RESEARCH

RELAXATION ENVIRONMENT FOR THE HUMANIZATION OF HOSPITAL DELIVERY CARE

O AMBIENTE DE RELAXAMENTO PARA HUMANIZAÇÃO DO CUIDADO AO PARTO HOSPITALAR

EL AMBIENTE DE RELAJAMIENTO PARA HUMANIZACIÓN DEL CUIDADO AL PARTO HOSPITALARIO

Natasha Faria Barros Guida [1]
Gabrielle Parrilha Vieira Lima [2]
Adriana Lenho de Figueiredo Pereira [3]

[1] Nurse. Specialization Course in Obstetrical Nursing, Residency. College of Nursing. Rio de Janeiro State University. Rio de Janeiro, RJ – Brazil.
[2] Nurse. College of Nursing. Rio de Janeiro State University. Rio de Janeiro, RJ – Brazil.
[3] Nurse. Adjunct Professor, Department of Maternal-Childhood Nursing. College of Nursing. Rio de Janeiro State University. Rio de Janeiro, RJ – Brazil.

Corresponding Author: Natasha Faria Barros Guida. E-mail: nashguida@gmail.com
Submitted on: 06/15/2011 Approved on: 06/04/2013

ABSTRACT

In the public maternity hospital of the city of Rio de Janeiro, connected to the obstetrics unit, an environment of care for parturients was implemented, called the relaxation room. The obstetrics unit still maintains its traditional architecture, with two distinct settings for labor and delivery assistance. The labor room provides little privacy for the parturients due to a lack of cubicles for individual care, but there are curtains to separate the hospital beds. To investigate this experience, a qualitative study was proposed, which aimed to describe the criteria used by nurses to indicate the relaxation environment for parturients and to analyze the meanings, for nurse-midwives, of the care provided in this environment. Twelve nurses were interviewed, and the interview transcripts were submitted to thematic content analysis. The criteria to indicate the relaxation room were grouped under the following themes: needs and desires of the parturients, favorable obstetric criteria, and unfavorable environmental conditions in the delivery process. The meanings of obstetrical nursing care within this relaxation environment were grouped as follows: respecting the rights of women in obstetric care, promoting comfort, and encouraging natural childbirth. The relaxation room is an initiative of obstetric nurses to ensure the principles and values of humanized care in the hospital environment. The traditional environment of the obstetric care unit requires changes for the humanization of care and the comfort to become the right of all parturients and to encourage natural childbirth.

Keywords: Obsteric Labor; Humanizing Delivery; Nursing Care; Obstetrical Nursing.

RESUMO

Em uma maternidade pública da cidade do Rio de Janeiro foi instituído um ambiente de cuidado para as parturientes, anexo ao centro obstétrico, denominado sala de relaxamento. O centro obstétrico ainda tem arquitetura tradicional, com dois espaços distintos para a assistência ao trabalho de parto e parto. A sala do pré-parto proporciona pouca privacidade para as parturientes, devido à ausência de boxes para o cuidado individualizado, mas há cortinas para separar os leitos. Para investigar essa experiência, foi proposta pesquisa de abordagem qualitativa, que objetivou descrever os critérios utilizados pelos enfermeiros para indicar o ambiente de relaxamento às parturientes e analisar os significados, para as enfermeiras obstétricas, dos cuidados realizados nesse ambiente. Foram entrevistadas 12 enfermeiras. As entrevistas transcritas foram submetidas à análise de conteúdo temática. Os critérios para indicar o ambiente de relaxamento foram agrupados nos seguintes temas: necessidades e desejo da parturiente; critérios obstétricos favoráveis e condições desfavoráveis do ambiente no processo do parto. Os significados do cuidado de Enfermagem obstétrica no ambiente de relaxamento foram agrupados nos seguintes temas: o respeito aos direitos das mulheres na assistência obstétrica e a promoção do conforto e o favorecimento do parto normal. A sala de relaxamento é uma iniciativa das enfermeiras obstétricas para assegurar os princípios e valores do cuidado humanizado no ambiente hospitalar. O ambiente tradicional do centro obstétrico necessita de mudanças para que a humanização da assistência e o conforto sejam direitos de todas parturientes e favoreça o parto normal.

Palavras-chave: *Trabalho de Parto; Parto Humanizado; Cuidado de Enfermagem, Enfermagem Obstétrica.*

RESUMEN

En una maternidad pública de la ciudad de Río de Janeiro fue creado un ambiente de cuidado para las parturientes, anexa al centro obstétrico, nominada de sala de relajamiento. El centro obstétrico aún tiene una arquitectura tradicional, con dos espacios diferenciados para la asistencia a lo trabajo de parto y parto. La sala de preparto ofrece poca privacidad para las embarazadas debido a la ausencia de boxes para lo cuidado individualizado, pero hay cortinas para separar las camas hospitalarias. Para investigar esa experiencia local, fue propuesto de investigación del abordaje cualitativa, tipo estudio de caso, que objetivó describir los criterios utilizados por las enfermeras para indicar el ambiente de relajamiento a las parturientes y analizar los significados de la atención prestada en ese ambiente. Fueran entrevistadas doce enfermeras. Las entrevistas transcritas fueron sometidas a análisis de contenido temático. Los criterios para indicar la sala de relajamiento se agruparon en los siguientes temas: necesidades y el deseo de la parturiente, criterios obstétricos favorables y condiciones desfavorables del ambiente en el proceso de parto. Los significados del cuidado de enfermería obstétrica en el ambiente de relajación fueron agrupados en los siguientes temas: el respeto a los derechos de las mujeres en la asistencia obstétrica, la promoción del conforto y el favorecimiento del parto normal. La sala de relajamiento es una iniciativa de las enfermeras

obstétricas para garantizar los principios y valores del cuidado humanizado en el hospital. El ambiente del centro obstétrico tradicional necesita de cambios para que la humanización de la asistencia y el conforto sean derechos de todas mujeres embarazadas y favorezca el parto normal.
***Palabras clave**: Trabajo de Parto; Parto Humanizado; Atención de Enfermería; Enfermería Obstétrica.*

INTRODUCTION

In the 1990's, the Brazilian Health Ministry confirmed that prenatal and delivery care were of low quality, with a high rate of Caesarian sections (C-sections) and a high rate of maternal and perinatal morbimortality in Brazil. Among the strategies employed to combat this problem, the Ministry promoted natural childbirth, restricted payments for C-sections, and encouraged obstetrical nursing care for natural childbirth.[1]

Despite these governmental actions, in 2006, C-sections represented 43% of the total number of births performed in both the public and private sectors in Brazil. Considering only private healthcare plans, this percentage is even larger, having reached 80% of the total number of births. This type of surgery is more common among women with a higher educational level, with 12 years of study or more (nearly 70%), while the number of births by C-section is lower among women with a lower educational level (below 20%).[2] These indicators demonstrate that the quantity and distribution of C-sections are problems that have been worsening as regards Brazilian obstetric care. By contrast, prenatal care has been growing in Brazil, with a growth in the rate of live births from mothers who had had seven or more prior antenatal visits, rising from 43.7% in 2000 to 54.5% in 2006.[2]

In the city of Rio de Janeiro, the Municipal Health Department (SMS/RJ) also sought to qualify and humanize obstetric care. They launched the SMS/RJ Resolution 667/98, which guarantees the presence of an accompanying person during both labor and delivery, reforms the obstetric centers, and expands and improves prenatal, labor, and delivery care.[1]

In addition to these actions, the nurse-midwives were introduced within prenatal care as well as in the direct care during the delivery process. Since 1998, large-scale public maternity hospitals have counted on nurse-midwives who act in direct care during labor and normal delivery in obstetrics units. This initiative seeks to improve perinatal care and offer the woman the possibility of experiencing the delivery and birth of her child in a more humanized manner.[1]

Due to this initiative from the public sector, in a maternity hospital located in the North Zone of Rio de Janeiro, nurse-midwives have created an environment for care during labor, which is connected to the obstetrics unit. This environment aims to offer the pregnant woman a more humanized experience of the delivery process with privacy, security, and comfort. This sector of the obstetrics unit has been functioning since 2000 and was given the name "relaxation room".

Generally, hospitals have environments with excessive illumination and noise, as well as a lack of privacy, which can cause both stress and tension. When in labor, the hospital environment can have a negative impact on the delivery process, due to the stimulus applied to the neocortical region of the brain and, in this manner, inhibit the secretion of endogenous oxytocin, responsible for uterine contractions.[3]

By contrast, the hegemonic obstetrics model has influenced hospital care environments. In this model, the means through which care is produced is similar to a "baby factory". The woman is "processed" and passes through various stages of labor – pre-labor, labor, post-labor – as if in a production line. In the places where this logic prevails, the women are generally isolated from their family members during delivery; are cared for by unfamiliar people, with different teams in each sector; remain restricted to their beds, receiving an intravenous (I.V.) injection of oxytocin to accelerate the labor; are subjected to prolonged fasting; and have their perineum surgically cut to facilitate the birth of the newborn child.[4]

Florence Nightingale considers that the nurse's care must be able to build a favorable and balanced environment, in an attempt to conserve the patient's vital energy.[5] Comfort contributes to one's health, well-being, and satisfaction of the person's needs in the care environment. The intrinsic conditions for this comfort are related to the patient, such as those necessary to maintain the patient's vital functions, including homeostasis, body temperature, food intake, sleep, and rest. The intrinsic conditions involve personal relationships and the patient's adaptation to the care environment.[6]

Obstetric care must provide a receptive and pleasing space which allows for privacy and the establishment of a connection with the patient, contributing to reducing stress during labor. The shapes, colors, and light within the environment exert a true impact on the patient's well-being and health.[5]

Keeping the environment silent and promoting comfort and relaxation during labor are cares that must be instituted. Silence and comfort are necessary for the physiological phenomenon involved in the delivery process to occur in a proper manner, including the release of oxytocin and endogenous endorphins, in turn facilitating the natural course of childbirth.

The implementation of this care environment, as a local and innovative experience, inspired the proposal for the present work, which aims to describe the criteria used by nurses to

recommend *the relaxation room* to parturients and analyze the results of the care provided in this environment.

METHODOLOGY

This investigation was a qualitative research conducted in a large-scale public maternity hospital, located in the North Zone of the city of Rio de Janeiro, which offers medical services for pregnancy, delivery, and childbirth, of both high and low obstetric risk. This institution has a large obstetrics unit, with 12 pre-delivery beds, and attends to more than 5,000 childbirths annually. In 2007, 3,383 live and well babies were born by natural childbirth, with 1,854 (54.8%) births attended to by nurse-midwives.

The pre-delivery beds are individualized by dividing curtains, which takes away the comfort and privacy of the parturients and their accompanying person. The physical space has been remodeled, but it still remains separated from the care environments for labor and delivery. Twelve nurse-midwives work in this center and care directly for labor and delivery, under the work shift of 12 hours on-call per 60 hours of rest.

The relaxation room has been up and running since 2000. In 2007, this environment cared for 648 parturients, whose obstetric profile was of low-risk pregnant women, nulliparous women, and those in the active stage of labor. The most common forms of care provided were a warm bath (76.4%), ambulation (56.2%), and massage (52.8%). The majority (86.3%) of the parturients attended to in this room had their child by natural childbirth, and the C-sections represented only 11.1% of these women's deliveries.

This room is attached to the obstetrics unit and is geared toward the individualized care of the parturients and their accompanying person. It has a differential structure and is similar to a room in a home. Inside it, the decoration is in pastel tones, which makes it possible to reduce the lighting and to use soft music, body massage oils, and incense, according to the wishes and needs of each woman.

Also in this room is a padded medical table, whose dimensions are the same as a king sized bed; parallel bars; a half-moon bench; a bobath ball to allow for the freedom of movements and body positions, such as squatting and pelvic twists during the active stage of labor. There is also an attached bathroom, where the patient can take a warm water shower bath.

As the pre-delivery environment of the maternity ward has an old architectural structure and does not have individual cubicles with a hospital bed for pre-delivery, delivery, and post-delivery care, the relaxation room was created as a care room that is better prepared for the practices of obstetrical nursing care geared toward the humanization of natural childbirth in the hospital. This room is small, measuring approximately 9 m^2, and can attend to only one parturient at a time.

Data collection was carried out in September 2010, respecting core principles in research ethics. This study was approved by the Research Ethics Committee from the Municipal Health Department from the city of Rio de Janeiro, under protocol number 206A/2010. The interviews were previously scheduled and administered by nurses after the patient had agreed to participate in the study and had signed the informed consent form.

The subjects of this research were the 12 nurse-midwives who were responsible for the direct care during natural childbirth in the obstetrics unit of this institution. The semi-structured interviews were based on a previously prepared script, conducted individually and recorded on an MP3 recording device. To assure the anonymity of the participants, the personal accounts were codified by the order in which the participants had agreed to do the interviews (E1, E2, E3...).

The data were analyzed by means of Bardin's Thematic Content Analysis[7], using the following phrases: a) pre-analysis of the account, b) exploration of the material and treatment of the results, and c) inference and interpretation. The aim of this technique is the word, that is, the individual and current aspect of the language, focusing on the meanings attributed by the subjects concerning a specific phenomenon of reality. The content analysis seeks to understand the actors or the environment in which the scene is produced at a determined moment and to become familiar with the content of communication regarding these subjects.

This analytical course determined the construction of two thematic categories: the criteria necessary to recommend this relaxation environment and the meanings of obstetrical nursing care in the relaxation environment.

RESULTS AND DISCUSSION

The criteria necessary to recommend the relaxation environment

The nurses recommended the relaxation environment under the following conditions: needs and wishes of the parturient, favorable obstetric criteria, and unfavorable conditions within the labor environment, which formed the thematic groups.

The first adopted criterion referred to the needs and wishes of the parturient, which involve the physiological phenomenon related to the delivery process. During labor, the distension of the uterus and vaginal wall, caused by the head of the fetus upon each uterine contraction, stimulates local nerve endings which send signals to the hypothalamus to increase the release of oxytocin. This in turn intensifies the uterine muscular contraction, augmenting the stimulus of the posterior pituitary gland for its secretion.[4]

Stress is an adaptive and biological mechanism of defense, characterized by the immediate activation of the sympathetic nervous system, measured by the increased secretion of adrenaline. The excess of sensorial stimulus intensifies the neocortical activity, such as fear and insecurity, which raises the adrenaline levels and inhibits the release of endogenous oxytocin.[8] Therefore, stress does not favor the stages of labor.

This unfavorable emotional state of women during labor has suggested the need for care in the relaxation room, as mentioned in the following accounts.

> *I recommend [the relaxation room] when the parturient appears to be very stressed, very anxious, or even, in some cases, stressed due to pain, to labor, which is at times quite prolonged (E5).*

> *I recommend [the relaxation room] mainly if the woman is very stressed with a high adrenaline level [...] (E8).*

Another criteria used by the nurses is the identification of women who wish to use the relaxation environment during labor. The humanization of the care predicts and considers the rights of the citizen, such as the freedom of choice and the active participation of the user in healthcare, including the exercising of autonomy.[9]

Respecting the wishes of the woman as a recommendation criteria for the relaxation environment were mentioned in the following accounts:

> *I give her [the parturient] full autonomy so that she can choose whether or not she wants to go to the room. Many prefer to stay in the pre-delivery room itself (E1).*

> *Since some women become shy, they prefer to stay in the infirmary, and we understand that (E4).*

The favorable obstetric criteria are assessed by the nurses when recommending the relaxation environment. The absence of gestational risk is an important condition to determine the obstetric profile of the parturients that can be cared for in this environment, as mentioned in the following account:

> *The first criteria is to verify if this patient has a low-risk [obstetric] profile, which is a kind of patient that nurse-midwives can follow and "look after" better (E3).*

Finally, the unfavorable condition of the labor environment is also considered when recommending the relaxation room. Maternity wards in general keep a number of parturients in the same environment, causing a lack of privacy for the parturients to feel at ease to express their feelings and pain, which are major stress factors for the woman.[10]

The nurses' accounts corroborate with this affirmation, assuring that the environment influences the emotional state of the parturient and, consequently, on the delivery process, as illustrated above. The following account characterizes this analysis:

> *The pre-delivery environment many times does not offer a calm moment for her [the parturient] to concentrate on her labor. She continues to be worried about the condition of the pregnant woman beside her. So, a more stressful pre-delivery environment makes it so that, many times, she gets upset, tense, nervous (E1).*

The experience of the delivery process in a hospital environment can generate positive and unique feelings, such as the birth of a child, and negative feelings, such as the lack of privacy and the need to adapt to the environment and to strangers. Therefore, the nurse must recognize the sociocultural, environmental, care, and physiological factors of the delivery process in an attempt to promote a humanized and complete care.[10]

Meanings of obstetrical nursing care in the relaxation environment

The meanings of the obstetrical nursing care in the relaxation environment were placed in the following groups: respect for women's rights in obstetric care, promotion of comfort, and favoring of natural childbirth.

Healthcare as a civil right was guaranteed by the Brazilian Federal Constitution and is one of the core principles of the Unified Health System (SUS). The Rights of Health Services Users and Actions Law defends the respect of women's rights during pregnancy and during the delivery process, which institutionalizes innumerous accomplishments from social movements and serves as an instrument to promote change in healthcare services and in the creation of improved conditions for the full exercise of citizenship.[11]

In this sense, nursing care must necessarily restore subjectivity, guarantee inalienable rights, and build democratic human relationships, overcoming the asymmetries of power that still linger in our society, especially concerning healthcare for women.

This type of care includes not only techniques and healthcare procedures. Care involves concern, interest, and inspiration, as well as kindness, respect, and consideration for the other, the care receiver. There is also the intention to promote the patient's well-being, to maintain the patients safe and comfortable, to offer support, to minimize the risks, and to reduce the patient's vulnerability.[12]

Obstetrical nursing care must promote comfort and empower the woman during labor and delivery, in turn allowing for her, her husband, and her family to experience the moment of the birth of their child as a unique, singular, and extraordinary experience. Freedom, will, and emotion are conscientious expressions that influence the labor and delivery processes. Such a perspective can be seen in the following accounts:

> *But we leave her free to choose, if she wants to take a bath, if she wants to sit, or even if she wants to continue lying down (E11).*

> *When you take them to that more private, more reserved environment, you can see that they feel less invaded, and they are more respected regarding the autonomy of their bodies (E10).*

Nursing care must favor the autonomy of the woman through the presence of the accompanying person of their choice, of the information about the procedures that will be performed, and of the respect for their citizenship rights. In addition, their feminine physiology must be respected, not intervening unnecessarily, offering emotional support to the woman and her family, and facilitating the building of a bond between the mother and the newborn child.[13]

Privacy is also a right that must be guaranteed. In a public maternity hospital in Rio de Janeiro, a cross-sectional study identified that the women gave more value to the proper care during the delivery, when there is physical comfort, psychological support, and privacy, as well as when the professionals answer their questions and acknowledge their needs.[13]

With the institutionalization of the delivery process, women began to be hospitalized in collective pre-delivery rooms, with little or no privacy. With the policy of humanization, some maternity hospitals have remodeled the obstetrics unit environment to make it possible for the accompanying person to stay with the parturient, as well as the implementation of the model known as pre-delivery, delivery, and postpartum (PPP), allowing for the care provided during the clinical periods of the delivery process to be conducted in the same place, which promotes comfort and individualized care.[14]

Humanization, as a care principal, is understood as an obligation of healthcare units to receive the woman, her family members, and the newborn child with dignity. Such a fact demands that the professionals and the organization of the institution assume an ethical and caring stance, promoting a welcoming environment, with hospital routines that do away with the classic isolation imposed upon the woman and the adoption of measures and procedures that are beneficial when accompanying the delivery process and childbirth.[15]

In the studied maternity hospital, the segmentation between the labor and delivery environments still exists. Although the relaxation room has the purpose of promoting humanized care for women during labor, this is dealt with in the delivery room, maintaining the special separation between labor and birth. Such a fact demonstrates that the space and the healthcare practices remain confined to the precepts of the hegemonic obstetric paradigm.

Themes, such as emotional support, the presence of an accompanying person, the offering of advice, and the humanization of care were also pinpointed by this research. Therefore, such findings denote that quality obstetrical nursing care involves attributes including ethics and respect for human dignity, in addition to the stimulus for autonomy and the full exercise of women's rights.

Providing comfort was the second meaning of nursing care within the relaxation environment. The nurses mentioned that they use a warm bath, massage, respiratory exercises, among other forms of care.

In obstetrical nursing, the care technologies involve the techniques, procedures, and knowledge used by the nurse during the care process, which are employed in the different phases of the labor and delivery processes. These technologies are based on the perspective that gestation, delivery, and childbirth are natural events of human life and that their application seeks not to intervene in the physiological processes involved.[15]

Care and comfort are intimately linked and are crucial to the woman during delivery. The favorable environment is an essential condition to comfort and provide the sensation of a welcoming environment, protection, and well-being for the person receiving the care. Comfort provides the advantages of the promotion of strength, empowerment, well-being, capacity to gather the mechanisms necessary to confront the situation, the improvement of one's quality of life and the adaptation to the patient's present condition.[16]

The following excerpts of interviews express this promotion of comfort:

> *Generally, I use relaxation techniques, soft music, lighting, also indirectly, and offer a warm bath (E5).*

> *[...] use of hydrotherapy, the ball, massage, music therapy, and aroma therapy. We use these according to the specific [care] technology that the patient likes (E3).*

Hydrotherapy during labor can cause a relaxing sensation and alleviate pain. It is a technique that uses surface heat for cutaneous stimulation which, associated with the intensity and application times, produces a local, regional, and overall effect. In this sense, it is presented as a complementary and alternative treatment to the obstetric practice.[17]

Among the factors that increase the se-nsation of pain during delivery include: fear, stress, tension, fatigue, cold, hunger, feeling alone, social and affective abandonment, absence of knowledge about what is happening, and the unfamiliar environment. Such a sensation of pain can be reduced through relaxation, trust, correct information, and continuous contact with family members in a comfortable environment.

To minimize the pain, care and comfort technologies can be used, such as immersion in a warm bath, lower back massage, respiratory exercises, and muscle relaxation exercises. These technologies, when applied in a combined or isolated manner, reduce the sensation of pain and the use of pharmacological methods, such as analgesics by I.V. or epidural analgesia.[16] Such considerations were mentioned in the following account:

> *[...] it has to be something that she [the parturient] feels pleasure, feels comfortable, in a welcoming environment. So, we offer the care that she is willing to accept (E7).*

The results shown in this work illustrate that the obstetrical nursing care practice in the relaxation environment contributes to the humanization of the stages of labor in the hospital and improves the experience of the pregnant women during delivery.

The third meaning of nursing care in the relaxation environment was the favoring of natural childbirth, also valuing the technical procedures used for the surveillance of maternal and fetal well-being, as well as the for the stages of labor. The excerpt of the interviews that best illustrates this care was the following:

> *Checking the vital signs of the parturient, of the fetal heart rate, the full examination of the baby and the mother (E4).*

The Brazilian Health Ministry[18] recommends that the evaluation of the pregnant woman include the checking of vital signs (blood pressure, pulse, temperature) and the full physical exam. Also essential is the performance of an obstetric exam, which consists of the periodic auscultation of the fetal heart rate; the measure of the fundal height; obstetric palpation; evaluation of uterine activity, and digital vaginal exam at regular intervals, according to the stages of labor and strictly when necessary for the evaluation of its progress; the follow-up on the stages of labor by means of a partogram to diagnose possible changes and to recommend what appropriate conduct should be taken to correct the problem, avoiding unnecessary interventions. Therefore, human, technical, and qualified care can achieve the improved maternal and neonatal results.

The favoring of natural childbirth was expressed in the following account:

> *[...] when she [the parturient] is relaxing, she can obviously go through labor much more easily. Besides working with respiration and whatnot. Thus, the delivery tends to happen in a smoother and calmer manner, and the results are normally better. These are better deliveries, with children that have a much better reactivity shortly after birth (E3).*

The parturient that participates actively in the delivery process can have a quicker and more satisfactory evolution. This qualitative research analyzed the postpartum feeling in the delivery and birth of children and identified that the access to prior information, the application of care to alleviate the pain, and the appropriate interpersonal relationship between the woman and the healthcare professional contributed to a more satisfactory experience and facilitated the evolution of the delivery process.[19]

FINAL CONSIDERATIONS

The present study demonstrated that the relaxation environment is used by nurses with parturients who have low-risk gestations and who experience intrinsic and extrinsic stress factors during labor. The intrinsic factors can be provoked by the emotional state of the parturient, such as pain and anxiety. The extrinsic factors are generated by the proper pre-delivery environment, which can cause insecurity, fear, fatigue, among other factors that are the consequence of the absence of appropriate conditions for comfort and privacy. These factors interfere in the physiology of the delivery process, provoking alterations in the neurochemical mediators involved in this process.

For the nurse-midwives, the care provided in the relaxation environment respects the women's rights to experience the delivery and birth of their children as a pleasurable and humanly dignified moment, which promotes privacy and physical comfort, in turn favoring natural childbirth.

The relaxation room is a local experience, fruit of the initiative of obstetrical nursing, which seeks to honor the principles and values of human care in the hospital environment. This fact confirms the need for architectural changes in obstetrics units in the studied maternity hospital, given that the organization and functionality of this healthcare environment is directly related to the paradigm of healthcare and to work in the field of health. Therefore, healthcare practices that are fragmented and include unnecessary intervention during the delivery process are contraindicated by scientific evidence.

If the policy of humanization seeks to institute changes in obstetrics healthcare, then changes in both the organization and the architecture of the obstetrics units are also necessary. To attend to these recommendations, the physical structures of some

maternity hospitals and wards have been modified so as not to separate the care environment from the labor and delivery environment. In the maternity hospital where this study was developed, the traditional pre-delivery framework still remains. In this location, the comfort and the privacy of the parturients are compromised, constituting a care environment that is unfavorable to the physiology of delivery and childbirth. These characteristics inspire the nurses to institute a differential environment to promote humanized care and encourage natural childbirth.

These findings can aid similar initiatives in other maternity hospitals as regards the formulation of sensitive and humane nursing care provided to the woman, to her child, and to her family, while their obstetrics units fail to offer the architectural characteristics that are coherent with the policy of the humanization of the delivery process and childbirth. In this light, other studies are warranted to elucidate the perspective of women concerning this relaxation environment.

REFERENCES

1. Pereira ALF. Atuação da enfermeira obstétrica na política pública de humanização ao parto no Rio de Janeiro. REME - Rev Min Enferm. 2006;10(3): 233-9.
2. Instituto Brasileiro de Geografia e Estatística. Indicadores sociodemográficos e de saúde no Brasil. Rio de Janeiro: IBGE; 2009.
3. Brasil. Ministério da Saúde. Política Nacional de Atenção Integral a Saúde da Mulher. Brasília (DF): Ministério da Saúde; 2004.
4. Odent M. A cientificação do amor. Florianópolis (SC): Saint Germain; 2002.
5. Haddad VCN, Santos TCF. A teoria ambientalista de Florence Nightingale no ensino da escola de enfermagem Anna Nery (1962 - 1968). Esc Anna Nery Rev Enferm. 2011; 15(4): 755-61.
6. Silva CRL, Carvalho V, Figueiredo NMA. Predicações de conforto na perspectiva de clientes e de enfermeiros. Cogitare Enferm. 2011; 16(1):49-55.
7. Bardin L. Análise de conteúdo. São Paulo (SP): Edições 70; 2011
8. Almeida NAM, Silveira NA, Bachion MM, Sousa JT. Concentração plasmática do hormônio adrenocorticotrófico de parturientes submetidas a método não farmacológico de alívio da ansiedade e dor do parto. Rev Latinoam Enferm. 2005;13(2): 223-8.
9. Davim RMB, Torres GV, Dantas JC. Efetividade de estratégias não farmacológicas no alívio da dor de parturientes no trabalho de parto. Rev Esc Enferm USP. 2009; 43(2):438-45.
10. Sodré TM, Bonadio IC, Jesus MCP, Merighi MAB. Necessidade de cuidado e desejo de participação no parto de gestantes residentes em Londrina-Paraná. Texto Contexto Enferm. 2010;19(3): 452-60.
11. Brasil. Ministério da Saúde. Direitos dos usuários dos serviços e das ações de saúde no Brasil: legislação federal compilada, 1973 a 2006. Brasília (DF): Ministério da Saúde; 2007.
12. Waldow VR. Atualização do cuidar. Aquichán. 2008; 8(1):85-96.
13. Domingues RMSM, Santos EM, Leal MC. Aspectos da satisfação das mulheres com a assistência ao parto: contribuição para o debate. Cad Saúde Pública. 2004; 20(Supl 1):S52-S62.
14. Brüggemann OM, Parpinelli MA, Osis MJD. Evidências sobre o suporte durante o trabalho de parto/parto: uma revisão da literatura. Cad Saúde Pública. 2005; 21(5):1316-27.
15. Progianti JM, Vargens OMC. As enfermeiras obstétricas frente ao uso de tecnologias não invasivas de cuidado como estratégias na desmedicalização do parto. Esc Anna Nery Rev Enferm. 2004; 8(2):194-7.
16. Carraro TE, Knobel R, Radünz V, Meincke SMK, Fiewski MFC, Frello AT *et al*. Cuidado e conforto durante o trabalho de parto e parto: na busca pela opinião das mulheres. Rev Latinoam Enferm. 2006; 15(n.esp):97-104.
17. Mazoni SR, Faria DGS, Manfredo VA. Hidroterapia durante o trabalho de parto: relato de uma prática segura. Arq Ciênc Saúde. 2009; 16(1):40-4.
18. Brasil. Ministério da Saúde. Parto, aborto e puerpério: assistência humanizada à mulher. Brasília (DF): Ministério da Saúde; 2001.
19. Lopes CV, Meinck SMK, Carraro TE, Soares MC, Reis SP, Heck RM. Experiências vivenciadas pela mulher no momento do parto e nascimento de seu filho. Cogitare Enferm. 2009; 14(3):484-90.