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Perception of communication, satisfaction and importance of family needs in the Intensive Care Unit

Percepção da comunicação, satisfação e necessidades dos familiares em Unidade de Terapia Intensiva

Percepción de la comunicación, satisfacción y necesidades de la familia en una Unidad de Cuidados Intensivos

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Abstract

Objective: To identify and compare the nonverbal perception during hospital visits with the level of satisfaction and importance for the family related to their needs during these visits to the ICU. **Methods:** a descriptive and cross-sectional quantitative study. An identifying instrument for the adapted nonverbal communication and the Critical Care Family Needs Inventory (CCFNI) Portuguese version were used. **Results:** the family members have needs that were considered important and these needs were not fulfilled by the multiprofesional and dynamic team in the ICU. Nonverbalsignals for approach and comfort (body position facing the patient and the low voice volume suitable for a ICU) and defense and discomfort (tense facial expression showing anxiety, fear, doubt or even being inexpressive body movements and a rapid rigid and tense posture) expressed by them during the hospital visit. **Conclusion:** The higher the importance of support-related needs assessment, the greater the use of effective nonverbal behaviors during the visit.

Keywords: Nonverbal Communication; Intensive Care Units; Family.

Resumo

O objetivo deste estudo foi identificar e comparar a percepção da comunicação não verbal expressa durante a visita hospitalar com o grau de satisfação e de importância dos familiares em relação às suas necessidades na UTI. **Métodos:** estudo descritivo e transversal quantitativo. Um instrumento de identificação da comunicação não verbal adaptado e o Inventário de Necessidades e Estressores de Familiares em Terapia Intensiva (INEFTI) foram utilizados. **Resultados:** os familiares têm necessidades consideradas importantes que ainda não são satisfeitas pela equipe multiprofissional e dinâmica na UTI. Perceberam sinais não verbais de aproximação e conforto e de defesa e desconforto (expressão facial tensa, de ansiedade, medo, dúvida ou inexpressiva, movimentos corporais rápidos e uma postura corporal rígida e tensa) expressos por eles mesmos durante a visita hospitalar. **Conclusão:** quanto maior a avaliação da importância das necessidades relacionadas ao suporte, maior foi o uso de comportamentos não verbais efetivos pelo familiar durante a visita.

Palavras-chave: Comunicação não verbal; Unidades de Terapia Intensiva; Família.

Resumen

Objetivo: Identificar y comparar la percepción de la comunicación no verbal expresa durante la visita a un familiar hospitalizado con el grado de satisfacción e importancia de la familia en relación a sus necesidades en la UCI. **Métodos:** Análisis cuantitativo descriptivo y transversal. Fue utilizado un instrumento de identificación de la comunicación no verbal adaptado y un Inventario de Necesidades y Factores Estresantes de la Familia en Cuidados Intensivos (INEFTI). **Resultados:** Los familiares tienen necesidades consideradas importantes y que todavía no están satisfechas por el equipo multiprofesional y por la dinámica de la UCI. Se percibió señales no verbales de aproximación y comodidad y de defensa y malestar expresados por ellos durante la visita al hospital. **Conclusión:** Cuanto mayor es la evaluación de la importancia de las necesidades relacionadas con el soporte, mayor fue el uso de comportamientos no verbales efectivos por el familiar durante la visita.

Palabras-clave: Comunicación no Verbal; Unidades de Cuidados Intensivos; Familia.

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INTRODUCTION

During the time of visit, family members can give "non-verbal" clues of how they feel and are living the experience of having a loved one hospitalized in an Intensive Care Unit (ICU). Two-thirds of the meaning of messages perceived by the receiver, in interpersonal relationships, are non-verbal[1,2]. Regardless of the nurse's area of performance, it is essential that they develop the ability to correctly identify the non-verbal communication. This will facilitate the approach and present a distinctive character where there is need for an intervention, both in direct care, as well as with relatives, who are also part of the patient's health care process[3].

The ICU is characterized as a complex unit equipped with a continuous monitoring system, which allows potentially serious or decompensation of one or more organic systems and that patients with intensive support and treatment, have a chance to recover. This environment is associated with higher human and technological resources, but is perceived by family members, often as cold and harsh environment as well as distressing. Hence the need to establish a clear and constant communication, as a means of reducing anxiety responses when facing the possibility of death, separation and changes in the routine of life experienced by family members, who have often perceive their loved ones with a greater severity than might be their reality[4].

The anxiety generated by the possibility of loss and separation, as well as the greater residence time of severely ill patients in ICUs are factors that have led to the need of improving interpersonal communication between all those involved in the treatment, necessarily including the family. Communication in these more acute and stressful situations becomes more complex due to the influence of numerous factors that interfere with the understanding and expression of feelings by individuals who experience this process[5]. Therefore, positive and appropriate behavior in the expression and perception of verbal and nonverbal cues, effective therapeutic relationship and interpersonal interaction can be identified in the dynamics of nursing care in the ICU as important precepts for a more holistic and humane care[6].

Whereas the interpersonal communication as a two-way process that depends on both the sender and the receiver of the message. It becomes necessary that the professional, to take care of the family, decode correctly body signals of remoteness, insecurity, interpret the silence in an appropriate manner, as well as express them self properly, with body posture open and available, showing security by tone of voice and by an appropriate choice of words, in a quiet and reserved place.

For the hospitalized individual, the family is the most important social group and has the function of helping to emotional stability, happiness and well-being of its members[4]. The family can be understood as a dynamic unit formed by people who recognize themselves and organized themselves as a family, sharing and living with the purpose of building a life story. These individuals can be united by blood ties or affectively. This family group has beliefs, values and knowledge influenced by their culture and socio-economic level, sharing rights and responsibilities, as well as promoting growth, development, health and well-being for its members[7].

Family members of ICU patients may experience feelings of uncertainty and helplessness against the inevitable and the unknown. For this reason, they may have the tendency to remain on the defensive and have difficulties to develop a genuine relationship with the healthcare team, maintaining a certain distancing[8].

The care of the patient's family in the ICU nursing staff suggests a more comprehensive approach that includes sensitivity and attention. Even if all available life-sustaining resources vanish, the family should be cared for by staff and never seen as technical resource to their work. For this reason, professionals must have respect and carry out assessment of the family guided by the criteria and clinical trials and interpersonal trust[9].

Caring for the family implies perceiving the other in their gestures and speech, limitations on their concepts and therefore includes conversation and relevant to what the individual wants to know, information sharing efforts and responsibilities. The information must be clear and objective and include clarifications about the diagnosis, prognosis and treatment of the patient and on the equipment, probes, catheters and drains on them. Hence the importance of knowledge of non-verbal signals for identification of doubts, fears, anxieties, among many other feelings that may arise at this point. The relationship with the family can become therapeutic as family trusts and helps professionals who are promoting assistance to their loved one, promoting dialog and mutual respect[6].

Communication is an important factor in the formation of the bond. Communication is the exchange of messages that exerts influences the behavior of people involved in the process and it is through the ability to communicate that man relates and transmits their knowledge to the world[10]. It involves exchange of messages sent and received and influence on behavior, both in the short, medium or long term; it is essential in humanized care[11]. This interpersonal competence or capacity allows the professional decode, decipher and understand fully the patient and his family, allowing a proper interaction between the parties[3].

The communication goes beyond words and contemplates gestures, silence, facial expressions, body movements and distances maintained between people. Many times, by shame, fear, anxiety, among other feelings, family members do not express verbally their needs[10].

Considering the importance of interpersonal communication professional and family for the existence of real care also focused at the heart of the patient and that in Brazil, there are no studies that examine the relationship between the degree of satisfaction manifested by relatives in the care received in the ICU and the

non verbal signals expressed by them during the hospital visits, it is the justification for this study. For an interpersonal relationship and effective with creation of bond, the professional must be available and attentive to non-verbal communication of the family.

OBJECTIVE

Identify and compare the perception of nonverbal communication expressed during hospital visit with the degree of satisfaction and importance of the family in relation to their needs in the ICU.

METHOD

Descriptive cross-sectional study with a quantitative approach carried out in 3 ICUs and 1 Semi-Intensive Hospital São Vicente de Paulo, Jundiai, totaling 45 beds.

Family members of patients were selected through non-probability sampling and convenience, according to the inclusion criteria where everyone should be part of the patient's emotional circle, not necessarily with a blood linked relationship; are adults between 18 and 60 years, with teaching full fundamental (due to the need to complete the instruments) and have a loved being hospitalized for more than 48 hours. Were excluded from family members who do not know how to read or who had not completed elementary school.

Data collection occurred between August and September 2012, after approval by the Faculty of Medicine of Jundiaí Research Ethics Committee - Process Nº 185/2012.

The research subjects were identified by means of an instrument sample characterization with issues related to bond the family with the patient and his prior contact with ICU.

An instrument was designed for the identification of non-verbal communication of family members in the ICU by adapting the behaviors present in the Context of Models of non-verbal Communication[10] the situations experienced in the ICU. The purpose of the instrument was to identify the predominant behaviors of "approximation and comfort" or "defense and discomfort" in relatives in an ICU. The instrument consisted of 20 items that mainly involved kinesics (gestures and body posture), but also proxemics (distance, personal space), touch and paralanguage (tone of voice) towards the ICU environment during the time of hospital visit. The higher the score presented higher frequency of behaviors approach and comfort of the familiar with the patient during the hospital stay and in the ICU environment.

This instrument was applied in the form of an interview to which the researchers could help the subject of the research to identify the own non-verbal communication. We opted for this type of procedure due to the complexity of the non-verbal communication expressed by family members during a hospital visit.

The Needs Inventory and Family Stressors in Intensive Therapy (INEFTI) is a derivative of the Critical Care Family Needs Inventory (CCFNI), adapted and validated for Brazilian culture, which evaluates the importance of the needs of family members of patients in the ICU and the satisfaction with the service in this unit. The instrument addresses needs related to five dimensions: Information, Safety, Proximity, Support and Comfort. The version available in Portuguese is composed of 43 items[12,13]. The scoring system adopted was the same as the CCFNI, with a variation of 1 to 4 (not important to very important and dissatisfied to completely satisfied), in order to facilitate comparison with other studies, so the total score of the instrument may vary from 43 to 172. The distribution of items by size adopted in this study was: security with 7 items (1, 5, 14, 17, 33, 40, 41), proximity with 9 items (6, 10, 29, 34, 37, 38, 39, 42, 43), information with 8 items (3, 4, 11, 13, 15, 16, 19, 36), comfort with 6 items (8, 20, 21, 23, 28, 32) and support with 13 items (2, 7, 9, 12, 18, 22, 24, 25, 26, 27, 30, 31, 35)[12].

Data were analyzed using means, standard deviation, median or absolute and relative frequencies. The total score of the instrument of communication was done by the sum of the behaviors of approximation and comfort, since the behavior of defense and discomfort are antagonistic to them. The scores of the two instruments were evaluated for internal consistency by means of alpha coefficient of 68%, and for normal distribution using the Kolmogorov-Smirnov test. As the normal distribution was not verified, the comparison between the values according to the characteristics of the sample was performed by means of Mann-Whitney tests (when assessed in two categories) and the Kruskal-Wallis test (more than two categories), and among them by means of the Spearman Correlation Coefficient. The level of significance used in sample was 5% and the software used was SAS version 9.2.

RESULTS

For the sample selected for this study, the coefficient of internal consistency and validity of the instrument of non-verbal communication presented a good index (0.72). As for the coefficient of INEFTI - importance was observed a reasonable index (0.65) and the questionnaire INEFTI - a very good satisfaction index was observed (0.90).

The total sample consisted of 40 family members, composed of a majority of women (n = 26, 65%), with high school (n = 24, 60%) and with bond with the patient characterized as intense (n = 35, 87.5%). The participants on average were 42 years ICU. Married Individuals (n = 17, 42.5%), with degree of kinship son or daughter with the patient (n = 14, 35%) and the data collected at the Neurology ICU (n = 15, 37.5%) were the highest incidences in this sample.

The descriptive analysis of the responses of family members through the instrument identification of non-verbal communication (Table 1) showed that the family assess their nonverbal communication behaviors with greater frequency approximation and comfort to the patient during the hospital stay and in the ICU environment.

Table 1. Descriptive Analysis of the areas studied in the instruments applied. Jundiai, 2012

	Score Variation	Average	Standard Deviation	Median
Instrument for the identification of non-verbal communication	0-20	16.6	2.8	17.0
INEFTI Importance				
Safety	7-28	27.8	0.8	28.0
Proximity	9-36	33.9	2.6	34.5
Information	8-32	30.2	1.8	31.0
Comfort	6-24	21.6	2.9	22.0
Support	13-52	47.6	3.9	48.0
Total	43-172	161.1	12	163.5
INEFTI Satisfaction				
Safety	7-28	25.2	4.2	26.0
Proximity	9-36	25.6	6.4	25.0
Information	8-32	25.0	5.2	26.0
Comfort	6-24	16.1	4.6	15.0
Support	13-52	39.6	8.5	40.5
Total	43-172	131.5	28.9	132.5

The behaviors approximation and more comfort for family members were identified using simple, discreet and appropriate clothes for an ICU, then the positioning of the shoulders and torso bent forward and/or facing the patient, toward the feet parallel or facing the patient and the low volume of voice appropriate for an ICU.

The defensive behaviors and discomfort most identified by family members were tense facial expression, anxiety, fear, doubt or insignificant, then the fast speed of their body movements and a stiff or tense body posture during the hospital visit.

Responses to INEFTI showed that relatives gave most importance to their needs than were met (Table 1). Needs considered very important by 97.5% (n = 39) of the family members were 8: (1) know what are the chances of improvement of the patient, (3) be able to converse with the doctor all days, (5) have questions answered with candor, (15) learn what the professionals are taking care of the patient, (17) be sure that the best possible treatment is being given to the patient, (33) receive explanations that can be understood, (39) To receive information about the patient at least once a day, (41) be informed about everything that relates to the evolution of the patient. It is noteworthy that 8 of needs considered very important 5 are related to the Safety dimension. The need considered less important was the item 18 of INEFTI (have a place in which can be alone while in the hospital).

The only need considered fully satisfied by 97.5% (n = 39) of the family was number 2 (to have general guidelines on the ICU on the first visit). The need considered less satisfied by relatives was item 4 (having a person who can give information by telephone).

There was a significant correlation with the responses obtained with the instrument for the identification of non-verbal communication and with the INEFTI in assessing the importance of the Support dimension, being this positive correlation, but weak (0.343 at) (Table 2). Namely, the higher the evaluation of the importance of the related support, greater needs was using behaviors of comfort and approximation by relatives during the visit.

Table 2. Study of the Correlation between the questionnaires used - Instrument for the identification of non-verbal communication and INEFTI. Jundiai, 2012

	Correlation with the Non-Verbal Communication Identification Instrument	
	p-value of r	r
INEFTI Importance		
Safety	0.205	0.205
Proximity	0.648	-0.075
Information	0.768	0.048
Comfort	0.538	0.100
Support	0.030	0.343
INEFTI Satisfaction		
Safety	0.130	0.243
Proximity	0.105	0.260
Information	0.092	0.270
Comfort	0.426	0.129
Support	0.091	0.271

In the Support dimension items considered important by 92.5% (n = 37) of the family members were (2) to have general guidelines on the ICU in the first visit and (27) have someone who cares about my health. This shows an essential question of nursing care in these situations: support means "look at" and recognize the family members as people who suffer and need care for then being aids in patient care.

The responses of the study subjects were analyzed according to the characteristics of the sample. As far As the instrument for the identification of non-verbal communication of family members of patients in the ICU, the responses according to the characteristics of the sample did not differ in a statistically significant manner.

Regarding the comparison of the responses to the INEFTI and the characteristics of the sample studied (Tables 3 and 4), statistically significant differences were found 4 times in Safety dimension and only 1 time in Proximity dimension, showing that, unlike the other dimensions (Information, Comfort and Support), the needs of Security and Closeness may vary with the intensity of the family link-patient, number of times that the family entered into an ICU, location of the patient's hospital stay and age of the family member.

Considering the average found in statistically significant different situations. The highest average size found in Safety-importance dimension was related to an intense family-patient bond (importance of needs). Dimension In Security-satisfaction the highest averages were in Cardiology ICU, among relatives of 35 to 40 years and bond of regular family-patient. The largest average found in dimension Proximity-importance was when the family had already entered into an ICU twice, i.e., it was not the first time.

DISCUSSION

The needs of family members of patients hospitalized in the ICU has been the object of interest in several studies, with different methods, quantitative or qualitative, seeking to identify such needs in intention to implement the planning of interventions that meet the needs of both the patient and the family.

This study highlights the need for Safety as the most important and is in convergence with the validation study and cultural adaptation of the CCFNI, which gave rise to the INEFTI, conducted with 103 family members of patients with brain trauma in that it was identified that 74% of needs considered extremely important or very important were related to Information and Safety. The related to infrastructure, organization and functioning of the ICU accounted for 26% of these needs[12].

The need for safety is related needs to feel secure, less anxious and fearful about the state of health and the prognosis of your loved one. Pointing to the urgency in the implementation of measures that take into account the availability of accurate and clear information about the prognosis of the patient and information about the care provided, about the routines of the ICU and guidelines to which the family can contribute to the well-being of the patient[14].

Hospitalization in the ICU generally occurs in acute form and unexpected fact that affects the family changing their entire routine. The crisis experienced by family members can be observed by the disorganization of interpersonal relations due to the physical distance of the patient, the financial problems and the fear of the loss of the loved one. The family members demonstrate this imbalance by reducing the number of hours of sleep, due to a disorder in supply and increase in use of anxiolytics. Many questions may emerge on the part of the family in these situations, issues concerning the potential sequelae, general condition and possibility of death. Whereas it is important, that the staff is attentive and sensitive to family needs, seeking effective ways to meet their needs[15].

Moreover, one can note the difficulties in establishing a team effective interpersonal communication with family members, whether the possibility of identifying with the situation, by the fears of getting involved emotionally or even by unpreparedness in dealing with situations of loss.

A qualitative study was carried out focusing on similarities and differences of the feelings that emerge from a family in the ICU in a public and private hospital when experiencing the hospitalization of a family member. At the ICU of the private hospital, six thematic categories emerged: (1) difficult, painful experience, no words, (2) put them self in the place and understand the other: approach to the patient's suffering, (3) disruption of the relationship with the family routine, (4) the fear of death of the family member,

Table 3. Presentation of the statistically significant differences found in INEFTI in assessment of importance. Jundiai, 2012

Dimension	Sample Characteristic	Average	Standard Deviation	Median	*p*-value
	Bond	26.8	1.8	28.0	0.0422
Safety	Regular	27.9	0.4	28.0	
	Intense				
	Nº of times that entered the ICU	34.8	1.1	35.0	0.0156
	1	35.3	1.9	36.0	
Proximity	2	32.7	3.1	33.5	
	3 to 10	33.8	2.1	33.5	
	More than 10				

Table 4. Presentation of statistically significant differences in the assessment of satisfaction INEFTI. Jundiai, 2012

Dimension	Sample Characteristic	Average	Standard Deviation	Median	*p*-value
Safety	Location	26.6	1.2	27.0	0.0189
	ICU Neuro	26.4	1.5	26.0	
	Semi Neuro	28.0	-	28.0	
	Cardio ICU	21.0	6.7	23.5	
	General ICU	26.6	1.2	26.0	
	Semi-intensive				
Safety	Age	22.2	7.0	24.5	0.0211
	Less than 35	27.2	0.8	27.0	
	35 to 40	26.0	3.0	27.0	
	41 to 50	25.5	1.4	26.0	
	Over 50				
Safety	Bond	27.4	0.9	28.0	0.0273
	Regular	24.9	4.4	26.0	
	Intense				

(5) ICU: dreaded scenario, but necessary, (6) concern for the care of the family member. In the public hospital, four thematic categories emerged: (1) difficult, terrible and painful experience; (2) ICU - environment that offers fear and care; (3) change in family daily life and (4) possibility of death. The categories that emerged from both the public and the private were converging, allowing concluding that regardless of the characteristic of the institution, the family lives in a similar way the family member's hospitalization process in the ICU[15].

However, another study of 25 family members in a public institution and 19 private institutions of family members that used the INEFTI showed a significantly greater dissatisfaction in the family members of the public hospital. Such dissatisfaction, especially in relation to the needs for support and information, can be related to the reduced number of visits to the patient, that happened once a day and during limited time; the restricted contact with the team of professionals, being that the only professional responsible for providing information about the condition of the patient was the doctor; the absence of integration strategies nurse-family and difficulties of communication, whether on the basis of a lower level of education, or by a change in the emotional state, compromising the interaction with the team and exacerbating the anguish of family members[9].

A qualitative study addressing the same theme obtained as central result that the greater discomfort for the relatives of people who were hospitalized in the ICU is the discontinuity of everyday life, which was characterized by four categories: (1) living the anguish of the possibility of loss, (2) living a division in family life, (3) suffering from changes in social and professional life and (4) having difficulty to take care of them self. These data reinforce the importance to consider the anguish of the family division in family life and changes in social and professional life within the family as part of the nursing care[16].

Understand what the other signals can enable humanization of the service provided and a unique and comprehensive assistance to family, patient and staff. Aiming to identify the perception of the immediate needs (from 48 to 96 hours after admission) of family members, after the admission of a relative in an ICU in Hong Kong, a study compared the perceptions of 37 family rooms and 45 nurses. The Chinese version of the self-report Inventory Needs Family Assistance was used. The findings in order of importance were having answered questions honestly; knowing what employees can give information; see patient with frequency; feel that there is hope[17].

A descriptive cross-sectional study was carried out in four ICUs of public hospitals in the north and middle Jordan with the aim of identifying the needs perceived families of hospitalized critical patients. The research Participants were family members of hospitalized patients within 18 to 72 h after the admission. The needs identified as most important were the Information, Safety and Proximity. In addition, those of lesser importance were Support and Comfort[18].

More attention in communication expressed and perceived can significantly improve the assistance. The non-verbal communication is transmitted by means of gestures, postures, and facial expressions, orientations of the body, disposal of objects or even the distance between the individuals[10].

The non-verbal signals determine how to interpret the attitudes and words once the facial expressions activate the emotional responses of the listener, facilitating the interpretation of the message. It is important that the nurse is attentive to these signals to be implemented measures to improve assistance to families and the interpersonal relationship of the multiprofesional team and the family toward a care that really add the assistance.

However, for which there is a more effective action by the team, attention is required as to the interpretation of communication

in its entirety. This requires training and provision, because only the set of signals enables the perception of trusted message, and recognize that it is necessary a time that to interpret the communication from another you must learn to deal with their own way to communicate[10].

The needs of the family of patients hospitalized in the ICU can be further explored, as well as satisfied, continuing with the investigations that we show more and better, as the family experiences such experiences. Thus constituting benchmarks that allow health professionals perceive such needs, giving more consistency and sense the propositions of care and their interventions, benefiting those who cares, who is careful and who apparently is of spectator, as the family.

CONCLUSIONS

The family rooms have needs considered important that are still not satisfied by the multiprofesional team and dynamic adopted in the ICU.

The family members perceived nonverbal signs of rapprochement and comfort (body position facing the patient and the volume low and appropriate voice for a UTI) and defense and discomfort (strained facial expression, anxiety, fear, doubt or meaningless, rapid body movements and a rigid and tense) body posture expressed by them during their hospital visit.

The majority of the needs deemed important by family members in this study depends on the initiative of the professionals to improve the relationship with the family, explaining the chances of improvement and properly informing the evolution of patient, talking all the days and, at the very least, once a day, answering questions with candor, clarifying what the professionals who are providing care directly from the patient, ensuring that the adopted treatment is the best possible, giving explanations of an easy way to be understood.

Comparing the two instruments used in this study, the higher the evaluation of the importance of the needs related to support, the greater was the use of non-verbal behaviors effective by family during the visit.

This study contributes to the area of healthcare, not just the ICU professionals, it reflects on the importance of the communicational professional posture in their daily work, which can elevate the concept of user/patient satisfaction, even not having all the desired conditions or material resources.

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