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Original Article

FAMILY COMFORT TO A RELATIVE IN THE INTENSIVE THERAPY UNIT

CONFORTO FAMILIAR A UM PARENTE INTERNADO NA UNIDADE DE TERAPIA INTENSIVA

CONFORT FAMILIAR A UN PARENTE INTERNADO EN LA UNIDAD DE TERAPIA INTENSIVA

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Objective: to verify the comfort leve given by family members to intensive care unit patients. Method: cross-sectional quantitative study that interviewed 98 relatives of adult patients admitted to a public hospital in Feira de Santana, Bahia, applying the Comfort Scale for Relatives of Critical Patients (CSRCP). Data were analyzed using descriptive statistics. Results: the overall mean of comfort level was 3.83 (±0.53). For the Safety dimension, the mean was 4.38 (±0.54), for Interaction between family and patient, 4.19 (±0.70) and for Support, 2.92 (±0.74). Conclusion: comfort levels showed that the family members felt more comfortable when they perceived the technical-scientific competence and the interpersonal relationship of the hospital staff and the possibility of recovery and support to their relative. Lower comfort was related to the limitations to be with or near the relative and to the gaps in the hospital information system.

Descriptors: Comfort care. Family. Nursing.

Objetivo: verificar o nível de conforto de familiares com um membro em unidade de terapia intensiva. Método: estudo quantitativo, de corte transversal, que entrevistou 98 familiares de pacientes adultos internados em um hospital público em Feira de Santana, Bahia, aplicando-se a Escala de Conforto para Familiares de Pessoas em Estado Crítico de Saúde (ECONF). Os dados foram analisados pela estatística descritiva. Resultados: a média do nível global de conforto foi de 3,83 (±0,53). Para a dimensão Segurança foi de 4,38 (±0,54), Interação familiar e ente de 4,19 (±0,70) e Suporte de 2,92 (±0,74). Conclusão: os níveis de conforto evidenciaram que os familiares sentiam-se mais confortáveis quando percebiam a competência técnico-científica e o relacionamento interpessoal da equipe hospitalar e a possibilidade de recuperação e apoio ao seu parente. Menor conforto foi relacionado às limitações para estar com ou próximo ao parente e às lacunas no sistema de informação hospitalar.

Descritores: Cuidados de conforto. Família. Enfermagem.

Objetivo: verificar el nivel de confort de familiares con un miembro en unidad de terapia intensiva. Método: estudio cuantitativo, de cohorte transversal, que entrevistó 98 familiares de pacientes adultos internados en un hospital público en Feira de Santana, Bahia, aplicando la Escala de Confort para Familiares de Personas en Estado Crítico de Salud (ECONF). Los datos fueron analizados por la estadística descriptiva. Resultados: la media del nivel global de confort fue de 3,83 (±0,53). Para la dimensión Seguridad fue de 4,38 (±0,54), Interacción familiar y ente de 4,19 (±0,70) y Soporte de 2,92 (±0,74). Conclusión: los niveis de confort mostraron que los familiares se sentían más confortables cuando percibían la competencia técnico-científica y la relación interpersonal del equipo hospitalario

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Descriptores: Cuidados de confort. Familia. Enfermería.

Introduction

The problems experienced by families who have one member admitted to an Intensive Care Unit (ICU) are usually permeated by discomforts that are understood as physical, psychological and social changes, disturbances and difficulties, mainly due to the uncertainty of recovery and of the outcome of the clinical picture of their relative. These changes generate various needs, such as a closer contact with the hospitalized relative, access to information, support, security and comfort[1-4].

The family becomes apprehensive due to the possibility of unexpected clinical events and the risk of imminent death of their relative. This experience interferes in their ability to interact with the world, in the organization of daily life and in their well-being[5,6].

The specific characteristics of ICUs, among them the work dynamics and the complexity and invasive nature of the treatment and the procedures performed lead people to have the fear of this environment. ICUs also often give the impression of coldness and detachment from the part of the people working there before the suffering of others.

Aspects related to hospital infrastructure, visitation policies, access to information and the way relationships are established between family members and health professionals directly affect the level of comfort experienced[1,4,7-9]. Comfort is considered a positive, multidimensional, subjective and dynamic experience that changes in time and space and its promotion is the goal of nursing care[7,8]. The literature reinforces that the promotion of comfort is a desired result of care practices, be they addressed to the patients, or to their relatives[1-4,6].

Thus, a growing concern has taken place in recent years about turning the ICU environment less impersonal, but more welcoming, not only in its physical space, but also in relation to the relationships established between the health team, patients and their families, based on a dialogic relationship and in the conciliation between rationality and sensitivity in the therapeutic proposal[2,9-10].

The promotion of comfort becomes a moral imperative in the face of the problems experienced by families during the hospitalization of their relative. Comfort should be considered as an object of care and, therefore, integrated to health care and treatment projects.

Studies on the level of comfort of family members in ICUs are scarce, as well as the instruments for their measurement. The only nationally validated scale for this measure is the Comfort Scale for Relatives of Critical Patients (CSRCP). When applied, this scale can express the effectiveness of care practices directed at the family. In view of the above, the present study has as a research question: what is the level of comfort of family members of adults admitted to intensive care units of a public hospital in Feira de Santana, Bahia?

To answer the questioning and seeking to minimize the existing gap in this area of knowledge, this research aimed to verify the level of comfort of relatives of adults hospitalized in intensive care units.

Method

This is a cross-sectional study carried out in 2015 in two intensive care units of a large public hospital in the city of Feira de Santana, state of Bahia. The study is a subproject of the matrix research project entitled "Construction and Validation of a Comfort Scale for Relatives

of Critical Patients". The project was approved by the Research Ethics Committee (REC) and complied with the Resolution n. 466/12 of the National Health Council and approved under REC Protocol n. 078/09.

Participants were relatives of adults admitted to the ICU who met the inclusion criteria: having an adult relative admitted to the ICU for more than 24 hours, minimum time for perception of the experience; being the closest person to the hospitalized person; aged 18 years or over; having visited at least once the relative and be in proper emotional conditions to answer the research questions.

Two instruments were used in the interviews for data collection. The first one consisted of closed questions about clinical and sociodemographic characteristics of the hospitalized person and the family. Data on the time of interaction and the relationship of the family with the hospitalized person, as well as previous experiences with ICU hospitalizations, were also collected.

The second instrument consisted of the CSRCP, which is an instrument for comfort measurement validated by Freitas[4]. The version of the instrument adopted in the study consisted of 46 items, distributed in three dimensions: Safety (20 items), Support (20 items) and Interaction family-patient (6 items).

The CSRCP is a *Likert-type* scale, with five response intervals: 1 - not at all comfortable, 2 - not very comfortable, 3 - more or less comfortable, 4 - very comfortable and 5 - totally comfortable. The scale is increasing, that is, the greater the value assigned to the items, the is greater the degree of comfort.

In the daily census of intensive care units, people with an length of hospital stay of more than 24 hours were selected for the election of the family members, considering the need for at least one visit to the ICU. After this screening, family members who met the other inclusion criteria were searched.

Family members were informed about the objectives and procedures of the research and after signing the Informed Consent Form (ICF), they were invited to participate in the interview, in a private room close to the ICU. Up to two members of the same family were interviewed.

Data were stored and analyzed in the *Statistical Package for the Social Science* (SPSS), version 20.0, Windows platform. The categorical variables were analyzed in absolute and relative frequencies and the quantitative variables were analyzed in terms of mean and standard deviation.

For the analysis of comfort level, the overall mean and standard deviation were calculated based on the set of items that compose the scale, as well as the mean and respective standard deviations of each of the dimensions.

Results

The results obtained from the data collection will be presented below. Results were divided into three categories: Characterization of ICU patients, Characterization of relatives of ICU patients and Analysis of the comfort level of relatives of ICU patients.

Characterization of ICU patients

Patients were hospitalized in two intensive care units, ICU I (57.1%) and ICU II (42.9%). The length of stay in these units varied in average 12.0 (± 11.3) days. The majority of hospitalized patients were male (59.7%) with a mean age of 49.4 years (± 20.0) years; the predominant diagnosis was clinical (57.1%), followed by surgical (33.8%) and clinical that evolved to surgical (9.1%). Neurological disorders (26.0%), postoperative disorders (24.7%), respiratory disorders (14.3%) and polytrauma (10.4%) prevailed among the diagnoses; the less frequent were kidney disorders (9.1%), septic shock (7.8%), cardiac disorders (6.5%) and hematological disorders (1.3%).

Characterization of relatives of ICU patients

A total of 98 family members were interviewed; most of them were female (62.2%) with an average age of 40.92 years (± 12.87). Regarding

the level of education, a significant part of the family members had incomplete or complete secondary education (63.3%), followed by those with primary education (20.4%) and superior education (13.3%). There were no illiterates in the interviewed group and few family members had a postgraduate degree (3.1%). Concerning the marital situation, half of the interviewees were married/consensual union (50.0%). Most of them lived in Feira de Santana (64.3%), were Catholic (56.1%) and had no prior experience with ICU admissions (70.4%). Regarding the labor situation, the employed (29.6%), the self-employed (35.8%) and engaged in domestic activities (15.3%) were more most frequent situations. The most common kinship of the patients admitted to the ICU were children (34.5%).

Analysis of the comfort level of relatives of ICU patients

The overall mean of the comfort level was 3.83 (± 0.53), showing that family members felt more comfortable than uncomfortable. Considering the overall score of each dimension, it was found that the Safety dimension had a higher mean, 4.38 (± 0.54), followed by Interaction family-patient, 4.19 (± 0.70), and Support, 2.92 (± 0.74).

Regarding the Safety dimension, which expresses the technical-scientific skills of the health team and their performance in interpersonal relationships, the items that scored the highest level of comfort evidenced the family members' perception that their relative received hygiene care (4.58 ± 0.80), as well as the perception of professional competence of ICU professionals (4.57 ± 0.76) and the kindness with which they were treated (4.57 ± 0.69). Lower level of comfort was related to the items referring to the perception of fast provision of care to the relative (4.02 ± 1.34), the recognition of the professionals who can help the family member when needed (3.78 ± 1.43) and the information received about the hospitalized relative at any time (2.79 ± 1.68). These data are shown in Table 1.

Table 1 – Comfort level of family members per item of the Comfort Scale for Relatives of Critical Patients, according to the Safety dimension. Feira de Santana, Bahia, Brazil, 2015 (to be continued)

Items of the CSRCP Safety dimension	Mean	Standard deviation
Perception that the relative has received hygiene care	4.58	± 0.80
Perception of the professional competence of ICU staff	4.57	± 0.76
Kind treatment by ICU professionals	4.57	± 0.69
Awareness that the best possible care is being given to the relative	4.57	± 0.59
Awareness that the ICU offers security for the recovery of the relative	4.53	± 0.80
Perception of a calm assistance from the part of the team	4.51	± 0.63
Availability of professionals to assist the relative	4.49	± 0.83
Perception that the ICU staff provides information with good will	4.46	± 0.95
Kind treatment at the ICU reception	4.46	± 0.81
Perception that the team has patience to listen to family members	4.46	± 0.76
Feeling that the team is interested in the recovery of the relative	4.45	± 0.87
Perception of tranquility in the care provided to the relative	4.44	± 0.70
Perception that the team pays attention to the conditions of the relative	4.35	± 0.92
Provision of detailed information about the situation of the relative	4.29	± 1.00
Provision of information from professionals in a way that the listener can understand	4.28	± 1.09
Perception that ICU professionals understand the situation family members are experiencing	4.27	± 1.10
Words of support from the team during ICU admission	4.20	± 1.21

Table 1 – Comfort level of family members per item of the Comfort Scale for Relatives of Critical Patients, according to the Safety dimension. Feira de Santana, Bahia, Brazil, 2015 (conclusion)

Items of the CSRCP Safety dimension	Mean	Standard deviation
Perception that the professionals do not insist that the family member leaves at the end of the visit	4.10	± 1.21
Information on what treatment is being given to the relative	4.10	± 1.05
Perception that the relative receives prompt care when needed	4.02	± 1.34
Knowing who professionals may help when needed	3.78	± 1.43
Provision of information about the relative at any time	2.79	± 1.68

Source: Created by the authors.

The level of comfort in the Interaction family-patient dimension showed that the relatives perceived specially the possibility of recovery of the relative (4.45 ± 0.84) and believed that they could help in this (4.44 ± 0.93) and that they enjoyed the interaction with their hospitalized relative (4.39 ± 1.15). Lower comfort level in this dimension was related to the perception of the relative's satisfaction regarding the service rendered (3.32 ± 1.77). These data are shown in Table 2.

Table 2 – Comfort level of family members per item of the Comfort Scale for Relatives of Critical Patients, according to the Interaction family-patient dimension. Feira de Santana, Bahia, Brazil, 2015

Items of the CSRCP Interaction family-patient dimension	Mean	Standard deviation
Perception that the relative is responding well to treatment	4.45	± 0.84
Being able to help the relative deal with this situation	4.44	± 0.93
Knowledge that the relative realizes that the family is around	4.39	± 1.15
Perception that there is a chance of recovery of the relative	4.39	± 0.89
Seeing the relative out of risk of death	4.19	± 1.26
Perception that the relative likes the treatment provided	3.32	± 1.77

Source: Created by the authors.

The Support dimension evaluates the comfort related to the support offered by the hospital structure and staff or their social environment. With respect to interpersonal interactions, there was a higher level of comfort in items related to the information offered to the family members, be those shared by the physician at daily basis (4.64 ± 0.78), or those related to transfers, discharge, exams and new treatments (4.04 ± 1.35). Other items that had high level of comfort were having support from friends during the visit (4.09 ± 1.31) and enjoying a conversation with someone from the team (4.15 ± 1.28). Regarding the hospital structure, the more comfort was experienced in the fact that family members had a waiting room (4.45 ± 0.72) with nearby bathrooms (4.02 ± 1.32). Lower comfort levels were related to the difficulty of being with or near to the relative whenever desired, for lack of permission to see the relative or to be in the waiting room except for the visiting hours (1.43 ± 1.94). Gaps in the information system also promoted a lower level of comfort, such as not always receiving information about changes in the relative's clinical condition (1.44 ± 1.98) or when requesting information by telephone (1.23 ± 1.78). Other items that reduced the comfort of family members were associated with satisfaction of feeding needs (2.35 ± 1.74) and access to drinking water (1.76 ± 1.74).

Table 3 – Comfort level of family members per item of the Comfort Scale for Relatives of Critical Patients, according to the Support dimension. Feira de Santana, Bahia, Brazil, 2015

Items of the CSRCP Support dimension	Mean	Standard deviation
Provision of medical information in daily basis	4.64	± 0.78
Waiting room near the ICU	4.45	± 0.72
Conversation with someone on the team	4.15	± 1.28
Presence of a friend or family member during the visit	4.09	± 1.31
Provision of explanations about what will happen to the relative (transfers, discharge, exams, new treatments)	4.04	± 1.35
Bathroom near the waiting room	4.02	± 1.32
Availability of means of distraction in the waiting room (magazines, TV, radio)	3.97	± 1.06
Provision of information about the operation of the ICU	3.61	± 1.53
Comfortable furniture in the ICU waiting room	3.09	± 1.44
Provision of information about the reason for the delay of the visit when it occurs	2.98	± 1.92
A place to eat in the hospital or nearby	2.35	± 1.74
Permission for a larger number of visitors when needed	1.99	± 1.94
Availability of drinking water in the waiting room	1.76	± 1.74
Permission to stay in the ICU waiting room in moments out of the visiting hours	1.67	± 1.83
Communication of changes in the clinical condition of the relative when family members are at home	1.44	± 1.98
Seeing the relative in moments besides the visiting hours when necessary	1.43	± 1.94
Being able to receive information about the relative when calling through the telephone	1.23	± 1.78
Pay phone near the waiting room	1.01	± 1.62

Source: Created by the authors.

Discussion

The levels of comfort obtained showed that family members experience more comfort than discomfort in the interaction, both with objects of the hospital and with the relative.

Regarding the interaction with the hospital staff, the level of comfort obtained in the safety dimension indicated that the professionals who provided care in the ICU, *locus* of the study, showed their technical and scientific excellence as well as welcoming reception to the family members. The care and treatment offered made it clear that their relatives were in a safe place. The safety of the family is ensured when its needs and those of their hospitalized members receive qualified attention from the pharmacological, technological and human point of view. Although technical excellence promotes comfort by implying security during recovery, this state is also achieved by establishing kind relationships between clients and professionals, who express tranquility and understanding of the situation faced by the family members. This means that comfort comes from caring practices that value humanity associated with rationality[11-13]. Safety is experienced by the family when a relationship of trust is established with health professionals, when the family perceives the solidarity of people in the care system and has access to detailed and understandable information about the conditions of the patient.

Attention, respect, solidarity and dialogue should guide the interaction with the relatives of critically ill people. Nursing workers must be trained and sensitized to establish a relationship of empathy and trust with the family, communicate in proper manner, encourage and motivate family members to express their doubts, in order to meet the need for information and,

with this, reduce the distress and suffering of all those involved[14]. They need to be willing and available to provide information to family members whenever they are requested.

The level of comfort gained by family members in the Interaction family-patient dimension was good and promoted by the feeling of being physically and emotionally close to the patient and being able to support him/her, as well as by having the fear of loss minimized by becoming aware of the his/her chances of recovery. Less comfort was associated with the perception that the relative enjoyed the treatment received, which is difficult to fully achieve given the very nature of intensive care. These data showed that it is necessary to allow the presence of the family whenever possible and desired. The proximity with the hospitalized relatives is, in general, a necessity and enables the families to follow the reactions and progress of the patients, seeing them out of risk, supporting them, feeling present, which minimizes their suffering[15]. Other research studies have also shown that comfort to family members means being at the side of their relative and enjoying the interaction established between them, as well as having the opportunity to closely monitor their state and identify what they need[2,6].

The level of comfort in the support dimension was the lowest among family members, especially in items related to the restricted number of visitors, being able to be in the waiting room whenever they want and having water to drink, access to information when making phone calls and being communicated about changes in their relatives' health condition. These data show that comfort is promoted by the effective communication system established with health professionals. This also highlights that nurses must be prepared, sensitized and available to offer information whenever requested, shared with the health team. They reinforce the importance of making hospital standards and routines more flexible to allow the presence of relatives next to the patients whenever possible.

The level of comfort in the support dimension showed that the family members feel more relaxed when they have access to information about the hospitalized relative and the certainty that this is transmitted with truth and precision[12,16-17]. The support from hospital structure to the family members was undoubtedly necessary to ensure their comfort, as well as the support they received from friends and family.

The care practice in the ICU showed in the evidence raised in this research and in the literature confirms the need to include family members as subjects of health care, taking their feelings, fragilities and needs into account at that moment of hospitalization. However, the insertion of the family in this context and the identification of their demands for comfort are not easy. The professional-family relationship tends to become distant due to the strict norms of the intensive care sector. These norms are determined by the professionals themselves and by their work overload, who often believe that the presence of individuals in this environment makes their work difficult. This distance between professionals and the family is also a reflection of a reductionist academic formation in the health field, although there are efforts in the direction of questions related to the humanization of health practices and the consideration of a holistic approach of the subjects.

As evidenced in this study, comfort was related to the consideration of family members as subjects of health care. The family's interest in participating in the care and the relationship with the nursing team can be facilitating elements for the hospitalization process[18-19]. The promotion of comfort should be considered as a goal of health and nursing care. Understanding this construct and its dimensions requires an understanding of the family universe and the different processes that accompany them throughout the hospitalization.

The democratization of labor relations and the valorization of health professionals, stimulating processes of permanent education and the expansion of dialogue with other professionals, with the population and with managers allow a better preparation of professionals to understand and assist families[20]. The study showed that

the promotion of comfort implies reconciling sensitivity, rationality and material conditions in the care of families and their hospitalized members.

Conclusions

Considering the analysis of the 98 items of the CSRCP, it was observed that most of the family members experienced a more comfort than discomfort in all dimensions of the scale. Both the comfort and the discomfort experienced by these family members were directly related to the relationships established with their relative, the institution and the people of the hospital care system during their stay in the ICU. Comfort levels showed that the family members felt more comfortable when they perceived the technical-scientific competence and the interpersonal relationship of the hospital staff, and the possibility of supporting and seeing the recovery of the relative. Lower comfort was related to the limitations to be with or near the relative and to the gaps in the hospital information system.

The study reinforces that family comfort can be achieved when an ethical, respectful, and solidary relationship is established between the triad professional - hospitalized patient - family, and that simple measures regarding ambience, sensitive listening, reception and appropriate provision of information are key elements.

The analysis of the comfort level of family members evidenced in this study can help nurses and other health professionals to evaluate the effectiveness of interdisciplinary care and to guide comfort measures aimed at this public.

Colaborações

1. conception, design, analysis and interpretation of data: Camila Oliveira Valente, Gabriella Morais Fonseca, Katia Santana Freitas and Fernanda Carneiro Mussi;

2. writing of the article, relevant critical review of intellectual content: Camila Oliveira Valente, Gabriella Morais Fonseca, Katia Santana Freitas and Fernanda Carneiro Mussi;

3. final approval of the version to be published: Camila Oliveira Valente.

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