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ORIGINAL ARTICLE

COMFORT IN PALLIATIVE CARE: THE KNOW-HOW OF NURSES IN GENERAL HOSPITAL

CONFORTO EM CUIDADOS PALIATIVOS: O SABER-FAZER DO ENFERMEIRO NO HOSPITAL GERAL

CONFORT EN CUIDADOS PALIATIVOS: EL SABER HACER DE LAS ENFERMERAS EN UN HOSPITAL GENERAL

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ABSTRACT

Objectives: identifying the nursing care related to the comfort of patients in palliative care and discussing their implications for the expertise of nurses. ***Method:*** a descriptive study with a qualitative approach, which uses the track 2 the mapping method carried out with 30 nurses from the inpatient unit of a general hospital in the city of Rio de Janeiro/RJ. The data were produced by semi-structured interviews and observation non-participant and analyzed by content analysis technique, after approval of the research project by the Research Ethics Committee, CAAE n. 12586513.6.0000.5285. ***Results:*** for nurses, nursing actions in palliative care should prioritize the promotion of comfort, being referenced comfort in its physical dimension, linked to nursing procedures aimed at relieving pain and physical symptoms. ***Conclusion:*** the care of nurses in palliative care aims to contemplate the physical comfort of the patient. Psychological, spiritual and social components those also involve comfort were not mentioned as inherent to nursing care. ***Descriptors*:** Nursing; Palliative Care; Care Comfort.

RESUMO

Objetivos: identificar os cuidados dos enfermeiros relacionados ao conforto de pacientes em cuidados paliativos e discutir suas implicações para o saber-fazer dos enfermeiros. ***Método:*** estudo descritivo, de abordagem qualitativa, que utiliza a pista 2 do método cartográfico realizado com 30 enfermeiros da unidade de internação de um hospital geral do município do Rio de Janeiro/RJ. Os dados foram produzidos por meio de entrevistas semiestruturadas e observação não participante e analisados pela Técnica de Análise de Conteúdo, após aprovação do projeto de pesquisa Comitê de Ética em Pesquisa, CAAE n. 12586513.6.0000.5285. ***Resultados:*** para os enfermeiros, as ações de enfermagem em cuidados paliativos devem priorizar a promoção do conforto, sendo referenciado o conforto em sua dimensão física, atrelado aos procedimentos de enfermagem que visam o alivio da dor e sintomas físicos. ***Conclusão:*** os cuidados dos enfermeiros na assistência paliativa objetivam contemplar o conforto físico do paciente. Os componentes psicológicos, espirituais e sociais, que também envolvem o conforto, não foram mencionados como inerentes ao cuidado de enfermagem. ***Descritores:*** Enfermagem; Cuidados Paliativos; Cuidados de Conforto.

RESUMEN

Objetivos: identificar la atención de las enfermeras relacionada con el bienestar de los pacientes en cuidados paliativos y discutir sus implicaciones para la experiencia de las enfermeras. ***Método:*** un estudio descriptivo, con abordaje cualitativo, que utiliza la pista 2 del método de mapeo realizado con 30 enfermeros de la unidad de hospitalización de un hospital general en la ciudad de Río de Janeiro/RJ. Los datos fueron producidos por entrevistas semi-estructuradas y observación no participante y analizados por la Técnica de Análisis de Contenido, después de la aprobación del proyecto de investigación del Comité de Ética de Investigación, CAAE. 12586513.6.0000.5285. ***Resultados:*** para las enfermeras, las acciones de enfermería en cuidados paliativos deben priorizar la promoción de la comodidad, siendo referenciado el confort en su dimensión física, remolque procedimientos de enfermería que visan a la relevación del dolor y los síntomas físicos. ***Conclusión:*** el cuidado de enfermería en la asistencia paliativa pretende contemplar el confort físico del paciente. Los componentes psicológicos, espirituales y sociales, que también implican la comodidad, no se mencionaron como inherentes a la atención de enfermería. ***Descriptores:*** Enfermería; Cuidados Paliativos; Cuidados de Confort.

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INTRODUCTION

Patients presenting advanced disease receive some kind of assistance which do not more objectives the cure, but the control of the symptoms of palliative way, providing them greater quality of life and comfort. Nowadays, this kind of treatment is called palliative care, and it is estimated that over the next year, about a million people will need such care.[1]

Palliative care has been defined by the WHO in 2002 as an approach that promotes the quality of life of patients and their families facing a life threatening illness, through the prevention and relief of suffering, early identification, assessment is required for this and treatment of pain and other problems of physical, psychosocial and spiritual nature.[2]

In 2002, two important documents were published by WHO: The Solid Facts of Palliative Care and Better Care of the Elderly. Both recommend palliative care as a share of national health systems strategy, not only in the realm of cancer but also in other areas of knowledge, such as pediatrics, geriatrics, HIV/AIDS and chronic diseases.[3]

Specificity in the area of palliative care goals of nursing permeate the promotion of comfort and quality of life through symptom control and needs of psychological, social, emotional, and spiritual support of patients and relatives.

The nurse plays a key role in this context because, by virtue of their work is more intense and direct contact with patients, not only in its terminal phase, but throughout the course of the disease , they present weaknesses and limitations of specific natures physical, psychological, social and spiritual.[Erro! Fonte de referência não encontrada.5] Florence Nightingale, in her Notes on Nursing, says that comfort is an important aspect of care, taking into account the quality of nursing care, a practice regarded by her as the primary responsibility of the nurse in relation to the process restoration of health.[6]

It is essential to know the nurses what they think about the care they provide in relation to the idea of comfort and for that you need to keep in mind the doctrine of the basic principles of nursing care, because every human being feels differently needs, characteristics and spirituality.[7]

Are described in the literature 21 nursing problems related to biological, psychological and social conditions, making it clear that the professional role, the nurse should include not only the care of the patient body, but also attention to the person in all his dimensions life.[8]

Despite careful not be the prerogative of a single profession, undeniably, is the nurse who has more opportunity to care, and thus incorporates this function as an essential object of their practice, given that these are professionals who spend twenty-four hours a day with the patient. Thus, the nurse and his team can assist and support the patient in physical, emotional, social and spiritual changes, identifying their real needs and providing greater comfort.

Considering its importance and magnitude to the practice of nurses, the discussion of this topic is needed to improve the quality of care reasons the practice from the technical, scientific and ethical precepts that emerge in situations of illness and impending death.

OBJECTIVES

- Identifying the care of nurses related to the comfort of patients in palliative care.
- Discussing the implications of the care for the know-how of nurses.

METHOD

Article drawn from the dissertation <<***Palliative care in the general hospital: the know-how of nurses***>>, presented to the Postgraduate Program in Nursing, Federal University of the State of Rio de Janeiro (UNIRIO), Rio de Janeiro-RJ Program, Brazil. 2013.

This is a descriptive study with a qualitative approach. Was also used to track 2 of the cartographic method is to monitor processes and is done through eight tracks that can be chosen according to what is being investigated.[10] In this study, the selected track 2, which relates to the functioning of attention during the field work and is the time of production of research data. There are four varieties of attention Cartographer: screening, touch, landing and recognition aware.[10-11]

Screening is a gesture of scan field, aiming at a target. The important thing is the location of tracks, signs processuality, monitoring of changes in position, velocity, acceleration, and pace. The basic principle is to open and unfocused attention, with a thin line with the problem. It is an attitude of concentration.[10-1]

The touch, in turn, is the haptic perception and is formed by movements of exploration tactile perceptual field, to build knowledge of the object, considering that the haptic perception "she mobilizes attention and requires a large working memory for that after the

operation, there is a synthesis, which results in the knowledge of the object".[10:41]

The gesture of landing indicates that perception, whether visual, auditory or otherwise, makes a stop and the field closes in a kind of zoom. Forms a new territory, the attention shifts of scale.[10-1]

The attentive recognition is the fourth gesture or attentional selection. Recognize an object is whether use of it. The perception is thrown for images of the past, contrary to what occurs in the automatic recognition; she is thrown for future action.[10-1]

The scenario chosen was the inpatient unit of a federal hospital in the city of Rio de Janeiro and the data collection was carried out between June-August 2013, through semi-structured interviews. The subjects were 30 laborers and nurses on duty the inpatient unit who agreed to participate in the study by signing the consent form and were excluded only those nurses who were on vacation or sick leave during the period of data collection.

This study was approved by the Research Ethics Committee of the Federal University of the State of Rio de Janeiro and the Federal Hospital of Bonsucesso on June 7th, 2013, registered under the number CAAE 12586513.6.0000.5285. All ethical and legal requirements for the development of research on human beings, present in Resolution n. 466/2012196/1996 CNS, were adopted.

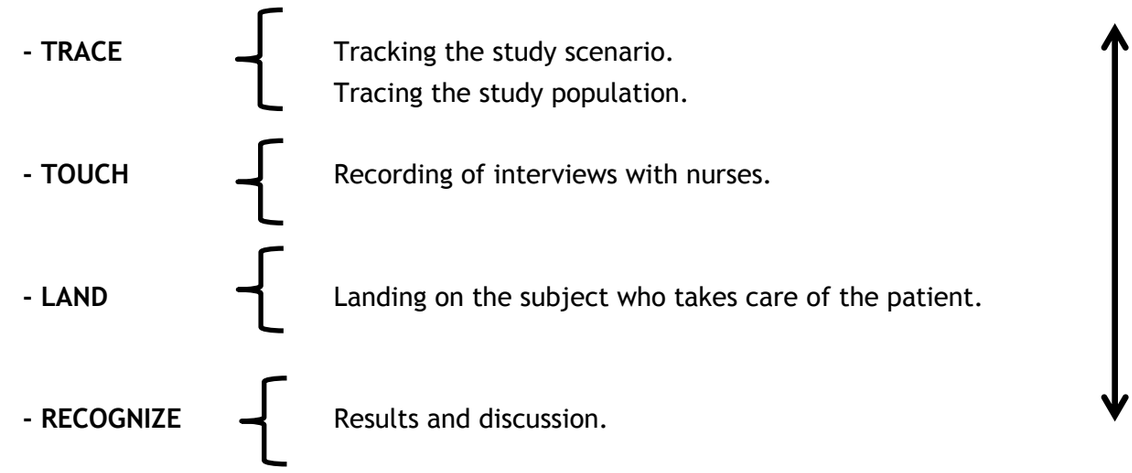

Figure 1: The attention of the cartographer

RESULTS AND DISCUSSION

♦ Demographic data

Of the nurses interviewed, 87% (26) were female and 13% (4) male. Nursing is a predominantly female profession and territory created by Florence Nightingale permitted the opening of a broad social and epistemological space to develop care, covering women's skills and embedding many moral and social values in the very formation of modern nurses.[12]

The age range of the study subjects varied from 28 to 69 years old, with half of respondents (15) were between 31 and 40. These data point to a relatively young team of nursing, which confirms that the majority of nurses are aged more productive in their lives.[13-4]

Regarding religion, 44% (13) reported being Catholics, 33% (10) Evangelicals, 20% (6) said that they have any kind of religion, and 3% (1) spiritualists. Professionals of nursing care for people who profess a wide range of religions and, therefore, should be alert to the way of how spirituality is expressed, in order to share in the spiritual dimension of care. Find distinguishing personal characteristics of each person contribute to the personalization of care and also to build the skills and abilities necessary for excellence in professional practice sought.[15]

It was found that 63% of respondents (19) had more than 10 years of training. This percentage may bear a significant growth in the coming years due to the expected graduates of nursing degree, which has evolved significantly the increase from 2001.[15]

With regard to the time of operation, 73% (22) of the nurses worked for over five years at a general hospital, study setting.

♦ Comfort in palliative care: the landing

Participants were asked about what types of nursing care that they rendered to patients admitted to palliative care in their work

sector. Upon landing in the testimonies of the interviews, it was possible to recognize that the word comfort was raised significantly by the nurses in the study, which gave rise to the following category: promoting comfort and physical dimension of comfort.

Comfort etymologically originates from *confortare in* Latin, meaning fortification, certify, corroborate, grant comfort, relieve, assist, help and assist. The comfort can take the meaning of the act to comfort you and to comfort each other.

According to the testimony, we note that for nurses, nursing actions in palliative care should prioritize the promotion of comfort.

> *Those are cares to promote patient comfort even at death. (E16)*
>
> *Are to promote comfort care to patients who are already in an advanced stage disease at the time did not have a chance of cure or treatment. It is a patient who has reached a final stage and is maintained and measures to ease the pain, suffering, symptoms that give discomfort to the patient. (E7)*
>
> *Palliative care would be the one to provide comfort and well-being of the patient. (E9)*
>
> *Are maintained to ensure comfort, minimize suffering and provide dignified end of life to patients without expectation or cure. (E11)*

It was assumed in the study the following concept of comfort:

> *Comfort is a state of relaxation experienced in the body followed by physical, psycho-spiritual and social well-being because of nursing care and satisfying the needs expressed by the client, which can result in quality life.*[8:54]
>
> Comfort is the immediate experience of being strengthened by having needs for relief, tranquility and transcendence met in four contexts (physical, psychospiritual, social and environmental). "It is much more than the absence of pain or other physical discomforts.[16:14]

One of the special care of terminal patients is to promote comfort through control of symptoms; attention on feeding, body hygiene, according to the conditions and needs of the patient and maintenance of well-being; pleasant environment, coupled with spiritual comfort, stimulate the presence of family members with the patient and demonstration of affection, concern and compassion from professionals.[16]

The statements and observations of nurses, it was noted that the "promotion of comfort" verbalized by them refers almost exclusively to technical comfort, ie nurses relate the promotion of comfort with the technical procedures performed with physical comfort and do not refer to the psycho-socio spiritual comfort. For nurses, comfort seems to have a direct relationship with the absence of physical conditions they deem undesirable for their clients, such as perception of pain and dyspnea.

> *As a nurse I try to offer comfort to this patient in palliative care, this patient needs care and hygiene, nutrition, may need a nasoenteric probe, serum therapy, medication to relieve the pain [...] (E14)*
>
> *I try to provide as much comfort as possible, meeting the basic needs of the patient, for example, if it is with dyspnea I request medical evaluation, I provide oxygen, try to guide technicians to make the pain medication at the right time [...] (E4)*
>
> *Here we work with more patient comfort [...] Comfort is everything that is done to improve survival and relieve pain. (E03)*
>
> *[...] palliative care is to provide comfort on terms of pain, in terms of breathing pattern [...] (E15)*

Observed little concern from nurses with psychological, emotional comfort:

> *You must be present to hear the patient so that he can feel welcomed. Thus, our operations will generate well-being and comfort, physical and emotional comfort [...] (E10)*

Comfort depends primarily about what nurses do and what is comfortable for them.

Florence Nightingale, in her Notes on Nursing has emphasized the importance of making the environment comfortable and desirable goal in the/nursing care. Although the idea of comfort has been addressed in the nursing literature as part of physical care, with emphasis on actions for hygiene, customer's position in the bed, maintaining body integrity, sleep and rest, Nightingale, in the same work, said comfort is an important aspect of care taking into account the quality of nursing care in a practice understood by her as the primary responsibility of the nurse in relation to the process of restoring health.[6]

Comfort is described in three stages: the first is when nurses assess the needs of the individual holistically comfort (physical psychospiritual, sociocultural and developmental /environmental). In the second stage, nurses implement a variety of interventions in the care and must measure or assess levels of comfort and its range before and after the performance of these nursing interventions. There are variables such interventions, positive and negative, but must be considered the range of comfort throughout the development process of care. In the third, the engagement of the patient and family in the process strengthens the

comfort to be prepared, allowing the permanence of the escort who goes to work as a caregiver, with clear definitions of performance, without compromising quality of care, as well as the security ethical aspects.[17]

The comfort is contained in the environment (objective and subjective), the body (for those who care and are cared) and nursing care as facilitator and/or effector agent "welfare".[8]

The subjectivity encompasses a process of training and disinformation pictures/images that allows us to look at what is inside and outside the body. For this author, the subjectivity, the skin is replaced by an illusory density to be ephemeral, as a mobile tissue of forces and flows that make up the variable means involving the subjectivity. However, when considering the subjectivity in the act of nursing care, such consideration is necessary to refer to the need for a look by those who care and who are addressed beyond the physical manifestations and biological character.[18]

In just two interviews were mentioned concern for the family and its importance for patient comfort.

> *We try here at the clinic do the best, the best for the patient and family. At this time, the family wants to stay close as a nurse leader and I always release the family to accompany the family has free access. I think the important participation of the family and thus I notice that the patient is calmer, more comfortable and makes a peaceful departure. (E14)*
>
> *We must always be bringing the family closer to that patient in palliative care. I always leave the family to be present, even if we do not know yet what will happen: death, so I want to have that close relationship with the family and with the patient so that he can feel comfortable and secure. (E02)*

These statements raise the reflection of what is actually understood as comfort and the kind of comfort nurses are promoting these patients living a difficult and unique moment.

The assistance of nurses today is directed primarily to physical comfort, always linked to the implementation of techniques and procedures, leaving aside the spiritual and psychosocial comfort. When a person has a disease that threatens her life, many changes occur. These are more than physical due to the disease and its symptoms are also social, psychological and spiritual and occur only in the person who has the disease as in all family members - everyone will feel some degree of impact of the disease.

Most often, it is the family that the individual seeks help to overcome the difficulties that arise throughout life. The presence of family illness causes rupture with the past life and adjustment to a new social/spiritual reality; implies a process of reorganization in its structure, roles and affective relationships. Changes each family related illness of one of its members depend on the social role of the patient, age, gender and family structure itself. These and other variables will influence the whole process of adjustment, its dynamics and the perception that each stakeholder has on the events.[16]

Caring involves long periods of time given to the patient causing physical and psychological strain. Terminal illnesses generate repeated hospitalizations and treatments, cause changes in the patient's life, but also of their families, given the ineffectiveness of curative treatment, is confronted with the natural course of the disease and the palliative phase. But at the same time, it is known that the participation of the family in providing comfort care to their patients is essential because it allows them to maintain control of the situation when the patient powerless and disease. For the family to play its role as caregiver has to be supported in providing care and informed about the changes that occur.[16]

Communication between health professionals and families is essential and nurses are professionals who play a key role in the orientation and training of these caregivers/family members should encourage and enable direct participation of the family in caring for patients.

Finally, all human beings have, psychological, social, emotional, spiritual, physical practices and information needs.[19] Then incumbent, health professionals, especially nurses for his performance as close to the patient/family, recognize and provide nursing care quality and comprehensive.

CONCLUSION

The expertise of nurses about comfort in patients in palliative care is directly related to its physical component, and involves making techniques and procedures for the relief of pain and physical symptoms only. Psychological, spiritual and social components that also involve the concept of comfort were not mentioned as inherent to nursing care.

Comfort transcends the physical dimension, is much more than the absence of pain involves physical, psychospiritual, social and environmental components. Nurses should act promoting comfort in all its dimensions and do

not answer solely on physical comfort, promoting holistic nursing care.

It is noteworthy that the multidimensionality of comfort requires that the nurse also knows the philosophical aspects of the care and comfort and care for oneself, so it can realize the needs of others and yourself. It is noteworthy that live in comfort means not being comfortable in all aspects of life at the same time, but the ability to maintain or restore the subjective well-being, within their means, the balance between its limitations and potential.

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