracement is also one of the guidelines of the National humanization Policy, created in 2003 for Care and Management in the Unified Health System. This makes the process part of health production and promotion practices. Professionals are responsible for creating windows that permit qualified listening, leading to accountability for users' problems and providing them with adequate responses.

To attend to the requirements workers will be exposed to, their health should be taken into account, as this demand can cause too high a burden in case they are not equipped to work with the increased work deriving from the qualitative expansion of health needs they have to be accountable for[3].

It is often perceived that the technology used at health services is widely valued, to the detriment of the relation between professionals and users. Using it as such, however, means ignoring users' needs and expectation, opinions and demands[4]. One question is due here: If we do not consider that users want to transmit their need, how can comprehensive care be offered?

Comprehensive care means a broader, transformative, individual-centered care, involving the valuation of care and user embracement. From a user perspective, comprehensiveness is related to dignified, respectful and high-quality treatment, user embracement and bonding, permanently addressing knowledge and practice[5].

In view of the above, user embracement cannot be seen solely as something contained in professionals' discourse, but implies their attitude with a view to acknowledging and attending to service users' needs. In this sense, the goal of user embracement is to broaden subjects' access to the service, enhancing humanization and contributing to the reorganization of the work process at health units[6].

At emergency care units, the characteristics of care delivery are unpredictability, accelerated work rhythm, professionals' physical overburden, working to preserve life. Often, humanization and care comprehensiveness aspects are not preserved[7].

According to the Brazilian Ministry of Health's definition, Emergency Care Units serve to "deliver care to individuals, whether at risk of death or not, whose health problems need immediate care". The main care focus is the disease, including its signs and symptoms[8]. Inserting humanization into this sector demands sensitivity and communication from health professionals, besides empathy, as a way to achieve partnerships with users[7].

At a Child Emergency Care (CEC) Unit, it is acknowledged that, in addition to the child's physical condition, the parents' emotional burden, suffering and pain have to be considered, which produce tension and anguish in the environment. The families need communication and information to minimize suffering and express their emotions; hence, nurses need sensitivity to work with family members, demonstrating adequate communication skills for each situation[9].

In view of the above, this study is developed to: understand the meaning nurses attribute to and their experience regarding quality involved in user/companion user embracement at the CEC Unit of a teaching hospital in São Paulo City.

METHODS

In this exploratory and descriptive study, the qualitative method was adopted. This approach aims to understand and describe the dynamics of social relations, working with experience and daily reality, in the universe of human beings' meanings, beliefs, values and attitudes[10].

The place of study was the Child Emergency Care Unit of the University of São Paulo University Hospital (HU-USP). The care population includes the community living in the Butantã region, teaching staff, students, technical-administrative staff and their dependents. Participants were eight nurses who had been working in the study context for at least six months.

Approval for the research project was obtained from the Nursing Department (DE-HU-USP), the Institutional Review Board and the Institution's Chamber of Research, registration 887/09-SISNEP AE: 00080198000-09. After receiving approval, all nurses were invited to participate in the study, informed about the aims and methods and signed the Informed Consent Term.

Data were collected between March and May 2009 through semistructured interviews. A script was used

with identification data and five guiding questions, which were: What do you consider as child/companion user embracement at the CEC of the HU-USP? How do you act in child/companion user embracement? During the time you have worked at the institution, have you perceived changes in the way the child/companion is welcomed? How do you perceive the issue about the quality of child/companion user embracement? What facilitators and constraints do you face to deliver high-quality user embracement to the child/companion?

The interviews were scheduled in advance and took place in a private room at the institution. To preserve participants' identity, letters and numbers were used for their identification - E1 till E8.

The researcher transcribed the recorded material and content analysis[11] was used for interpretation and discussion, including the following phases: pre-analysis: organization of empirical material; content exploration: vertical analysis and recoding of the material; result treatment and interpretation: the results that led to the empirical categories become significant and valid, revealing the constituent elements of user embracement quality at the CEC.

Next, the results were analyzed in the light of the theoretical framework of user embracement and quality in health.

RESULTS

Data analysis permitted the identification of four categories: meaning of user embracement: professional conceptions and attitudes; user embracement: from the real to the ideal; nurses' experience in the establishment of changes; user embracement process: intervening factors.

Meaning of user embracement: professional conceptions and attitudes

In this category, the following units of meaning were inferred: conceptions, involving the relation with the child/companion and with professionals' job world; and attitudes towards user embracement, considering that professionals can and should welcome throughout the hospitalization process.

The nurses attributed different meanings to user embracement mainly considering the elements involved in the interpersonal relation with the child/companion and the work process, in line with E2 and E8's discourse:

"User embracement is listening... I consider, let's say, that user embracement is a strategy to change the work process."

"User embracement is that thing of embracing the other person's problem, adopting a more sensitive look, individualizing care, in view of the child's age and what he or she may understand of the situation. It also means praising the child, mainly when showing courage, it means not deceiving (...)"

Professional posture and attitude were also part of the meaning of user embracement, establishing a relation of approximation and empathy with users.

"I see that, each time we adopt a professional attitude, we manage to solve the problem, establish bonds, no matter how short, patients and companions remember your name and say that they've already stayed with you." (E1)

"I show my availability to welcome, often, if you show you're available to solve any doubt things change completely, you see that they [children and companions] *trust you much more and feel safer. I put myself in the mother's place, and the first thing I do is present myself, tell them my function and put myself at their disposal (...). I also direct the entire team to do the same".* (E6)

User embracement: from the real to the ideal

This category is related to the nurses' understanding about the meaning of user embracement, its importance and objectives, pointing towards the present-real and the future-ideal.

The units of meaning refer to quality in the structure, process and outcome dimensions. The structure dimension was addressed through aspects involved in the physical area and inputs; the process dimension looked at the dynamics of the professionals' work, as well as the health team's level of involvement; and, in the outcome dimension, the companions' satisfaction level was considered.

These dimensions were presented in view of the concrete job world and the subjects' imaginary, projected as ideal.

Regarding the structure component, E3 presents the concrete world:

"Having a companion is compulsory at the CEC, but the physical structure offers no conditions, nor can meals be offered (...). The fact that the hospital only provides soup is a constraint for high-quality user embracement. When the parent tells me that he's been here for I don't know how many hours, that he's hungry, and needs to eat rice and beans (...) it's difficult for you to work with this situation."

In the process dimension, the dynamics of professionals' work was highlighted, as well as the degree of the health team's involvement in care delivery, as observed in E2's discourse:

"The companion shows up at the sector and feels lost. When you turn to him, or look at him indicating that you will see to him, you end up user embracement. We often will not be able to solve that problem, but we can guide him by indicating who can, and that's what can be done. I try to transmit that to the group too."

In the outcome dimension, the actions the health team developed to improve care quality were assessed through

the care the team delivers and role performance, as E7 and E5 reported:

"I see that there's always something to improve, even now. Errors or communication flaws happen. Sometimes the mother does not understand correctly what we tell her, she arrives here very early and stays the whole afternoon awaiting test results, and the physician who attended her in the morning is no longer here, that ends up stressing the mother. I take great care with that communication. I leave my shift and always think about what I did, what happened in that situation, what I need to improve."

"We always join the nursing team to see what we did wrong, what could be done better (...)"

Nurses' experience in the establishment of changes

Throughout the years, the participants identified changes in their attitudes, postures, interpersonal relations with users, companions and health professionals. These changes were related with a better quality of care delivery. User embracement has gained more room in group discussions and has been increasingly studied, to the extent that its outcomes are verified, as observed in E1, E2 and E7's reports:

"The view of user embracement has changed over the years. Of actually looking at the pair (child/companion), as the center of care, of trying the center care on the family as well, although the environment is not favorable. The change occurred in the mind of nurses who got training for this."

"I perceived a lot of change over time (...). This change comes from the head, from our daily team, always insisting on the user embracement posture, on further considering family members' complain, what they are looking for and what they need. It means you paying attention to that."

"I saw that I had to change my way of user embracement and worked for that, to be able to improve my work and develop the activity."

User embracement process: intervening factors

In this category, certain factors were listed that facilitate or hamper high-quality user embracement in practice.

Some characteristics were considered facilitators in the user embracement process, such as teamwork, individualized care, the head's role, the language professionals use to talk to users/companions, experience sharing and empathy.

"This characteristic of nurses is strongly present at the HU and the nursing team's better preparation for user embracement, there's the nursing care systemization. Another factor is that the head collaborates a lot to facilitate user embracement." (E4)

"Another aspect is not calling her [the child] *by the bed or number, we call by the name, mother and child. On some occasions, the staff says that she's from that bed, and I answer: who's that from that bed? I know them by the name, I remember the child. You don't individualize by the number, also because so many children have used that number. People are called by their name here, you can see that."* (E8)

On the opposite, the nurses appointed the following constraints: the characteristics of the CEC environment, with high patient turnover levels, high numbers of patients attended, besides the lack of health team training. These situations can be observed in the statements below:

"As for the constraints, I think that not the entire team is sensitized." (E2)

"(...) the family's stress who comes to the door and often does not receive information about what's happening from the medical team, and then comes to nursing and hands over so many things together that it seems like a bomb is going to explode." (E5)

"Regarding user embracement, I think we are just beginning. We can improve a lot, it's not about keeping up teaching about user embracement. It means having a professional who provides advice on this issue. It means bringing in a person from outside, with an external look, and setting up a group." (E8)

DISCUSSION

The nurses considered that child/companion user embracement refers to how to approach them and insert them in the CEC environment with a view to practicing empathy, dialogue and listening, which are constituent steps of comprehensive care delivery.

Regarding children's hospitalization, including humanization in advanced life support practices is possible, provided that humanistic competency development takes place at the same level as workers' technical-scientific competency is stimulated. Besides, these professionals should be involved in a new attitude towards daily demands[7]. Humanizing means user embracement with solidarity, understanding each patient's user embracement, enhancing a calm and safe environment[12].

The changes user embracement achieves rekindle the ability to change practices, through analysis and daily review in the health system, as they refer to co-accountability among subjects in care delivery[13].

It should be highlighted that, from the continuous quality improvement perspective, using Donabedian's triad[14], the search to identify problems is fundamental, with a view to putting in practice effective actions, monitoring their development and using an assessment model, representing a non-stop sequence to reach standards of care excellence.

Concerning the agents of work (the workers), setting up user embracement demands attendance to their permanent education, supervision and institutional support needs, so that the work they perform can be qualified beyond doubt[1].

In view of the changes the health professionals identified in their care practices, furthermore, some characteristics were observed which were considered facilitators and others constraints in the user embracement process.

Among the facilitators, working as a team, adopting an attitude, the entire team's change in professional posture and further commitment, speaking the same language, sharing experience, being empathetic and trained[15] are considered favorable characteristics to put in practice high-quality user embracement, which could be observed as important factors in the nurses' reports in this research.

On the opposite, nursing care at the emergency unit is related with characteristics of this environment. Thus, high patient turnover, the large number of patients attended, professionals' lack of sensitivity and lack of teamwork, the agitated environment, lack of privacy and structural conditions are considered constraints of high-quality care.

In the Emergency Care context, knowing how to listen to patients represents a challenge, with a view to collecting the data needed for treatment, knowing that these data can offer benefits or not, depending on how they are collected[15]. User embracement serves as a facilitator, provided that the entire team uses it during the child/companion's hospitalization process.

CONCLUSION

This research evidenced the complexity of user embracement at the Child Emergency Care Unit, in view of the countless factors influencing care quality.

As for the factors facilitating or hampering high-quality user embracement in practice, it could be observed that the lack of meals for companions and their difficulty to get food outside the institution were constraints. Regarding the team, the participants mentioned that some professionals have not developed user embracement in their daily care practices yet, which makes it difficult to achieve high-quality care.

Teamwork and the head's role performance were considered facilitators for user embracement in care delivered to children and their companions. This joint work permits group discussions on the main points to be addressed with a view to improving care delivery.

In this research, the meaning the nurses attribute to user embracement was apprehended. These professionals considered that user embracement should happen, considering the pair child-companion, and be part of managers' concerns to enhance workers' training on this theme.

The need for further research is acknowledged though, as the discussion about user embracement is recent at emergency care units, demanding theoretical support that encourages the inclusion of humanization in these units' care practice, marked by agility and unpredictability.

At the end of this research, it is ratified that in the context of quality management, different strategies and tools can be used. It is fundamental, however, that these involve staff participation, as these professionals are involved in the dynamics of work and picture the group's potential.

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