

Humanitude care methodology: difficulties and benefits from its implementation in clinical practice

Metodologia de cuidado humanitude: dificuldades e benefícios da sua implementação na prática

Metodología de cuidado humanitud: dificultades y beneficios de su aplicación en la práctica

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Abstract

Background: Through a structured sequence of humanitude care procedures, the humanitude care methodology (HCM) allows for the humanization of care.

Objectives: To identify nurses' perceptions of the difficulties and benefits from the implementation of the HCM in clinical practice.

Methodology: A qualitative exploratory-descriptive study was conducted involving 7 nurses with previous training on HCM. Data were collected through semi-structured interviews and analyzed using the content analysis technique.

Results: The discourse analysis showed that the main difficulties in the implementation of HCM were related to personal and organizational factors. The implementation of this methodology had more benefits for the professionals, the patients, and the institutions.

Conclusion: Given the benefits identified in the implementation of the HCM, it is fundamental to take into account the factors that hamper this process, as well as to develop some strategies, such as leader involvement, with the purpose of creating the conditions for an effective implementation and consolidation in clinical practice.

Keywords: humanitude care; nursing care; nurse-patient relations; humanization of assistance

Resumo

Enquadramento: A metodologia de cuidado humanitude (MCH), através de uma sequência estruturada de procedimentos cuidadosos humanitude, permite operacionalizar a humanização dos cuidados.

Objetivos: Conhecer a perceção dos enfermeiros sobre as dificuldades na implementação da MCH e os benefícios da sua aplicação na prática.

Metodologia: Estudo exploratório descritivo, de natureza qualitativa que envolveu a participação de 7 enfermeiros com formação sobre MCH. Os dados foram colhidos através de entrevistas semiestruturadas e o tratamento dos dados seguiu a técnica de análise de conteúdo.

Resultados: Da análise dos discursos emergiram dificuldades na implementação da MCH relacionadas com factores pessoais e organizacionais. Os principais benefícios da implementação desta metodologia abrangem os profissionais, as pessoas cuidadas e as instituições.

Conclusão: Dados os benefícios identificados na implementação da MCH, torna-se fundamental ter em conta os factores que dificultam este processo, e desenvolver algumas estratégias como o envolvimento dos líderes, no sentido de criarem as condições para uma efetiva apropriação e consolidação na prática.

Palavras-chave: cuidado humanitude; cuidados de enfermagem; relações enfermeiro-paciente; humanização da assistência

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Resumen

Marco contextual: La metodología de cuidado humanitud (MCH), a través de una secuencia estructurada de procedimientos de cuidado humanitud, permite poner en funcionamiento la humanización del cuidado.

Objetivos: Conocer la percepción de los enfermeros sobre las dificultades en la implementación de la MCH y los beneficios de su aplicación en la práctica.

Metodología: Estudio exploratorio descriptivo de naturaleza cualitativa que involucró la participación de 7 enfermeros con formación sobre MCH. Los datos se recogieron a través de entrevistas semiestructuradas, y el tratamiento de los datos siguió la técnica del análisis de contenido.

Resultados: Del análisis de los discursos surgieron dificultades en la implementación de la MCH relacionadas con factores personales y de organización. Los principales beneficios de la implementación de esta metodología engloban a los profesionales, a las personas cuidadas y a las instituciones.

Conclusión: Debido a los beneficios identificados en la implementación de la MCH, es fundamental tener en cuenta los factores que dificultan este proceso y desarrollar algunas estrategias, como la participación de los líderes, para crear las condiciones necesarias para una efectiva apropiación y consolidación en la práctica.

Palabras clave: cuidado humanitude; atención de enfermería; relaciones enfermero-paciente; humanización de la atención

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Introduction

As a result of health changes, health professionals, especially nurses, need to find new strategies that can improve health care quality. The humanitude care methodology (HCM) is one of those strategies. This methodology has already been implemented in several countries, namely in France, Switzerland, Belgium, Luxembourg, Germany, Canada, Portugal, the United States of America, and Japan (Melo, Queirós, Tanaka, Salgueiro, et al., 2017), having shown “indisputable gains in the recovery of the quality of life of bedridden elderly patients with dementia and other situations of frailty” (Simões, Salgueiro, & Rodrigues, 2012, p. 82). According to these authors, its implementation in nursing care leads to improved patient well-being and increased professional satisfaction and achievement. However, the implementation of this methodology in clinical practice raises some challenges due to the culture of care and the professionals’ resistance (Simões et al., 2012). In view of the above, a qualitative descriptive-exploratory study was conducted with the purpose of identifying nurses’ perceptions of the difficulties and benefits from the implementation of the HCM in clinical practice.

Background

Today, healthcare professionals, particularly nurses, face numerous challenges. In keeping up with the technological advances, and for the techniques to become effective care, health professionals must not forget to consider the patient as a person (Phaneuf, 2007). In fact, it is much more than a challenge; it is a professional responsibility, as can be seen in article 103 of the Statute of the Portuguese Order of Nurses (Lei n.º 156/2015 de 16 de setembro), where the nurse, safeguarding the person’s right to life throughout the lifecycle, assumes the duty to assign equal value to every life; respect their biopsychosocial, cultural, and spiritual integrity; participate in professional efforts to improve their life and quality of life; and refuse to participate in any form of inhuman or degrading treatment (Lei n.º 156/2015 de 16 de setembro). Thus, the challenges inherent to the profession and the professional responsibilities justify the

constant search for new care methods with the purpose of giving intentionality to the interaction between the nurse and the patient, dignifying it (Simões et al., 2012). It is in this context that the HCM emerged. Also known as the care methodology of Gineste-Marescotti® (MGM®; Gineste & Pellissier, 2008), the HCM has been developed since the 1970s by Yves Gineste and Rosette Marescotti. It is based on the observation of clinical practice, the assimilation of knowledge from different areas of knowledge, and the integration of principles from the humanitude philosophy (Salgueiro, 2014). It is based on three relational pillars (gaze, speech, and touch) and the identity pillar (verticality). The professionalization of these pillars and the application of a set of technical-relational procedures allow for the humanization of care (Melo, Queirós, Tanaka, Salgueiro, et al., 2017; Simões et al., 2012).

Today, based on the pillars and principles of humanitude, the HCM follows a structured sequence of humanitude care procedures (SEPCH) divided into five dynamic and successive steps: (1) openings, (2), preliminaries, (3) sensory circle, (4) emotional consolidation, and (5) appointment (Melo, Pereira, Fernandes, Freitas, & Melo, 2017; Simões et al., 2012). According to Simões et al. (2012), openings allow bringing people closer in the care relationship and preparing the person to meet with the caregiver. Preliminaries consist in the establishment of a positive relationship to promote acceptance of care. They involve coming closer to and being in harmony with the person through gaze, speech, and touch (Simões, Rodrigues, & Salgueiro, 2011). For these authors, the sensory circle is achieved when the relational pillars are integrated into care delivery, leading to a bodily sensation of well-being. The fourth step - emotional consolidation - begins at the end of care delivery. Here, the caregiver positively strengthens the collaboration efforts and the progress achieved, thanking the patient for the relational moment. The last step of the methodology is the appointment, which consists in scheduling the next appointment, thus preventing the patient from feeling abandoned and neglected (Melo, Pereira, et al., 2017).

Phaneuf (2007) believes that this rich methodology should be applied in general care, regardless of the patient’s age and health problems.

However, in the case of the person in a situation of vulnerability and weakened by the disease, particularly with cognitive impairment, the use of the HCM improved acceptance of care and reduced the number of agitation behaviors (Honda, Ito, Ishikawa, Takebayashi, & Tierney, 2016; Melo, Soares, Manso, Gaspar, & Melo, 2017). According to Melo, Queirós, Tanaka, Salgueiro, et al. (2017), the results from the authors' work, namely reduction in the number of agitation behaviors, increased autonomy, and reduction in patient absenteeism rates led to the dissemination of this care methodology to several countries worldwide. However, the routinized and mechanized way of delivering care has hampered its implementation in clinical practice, being necessary an awareness of the gestures (Phaneuf, 2007) and their integration into nursing education (Simões et al., 2012), which is already taking place in some nursing schools in Portugal (Melo, Queirós, Tanaka, Salgueiro, et al., 2017).

The issue of the difficulties and benefits from the implementation of the HCM in clinical settings is an understudied topic, for which reason this study was conducted.

Research questions

What are the nurses' perceptions of the difficulties in the implementation of the HCM in clinical practice?

What are the nurses' perceptions of the benefits from the implementation of the HCM in clinical practice?

Methodology

A qualitative exploratory-descriptive study was conducted. The intentional sample was composed of seven nurses. The inclusion criterion was having received training in HCM in order to be considered experts in the area of humanitudo care. Given the recognized expertise in the area of humanitudo, both nationally and internationally, an 81-year old participant was included. The participants' age ranged from 28 to 81 years, with the most common age being 33 years. Six participants were women and one was a man. Six participants worked in differen-

tiated care and one was retired. With regard to education, five of the participants had a bachelor's degree and two had master's degrees. They had received between 27 and 60 hours or more of training.

The number of interviews took into account the theoretical saturation of data. Participants chose where they wanted to be interviewed and the interviews lasted about one hour. Data were collected by the researcher using semi-structured interviews, which were then transcribed and identified by combining letter N with a number. Data were processed and analyzed according to the content analysis procedures proposed by Bardin (2009). The categories and subcategories were established later on, with the contribution from other researchers who were experts in the area.

To comply with the formal and ethical aspects, this study was initiated after obtaining the favorable opinion of the Ethics Committee of the School of Health of Viseu (Opinion No. 4/2015). All participants gave their written informed consent for the interviews and ensured anonymity and data confidentiality; they were also informed that they could withdraw or interrupt the interviews at any time and have access to the audio recording, the transcriptions, and the final study.

Results

Two major themes emerged from the content analysis of the interviews: the difficulties and the benefits from the implementation of the HCM in nursing practice. Two categories emerged from the analysis of the discourses about the difficulties in the implementation of the HCM: internal or personal factors and external or organizational factors. In relation to the personal factors, the following subcategories emerged: routinization of practices, resistance to change, and lack of training. The routinization of practices was one of the difficulties identified by participants, as illustrated in this account: "Routinization of practices is a major obstacle to the implementation of the methodology" (N6; June, 2015). "In the nursing degree, in theory, the emphasis is placed on caring for the other as being the basis of our profession, but, in practice, care is routinized and little importance

is given to the relationship” (N2; April, 2015). These results were also corroborated by Melo, Queirós, Tanaka, Costa, et al. (2017) in their identification of the causes for students’ difficulties in interacting with the patients, namely the difference between what is valued in theory and what they observe in clinical practice. Another difficulty experienced by the participants was the resistance to change, as can be seen in the following accounts: “The existence of people who are resistant to change at the unit is a challenge” (N2; April, 2015), but, on the other hand, “thinking that we know everything can also make it difficult to change the practices, as it is essential to develop the capacity for observation and critique about what you do and how you do it, as well as be open to using new care methodologies” (N6; June, 2015). As mentioned by Simões et al. (2012, p. 92), the practices move away from the HCM because the procedures are rooted in “traditions, some are based on false principles which, passed from generation to generation, gave rise to a culture of care that is difficult to change and requires greater intervention and explanations based on scientific principles from several areas of knowledge”. In the subcategory lack of training, the nurses emphasized the lack of training of relational techniques and the need to update their knowledge, as can be seen in these accounts: “the lack of knowledge is a major obstacle to the implementation of the HCM” (N6; June, 2015), “we had little practical training, it would be an added value for us and the patients if we could practice more because then we could consolidate our knowledge better” (N5; June, 2015). Another participant emphasized that “it was also necessary to update and continuously monitor our knowledge for better consolidation” (N7; July, 2015); “it is necessary to receive practical education and training, since learning how to place your voice can take months and how to professionalize the touch can take 1 year, therefore it is important to practice and give intentionality to what you do and how you do it” (N4; May, 2015). Melo, Queirós, Tanaka, Costa, et al. (2017), in a study with nursing students, also found that the reason for their difficulties in interacting with the patient was associated with the professionals’ lack of training on humanity. Costa, Galvão, and Baptista (2014) also suggest the need for providing train-

ing on humanity to all of those involved in the caring process, namely caregivers and management bodies, as one of the aspects that could facilitate the implementation of the HCM.

As regards the category External or organizational factors, the following subcategories emerged: lack of human resources, established routines, task-centered care organization, lack of leader involvement, and inappropriate environment. Due to the lack of human resources and the need for compliance with the established routines, nurses perceived a lack of time to provide care according to the HCM, as it is reflected in the following statements: “the lack of professionals creates more complications, leading to an increase in the number of patients in the shift” (N2; April, 2015);

The nurse-to-patient ratio is not suitable, . . . we’re always running and stressed out because we have many routine tasks to perform and, when we stop to think about them, we realize that we haven’t followed the methodology. (N3; May, 2015)

Another participant stated that “it is difficult to be available to apply the methodology when there is a staff shortage” (N5; June, 2015). However, this perceived lack of time is challenged with this statement: “the lack of time is a fallacy because humanity care are softer and patients become calmer, more cooperative, more autonomous and independent, requiring less of our time” (N6; June, 2015). As evidenced in the study by Honda et al. (2016), this methodology reduces care time because it reduces agitation and resistance to care. The task-centered care organization is also perceived as a complicating factor in the implementation of the HCM: “task-centered rather than patient-centered care impedes humanity care because the focus is no longer on the interaction, but rather on the task to be performed” (N6; June, 2015); “because, in practice, what matters is that the routines are performed (hygiene, dressings, treatment, etc.) and preferably as quick as possible, regardless of patient satisfaction” (N7; July, 2015). Moreover, Simões et al. (2012, p. 91) also found “that they are somehow professionally wired to focus on the performance of the procedure”, not being empowered and encouraged to analyze and reflect on the way of caring for patients. Thus, for these authors, a serious reflection is needed to

identify the issue, the strategies, and the actions to put into practice, given that this form of task-centered care organization contradicts the values upheld, caring for the person as the focus of one's work, and the fragmented, task-centered practice (Lopes, 1995).

The lack of training and involvement of the multidisciplinary team and the recognition of the HCM value may be complicating factors in a successful implementation of the HCM, as evidenced by these participants: "professionals, doctors, nurses, technicians, social workers . . . should receive training on the HCM so that they can recognize its value and apply it" (N2; April, 2015); "if all professionals received the same training and were aware of these aspects, I think that it would be easier to implement it in clinical practice" (N4; May, 2015); "avoiding triggering stress and agitation in the patient, being thus possible to apply the methodology more effectively, . . . not knowing these techniques, can lead to iatrogenic attitudes that caregivers must avoid" (N7; July, 2015). The lack of interdisciplinarity is also evidenced in this extract: "We talk a lot about interdisciplinarity, but we are constantly isolating ourselves and not working together with other professionals" (N6; June, 2015). Biquand and Zittel (2012) also refer that humanitude care should promote collaborative work through the interaction between different professionals. The participants in this study also perceived diffi-

culties in the implementation of the HCM, which are related to the lack of leader engagement and institutional support, as reflected in these statements: "the lack of support and involvement of the decision-makers" (N2; April, 2015); as well as the leaders' devaluation of the gains achieved through its implementation" (N6; June, 2015). This view is corroborated by Simões et al. (2011, p. 78): "the policies and institutions sometimes devalue humanitude care and the importance of the relationship in the health gains". On the other hand, Simões et al. (2012) identified the leaders' receptivity and openness as favorable conditions for its implementation.

Nurses also mentioned the inappropriate work environment as a complicating factor in the implementation of the HCM in clinical practice, as these participants reported: "We should have a different environment, calmer . . . stress-free" (N7; July, 2015), "professionals speak too loud and too fast, they are always in a hurry, . . . they agitate people and have difficulties focusing on the here and now" (N6; June, 2015). In addition, Biquand and Zittel (2012) believe that the institutions need to implement organizational changes and develop specific ways of creating an environment that facilitates the implementation of the humanitude philosophy. Table 1 shows the categories and subcategories emerging from the theme Difficulties in the implementation of the HCM.

Table 1

Categories and subcategories emerging from the theme Difficulties in the implementation of the HCM

Difficulties in the implementation of the HCM			
Categories	Subcategories	Excerpts	Number of interviews
Internal or personal factors	Routinization of practices	2	2
	Resistance to change	2	2
	Lack of training	10	6
External or organizational factors	Lack of human resources	7	4
	Established routines	2	2
	Task-centered care organization	2	2
	Lack of training of the multidisciplinary team	4	4
	Lack of leaders' engagement	2	2
	Inappropriate environment	2	2

After identification of the difficulties in the implementation of the HCM, this study aimed to identify nurses' perceptions of the benefits of its implementation in clinical practice. The following categories emerged from the analysis of the interviews: Benefits for the professionals, Benefits for the patients, and Benefits for the institutions. The Benefits for professionals included: to facilitate the relationship and care delivery, emotion management, fewer physical problems and burnout, and increased professional satisfaction. With regard to facilitating the relationship and the provision of care to patients with cognitive impairment, emphasis was given to the development of techniques to professionalize the relationship, as it is evident from the following accounts: "Humanitude teaches how to approach the patient with cognitive impairment and how to solve problems of relationship with these patients with behavioral disorders such as those who are agitated or refuse to eat, take a shower, get out of bed" (N6; June, 2015). "This methodology teaches us to structure and give intentionality to the relationship" (N7; July, 2015), which is in line with Watson (2002) who argues that nursing care focus on interpersonal relationships and that caring involves values, intentionality, skills, commitment, and concrete actions. "This intentionality is essential in caring for people with cognitive impairment" (N7; July, 2015). Another participant stated that "by using the methodology, the relationship becomes closer, patients become more cooperative, more receptive . . . and this facilitates care provision a lot" (N4; May, 2015). "Caring for the patient with cognitive impairment becomes exhausting, but we have achieved a higher level of collaboration by using the methodology, so it is easier" (N7; July, 2015). The use of these relational techniques in caring for people with cognitive impairment allows involving the patient in care delivery, reducing agitation and resistance to care and facilitating management of professionals' emotions, as emerges from these accounts: "After training, we started to understand patients better and, consequently, their reactions, so we take it a little easier" (N5; June, 2015), "since we have strategies for dealing with people, we are no longer a stressor" (N7;

July, 2015), "makes us less 'aggressive', even when we have to perform a more invasive technique, people collaborate more and we are less anxious" (N4; May, 2015). Moreover, Simões et al. (2011) believe that this methodology facilitates communication with the patients. Other benefits included the reduction in the number of physical problems and in professionals' burnout:

as a consequence of humanitude care delivery and avoiding a surprise approach, patients no longer resist but rather participate in care delivery and nurses apply less strength, preventing musculoskeletal problems and burnout because we are less stressed out. (N6; June, 2015)

On the other hand, nurses also highlighted "the importance of the technical-relational procedures that facilitate patient mobilization and avoid inappropriate postures and the use of unnecessary force" (N3; May, 2015), "reducing our efforts and possible musculoskeletal injuries" (N2, April, 2015). These results are in line with those obtained by the authors of the HCM (Gineste & Pellissier, 2008) in terms of the professionalization of soft techniques, without the use of force, preventing musculoskeletal injuries. The nurses participating in this study also considered the use of the HCM as a contributing factor to the increase of their personal and professional satisfaction, as shown in the following excerpts: "Learning about this care methodology made my journey richer and more pleasant . . . but it also makes us feel good about ourselves" (N2; April, 2015), "because care delivery is no longer a struggle, but rather a pleasant moment where two people are sharing" (N6; June, 2015), "the results start to appear, it increases our self-esteem and our well-being a lot" (N4; May, 2015). Moreover, Simões et al. (2012) underline that patients' well-being gains extend to the professionals, increasing their satisfaction and sense of professional achievement.

In relation to the category Benefits for patients, the following subcategories emerged: reduction of agitation and increase of care acceptance, promotion of autonomy, promotion of self-care, promotion of self-esteem, fewer problems associated with immobility,

and families recognize the change. With regard to the benefits for patients, nurses reported a reduction of agitation and increase of care acceptance: “the HCM is based on the preservation of fundamental characteristics to the essence of the human being and their values and the safeguarding of the principles of respect and dignity, leading to the involvement in and acceptance of care” (N7; July, 2015), “since the surprise approach is avoided, the patient is calm and accepts the care being provided” (N5; June, 2015), “reduces resistance to care and the number of agitation behaviors in case of patients with dementia, because the approach allows them to understand the care being provided, being calm, accepting and participating in care delivery, without having to use defensive behaviors” (N6; June, 2015). Other studies corroborate these data about the control of agitation behaviors in elderly patients with dementia and the decrease of agitation and care refusal behaviors, especially in hygiene care (Melo, Soares, et al., 2017). In a study with elderly patients with psychological symptoms of dementia who were admitted to an acute care hospital, Honda et al. (2016) concluded that the number of these behaviors reduced when they used the MGM® when compared to conventional care. The promotion of patient autonomy, self-care, and self-esteem was among the benefits found, as can be seen in these excerpts: “This methodology encourages their decision making, involvement, and participation in the care being provided” (N2; April, 2015),

it teaches us that it is always possible to promote patient autonomy by promoting their decision making . . . just simple things like putting the person in front of a mirror to comb their hair or encourage them to choose their clothes, keeping them autonomous and dignifying them. (N4; May, 2015)

Nurses also mentioned that “the underlying philosophy is not to replace the person, but rather to stimulate their life forces, their remaining abilities with a view to promoting their autonomy and self-care, participating actively in the whole process” (N6; June, 2015). Another benefit was the increase in self-esteem: “since their specificities are respected

and their abilities are recognized, patients feel that they are capable of doing things, improving their self-esteem” (N7; July, 2015). Nurses identified the reduction in the number of problems associated with immobility as another benefit for the patients: “it promotes verticality and functionality, helping to prevent complications associated with immobility in bedridden patients, such as pressure ulcers, muscle stiffness, muscle atrophy” (N2; April, 2015); “verticality is critical to prevent immobility and the associated complications” (N6; June, 2015). These data are corroborated by Simões et al. (2012) and the authors of the HCM (Gineste & Pellissier, 2008) who underline the importance of respecting the patient’s specificities and stimulating their remaining capacities and verticality to prevent the complications resulting from immobility. On the other hand, the participants’ perceptions demonstrate that the benefits for patients extend to their families, as shown in the following excerpts: “I also noticed some changes in the families . . . after seeing how we care for their relatives, they begin to trust us more and are reassured because they see that our purpose is the patient’s well-being and comfort” (N5; June, 2015). “The results are amazing at so many levels . . . even in the relatives. This is very important, as families realize the changes and thank us” (N6; June, 2015).

In this study, the participants also identified benefits for the institutions where the HCM was implemented, namely the changes in the culture of care, the lower professional absenteeism rates, and reduction of economic costs. With regard to the changes in the culture of care, these participants underlined that “in the institution, the culture of care became more focused on people, giving intentionality to the interaction” (N6; June, 2015), thus “creating an environment and an organizational climate that promotes the humanization of care” (N7; July, 2015). This environment and the way of caring for the patients contribute to “reducing the professionals’ absenteeism rate because the exhausted professionals miss work because they are unhappy with the way in which care is provided” (N6; June, 2015); “well-being and serenity in care delivery have a positive impact on the professionals’ health

and absenteeism due to exhaustion” (N2; April, 2015). On the other hand, it may have an impact “on the economic aspects because we reduce the costs associated with treatments and the complications of patient dependency such as pressure ulcers” (N4; May, 2015), “the treatment of pressure ulcers is expensive” (N2; April, 2015). A study conducted by Simões et al. (2012) also revealed the existence of multiple benefits for patients, professionals, and the institutions where the HCM is implemented. These authors reported that well-being and serenity in care delivery have a positive impact on the professionals’ health and sense of pro-

fessional achievement, reducing the number of musculoskeletal injuries and leading to lower absenteeism rates due to exhaustion. The fact that there are benefits from the application of this methodology led Phaneuf (2007) to consider extending its application to all types of care, regardless of the patients’ age or underlying problems. Indeed, the perception of the HCM richness is so vast that Costa et al. (2014) reported that it is feasible to use it also in health care management.

Table 2 shows the categories and subcategories emerging from the theme Perceptions of the benefits of the implementation of the HCM.

Table 2

Categories and subcategories emerging from the theme Benefits of the implementation of the HCM

Benefits of the implementation of the HCM			
Categories	Subcategories	Excerpts	Number of interviews
Professionals	Facilitates relationship and care delivery	3	3
	Emotion management	3	3
	Less physical problems and burnout	3	3
	Personal and professional satisfaction	3	3
Patients	Reduction of agitation and increase of care acceptance	3	3
	Promotion of autonomy and self-care	4	4
	Fewer problems associated with immobility	2	2
	Families recognize change	2	2
Institutions	Change in care culture	2	2
	Lower absenteeism rates	3	2
	Reduction of economic costs	2	2

Discussion

Not all categories identified in this study on the difficulties and benefits of the implementation of the HCM are found in the available evidence. Therefore, this study identified the following new difficulties in the implementation of the HCM: the lack of involvement and training of the multidisciplinary team, and the inappropriate environment. In relation to the benefits of the implementation of the HCM, this study found the following new aspects: increase in self-esteem, families’ recognition, and impact of its implementation on the reduction of economic costs. Further research studies should be conducted

for a more effective implementation of this methodology in clinical practice, the development of new knowledge, and the demonstration of health gains.

Conclusion

In this study, the participants considered that there were difficulties related to personal or internal factors and external or organizational factors in the implementation of the HCM. As internal or personal factors, they identified the routinization of practices, the resistance to change, and the lack of training. As external or organizational factors, they highlighted

the lack of human resources, the established routines, the task-centered care organization, the lack of leaders' involvement, and the inappropriate environment. Despite the difficulties in the implementation of the HCM, the participants also identified several benefits for the professionals, the patients, and the institutions. Among the benefits for professional, the participants reported that the HCM facilitated the relationship with and the delivery of care to patients with cognitive impairment, reduced the number of physical and emotional problems, and increased professional satisfaction. The benefits for patients were the reduction of agitation and the increased acceptance of care, the promotion of autonomy and self-care, the reduction in the number of problems associated with immobility, and the families' recognition of the changes. The benefits for the institutions included a change in the culture of care, a reduction in the professionals' absenteeism rates, and a reduction of economic costs due to the promotion of patient autonomy and independence. In view of these results, this care methodology should be disseminated to achieve scalability.

Implications for practice and research

Based on the benefits obtained for patients, professionals, and institutions, the HCM should be implemented taking into account some factors that may hinder its implementation in clinical practice, such as the need for the involvement of institutional leaders in order to understand its importance and create the conditions for its effective implementation and consolidation in clinical practice. This topic is still an understudied area both nationally and internationally; hence, further studies should be developed in various types of care to allow data comparison and demonstrate its effectiveness in all types of care throughout the life cycle.

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