PENSAR ENFERMAGEM
Revista Científica | Journal of Nursing

Guidelines for the humanization of care provided by the multidisciplinary team in the adult emergency department

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Received: 13.02.2023
Accepted: 08.10.2025

Editor: Pedro Lucas

Abstract

Introduction
Portugal ranks among the leaders in the OECD for access to emergency services, where users require immediate, efficient, and highly technology- and staff-intensive care. Multidisciplinary team professionals deliver care in a routine, high-pressure therapeutic environment that generates suffering and increases the vulnerability of care recipients. Humanism regards human dignity as the highest value of life; when applied to health, its principles call for realigning care goals beyond the biomedical perspective — a process we term "humanization of care."

Objective
To define guidelines for providing humanized care in the emergency department through an integrative review of the literature; and to validate the content of those guidelines for emergency department practice using a panel of experts and the Delphi methodology.

Methods
A simple descriptive observational study. For content validation of the 170 items composing the guidelines, 20 health professionals with advanced training participated. The 170 items were identified through an integrative review and organized into three levels: structural, professional, and care. The ethics committee approved the study.

Results
After drafting the guidelines via an integrative literature review, a panel of experts was convened, and two Delphi rounds were conducted to validate the content. Of the 170 items initially evaluated, 167 were confirmed as valid after the second round. I-CVI values ranged from 0.85 to 1.00, and S-CVI values ranged from 0.90 to 0.98.

Conclusion
Caring for others while feeling valued — by combining technical and scientific competence with empathy and active listening — is the path toward a future in which health professionals can make small but meaningful changes in the lives of care recipients, "making them human."

Keywords
Emergency unit; Humanization of Assistance; Delphi Technique.

How to cite this article: Campino S, Dixe MACR. Guidelines for the humanization of care provided by the multidisciplinary team in the adult emergency department. Pensar Enf [Internet]. 2025 Jan-Dec; 29(1): e00426. Available from: https://doi.org/10.71861/pensarenf.v29iSup.426

Introduction

Portugal leads the OECD in access to emergency departments (EDs), with approximately 6.3 million ED episodes per year, a volume often attributed to citizens' inappropriate use of these services to meet their health needs.[1] Open 24 hours a day, seven days a week, the emergency department is used by many as the first point of contact with the Serviço Nacional de Saúde (SNS, National Health Service), since it does not distinguish social classes or economic status and follows a universal, general, and largely free-of-charge philosophy that welcomes everyone who presents.[2] When a person turns to the ED, they expect immediate, efficient care that is highly differentiated in terms of technology and human resources.[3] As access increases — much of it driven by people with low-urgency or nonurgent health problems — the challenges of providing care in the ED setting grow.

In pursuit of rapid and efficient care, a routine, high-tension therapeutic environment is frequently created, generating anxiety and stress that heighten in the care recipient's (CR) feelings of vulnerability, anguish, and fear of death, pain, and loss of functional capacity.[4] Lemos[5] notes that even when surrounded by familiar persons and highly qualified health professionals, an adult experiences the impact of an emergency episode through physical, psychological, emotional, and existential suffering, accompanied by a profound sense of abandonment and isolation. All this often culminates in conflicts stemming from misunderstanding the service's operating dynamics and from the conviction that one's own health problem requires immediate attention, even when there are other situations of greater complexity and severity.[6] However, the burden of suffering caused by death, pain, and disease — and by emergency department overcrowding — does not fall solely on CRs and their families: health professionals, as human beings, also suffer in specific ways, since working in an ED entails biological, social, and psychological risks often masked by a smile or by a supposedly cold and distant demeanor.[7]

The biomedical model implemented in EDs arises from professionals' disease-centered focus, underpinned by advances in biotechnology, pharmacology, radiology, and other fields that provide objective and specific data about a person's clinical condition; these developments have enabled increasingly specialized procedures for treating and curing diseases that, until recently, had poor prognoses and now offer new hope to CRs and professionals facing life-threatening problems.[8] However, the drive to avert death at all costs and to reduce the person to a diseased body whose problems are to be solved by complex, high-technology therapeutic protocols has eroded the meaning of caring for the human being as a biopsychosocial person with feelings, beliefs, concerns, and agency. This approach creates a barrier between the person and health teams, who may view death as a failure and suffering as a consequence that can be sedated or suppressed with medication.[9]

This posture of distancing and abstraction of the care recipient as a human being, often adopted by professionals as a defense against their own frustrations and fears, compromises the quality of care by affecting ethical decision-making, the development of therapeutic bonds, and the establishment of trust between the care recipient and the health team, so that the person feels supported and listened to in all their individual needs.[10] From this shift in how the care recipient is conceived in the emergency context arise paternalism and the "disappearance of the human subject," which Ávila-Morales[11] classifies as the dehumanization of health: a loss of fundamental values in the efficient pursuit of curing organic diseases, leading to depersonalization through disease codifications, the absence of a relationship with the care recipient, the failure to recognize individual dignity by applying principles of equality to all, the lack of participation of the care recipient in decision-making, the imposition of a power dynamic over the care recipient and their decisions, and the conception of the care recipient as a biological entity defined by a pathology (psychiatric patient, HIV positive, etc.). In the ED, these aspects take on greater significance, since the CR is in an acute situation in which decision-making capacity may be compromised, and the goal is rapid and effective treatment to remove them from a life-threatening condition. This depersonalization of care multiplies immeasurably when demand for services is excessive, physical conditions are inadequate, and staff-to-patient ratios are disproportionate, reducing the time available for care.[12] The physical and psychological fatigue of professionals, as well as the increasing complexity of patients in the ED, are identified as indicators of the lack of implementation of quality practices, particularly in the personalization of care, which Barros[13] highlights as the driving force for initiating a profound reflection on the quality of ED care practices. Thus, a research problem emerges: the promotion of humanization of care provided by the multidisciplinary team in adult emergency departments.

Health care services adhere to scientific principles in the systematization and organization of work, with the overarching goal of preserving life through advanced technological means in diagnostic and therapeutic areas.[14] When discussing the humanization of health services, the first temptation may be to associate such projects with criticism of how care is currently provided, even considering it an affront to the supposed lack of humanistic capacity among professionals working in these services, which generates negative reactions and resistance to implementation.[15] Another temptation is to assume that the humanization of care undermines scientific methods, as if the intention were to turn professionals into "good people" or demand immeasurable altruism and kindness in a harmonious relationship with the CR.[16] It is necessary to demystify the notion that professionals are the main agents of the dehumanization of care, since, on the contrary, they are also victims of the system, which — focused on the

biomedical model and on financial, economic, rigid, bureaucratic, and vertically hierarchical service management — undermines relationships between care recipients and health teams by depriving both parties of autonomy in this care-provision dyad.[17]

The concept of humanism is philosophical in nature, regarding the dignity of the human condition as life's highest value and defining the human being's mission as seeking to understand humankind and to create tools that recognize the Other as an individual, free being with their own potential and autonomy and with the right to happiness.[18] When applied to the challenges of health care, the principles of humanism necessarily call for realigning care objectives beyond the classification, cure, and treatment of diseases, and for dismantling the notion of care as merely service delivery focused on biomedical aspects that obscure everything that makes the CR truly a person.[19] This shift in perspective in health care provision can thus be termed "humanization," in the sense that it values the interaction among the various stakeholders in care delivery (managers, health professionals, CRs, and their families), with respect for the dignity and autonomy of each individual through sociability, empathy, understanding of beliefs, values, perspectives of the Other, optimism, and a measure of compassion for those who suffer.[20] Building bonds between health professionals and those they care for is at the core of humanizing care, since the therapeutic relationship reflects the valuing of the human being and the ethical and humane attitude in approaching a person in a situation of particular vulnerability.[21] This change in the organization of the health system as a whole will allow for dignified, ethical, and personalized care, where dialogue and listening are as fundamental as a stethoscope, and where improving physical and technical conditions will always prioritize the comfort of those who use health services.[22] Humanization of care enables the CR to share responsibility for their health/disease trajectory, since they are the protagonist of the care provided, the services offered, and the networks of cooperation built around them.[23] Recognizing the uniqueness of the CR beyond physical needs is the greatest challenge for humanizing care in the ED, since the time required for active listening — indispensable for understanding both speech and silence — is scarce, making it difficult for the professional to acknowledge all dimensions of the person seeking help.[24] Creating the conditions for this humanization of care in the emergency context is the primary challenge to ensure respect for privacy, dignity, ethical and moral values, and autonomy, while improving interactions among the various actors in care provision with the ultimate goal of reducing suffering and making the emergency episode as minimally traumatic as possible.[25] Considering all these aspects, this study was designed to address the research question: "What measures can be implemented in adult emergency departments to promote the humanization of care provided by the multidisciplinary team?" The objectives are to define guidelines for providing humanized care in the ED through an integrative review of the literature and to validate the guidelines for humanized care in the ED through an expert panel using the Delphi methodology.

Methods

To answer the research question and meet the proposed objectives, a simple descriptive observational study was designed to establish a broad consensus on the humanization of reception and care provided in EDs by multidisciplinary teams.

Sample

To select the panel of experts that composed the sample, an invitation email was sent to several health institutions, committees, and professionals who met the following inclusion criteria: interest in the study topic; being a physician or nurse who provides (or has provided within the last two years) care in adult EDs with at least 10 years of professional experience; having advanced training in Urgency and Emergency care, medical-surgical care, or Bioethics; holding hospital management positions or working in adult ED management (or having training in this area); membership in patient/user committees with more than three years of active service; membership in Ethics Committees for the Life Sciences; being a clinical psychologist experienced in delivering bad news; or being a representative of the Health Regulatory Authority. These criteria were defined to ensure that participating experts had practical experience in ED care, ethics, and psychology. Members of patient/user committees were invited to provide the service-user perspective without the bias that professionals' operational knowledge of services might introduce.

To screen participants who registered for the study according to the defined inclusion criteria and to characterize the future expert panel, respondents were asked to complete a Microsoft Forms questionnaire presenting the Informed Consent Form (ICF) for study participation.

Thirty participants responded to the invitation to form the panel of experts, of whom 27 (90%) met the defined criteria. However, after the first validation round, only 20 (67%) of those enrolled responded, so only these participants were considered for the expert panel. In addition to answering sociodemographic and professional characterization questions, participants were asked two open questions: "What does humanizing health care mean to you?" and "Why did you decide to pursue your profession?" These questions were posed prior to the application of the guidelines-validation questionnaire to learn what motivates these professionals in their daily work and what they think about the study topic, thereby fostering preliminary reflection. Only physicians and nurses accepted the invitation to participate in the study. The expert panel was

characterized according to professional background and the region of the country to which they belong, as shown in Table 1:

Table 1. Professional characterization of the experts (n = 20).

Physician n = 5 (25%)			
Years of experience (mean)	Professional experience	13,2 years	
	Professional experience in ED	12,6 years	
		(n=)	**%**
Professional career category	General clinician	1	20%
	Attending physician	2	40%
	Staff physician	2	40%
	Senior staff physician	0	0%
Health system sector	Public	5	100%
	Private	0	0%
Region	North	0	0%
	Center	5	100%
	Lisbon and Tagus Valley	0	0%
	Alentejo	0	0%
	Algarve	0	0%
	Autonomous Region of the Azores	0	0%
	Autonomous Region of Madeira	0	0%
Nurse n = 15 (75%)			
Years of experience (mean)	Professional experience	19,3 years	
	Professional experience in ED	14,1 years	
		(n=)	**%**
Professional career category	Nurse	6	40%
	Specialist nurse	8	53%
	Nurse manager	1	7%
Health system sector	Public	15	100%
	Private	0	0%
Region	North	2	13%
	Center	8	53%
	Lisbon and Tagus Valley	4	27%
	Alentejo	1	7%
	Algarve	0	0%
	Autonomous Region of the Azores	0	0%
	Autonomous Region of Madeira	0	0%

Experts were asked to disclose their advanced training in Urgency and Emergency care and in Bioethics. Of the 20 experts, 5 (2 physicians and 3 nurses) did not have advanced training; among the remainder, some individuals held more than one qualification, as described in Table 2:

Table 2. Training of the experts (total trainings: n = 24).

Level of training	(n=)	%	Course/training name
Included in undergraduate medical training	2	8%	Intensive care medicine Urgency and emergency care for adult medical conditions
Postgraduate diploma	6	25%	Critical care (n = 2) Critical care nursing Urgency and emergency care Intensive care and emergency care Emergency and trauma
Postgraduate specialization	4	17%	Medical-surgical nursing (n = 2) Medical-surgical nursing in the area of critical care (n = 2)
Master's degree	6	25%	Medical-surgical nursing — specialization in nursing for persons in critical condition (n = 5) Bioethics
Prehospital care training	6	25%	Immediate life support — nurses Emergency medical care in the prehospital setting Helicopter transport VMER (Medical Emergency and Resuscitation Vehicle) (n = 2) Trauma

Instruments

Following a brief preliminary search prior to the start of this study, we identified several publications on the humanization of care provided by nursing teams. However, one objective of this study was to define guidelines for the humanization of care delivered by the multidisciplinary team, aiming to encourage all professionals to create a more humanized care environment for those who seek EDs, placing the person at the center of the team's care. To develop the guidelines and the items intended to achieve this objective, an integrative review of the literature was conducted because it enables the clarification and synthesis of research findings on a topic.[26] By identifying what is already implemented in the field of humanization of care and which studies exist, it was possible to establish items to be implemented to improve the quality of care delivered in EDs and to submit them for validation by the expert panel. For this integrative review, the following inclusion criteria were defined: all professional groups that assist people in adult hospital emergency departments; all previously described measures that promote individualized care delivered by the multidisciplinary team; any documentation produced on the humanization of health care; documentation in Portuguese, English, and Spanish; and any types of documents for which full-text access was available. The databases searched according to these criteria were EBSCOhost, SciELO, PubMed, BioMed Central, the Virtual Health Library (Biblioteca Virtual da Saúde), and the Portuguese Open Access Scientific Repositories. The following Health Descriptors (DeCS and MeSH) were used with the Boolean operator AND: "humanização da assistência"/"humanization of assistance"/"Humanización de la Atención"; "serviços médicos de emergência"/ "emergency care"/"Servicios Médicos de Urgencia"; "adulto"/"adult."

In an initial title screening, 1,934 records were selected for abstract review, of which 146 were selected for full-text reading. Applying the inclusion criteria above, 37 articles were selected by the principal investigator to define the guidelines; full analysis and reading of these documents made it possible to extract 170 items, which, as they emerged from the reviewed documents, required organization into multiple levels and domains, as shown in Table 3:

Table 3. Guidelines for the humanization of care provided by the multidisciplinary team in the emergency department.

A: STRUCTURAL LEVEL
This level lays the foundations required to deliver humanized care in Emergency Departments (EDs), covering national policy, community health interventions, adequacy of physical infrastructure and service support, and hospital management.
A1: National policy domain [10,21,22]
A national, cross-cutting response across all health institutions is essential to address the humanization of care throughout health services.
A1.1. Develop a National Plan for Humanized Healthcare (PNHCS).
A1.2. Involve nurses, social workers, and psychologists in developing the national plan.
A1.3. Include the PNHCS in the next National Health Plan.
A1.4. Replace the designation "user" with "care recipient (CR)."
A1.5. Streamline access to healthcare.
A1.6. Streamline the referral network.
A1.7. Streamline internal care networks.
A1.8. Implement triage and risk classification in all health institutions.
A1.9. Conduct regional studies of ED user populations and tailor responses accordingly.
A1.10. Conduct municipal studies of resident populations and adapt responses at the primary care level.
A1.11. Promote cooperation between regional and municipal authorities to implement measures that promote individual and community health.
A1.12. Promote cooperation between regional and municipal authorities to implement disease-prevention measures.
A1.13. Create effective communication channels between the public and health institutions.
A1.14. Establish forums for dialogue between communities and health institutions about needs and barriers.
A1.15. Create mechanisms to foster individual accountability of the CR for their health care pathway.
A1.16. Identify the CR and a designated family member as part of the multidisciplinary care team.
A2: Community health intervention domain [27,28]
To ensure appropriate ED use, promote health literacy and public awareness at individual and community levels. By strengthening local care delivered through health centers and family health units, reduce ED visits for low-acuity or non-urgent conditions and enable professionals to focus on urgent and emergency cases.
A2.1. Empower citizens to take an active role in their health-care pathway.
A2.2. Implement individual health projects in Primary Health Care (PHC).
A2.3. Implement community health projects.
A2.4. Conduct media campaigns across communication channels to clarify the role and scope of Emergency Departments.
A2.5. Distribute posters explaining Primary Health Care and its scope of services.
A2.6. Conduct seasonal health promotion and disease-prevention campaigns targeting different age groups.
A2.7. Conduct health education campaigns explaining which urgent and emergencies justify ED visits.
A2.8. Implement health education protocols across all care levels to define which urgent and emergencies justify ED visits.
A2.9. Implement health education protocols across all care levels to clarify the CR's role in their health-care pathway and their co-responsibility within the care team.
A2.10. Implement triage-based health education protocols to explain priorities for care.
A2.11. Implement caregiver support programs to strengthen caregivers' knowledge of health promotion and of preventing acute exacerbations of chronic conditions
A3: Infrastructure adequacy domain [29, 30, 31]
The physical environment, equipment, and appearance of EDs play a central role in promoting environmental comfort and the well-being of CRs, reducing suffering and psychological distress, and clarifying internal service pathways.
A3.1. Allocation of financial resources for the physical redesign of EDs.
A3.2. Physical layout of EDs that is flexible and adaptable to exceptional events, disasters, pandemics, etc.
A3.3. Regular acquisition of modern, high-quality equipment to replace items that are inoperable and/or outdated.
A3.4. Adequate and regular maintenance of equipment.
A3.5. Regular maintenance of the service's physical premises.
A3.6. Adequacy of triage areas to ensure calm and full privacy.
A3.7. Creation of individual changing rooms for dressing and undressing CRs on arrival and departure.
A3.8. Adequacy of physical spaces for assessment of CRs with privacy, comfort, and without interruptions.
A3.9. Adequacy of consultation rooms for family members/companions to collect clinical information and to receive updates on the CR's clinical progress.
A3.10. Adequacy of physical spaces to guarantee full privacy for CRs during procedures and clinical observation.
A3.11. Creation of a lactation room with access to a breast pump.
A3.12. Clear identification of internal routes and the various rooms of the ED in a simplified, visible, and accessible manner.
A3.13. Provision of information about internal routes at multiple points throughout the service.
A3.14. Adequate signage for restrooms, exits, routes, information services, and other key areas.
A3.15. Reduction of noise (alarms, architectural interventions).
A3.16. Lighting with adjustable intensity options across different rooms.
A3.17. Service layout that allows natural light to enter, enabling staff and users to distinguish the time of day.
A3.18. Placement of clocks in all rooms and corridors.
A3.19. Installation of air renewal/ventilation systems to ensure air quality and odor removal.
A3.20. Creation of free access water points.
A3.21. Installation of air-conditioning systems that allow control and maintenance of a comfortable temperature across rooms.
A3.22. Playing ambient music that promotes calm in waiting rooms.
A3.23. Provision of charging points for electronic devices.
A3.24. Provision of free-access Wi-Fi.
A3.25. Installation of televisions in waiting rooms with messages aimed at health education, explanations of internal routes, priorities for care, and other relevant topics.
A3.26. Broadcasting of nature films on televisions that do not require audio.
A3.27. Pleasant decoration of waiting rooms through the display of art, soft colors, and similar measures.
A3.28. Paint waiting rooms in different ED areas according to the triage priority color.
A3.29. Provision of equipment to allow companions to rest overnight while accompanying a CR with a high degree of dependency.
A3.30. Allocation of rooms for delivering bad news that ensures total privacy, without unnecessary interruptions, and in which family members and companions recognize a safe space to express their emotions.
A3.31. Creation of relaxation spaces for staff, properly equipped and with comfortable furniture.
A4: Institutional and emergency departments management domain[29, 32]
Hospital management that promotes humanized care should foster cooperation and participation among managers, professionals, and service users. Middle management in EDs must ensure staff well-being and the proper functioning of multidisciplinary teams so care is delivered by professionals who feel valued and fulfilled in their work.
A4.1. Ensure safe staffing levels for the multidisciplinary team.

A4.2. Conduct quarterly studies on ED access (number of visits, acuity levels, waiting times, length of stay) to adjust staffing rosters and work schedules.

A4.3. Establish standby teams to be activated during periods of higher ED attendance or when there is an increased number of complex patients requiring higher staffing ratios.

A4.4. Create reinforced staffing rosters for days with expected higher ED attendance.

A4.5. Implement strategies to reduce time to first contact.

A4.6. Refer non-urgent patients or those meeting "white wristband" criteria to specialty outpatient clinics or PHC.

A4.7. Expedite intra- and inter-hospital referral networks.

A4.8. Organize ED specialty teams to operate in a complementary model.

A4.9. Create referral teams in the ED for the various medical specialties and for social work.

A4.10. Define CR referral pathways to be used by physicians and nurses.

A4.11. Create care circuits centered on the CR.

A4.12. Encourage a culture of reporting problems and resolving them through cross-functional co-management that involves all multidisciplinary team members and includes them in major management decisions.

A4.13. Establish focus groups to evaluate the implementation of new care strategies, involving health professionals, managers, and service users through problem-based discussion.

A4.14. Create multidisciplinary working groups (health councils) to manage work organization processes, analyze productivity, define tasks, and develop continuous quality improvement projects.

A4.15. Address hierarchical power dynamics between professional groups.

A4.16. Promote teamwork with the shared goal of providing humanized, high-quality care.

A4.17. Acknowledge legitimate differences among team members, promote unity, and develop action strategies for critical situations through team-building events.

A4.18. Define technical and humanistic criteria for admitting professionals to provide care in EDs.

A4.19. Promote a collaborative, low-conflict professional environment.

A4.20. Motivate and recognize proactive professionals as champions and leaders of change.

A4.21. Create a hospital humanization group.

A4.22. Define liaison roles within services for the humanization of care.

A4.23. Promote spaces for reflection and discussion to resolve conflicts and foster attitude change.

A4.24. Establish a structured listening system at management levels to collect concerns, receive feedback, and develop solutions, including an open communication channel for service users.

A4.25. Implement an open-door policy allowing companions to remain with the CR continuously, regardless of their level of dependency.

B: PROFESSIONAL LEVEL

Professionals from the various fields who work in EDs are the primary actors in implementing measures for humanized care. Therefore, they should also be targeted by humanization measures so they can perform their work satisfactorily for themselves and for those they serve. In addition, it is essential to promote initiatives that produce knowledge and provide continuing education.

B1: Domínio da Formação dos Profissionais do Serviço de Urgência [8,11, 15, 17, 19, 21, 22, 24, 33,35,36, 37]

Introducing humanized care into medical and nursing curricula is part of the path to ensure that future health professionals are mentored and trained in humanized practices and in holistic clinical assessment.

B1.1. Administer psychometric assessments as part of admissions to higher-education health programs.

B1.2. Assess humanistic and interpersonal competencies of students enrolled in health-related programs.

B1.3. Ensure medical, nursing, and healthcare assistant curricula include a mandatory component to develop humanistic competencies, communication skills, and holistic clinical practice.

B1.4. Establish graduate-certificate programs in humanized care.

B1.5. Foster closer links between health schools (medicine and nursing) and care institutions to increase research and scientific production in humanized care.

B1.6. Implement mentorship programs in medical and nursing education focused on humanized care and on creating safe spaces for students and tutors to share experiences and cultivate professional bonds.

B1.7. Create internship programs within Life Sciences Ethics Committees for medicine and nursing students.

B1.8. Develop Ethical Life Support courses for multidisciplinary teams working in EDs (A — Recognition; B — Care; C — Communication; D — Management).

B1.9. Train ED professionals in communication techniques, with refresher training every 5 years.

B1.10. Provide specific mental health training for ED professionals who are not mental health specialists, with refresher training every 5 years.

B1.11. Train ED administrative staff in communication and in serving people with special needs.

B1.12. Train medical and nursing teams in delivering bad news.

B1.13. Conduct practical drills for caring for people presenting to EDs after a suicide attempt.

B1.14. Train multidisciplinary teams in family support during resuscitation.

B1.15. Provide training to all ED team members on cultural differences and on personalized care for people from other cultures, religions, or belief systems

B2: Support and professional recognition domain [4,7, 8, 10, 14, 15, 17, 19, 20,21, 22, 27, 29, 33]

Recognition, promotion of staff satisfaction, and the health of multidisciplinary teams enable them to provide higher-quality care and to be more available to apply the humanized care principles.

B2.1. Establish incentive schemes that support training, capacity building, and professional development tied to career progression.

B2.2. Promote staff satisfaction through employment stability, improved compensation, productivity incentives, and recognition of individual and team competencies.

B2.3. Implement initiatives to promote work-life balance.

B2.4. Implement physical and emotional support programs for ED staff.

B2.5. Require annual mental health screening of ED professionals by a clinical psychologist to identify mental health conditions and burnout.

B2.6. Provide decompression areas outside clinical zones where staff can rest and recover from stress.

B2.7. Promote team-building events to foster positive interprofessional relationships, empathy, sociability, resilience, and self-control in high-pressure or conflict situations.

B2.8. Implement multidisciplinary reflection cycles on humanized care practices and on coordinated, collaborative work between teams, recognizing each member's role.

B2.9. Define performance evaluation objectives collaboratively with staff and align them with ED care delivery.

B2.10. Promote inclusive decision-making by involving staff in developing inclusive work methodologies aimed at a shared objective: CR well-being and professional recognition

C: CARE LEVEL

Changes in work methods and in approaches to attending CRs and their companions—grounded in all previously described domains—enable the transition from a biomedical view of the person to a holistic perspective, shifting the focus from disease to the person and their needs. This approach supports the delivery of humanized, personalized care that dignifies the individual as a unique person with specific needs.

C1: User embracement domain [4,5,6, 8, 17, 21, 22, 27, 28, 29, 33, 34, 36, 38]

Pain, physical and mental illness, and the time CRs and their companions spend in the waiting room before medical attention generate anxiety and tension. User embracement throughout the ED stay addresses these situations and seeks to reduce the suffering they cause.
C1.1. Reduce bureaucracy in ED registration.
C1.2. Privately record the reason for ED presentation (assault, fall, pregnancy, etc.) during triage.
C1.3. Minimize or eliminate interruptions during triage.
C1.4. Provide CRs with information at triage about care available in EDs and PHC when the assigned priority is not urgent, very urgent, or emergency.
C1.5. Flag the need for social support during triage when appropriate.
C1.6. Inform CRs and their companions about waiting times, ED workflows, and referral pathways; answer questions and listen to their concerns and expectations.
C1.7. Ensure transfer equipment allows safe and comfortable movement of CRs.
C1.8. Allow continuous presence of a companion during CRs' ED stay, except during exposure, invasive, or diagnostic procedures, unless the CR consents.
C1.9. Implement a culture of continuous information sharing with CRs and their companions, with CR's consent.
C1.10. Create a reference nurse or care-manager nurse role to follow CRs from admission to clinical discharge, serving as a liaison between the multidisciplinary team and CRs and their companions.
C1.11. Create a quick-reference guide on cultural practices and norms to support respectful reception and care for people from diverse cultural backgrounds.
C1.12. Develop communication booklets for use by the ED for people with cognitive, hearing, or visual impairments.
C1.13. Produce documentation in Braille (e.g., informed consent forms, treatment instructions, etc.).
C2: Clinical assessment domain [6, 8, 22, 29, 31, 33, 39]
The clinical assessment performed by the multidisciplinary team must cover multiple components related to physical and mental health as well as psychosocial issues. Effective, solution-oriented communication and active listening are essential tools to ensure CRs feel heard and properly attended to.
C2.1. Integrate social assessment into CRs' clinical assessment.
C2.2. Implement rapid mental health screening protocols and referral pathways to mental health services (psychiatry or clinical psychology).
C2.3. Conduct clinical assessments in a calm, quiet environment designed to assure CRs that the consultation is a setting for attentive, qualified listening to their concerns, with privacy and without interruptions.
C2.4. Recognize and prioritize pain complaints as a core element of clinical assessment.
C2.5. Establish therapeutic bonds with CRs.
C2.6. Implement ED admission protocols that include two separate clinical assessments: a medical assessment followed by a nursing assessment.
C2.7. Use plain language when communicating with CRs.
C2.8. Minimize bodily exposure and ensure it occurs in locations that guarantee full privacy.
C2.9. Limit the number of professionals present during exposure and physical examinations to the minimum strictly necessary.
C2.10. Ensure nursing assessment and the development of individualized care plans based on needs identified in the assessment
C3: Person-centered care domain [3,4,5,6,8,10,12,14,15,19,20,22,23,24,25,27,28,29,31,33,35,39,40,41,42]
Teamwork with a person-centered focus enables differences of opinion to enrich the care process among the various professionals in the teams. The ED should act as a starting point or a moment to revise the person's individual health plan, in which the person, together with professionals, establishes a shared plan for their life-course and health/illness trajectory in coordination with their family and PHC.
C3.1. Create a 24-hour bioethics advisory service to support professionals and families.
C3.2. Structure the medical consultation around the CR through active listening.
C3.3. Assess social conditions and support needs during the medical consultation.
C3.4. Deconstruct paternalistic approaches toward the CR: introduce yourself (e.g., "My name is X and I am Y"), smile, greet the person, adapt technical language, show interest in what they say, and make eye contact.
C3.5. Use friendly conversation as a data-collection tool.
C3.6. Identify the person by their preferred name rather than by their pathology during contacts and at transitions of care.
C3.7. Conduct a nursing assessment after the medical consultation according to the person's basic human needs and ensure these are met (hygiene, hydration, adequate meals, etc.).
C3.8. Create nursing consultations for low- and non-urgent situations to assess teaching needs and to promote the person's participation in their individual health plan.
C3.9. Promote autonomy and independence at all times during care delivery.
C3.10. Maintain continuous negotiation of care with shared responsibility by the person for their role, involving them in decision-making processes and recording their preferences, feelings, and beliefs in the clinical record.
C3.11. Explain procedures performed, their benefits and risks, and the rationale for complementary diagnostic tests.
C3.12. Request feedback from the CR on the current therapeutic plan and clarify any doubts.
C3.13. Continuously assess therapeutic adherence.
C3.14. Explore reasons for nonadherence at home and define strategies to address gaps.
C3.15. Provide ongoing information to the CR about possible diagnoses, eliminating deception and the "conspiracy of silence," while never abandoning hope.
C3.16. Promote inclusion of the companion in care delivery when authorized by the CR, avoiding situations in which family members assume guardianship over an older adult, and maximizing the person's autonomy when cognitively intact.
C3.17. Assess burnout in the primary caregiver.
C3.18. Inform family members about the CR's clinical situation whenever possible and with prior authorization from the CR.
C3.19. Permit the presence of a family member during resuscitation if they wish, with a designated staff member present to support them and to explain all interventions being performed.
C3.20. Ensure the multidisciplinary team maintains continuous attention to reducing, eliminating, and controlling acute and chronic physical and psychological pain.
C3.21. Train volunteers to implement non-pharmacological pain-management strategies (distraction techniques, among others) and to provide emotional support.
C3.22. Administer analgesia for all procedural interventions, regardless of their complexity.
C3.23. Communicate bad news to the CR and/or their family in a calm, uninterrupted setting, allowing them space to share their feelings, doubts, and anguish.
C3.24. Create protocols for delirium management in the ED that include chemical restraint when appropriate, reduction of sensory stimuli, and the presence of a companion if they are a calming influence for the CR.
C3.25. Avoid physical restraint whenever possible; if unavoidable, limit its duration to a defined maximum number of hours and inform the CR of its necessity.
C3.26. Allocate people under observation according to their gender, prioritizing care provision by same-gender staff when appropriate.
C3.27. Understand and accept a CR's refusal of treatment, ensuring they are informed of the risks of their decision and documenting this in the clinical record.

C3.28. Schedule timely medical re-evaluation appointments in PHC after an ED episode.
C3.29. Create a nursing follow-up consultation after medical discharge from the ED to provide education on the therapeutic regimen, address the CR's needs, and answer questions
C4: Death and end-of-life domain [8, 9, 12, 22, 41] Death and end-of-life situations are common in EDs. Creating conditions that allow CRs and their families to experience these moments with dignity ensures humanized care continues until the person leaves the department.
C4.1. Promote completion of advance directives among the population.
C4.2. Transfer CRs in cardiac arrest to a designated area away from other patients and their families.
C4.3. Limit invasive interventions that cause suffering in terminally ill CRs.
C4.4. Empower CRs in the terminal phase by offering choices about end-of-life care.
C4.5. Establish palliative care teams with a permanent on-site presence in EDs.
C4.6. Minimize the suffering of CRs and their families by applying principles associated with a good death.
C4.7. Encourage open discussion about death with families and among professionals.
C4.8. Make psychological support available to families.
C4.9. Create spaces where CRs can die with dignity and be accompanied by their loved ones.
C4.10. Provide emotional-intelligence training for professionals to help them cope with death and with treatment failure

Guidelines validation procedures

The Delphi methodology enables building consensus when empirical and scientific evidence on a given topic is dispersed, by using a panel of experts chosen according to predefined criteria.[43] As Barrios et al. note[42], the Delphi process allows anonymous participation, which reduces social pressure on individual responses and helps achieve a convergence of opinions that more faithfully reflects participants' convictions despite their diverse backgrounds and levels of experience. The questionnaires used to validate the guidelines were created in Microsoft Forms and divided according to the three previously presented levels (A: Structural; B: Professional; C: Care) to accommodate the required number of responses and to avoid software limitations. They were sent to the email addresses that experts had provided in the first survey using the code assigned as their name. The investigators had access only to the code and the corresponding email address and, therefore, could not identify who completed the surveys, which ensured participants' full anonymity because respondents were not asked to identify themselves.

The items for validation were presented according to Table III, and experts were asked to rate each item using the following Likert scale:

1. Totally disagree
2. Partially disagree
3. Neither agree nor disagree
4. Partially agree
5. Totally agree

When a score of 1, 2, or 3 was assigned, experts were asked to provide a comment justifying their disagreement or lack of agreement with the item. The scores were then used to compute content validity indices. Yusoff[44] recommends an item-level content validity index (I-CVI) of at least 0.78 to consider an item valid for a panel size of nine or more. Because a panel of 20 experts was assembled, this threshold was adopted to define positive item validation. In the first round, only 6 items (3.5%) failed to reach agreement; these items were revised according to experts' suggestions and resent for revalidation. In the second round, 15 experts (75% of the panel) responded to the revalidation of the revised items; of those revised items, only 3 (50%) achieved agreement. Consequently, the three items that failed to obtain agreement in both rounds were removed from the initial set. The calculations used to establish content validity followed Yusoff[44] and included: Experts in Agreement (EA); Universal Agreement (UA); item-level content validity index (I-CVI); and scale-level content validity index (S-CVI), computed both by the Mean Method and by the Universal Agreement Method.

Ethical considerations

The Ethics Committee of the School of Health of the Polytechnic Institute of Leiria approved the study. In the initial questionnaire, participants were asked to identify themselves using an initialism formed from the initials of their name (for example, SRVC), so that investigators could link email addresses for feedback on the study's progress while preserving participants' anonymity.

Results

The first Delphi validation round included the 20 selected experts, who were numbered P1–P20 to preserve the anonymity of their responses. The results are presented in Table 4:

Table 4. Results of the first validation round.

A: STRUCTURAL LEVEL			
A1: National policy domain			
Items	**Experts in agreement**	**Universal agreement**	**I-CVI**
A1.1	20	1	1.00
A1.2	20	1	1.00
A1.3	20	1	1.00
A1.4	12	0	0.60
A1.5	19	0	0.95
A1.6	19	0	0.95
A1.7	20	1	1.00
A1.8	20	1	1.00
A1.9	20	1	1.00
A1.10	20	1	1.00
A1.11	20	1	1.00
A1.12	20	1	1.00
A1.13	19	0	0.95
A1.14	19	0	0.95
A1.15	19	0	0.95
A1.16	18	0	0.90
S-CVI (mean): 0.95		**S-CVI (UA): 0.56**	
A2: Community health intervention domain			

A2.1	20	1	1.00
A2.2	20	1	1.00
A2.3	20	1	1.00
A2.4	19	0	0.95
A2.5	19	0	0.95
A2.6	20	1	1.00
A2.7	20	1	1.00
A2.8	20	1	1.00
A2.9	20	1	1.00
A2.10	19	0	0.95
A2.11	20	1	1.00
S-CVI (mean): 0.99		**S-CVI (UA): 0.73**	
A3: Infrastructure adequacy domain			
A3.1	20	1	1.00
A3.2	20	1	1.00
A3.3	20	1	1.00
A3.4	20	1	1.00
A3.5	20	1	1.00
A3.6	20	1	1.00
A3.7	18	0	0.90
A3.8	20	1	1.00
A3.9	20	1	1.00
A3.10	20	1	1.00
A3.11	20	1	1.00
A3.12	20	1	1.00
A3.13	19	0	0.95
A3.14	20	1	1.00
A3.15	20	1	1.00
A3.16	20	1	1.00
A3.17	20	1	1.00
A3.18	20	1	1.00
A3.19	20	1	1.00
A3.20	20	1	1.00
A3.21	20	1	1.00
A3.22	18	0	0.90
A3.23	20	1	1.00
A3.24	19	0	0.95
A3.25	20	1	1.00
A3.26	16	0	0.80
A3.27	20	1	1.00
A3.28	16	0	0.80
A3.29	20	1	1.00
A3.30	20	1	1.00
A3.31	20	1	1.00
S-CVI (mean): 0.98		**S-CVI (UA): 0.81**	
A4 – Institutional and emergency department management domain			
A4.1	20	1	1.00
A4.2	19	0	0.95
A4.3	20	1	1.00
A4.4	20	1	1.00
A4.5	20	1	1.00
A4.6	19	0	0.95
A4.7	20	1	1.00
A4.8	20	1	1.00
A4.9	20	1	1.00
A4.10	19	0	0.95
A4.11	20	1	1.00
A4.12	20	1	1.00
A4.13	20	1	1.00
A4.14	20	1	1.00
A4.15	18	0	0.90
A4.16	20	1	1.00
A4.17	20	1	1.00
A4.18	20	1	1.00
A4.19	20	1	1.00
A4.20	20	1	1.00
A4.21	19	0	0.95
A4.22	20	1	1.00
A4.23	20	1	1.00
A4.24	19	0	0.95
A4.25	15	0	0.75
S-CVI (mean): 0.98		**S-CVI (UA): 0.72**	
B: PROFESSIONAL LEVEL			
B1: Training domain for emergency department professionals			
B1.1	18	0	0.90
B1.2	20	1	1.00
B1.3	20	1	1.00
B1.4	19	0	0.95
B1.5	19	0	0.95
B1.6	18	0	0.90
B1.7	17	0	0.85
B1.8	19	0	0.95
B1.9	19	0	0.95
B1.10	18	0	0.90
B1.11	20	1	1.00
B1.12	20	1	1.00
B1.13	19	0	0.95
B1.14	19	0	0.95
B1.15	19	0	0.95
S-CVI (mean): 0.95		**S-CVI (UA): 0.27**	
B2: Support and professional recognition domain			
B2.1	20	1	1.00
B2.2	20	1	1.00
B2.3	20	1	1.00
B2.4	20	1	1.00
B2.5	20	1	1.00
B2.6	20	1	1.00
B2.7	20	1	1.00
B2.8	19	0	0.95
B2.9	20	1	1.00
B2.10	19	0	0.95
S-CVI (mean): 0.99		**S-CVI (UA): 0.80**	
C: CARE LEVEL			
C1: User embracement domain			
C1.1	19	0	0.95
C1.2	17	0	0.85
C1.3	20	1	1.00
C1.4	18	0	0.90
C1.5	17	0	0.85
C1.6	20	1	1.00
C1.7	20	1	1.00
C1.8	16	0	0.80
C1.9	19	0	0.95
C1.10	17	0	0.85
C1.11	16	0	0.80
C1.12	16	0	0.80
C1.13	19	0	0.95
S-CVI (mean): 0.91		**S-CVI (UA): 0.23**	
C2: Clinical assessment domain			
C2.1	17	0	0.85
C2.2	19	0	0.95
C2.3	19	0	0.95

C2.4	18	0	0.90
C2.5	15	0	0.75
C2.6	17	0	0.85
C2.7	19	0	0.95
C2.8	19	0	0.95
C2.9	19	0	0.95
C2.10	17	0	0.85
S-CVI (mean): 0.90			**S-CVI (UA): 0.00**
C3: Person-centered care domain			
C3.1	16	0	0.80
C3.2	19	0	0.95
C3.3	17	0	0.85
C3.4	20	1	1.00
C3.5	19	0	0.95
C3.6	19	0	0.95
C3.7	20	1	1.00
C3.8	15	0	0.75
C3.9	20	1	1.00
C3.10	20	1	1.00
C3.11	20	1	1.00
C3.12	19	0	0.95
C3.13	19	0	0.95
C3.14	19	0	0.95
C3.15	19	0	0.95
C3.16	20	1	1.00
C3.17	19	0	0.95
C3.18	20	1	1.00
C3.19	13	0	0.65
C3.20	19	0	0.95
C3.21	16	0	0.80
C3.22	19	0	0.95
C3.23	20	1	1.00
C3.24	19	0	0.95
C3.25	19	0	0.95
C3.26	17	0	0.85
C3.27	20	1	1.00
C3.28	20	1	1.00
C3.29	18	0	0.90
S-CVI (mean): 0.93			**S-CVI (UA): 0.34**
C4: Death and end-of-life domain			
C4.1	17	0	0.85
C4.2	14	0	0.70
C4.3	20	1	1.00
C4.4	19	0	0.95
C4.5	17	0	0.85
C4.6	20	1	1.00
C4.7	20	1	1.00
C4.8	20	1	1.00
C4.9	19	0	0.95
C4.10	19	0	0.95
S-CVI (mean): 0.93			**S-CVI (UA): 0.40**

In summary, the structural level submitted the largest number of items for validation (n = 83), followed by the care level (n = 62) and the professional level (n = 25). The item with the lowest item-level content validity index was A1.4 (I-CVI = 0.60), corresponding to the proposed change of the designation "Utente" (user) to "Pessoa Cuidada (PC)" (care recipient). A brief analysis of the calculations shows that all domains exhibited a mean scale-level CVI between 0.91 and 0.99, indicating a high degree of agreement with the items presented. However, when considering S-CVI by Universal Agreement (S-CVI/UA), no domain reached absolute UA (1.0); values ranged from 0 (Domain C2 — Clinical assessment) to 0.81 (Domain A3 — Infrastructure adequacy). A summary of S-CVI by domain is shown in Figure 1:

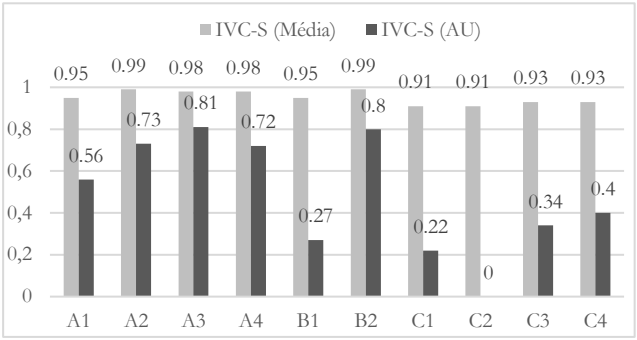

Figure 1. Summary of S-CVI by domain.

For the second round, the six items with I-CVI < 0.78 were identified and their content revised according to experts' suggestions, yielding the following proposed changes:

- A1.4: Change the designation "Utente" to "Pessoa Alvo dos Cuidados" (PAC) and standardize this nomenclature.
- A4.25: Implement an open-door policy allowing companions to remain continuously with the CR, regardless of the CR's level of dependency, except in clinical areas with patients in critical condition and during procedures or situations that require bodily exposure.
- C2.5: Develop strategies to establish rapid yet effective therapeutic bonds with the CR.
- C3.8: Schedule nursing appointments at Primary Health Care (PHC) centers for low- and non-urgent cases to assess educational needs and promote the person's participation in their individualized health plan.
- C3.19: Permit the presence of a family member at the start of resuscitation, if the family member so wishes, assigning a staff member to accompany them to a quiet area to await information from a member of the resuscitation team after the procedure.
- C4.2: Transfer PACs in cardiopulmonary arrest to a designated resuscitation area away from other CRs; if resuscitation is unsuccessful, allow family members to be with the body to begin mourning.

Fifteen experts (75% of the panel) responded in the second round:

Table 5. Results of the second validation round.

Items	E1	E2	E3	E4	E5	E6	E7	E8	E9	E10	E11	E12	E13	E14	E15	E16	E20	EA	UA	I-CVI
A1.4	0	0	1	0	1	0	1	0	1	1	1	0	0	0	0	6	0	6	0	0,40
A4.25	1	1	1	0	0	1	1	0	0	1	1	0	1	1	0	9	1	9	0	0,60
C2.5	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	14	1	14	0	0,93
C3.8	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	15	1	15	1	1,00
C3.19	1	0	1	0	1	0	1	1	0	1	1	0	0	1	1	9	1	9	0	0,60
C4.2	1	1	1	1	0	1	1	0	1	1	1	1	1	1	1	13	1	13	0	0,87
S-CVI (mean): 0,73											S-CVI (UA): 0,17									

Consequently, items A1.4, A4.25, and C3.19 were removed from the initial set. The revised versions of items C2.5, C3.8, and C4.2 were approved and, therefore, represent the final versions to be implemented as guidelines.

Discussion

This research project set out to identify ways to overcome the challenges to humanizing care in EDs and to define the measures needed, based on existing knowledge, to humanize the care delivered by multidisciplinary teams. The literature review revealed that this is a concern among nurses who conduct studies and propose measures to enhance the care they provide, thereby contributing to the updating of the conceptualization of Caring and the development of nursing knowledge, which in turn reinforces their mission within health services and improves quality.[45] Driven by the biomedical model implemented in EDs and by the exponential growth of health technologies, the depersonalization of care has distanced professionals from those they care for, and vertically hierarchical service management pressures them to produce rapid, efficient results, hindering recognition of the person's uniqueness beyond their physical needs.[24] Humanization of care requires the involvement of all stakeholders — direct and indirect — in creating conditions for personalized care grounded in therapeutic relationships that confer dignity and comfort to those who seek EDs [22]. In response to the research question, 170 measures were defined and categorized into three levels (Structural, Professional, and Care) after a full-text review of 37 articles, resulting in measures distributed across 10 domains. In addition to the guidelines defined, it is worth noting that concern for humanizing care already exists as national programs in other countries and as continuous improvement projects in obstetric, pediatric, and psychiatric settings. The greatest number of proposed measures is in the domain of infrastructure adequacy (n = 31), while the fewest are in the domains of clinical assessment, professional support and recognition, and death and end-of-life care (n = 10). This distribution reflects the larger number of studies proposing changes in those areas rather than a difference in relative need.

After being defined through the integrative literature review, the guidelines' content was validated in two rounds using the Delphi methodology, which is recognized for its efficiency in building consensus among diverse professionals on topics where they hold relevant professional and academic experience.[43] Barrios et al.[42] emphasize that appropriate expert selection reduces bias, that opinions are principally shaped by researcher feedback rather than by experts' sociodemographic or professional attributes, and that decision validity is strengthened by submitting proposals to multiple rounds, as done here. Because no substantive feedback was provided to participants between rounds, we minimized the investigator's influence on experts' opinions. Twenty experts were selected according to the predefined criteria and participated in this study; in the first round, they approved 164 proposed guidelines. After the second round of validation of the remaining measures, now evaluated by 15 experts, three items were eliminated at the end of the study.

When asked at the start of the study why they had chosen to become physicians and nurses, the experts reported: a strong community-oriented drive to help others; a passion for caring for other people; the conviction that helping another human being can contribute to the change they wish to see in the world; and the experience of caring as work that fulfills the professional and makes them feel complete as a person—motivations rooted in family illness histories and values received during personal development. Being part of that change motivated all these professionals to pursue (and to remain in) their chosen professions and to participate in this study. For the surveyed experts, the humanization of care entails a necessary renewal of clinical practice toward personalization of care and liberation from a mechanistic model of health care delivery, placing the person and their needs at the center. Their contribution to this study enabled the presentation of a proposal for change in EDs and addressed the need to humanize care through implementation of good practices and recognition of the role professionals can play—beyond technical and scientific competence—in improving the lives of those they care for.

The item-level content validity index calculation enables the quantification of experts' agreement for each proposed measure, with values ranging from 0.60 to 1.00. An absolute value (1.00) corresponded to Universal Agreement, which was achieved for 89 of the items under validation (52%). Thus, the items can be considered to have been well approved by the panel, since only 6 (3.5%) required reformulation and revalidation in the subsequent round. Further evidence of high agreement is provided by the mean scale-level content validity index, whose values across domains ranged from 0.91 to 0.99, with an overall mean of 0.95 for all items. The domains with the highest levels of agreement were A2 and B2; those with the lowest were C1 and C2. Achieving this broad consensus demonstrates how the plurality of opinions among diverse experts can coincide even when responses are provided anonymously.

Universal Agreement was never reached at the domain level (UA = 1.00), despite 89 items attaining UA = 1. Although consensus was reached for the 164 items validated in the first round, no domain achieved universal agreement across all proposed measures. Indeed, the S-CVI (UA) calculation shows that domain C2 had no items with UA, while A3 had the highest mean UA (0.81). Therefore, consensus is attainable even when experts do not fully agree on every item. Ideally, UA would be achieved for all items, but the diversity of opinions enriches studies of this nature because it yields multiple perspectives on a topic while allowing the panel to conceive and validate concepts considered acceptable by the majority of its members.

As noted above, six items did not reach an I-CVI ≥ 0.78 and were therefore revised and resubmitted for a second round. In that round, 15 of the 20 experts (75%) participated, and this decline was one of the challenges encountered during the study. One possible explanation for the reduced participation is the limited time available to reflect adequately on the presented items, since all participants are active health professionals facing daily demands on their time and physical/mental energy. In this second round, only 50% of the revised items achieved approval despite an S-CVI (mean) of 0.73. Interestingly, only one item reached Universal Agreement (C3.8). This finding reflects recognition of the importance of follow-up by Primary Health Care nurses for care recipients who visit an ED and are assigned a low- or non-urgent priority. Andrade and Donelli[27] propose such follow-up to provide clarification of treatment regimens, condition-specific education, and reassessment of needs. The need to establish care networks among institutions through referral pathways is also recognized at this level of agreement and UA, as Lopes argues.

Item A1.4 failed to obtain approval in both rounds, recording an I-CVI of 0.60 in the first round and 0.40 in the second, even after its content was revised. Although Lopes argues that people who seek health care should not be seen as clients but as persons in need of help — and therefore labelled Pessoa Cuidada or Pessoa Alvo dos Cuidados (PAC), a nomenclature to be standardized as part of a person-centered care policy — this item was removed. Experts' justifications included: the complexity of the proposed nomenclature; doubts as to whether the change would actually improve care delivery; the fact that the acronym PAC is already used to denote community-acquired pneumonia, creating confusion and communication difficulties within teams; the term "alvo" (target) not conveying the person's involvement in their care; and the concern that associating the label "cuidado" (care) with the person could create a sense of loss of autonomy for the CR.

Item A4.25 followed the same downward trend in I-CVI after its content was revised, reflecting experts' concerns about clinical areas where patients are critically ill, privacy, and confidentiality. In both rounds, experts emphasized that their clinical experience revealed companions may hinder care delivery due to unfamiliarity with service dynamics, frequent overcrowding in EDs, companions' refusal to assist with hygiene and feeding tasks, inappropriate conduct, and infection-control risks. Lemos[5] advocates applying the pediatric model of companion presence to adults in EDs to reduce the suffering and anxiety this setting causes CR. This view is reinforced by Rios[19], who notes that companions' presence was one of the earliest humanizing practices in services because it did not alter organization or management methods and can serve as support for both the CR and staff. Freitas et al.[23] corroborate these perspectives, but stress the importance of creating spaces that can accommodate companions, as their own discomfort can generate conflicts with staff. Other considerations allowing companions to remain with the CR include providing a private area where they can receive information about their relative's clinical condition and recognizing older people's need for the presence of a trusted person as a "safe haven" in a service whose conditions may not support the comfort they require.[28] In situations of delirium, which are common in EDs, the presence of a family member is particularly important to reassure the CR and to help ensure that physical restraint is used only as a last-resort intervention.[39]

The difference between the two rounds in the validation of item C3.19 was not large; nevertheless, it was eliminated like the two previous items. Dall'Orso and Concha[34] report that professionals view the presence of family members during resuscitation negatively, arguing that it may interfere with procedures and that cessation of resuscitation efforts can be misinterpreted. However, interviews by Dall'Orso and Concha[34] with family members show that, despite the heavy emotional burden and the difficulty of managing it individually, their presence during resuscitation was beneficial for making sense of death, reducing anxiety, and enabling the initiation of grieving — provided they are supported by a professional who explains what is being done and why. The removal of this item highlights the work that still needs to be done with professionals to manage these situations and encourages reflection on family presence during resuscitation.

The Delphi methodology proved effective for gathering consensus within a heterogeneous group of people with different opinions, professions, and experience in ED care. A major advantage of this method, as noted by Marques and Freitas[45], is anonymity, which reduces confrontational debate and prevents opinion shifts due to group pressure or perceived need to follow a single direction to facilitate item validation; it also fosters creativity and deeper reflection on the topics under study. Conducting the process via online questionnaires, as in this study, increases flexibility for experts' participation because it enables geographically dispersed panel members with different work schedules to take part without the time pressure imposed by, for example, a focus-group meeting.[45] Barrios et al.[42] argue that experts' opinions are shaped by feedback received during

the study rather than by sociodemographic factors; in this study, only the need to revalidate the six items that failed to reach agreement in the first round was communicated to the experts. One limitation encountered — and a known drawback of this method, as Marques and Freitas[45] note — was timing: it was necessary to send multiple reminder emails encouraging experts to participate in the content validation and to respond to the three questionnaires (one corresponding to each defined level).

Conclusion

Implementing the presented guidelines requires investment — financial, academic, managerial, and in the workforce (including leadership commitment and staff training) — to shift the biomedical perspective that currently governs service operations, a perspective centered on disease classification, treatment, and cure. The anxiety and tension generated by an emergency episode can be reduced through humanized care without defaulting to sedatives or anxiolytics, and humanized approaches may also promote greater therapeutic adherence to a shared health plan through the involvement and shared responsibility of the care recipient. This work can contribute to much-needed changes in health services, specifically in emergency departments, and to reflection on humanization by policymakers and health professionals, prompting individual practice changes that spread across teams and foster a more humanizing approach. Therefore, psychometric validation of the guidelines on a larger, national sample of professionals is required.

Caring for others while feeling valued — combining technical and scientific competence with empathy and active listening — is the path to a future in which health professionals can make small but meaningful improvements in the lives of those they care for, "making them human." Let us have the courage to change and break the vicious cycles in which a prescriptive model traps us, rendering us cold and distant: one day it may be us who need care and those who accompany us. Let us create a safe, welcoming, and reassuring care environment in which trust in professionals is complete, because we know they will attend to us, our family members, and our friends with a humanizing, attentive gaze that values our needs and offers relief from physical and/or psychological suffering. We should also consider investigating, testing, and implementing humanizing measures across all health professions, bearing in mind that the person is the alpha and the omega of our health care system.

Study limitations

Only physicians and nurses responded to the invitation to participate in this study as experts, despite the invitation being extended to other professionals and to patient/user committees. This is a limitation, since diverse perspectives could have enriched the validation and revision of proposed items from ethical, managerial, psychological, and user-experience standpoints. A further limitation is that the study involved a tiny fraction of health professionals providing care in some regions of the country and is, therefore, not nationally representative.

Author contributions

SC: Study conception and design; Data collection; Data analysis and interpretation; Manuscript writing; Critical revision of the manuscript; Approval of the final version of the manuscript and assumption of responsibility for it.
MD: Study design and conception; Critical review of the manuscript; Approval of the final version of the manuscript and assumption of responsibility for it.

Conflict of interest

No conflict of interest was declared by the authors.

Sources of support/funding

This study did not receive any funding.

Acknowledgements

To the esteemed experts who participated in the study and enabled the validation of more than a hundred items with measures to be implemented in our emergency services to humanize the care provided there: may you maintain the resilience that characterizes the role you play in your services and motivates you to participate in research projects to improve clinical practices.

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