

Humanization in the Intensive Care: perception of family and healthcare professionals

Humanização na Terapia Intensiva: percepção do familiar e do profissional de saúde
La humanización en cuidados intensivos: percepción de familiares y de profesionales de salud

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ABSTRACT

Objective: Understanding perceptions of family members and healthcare professionals about humanization at the Intensive Care Unit (ICU) to direct it to an educational action. **Method:** Exploratory descriptive and qualitative study conducted in an ICU level 3 of a public hospital in Porto Alegre, RS, Brazil, with fourteen subjects, eight family members and six healthcare professionals. Data collection carried out through semi-structured interviews and focus group. Content Analysis was used. **Results:** Emerged categories were: welcoming; communication; ethical and sensible professionalism; unfavorable aspects; perception on humanization; and religiosity/spirituality. **Final considerations:** Although the subjects have expressed their perceptions about humanization in different ways, both groups pointed out the same needs and priorities to improve humanization in Intensive Care. From the results, we created a reflective manual of humanizing assistance practices for professionals, a board to facilitate communication of these professionals with patients and a guideline book for family members.

Descriptors: Assistance Humanization; Critical Care; Health Education; Professional-Family Relationship; Health Personnel.

RESUMO

Objetivo: Compreender as percepções de familiares e profissionais de saúde sobre humanização na Unidade Terapia Intensiva (UTI) para direcionar a uma ação educativa. **Método:** Estudo exploratório-descritivo qualitativo, realizado em uma UTI nível III de um hospital público de Porto Alegre/RS com 14 sujeitos, sendo oito familiares e seis profissionais de saúde. Coleta de dados realizada por meio de: entrevistas semiestruturadas e grupo focal. Utilizou-se Análise de Conteúdo. **Resultados:** As categorias emergidas foram: acolhida; comunicação; profissionalismo ético e sensível; aspectos desfavoráveis; percepção sobre humanização; e religiosidade/espiritualidade. **Considerações finais:** Apesar dos sujeitos expressarem de maneiras distintas suas percepções sobre humanização, os dois grupos comparados elencaram iguais necessidades e prioridades para o aprimoramento da humanização na Terapia Intensiva. A partir dos resultados, criou-se um Manual Reflexivo de práticas assistenciais humanizadoras para os profissionais, um tabuleiro para facilitar a comunicação destes profissionais com os usuários e um guia de orientações aos familiares.

Descritores: Humanização da Assistência; Cuidados Críticos; Educação em Saúde; Relações Profissional-Família; Pessoal de Saúde.

RESUMEN

Objetivo: Comprender las percepciones de familiares y de los profesionales de salud acerca de la humanización en la unidad de cuidados intensivos (UCI) a fin de determinar una acción educativa. **Método:** Estudio exploratorio-descriptivo cualitativo, llevado a cabo en la UCI nivel III de un hospital público de Porto Alegre, Brasil, con catorce personas: ocho familiares y seis profesionales de salud. Para la recolección de datos se empleó entrevistas semiestructuradas y grupo focal, además del análisis de contenido. **Resultados:** Aparecieron las siguientes categorías: acogida; comunicación; profesionalismo ético y sensible; aspectos desfavorables; percepción acerca de la humanización; y religiosidad/espiritualidad. **Conclusión:** Aunque los participantes expresaron diferentes percepciones acerca de la humanización, los dos grupos estudiados manifestaron necesidades y prioridades iguales para mejorar la humanización

en cuidados intensivos. Desde los resultados se estableció un Manual Reflexivo de prácticas asistenciales de humanización a los profesionales, un tablero para facilitarles la comunicación con los usuarios y un guía con orientaciones dirigido a los familiares.

Descriptor: Humanización de la Atención; Cuidados Críticos; Educación en Salud; Relaciones Profesional-Familia; Personal de Salud.

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INTRODUCTION

Intensive Care Unit (ICU) is a different hospitalization ambience, as it aims at life maintenance and health recovery of people who need intensive care. This unit requires a high cost due to diversity of technological resources, with a distinct physical space and constant multi-professional clinical evaluation⁽¹⁾.

In the ICU scenario, discussions about assistance and working ways of health professionals are common. Their practices are often questioned and they are usually criticized for their excessive technicality and reductionist attitude regarding human beings resulting from technologies and immediate action needs typical of this area⁽²⁾. Besides specific skills of each healthcare professional, it is essential to develop skills by joining technical/scientific knowledge and technologies with care humanization and individualization for a better quality assistance⁽³⁾.

Thinking of an assistance practice that considers healthcare patients and their families as human beings with feelings and opinions, not only as work objects of health professionals is an urgent and challenging need. That is why government strategies started since the publication of the National Program for Humanization of Hospital Care in 2001. Such strategy was changed to National Humanization Policy (NHP) in 2003⁽⁴⁾.

The NHP aims to diffuse humanization practice in all services of the Brazilian Unified Health System (SUS), by actions such as sensitizing workers about people suffering, end of disrespectful treatment and isolation of people from their social and family networks in the procedures, improvement of work environments, among others. However, the planned strategies did not advance in all healthcare areas⁽⁴⁾.

Besides, there is a shortage of discussions about organizational, political, institutional and social dimensions that involves humanization projects of healthcare professionals⁽⁵⁾. By noticing the need to increase discussions and reflections on the topic due to observation of professionals unprepared to offer a more humanized assistance to patients that follows the NHP precepts, significant provocations for understanding of the research problems of this study came up: What is the perception of family members about humanization in the ICU? How do healthcare professionals perceive humanization in the ICU and how do they apply it to their practices? To respond to these problems, the objective outline for this study is to understand perceptions of family members and healthcare professionals about humanization in the ICU in order to conduct an educational action in this area.

METHOD

Ethical aspects

During the whole process of this research, we respected fundamental scientific and ethical requirements, which describe

guidelines and standards that regulate investigative processes involving humans⁽¹⁰⁾. The research individuals were equally invited, respected and informed about all of their rights as informants by signing the Informed Consent Form, which was different according to the group of individuals, due to different data collection techniques. The research began only after the Ethics Committee of the hospital approved it.

To ensure anonymity of respondents, speeches were identified by the letter "F" to refer to the group of family members, numbered from F1 to F8 according to the order in which they were interviewed; the letter "P" was used to identify the group of healthcare professionals, numbered at random from P1 to P6.

Type of study

This is an exploratory and descriptive field study with qualitative approach.

Study scenario

The research was developed in a level 3 ICU located in a large hospital in Porto Alegre city, Rio Grande do Sul (RS), Brazil. The scenario choice considered the approval of the coordinators of this ICU and their interest in the development of this research as well as in collaborating with the area, directing objectives to favor and improve more humanizing actions regarding perception of family members and healthcare professionals on the topic.

Data source

Participants were formed by two groups of subjects: the first was formed by eight family members of patients hospitalized in the ICU and chosen at random, by using semi-structured interview methodology. These were the fundamental standards for this group: aged 18 (eighteen) or older; and who constantly visited their dear ones (at least five days of visit). This visiting frequency was confirmed by the visitors' record available at the reception of this area, as we believe this is the time it takes to form an opinion on the topic proposed.

The second group is constituted by six professionals, one of each healthcare category, who should work directly or indirectly with patients hospitalized in the same ICU of the family group, using the focus group methodology. They were selected through intentional sampling, by previous observation, since we noticed their affinity with the humanization topic for their actions during the work routine. Mixed methods combine multiple ways of data collection that are compatible within a research paradigm, assuming that there will be a better understanding of the problem researched⁽⁶⁾.

Data collection

Data collection occurred from July to August 2015, at different times for the two groups researched. For the family members'

group, semi-structured interviews were carried out in July and guided by a script elaborated based on the study objectives. The instrument with closed and open questions was organized into two parts. The first one had demographic data of subjects, while the second one included issues related to the study object, that is, assistance humanization for patients in the ICU context. Interviews were individually conducted, always next to visit times to patients (before or after), since those were the best moments to find family members. Interviews lasted around eight minutes each, and took place in a reserved room, thereby ensuring confidentiality and anonymity.

For the healthcare professionals, interviews were conducted in focus groups. Three meetings happened on different days of August, always from 2 to 4 p.m., therefore, with exactly two hours of discussions and reflections, also in a reserved room and led by the same researcher, which was the group mediator as well. The six subjects in this category who accepted to be part of this sample demonstrated equal representation and importance in the group formed. They participated in the three pre-established meetings, which were thought and prepared with clearly defined steps to achieve the objectives of the focal questions elaborated.

Data abundance was what determined the number of subjects in the first group. Six subjects were necessary for the second group in order to achieve the objectives proposed with the group sessions, as it is consonant with the ideal number of six to eight people of this methodology according to the literature⁽⁷⁻⁸⁾.

Data analysis

Data analysis was carried out based on Bardin's Content Analysis, defined as a set of assessment techniques of communications, accomplished through objective and systematic procedures of message content description. In order to ensure analysis accuracy, this technique assumes a chronological sequence: pre-analysis (recalling research objectives and exploratory reading of the material to constitute the set of documents examined and hypotheses formulation); exploration of the material (data gathering and classification, and elaboration of possible categories); analysis of results (with interpretations and discussions along with reflections based on bibliographic review of the study)⁽⁹⁾. By examining the data, the aim was to know the perception of subjects about humanization through content messages they expressed, since we understand that these messages reflect feelings and sensations experienced.

All individual and focus group interviews were recorded on audio files in mp4 format and literally transcribed. After that, a schematic map was designed, drawn on paperboard with the narratives, which provided a better organization and visualization of such data.

RESULTS

Although men and women have been equally invited to take part in the research, all of the subjects of both groups were coincidentally females.

Age of family members ranged from 20 and 62 years old. Regarding the hospitalization time of patients, it varied from 6 up to 150 days, similar periods to the hospitalization time in

the ICU researched, which was from 5 up to 141 days. Only one respondent reported the experience of having this same relative previously hospitalized in the same ICU, for two other times at very different periods.

Sociodemographic profile of the healthcare professionals' group was not researched, since we understood that age and time of occupation would not be significant regarding humanization perception. We considered that group interviews with professionals of different academic backgrounds who worked in the same ICU, were necessary conditions to enrich the topic. Thus, the research universe was formed by the following professionals: a nurse, a nursing technician, a physical therapist, a nutritionist, a doctor and an administrative assistant, regardless of service period or having or not a graduate specialization in Intensive Care.

From the topic analysis of contents of the interview with subjects of the family members' group, six categories emerged, resulting from the most significant speeches, according to the register units that came up and addressed humanization in Intensive Care according to the study objectives. However, by comparing this group with the healthcare professionals' group, we noticed a similarity of speeches, which allowed us to generate the same categories and subcategories for the two groups researched, as demonstrated next.

Category 1: Welcoming

This category emerged from the various speeches of respondents about the value of personal presentation, of being treated by their own names, that is, the importance of knowing to whom you talk or simply express yourself. To respondents, feeling welcomed also involves affectionate moments or simply actions of non-verbal communication such as: a touch, a smile or being available to listen and open to understand needs.

I have no complaints about this place and even in other times visiting other people, I've never had. It's all very easygoing. They have always treated us well and have identified themselves, nothing happened like "this is a hospital, you're not important," but behind that, there's the feeling. Your dear one is here, it hurts. But, sometimes, you don't want to come, nobody wants to come here, but we have to come, so if we're greeted with a smile, it changes things a lot [...]. (F7)

I believe it is important to know how the patient is feeling. How last night was, what he or she ate. Saying self-esteem words like: "These things are going to pass," "This is just a bad period," "Sir, you've been getting better and better." (P2)

The subjects' speeches emphasize how welcoming from ICU receptionists and other healthcare professionals makes a difference. For that reason, from the first category, called "Welcoming," two subcategories emerged to distinguish it: from receptionists and from healthcare professionals.

Subcategory 1: Welcoming from receptionists

Welcoming from receptionists refers directly to professionals who help people at the ICU entrance. Often, healthcare professionals do not know them and do not even know their names, only that they exist and receive visitors. However, it is evident in

the speeches of family members that receptionists are not extras, but professionals who are remembered by most respondents as important welcomers, even not knowing their names.

I was crying a lot, the receptionist came from there and brought me a napkin, so she was very sweet and said I could call, because I didn't want to leave, but she made me go at 10 p.m., and said I could call to ask her, so she was going to see her for me [...]. (F5)

When I come here, I usually speak directly with the reception lady. I don't know her name so far, she treats me very well, I have nothing to complain about her. Actually, when I get here, I always look for her. She works very well, she knows how to help people, that's what I think. (F1)

Nevertheless, there are interviewed family members who do not remember reception in a welcoming way. Although SUS does not preconize such actions, it is important to show the view of these users regarding the attitude of professionals of the ICU entrance, since they can influence the entire welcoming perception of Intensive Care.

[...] I've organized my schedule to come visit. When I arrived, the receptionist informed me that there was someone in the room, so I waited. I waited and waited and nothing happened. The person left and the receptionist didn't even notice it. She took off her ID card and left. She didn't know to tell me anything. She doesn't know who comes in and who gets out. I just kept waiting and this is a very bad thing. (F8)

The perception of the interviewed professionals about receptionists is that most of them provides bad assistance, with carelessness about users and have no interest in welcoming visitors. Such perception may be due to lack of communication between these professional categories and because they suggest that there is no in-service training for these receptionists.

[...] I've worked in all shifts, I see it may be difficult, but I still think you need to have the profile and the gift of talking to people. The reception is the front door. They don't realize that. They talk to a family member while eating a cookie, texting on the cell phone, or using the computer. (P6)

The reception is very, very bad [...] they lose themselves. There are a lot of people. Sometimes, there is one of them for 59 beds, there's no way with just one person. That happens because there is a lack of qualified professionals for this function, it lacks orientation, training, there's no way. (P1)

Subcategory 2: Welcoming from healthcare professionals

This subcategory has emerged through reported differentiation of welcoming of healthcare professionals. Family members classified as a warm welcome the care offered by the multi-professional team that works with Intensive Care. All this can be noticed in the following speeches:

I have no complaints about nurses there. The head nurse comes to me and says: "Dear!" (F5)

I think it is very welcoming here. I think they treat people well. Something that has already happened is I got in the room during visiting hours and saw them [referring to nursing technicians] feeding her. (F8)

The service here is great. It all started with the doctor [Mr. So-and-So], super thoughtful, I love that doctor! At the moment she got there really bad, everybody [reference to the entire multi-professional team] talked to me. (F5)

This emphasizes the view of family members about the importance of simple gestures as offering a meal, using sweet expressions or even giving attention and information; these are situations that provide welcoming for those in need of health services.

To my mind, understanding towards humanization requires listening and wanting to understand, making an effort to do it so. Under the conditions we find patients, with a tube in their mouth, or with a tracheostomy, or waking up, and then you have to hear: "Oh! He's agitated." And that's it. They don't want to understand him. We hear many people saying they prefer to assist two intubated patients than one awake. (P2)

Healthcare professionals also claim that welcoming is intended to qualified listening and must promote effective resolution of demands of users, through some involvement in the relationships.

Category 2: Communication

Communication is treated as the main factor for humanized service by both healthcare professionals and family members, which is evident in this research by observing the statements of the subjects. According to them, there is no way to provide a good welcoming without a bit of effective and clear communication.

Every time I come, I haven't been having problems with service here, except this little communication problem. I do think communication is the biggest problem, because we don't know who's in there, they [referring to the reception] can't give information, because there is no name, there's nothing, you don't have to identify yourself not even when you come in [...] Here, they just say someone is in there, but you don't know who it is. (F8)

I believe we must improve communication with patients, providing a bell for those who can call someone and express themselves. We must talk to patients and family daily and also improve communication among professionals. Even in case they don't like each other, interpersonal relationship is essential and must be respected. (P5)

When I go see patients, I always introduce myself, I put my hand on their chest and tell who I am, because I am invading their territory, it's their body, it's them. People who don't do it lose everything we receive in return. When you're like that, you gain so much more. (P4)

Non-verbal communication refers to gestures, expressions, touch and attitude towards the other. Besides, the subjects of this research believe it to be relevant to healthcare practice and a more humanizing service.

Category 3: Ethical and sensible professionalism

This category had a huge impact in this study due to the significant number of register units that appeared in the two groups of subjects, since it is seen as a fundamental point for humanization.

The existence of an ethical and sensible professionalism that transcends theoretical knowledge, allowing to apply actions and procedures that do not violate moral and scientific principles, resulting in more “human” outcomes, is seen as a guideline for humanization in Intensive Care. This can be better understood through the speeches:

Then, a nurse brought her a TV, it's not my demand or hers, I was surprised. I was happy for at least she was entertained by the TV [...] Also, the head of the night shift came and asked me if I was her mother, I said: “I am.” Then she said: “Stay here and give her the porridge. You can stay.” So I think this is so wonderful [...]. (F5)

Actually, this thing of caring about people, I remember when I started to work here: “Oh! You can't visit patients. Oh! You must not care so much, getting involved with patients, you can't get involved.” But that's why I work with people. If I didn't want to get involved, I would work with papers [...]. (P4)

The speeches allow us to realize that actions considered simple and easy to implement, can be mocked, distrusted or even unfounded, since they were not designed for the health-care context, much less for a restricted area as the ICU.

I will never, ever forget that, one day, at the old ICU, we had a really agitated patient. I asked him: “What do you want, sir?” He said: “I want a cigarette.” “But you can't smoke, sir.” “I don't want to smoke.” We gave him a cigarette and he spent the whole afternoon with the cigarette in his mouth and didn't bother anymore [...] I also remember this boy with paralysis. He was very little and wanted a grape lollipop. It was a tiny little thing that made the child happy [...]. It's a good thing that you do and sometimes, it calms them down. (P3)

We observed that gestures considered “awkward” can provide a more affectionate assistance, leaving memories for both those who practice them as to those who receive these actions.

Category 4: Unfavorable aspects

This category points out aspects that make humanization more difficult in Intensive Care, for being treated as actions, gestures and procedures that create barriers for humanization in healthcare assistance. That can be noticed in the statements of family members:

[...] you see, my daughter tried to commit suicide. So, every day, there was regular food, with a fork and a knife [...] Yesterday, they brought beef stew with a plastic fork and knife and they broke, so honestly, I think this is discrimination [...] If she were dangerous, then it would be fine. She is about to see a psychiatrist for treatment [...] It's prejudice, I'm telling you, you know, because they say she is bipolar, but this is prejudice and prejudice hurts. Then, yesterday at lunchtime [...] someone asked for another dessert in her name and took

it to another patient, or someone ate it, then in the evening, there was no dessert for her. Today at noon, dessert didn't come again, then this evening, same thing happened [...]. So I think that's cruel. Discrimination is bad. (F5)

[...] the doctor arrived and gave the girl a chocolate, so she took it and started to eat it. After a while, the nurse came, simply grabbed the chocolate and roughly threw it in the wastebasket. It happened more than once. The other day, the same doctor gave her another chocolate, she wanted to please her, she decided to give it, I don't know why. Then, the nurse came in, cursed at everyone and once again, she threw it away. She could be a little more polite. That's all I heard them talking with criticism. In general, they say good things about it. (F8)

Some professionals realize that many aspects of management with users (patients and their families) can be dehumanizing and, thus, can raise difficulties to the process that leads to execution of guidelines suggested by the SUS regarding treatment and involvement with users.

There is much dehumanization in all over the hospital, because often, they are thrown out here, and they come with this prejudice that the ICU is the end. (P6) Another thing is personalization. Sometimes, people say: “Are you with the patient of the 58?” This person has a name, it's on the door, it's easy to look at. (P4)

Aspects considered unfavorable to humanization were remembered by the respondents as situations that distance subjects, which raises difficulties to create bonds and co-responsibility.

Category 5: Perception on humanization

This category was built through concepts developed, redesigned or simply cited by the respondents. All the professionals interviewed presented their own definitions and expressed working ways they consider humanizers in the exercise of their assistance and managing activities.

However, in the category of family members interviewed, most failed to formulate a concept of humanization when asked. In fact, they were not familiar with such a word. After the concept was formulated and explained, all of them were able to express their perceptions regarding their experiences with the assistance processes and especially, the way they were welcomed by the professionals.

I think humanization is a person to be human with others, right? To be nice, right? The way I see it, humanization is to be human, charitable, sweet, isn't it? (F5)

To my mind, it's humanity, it's thinking about other people, not just being the professional [...]. (F7)

It's taking care with affection and sensibility, listening to the other person. (P1, P2, P3, P4, P6)

Perception on humanization of the subjects of this research first appeared through questions about what humanization would be. Then, some definitions emerged, as evidenced in the speeches.

This became an important category for directly revealing the perceptive impressions family members of patients hospitalized in the ICU, as well as the professionals of this area, have about humanization in this environment considered of high complexity.

Category 6: Religiosity/Spirituality

Despite being a category with a smaller number of register units in the two groups of subjects compared in this study, Religiosity/Spirituality is still important for its outstanding presence, notice by the interviewer on intonations and speech variations of the respondents when dealing with the topic.

When addressing faith, prays, or even the use of blessed objects as a pressure valve, the only way of hope for a treatment or recovery of an illness condition, the importance of this category as a requirement for humanization of the ICU becomes clear. All this can be perceived in the speeches:

[...] people say when a person is in a coma and you talk, talk and talk to him or her, and I prayed a lot, for me, I thought it was great because they let me, then she woke up. The other day, she started to feel better and better, and now thank God she's about to be discharged. (F5)

[...] some people talk, some people pray, say prayers and I also say it's a good thing that changes outcomes. There's no scientific proof about it, but we know that happens, so I tell them (family/companion) to say their prayers, that's my role too. (P1)

Being able to understand cultural differences and religious faiths is part of the precepts established by NHP when assumes that people are unique, have previous knowledge, have different understandings about the world, with different values related to the matter, beings and the supernatural.

DISCUSSION

Regarding welcoming, this is understood as the reception of users by the healthcare professionals, since their arrival in the services, being fully responsible for them, allowing them to express their concerns and anxieties, assuring resolute attention and articulation with other health services to continue assistance when it is needed⁽¹¹⁾, in the same way that was perceived by the subjects of the research.

In the booklet *Acolhimento nas práticas de produção de saúde* [Welcoming in the practices of health production] from 2010, the NHP of the Ministry of Health elucidates welcoming as a guideline with no specific location, time or professional to happen, since this is an ethical attitude of attention and management that involves listening to users and recognition of their needs, in order to favor a commitment and solidarity relationship among all people involved.

The welcoming proposal articulated to other proposals for changes in the work process, such as ambience, workers' training and expanded clinic are important resources for humanization of health services⁽¹¹⁾. Therefore, users expect to be welcomed when coming to such a complex service such as the ICU, since respectful treatment allows to start and narrow

important bonds in life stressful situations, in which even a simple waiting room can become welcoming.

In addition, welcoming must be understood as a users' approach process that encompasses the physical space in which they are received, which must be properly prepared to offer comfort, well-being and privacy⁽¹²⁾. Therefore, it is important that professionals are empathetic, introduce themselves and put themselves at their service. Understanding welcoming as one of the paths for humanization implies ensuring access to everyone through respect and qualified listening of users, in order to always provide a positive response to their health problems and taking responsibility for resolution of their demands⁽¹³⁾, which is in accordance with the perception of both family members and professionals interviewed.

A study that reviewed 21 articles that address the welcoming concept in healthcare practices, presents welcoming as a technological arrangement that aims to ensure access to users, aimed at listening, resolutions with responsibility and approximation among the actors involved, in order to enable the establishment of bonds⁽¹⁴⁾, thus consonant with the results found in this research.

As made explicit in the professionals' speeches, there are subjects who practice welcoming and clearly understands this is part of their roles as healthcare operators, following the guidelines proposed in the NHP, which address welcoming as a technology for all healthcare levels such as resolution managing and responsibility towards the users.

This study clarifies that healthcare professionals know the importance of a welcoming service, as proposed in the NHP of the SUS and, above all, they constantly perform such guidelines during their activities. Moreover, family members identify welcoming as a fundamental tool to meet their needs and feel more considered, understood and supported when welcomed by the entire team.

Regarding communication, it involves verbal and non-verbal forms. To guarantee a good interaction among healthcare professionals and users, developing skills is essential in order to apply the communication process properly in all assistance and managing practices⁽¹⁵⁾; in this research, it was evidenced by family members and healthcare professionals who pointed out the importance of good communication in Intensive Care, as well as non-verbal interactions such as a touch or a smile.

Communication must go beyond words and information, because people who are hospitalized lose their privacy, expose their bodies, restricted and susceptible in bed and, at that moment, communication happens through their bodies. Besides, getting to know the elements that form the communication process between the interlocutors, as well as negative and positive interference in order to have a concrete and solid relationship, is a key requirement to provide a humanized assistance⁽¹⁵⁾.

The importance of a consistent communication is incontestable, able to promote well-being among everyone involved. This can be noticed when the subjects approached benefits and harms that communication can offer, in case it is not proper, effective, respectful and sincere.

Regarding ethical and sensible professionalism, health services must be prepared to face specific situations of each individual, providing resources for various experiences, which,

even if they seem unusual, they are peculiar and important for those who experience them. Therefore, in their formulation and development, healthcare best practices include theoretical foundations (scientific evidence), environment understanding, the whole context of patients, beliefs, values and ethical principles of those who build and those who benefit from actions and services⁽¹⁶⁾.

The idea of ethical and sensible professionalism on assistance humanization refers to the imminent need of professionals who work with healthcare system users to walk on their shoes, wondering how they would like to be assisted, which actions they would consider important for their treatment and how they would like to be heard and treated. Thus, many attitudes could be revised, reformulated or even abolished for not being compatible with a holistic and humanizing assistance.

Regarding unfavorable aspects, situations said to be dehumanizing, such as inappropriate comments, constant noise, lack of privacy for users and use of labels and nicknames to refer to them, happen in many health assistance areas, not exclusively in high complexity places or places with large technological resources⁽¹⁷⁾, which was also pointed out by the participants of this study.

The NHP has been thought due to the difficulties to provide a more humanized treatment, especially regarding participatory management and teamwork, generating a commitment of healthcare practices and responsibility with users on their different needs, with an extreme respect to their rights. Phenomena generally pointed as inhuman, indicate more than ethical failures of workers or administrators. They correspond to facts whose origin demonstrates and expresses certain work conceptions and their organization ways⁽⁴⁾.

Perception on humanization is understood as subjective ideas, originated from sensations and external stimuli directed to the central nervous system, giving human beings the ability to associate information with the memory, forming concepts and behaviors⁽¹⁸⁾.

What is evident is that all respondents, with greater or lesser clarity, have their own humanization concepts, which must be respected and considered, because there is no single or simple definition to ensure exactly how to act to be "humanizing."

Although the use of the terms faith, belief, religion and spirituality are often considered synonyms, it is noteworthy that, at this moment, knowing how to conceptualize each one is not important, rather than the dimension that each term can give people⁽¹⁹⁻²⁰⁾, including meaning of life or a way of hope in the face of certain difficulties for some respondents.

What we can state is the NHP of the Ministry of Health exists to try to ensure that healthcare professionals treat users and are also treated in the best way possible, with "humanized"

resources through a number of recommendations, precepts and suggestions to implement humanization. Learning to respect cultural, religious and belief diversity is a humanized attitude as well that must be daily present in the healthcare process.

Study limitations

Situations such the ones reported by the respondents, considered in this study as unfavorable aspects for a welcoming service, sometimes lead to distance between professionals and users. This distance results in voice and identification denial of people as co-participants of their care process, that is, they should have autonomy to decide, give opinions or integrate the health system. Many healthcare professionals have this idea that, since they have the knowledge used in their practices, the users are merely "patients" who receives the action. As this study was aimed at the perception on humanization and its practice in healthcare, we did not expect to highlight non-humanizing aspects in the ICU and, therefore, they have not been properly explored.

Contributions to the healthcare field

From the results of this research, we created a Reflective Manual of humanizing assistance practices for professionals, a board to facilitate communication of these professionals with patients and a guideline book for family members.

FINAL CONSIDERATIONS

Subjects of this research showed different perceptions on humanization, although converging to the same point: treatment with appreciation of singularities, with respect to difference of opinions and in a welcoming way.

Despite some difficulties of family members to conceptualize humanization, within their expression manners and experiences, they brought their opinions about treatment, whether humanized or not. Healthcare professionals understand the NHP guidelines, and they claim to use them in their assistance practices, despite reporting that there are still many failures in the ideal path for an effective humanization in health services.

We can infer that the terms "acceptance," "communication" and "sensibility" appear as determinants for humanization in the ICU, and most actors involved in this process notice that there is a humanizing treatment with appreciation and responsibility in a huge part of assistance, practiced by many healthcare professionals. However, unfavorable aspects, represented by actions that do not add value to users, do not insert them as protagonists of their own care, are considered as dehumanizing for assistance in healthcare services.

REFERENCES

1. Nogueira LS, Sousa RMC, Padilha KG, Koike KM. Clinical characteristics and severity of patients admitted to public and private ICUS. *Texto Contexto Enferm* [Internet]. 2012 [cited 2016 Jul 7];21(1):59-67. Available from: http://www.scielo.br/pdf/tce/v21n1/en_a07v21n1.pdf
2. Silva RC, Ferreira MA. The practice of intensive care nursing: alliance among technique, technology and humanization. *Rev Esc*

- Enferm USP [Internet]. 2013 [cited 2016 Jul 7];47(6):1324-31. Available from: http://www.scielo.br/pdf/reeusp/v47n6/en_0080-6234-reeusp-47-6-01325.pdf
3. Camelo SHH. Professional competences of nurse to work in Intensive Care Units: an integrative review. *Rev Latino-Am Enferm* [Internet]. 2012 [cited 2016 Jul 7];20(1):192-200. Available from: <http://www.scielo.br/pdf/rlae/v20n1/25.pdf>
 4. Brasil. Ministério da Saúde. Política Nacional de Humanização. Série B. Textos Básicos de Saúde, cadernos Humaniza SUS. 2010.
 5. Silva AM, Sá MC, Miranda L. [Concepts of subject and autonomy in humanization of healthcare: a literature review of experiences in hospital service]. *Saúde Soc* [Internet]. 2013 [cited 2016 Jul 7]; 22(3): 840-52. Available from: <http://www.scielo.br/pdf/sausoc/v22n3/17.pdf> Portuguese.
 6. Dal-Farra RA, Lopes PTC. [Mixed methods in education: theoretical assumptions]. *Rev Nuances* [Internet]. 2013 [cited 2016 Jul 7];24(3):67-80. Available from: <http://revista.fct.unesp.br/index.php/Nuances/article/viewFile/2698/2362> Portuguese.
 7. Boccato VRC, Ferreira EM. [Comparative study between focus group and verbal protocol in group in the improvement of controlled vocabulary in Physical Therapy: a qualitative – cognitive methodological proposal]. *Rev Ciência Info Doc*[Internet]. 2014 [cited 2016 Jul 7];5(1):47-68. Available from: <http://www.revistas.usp.br/incid/article/view/63986/82232> Portuguese.
 8. Gatti BA. Grupo focal na pesquisa em ciências sociais e humanas. Brasília: Liber livro; 2012.
 9. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.
 10. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução nº 510, de 7 de abril de 2016. Diário Oficial [da] República Federativa do Brasil. Brasília (DF) [Internet]. 2016 [cited 2016 May 24];(1): 44-6. Available from: <http://conselho.saude.gov.br/resolucoes/2016/Reso510.pdf> Portuguese.
 11. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. Acolhimento nas práticas de produção de saúde. 2 ed. Brasília: Ministério da Saúde; 2010.
 12. Merenda Júnior J, Sylla MCDT. [Chromotherapy, environment and reception in the ESFs SUS user]. *Rev Colloquium Vitae* [Internet]. 2013 [cited 2016 Jul 7];5(esp):16-22. Available from: <http://www.unoeste.br/site/enepe/2013/suplementos/area/Vitae/Medicina/Cromoterapia,%20ambi%C3%Aancia%20e%20acolhimento%20ao%20usu%C3%A1rio%20do%20US%20nas%20ESFs.pdf> Portuguese.
 13. Guedes MVC, Henriques ACPT, Lima MMN. [Embracement in an emergency service: users' perception]. *Rev Bras Enferm* [Internet]. 2013 [cited 2016 Jul 7];66(1):31-7. Available from: <http://www.scielo.br/pdf/reben/v66n1/v66n1a05.pdf> Portuguese.
 14. Garuzi M, Achitti MCO, Sato CA, Rocha SA, Spagnuolo RS. [User embracement in the Family Health Strategy in Brazil: an integrative review]. *Rev Panam Salud Publica* [Internet]. 2014 [cited 2016 Jul 7];35(2):144–9. Available from: <http://www.scielosp.org/pdf/rpsp/v35n2/a09v35n2.pdf> Portuguese.
 15. Broca PV, Ferreira MA. Communication process in the nursing team based on the dialogue between Berlo and King. *Esc Anna Nery Rev Enferm*[Internet]. 2015 [cited 2016 Jul 7];19(3):467-74. Available from: <http://www.scielo.br/pdf/ean/v19n3/1414-8145-ean-19-03-0467.pdf>
 16. Guerrero P, Mello ALSF, Andrade SR, Erdmann AL. User embracement as a good practice in primary health care. *Texto Contexto Enferm* [Internet]. 2013 [cited 2016 Jul 7];22(1):132-40. Available from: <http://www.scielo.br/pdf/tce/v22n1/16.pdf>
 17. Silva FD, Chernicharo IM, Silva RC, Ferreira MA. Speeches of nurses about humanization in the Intensive Care Unit. *Esc Anna Nery Rev Enferm* [Internet]. 2012 [cited 2016 Jul 7];16(4):719-27. Available from: <http://www.scielo.br/pdf/ean/v16n4/11.pdf>
 18. Oliveira AO, Mourão-Júnior CA. [Theoretical study on perception in philosophy and neuroscience]. *Rev Neuropsicologia Latinoamer* [Internet]. 2013 [cited 2016 Jul 7];5(1):41-53. Available from: http://www.neuropsicolatina.org/index.php/Neuropsicologia_Latinoamericana/article/view/83/97 Portuguese.
 19. Souza VM, Frizzo HCF, Paiva MHP, Bousso RS, Santos AS. Spirituality, religion and personal beliefs of adolescents with cancer. *Rev Bras Enferm* [Internet]. 2015 [cited 2016 Jul 7];68(5):509-14. Available from: http://www.scielo.br/pdf/reben/v68n5/en_0034-7167-reben-68-05-0791.pdf
 20. Borges MS, Santos MBC, Pinheiro TG. [Social representations about religion and spirituality]. *Rev Bras Enferm* [Internet]. 2015 [cited 2016 Jul 7];68(4):609-16. Available from: <http://www.scielo.br/pdf/reben/v68n4/0034-7167-reben-68-04-0609.pdf> Portuguese.
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