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RESEARCH

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Comfort requirements of patients assisted by the urgency and emergency service: implications for the nursing profession

Necessidades de conforto de pacientes atendidos no serviço de urgência e emergência: implicações para enfermagem

Necesidades de comodidad de pacientes atendidos en el servicio de urgencia y emergencia: implicaciones para enfermería

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ABSTRACT

Objective: The study's purpose has been to describe the comfort requests of patients assisted in the urgency and emergency services and its implications for the nursing care. **Methods**: It is a descriptive-exploratory study with a qualitative approach, which was performed over the period from November 2014 to February 2015. The study counted with 85 participating patients from the Urgency and Emergency Unit of a referral hospital in the Northern region of *Ceará* State. The information passed through content analysis and the results were presented in thematic categories. **Results**: Considering the physical aspect, the pain addressed as the main discomfort in the physical aspect; in the psycho-spiritual and sociocultural context, waiting for care, lack of resolution and attention of some professionals were the issues; and in the environmental aspects, uncomfortable beds and noise. **Conclusions**: This study addresses relevant comfort requests such as pain relief, comfort in the bed, support and good team relationship, family presence and agility of procedures. Furthermore, the nursing professionals were cited as those who contribute the most to relieving the patients' discomfort. **Descriptors**: Comfort, patient, urgency and emergency, nursing.

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RESUMO

Objetivo: Descrever conforto para pacientes em serviço de emergência e implicações no cuidado de enfermagem. **Método**: Estudo exploratório descritivo qualitativo, realizado em hospital do Norte do Ceará referência para 55 municípios, com amostra de 85 pacientes, internados de 12 a 24 horas no Serviço de Emergência, investigados por meio de formulário, entre novembro de 2014 a fevereiro de 2015, com dados tratados segundo análise temática de Minayo. CEP 793.626 e CAAE 30640114.7.0000.5053. **Resultados**: No aspecto físico, a dor é o principal desconforto; no contexto psicoespiritual e sociocultural, a espera por atendimento; nos aspectos ambientais, os leitos. **Conclusão**: Os profissionais da enfermagem foram citados como os que mais contribuem para amenizar o desconforto dos pacientes.

Descritores: Paciente, emergência, enfermagem.

RESUMEN

Objetivo: Describir comodidad para pacientes en servicio de emergencia e implicaciones en el cuidado de enfermería. **Método**: Estudio exploratorio descriptivo cualitativo, realizado en hospital del Norte de Ceará referencia para 55 municipios, con muestra de 85 pacientes, internados de 12 a 24 horas en el Servicio de Emergencia, investigados a través de formulario, entre noviembre de 2014 a febrero de 2015, con datos fueron tratados según análisis temático de Minayo. CEP 793.626 y CAAE 30640114.7.0000.5053. **Resultados**: En el aspecto físico, el dolor es el principal malestar; en el contexto psicoespiritual e sociocultural, la espera por atención; en los aspectos ambientales, los lechos. **Conclusión**: Los profesionales de la enfermería fueron citados como los que más contribuyen para amenizar la incomodidad de los pacientes.

Descriptores: Paciente, emergencia, enfermería.

INTRODUCTION

Comfort is a positive, multidimensional, subjective and dynamic experience that changes in time and space. It is the result of the interactions that the individual establishes with himself, with those that surround him and with situations faced.[1] Contemplated as an immediate and holistic experience, comfort is reinforced through the satisfaction of the needs of relief, tranquility, and transcendence, present in certain contexts of human experience and expressed by patients in their illness.[2] The personal control of the situation in which they are found and the therapeutic interactions received contribute to the emotional comfort reflecting positively in their recovery.[3] Therefore, in the process of illness and health care, comfort is one of the goals of nursing,[4] then requiring particular attention when it comes to urgent and emergency care.

Because it is considered an area of great complexity within hospitals, the urgency and emergency service is distinguished from others by demanding immediate, efficient and integrated assistance, with extensive technical knowledge and professional ability, as well as the use of technological resources. It is compared to a subsystem of health by requiring several associated services such as surgical center, intensive care unit, radiology, laboratory, among others.[5] This type of unit is considered a life-saving facility. However, to be effective, urgency and emergency care must be done in a flexible and organized way, in order to guarantee the delivery of quality health care and assistance. It should be equipped not only for urgency and emergency care, but also for diagnostic research, minimum necessary treatment and client accommodation.[6] The conception of ambiance in this service, for instance, that includes the physical space, technology, and interpersonal relations, should aim at the privacy and individuality of the subjects involved.[7]

Nonetheless, in Brazil, this type of unit responds to demands overload, high patient turnover, long waiting time, great pressure for immediate care and high tension in the care team.[8] Caring for the patients' comfort in these units is a considerable difficulty faced by the health team due to both overcrowding and inadequate physical space.[9] The diversity of care provided and the stressful environment of professional performance can, therefore, result in a decrease in the quality of care offered[(10)] and, consequently, in the increase of morbidity and mortality rates.

There are numerous situations and causes of discomfort when it comes to hospitalized patients. A newly admitted patient in a hospital is subject to the stresses that accompany the arrival in any strange environment.[11] It is necessary to emphasize that when people are sick, they fear pain, death, and limitations and worry about their ability to withstand the tensions that are to come. The patient and the family face a crisis of discomfort generated by the deprivation of the conviviality, the possibility of loss, the change in the routine of family life and the need to adapt to the routines of the institution of internment. Neglect or care by inflexible or indifferent professionals can also contribute to patient discomfort. Other causes of discomfort in patients are the excessive stimulation they receive either by factors such as ambient heat, poor bed rest, continuously lit lights, noise from staff and equipment in the unit, either by interventions such as medications at dawn, wake up early or a long wait for meals.[11] Consequently, promoting comfort to users within this context is challenging.

Nevertheless, in hospital settings, especially in critical units, nursing is recognized for providing patient safety,[12] acting with attentive listening, which is essential to identify their needs and also minimize anxiety. It is of note the nurse's work in developing specific skills that contribute to assertive decision making. Therefore, the patient seeks the understanding and support of the nursing team in order to obtain some comfort.[13] The nursing profession has several resources at its disposal to alleviate patient discomfort, but it is only through a systematic approach to the problem, applying the nursing process, that effective measures can be selected, since the results of the interventions for comfort vary from person to person.[14] In addition to individual particularities, comfort can be classified, according to the Kolcaba Theory, in physical, psycho-spiritual, environmental and sociocultural. The physical sensations, homeostatic mechanisms and immune functions of the organism belong to the type of physical comfort; in the psychospiritual comfort, the inner self-consciousness, including self-esteem, self-concept, sexuality, meaning in one's life and relationship to the divine being; environmental comfort is focused on the environment, on external conditions and influences.

Conclusively, sociocultural comfort turns to interpersonal, family and social relationships.[4]

Because of these particularities, nursing must seek combinations of more effective measures to ensure comfort for each patient, such as through the Nursing Process directed by the Nursing Care Systematization (NCS), which allows the detection of intervention priorities. In urgency and emergency services, nurses should be directed to apply this methodology for the benefits that it brings. The NCS starts from the evaluation of the patient, family, and community data in the different contexts of insertion, allowing the nurse a critical judgment, favorable to the practice of care and clinical decision-making based on evidence.

Given the aforementioned, it is necessary to know the comfort requirements of patients assisted in the urgency and emergency services as a starting point for paradigm shifts. Considering its relevance to nurses' practice of care, the discussion on this theme implies improving the quality of care based on theoretical, technical, scientific and ethical precepts that emerge in the situation of illness and imminent death,[15] as is the case of urgency and emergency services.

METHODS

It is a descriptive-exploratory study with a qualitative approach. This study was carried out in the medium complexity of the Urgency and Emergency Unit of a large hospital, which is a referral for the Northern region of the *Ceará* State. The hospital is located in *Sobral* city, which is 235 km far way from the Capital (*Fortaleza* city). In addition to the municipal population of 197,663 inhabitants, the hospital serves 55 surrounding municipalities.[5]

The hospital founded 90 years ago, has 370 beds directed to the *Sistema Único de Saúde (SUS)* [Unified Health System], recognized as a teaching hospital by Interministerial Ordinance No. 2,576 of October 10th, 2007, the 9th in this category in the *Ceará* State, the first being outside the Capital. Nowadays, it has medical and multiprofessional residences, including in Urgency and Emergency.[5]

The Urgency and Emergency Service of the hospital, a research scenario, has an assistance team composed of technicians and nursing auxiliaries, nurses, physicians, social workers and nutritionists.[16] The unit has medical offices, rooms for medium complexity procedures, an Adult Intensive Care Unit, adult, female and male observation units; room for patient reception and classification with regards to the risk and care priority.

Eighty-five (85) patients participated in the study, individually invited, randomly selected, using as inclusion criteria the age of 18 years old or more, who were hospitalized in the medium complexity, with a stay time of 12 to 24 hours. As an exclusion criterion, people who did not meet the criteria mentioned above, very unstable critical patients with altered level of consciousness, moderate to severe pain or some difficulty that prevented their participation.

Information was collected from November 2014 to February 2015. As an instrument, a form was chosen containing questions related to the sociodemographic and clinical profile of the participants, the discomfort situations presented by the participants and health professionals who contributed to the promotion of your comfort.

The information was analized according to Minayo's thematic analysis,[17] divided into three stages, the first one being pre-analyzed, which consisted in the choice of the documents to be analyzed and the resumption of the hypotheses and the initial objectives of the research; and pro-analysis, which in turn was decomposed into tasks (floating reading, constitution of the corpus, formulation and reformulation of hypotheses and objectives). The second stage, known as material exploration, essentially consisted of a classificatory operation aimed at reaching the core of the text. The third stage is the handling of the obtained results and interpretation, in which the raw results are submitted (traditionally) to statistical operations (percentages) or complex (factorial analysis) that allow highlighting the information obtained.[17]

This research was approved under the Legal Opinion No. 793.626 and the *Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Appreciation] No. 30640114.7.0000.5053. All the ethical aspects of research involving human beings have been respected as confidentiality and privacy of the researched individuals guaranteeing the protection of their image. The recommendations of the Resolution No. 466 of December 12th, 2012, which establishes guidelines on research involving human beings, have been observed. This resolution incorporates, from the viewpoint of both the individual and the collectives, bioethical references such as autonomy, not maleficence, beneficence, justice and equity, among others. A Free and Informed Consent Term was also used for all participants in the survey. The research did not involve direct risks to participants.

RESULTS

The results were organized according to the sociodemographic and clinical characterization of the participants, discomfort situations experienced by patients in urgency and emergency, and professionals who contributed to comfort. In sociodemographic and clinical characterization, the patients were within the age group from 18 to 75 years old; 62% were married; 66% had children; 64% lived outside Sobral. As for schooling, 16% declared themselves illiterate, 51% were between literate and with complete elementary education and 33% were between incomplete high school and college education in progress. About their occupation, 8 responded that they were domestic workers, 12 housewives, 6 production auxiliaries, 20 farmers and the rest were in other professions with only one representative in each.

Patients admitted to the urgency and emergency unit reported physical, psychic, spiritual, environmental, social and cultural discomforts. However, there were conflicting reports, in other words, the presence of comfort, despite hospitalization. As for the comfort needs in the physical context, the pain was the main discomfort presented. Patients also complained of discomfort in the bed.

It is worth illustrating that the unit studied meets a demand that exceeds its capacity. Patients are arranged in beds so close together that assist one of them, it is often necessary to move others. "We need to be leaving all the time," reports one interviewee. The insufficient number of beds is mitigated by the use of stretchers, which in turn are also smaller than necessary, with the more stable patients being accommodated in chairs for an indeterminate time. From the stretchers there are also complaints of discomfort because they are narrow and poorly padded, a fabric that facilitates hygiene, but which generates an undesired increase in skin temperature, worsening the ambient thermal sensation. Other physical discomforts verbalized were as follows: imposed bed resting due to immobility of the lower limbs, post-lumbar puncture discomfort, heat, difficulty to rest, respiratory problems, palpitation and prolonged fasting. The latter, when higher than the time provided for conducting examinations or procedures.

As for the comfort needs in the psycho-spiritual context, anxiety was the greatest discomfort generated, arising from the space of time that extends beyond the expected or the desirable in each one of the stages of the hospitalization process, from the entrance until the definition of flow Last. The reports describe delay in the initial medical care after the classification of risk, in the accomplishment of the requested tests, in the results of the exams after its accomplishment, in the lack of definition of which professional will analyze the results, in the evaluation of the exams after the arrival of the results, in the definition of conduct after examination analysis and in procedures after definition of conduct.

The study participants also lamented the lack of attention of the professionals in the clarification of the doubts manifested in each one of the stages previously mentioned. Responses to inaccurate information or those that provide longer waiting times also caused discomfort, increasing patients' distress. There were reports of "depression" and involuntary submission to the institution's routines. Relying on a health care that ignores the patient's participation in the conduct of their health and illness processes is also a source of discomfort. Among those interviewed, the feeling of not being perceived by professionals ("I look invisible", "they are indifferent") was verbalized. This perception of patients is strengthened when they complain, for example, of pain and are not medicated in a timely manner. Discomfort in relationships during hospitalization is even mentioned when more stable patients are incomprehensible regarding the comfort needs or priority of more severe patients. Concerning the risk classification, the severity of the patients is evident even to a layperson. A feeling of indignation is created among the patients who, due to having arrived "earlier" or having "determined" health problem, "deserve to be assisted first".

Concerning the comfort needs in the sociocultural context, the needs of accompanying relatives or someone who promoted safety throughout the hospital stay were reported. As a way to compensate for this absence, mobile devices come on the scene. Nonetheless, if, on the one hand, they can be used as a source of comfort by allowing the inpatient to communicate with the family, on the other hand, they increase the possibilities of noise in the environment, causing disturbance of sleep and rest and generating other types of discomfort, beyond the risk of invasion of privacy, unnecessary public exposure, incurring unethical processes difficult to manage. Still, in the sociocultural context, there was also a report of a patient inconvenienced with certain postures adopted by the professionals. In a tone of indignation, there was a report of a patient who compared the attitudes of the professionals and concluded that while some are dedicated to working, others are idle or distracted without providing the necessary care.

The complaints of discomfort in the environmental context pointed to the patient's contact with a typical scenario of an overcrowded emergency room with undersized, agitated, stressful, noisy staff, receiving trauma victims, for example, sometimes mutilated, injured by arms, with exposed fractures, bloody, burned, groan, in cardiorespiratory arrest, evolving with death, among other cases of difficult assimilation with naturalness by a layman. The visualization of these facts was pointed out as a generator of psychic and emotional discomfort. This environment has an impact on the patient's comfort not only because they are shocking in themselves, but also because of the feeling of powerlessness in the face of the risk of death and fear of it happening to them.

When inferred to choose comfort situations experienced, the emphasis is on the well-being caused when they perceive relief of their pain, or when they perceive speed in the medical care and the accomplishment of the examination, or if it obtains explanations with clear answers on the attendance; or when they move from a less suitable bed to a better bed, or when the professionals are friendly, or when they meet their sleeping and resting needs. The presence of family members with some patients promoted comfort in the sociocultural context and even better satisfaction with the environment.

The results allowed to demonstrate that the participants of the study perceived and felt comfortable when at any moment some health professional applied to his medication, the accomplishment of procedures like dressings, probes, cleaning of secretion and help etc. In the report of study participants were present physicians, academics, nurses, nursing technicians and academics that contributed to the comfort and relief control of their pain related to the physical aspect.

They point out as another comforting factor, the support and good relationship with the health team and with the other patients, as illustrated by the following statements: "because when we come here, we know several people, then the time goes by and I feel comfortable because of it "; "It is going to be fine, as long as they are taking care of us with affection"; "I was soon assisted by the professionals and when I arrived with pain, the nurses took care of me very well"; "The nurses, the doctor soon examined me, did the cleaning and the dressing"; "The concierge, the doctor and the nurse took care of me, were attentive"; "They (employees) were always looking for a better place to put me, if they were in the hall they took me out and looked elsewhere. They were worried, and the nurse was who did it."

When asked to elect the professionals who contributed the most to the comfort situations experienced, in a quantitative analysis of the professionals cited by the patients who contributed to the comfort in the urgency and emergency unit, we have the following: nursing professionals cited 18 times; the physicians, 15 times; both nursing auxiliaries and nurse technicians 9 times; all the previously mentioned professionals 06, none 02, concierge and 01 radiology technician each, and those that do not know who were the professionals who promoted their comfort 01. The nursing professional was mentioned as the principal responsible for promoting the comfort of these patients. It is questioned if it would be because these professionals are the ones who remain for more time at the bedside in the performance of their activities. In speeches, the physician prevailed as necessary for better agility in the care provision.

DISCUSSION

The characterization of the profile of the users served in urgency and emergency services brings subsidies for the reorganization of the management of the health system and highlights the challenge of implanting the emergency care network in Brazil.[18] A similar study was found to be predominant in emergency and male emergency services, the average age was 46 years old, the majority of the patients had only elementary education, 10% were illiterate and 8% were unemployed.[19] In another study, female patients, single, within the age group from 21 to 40 years old, with up to 10 years of schooling and family income fewer than three minimum wages predominated.[20] In another analysis, the majority of the population was female, married, with the age group from 30 to 49 years old, family income from 1 to 3 minimum wages, with most users having a high school certificate.[21] Based on the findings and bibliographic references of this study, the epidemiological clinical profile of the users of the emergency network is composed of a population that is in the productive age range, with low educational level and precarious socioeconomic status.

Regarding the overcrowding of Urgency and emergency Units, researchers found that in these units there is a high proportion of people with health problems that could be solved, more appropriately, in Basic Health Units (BHU).[22,23] The patients investigated showed distrust regarding the care in the BHU, preferring the technological resources made available and the sensation of resolubility of the emergency aids, by performing several exams and being medicated "on the spot". Unrestricted access to first aid may be one of the causes of the high incidence of users seeking immediate care for simple problems.

Hence, this large number of urgency and emergency services end up overwhelming the multiprofessional team, especially the nursing team because they require a large amount of assistance, even among outpatients. Examples are those who are treated in the suture rooms, outpatient procedures, medication administration room, inhalation room, referrals and guidelines for performing laboratory and imaging tests.

Amongst the urgency and emergency services, the following physical problems were identified: edema, tingling, discomfort on standing, dehydration, needing help to move around.[22] The authors address as care that promotes comfort: satisfaction of basic human needs, the accomplishment of technical procedures, presence of equipment, control and pain relief of clinical symptoms, availability of medications, diagnostic and therapeutic preparation procedures, bed comfort and promotion of sleep and rest. However, pain relief was cited in the texts as the greatest source of comfort.

The work of the nursing team should, in an independent and collaborative way, understand the identification of the pain complaint and perceive the characterization of the painful experience in all its domains: the measurement of the repercussions on the biological, emotional and behavioral functioning of the individual, identification of factors that contribute to the improvement or worsening, the selection of treatment alternatives and the verification of the efficacy of the interventions for the relief of the pain of these patients in emergency units.[23]

Given this context, it is of fundamental importance that the nurse understands the patients' needs, understands and has a humanistic look at the suffering patient. Therefore, the nursing commitment to ease discomforts goes beyond biological and physical interventions, since the focus must be on existential aspects that allow the expression of feelings, so that it is necessary to listen to the patient in a situation of pain and seek alternatives to alleviate their suffering.

CONCLUSIONS

Through this study it was possible to describe the comfort requests of patients assisted in the urgency and emergency services and its implications for the nursing care. Considering the physical context, the pain was the main discomfort addressed. Other reports report the impossibility of ambulation, bed discomfort, anesthesia puncture, dyspnea, tachycardia, and prolonged fasting. Concernig the psycho-spiritual and sociocultural context, the comfort requirements were directed to waiting for care, lack of attention of some health professionals, sadness, depression, moving from their home city and lack of either relatives or companions. Regarding the environmental context, patients feel uncomfortable seeing others in more severe conditions, and they also mentioned uncomfortable beds and various noises.

In contrast, this study also showed reports of patients who, even under the same conditions as the previous ones, feel comfortable. The satisfaction of their comfort needs was recorded for pain relief, bed adequacy, the satisfaction of sleep and rest needs, support and good relationship with the health team, the presence of a relative during hospitalization, satisfaction with cleanliness the availability of medicines and the implementation of procedures that have solved their health problem. The findings reveal how much the perception of comfort can be individual.

With regards to the professionals cited by the patients who contributed to the promotion of comfort, the nursing professionals were the majority followed by the medical

team. The results allow reflections on the continuous improvement of health care. This study identifies comfort needs, which it is possible to draw care plans focused on the satisfaction and needs of patients in similar environments as the one researched.

Among the limitations of this study are the difficulties in obtaining the participants' agreement, the place of study, the professionals that somehow made the collection process difficult and insufficient time spent together with the participants.

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