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FAMILY EXPERIENCE OF EMERGENCY CARE

VIVÊNCIA FAMILIAR DO ATENDIMENTO DE EMERGÊNCIA

EXPERIENCIA FAMILIAR DE ATENCIÓN DE EMERGENCIA

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Objective: to understand the family perception on the experience of emergency care to one of its members. Method: descriptive study of qualitative nature, carried out in three municipalities in Southern Brazil. Data were collected in June 2015 through semi-structured interviews, held in the home of 16 individuals who accompanied their relatives in the emergency unit. The interviews were recorded, transcribed and submitted to thematic Content Analysis. Results: the families revealed intense suffering during the emergency care with the family member. The fast and effective care, the presence of effective communication and the possibility to monitor the assistance were perceived by the family, when present, as care qualifiers and, when absent, as disqualifiers. Conclusion: the family life during the emergency care has been characterized by intense suffering, which is directly influenced by how health professionals receive and meet the patient and his/her family.

Descriptors: Family. Professional-family relations. Emergency Medical Services.

Objetivo: compreender como a família percebe a vivência do atendimento emergencial a um de seus membros. Método: estudo descritivo de natureza qualitativa, realizado em três municípios do Sul do Brasil. Os dados foram coletados em junho de 2015 por meio de entrevistas semiestruturadas, realizadas no domicílio de 16 indivíduos que acompanharam seus familiares em unidade emergencial. As entrevistas foram gravadas, transcritas e submetidas à Análise de Conteúdo, modalidade temática. Resultados: as famílias revelaram intenso sofrimento durante o atendimento emergencial de seu familiar. A rapidez e resolutividade no atendimento, a presença de comunicação efetiva e a possibilidade de acompanhar a assistência foram percebidas pelos familiares, quando presentes, como qualificadores do atendimento e, quando ausentes, como desqualificadores. Conclusão: a vivência familiar durante o atendimento emergencial foi caracterizada por intenso sofrimento, o qual é diretamente influenciado pelo modo como os profissionais de saúde acolhem e atendem o paciente e sua família.

Descritores: Família. Relações Profissional-família. Serviços Médicos de Emergência.

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Objetivo: comprender cómo la familia percibe la experiencia de atención de urgencia a uno de sus miembros. Método: estudio descriptivo de carácter cualitativo, realizado en tres municipios del Sur de Brasil. Los datos fueron recolectados en junio de 2015 mediante entrevistas semi-estructuradas, realizadas en la casa de las 16 personas que acompañaron a sus familiares en la unidad de urgencias. Las entrevistas fueron grabadas, transcritas y sometidas a Análisis de Contenido temático. Resultados: las familias revelaron intenso sufrimiento durante los cuidados de emergencia para su miembro. La rapidez y la eficacia en la atención, la presencia de una comunicación efectiva y la posibilidad de monitorear la asistencia fueron percibidas por la familia, cuando presentes, como calificadores de cuidado y, cuando ausentes, como descalificadores. Conclusión: la vida familiar durante la atención de emergencia se ha caracterizado por un intenso sufrimiento, que está directamente influenciado por cómo los profesionales de la salud reciben y atienden al paciente y su familia.

Descriptores: Familia. Relaciones Profesional-familia. Servicios Médicos de Urgencia.

Introduction

Emergency units aim to promote health assistance with urgent nature and to prolong life or prevent critical consequences to patients[1]. They constitute one of the main alternatives for access to health services, although the service policy based on the Health Care Networks point the Basic Health Care as preferential entry door. This occurs because, according to the users, the emergency units concentrate different resources - medical appointments, laboratory tests, medicines, nursing procedures and interventions - that usually meet their expectations and needs[2]. Thus, in many situations, even in cases of little or no urgency, users seek such units as the first option[3-4].

The spontaneous and unrestricted demand, often higher than that supported by services, triggers overcrowding and jeopardizes the transfer of critical patients to in-hospital sectors with higher technological density[5]. Moreover, the precariousness of human and material resources and adequate physical infrastructure hinders, especially, the maintenance of the privacy of individuals and their families, as well as the actions of the team[6]. This reality is shared by different emergency units and is one of the determinants for the non-qualified reception of the family in those spaces.

One should also consider the specific characteristics of critically ill patients admitted to emergency services. These require immediate professional assistance, and consequently, the team's attention focuses exclusively on the victim until the stabilization of the condition[7]. This fact helps understanding the reasons that lead professionals to request family members to wait until the end of the call at the reception of the unit or in the waiting room. However, the literature on the theme[2,7-8] indicates that an individual, after receiving the news that the family member needs intensive and acute care, presents a set of feelings, such as estrangement, anxiety, helplessness and fear, which can lead to emotional imbalance and, possibly, family crisis[2]. Added to this, the communication failure between the professional-patient binomial - resulting from the omission of information at the appropriate moment, with the exclusion of the family from decisions related to treatment and the use of complex terms in the dialog - collaborates to increasing family's confusion and stress[8].

In this context, when questioned, the patients' families classified the need for shared information, skillful communication, support and closeness with their family member as priorities in the care received[1,9]. Thinking and rethinking the family in highly stressful situations for the family core, such as the emergency care with one of its members, in the perspective of the family-centered care, and intervening in relation to the family suffering identified, have become an increasing demand in the health area and, specifically, in nursing, in the practice, teaching and research contexts[10].

In this way, the findings of this research can cooperate for the most fruitful understanding of the experiences and particular needs of

families who experience the care in emergency units. This, in turn, has the potential to promote greater awareness in health professionals for the adequate reception of the most basic care demands of families and qualify the attention, which, therefore, leads to greater satisfaction of family members with the health service.

Thus, through the following research question "How was the experience of patients' family members in the emergency care?", the objective of this study was to understand how the family perceives the experience of emergency care to one of its members.

Method

Descriptive study of qualitative nature, carried out in three small-sized municipalities, in northern Paraná state and their respective public emergency care units. The interviewees were identified in May 2015, based on a record made by nurses from different shifts. All nurses were instructed by the researchers to approach the relatives of seriously ill patients (classified as red in the admission protocol with risk classification), after the initial treatment and the stabilization of the patient's clinical picture. In this approach, they should explain concisely the research objectives for the family and reinforce that this was not an activity of the health institution, and that participation was voluntary. If the family allowed, the nurses recorded the identification data (full name, address and phone number) for further contact.

Every week, the researchers went up to the investigated units and accessed the information recorded by the nurses, and, based on those data, selected the participants. The contact with the families to schedule the interviews occurred approximately 30 days after the call at the emergency unit, in order to provide a minimum time for the participant reflect on the experience regarding the care provided to his/her family member and provide a meaning for his/her perception. Thus, data collection occurred in June 2015.

Initially, the researchers contacted, by telephone, the likely study participants and checked if those people met the inclusion criteria selected: aged 18 or more years and being a companion of the family member classified as red in the admission protocol used in emergency units. Then, considering the day and time most suitable to family members, a home visit was scheduled. For purposes of this study, the family member was considered the person who, to accompany the patient to the emergency unit, identified for the nurse as the patient's family member, regardless of the degree of kinship.

The participants were 16 family members, being 5 from Unit A, 5 from Unit B and 6 from Unit C. Only the family member who accompanied the patient in the emergency service participated in the interviews, with no interaction from other family members.

The interviews, which lasted on average 45 minutes, followed the guiding question: "Tell me your perceptions about the experience of the call to your family member that day you sought the municipal emergency care". The total number of participants in the study was determined considering the criterion of data saturation. Thus, the search for new informants ended when the speeches became repetitive[11] and the survey goal was met.

The speeches were recorded, fully transcribed and submitted to thematic Content Analysis[12], using the following steps: pre-analysis, material exploration and data treatment. In the phase of pre-analysis, there was the transcription of the speech, with subsequent organization and separation of the empirical material. After reading the data, with identification of emerging and relevant aspects to meet the proposed objective of this research. During the exploration of the material, there were the classification and aggregation of incidents, developed after a thorough and exhaustive process of reading, followed by identification and clipping of the aspects that were common and specific, which led to the preliminary categories. Moreover, in the end, in the data processing stage, the categories were deepened by the articulation of initial data with the literature about the theme.

The research was developed in accordance with the guidelines regulated by Resolution

n. 466/12, of the National Health Council, and its project was approved by the Human Research Ethics Committee of the signatory Institution (Opinion n. 1.166.681; CAAE: 43765315.7.0000.0104). All participants signed the Informed Consent Form (ICF) in two copies. In order to maintain anonymity, the participants were identified by codenames, composed of the interviewee's relationship with the patient, and the diagnosis of his/her family member.

Results

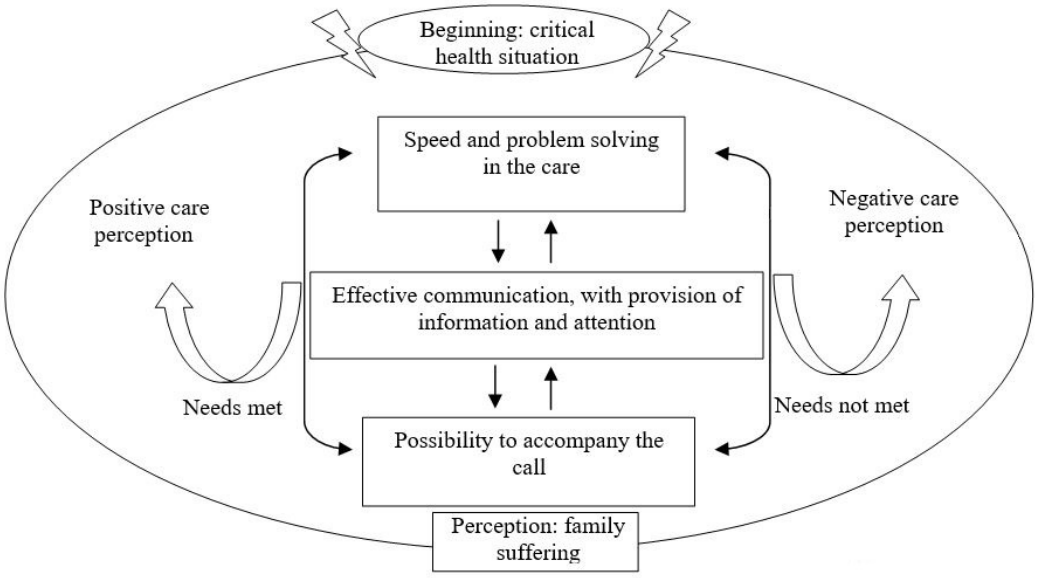
The participants were 16 relatives of patients treated in emergency units, aged between 23 and 80 years, being 13 female, 12 of race/color white, 5 spouses, 4 mothers, 4 children, 2 parents and 1 daughter-in-law. Regarding schooling, 9 had complete primary education, 4 complete secondary education, 2 complete higher education and 1 was functional illiterate.

Concerning the clinical diagnoses of patients who drove the search for the health service: six occurred by cerebrovascular problems, three by external causes, two by acute complications of oncological disease, one by allergic process, one by exogenous intoxication, one by convulsive crisis, one by severe dehydration, and one by worsening of chronic obstructive pulmonary disease. Six patients progressed to death, five were transferred to other healthcare units with higher technological resources, and five were discharged from the emergency unit, of which only two occurred on the same day.

The categories that emerged in this study reveal how participants realized the care provided to the relatives and themselves in the emergency unit. In general, families realized the experience of the situation with intense suffering, characterized by the interviewees as experiencing a "whirlwind of feelings" [*in vivo* code] involving sadness, anguish, despair, fear of the unknown and the loss. Factors such as speed and problem solving in the initial call, presence of effective communication, provision of information and attention and opportunity to follow the care in the emergency room, constituted, when present, care qualifiers. This triggered a positive perception in family members and facilitated the experience of a critical situation.

On the other hand, when those same aforementioned factors were absent, families realized the care in a negative way. The statements reveal that those interfering factors in the family perception of care were not isolated or were sealed. In fact, inter-related to each other, because the experiences and needs of families in the emergency service were complex, and the satisfaction with the assistance depended on fully meeting those needs (Figure 1).

FIGURE 1– Family perception and needs during the emergency care



Source: Created by the authors.

The entire data analytical procedure led to the identification of two thematic categories, namely: "Positive perception of care: recognizing the peculiarities of an adequate care" and "Negative perception of care: the barriers faced by the family", which will be described below.

Positive perception of care: recognizing the peculiarities of an adequate care

Although the suffering was described as intense, most interviewees (11 cases) perceived the care with the patient and the family positively. The contentment was expressed with the fast provision of assistance and the solving of the problem that led to the health service, mainly through the referral of patients to other hospital units of greater complexity and technological resources to allow continuity of treatment:

> *That day, everything was very tumultuous, everyone was too worried. But, still, I managed to see that the service was quality* [...] *it was all very fast here in the emergency room, he was met very quickly and already sent to an ICU. They said they would handle better his problem there.* (Daughter-in-law 01, family member with Chronic Obstructive Pulmonary Disease).

> *It was not easy to go through all that before he died, all that anguish of the service, asking God for his life. But, we have to believe that God was merciful, because He put good professionals in our path who met him quickly and with concern, that was good.* (Wife 02, family member with Hemorrhagic Cerebrovascular Accident).

In the family perception, the agility in the service provision, the demonstration of concern with the patient and the initial problem solving, upon referral to other health services, were good indicators of care quality. Furthermore, the transfer of the family member to a reference service, with more advanced technological support, made relatives calmer, because they saw a continuity in the care provided.

Another relevant aspect pointed out by family members was the provision of information about the clinical picture of the relative and the words of comfort and confidence given by professionals:

> *In the middle of that whirlwind of feelings and things happening, the nurse stopped and spoke to me, said he was alive, the doctor came later and explained to me that he had a heart attack, that I was supposed to be calm and have faith, that everything would be fine, I liked the attention I received.* (Wife 01, family member with Acute Myocardial Infarction).

> *The doctor talked to me a lot, very clearly, told me to be calm, but that the case was very serious. He also said that I had to stay alive and kicking, because he needed us and we needed him. The nurse also talked to me, said that he was fine, tried to cheer me up, said that everything was going to be all right, it calmed me down back then.* (Daughter 03, family member with Convulsive Crisis).

The health professional's approach to family members had positive repercussions. According to the reports, receiving information on the health status of the family member or even attention, through the comfort words, represented an aspect that facilitated the experience of the situation, promoting a feeling of calm among family members.

The participants, when accompanying the call in the emergency room, also realized the situation with intense suffering. Nevertheless, somehow, they felt more comforted by being close, and with it, the perceptions concerning the team and the assistance received were more positive:

> *Wow! That day was difficult, but with me, I have nothing to complain about, because they gave me attention, they let me enter the emergency room to be with him, they explained everything to me correctly, and soon he was already sent to the University Hospital.* (Mother 02, family member with Exogenous Intoxication).

> *The service was better than I expected, because they let me participate in everything, I was in the emergency room all the time with my mother, it comforted me a lot.* (Daughter 04, family member with Congestive Heart Failure).

In this way, the family members felt safer and comforted when their permanence was authorized in the emergency room for the full monitoring of care. Since family members know that staying with the patient in the emergency room is unusual in the everyday reality, they were surprised positively with the assistance when experiencing such situation.

Negative perception of care: the barriers faced by the family

When facing obstacles during the emergency care, some family members (five cases) demonstrated, through their statements, that the lack of communication from health professionals, the delay for the care and the little problem solving of the care reflected negatively on satisfaction

with the service, awakening, sometimes, or even intensifying, the family suffering:

> *I was sad that he was not the first to be seen, because he was so bad* [...] *The service could have been better, they should have come talk to me, tried to calm me down, I was alone, standing in the hall. Then I asked about his condition, when they asked me to sit in a small room and wait.* (Wife 03, family member with Acute Myocardial Infarction).

> *They did almost nothing for my son, nor did they give me any information, even if he was alive or dead* [...] *the service was terrible, no one should do that to a father, it is very hard.* (Father 01, family member Victim of Traffic Accident).

Furthermore, the relatives longed to be close, to receive information and to be perceived as part of their lives, by receiving attention from health professionals.

> *In that moment of suffering and despair, without knowing anything, the service is also terrible? The doctor didn't even look me in the face. That was that most anguished us, it could have been better.* (Wife 04, family member with Acute Myocardial Infarction).

> *The nurse mistreated me, also asked me to leave the emergency room. I didn't want to be outside, my son was scared and crying, I just needed to take care of him.* (Father 02, family member with Anaphylactic Shock due to Exogenous Intoxication).

> *People say they have to meet the family too, but I think that, in our municipality, nurses do not have this training. The professionals didn't even look at me or speak to me, they just told me to stay in the quiet. You can't imagine what my mom and I went through that day.* (Daughter 02, family member with fall-related Cardiopulmonary Arrest).

The dissatisfaction of some interviewees was noticeable when reporting the poor reception and information in the emergency services. There stands out the precarious attention from the professional, simultaneously relating type of behavior to the professional unawareness and disqualification. This intensified the experience of negative feelings about the service, such as anguish, by the family.

Discussion

The findings of this study revealed that respondents experienced the emergency care with their family member with intense suffering. This moment was permeated by fears and anxieties, which did not prevent the majority from realizing and qualifying the assistance as positive. In this way, they reported being satisfied when observing the dedication and the concern of the professionals, which reflected, in participants, feelings of calm and satisfaction with the health service. Nonetheless, some respondents felt that the suffering was intensified by the lack of communication, attention and problem solving and the impossibility of being with the family member during the assistance, which culminated with the worse perception of care.

Health professionals need to understand the emergency care based on the perspective of integral care. This is because the experience of a critical situation involves a wide context, in which the family unit is inserted and, therefore, also needs to receive the care. Even in cases of overload of chronic care, routinely, families want to be with the patient[13]. Thus, when experiencing a situation of unexpected disease/health problem or exacerbation of chronic condition in one of its members, the family requires special attention, because, in most cases, feels helpless, fragile and incapable[9]. In this sense, the findings of this study allowed identifying care demands that the families of severely ill patients present during care provision, sometimes disregarded by health professionals in the emergency services.

Most of the demands presented by families related to the professional behavior, and not to inadequate physical structure, or lack of human resources, arguments that the professionals commonly use to justify the lack of reception of families in emergency services[14]. Therefore, the way the professional receives and accepts the patient and his/her family in the emergency unit directly influences the family perception of the care, in addition to being able to cause stress and intense suffering in the entire family context.

Corroborating this finding, a research conducted with eight family members and four patients treated in the emergency room of a public hospital in Brazil identified that the family members who felt better met, and thus handled and experienced better the situation, were precisely those that reported having received information in advance, even during the implementation of assistance[8].

From this perspective, the family needs different care, as well as the patients, because, when facing the hospitalization of a family member in critical sectors, the family has feelings of fragility and helplessness[1]. In this way, when assisting the family in its various needs and establishing next to it an effective, clear and objective communicational process, health professionals can provide to each family member the recognition of strengths and, thus, contribute to all members experience the critical moments.

When professionals, especially nurses, recognize that both the patient and the family need care, they are able to perform simple attitudes, such as demonstrating devotion to the demands and feelings and, thus, promote the motivation of the rest of the team, which culminates in an integral, human and holistic assistance. In addition, a study with relatives of severely ill patients identified that there should be the search for the care integrality on the part of the healthcare team, especially nursing, since the needs presented by the family showed the urgent need to incorporate the family as part of the care, forming an inseparable binomial: patient/family[15].

However, concerning this reception of the family, the lack of training and precarious awareness of professionals are noticeable. Studies conducted in Brazil[16], United States[17], Australia[18] and in Finland[19] found that health professionals consider the family participation in emergency care an obstacle, due to the questionings and the attention that the family requires. This posture leads to behaviors that do not meet family demands and result in suffering and dissatisfaction of families regarding the care provided in the emergency department.

In this sense, scientific evidence[7,16] indicates that the family participation in critical and acute care is crucial, so that it can observe the efforts to save the family member's life, as well as receive information in advance. Thus, there is a greater tendency to improve the service when triggering greater safety and emotional support to the patient during the whole care[7]. The present study contributed to identifying that the family member's entry in the emergency room led to greater emotional safety for the family.

Even if the family insertion in the emergency room is a distant reality in most Brazilian emergency care units, especially by the precariousness of physical infrastructure to receive this family, deficit of nursing team personnel or by the lack of training and unawareness of health professionals to understand the family role in the emergency care space[20], the professionals working in those sectors, as soon as possible and gradually, must receive families, providing them with information, since the present investigation found that the families' suffering were potentially exacerbated when communication was not effective.

In this context, the failure of communication is an important barrier in emergency services, because its maintenance jeopardizes the integrality of the provided care, with emotional harm to the family core[8]. Thus, those families need careful explanation, time to process the information received and the consistent professional support to enable them to decision making and facilitate coping with the challenges[7].

A study carried out in Chile, with 30 family members of patients treated in an emergency unit corroborates such information[6]. According to the family member, the relationship with the team was tenuous, communication virtually was often non-existent and many sought to interpret the gestures and attitudes of professionals to understand what was happening. Thus, the communication constitutes a key element for the provision of guidance and establishment of trust in the professional-patient-family triad. An effective communication eases the anxieties during this stressful time and enhances the sense of safety for both the patient and the family, as well as collaborates to the patient's recovery[16].

Moreover, the health team needs training on this theme, since the family realized the poor knowledge, characterizing it as precarious qualification. A study conducted with 160 nurses working in two emergency services in Northern Ireland pointed out that the majority recognized

the holistic family-centered care during and after the emergency care as a professional duty, however, this does not occur, among other factors, by inadequate training. In the light of this finding, the authors suggested that nurses should participate in continuing education sessions and monitoring programs, to better prepare the professional teams regarding the families' reception in emergency services[14].

Another study performed with nurses from a critical care unit in Australia showed that the academic training was regarded as inadequate, in relation to the ability to meet the complex care needs of families in moments that precede and follow patients' death[21]. In this sense, the most current evidence showed that the positive impact of professional qualification in the providers' attitudes in relation to the presence of the family in critical care[22]. Thus, the professional qualification can improve the performance of health professionals in emergency, favoring the bond and trust between patients, families and professionals, especially in the provision of guidance, and promoting multidisciplinary reception. Furthermore, when the professional's approach to the family is a unique chance to be present and sympathetic in this relationship, which brings benefits to the entire family core in this care instance. An assertive communication with family and the family's reception can be the foundation for the individualized care, which contemplates subjectivities inherent to the human being. To this end, there is need for ethical professionalism and sensitivity[23].

There is an imperative need for health professionals receive and insert the families in the severely ill patient care, not only because it can be a source of information about the patient's health condition for the health team, but mainly because it constitutes a source of support for the coping process and suffering experienced by the patient in emergency units and other family members.

Possible limitations of the study relate to the fact that the nurses from the units were responsible for identifying and indicating the likely participants and, as they were aware of the study purpose, may, to some extent, have modified their attitudes in relation to the family; moreover, the fact that the interviews had occurred approximately 30 days after the family experience in the emergencies, which can lead to bias of forgetfulness.

Conclusion

The perception of family experience during the emergency care is characterized by intense suffering, directly influenced by the way professionals receive and accept the patient and his/her family. According to the family, the provided care was mostly perceived as satisfactory, considering factors such as: assertive communication, provision of attention, initial problem solving of the health problem through agility in the transfer to a health service with higher technological support, and the possibility of being with the family member in the emergency room during the call. On the other hand, in the perception of family members, the absence of those factors characterized a bad call, which increased the family suffering, hindering even more the experience of the situation.

The findings of this study advanced in knowledge by pointing out the urgent need to discuss and better prepare health professionals for a more qualified work with families in the emergency wards.

Collaborations

1 – conception, design, analysis and interpretation of data: Mayckel da Silva Barreto, Sonia Silva Marcon and Cristina Garcia-Vivar;

2 – writing of the article and relevant critical review of the intellectual content: Mayckel da Silva Barreto, Sonia Silva Marcon, Cristina Garcia-Vivar, Eleandro do Prado, Josane Rosenilda da Costa, Patrícia Chatalov Ferreira and Ricardo de Souza Campos Seguraço;

3 – final approval of the version to be published: Mayckel da Silva Barreto, Sonia Silva Marcon, Cristina Garcia-Vivar, Eleandro

do Prado, Josane Rosenilda da Costa, Patrícia Chatalov Ferreira and Ricardo de Souza Campos Seguraço.

References

1. Flannery L, Ramjan LM, Peters K. End-of-life decisions in the Intensive Care Unit (ICU) – Exploring the experiences of ICU nurses and doctors – A critical literature review. Aust Crit Care. 2015;28(4):1-8. DOI: https://doi.org/10.1016/j.aucc.2015.07.004

2. Acosta AM, Marques GQ, Levandovski PF, Peralta JP, Lima MADS. Satisfação dos usuários com cuidados de enfermagem em serviço de emergência: uma revisão integrativa. Rev min enferm. 2016;20:e938. DOI: http://www.dx.doi.org/10.5935/1415-2762.20160008

3. Antunes BCS, Crozeta K, Assis F, Paganini MC. Rede de atenção às urgências e emergências: perfil, demanda e itinerário de atendimento de idosos. Cogitare Enferm. 2018;23(2):e53766. DOI: http://dx.doi.org/10.5380/ce.v23i2.53766

4. Roncalli AA, Oliveira DN, Silva ICM, Brito RF, Viegas SMF. Protocolo de Manchester e população usuária na classificação de risco: visão do enfermeiro. Rev baiana enferm. 2017;31(2):e16949. DOI: 10.18471/rbe.v31i2.16949

5. Gomes ATL, Ferreira-Júnior MA, Salvador PTCO, Bezerril MS, Chiavone FBT, Santos VEP. Safety of the patient in an emergency situation: perceptions of the nursing team. Rev Bras Enferm. 2019 Jun;72(3):753-9. DOI: https://doi.org/10.1590/0034-7167-2018-0544

6. Dall'Orso MS, Concha PJ. Presencia familiar durante la reanimación cardiopulmonar: la mirada de enfermeros y familiares. Cienc enferm. 2012;18(3):83-99. DOI: http://dx.doi.org/10.4067/S0717-95532012000300009

7. Mekitarin FFP, Angelo M. Family's presence in the pediatric emergency room: opinion of health professionals. Rev Paul Pediatr. 2015;33(4):460-6. DOI: 10.1016/j.rpped.2015.03.010

8. Barreto MS, Garcia-Vivar C, Matsuda LM, Angelo M, Oliveira MLF, Marcon SS. Presença da família durante o atendimento emergencial: vivência de pacientes e familiares. Texto Contexto Enferm. 2019;28:e20180150. DOI: http://dx.doi.org/10.1590/1980-265X-TCE-2018-0150

9. Soares JR, Martin AR, Lopes APAT, Marcon SS, Barreto MS. Possibility of accompanying emergency care from a family perspective: a descriptive study. Online braz j nurs. 2017;16(1):188-98. DOI: https://dx.doi.org/10.17665/1676-4285.20175585

10. Barreto MS, Arruda GO, Garcia-Vivar C, Marcon SS. Cuidado centrado na família em unidades emergenciais: percepção de enfermeiros e médicos brasileiros. Esc Anna Nery. 2017;21(2):e20170042. DOI: https://doi.org/ 10.5935/1414-8145.20170042

11. Minayo MCS. Amostragem e saturação em pesquisa qualitativa: consensos e controvérsias. Rev Pesq Qualitativa[Internet]. 2017 [cited2020Jan5];5(7):1-12. Available from: https://editora.sepq.org.br/index.php/rpq/article/view/82/59

12. Bardin L. Análise de Conteúdo. 7a ed. São Paulo: Edições 70; 2016.

13. Arruda GO, Leal LB, Peruzzo HE, Nass EMA, Reis P, Marcon SS. Percepções da família acerca do cuidado ao homem com alguma condição crônica. Ciênc Cuid Saúde. 2018;17(1):268-74. DOI: 10.4025cienccuidsaude.v17i1.43845

14. McLaughlin K. Family-centred care during resuscitation events. Emerg Nurse. 2013;21(3):28-34. DOI: 10.7748/en2013.06.21.3.28.e1152

15. Vasconcelos EV, Freitas KO, Silva SÉD, Baia RSM, Tavares RS, Araújo JS. O cotidiano de familiares de pacientes internados na UTI: um estudo com as representações sociais. J res: fundam care online. 2016;8(2):4313-27. DOI: 10.9789/2175-5361.2016.v8i2.4313-4327

16. Barreto MS, Peruzzo HE, Garcia-Vivar C, Marcon SS. Family presence during cardiopulmonary resuscitation and invasive procedures: a meta-synthesis. Rev esc enferm USP. 2019;53:e03435. DOI: https://doi.org/10.1590/s1980-220x2018001303435

17. Twibell R, Siela D, Riwitis C, Neal A, Waters N. A qualitative study of factors in nurses' and physicians' decision-making related to family presence during resuscitation. J Clin Nurs. 2018;27(1-2):e320-34. DOI: https://doi.org/10.1111/jocn.13948

18. Giles T, Lacey S, Muir-Cochrane E. Factors influencing decision-making around family presence during resuscitation: a grounded theory study. J Adv Nurs. 2016;72(11):2706-17. DOI: https://doi.org/10.1111/jan.13046.

19. Sak-Dankosky N, Andruszkiewicz P, Sherwood PR, Kvist T. Health care professionals' concerns regarding in-hospital family-witnessed cardio-pulmonary resuscitation implementation into clinical practice. Nurs Crit Care. 2018;23(3):134-40. DOI: https://doi.org/10.1111/nicc.12294

20. Barreto MS, Marcon SS, Garcia-Vivar C. Patterns of behaviour in families of critically ill patients in the emergency room: a focused ethnography. J Adv Nurs. 2017;73(3):633-42. DOI: https://doi.org/10.1111/jan.13156

21. Bloomer MJ, Morphet J, O'Connor M, Lee S, Griffiths D. Nursing care of the family before and after a death in the ICU – An exploratory pilot study. Aust Crit Care. 2013;26(1):23-8. DOI: https://doi.org/10.1016/j.aucc.2012.01.001

22. Powers K. Educational interventions to improve support for family presence during resuscitation: A systematic review of the literature. Dimens Crit Care Nurs. 2017;36(2):125-38. DOI: 10.1097/DCC.0000000000000228

23. Luiz FF, Caregnato RCA, Costa MR. Humanização na Terapia Intensiva: percepção do familiar e do profissional de saúde. Rev Bras Enferm. 2017;70(5):1095-103.DOI:http://dx.doi.org/10.1590/0034-7167-2016-0281

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