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Humanization of healthcare at the emergency department: a qualitative analysis based on nurses' experiences

Humanização dos cuidados de saúde no serviço de urgência: análise qualitativa basea-da nas experiências dos enfermeiros

Humanización de la asistencia en urgencias: un análisis cualitativo basado en las experiencias de las enfermeras

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Abstract

Background: The working conditions of emergency department professionals and the technification of healthcare have had a negative impact on the healthcare professional-patient relationship, dehumanizing it.
Objective: This qualitative study explored nurses' perspectives about the humanization of healthcare in Spanish emergency departments.
Methodology: A qualitative design, centred on the opinions of 11 nurses working in the emergency department was applied via semi-structured interviews. Data were analysed using the content analysis technique.
Results: Two main themes were identified: The dimensions of humanized healthcare and implementing humanized healthcare at emergency departments, as well as five subthemes.
Conclusion: Recommendations are put forward to strengthen initiatives for implementing integrated models of healthcare assistance. The implementation of holistic, patient and family-oriented healthcare is essential to guaranteeing humanized healthcare at the emergency department.

Keywords: emergencies; nursing

Resumo

Enquadramento: As condições de trabalho dos profis-sionais dos serviços de urgência e a tecnicização dos cui-dados de saúde tiveram um impacto negativo na relação profissional de saúde-doente, desumanizando-a.
Objetivo: Este estudo qualitativo explorou as perspeti-vas das enfermeiras em relação à humanização dos cui-dados de saúde nos serviços de urgência em Espanha.
Metodologia: Foi realizado um estudo qualitativo com recurso a entrevistas semiestruturadas a 11 enfermeiros a trabalhar em serviços de urgência. Os dados foram analisados com recurso à técnica de análise de conteúdo.
Resultados: Foram identificados dois temas principais: As dimensões dos cuidados de saúde humanizados e implementação de cuidados de saúde humanizados nos serviços de urgência, bem como cinco subtemas.
Conclusão: São apresentadas recomendações para re-forçar as iniciativas para implementação de modelos in-tegrados de assistência em saúde. A implementação do cuidado holístico, centrado no doente e na sua família é essencial para garantir a humanização dos cuidados de saúde nos serviços de urgência.

Palavras-chave: emergências; enfermagem

Resumen

Marco contextual: Las condiciones laborales de los profesionales de los servicios de urgencias y la tecnifi-cación de la atención sanitaria han tenido un impacto negativo en la relación médico-paciente, y la han deshu-manizado.
Objetivo: Este estudio cualitativo exploró el punto de vista de las enfermeras sobre la humanización de la aten-ción sanitaria en los servicios de urgencias españoles.
Metodología: Se aplicó un diseño cualitativo, centrado en las opiniones de 11 enfermeros que trabajan en el servicio de urgencias, mediante entrevistas semiestruc-turadas. Los datos se analizaron mediante la técnica del análisis de contenido.
Resultados: Se identificaron dos temas principales: Las dimensiones de la atención humanizada y la implemen-tación de la atención humanizada en el servicio de ur-gencias, así como cinco subtemas.
Conclusión: Se presentan recomendaciones para forta-lecer las iniciativas de implementación de modelos in-tegrados de atención de la salud. La aplicación de una atención holística, centrada en el paciente y en su familia, es esencial para garantizar la humanización de la atención sanitaria en los servicios de urgencias.

Palabras clave: urgencias médicas; enfermería

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Introduction

Since the second half of the twentieth century, hospital emergency departments (EDs) have undergone extensive structural and technical changes in line with social and cultural advances in the pursuit of patients' self-determination and empowerment (Bates, 2018). However, this process has had a negative impact on the patients' relationship with healthcare professionals and institutions (Bates, 2018). Some of the unfavourable working conditions identified are: high levels of attendance, overcrowding, heavy workload, and limited time for contact with patients (Sanjuan-Quiles et al., 2018). All of these factors, together with the predominant, technified, biomedical model of healthcare, have lead to its depersonalization, thus neglecting the dignity of those it supposedly cares for (Tudela & Mòdol, 2015).

Recognizing the need to address these phenomena, there are currently a range of initiatives for implementing integrated models of healthcare with a view to improving quality as perceived by patients, as well as enhancing job satisfaction and improving population health outcomes. The humanization of care is inherent to the incorporation of a patient-centred healthcare system, in which patients are seen in a holistic and integrated manner, and healthcare professionals have both technical and non-technical competencies (Silva, Freitas, Araújo, & Ferreira, 2016).

Since humanization is not fully implemented or normalized in Spanish EDs, the aim of the present study was to explore nurses' perspectives about the humanization of care in Spanish EDs.

Background

There are different nursing models and theories that guide nursing care toward a more humanized practice, such as the Peplau and Travelbee models. These epistemological underpinnings of nursing care focus on the subjectivity and experience of the person in their health-disease process, favoring the development of the interpersonal relationships that occur during the therapeutic encounters in which the needs of the person/patient are met, giving it a meaning (Elers Mastrapa & Gibert Lamadrid, 2016).

Various authors have proposed different strategies for promoting humanization in a range of contexts, such as oncology (Potter el al., 2010), EDs (Bermejo, 2014), and particularly intensive care units (Luiz, Aquino Caregnato, & Costa, 2017), developing innovative projects such as the H-UCI in Spain (Heras La Calle & Zaforteza Lallemand, 2014).

Despite the introduction of new policies for healthcare humanization within the nursing field, healthcare professionals must demonstrate commitment in their practices (Bermejo, 2014), as well as recognition of basic human and patient rights while respecting their dignity (Luiz et al., 2017).

Research question

How is the experience of Spanish nurses regarding the humanization of care in hospital EDs?

Methodology

A qualitative study was conducted to explore the opinions of ED nurses through semi-structured interviews (Paley, 1997). The phenomenological approach to the phenomenon of humanization aims to know and understand the phenomenon of humanization in EDs, its changing phenomena, and the meanings assigned to this phenomenon based on the reality of the professionals who work there, that is, through narratives that describe their beliefs, thoughts, emotions, and experiences of how they live and feel in their daily work. Threfore, the approach to the phenomenon of humanization through phenomenology describes its general and specific nature, and provides a description and analysis of the inner world of the protagonists (Gomes, Paiva, Valdés, Frota, & Albuquerque, 2008).

Furthermore, an inductive approach was applied (Woo, O'Boyle, & Spector, 2017). This manuscript follows the recommendations in the Consolidated Criteria for Reporting Qualitative Research (COREQ), a 32-item checklist for reporting interviews (Tong, Sainsbury, & Craig, 2007).

Study sample
The initial sample consisted of 35 ED nurses from the Province of Murcia (Spain). The selection was performed via a convenience, non-probabilistic sampling method while attempting to achieve representativeness. The inclusion criteria were: to

be actively working in the public sector and to have at least 1 year of experience at their current workplace. Five potential participants refused to participate or dropped out due to lack of interest. Finally, 11 nurses met the inclusion criteria and participated in the study until data saturation. Table 1 shows the sample characteristics. Women made up 54.6% of the sample. The mean age was 40.5 years (*SD* = 6.6). The mean length of service at EDs was 11.7 years (*SD* = 7.2). The nurses working in EDs had a bachelor's/master's degree, since there is no specialization training in emergencies at the Spanish National Health System. The aforementioned sample characteristics were comparable to those (age, gender, and experience) of those candidates who did not provide their consent and/or meet the inclusion criteria.

Table 1

Characteristics and professional profile of the sampled nurses

Nurse	Age (years)	Gender	Experience at EDs (year)	Interview date
E1	42	Male	15	2-02-2015
E2	50	Female	25	16-02-2015
E3	39	Male	13	31-03-2015
E4	36	Male	3.5	30-04-2015
E5	38	Male	10	11-05-2015
E6	52	Male	8	31-05-2015
E7	41	Female	18	9-06-2015
E8	45	Female	20	15-09-2015
E9	29	Female	3	13-10-2015
E10	35	Female	4	3-11-2015
E11	39	Female	9	14-12-2015

Note. ED = Emergency Department.

Data collection

Potential participants were identified via key informants (nursing supervisors) and then contacted via electronic mail. Once contact was established, the researchers explained them the study characteristics and invited them to participate. Researchers then called the candidates on the phone, explaining the study characteristics and inviting them to participate. All the candidates agreed to voluntarily participate in the study and signed an informed consent form. Two researchers carried out all interviews, which lasted around 45 minutes. Both are female nurses with previous experience in conducting qualitative research. The semi-structured, face-to-face interviews were conducted at a center chosen by the interviewees where an appropriately confidential environment was created. The interview consisted of 10 questions based on the review of relevant literature and the specific study objectives: *What is the nurse-patient relationship like at EDs?*; *Overall, how would you describe the type of care provided by ED nurses?*; *What do you understand by the term "humanization of care"?*; *What factors/behaviours favour the humanization of care?*; *Do you recall any experience in which contact of this nature was established with a patient and/or their family?*; *What is the degree of humanization at EDs?*; *What traits and abilities do ED nurses possess to promote the humanization of care?*; *How would you define the communication skills and the therapeutic relationships at EDs?*; *What value do such skills hold in the nurse-patient/family relationship?*; and *How do you feel about humanization training?*

Each interview was assigned a numeric code in order to guarantee the interviewees' anonymity and confidentiality, consisting of the letter "E" followed by consecutive numbers according to the chronological order in which they were held (E1, E2, E3, …E11); see Table 1. Data collection ended after 11 interviews because similar themes were repeatedly being addressed.

This was interpreted as data saturation.
The interviews were recorded in digital audio format and then transcribed *verbatim*. Participants were shown their contribution so they could corroborate the level of accuracy of the transcription. Each interview and any notes were proof-read in an exhaustive and meticulous way.

Data analysis
Data were analysed following the six-step thematic analysis framework by Braun and Clarke (2006). First, all interviews were re-ad and re-read at least one more time using a triangulation method. The repetitive reading of the transcripts helped researchers to familiarize themselves with the data. Second, the authors identified an initial list of thematic codes reflecting frequency of occurrence. Third, via a dynamic process, the initial codes were collated into potential themes and subthemes. Once the differences between the latter and those of the available literature and/or conceptual framework were identified, the team completed the fourth step. They consensually refined the classification as to which data were most relevant and provided significance to the themes and subthemes generated. In the fifth step, the authors generated more concise names for the themes and subthemes. As a sixth and final step, the findings were reported in written form, including examples capturing the essence of the information being discussed. No software was used for qualitative analysis because the research team preferred to approach it in the traditional manner.

Ethical considerations
All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research ethics committee and the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. All subjects were informed about the purpose of the study. Informed consent was obtained from all individuals included in the study. Additionally, authorization was obtained from the institutions where they worked.

Results

Two themes and five subthemes were identified during the interviews which helped describe the situation (Table 2).

Table 2
Themes and subthemes

Theme	Subtheme
1. Dimensions of humanized healthcare	1.1 The humanization concept
	1.2 Patient/family-centred healthcare
	1.3 Power symmetry and the development of trust in the nurse-patient relationship
2. Implementing humanized healthcare at EDs	2.1 Acquisition of psychosocial skills
	2.2 Teamwork and communication

Theme 1. dimensions of humanized healthcare

1.1 The humanization concept
For the interviewed nurses, the humanization concept is multidimensional. It is based on the relationship established with the patient and their family, in which the healthcare professional is able to combine technical interventions with personalized healthcare tasks while attempting to establish an empathetic, kind, and respectful relationship (Figure 1).
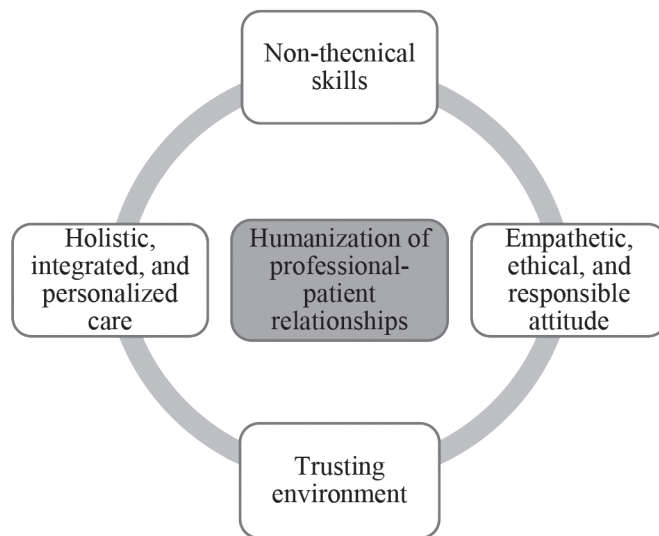
Figure 1. Aspects involved in humanized professional-patien relationships.

1.2 Patient/family-centred healthcare

The participants considered that the humanization of care is based on establishing an effective relationship with the patient/family and being aware of their vulnerability when resorting to an ED:

"It's a matter of creating a climate of trust, in which people feel at ease . . . it's treating the patient as a person, as a human being." (E7; June, 2015).

"It's being aware of a patient's mood or concerns, rather than being only a good technical nurse." (E2; February, 2015).

"It's about looking after the fine details, a caring touch, a kind gesture, a smile: I think that's a part of the humanization of care and not just, Bingo! ... getting a line in without even making eye contact . . . " (E5; May, 2015).

The use of social and communication skills was highlighted as an essential part of nursing, as well as being aware of the singularity of each patient/family and providing the necessary information regarding their situation for ensuring patient autonomy and self-determination. For instance, in the words of one interviewee:

"It means the patient receives accurate, pertinent, and understandable information regarding their situation, the techniques they are to undergo, and above all an explanation regarding the process and the steps to be followed at the

ED" (E8; September, 2015).

Most of the interviewees identified the concepts of continuity and personalization of care as being essential to the humanization of care and proposed the Reference nurse model as ideal for humanizing EDs (Figure 2).

> The doctor and the nurse introduce themselves - my name is such and such and I will be looking after you during your stay . . . since it makes them more relaxed . . . at least the patient knows who to turn to . . . . (E2; February, 2015)

The interviewees highlighted the importance of the greeting process, of establishing positive relationships in order to provide integrated care to the patient/family, appropriate assessment and follow-up, with the patient taking an active part in the process.

"When a patient arrives at the emergency department, it is important to accompany them, dedicate your time to them, and talk to them so they feel safer and calmer." (E3; March, 2015).

"To explain how the department works and tell them you'll speak with their family helps to greatly diminish their level of anxiety as well as that of their family members." (E9; October, 2015).

"If you have assessed them properly, you know what their needs will be, their concerns, whether they have family waiting or not, you understand the situation." (E8; September, 2015).

1.3 Power symmetry and the development of trust in the nurse-patient relationship

For symmetrical power relations to develop into trusted relationships, both parties need to share the same goals. The interviewees identified the need to establish a bilateral relationship in which the hegemonic-paternalistic model of depersonalized healthcare (where the patient is merely considered a case, an illness, or a number) is uprooted.

We're all equal. We should forget about power trips, where the patient is down there, and the professionals are up here, shouldn't we? We're the ones with the knowledge and the patient needs our help but it should be in a kindly manner, on an equal basis. (E3; March, 2015)

"Well, I think it's easier to just ask: How are you? How do you feel? Are you alright? Do you need anything?" (E7; June, 2015).
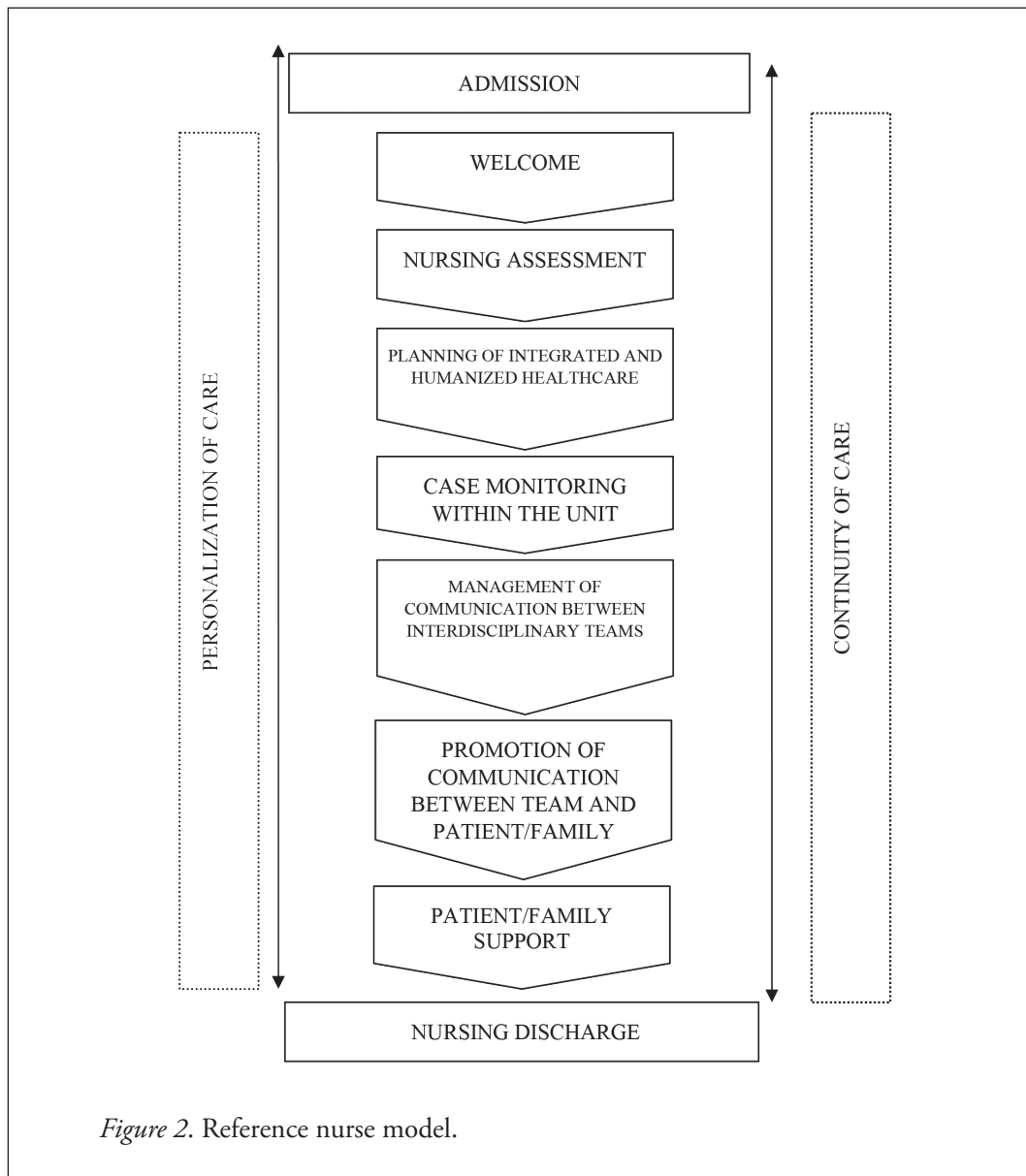

Figure 2. Reference nurse model.

Theme 2. Implementing Humanized Healthcare at EDs

2.1 Acquisition of psychosocial skills

Participants recognised that nurses play an essential role in the humanization process and that their engagement, sense of duty, and awareness are necessary. Participants identified the need for nurses to have both technical and non-technical skills in order to manage each situation effectively, placing importance on the finer details (Beltrán-Salazar, 2015). Furthermore, they also identified the need for socio-psychological skills and capacity for developing therapeutic relationships "to humanize oneself in order to humanize (others)": "Training in communication skills can help you realize you have internalized things that you think are not bad. It can make you see that what you're used to doing is not good." (E8; September, 2015).

Nonetheless, they felt that the onus for training such skills should fall upon the healthcare professionals themselves and not the institution. One interviewee stated:

"It depends on each person's capacity or motivation to learn. To me, all professionals should be concerned about furthering their skills, getting involved" (E5; May, 2015).

2.2 Teamwork and communication

Nurses are part of an interdisciplinary healthcare team and the characteristics of an ED team influence the quality of the healthcare provided. Those characteristics identified from the interviews were 1) group identity; 2) team cohesion, since, according to the study participants, a unified team favours a working atmosphere conducive to seeking the common good; 3) optimal team coordination, with participatory management, non-hierarchical relationships, and mutual trust; all of which should be based on effective communication, with confidence and proximity being fundamental to a positive working environment. It is important to feel comfortable around other people, to create a team, to work well together.

> There should be politeness and respect. That leads you subconsciously to work well and the department to function properly . . . and the patient, who is the most important aspect in this case, will benefit from that and will notice the difference. (E3; March, 2015)

For those professionals who work on a daily basis at EDs, recognition for a job well done from everyone (patients, families, teams, and institution) was the main aspect leading to a sense of satisfaction and enhanced quality of care.

Discussion

This paper reported the findings of the first study conducted in Spain about healthcare professionals' perspectives of humanized healthcare. It identified those attitudes and behaviours which promote humanized healthcare at EDs. Many revealing observations were uncovered in line with international research.

Two main themes were identified describing situations which arose frequently during the interviews: The Dimensions of humanized healthcare and Implementing humanized healthcare at EDs, as well as five subthemes.

Interviewees identified humanization as a multidimensional concept based on the relationship established between the patient/family and the work team.

According to the findings of the present study, on the one hand, biomedical and technified healthcare models centred on the reason for admission should be replaced by models which prioritize healthcare itself and facilitate accompaniment by family members or close relatives of frail patients, particularly in the case of young children, older people with cognitive impairment, and individuals with mental illness or disability (Gamella Pizarro, Sánchez Martos, González Armengol, & Fernández Pérez, 2014), involving them in all aspects and stages of the healthcare process (Bates, 2018). On the other hand, the implementation of a resource allocation and management system based on the reference nurse model is also necessary in our context to achieve ongoing and individualized patient/family-centred healthcare (Silva et al., 2016). Nurses are ethically, professionally, and legally accountable for their actions. Given their key position as therapeutic agents and members of the healthcare team, the reference nurse would be in charge of welcoming the patient to the service, acting as a link between those involved, promoting effective communication (O'Rourke, Thompson, & McMillan, 2019), and enhancing the knowledge about

the patient's real needs (Gamella Pizarro et al., 2014). They would also contribute to reducing unwanted occurrences during their admission to what can be a hostile environment and supporting them to cope with the problems that lead to ED admission (Juliá-Sanchis et al., 2019). Thus, the patient would play a more active and participatory role, especially in the decision-making processes regarding their health (Coulter & Collins, 2011), which would promote their empowerment and improve their, satisfaction, enhance clinical safety and, thereby, improve the quality of healthcare at EDs (Silva et al., 2016).

First, to humanize healthcare, every ED nurse should analyse their own daily practice, skills, and limitations. Nurses should consider whether they offer patients/families an ethical and high-quality nursing care, based on relevant ethical and moral principles such as respect, trust, and dignity.

Second, to develop better interpersonal relationships with the patient/family, ED nurses should be competent in both technical and non-technical skills (O'Rourke et al., 2019), as well as show an interest and dedicate more time to them (Beltrán-Salazar, 2015). To this end, the institution should provide specific training programmes in humanized healthcare (Bermejo, 2014) and non-technical skills which could be analysed at a future stage.

In line with the available literature (Silva et al., 2016), interviewees identified interdisciplinary teams (workers trained in different disciplines working together towards a common goal and sharing a team identity) as fundamental for the humanization of care at EDs. Gamella Pizarro et al. (2014) also found that the lack of interdisciplinary teamwork, or institutional, structural and managerial support, would dehumanize EDs. Thus, proper coordination and communication within the team are necessary to enhance the quality of healthcare, as well as the establishment of horizontal, non-hierarchical working relationships and the promotion of participatory management, conflict resolution, as well as the search for a common good (Luiz et al., 2017). The humanization of nursing care at EDs provides positive, added value to healthcare quality, with benefits for patients, their families, the healthcare professionals, the team, and the institution in general (Bermejo, 2014; Silva et al., 2016).

Nonetheless, this empathetic and respectful way of being and behaving can have a negative impact on the emotional health of staff working on a daily basis under high levels of stress, facing unexpected, critical, painful circumstances, and being the bearers of bad news (Potter et al., 2010). All of which, together with workplace conflicts and characteristics, can favour the development of emotional exhaustion or the burnout syndrome (Gómez-Urquiza et al., 2017). Thus, the institution should promote educational activities for ED staff in order to improve their capacity for coping with their workplace reality, as well as structural interventions which reinforce tolerance for physically and emotionally intense workloads while furthering a sense of job satisfaction (Juliá-Sanchis et al., 2019).

The data gathered reflect the experience of ED nurses in a particular region of Spain and, as such, they cannot be extrapolated to other locations that do not possess similar characteristics. However, the type of participant and the context chosen for this study can be considered representative on a national level given the intense and continuous debate generated by and about healthcare deliveryat EDs. This geographical limitation should be addressed in future research with a similar focus, albeit larger sample size.

Although data saturation was reached in the interviews and, despite statistical sampling methods not being a requisite for qualitative research models, further points of view should be studied in different contexts of the healthcare system.

Conclusion

A better understanding of the viewpoints of Spanish ED nurses about the humanization of healthcare in EDs was achieved. The humanization of healthcare should be systematically integrated into the daily practice of Spanish EDs, progressing to more holistic, integrated, and patient/family-centred healthcare models. Such a process involves a number of dimensions: *the healthcare professional*, as a cornerstone in the process through attitudes and behaviours which humanize the care they provide; the *human relationships* which are established and

maintain the continuity of patient/family-centred healthcare, in which the welcoming process and the use of communication skills are key points; and *the interdisciplinary team through teamwork*, as well as through the relationships established within the team, in the search for shared goals and the common good.

The humanization of care in EDs with the aforementioned characteristics will improve communication, and consequently improve patient safety and professional and patient/family satisfaction.

Acquiring updated data on the professionals' perspectives about the humanization of care in EDs allows organizations to reinforce certain aspects. Wider and specific training programmes are required to cover humanized healthcare and non-technical skills in Spanish hospitals while respecting the patient's autonomy and dignity. These training programmes should be analysed at a future time.

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