Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: http://dx.doi.org/10.12957/reuerj.2020.48849

Process of hospitalization in surgical-clinic unit at a public university hospital

Processo de internação em clínica cirúrgica de um hospital público universitário

Proceso de hospitalización em unidad clínica quirúrgica de un hospital universitario público

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ABSTRACT

Objective: to describe the current process of calling patients in for surgical-clinic unit, as well as communication between multidisciplinary team and patient in the preoperative period. **Method:** in this exploratory, qualitative, descriptive study, the 28 participants were members of the multidisciplinary team of surgical-clinic unit of a university hospital in Rio de Janeiro. Data were collected from February to April 2019 using two semi-structured interview scripts. The study was authorized by the research ethics committee. **Results:** the lack of planning and protocols and the intense flow of patients led to doubts, stress, and cancellation of surgeries during hospitalization. **Conclusion:** the absence of protocols coupled with actions and training impaired the hospitalization process, as well as communication between multidisciplinary team and patient. The line of care comprised: anamnesis, vital signs, medication reconciliation and general guidelines.
Descriptors: Hospitalization; Nursing Care; Communication; Perioperative Care.

RESUMO

Objetivo: descrever o atual processo de convocação de pacientes para procedimento cirúrgico, bem como a comunicação entre a equipe multiprofissional e o paciente no período pré-operatório e identificar a linha de cuidados prestados pela equipe multiprofissional no período pré-operatório. **Método:** pesquisa exploratória, descritiva e qualitativa. Amostra contemplou 28 participantes, membros da equipe multidisciplinar da clínica cirurgia geral de um hospital universitário do Rio de Janeiro. Os dados foram coletados por dois roteiros de entrevista semiestruturada, de fevereiro a abril de 2019, após autorização do Comitê de Ética em Pesquisa. **Resultados:** a falta de planejamento, protocolos e fluxo intenso de pacientes levou a dúvidas, estresse, cancelamento de cirurgias no decorrer da internação. **Conclusão:** a ausência de protocolos articulados com ações e treinamentos prejudicou o processo de internação, bem como a comunicação entre a equipe multiprofissional e paciente. Fizeram parte da linha de cuidados: anamnese, sinais vitais, conciliação medicamentosa e orientações gerais.
Descritores: Hospitalização; Cuidados de enfermagem; Comunicação; Assistência Perioperatória.

RESUMEN

Objetivo: describir el proceso actual de convocatoria de pacientes para unidad clínica quirúrgica, así como la comunicación entre equipo multidisciplinario y paciente en el período preoperatorio. **Método:** en este estudio exploratorio, cualitativo, descriptivo, los 28 participantes eran miembros del equipo multidisciplinario de la unidad clínica quirúrgica de un hospital universitario de Río de Janeiro. Los datos se recopilaron de febrero a abril de 2019 mediante dos guiones de entrevistas semiestructurados. El estudio fue autorizado por el comité de ética en investigación. **Resultados:** la falta de planificación y protocolos y el intenso flujo de pacientes generó dudas, estrés y cancelación de cirugías durante la hospitalización. **Conclusión:** la ausencia de protocolos sumados a acciones y formación perjudicó el proceso de internación, así como la comunicación entre equipo multidisciplinar y paciente. La línea de atención comprendió: anamnesis, constantes vitales, conciliación de medicamentos y pautas generales.
Descriptores: Hospitalización; Atención de enfermería; Comunicación; Atención Perioperativa.

INTRODUCTION

The work processes in health institutions happen in different configurations, and it is possible to state that some operating methods offer more adequate results in the care of human health[1]. Based on this reference, the empirical observation of the actions that make up the hospitalization process for performing a surgical procedure in a university hospital was the reference for this study.

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Received: Mar 3rd 2020 – Accepted: Aug 12th 2020

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: http://dx.doi.org/10.12957/reuerj.2020.48849

Hospitalization is an uncomfortable circumstance for the individual and the family, since it changes their life habits, day-to-day activities, and privacy, in addition to keeping them apart from their family and to significant devices. The surgical procedure can represent a remarkable moment in the person's life, generating doubts and vulnerabilities, which may impair the patient's recovery after the surgery[2].

Both in this study and in the daily practice, it is perceived that the hospitalization process causes anxiety, stress, and fear of pain and anesthesia in the patient. It is worth noting that the real content of the patient's social circumscription is not known, so it is difficult to estimate how much and how the surgical experiences influence on the individual, making it necessary that, in the multidisciplinary preoperative admissions, based on technical scientific knowledge, the surgical patient is allowed to understand the entire process[3,4]. Preoperative admissions help to identify risk factors and to clarify the patient's and family's doubts about the surgical process in a clear and objective way, aiming at the humanization of the health actions and services[4].

In this segment, the National Regulation Policy in Brazil, regulated in 2008, presents three guidelines. They are as follows: regulation of health systems; regulation of health care, and regulation of access to assistance. These guidelines aim to achieve equity and humanization in order to guarantee access to the population groups most in need of health, attenuating the relationship between the need and the offer to perform a surgical procedure[5,6].

Surgical procedures are intended to preserve lives, understanding that this fact requires attention in promoting safe care, at all levels of assistance. Therefore, effective communication between the multidisciplinary team becomes necessary in order to reduce adverse events. These events are defined as incidents generated by the care process, which result in real harms of varying magnitude to the patient's health. In this case, the team needs to be well-grounded in order to reduce harms to the patient and, in addition, be the light for comprehensive and humanized care[7,8].

From this perspective, it is assumed that guiding, sensitizing, and welcoming the patients in the pre-surgical period can reduce their insecurity and other stressors in the hospitalization process. In this way, they minimize physiological changes and contribute to the prevention of complications, showing how much the multidisciplinary team's actions are essential in this process, thus justifying this research.

The study aimed to describe the current process of summoning patients for a surgical procedure, as well as the communication between the multidisciplinary team and the patient in the preoperative period, and to identify the care provided by the multidisciplinary team in the preoperative period.

METHOD

This study comprises an exploratory, descriptive, and qualitative field research. The setting was a general surgery clinic in a university hospital, located in the municipality of Rio de Janeiro. Currently, the inpatient unit has 18 beds, nine of which are for men and nine for women. Patient turnover is high, expressed by the mean hospital stay of three days.

The participants of the study were the members of the multidisciplinary team composed of Nursing technicians, nurses, and Medicine, Nutrition and Psychology interns working at the general surgery clinic, as well as the administrative employee of the Internal Regulation Center (*Núcleo Interno de Regulação*, NIR).

The sample was closed at 28 participants, a number outlined during the fieldwork, when the organization of data and testimonies presented data saturation, that is, the verification of the particularity of the findings in the interviews, in agreement with the topics and with the veracity of the statements.

In data collection, which took place from February to April 2019, two semi-structured interview instruments were used, both with open questions regarding the hospitalization process, communication, and conducts with the patient, as well as closed questions about socio-economic and demographic data. The first instrument was targeted to the medical interns and consisted of seven questions; and the second, with five questions, was directed to the team of Nursing interns, nurses and Nursing technicians. The seven guiding questions of the interview were the following: 1. *What criteria or factors do you use to invite the patient to go to the hospital, with a view to performing the surgical procedure?* 2. *How and when do you inform the team that the patient will be admitted to the unit to undergo a surgical procedure?* 3. *How is your communication with the multidisciplinary team and with the surgical patient?* 4. *Do you welcome the patient at the time of admission? If so, how is the reception? If not, please justify your answer*. 5. *What conducts do you implement in the patient's preoperative period?* 6. *Do you consider that the form that the hospitalization process takes has any consequences for the patient in the perioperative period? Which?* 7. *Do you have any suggestions for improving the implementation and reception phases in the preoperative hospitalization process for the surgical patient?*

Research Article
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The study was carried out in accordance with Resolution No. 466/2012[9], with a favorable opinion from the institution's Research Ethics Committee (REC), under protocol/opinion No. 3,094,455.

The participants were informed about the interview process, previously scheduled, guaranteeing autonomy, non-maleficence, beneficence, justice, and equity. Thus, the aim was to ensure the rights and duties of the research participants. The interviews were conducted in a private setting in the general surgery ward, recorded on digital media, stored in *Windows* folders, transcribed, and analyzed.

The method used to characterize the participants was alphanumeric coding with letters E for nurses ("*Enfermeiros*" in Portuguese), TE for Nursing Technicians ("*Técnicos de Enfermagem*" in Portuguese), RM for Medical interns ("*Residente Medicina*" in Portuguese), RN for Nutrition intern ("*Residente Nutrição*" in Portuguese), RP for Psychology intern ("*Residente Psicologia*" in Portuguese), and PA for Administrative professional ("*Profissional Administrativo*" in Portuguese), followed by a random number sequence, in order to preserve anonymity.

Content analysis followed these stages: pre-analysis; exploration of the material or coding; treatment of the results, inference, and interpretation[10,11].

After skimming the testimonies, the units of meaning were selected, characterized by phrases, resulting in 628 Registration Units (RUs). They were grouped into 41 topics, divided by similar subject matters, from which three major categories and four subcategories emerged based on the quantification of the registration units for each topic.

RESULTS

The organization of the data generated two dimensions of results. The first is related to a brief characterization of the participants. The second presents the three categories, and their subcategories, and the participants' statements organized according to the research objectives.

Characterization of the participants

As for the interviewed participants, two groups were observed – one that works as permanent professionals and one temporary group, composed of multidisciplinary interns.

Most of the interviewees were professionals belonging to the institution's permanent staff – 17 (60.71%). Regarding gender in both groups, 24 (85.71%) were females. The most present category was that of nursing technicians, with 13 (46.43%) participants. On the other hand, in the group of interns, the ones who stood out the most were the medical interns, with 8 (28.57%).

Regarding the age group of the participants, it was from 20 to 59 years old. The age group more evidenced in both groups was 30 to 39 years old, with 9 (32.14%) professionals. Regarding the time of professional experience, the period from 1 to 7 years stood out, with 25 (89.29%) of the interviewees.

Description of the categories

Category 1 - Communication/Interaction

It addresses the institutional communication between professionals and patients and comprised 316 (50.32%) RUs, being the most eloquent of the categories, composed of two subcategories.

Subcategory 1 - Communication between the multidisciplinary team and the patient in the preoperative period

In this subcategory, topics such as effective and quality communication with the patient were addressed; in contrast, there were reports of poor communication between the medical team and the patient.

> *Try to be as objective as possible, clarifying the questions about dependence, informing the daily activities of the unit in a clear and simple way so that everyone understands them (TE 01).*
>
> *We see that the patient is not fully informed; some doctors don't interact with either the team or the patient, this happens here (...) (TE 02).*
>
> *Communication with the patients; as I see it, some doctors just don't do a good work and the patient feels very lost (E 19).*

Accordingly, it is evident that ineffective communication between the team and the patient impacts directly on the daily activities and on humanized reception, evidencing the identification of physiological and psychological changes in the patient, as described in some statements.

> *I notice that the patient comes unprepared to the hospital; some don't bring clothes or hygiene products. They arrive here in the morning, but they will be hospitalized only in the afternoon, they will only eat dinner, and patients are affected by this lack of information (E 08).*

Research Article
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> *It affects mainly the pressure, you can see it perfectly; then they come here, their pressure is high, they're nervous, sweating, I say: 'Guys, calm down!' Calm down that everything will be alright (laughs) (TE 22).*
>
> *Sometimes they are informed in the same day, they have to be here today; this causes some stress, is scary and causes anxiety; they arrive here with high blood pressure (TE 18).*

Subcategory 2 - Communication among members of the multi-professional team

This subcategory revealed situations of poor communication due to the lack of planning for admission and discharge, but there were also reports of teamwork and partnership.

> *It is confusing at times because the physician admits the patient and does inform us about this, and then we are lost, we don't know if they are going to do any procedure (TE 01).*
>
> *I don't always find a physician here, but whenever I have a question, I send a message and I can communicate with them and with you (RN 11).*

Category 2 - Hospitalization process

This category included 200 (31.85%) RUs and reports issues that interfere with the hospitalization process. It has two subcategories, described below.

Subcategory 1 - Surgical patient summoning process

It discusses neglect, difficulties, and gaps found in communication and the impact for the user.

> *There are patients who come here and wait five, six hours, they feel uncomfortable and then they get agitated, the pressure goes up, causes some problems, mainly due to the physician's lack of organization (TE 01).*
>
> *The other day the physician called the patient at six o'clock at night, she turned to the patient and said: 'If he isn't here by eight, he loses'; this messes the patient up psychologically (...) (E 19).*
>
> *These patients get irritated, they don't really know if they will undergo surgery; they wait for hours at a reception desk and it all ends up here to us. 'Lady, I'm hungry, I'm feeling sick' Why don't you get organized? I see patients harmed and lost in all the stages; they struggle to get here, when they finally get the spot, they think the problem is solved, it is not (...) (PA 26).*

The subcategory also demonstrates the hospitalization process, which determines the way patients are summoned by medical interns. The patients are constantly summoned less than 24 hours before the surgery and, because of this process, several surgeries are canceled.

> *There is the outpatient process, the SISREG, the urgency and severity of the condition, when it is more serious we cut the line and call first (...) we call and they are desperate because it is on the same day, like 'Can you come today?' It's really bad, like, we are kind of embarrassed to call and say 'Come now'; I think it is terrible (RM 09).*
>
> *So, there are patients who have been waiting for three years; when they receive that call they get desperate, sometimes they are so desperate that they don't even come to the hospital. This has happened a few times, he was so upset!!! He said, 'oh, no, doctor, I can't go through a surgery right now' and there he did not come (RM 04).*

Subcategory 2 - Admission and care in the preoperative period

It is observed in this subcategory that the sudden way of summoning patients for the surgical procedure impairs their admission process. At the same time, there are reports of effective and quality conducts in this process, as reported.

> *We try to get a brief medical history, the one which is the responsibility of the nursing technician, something simple that sometimes also goes unnoticed due to the amount of patients that come to us (TE 02).*
>
> *We get the medical history more or less focused on the problem they have and their background, something, like, really objective, that's it (RM 16).*
>
> *Well, first we need to assess their condition, fit all food according to the comorbidity, for them to have the best comfort, I keep writing down the progress in the medical record (RN 11).*

Category 3 - Needs for the improvement of the hospitalization process

This category comprised 112 (17.83%) RUs and reflects suggestions for improvements in the hospitalization process at the general surgery clinic, as described below.

> *To organize, create a hospitalization flow, create a routine, set a time, so that you can better receive the patient who is arriving (...) (TE 01).*
>
> *The ideal would be a unit of the hospital to control this hospitalization queue with a list that would be easily accessed by everyone; to have our maps made beforehand (RM 17).*

Research Article
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The category also discusses topics such as lack of administrative staff or consultation with the entire multidisciplinary team in the preoperative period, and the lack of autonomy of medical interns in the management of surgical beds.

> *We don't have a secretary, we end up playing this role a lot; we call the patient, summon them to the hospital, we do everything (RM 04).*
>
> *Informing the patient in advance, that would be essential; patients would be much better assisted and that would reduce costs in the hospital (E 06).*
>
> *So, I think it is very wrong for us to control our queue, because that leaves room (for mistakes), and maybe that is the biggest mistake (RM 09).*
>
> *I think that if there was a nurse responsible for a previous appointment, to provide guidance in the pre- and post-operative period, to alleviate the pain, the patient's anguish (E 19).*
>
> *We need to have autonomy regarding the beds here, because another clinic can take them and then we are at the mercy and this causes a lot of delay in the service (laughs) (RM 17).*

DISCUSSION

In the current hospitalization process of the general surgery at the studied hospital, it was identified that the contact with the patient, before a surgical procedure, is carried out by means of a private telephone of the medical intern in the field of specialization. The absence of an administrative employee to carry out this work, the deficiency in communication between the multidisciplinary team and the patient, and the lack of planning and management of beds and of protocols that facilitate the hospitalization process are problems that hinder its proper course. In addition, they lead to cancellation of surgeries and doubts, causing stress to the surgical patient during hospitalization.

Given the above, it is plausible to reflect, in the light of the literature, that the institution that does not promote the reception of patients and family members causes absolute difficulties in facing this process. The systematization of work in the hospital environment is a strategy that can both minimize and intensify the patient's restlessness during hospitalization[12].

Quality in the health sector is not a subjective matter and must be based on the principles of efficacy, effectiveness, efficiency, optimization, acceptability, legitimacy, and equity. These pillars are widely accepted as they contemplate the logic behind the use of resources, organization, activities, services and effects, and are considered extremely important as they contribute to management systems and hospital excellence[1].

The implementation of care protocols in hospital environments has become a necessity for reducing harms and improving the quality of care, which contributes as a reference for the multidisciplinary team in patient care[13]. In addition, it is observed that the absence of standards, rules and protocols does not depend only on technological support[14]. To insert this practice, the continuing education of the team and the availability of digital or printed records that are accessed in a practical way by professionals are recommended[13].

A fact that deserves to be highlighted is the need for hospitalization planning, hospital discharge, and bed management at the studied institution. The institution currently uses a SOUL MV operating system, considered a gold standard in health management software. Bases on the literature, institutions that use bed management and have a partnership with the aforementioned electronic system manage beds in a satisfactory manner[15]; however, for this to happen, the institution must work respecting units and specializations. In this sense, specific lines of care outlining the profile of the patient to be treated and investing in personnel to structure this service are needed to facilitate communication in the hospitalization and discharge from the institution[14,15]. These initiatives corroborate with the reflection that the importance of the hospitalization process is related to the appreciation of others as human beings[16].

Regarding the communication between the multidisciplinary team and the patient in the preoperative period, the interviewees statements point out that the inadequate number of employees for the service and the intense flow of patients in the unit contribute to the communication not being effective. In order to minimize this gap, the literature in the narrative of teamwork identified that mutual support, respect and working together are strong points found in the work environment for quality communication[17].

The polishing of communication among the members of a multidisciplinary team depends on a necessary change in the culture of the professionals. An interesting data found in the literature was the highlight of *WhatsApp* as a facilitating tool in this process. The app allows professionals to meet virtually, forming a round with instant messages, more agile, solving doubts in general[18].

Multidisciplinary communication is considered a factor that influences patient safety. This is not the responsibility of only one professional category, and should be addressed by the entire multidisciplinary team[19]. It is alleged that

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effective communication and humanization, when present, are the prism, the apparatus in the provision of care, being a perspective for the indisputability of health care, an intrinsic and necessary act in the hospitalization process and health care, requiring greater sociability among the health team-patient-family triad[20,21].

Regarding the line of care provided to the patient by the multidisciplinary team in the preoperative period, there were several statements about this topic; among them, a brief approach to the patient, such as a brief anamnesis, assessment of vital signs, medication reconciliation and guidance on the surgical procedure. The basic care provided to the patient in general can be simple, according to the reports in the research, but they can become complex when evaluated according to the specificity of each patient. In the understanding based on the literature, special attention is needed not only from the nurse, but also from the entire multidisciplinary team. The basic care offered to the patient is related to human needs for excretion, sleep, rest, food and the promotion of comfort[22,23].

With this in mind, the main preoperative recommendations and care are as follows: preoperative fasting, attention to the patient's anxiety and stress level, smoking cessation before surgery, normothermia, glycemic control, hair removal using clippers at the right time, the selection of antibiotic prophylaxis and the preoperative bath with chlorhexidine gluconate[22-24]. These are preoperative care measures with central interventions based on scientific evidence that contribute to a good surgical prognosis for the patient.

In this sense, it is necessary to create a systematization plan for the patient's hospitalization process for all members of the multidisciplinary team who, directly or indirectly, are inserted in this process in a centralized way, all walking in a single direction, aiming at a humanized service, with scientific, adjustable and elucidating support[19-22].

The limitations of this study were considered to be the impossibility of researching the theory further due to the few publications on the topic of hospitalization process, and the large number of employees working in the scenario relocated from other clinics, who are not part of the unit's staff, making impossible for them to participate in the research.

CONCLUSION

It is concluded that the absence of rules and protocols articulated with actions and training that assist the multidisciplinary team in the current process of summoning patients for the surgical procedure was a hindrance to this process. In addition, the communication between the multidisciplinary team and the patient was impaired, since the large flow of patients for surgical procedures and the non-standardization of services made the professionals' daily activities more difficult. In the line of care actions provided to the patient by the multidisciplinary team, the most mentioned ones were brief anamnesis, assessment of vital signs, medication reconciliation, and general guidelines.

The importance of having assistance based on protocols is highlighted, as, in addition to being an effective tool, its use directs health professionals, enhances the quality of hospital care, and provides the user with humanized and resolving care.

The research contributes to increase the scientific production on the subject matter and to trigger reflection in the multidisciplinary health team, as well as encourages future changes that benefit surgical patients and health professionals. This study is relevant and suggests the inclusion of policies that reduce and promote administrative adjustments in the hospital's operational routine.

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