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RESEARCH

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A satisfação dos pacientes com o cuidado de enfermagem na hemodiálise

The patients' satisfaction with nursing care in hemodialysis

La satisfacción de los pacientes con los cuidados de enfermería en hemodiálisis

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ABSTRACT

Objective: To assess the satisfaction of patients of the Hemodialysis regarding nursing care on the part of nurses. **Method:** This is a study of quantitative approach of descriptive, cross-sectional and exploratory type. The data collection was carried out using the Instrument of Patient Satisfaction (ISP), which is composed of 25 questions addressing all three dimensions of nursing care: trust; education and technical training. Each question can be scored from 1 to 5, being 2.5 the average between satisfied and dissatisfied. We included 100 patients who perform hemodialysis at a dialysis center of Rio de Janeiro. **Results:** The overall averagesatisfaction was 3.8; while the size confidence was 3.78; the dimension of education 3.6 and the size technical-professional 4.02. **Conclusion:** Despite fact that the score of satisfaction is above average, the detailed analysis of the issues of ISP reveals that patients of hemodialysis want greater attention and presence of nurses.

Descriptors: Nursing; nursing care; renal dialysis.

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RESUMO

Objetivo: Conhecer a satisfação dos pacientes da hemodiálise com relação aos cuidados de enfermagem por parte dos enfermeiros. **Método:** Trata-se de um estudo de abordagem quantitativa do tipo descritivo, transversal e exploratório. A coleta de dados foi realizada utilizando o Instrumento de Satisfação do Paciente (ISP), composto de 25 questões que abordam três dimensões do cuidado de enfermagem: confiança; educacional e técnico-profissional. Cada questão pode ser pontuada de 1 a 5, sendo 2,5 a média entre satisfeitos e insatisfeitos. Foram incluídos 100 pacientes que realizam hemodiálise em um centro de diálise do Rio de Janeiro. **Resultados:** A média geral de satisfação foi de 3,8; ao passo que a dimensão confiança teve 3,78; a dimensão educacional 3,6 e a dimensão técnico-profissional 4,02. **Conclusão:** Apesar do escore de satisfação acima da média, a análise pormenorizada das questões do ISP revela que os pacientes da hemodiálise desejam maior atenção e presença do enfermeiro.

Descritores: Enfermagem; cuidados de enfermagem; diálise renal.

RESUMEN

Objetivo: Evaluar el grado de satisfacción de los pacientes de hemodiálisis con respecto a cuidados de enfermería por parte de las enfermeras. **Método:** Este es un estudio de enfoque cuantitativo del estudio descriptivo, transversal y exploratorio. La recolección de datos se realizó mediante el Instrumento de la Satisfacción del Paciente (ISP), que se compone de 25 preguntas relacionadas con las tres dimensiones de los cuidados de enfermería: la confianza; la educación y la capacitación técnica. Cada pregunta puede ser puntuada de 1 a 5, siendo 2,5 el promedio entre satisfechos e insatisfechos. Se incluyeron 100 pacientes que realizan la hemodiálisis en un centro de diálisis de Río de Janeiro. **Resultados:** La satisfacción media global fue de 3,8; mientras que el tamaño de la confianza fue 3,78; la dimensión de la educación 3.6 y el tamaño técnico-profesionales 4.02. **Conclusión:** A pesar de la puntuación de satisfacción está por encima de la media, el análisis detallado de las cuestiones de la ISP revela que los pacientes de hemodiálisis desean prestar una mayor atención y presencia de enfermeras.

Descriptores: Enfermería; atención de enfermería; diálisis Renal.

INTRODUCTION

The incidence of Chronic Kidney Disease (CKD) has been increasing in Brazil and, as a consequence, the number of people who need some kind of renal replacement therapy. Recent data from the Brazilian Society of Nephrology[1] indicate that currently more than 110 thousand patients undergo dialysis in Brazil, of which more than 90% undergo hemodialysis (HD).

Although it is a method to delay life, HD brings a series of limitations to the life of the patient, such as food and water restriction, reduction of social and leisure time, as well as difficulties to perform common daily activities.[2]HD also causes changes in the lifestyle of patients and their families regarding the emotional, economic and social aspects.[3]

Thus, in addition to the limitations related to work and locomotion, there are sometimes emotional changes such as depression and the desire to die.[4]Factors such as the time spent in HD sessions, periodic medical visits, examinations, diets and the expectation of transplantation are factors that can contribute to the emergence of psycho affective diseases.[5]

For HD, patients usually go to a dialysis unit three times a week. In this way, they coexist intensely with health professionals, and especially with the nursing team. However, professionals and patients have different dimensions and perspectives about HD.[6]

In this sense, a study on the social representations of the health-disease process affirms that most patients have the affection as the main conception of health, being followed by the feeling of well-being and control of the disease. However, with regard to professionals, the same study points out that the main health representations were defined as normality, opposite or absence of disease, well-being and harmony/ homeostasis.[6]

Notwithstanding diversity, as far as the representation of health is concerned, the individual characteristics of both parties (professionals and patients) are able to interfere in the interpersonal relations acting on the dynamics of the groups inserted in these spaces and, nevertheless, generating conflicts.[7]

In recent years there has been an expressive development of nephrology as a specialty in the health area; an event that is mainly due to the improvement of dialysis and renal transplant techniques. In view of this event, nurses needed to learn the management of the equipment in search of the best way to care for those individuals affected by chronic renal failure.[8]

However, although it is a specialized care, it is expected that the nursing action will not be reduced to the accomplishment of a set of techniques. It is evidenced in HD the need for a care based on the qualification of professionals to seek the best conditions to provide the quality of life of the patient.[9]Therefore, nursing care in this scenario also involves interactive action, supported by the ethical dimension between caregiver and caregiver.[10]

It is in the scenario of HD that the encounter between the patients and the nurses takes place. These professionals are assigned supervisory activities of the team and linked to the management of the unit, to the detriment of the care directly related to patients who perform HD. Some authors point out the existence of a conflict between managing care and providing direct care to the patient, a situation aggravated by the excess of administrative activities, the insufficient number of nursing personnel and the lack of planning.[11]

Some authors affirm that patients wish that the central focus of nursing care is the sick person and his/ her humanity, together with the technical competence for the safe execution of the activities. Therefore, nursing care must ally with interpersonal competence and technique, in order to demonstrate not only the accomplishment of a technical procedure, but also to attend to the subjectivity that permeates the aspects that lead to illness.[11]

When they feel that their expectations regarding care are matched, patients are better able to respond positively to

the interventions proposed, with an even increase in their quality of life. Knowing patient satisfaction enables nurses to transform their practice in order to qualify care. The evaluation of patient satisfaction, in many cases, appears as a strategy for adherence to treatment, return to the health unit and even to indicate an institution to family and friends.[12]

To this end, it is recommended to use instruments with reliability and validity. Over the years, some instruments have been developed with the objective of evaluating the satisfaction of the users of health units, as a tool for improving services.

One of the instruments created with the purpose of knowing the satisfaction of the patient with regard to nursing care is the instrument of patient satisfaction (ISP). The Patient Satisfaction Instrument was developed in 1982 and addresses situations related to nurses' nursing care, within three domains: trust, educational and technical-professional.[13]

Given the specificities of the HD scenario and the relationship between the users and nursing professionals of this service, this discussion aims to satisfy the patients with the nursing care dispensed by the nurses.

This article is an integral part of a doctoral thesis, built with the purpose of discussing the relationship between the nursing team and patients in the context of HD. The present discussion, however, aims to know the satisfaction of HD patients with regard to nursing care by nurses.

METHOD

This is a descriptive, quantitative, descriptive, cross-sectional, and exploratory study conducted at a private dialysis center in the Rio de Janeiro area, where approximately 300 patients of both genders and of different age groups undergo treatment Hemodialytic. The center is composed of about 6 dialysis rooms, which have 10 to 15 patients each.

The selection of the sample of participants took place for convenience, in a non-probabilistic, intentional and opportunity manner. Thus, during the HD session the patients were approached and, after presentation of the study objectives, they were invited to participate in a free and free of charge form. In total, 100 patients were included. Those under 18 years of age were excluded and those who did not have the cognitive conditions to respond to ISP questions.

As mentioned, the ISP was used as a data collection tool, which was translated and validated through a work done for application in Portuguese language.[14]The ISP measurement scale is Likert-type, with five response options ranging from "fully agree" to "strongly disagree". For items with negative sentences, the scale score is evaluated in an inverted manner, and the higher the score obtained with the sum of the ISP scores, the higher the level of patient satisfaction with the care provided.[15]

With regard to the trust domain, the ISP is composed of eleven questions about the professional relationship with nurses; whereas the educational domain has seven questions that refer to the nurses' attitudes towards the patient; and the technical-professional domain, seven other items on the technical issues of care.

Considering that the answers can be scored in the interval between 1 and 5, for both positive and negative questions, the average (2.5) was determined as the cut-off point for the present discussion, in agreement with studies that also used this instrument.[15] Therefore, patients with a satisfaction score above 2.5 were considered satisfied with regard to nursing care.

The first phase of the data collection consisted of recording sociodemographic data of the study participants, in order to create a sample profile. Next, the ISP was applied in order to determine the degree of patient satisfaction for the nursing care offered by the nurses.

After the data collection, they were organized in an Excel spreadsheet and then submitted to analysis using StataSE 13 statistical software to obtain proportions, means, standard deviations and confidence intervals.

It should be mentioned that all the ethical precepts of the research involving human beings were followed, in accordance with Resolution 466, of December 12, 2012. In this sense, the patients' participation occurred through consent in the form of free and informed consent. The project was submitted to the Research Ethics Committee, which issued a positive opinion through the protocol number CEP/UERJ 1,393,230.

RESULTS

Table 1 presents the sociodemographic characterization of the patients included in the study. Through it we perceive that there is a predominance of females (56%). The distribution of the age groups obtained similar results for the 40 to 59 year olds (40.4%) and over 60 years old (41.4%), which shows that more than 80% of the study population was older or Equal to 40 years.

Regarding marital status, 41% of the patients stated that they had stable marital status and 59% lived alone, 29% of whom were single and 30% were separated or divorced.

Only 12.4% of the patients are in an active labor situation, 80% of whom are retired or receive some type of assistance due to their health condition. About 7% of the patients are unemployed and have no formal financial income.

Table 1 - Sociodemographic characterization of a sample of patients from a dialysis center in Rio de Janeiro, RJ, Brazil, 2016 (n = 100)

Variables	n	%	IC95%
Gender	100		
Male		44.0	34.4/54.0
Female		56.0	46.0/65.5

(To be continued)

(Continuation)

Variables	n	%	IC95%
Age	99		
From 20 to 39 years		18.2	11.7/27.2
From 40 to 59 years		40.4	31.1/50.5
60 yearsor more		41.4	32.0/51.5
Marital status	100		
Single		29.0	20.8/38.7
Married		41.0	31.7/51.0
Others		30.0	21.7/39.8
Professional situation	100		
Active		12.4	7.1/20.7
Active - Licensed		15.5	9.4/24.3
Unemployed		7.2	3.5/14.5
Retired		64.9	54.8/73.9
INSS Beneficiary	100	89.0	81.0/93.9
HaveReligion	100	87.0	78.7/92.4

Source: The author, 2016.

Among the participants in the study, 87% stated that they have a regular religious practice, of which 51.7% are catholic, 35.6% are evangelicals, 11.5% are spiritualists and 1.2% are spiritual.

Regarding the clinical aspects of DRC, 7.0% of the patients reported previous peritoneal dialysis (DP); As well as 10% reported having undergone kidney transplantation before, for various reasons, to perform HD. Therefore, 83% of the study participants did not perform any type of therapy, with HD being the first method chosen to replace renal function.

Commonly, many patients are diagnosed for DRC in the context of dialysis urgency, which poses serious health and survival risks. Regarding the mean time of diagnosis of DRC, for the patients included in the study, we had about 8.1 years, and the median of 8 years. The mean duration of HD was 5.5 years, and the median was 5 years. These indices, expressed in Table 2, seem to suggest that there was an average interval of about 3 years between the diagnosis of DRC and the initiation of renal replacement therapy (TRS), in this case HD.

Table 2 - Characterization of renal disease in a sample of patients from a dialysis center in Rio de Janeiro, RJ, Brazil, 2016 (n = 100)

Variables	Average (years)	Median	IC95%
Diagnostic time	8.1	8.0	6.4/9.6
HD Time	5.5	5.0	4.5/6.5

Source: The author, 2016.

Next, we present the results related to the satisfaction of the patients of the HD regarding nursing care by the nurse. As mentioned in the study methodology, these data were obtained from the application of the patient satisfaction instrument (ISP).

Table 3 shows the order in which each question is presented in the instrument, the domain to which it belongs, its statement, followed by the mean and the respective standard deviation, according to the data obtained study.

Table 3 - Distribution of mean patient satisfaction in a dialysis unit in the northern area of Rio de Janeiro, Rio de Janeiro, Brazil, 2016 (n = 100)

Order	Domain*	InstrumentItems	Average	DP
22	C	I was tired of talking to myself as if I were an inferior person.	4,6	0,79
20	TP	The nurse does not do her job properly.	4,4	0,71
3	C	The nurse is a nice person to have around.	4,3	0,78
4	C	We feel comfortable asking the nurse questions.	4,2	0,92
19	C	The nurse does not have enough patience.	4,2	0,84
13	TP	The nurse is always too disorganized to appear calm.	4,2	0,83
25	TP	The nurse is always too disorganized to appear calm.	4,2	0,75
7	E	The nurse explains things in simple language.	4,1	0,93
16	TP	The nurse really knows what she's talking about..	4,1	0,81
17	E	It is always easy to understand what the nurse is saying.	4,1	0,80
18	TP	The nurse is too slow to do things for me..	4,0	0,89
15	TP	The nurse gives good advice.	4,0	0,83
23	C	Just by talking to the nurse, I feel better already..	4,0	0,77
21	E	The nurse provides guidance at the correct speed.	3,9	0,88
14	C	The nurse is sympathetic when listening to the patient's problems.	3,9	0,86
6	C	The nurse is a person who can understand how I feel.	3,7	1,06
8	E	The nurse asks a lot of questions, but when he gets the answer, he seems to do nothing about it.	3,7	1,06

(To be continued)

(Continuation)

Order	Domain*	InstrumentItems	Average	DP
2	E	The nurse often thinks that you are not able to understand the medical explanation of your illness, so he simply does not bother to explain.	3,6	1,20
5	C	The nurse should be friendlier than he (she) is.	3,5	1,21
12	TP	The nurse wants to show me how to follow the medical guidelines.	3,4	1,15
24	E	The nurse always gives full and sufficient explanations of why the exams were requested.	3,4	0,99
9	C	When I need to talk to someone, I can tell my problems to the nurse.	3,2	1,06
10	C	The nurse is too busy at the post to waste time talking.	3,1	1,23
1	C	The nurse should be more attentive than he or she is.	3,0	1,39
11	E	I would like the nurse to give me more information about the results of my exams.	2,5	1,11

* Subtitle: C (Confidence); E (Educational) e TP (Technical-professional).

Source: The author, 2016.

Regarding the trust dimension, the issue that scored highest (4,6) was "I'm tired of the nurse talking to me as if I were an inferior person," indicating that the patient does not feel inferiorized by the nurse. That is, at this point aspect of the relationship with the nurse, the patients consider themselves extremely satisfied. This fact is reinforced by another question that obtained a fairly high average satisfaction (4.3), which is "The nurse is a nice person to have around."

However, the question "the nurse should be more attentive than he/she is"obtained the lowest score (3.0) related to the trust dimension, which is close to the average of the instrument. Thus, we understand that although the patient feels comfortable with the nurse and does not feel inferiorized by him, he considers that he receives little attention from this professional.

With regard to the trust dimension, it should be noted that two questions obtained equal results (4.1) for the average satisfaction. They were: "The nurse explains things in simple language" and "It is always easy to understand what the nurse is saying," which indicates that the nurse has the ability to communicate accessible to patients, making it easy to understand the information being transmitted.

However, the question "I would like the nurse to give me more information about the results of my exams" obtained the lowest average score (2.5) among all the questions of the instrument. This aspect can also be explained by the above, when we discuss the question of the overload of administrative activities, to the detriment of direct care to the patient, which also involves the provision of guidelines.

With questions related to the technical-professional dimension, the one that obtained the highest average (4.4) was "The nurse does not do his job correctly", which indicates that the patients are satisfied with the Work performed by the nurse and that, therefore, consider that the same does his work properly.

However, the question "The nurse wants to show me how to follow the medical guidelines" obtained the lowest mean of this dimension (3,4), again expressing a gap in the nurses' performance.

Table 4 presents the scores obtained for satisfaction in each of the three dimensions of the ISP and, finally, the overall satisfaction of the study. In addition to the averages, we present the standard deviation, the minimum and maximum values, and the confidence interval (95%) for each of these elements.

Table 4 - Satisfaction of patients with nursing care in a sample of users of two dialysis centers in Rio de Janeiro, RJ, Brazil, 2016 (n = 100)

Dimension	Average	DP	Min.	Max.	IC 95%
Confidence	3.78	0.66	1.54	5.00	3.65/3.92
Education	3.60	0.63	1.86	4.86	3.47/3.72
Technical-professional	4.02	0.60	2.00	5.00	3.90/4.14
Overall Satisfaction	3.8	0.59	1.92	4.84	3.69/3.92

Source: The author, 2016.

Observing the table presented, we found that all averages (of the three dimensions and the general mean of the ISP) are above 2.5, which appears as an indicator that the patients included in the study are satisfied with the care offered by the nurse. It should be mentioned that, of the total of the study participants, only 3 had a satisfaction score below 2.5, respectively: 1.99; 2.06 and 2.16.

In observing the general satisfaction score (3,8), we noticed that it is above the ISP average, which seems to indicate that the participants in the study are satisfied with regard to the nursing care offered by the nurse. At this point, it should be mentioned that only 3% of the patients had a below-average satisfaction score considered as a cutoff point.

Finally, Table 5 provides a cross-reference of the overall satisfaction and its respective dimensions, with the sociodemographic variables of the patients who participated in the study.

Table 5 - Mean of the satisfaction scores of patients with nursing care, by sociodemographic variables, in a sample of users of two dialysis centers in Rio de Janeiro, Brazil, 2016 (n = 100)

Variables	Confidence	Education	Technical (a)	Satisfaction (b)
Gender				
Male	3.70	3.56	4.00	3.75
Female	3.85	3.63	4.04	3.84
P-value	0.384	0.207	0.389	0.191
Dialysis Center				
Center1	3.83	3.62	4.07	3.83
Center2	3.73	3.57	3.97	3.75
P-value	0.692	0.645	0.763	0.239
Age				
From 20 to 39 years	3.52	3.25	3.88	3.54
From 40 to 59 years	3.85	3.68	4.06	3.86
P-value	0.219	0.203	0.510	0.126
Marital status				
Live alone	3.75	3.53	3.93	3.74
Live together	3.85	3.70	4.17	3.90
P-value	0.781	0.270	0.885	0.920
Professional Situation				
Active	3.55	3.46	3.87	3.61
Inactive	3.82	3.62	4.05	3.83
P-value	0.574	0.584	0.181	0.338
Beneficiary				
No	3.68	3.71	4.01	3.78
Yes	3.80	3.58	4.03	3.80
P-value	0.142	0.149	0.243	0.889
Have Religion				
No	3.64	3.56	4.05	3.73
Yes	3.81	3.60	4.02	3.81
P-value	0.397	0.490	0.612	0.525
DP(c) prior to HD				
No	3.75	3.57	4.00	3.77
Yes	4.18	4.04	4.30	4.18
P-value	0.552	0.679	0.563	0.645
TX(d) prior to HD				
No	3.81	3.61	4.04	3.82
Yes	3.56	3.48	3.93	3.64
P-value	0.117	0.254	0.193	0.560

Subtitle: (a) Technical-professional dimension; (b) Dimension of general satisfaction; (c) DP; (d) Kidney Transplantation

Source: The author, 2016.

DISCUSSION

The 2015 census[1] of SBN revealed that over the last year more than 110 thousand patients were kept on dialysis, with a prevalence of 544 patients per million population. There is an estimate that, each year, more than 36,000 people will be included in a dialysis program. In the state of Rio de Janeiro, there are more than 11 thousand patients on dialysis, with a prevalence higher than the national index of 687 patients per million population.

Similar to the data obtained from the characterization of the study population, the predominant age range in dialysis centers in Brazil is also considerably concentrated from the age of 45 years. Thus, among the 726 dialysis units in the country, about 22% are in the age group of 20 to 40 years; 42% between 40 and 60 years and 33% in the range above 60 years.

With regard to the distribution by sex, the SBN census [1]reports that 58% of dialysis patients in Brazil are male and 42% are female. Therefore, we have a reversal of the indexes when compared with the results of the present study, which can be attributed to the random selection of the sample, or to a regional difference related to the participating dialysis centers.

In view of the scores obtained with the issues related to the trust dimension of the ISP, we realized that the patient would like to have greater attention of the nurse and that, however, does not consider that this fact is related to the way of being of this professional, because he/she considers it " pleasant "and do not feel diminished by it. This finding is in agreement with that described by another study[16], which attributes the deficiencies of care to the nurse's excess of work activities.

When observing the disparity of the questions regarding the educational dimension, it is necessary to reflect on the practice of the nurse. In the context of health care, the nurse is expected to develop a series of managerial activities, many of them of importance for the realization of care.[17]However, by having to take on these activities, he/she sometimes moves away from direct patient care, failing to provide him with what is expected of him. In this sense, a study[18]affirms that "the nurse is too involved with activities that aim the interests of the institution, executing administrative and bureaucratic actions to the detriment of the caregivers".

The HD nurse should develop skills as an educator for interaction with the patient and their family members. It should focus mainly on supporting the patient in facing the therapy and in the process of adaptation to the new condition of life, conditions proper to that of a person with an incurable chronic disease, such as CKD.[19]

When we observe the general indexes obtained with the ISP, we realize that, although the nurse has the ability to communicate in an accessible language, it does not convey the information desired by the patients. In this case, data on routine exams performed periodically in the dialysis centers.

The highest scores obtained in each dimension seem to express the total set with respect to satisfaction. That is, the

patient expresses his satisfaction when having the nurse next to him, because he considers it pleasant. With the nurse, he can establish a dialogue in a simple way and understand the guidelines he has made.

However, the lower averages of each dimension seem to highlight the distance between the nurse and the patients in the context of HD. With each grouping of ISP issues, the patients expressed their need for more attention as well as more information and guidance from the nurse.

Although the questions related to the lack of information and orientation are quite specific, dealing respectively with the results of medical examinations and recommendations, we question the other orientations by the nurse. Considering the dissatisfaction of patients in this aspect of care, we reflect on the space for other guidelines that may be necessary, such as those aimed at encouraging self-care and adherence to treatment.

The scientific literature [20]reinforces this reflection by identifying that patients' expectations of care are aimed at more humanized nursing care with greater attention, dialogue, and affection on the part of the team. In addition, they expect a technically qualified, dignified and respectful attention.

Still on the ISP's results, one of the issues of the trust dimension seems to indicate that, in fact, there is no opportunity for the patient to address their personal issues with the nurse. Faced with the question "When I need to talk to someone, I can tell my problems to the nurse," the average was 3.2. Although it was above the average of satisfaction, it was one of the lowest score issues within the dimension that is proper to it.

At this point, reflecting on the reasons that can provide this distance, we observe the average for the question "The nurse is very busy at the post to waste time talking." This question, also related to the trust dimension, obtained a mean score of 3.1. Therefore, although it is discreetly above average, it can indicate that the attributions imposed on nurses in their professional practice, as already mentioned, can actually impair their interaction with patients, the institution of dialogue and, ultimately, care itself.

Looking at table 4, we would like to highlight that the highest average (4.02) is related to the technical-professional dimension, linked to the performance of procedures and other practical activities of the nurse. The education dimension was the one that obtained the lowest average (3.60) and, despite being above the cutoff point for satisfaction, suggests the need to reflect on the role of nurses in providing information and guidance.[15]

There is confirmation in the literature of this finding emphasizing that patients who reported receiving incomplete information on their treatment had lower levels of satisfaction regarding nursing care.[21]

In general, there were no significant changes in the overall satisfaction index or in the satisfaction related to the three dimensions of PSI when associated with variables: gender, dialysis center, marital status, and benefit.

Regarding the age group, it is noticed that younger patients (20 to 39 years) have lower general satisfaction, as well as in all ISP dimensions. It is possible to assume that the emotional impact of dialysis therapy is greater on a young individual, whose personal projects have not yet materialized due to the prematurity of the DRC incidence on their lives. In addition, HD causes impairment of the patient's self-image, which often leads to decreased social conviviality and depression.[22]

Likewise, patients who still have professional activity express lower overall satisfaction and in all three dimensions of the ISP. Contrary to what might be supposed, this association can perhaps be explained by the difficulty of reconciling work activity with the mandatory frequency at the dialysis center for HD.

The changes caused by DRC are not limited to those related to lifestyle, food and hydration. Its scope reaches the habits of life, work, leisure and social activity, bringing impact in all dimensions of the patient's life.[23]

Among the patients who declared that they did not have a religion, the confidence dimension had a considerable decrease, and the other dimensions did not change significantly. Those who claimed to have religion, however, had averaged above the general average for the ISP.

There is a significant influence of religiosity/spirituality on the quality of life of individuals. In many cases faith intensifies after the diagnosis of a serious or limiting illness. After the illness, there is a tendency for people to turn to religion more, which allows them to reshape their own values and attitudes towards quality of life.[24]

With regard to the DP realization previous to the current HD, there was an expressive increase in relation to the general satisfaction, as well as of the other dimensions of the ISP. To this fact we associate the idea that PD is performed daily, whereas HD is performed three times a week.

It can be assumed that HD, despite all its characteristics, may be more pleasing to a group of patients when compared to DP. In addition, the TRS experience is already part of the daily life of the individual. Therefore, the transition between the two methods may not have an impact on patient satisfaction. In addition, there is an increase in the survival of individuals when integrating the two dialytic modalities and, even more, in those who started the SRT in DP and were later transferred to HD. In this way, the patient can enjoy the contributions of each of the modalities.[25]

The same was not observed in patients who underwent kidney transplantation before performing the current HD. Patients who perform HD as a function of loss of renal graft function express greater general dissatisfaction and associated with all ISP dimensions. Since transplantation is the therapy most strongly desired by patients because it is the closest to the normal physiological behavior of the organism, we assume that the patients have a loss of their satisfaction when they need the HD to survive.

In this sense, when comparing the quality of life of patients in HD and those in a post-renal transplant situation, a significant improvement in the quality of life of the second group is observed. The same authors attribute this condition to the improvement of physical, social and economic conditions. Therefore, we can assume that, when moving in the opposite direction (from TX to HD), there is a decrease in the quality of life, with consequent decrease in patient satisfaction.[26]

The simple fact that the individual is awaiting the performance of the TX represents improvement of the quality of life, if compared with the quality of life of those who are in HD and who do not have perspective of receiving the organ in transplant[27].

Among the limitations of the study, we can cite the fact that it was performed inside the dialysis center, in which patients may eventually feel intimidated to offer good answers. However, this was the best strategy found to enable data collection.

CONCLUSION

At the end of the study, we conclude that the patients of the HD present above-average satisfaction with nursing care, in relation to the three domains of the ISP when analyzed in a general way. However, by looking at the issues in each domain in isolation, we have identified some aspects that express that patients want the nurse to be closer and also that he provides more information.

The educational score was the lowest among the three levels of the ISP, revealing a lower level of satisfaction with this aspect of nursing care. Likewise, the issues that, in isolation, obtained the lowest mean of the study are related to the educational dimension. The technical-professional dimension obtained the highest overall score, demonstrating that patients are satisfied with the procedures and other care offered from this perspective.

The distribution of variables in the study scenario, in general, was in line with the recent census of dialysis centers in the country. Some variables in the study had lower satisfaction scores, such as those in the 20-39 age group, or for patients who perform some type of work activity. On the other hand, patients who performed PD prior to HD had a higher overall satisfaction level than those who never performed the former.

Despite these apparent correlations, the statistical test did not reveal a consistent association that allowed affirming that the selected variables influence satisfaction in some way.

Finally, it should be mentioned that, despite the possible limitations of the study, it was possible to determine the degree of satisfaction with the nursing care offered by the nurses in the HD scenario. When considering the scores for ISP issues, we perceive that patients wish that these professionals are more present with them, performing educational actions, such as guidelines for adaptation to HD and the provision of test results.

Given these findings, it becomes possible for nurses to reflect on their praxis of care for HD patients, in order to implement constructive changes to improve the quality of care.

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