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Original Article

Family members' perceptions of nursing care for people with psychiatric symptoms

Percepções de familiares sobre o cuidado de enfermagem às pessoas com sintomas psiquiátricos

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ABSTRACT

Objective: to understand family members' perceptions of nursing care for people with psychiatric symptoms**. Methods:** qualitative study, with 13 family members, in five clinical inpatient units linked to the clinical nursing service of a general hospital. Data were collected through semi-structured interviews. **Results:** the challenges perceived by family members were turnover of professionals in the work schedules and difficulty in specialized management. The participants suggested training of the team, greater multi-professional integration, improved management and reduced turnover of professionals during care. **Conclusion:** family members verbalized difficulties and suggestions to support reflection on the care offered to people with psychiatric symptoms hospitalized in clinical units, in order to improve work practices and qualify care.

Descriptors: Nursing Care; Mental Health; Family; Psychiatry; Hospitals, General.

RESUMO

Objetivo: compreender as percepções de familiares sobre o cuidado de enfermagem destinado às pessoas com sintomas psiquiátricos. **Métodos:** estudo qualitativo, com 13 familiares, em cinco unidades de internação clínica vinculadas ao serviço de enfermagem clínica de um hospital geral. A coleta de dados ocorreu mediante entrevistas semiestruturadas. **Resultados:** os desafios percebidos pelos familiares foram: rotatividade dos profissionais nas escalas de trabalho e dificuldade de manejo especializado. Os participantes sugeriram capacitação da equipe, maior integração multiprofissional, melhora do manejo e diminuição da rotatividade dos profissionais durante o cuidado. **Conclusão:** os familiares verbalizaram dificuldades e sugestões para subsidiar a reflexão sobre o cuidado ofertado às pessoas com sintomas psiquiátricos internadas em unidades clínicas hospitalares, a fim de melhorar as práticas de trabalho e qualificar o cuidado.

Descritores: Cuidados de Enfermagem; Saúde Mental; Família; Psiquiatria; Hospitais Gerais.

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Introduction

From 2011, mental health beds in general hospitals became part of the Psychosocial Care Network, aiming to structure services that replace the mental asylum model[1]. These services advocate care in freedom and in the territory, with hospitalization being the last resort of treatment for people with mental disorders.

It is estimated that 25.0% of the world population present at least one mental disorder at a certain stage of life. In Brazil, mental disorders affect approximately 20.3% of the population[2]. Thus, compared to the general population, people with chronic diseases have higher rates of mental disorders, while they have a higher risk of developing chronic diseases[3-4] , and may come more frequently to health services, requiring hospitalization in clinical and/or surgical units[1].

In this sense, the presence of family members during hospitalization is essential, considering the need for attention and support that the hospitalized person demands[5]. From the changes experienced in mental health, the family has gained an important role in caring for people with psychiatric symptoms, being considered a fundamental part in the rehabilitation process. These families live a daily life full of challenges and, in most cases, actively participate in care[6], either at home or in the hospital environment.

However, many families end up receiving little support from the health system when inserted into care and are often unaware of aspects related to the behaviors, anxieties and challenges existing in the relationship with the hospitalized person. In this sense, this support nucleus needs the support of the nursing team, either to clarify the diagnosis or to provide guidance about the recovery process[7], which may help to face and manage the problems related to the disease, with more autonomy and safety[8].

Thus, the involvement of the family in the therapeutic process makes interventions more efficient, especially the patient's adherence to treatment, since therapy should not be limited only to the use of psychotropic drugs and/or procedures, but to integral and humanized care[8]. In this way, the insertion of the family in hospital care helps in the demands of the hospitalized patient, collaborating to monitor the care offered by nursing, besides making the connection between the needs verbalized by the patients and the care offered by these workers[5].

In this scenario, the care provided in the hospital environment requires preparation of nursing professionals, as assistance goes beyond drug administration, being an individual and collective process that must involve the context of each patient. Therefore, it is necessary that this team pay attention to the organization of its own practices, seeking to allow the approximation and sensitive listening to the patient, including the family in these spaces, providing qualified care[9].

Thus, this study is justified by the need to understand the perception of family members regarding the nursing care offered to people with psychiatric symptoms hospitalized in clinical care beds, since many have concomitant acute and/or chronic diseases. Moreover, the families of these people need to be included in the treatment, in order to favor rehabilitation and facilitate the hospitalization process, and it is up to the nursing staff to favor this insertion, meeting the changes recommended in the mental health area. This study aimed to contribute to qualify the care offered by the nursing team to people with psychiatric symptoms hospitalized in clinical units, from the families' point of view. Therefore, the guiding question was: what are the perceptions of family members about the care given to people with psychiatric symptoms?

This study aimed to understand family members' perceptions of nursing care for people with psychiatric symptoms.

Methods

Qualitative study[10], conducted in five clinical inpatient units, linked to the clinical nursing service

of a general hospital in southern Brazil. The hospital has 919 beds, of which 192 are part of the clinical nursing service, and 23 beds are intended for people with psychiatric symptoms, which are adapted to accommodate them, with bars on the windows and greater proximity to the nursing station.

At the time of data collection, of the 23 inpatients, 18 had family members present. Family members responsible for the patient were interviewed on this occasion, after previous signaling from the nurses of these units before the approach of the researcher. The responsible nurse was asked about the presence or not of a family member, communication conditions, and age of majority. After this signaling, the researcher went to the bed of these inpatients and proceeded to the presentation and invitation to participate in the study.

The inclusion criteria for the study were: family members of clinical patients with psychiatric symptoms hospitalized in beds intended for this public who had good communication skills and were familiar with the current care. The exclusion criteria were family members under 18 years old. Thus, thirteen family members met the criteria.

The semi-structured interview technique was chosen to collect the information, in which, in the first part of the script, identification data were obtained, such as age, gender, education, and, in the second part, the question was addressed: talk about the care provided to your family member with psychiatric symptoms in this unit.

Data collection occurred in October 2019, on the premises of the inpatient units of the study, in a room reserved for the interview, with the presence only of the researcher and the family member, with no need for further meetings. The average duration of the interviews was 30 minutes, which were recorded on audio devices and later transcribed verbatim for analysis. Anonymity was established, identifying them by the letter F for family member, followed by the number of the order in which the interviews occurred: F1, F2... F13.

Content analysis was the technique chosen for the analysis of information, according to five steps[10]: preparation of information, unitarization or transformation of content into units, categorization or classification of units into categories, description and interpretation. During data analysis, a floating reading of the interviews was performed for familiarization, preceded by exhaustive readings, aiming to understand the material, enabling the grouping into two analytical categories: Challenges for performing the care to the clinical patient with psychiatric symptoms and Suggestions for performing the care to the clinical patient with psychiatric symptoms.

The study was approved by the institution's Research Ethics Committee, under No. 3,689,029/2019, and met the aspects required by Resolution 466/2012. Terms of Free and Informed Consent were provided to the participants.

Results

Regarding the profile of the interviewees, two were between 20 and 29 years old; two, between 30 and 39 years old; three, between 40 and 49 years old; one, between 50 and 59 years old; four, between 60 and 69 years old; and one, between 70 and 79 years old. Regarding sex, six were female and seven were male. Regarding education, six had completed higher education; five had high school education; and two had elementary school education. The reasons for hospitalization were clinical issues, such as lung disease, diabetes, and heart failure; in people with psychiatric comorbidities, depression, eating disorders, and symptoms of alcohol dependence.

Challenges in performing care for clinical patients with psychiatric symptoms

In this category, family members pointed out the challenges evidenced in the execution of care, such as the high turnover of professionals in the work schedules and the lack of specialized management.

The high turnover and the non-standardization of care provided by professionals were pointed out by the interviewees as difficulties experienced by them in the hospital environment in these units: *There is variation from one professional to another, there are professionals who are more dedicated. You must really like it* (F1). *It depends on some teams that are in shifts, the management could be better, in terms of schedule, we realize that it is messy sometimes* (F9). *Of course, there have been many changes, many rotations of professionals, but nothing that disqualifies them* (F13).

Family members verbalized that they were not fully satisfied with the rotation of the nursing team, because they believed that it compromised the bond with the patient, interfering with the quality of care. Furthermore, they understood team rotation as a disorganization of the unit and, consequently, of the care provided to the family member. It is noteworthy that the nursing professionals are organized in six-hour shifts, that is, every new shift, workers are changed, making the bond with the inpatient difficult, according to the perception of the family members.

The lack of specialized management was also reported by the participants as another challenge observed in the care offered by the team. This difficulty in management may be related to the lack of preparation of professionals, considering that these workers are allocated in non-specialized units in the mental health area*: They do not have that structure to talk to the patient, they go straight to the chemist and do the restraint to calm down. Then, they give medicine in the morning or afternoon, and it works at night. They do not have the exact training for psychiatry because here it is clinical, so they end up treating the psychiatric patient through clinical pathology. For example, you are not going to come to a patient with depression in an aggressive way, he is going to get weird, he is going to back off, he is not going to give you any openings. The care had to be specific, to treat not only the clinical pathology of the patient* (F6*). There are some that arrive with the greatest care and, most of the time, they arrive already putting the oximeter on their finger, there are some that come here and say, "give me the finger". What I think is that when they are going to do this kind of procedure, they must explain why. That it is for your own good, to make you better, not just come and say that they are going to do this and then give it to you. This talking beforehand even calms the nervousness and anxiety* (F1). *They should only have a preparation with her psychology, you know, because nobody comes and talks, they just give up the food, the food, the medicine and leave, they should have a little more dialogue with her, a conversation at certain times* (F4).

Management remains one of the fundamental factors for care in the perception of family members since they observed the lack of preparation of workers to deal with people with psychiatric symptoms in the clinical unit. In this sense, care is sometimes reduced to the clinical illness, with emphasis only on technical procedures and the suppression of psychiatric signs and symptoms.

In addition, the interviewees verbalized the importance of professionals explaining in advance the procedures that will be performed both for the patients and their families. This attitude demonstrates safety and calms those involved in the care process, corroborating better management of the worker with these patients.

Suggestions for implementing care for clinical patients with psychiatric symptoms

In this category, the family members pointed out some suggestions in order to improve nursing care, such as training in the specialty of mental health, greater integration of professionals involved in the care, improvement in the management offered, and standardization of unit routines, in order to reduce the turnover of workers.

The interviewees mentioned the importance of training in the area of mental health for professionals who work in the clinical units, in order to qualify the approach to the patient and the care offered: *A course or a lecture on how to approach psychiatric patients and what are the risks for you and for them. Train the team more. It is not their fault, this is a clinic, but they must train, change their approach. More training in mental health would be very welcome and the patients would thank us* (F6*). There are some that you know that need to participate in some more courses, because they are still a little fragile in this area* (F7).

The absence of knowledge in the area of mental health is an aspect that interferes negatively in the quality of care mentioned by the interviewees, since it shows the fragility of these professionals when facing a person who presents other demands for care and the family member. In addition, the skills acquired in the area of mental health, associated with clinical knowledge, would help the nursing team in the execution of integral care.

The greater integration between the professionals involved in the care of the clinical patient with psychiatric symptoms favors the exchange of experiences, in which the person is perceived as a whole, having the needs met in the different spheres, according to the area of action of each worker*: Speaking of psychiatry, I believe that there could be more integration, a multidisciplinary joint, the psychiatric staff could integrate with the emergency staff, an exchange of ideas. The care is lost, it is another type of service, you end up getting used to working in that sector. I think it is interesting to have a conversation between one group and another, once a week, once a month* (F2). *A psychologist or psychiatrist coming here to talk, I think it is important* (F10).

As pointed out by the family members, the exchange of knowledge and information among professionals would provide a humanized and integrated care to patients, because the communication between sectors and workers from different areas would narrow the dialogue, avoiding loss of information, facilitating the care and psychiatric management.

The improvement of the management offered to the patients was cited by the family members interviewed as one of the suggestions to qualify the assistance to these people. They stated that conversation is one of the factors for quality care and that it is important to pay attention to those who are more demanding*: I think especially with older people, for example, my mother turned 82 years old in here. No matter how annoying and complaining she is, you must have this understanding with the elderly person* (F1). *In the sense of more attention and some things, you know... I just think that we need to improve the issue of conversations to calm him down* (F5*). I do not really know the norm in the hospital, but if I could talk more, it would be good. Talk, get some information out of her, because she does not talk much* (F8).

The family members pointed out that the conversation becomes a fundamental point for the management of the psychiatric patient, because, many times, the greatest demand is to have someone to talk to and share some experience. Thus, when they realize that they are being listened to, they feel more welcomed. Therefore, active listening is an indispensable indicator for the quality and improvement of the general condition of clinical patients with psychiatric symptoms.

Another suggestion from the interviewees was to review the way the schedules were organized in the clinical units. Standardizing the routines in these units and reducing the turnover of workers would facilitate the knowledge of patient demands and the establishment of the link, which sometimes ends up being harmed due to the rotation of the nursing team schedules: *This unit has a lot of turnover, a nurse who takes care of it today, will take care of it in three days, so, they do not integrate each patient very much, you know. I think that if the professionals were fixed for the patients, it would be better. To know a little more of their history* (F4). *I think that improving this question of organization, of management, having a standardization between shifts and such ... the question of silence, I think is important. It improves for the patient and the companion* (F9).

The management of the unit, as far as the nursing team is concerned, must analyze and reevaluate the unit's routines, enabling operating structures that also add to the well-being of the patient and the family member, as well as to the bond with the professional.

Discussion

The study has limitations, since it was carried out in a single hospital service, making it impossible to generalize the results. Thus, it is suggested that broader research be conducted in other settings, with different participants. Further research should also focus on the perceptions of nurses and people with psychiatric symptoms involved in care.

With this study, we hope to have given visibility to the perceptions of these patients' relatives, since

they are not always valued as an integral part in the rehabilitation process. Furthermore, the information from this research can help and stimulate new studies, as well as encourage health managers to perceive the challenges and suggestions that allow the adaptation of nursing care to people with psychiatric symptoms in clinical units, meeting what is recommended in psychosocial care.

The rotation in the work schedule, besides providing professional development, can promote personal performance, improving confidence to perform new tasks, optimizing flexibility in the work community, making work life more dynamic, and providing opportunities for workers' skills in different routines[11].

In this context, the activities that demand more attention may require greater rotation among team members, in order to provide a better division of tasks among workers[12]. On the other hand, the rotation may hinder the creation of a bond between patient and professional, an indispensable item for mental health care.

Thus, the nursing scales need to be reviewed in order to provide greater welfare to professionals, which will have repercussions on the quality of the assistance offered and satisfaction of family members, workers, and patients, will guarantee the continuity of care, and will avoid a break in the standard of care[13].

The lack of management was another difficulty highlighted by the interviewees for the execution of care when dealing with clinical patients with psychiatric symptoms. The challenges related to the stigma surrounding madness, the psychiatric diagnosis that labels the patient, and the lack of management may be associated with the difficulty professionals have in dealing with these inpatients. These representations, in turn, negatively influence the quality of care provided by health professionals[3]. The unpreparedness to approach and welcome patients and family members who go through moments of suffering in the hospitalization process is related to insecurity, fear and thoughts of incapacity, due to the limitations in knowledge for solving psychiatric crises[14].

In this context, the feeling of insecurity, when providing nursing care, can motivate unnecessary mechanical and chemical restraints by professionals, because they do not know the proper way of handling during care[14], focusing only on clinical signs and symptoms, with emphasis on the hegemonic medical model[3]. The training in mental health was brought as a suggestion by family members for a qualified care. Professional training for the care of people with psychiatric symptoms should be prioritized in undergraduate academic spaces, in order to stimulate the improvement of knowledge and specific skills for the assistance to these patients[15].

Health education is one of the most effective strategies for the qualification of workers, since they are determinants for a comprehensive and humanized care, which aims to return the patient home. Therefore, educational actions in the health sector need to be configured according to the demands and singularities of each work segment, in order to achieve transformations in the modes of care and management[16].

In addition, the workload stipulated for mental health subjects needs to be reviewed and internships in the healthcare network and specialized services should become mandatory. This valorization allows the training of professionals who are more prepared and aware of the transformations in the area, which will have repercussions on the care offered to patients[17]. Thus, the stimulus to critical and reflective thinking about professional performance can be developed during the internship, a unique period in the formation of the student in the area of mental health.

The demand for a greater dialogue among the professionals of the multidisciplinary team was another aspect verbalized by the family members, aiming at a more integral and less fragmented care. The learning of activities in different areas that make up a single health team is essential for patient care but working in a team goes beyond being together or just passing information from one to the other, it requires effective collaboration among members in order to

ensure complementation and interaction among all areas[18].

Therefore, interdisciplinarity provides a plural care, in which the user is the common denominator of the union of care practices. Therefore, team meetings allow the consolidation of an interdisciplinary work process that considers the demands of the assisted individual, thus constituting a valuable technology for the management of mental health care[19].

The crisis care of patients with psychiatric symptoms in general hospitals is a difficult issue to manage for most health professionals. Thus, another suggestion reported by the interviewees is that workers working in clinical units can improve the management of these inpatients.

The evaluation and management of mental health patients are complex and require multiple skills and knowledge that need to be applied in an integrated manner and with agility, because it is necessary that all team members involved, during the intervention of the situation, analyze collectively each conduct, approach and procedures to be instituted. Moreover, the understanding of possible failures in management is important for the training of workers to approach and intervene in similar cases. This thought coming from professionals can be performed in an attentive and receptive manner, never with the intention to punish[20].

The reduction in the turnover of professionals who build the care was another suggestion of the interviewees to strengthen the bonding process, especially, the rotation in scales provides an opportunity to recognize all activities and training in different tasks, which favors the best distribution, without generating overload for workers[13]. However, it is understood that, in the mental health area, the creation of bond and affection are indispensable items for the treatment, not being compatible with the high turnover of professionals for this care.

The bond facilitates the work of professionals in health services because the fact of caring about others, dedication, empathy and existence of humanized care are supports for the professional to help with quality and excellence[20]. Thus, general hospitals need to adapt to these patients, in order to recognize that this is one of the points of care of the Psychosocial Care Network and that it needs workers who have an individualized approach, in which affection and bonding are indispensable items and are sometimes hindered by the high turnover of professionals.

Conclusion

The family members verbalized difficulties and suggestions to subsidize the reflection on the care offered to people with psychiatric symptoms hospitalized in clinical units. The families also pointed out some difficulties in the process of inpatient care, such as rotation of work schedules and lack of specialized management by some professionals. The rotation of workers and the inadequate management with people with psychiatric symptoms hospitalized contributed to the difficulty in establishing a bond and empathy, which are essential to bring professionals and patients closer together.

In order to improve assistance, the participants suggested the integration of multidisciplinary teams, because due to the high turnover of professionals in the units and in the hospital, assistance is interrupted, in addition to offering courses as an action that can contribute to the quality of assistance and, consequently, improvement in the management of clinical patients with psychiatric symptoms.

Collaborations

Oliveira AM and Duarte MLC contributed to the conception and design, data analysis and interpretation, writing of the manuscript, relevant critical review of the intellectual content, and final approval of the version to be published. Silva DG and Mattos LG contributed to the relevant critical review of the intellectual content and final approval of the version to be published.

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