Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

ORIGINAL ARTICLE

SPECIAL NEEDS IN INTENSIVE CARE CENTER: AGGRAVATING AND MITIGATING FACTORS

NECESSIDADES ESPECIAIS NO CENTRO DE TERAPIA INTENSIVA: FATORES AGRAVANTES E ATENUANTES

NECESIDADES ESPECIALES EN EL CENTRO DE TERAPIA INTENSIVA: FACTORES AGRAVANTES Y ATENUANTES

Priscilla Tereza Lopes de Souza[1], Jocelly de Araujo Ferreira[2], Jaciara Milena de Araújo[3], José Joeudes Queiroz Nogueira[4], Mariana Albernaz Pinheiro de Carvalho[5], Jussara de Lucena Alves[6]

ABSTRACT

Objective: to investigate the special needs of hospitalized patients in the Intensive Care Unit and identify the factors that influence positively or negatively in meeting their special needs. ***Method***: a descriptive exploratory study with a qualitative approach, conducted with 10 patients of adult ICU of the HUAC, from a semi-structured instrument. The research project was approved by the Research Ethics Committee, with CAAE: 14308013.7.0000.5182. ***Results***: three categories emerged: Investigating the biopsychosocial needs as special needs of patients in intensive care; Identifying the contributing factors in meeting the special needs in intensive care; and Investigating the aggravating factors in meeting the special needs in intensive care. ***Conclusion***: the contributory factors in meeting the special needs in the ICU are: team work, acquired bond, agile assistance and constant companion. While aggravating factores are: absence of gregarious, social shame, temperature and lighting. ***Descriptors***: intensive Care; Nursing; Health Care.

RESUMO

Objetivo: averiguar as necessidades especiais de pacientes internados no Centro de Terapia Intensiva e identificar os fatores que influem, positiva ou negativamente, no atendimento de suas necessidades especiais. ***Método:*** estudo exploratório descritivo, com abordagem qualitativa, realizado com 10 pacientes da UTI adulto do HUAC, a partir de um instrumento semiestruturado. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE nº: 14308013.7.0000.5182. ***Resultados:*** emergiram três categorias: Investigando as necessidades biopsicossociais enquanto necessidades especiais dos pacientes em terapia intensiva; Identificando os fatores contributivos no atendimento das necessidades especiais em terapia intensiva; e Investigando os fatores agravantes durante atendimento das necessidades especiais em terapia intensiva. ***Conclusão:*** os fatores contributivos no atendimento das necessidades especiais no CTI, são: trabalho da equipe, vínculo adquirido, agilidade na assistência e companhia constante. Enquanto os agravantes foram: ausência de gregária, pudor social, temperatura e iluminação. ***Descritores:*** Terapia Intensiva; Enfermagem; Assistência à Saúde.

RESUMEN

Objetivo: averiguar las necesidades especiales de pacientes internados en el Centro de Terapia Intensiva e identificar los factores que influyen, positivamente o negativamente, en la atención de sus necesidades especiales. ***Método:*** estudio exploratorio y descriptivo, con enfoque cualitativo, realizado con 10 pacientes de la UTI adulto del HUAC, a partir de un instrumento semi-estructurado. El proyecto de investigación fue aprobado por el Comité de Ética en Investigación, CAAE nº: 14308013.7.0000.5182. ***Resultados:*** surgieron tres categorías: Investigando las necesidades biopsicosociales como necesidades especiales de los pacientes en terapia intensiva; Identificando los factores contributivos en la atención de las necesidades especiales en terapia intensiva; e Investigando los factores agravantes durante atención de las necesidades especiales en terapia intensiva. ***Conclusión:*** los factores contributivos en la atención de las necesidades especiales en el CTI, son: trabajo de equipo, vínculo adquirido, agilidad en la asistencia y compañía constante. Mientras que los agravantes fueron: ausencia de gregaria, pudor social, temperatura e iluminación. ***Descriptores:*** Terapia Intensiva; Enfermería; Asistencia a la Salud.

[1]Nurse, Resident in Intensive Therapy, Restoration Hospital. Recife (PE), Brazil. E-mail: priscillasouza_@hotmail.com; [2]Nurse, Master Professor, Federal University of Campina Grande/UFCG. Campina Grande (PB), Brazil. E-mail: jocellyaferreira@hotmail.com; [3]Graduated in Nursing, Federal University of Campina Grande/UFCG. Campina Grande (PB), Brazil. E-mail: jaciaramilena@gmail.com; [4]Nurse, Federal University of Campina Grande/UFCG. Campina Grande (PB), Brazil. E-mail:joeudes.q@hotmail.com; [5]Nurse, Master Professor, Federal University of Campina Grande/UFCG. Campina Grande (PB), Brazil. E-mail: mary_albernaz@hotmail.com; [6]Nurse, Resident in General Emergency, Restauration Hospital - UPE. Recife (PE), Brazil. E-mail: jussaradelucena@gmail.com

INTRODUCTION

After World War II, in the twentieth century and the increasing advancement in technology, there was the need to expand studies and improve material resources for care in intensive care. With these studies, it was sought to achieve satisfactory comfort and slow the process of death with innovations in treatment and improvements in practice, allowing a qualification in attendance.[1]

The Intensive Care Units (ICU) aims to provide a comprehensive and intensive care to patients who are in critical situation, however, recoverable[1]. This care leads to a costly demand, requiring a specific physical space with specialized human resources.[2]

The actions to this group of patients collaborate with the decrease in death rates, and contribute to a fast and energetic recovery. These patients may be arising from trauma, cardiovascular, respiratory, postoperative, invasive procedures for diagnostic purposes, in palliative care, with fragile medical condition and neurodegenerative diseases.[3]

Nursing should provide an individualized, holistic and quality care, based on the acquired scientific knowledge and guided in meeting the precisions of every being. The Systematization of Nursing Assistance (SAE) must be adjusted according to a theory and with the available resources of the institution, so that the patient is received and treated at the level of their needs.[4]

Human knowledge should not be sourced from only one philosophy, but rather a range of concepts dependent of each other, and nursing is no different. Following this premise, in the twentieth century the first theories of nursing appeared in order to decentralize the biomedical model, paying attention to the human being and not just the disease.[5] Contemporaneously, the process of caring for these professionals is based on these theories perpetuating and strengthening comprehensive care in all individual areas.

Among these theories, there are the Theory of Basic Human Needs based on Human Motivation Theory of Maslow, in which both understand the needs as universal and vital, however, distinguished by each subject characteristics.

The needs related to individuals are considered moments of conscious or unconscious anxieties resulting from bio-psycho-spiritual disorders and working in a hierarchical manner based on searching full satisfaction. Maslow proposed five levels to those needs: physiological, safety, social, ego and self-fulfillment. It is important to understand that the higher the satisfaction felt, the greater the need of service.[6]

Some factors change this dynamic, since the patient is in intensive care, need intensified, qualified and individualized attention. Given this intense affirmative, meeting the patients´ perception about their own condition and their needs, brings the professionals in the desired humanized scientific assistance. Thus, all views as basic needs - physiological, safety, social, ego and self-realization - may be perceived by professionals in a more differentiated way, understanding that the routine becomes special, thus requiring a closer view of the health team.

Given the above, the aim was to:

Investigate the assistance of the special needs of patients admitted to the Intensive Care Unit, and identify the factors that influence positively or negatively, in assisting their special needs.

METHOD

Article elaborated from the Completion Work of the Course << ***Challenge to care: Meeting the special needs of patients in intensive care***>>, of the Federal University of Campina Grande/UFCG. Cuité-PB, Brazil. 2013.

Exploratory and descriptive study with a qualitative approach. The exploratory study provides a greater understanding on this issue, its primary goal is the improvement and clarification of ideas or even the discovery of them, while the descriptive study for the cited author aims to know the characteristics of a given group.[7]

The qualitative approach works with the universe of meanings, reasons, aspirations, beliefs, values and attitudes, corresponding to a more established space relations, processes and phenomena that cannot be minimized to the operationalization of variables.[8] Thus, this type of study has helped to understand the special needs of patients in intensive care.

The scenario of the research included the adult ICU of the University Hospital Alcides Carneiro (HUAC), located in the city of Campina Grande-PB. This environment is covered with various technological devices in order to promote quality care to their patients, plus an intensive multidisciplinary team.

The study had a sample saturation with ten patients in the ICU of the HUAC, all selected

according to the inclusion and exclusion criteria, regardless of their condition or gender. From the use of a semi-structured instrument for data collection, it was possible to investigate the special needs of critically ill patients hospitalized in intensive care and to know the factors that influence their care.

As inclusion criteria in this study there were: patients who were hospitalized at the adult ICU in the HUAC; conscious; able to verbalize; and who were willing to participate freely in the study by signing the Informed Consent Form (TCLE). As exclusion criteria, there were those patients in ICU who were less than 24 hours and did not meet the above criteria.

After collecting data, the analysis was possible, which at first was due to the characterization of the subject and then the elucidation of the study objectives through the content analysis technique (AC).[9]

Being a research involving human beings, the ethical principles were observed, established by Resolution 466/12 of the National Health Council (CNS) 196/96, advocated in Chapter III that the research involving human beings must meet the fundamental scientific and ethical requirements, highlighting among its ethical principles (Chapter III, item 2.g), the need for informed consent form of the individuals.[10] Thus, this study was submitted to the Research Ethics Committee of the HUAC, approved by CAAE number 14308013.7.0000.5182.

RESULTS

As a result, there is the characterization of the subject expressed in Tables 1, 2 and 3 as well as the presence of three categories schematized in Figures 1, 2 and 3.

Table 1. Absolute and percentage distribution of research participants, according to gender, age and marital status. Campina Grande, in July and August 2013.

	Indicator	n	%
Gender	Male	03	30
	Female	07	70
Age group	18-30 years old	02	20
	31-40 years old	03	30
	41-60 years old	00	00
	>60 years old	05	50
Marital status	Single	04	40
	Married	04	40
	Widow	02	20
	Other	00	00

Table 1 shows that most were female, being 70% of participants, the prevalent age was over sixty years old, composing 50% of the total surveyed. Thus, the presence of the fragility of two major axes, femininity and the elderly phase, raises the need to accommodate these patients in the best possible manner, helping on their shortcomings and developing strategies to build an effective relationship between professional, patient and family.[19]

With regard to marital status, an equivalent quantity of single and married individual was found, which corresponds to 40%. The Brazilian Institute of Geography and Statistics states that the number of singles increased by 0.5% in the last ten years.[20]

Table 2. Absolute and percentage distribution of research participants, according to the education, profession and pathology according to the ICD 10. Campina Grande, July and August 2013.

	Indicator	N	%/CID 10
Education	Incomplete elementar school	08	80
	Complete elementar school	00	00
	Incomplete high school	00	00
	Complete high school	02	20
	Incomplete higher education	00	00
	Complete higher education	00	00
Occupation	None	04	40
	Farmer	03	30
	Trader	01	10
	Night doorman	01	10
	Gas station Attendant	01	10
Disease	Dengue	A0906	01
	Pancreas cancer	C25.0	01
	IAM	I21	02
	Bronchiectasis	J47	01
	Pneumonia	J12.9	02
	Bacterial Meningitis	G00.9	01
	TVP	I82.9	01
	Rectal Prolapse	K62.3	01

Table 2 shows the education, occupation and diseases with their respective ICDs 10 (International Classification of Diseases) of research participants. With regard to education, 80% have not completed elementary school and only 20% completed high school, which shows a group with little education and little knowledge; that was quite explicit when asked about their pathologies. The professions found among the study subjects were: 30% farmers, 10% traders, 10% night doormen and equal percentage of attendants; it is clear that these work activities are reflections of low educational levels.

Despite the reduction of illiteracy in our country over the past decade, it became clear in this study that the presented professions confirm the lack of education of the Brazilian population.[20] With regard to pathologies, there is a great diversity, clearly seen the intensive care unit as a hospital sector that covers a multitude of diseases and may be arising from respiratory, cardiovascular, renal, metabolic systems, infectious complications and hematological problems.[3]

Assuming that all intensive care patient is a particular patient, it is important to highlight that all their needs have to be seen as special. Therefore, all patient´s needs should be evaluated carefully, considering that he cannot do them alone.

CATEGORY I: Investigating the psychobiological and psychosocial needs as special needs of patients in intensive care

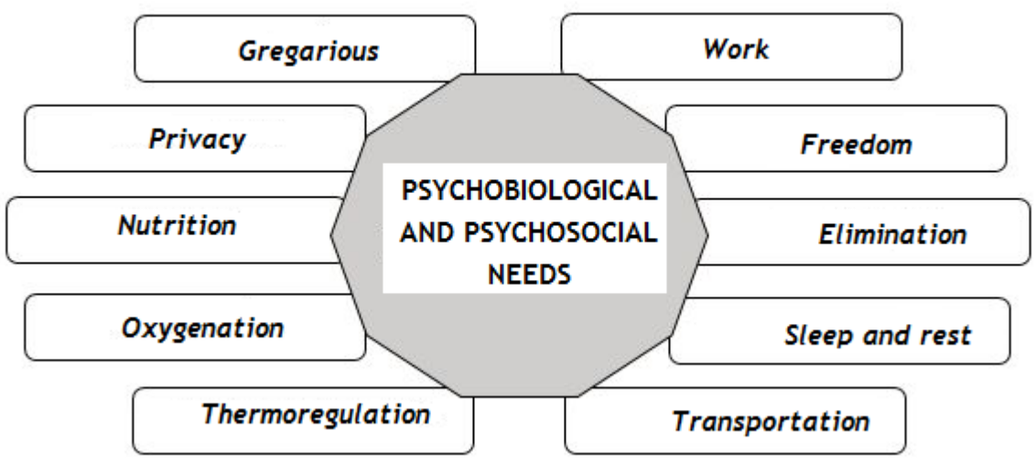

Figure 1. Representation of the thematic category I.

[...] It is important, it is! [...] On one hand, I think is good, on the other hand is bad because I think every time I ate with my hands and now I cannot eat with my hands. I think it is bad [...]. (INT 4)

[...] Look, my daughter is well attended, you know, but on one hand, it is bad

because of the use of it in the nose [...] You know, I live tired, you know so there is help, right! The bad thing is that is inside the nose making an itch, a bad thing [...]. (INT 5)

[...] It is a necessity thing. This thing there, my God, when we feel at ease and go to the pot and the we do it is fine. But a "thing" that is in the "thing" of us without us realizing it! Without seeing, without feeling [...] it bothers a little [...]. (INT 4)

According to the interviews, the psychobiological needs seen as special in the ICU are: nutrition, elimination, oxygenation, sleep and rest, thermoregulation and transportation. For the respondents, there are special requirements for leaving the normal home or need someone or something to do it:

[...] Of course it is special, the person does not live without it. [...] Walking, no way [...] For everybody I think it is [...] But it is not currently possible. (INT 3)

Eliminations needs are considered among the biological aspect, as the most relevant for the individual. They determine the behavior, so when patients are dissatisfied before their elimination, they tend to turn to the satisfaction of those needs. Thus, their future vision is limited to the mercy of achieving their exultation.[6]

It is also evident that self-care in the ICU is impaired, which implies a more careful view of nursing. It is the duty of nursing to prevent infection with indwelling catheters (CVD), preventing further injuries to the health of patients and the emergence of new problems. IN this study, it was expressed how urinary catheterization contributes negatively on the patient´s well-being in intensive care[5].

Related to the above, the sleep and rest is a need also impaired in the ICU. The noises coming from equipment, the conversations, low temperature and lighting are all factors that contribute to that need not adequately met. Thus, the professionals´ awareness is important so that the stressors are minimized and the critical patient has positive responses to their recuperation[16]. The need for temperature control is evident in the following report:

[...] Because, it is important to have all this just for my stay and my improvement here too. That´s why it is special. The air conditioner does not help. [...] I try to roll up and try to think of other things. (INT 6)

Oxygenation was also cited as a special need in the ICU. By using mechanisms of artificial ventilation such as goggles type catheter and Venturi type mask, patients felt uncomfortable and stuck to these resources. This need is at the top of the precisions of being and in order to be allowed, should inter-relate it to other necessities, since it is not manifested alone.[6]

On psychosocial needs, the interviewed make relevant the need to gregarious, privacy, freedom and work. The biological needs require a greater attention of nurses than social needs. This is achieved by the nurse´s strength in building a care plan aimed at this level. It is important to understand that these features are part of the human being and that they are also directly related to the rehabilitation process of the patient[17].

[...] Yes, a family member staying with us right, being with us here to ask and they talk to the nurse. Because it is too bad to stay here alone. (INT 2)

[...] It's too much [...] I worked all my life in the plantations and in my house, here we cannot do anything [...]. (INT 4)

Facing the need to gregarious, including the family in the intensive care would be a way to maintain the integrity of the emotional bond among family members. It is understood that this joint provide not only improving care but would also bring benefits to the family, which is the individual support.[21]

The presence of gregarious improves the health-disease in the critically ill patients, as the company of a family member could help in nursing work, with regard to the realization of some activities such as food and being an incentive to ensure greater cooperativeness when performing procedures.[21]

It could be observed that the feeling of impotence patients are clearly visible when asked about the lack of work or occupation. The work influences on human behavior. When the individual is fit to working conditions and performs it, their physical and mental health comes into balance. Thus, when the inpatient is not active, his health can become unbalanced by the lack of something that brings pleasure, in this case, this satisfaction may be arising from the work.

CATEGORY II- Identifying the contributing factors in meeting the special needs in intensive care

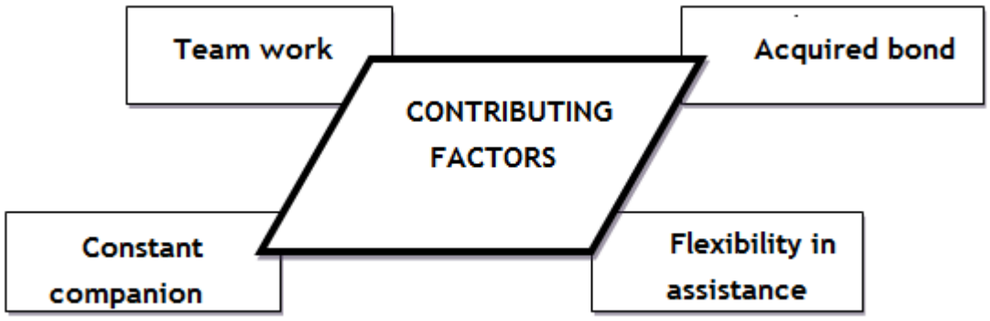

Figure 2. Representation of thematic category II.

[...] Here there was not lack of anything to me. I'm going to miss here [...] I never say so - Hey girls come here - for they do not come or leave for later. All at the right time. Very well treated [...] All I wanted they did to me [...] with the greatest patience [...] (INT 9).

[...] All we ask them they do [...] here is all fast [...]. (INT 2)

According to the reports described, it can be seen that the nursing work contributed substantially in meeting the special needs of ICU patients. Despite the stigmatized environment, nursing can demystify and make individuals feel well cared and supported, leaving them more relaxed and confident in their recovery.[22]

The work of the nursing staff aims to promote the well to the patient cared through behaviors of compassion, support and promote the improvement of the patient. Broadly, nursing seek an interactive relationship with the patient so that their integrity and their dignity are not denigrated.

This behavior assumed by nursing is based on the humanization of care, happening when it takes the position of the other and when the other is the way they would like to be treated at that time.[21] Therefore, it is possible to see that the health recovery of these patients is intrinsically related to the preparation of these professionals:

[...] They come over and over and talk to me [...] sometimes staying just the friends from here [...] they help, help [...]. (INT 4)

Disagreeing from the above, these aspects become unviable to run in the ICU. The daily routine and high complexity and involvement with the equipment make professionals of that environment to outweigh the technical and, most often, the act of talking and listening gets overlooked.[22]

It is clear in the reports described that the bond acquired promotes overcoming some difficulties, in which only the dialogue and listening alleviate the patient´s suffering. The way that the patient is welcomed allows their difficulties be overcome, even if the use of heavy technologies are excelled:[19]

The nurse should be placed in the care of competent and conscientious manner in relation to scientific knowledge and practice, to the achievement of a supported work on positive developments towards the patient.[23] Consequently, it was clear in the reports that nursing is being able to provide a flexible, quality and humanized service, meeting the needs that are applicable to every human being.

CATEGORY III: Investigating the aggravating factors during the meeting of the special needs in intensive care

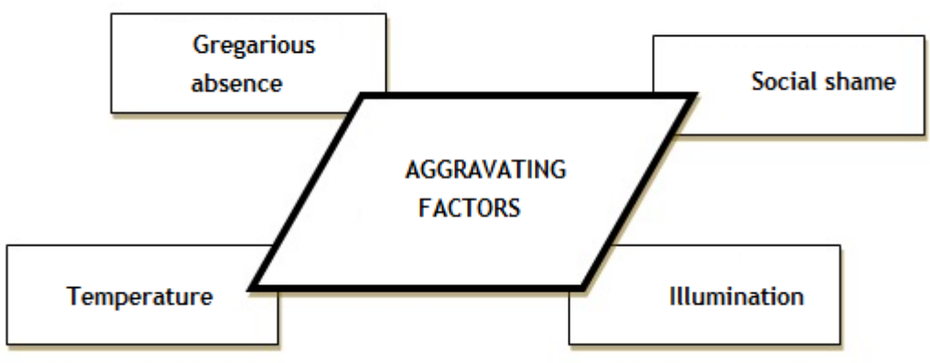

Figure 3. Representation outlined of the thematic category III.

[...] Only one factor is that the person is alone here [...] Empty, like I was alone in the world, as if no one else is around [...]. (INT 2)

[...] What I think is bad, girl you know ... yesterday I had lot of people here by my side ... This is bad huh ... I want my place [...]. (INT 5)

[...] Yes, a family member with us, right [...] a person is not well with a woman bathing in the person I've ever seen [...]. (INT 2)

[...] I try to roll up and try to think of other things. I know it's for my own good, right [...]. (INT 6)

This category present and discuss the speeches of patients that express the factors that prevent or hinder the fulfillment of special needs in the intensive care unit. It is the lack of relevance in most gregarious of respondents, making it clear that the absence of a companion is a crucial factor in satisfactory ICU stay, even if their needs are met by the nursing staff.

The complexity involved in this sector, the presented diseases and the need for rehabilitation of patients lead professionals to prioritize the reduction or absence of problems that may put the lives of patients at risk.[24] Thus, the rules are strict and strictly followed in visits and caregivers. In addition to all stress that the environment promotes the patient is deprived of the constant presence of someone to help in the tasks and to bring security and companionship for him, as explained in this statements:

[...] It's bad, right [...] only at the time of the visit, three hours [...]. (INT 8)

The physical structure that has no seats for caregivers, the restricted and recommended schedules to entry and the lack of preparation by professionals for the relatives, contribute to stigma and hostility of that environment.[25] Health is a biopsychosocial balance, emphasized that the family should be inserted into the ICU environment, becoming a facilitator and a contributory in meeting the special needs.[5]

Linked to the lack of gregarious, there is the fear of losing the personal, intrinsic lack of privacy, negatively influencing on meeting the special needs. It was evident in interviews that patients especially in the first days of ICU, they felt constrained to people, still considered strange, that in their work they perform the task of personal hygiene for such patients. In some statements of the participants, it is clear the fear and the shame of the unknown, exposed as follows:

[...] I am ashamed in the bath, but I have to take it [...] if I had someone like my mother [...]. (INT 6)

The service demand artificial lighting during the day and cooling between 21ºC and 24ºC. Artificial light causes the patient to lose contact with the natural lighting, losing track of time, factors that interfere in meeting the basic needs for sleep and rest. The low temperature makes it difficult to service their thermoregulation, however, it is a facilitator at the time of complications.[2]

CONCLUSION

To achieve patient satisfaction, it is necessary that the body is in biological, social and spiritual balance. Thus, it is necessary for professionals a scientific and technical preparation in order to meet the needs of patients so that they can feel good in the environment in which they are providing effective and quality care.

Comparing the data that were revealed during the study, the critical patient is in a different sphere of the needs they have, considering that these are unlikely to be found in other environments. Also, their accuracy should be observed in a more careful way so that harassed viewof the sector and the arduous routine imposed are not impediments in their recovery.

It became evident that when the care needs is outdated, by absence or even by factors and regulations of the sector that do not contribute, the body shall be liable to the imbalance and disharmony, which may cause harm to physical and mental health, evident in the mentioned reports.

Special patients are not only disabled to be considered, depending on the circumstances can all be considered special, and thus needing different points of the team that promotes care. Thus, if these patients are special, their needs are special too, needing to be seen and served, always estimating as their will. Thus, the significant contribution of nursing care in the rehabilitation of critically ill patients is exposed, as well as the need for changes in structure, rules and predetermined routines inside the intensive care units, to host the presented needs as special.

REFERENCES

1. Silva, RC. Practices of intensive care nurses in the face of technologies: analysis in the light social representations. Texto contexto-enferm. 2014 Apr-June [cited 2014 Aug 8]; 23(2): 328-37. Available from:

http://www.scielo.br/pdf/tce/v23n2/0104-0707-tce-23-02-00328.pdf

2. Oakes DF, Borges INK, Forgiarini Junior LA, Rieder MM. Assessment of ICU readmission risk with the Stability and Workload Index for Transfer score. J Bras Pneumol. 2014 [cited 2014 Aug 11]; 40(1): 73-6. Available from: http://www.scielo.br/readcube/epdf.php?doi=10.1590/S1806-37132014000100011&pid=S1806-37132014000100073&pdf_path=jbpneu/v40n1/1806-3713-jbpneu-40-01-00073.pdf

3. Brasil. Resolução COFEN nº 358/2009, de 15 de outubro de 2009. Dispõe sobre a Sistematização da Assistência de Enfermagem e a implementação do Processo de Enfermagem em ambientes, públicos ou privados, em que ocorre o cuidado profissional de Enfermagem, e dá outras providências. 2009 [cited 2013 Sept 27]. Available from: http://www.portalcorenrs.gov.br/docs/Legislacoes/legislacao_7a3914c30c09bb242f08c9f36a776fdd.pdf

4. Amante LN, Rossetto AP, Schneider DG. Sistematização da Assistência de Enfermagem em Unidade de Terapia Intensiva sustentada pela Teoria de Wanda Horta. Rev Esc Enferm USP. 2009; São Paulo, 43(1): 54-64.

5. Horta WA. Processo de Enfermagem. São Paulo: Editora Pedagógica e Universitária; 2011.

6. Regis LFLV, Porto IS. A equipe de enfermagem e Maslow: (in)satisfações no trabalho. Rev Bra de Enferm. 2006 July-Aug; 59(4): 565-8.

7. Gil AC. Métodos e técnicas de pesquisa social. 6. ed. São Paulo: Atlas; 2008.

8. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 8. ed. São Paulo: Hucitec; 2004.

9. Bardin L. Análise de conteúdo. Ed Rev e actual. Portugal: 70 ed; 2009.

10. Brasil. Resolução nº 466/2012. Aprovar as seguintes diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. 2012 [cited Sept 14]. Available from: http://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf

11. Brasil. Ministério da Saúde. Lei N.º 7.853 de 24 de outubro de 1989. Dispõe sobre o apoio às pessoas portadoras de deficiência sua integração social, sobre a Coordenadoria para a Integração da Pessoa Portadora de Deficiência – CORDE, institui a tutela jurisdicional de interesses coletivos ou difusos dessas pessoas, disciplina a atuação do Ministério Público, define crimes, e dá outras providências, 1989.

12. Brasil. Ministério da Saúde. Manual Brasileiro de Acreditação Hospitalar; Série A: Normas e Manuais Técnicos. 2002 [cited Aug 6]. 3 ed. (117): 105. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/acreditacao_hospitalar.pdf

13. Schmidt DRC, Dantas RAS. Qualidade de vida no trabalho de profissionais de enfermagem, atuantes em unidades do bloco cirúrgico, sob a ótica da satisfação. Rev Latino-Am Enfermagem. 2006; 14(1): 54-60.

14. Matos JC et al. Ensino de teorias de enfermagem em Cursos de Graduação em Enfermagem do Estado do Paraná – Brasil. Acta Paul Enferm. 2011; 24(1): 23-8.

15. Alcântara MR, Silva DG, Freiberger MF, Coelho MPPM. Teorias de enfermagem: a importância para a implementação da sistematização da assistência de enfermagem. Rev Cient Fac Educação e Meio Ambiente. May-Oct 2011 [cited Aug 11]; 2(2): 115-132. Availabe from: http://www.faema.edu.br/revistas/index.php/Revista-FAEMA/article/view/99/78

16. Neves RS. Sistematização da Assistência de Enfermagem em Unidade de Reabilitação segundo o Modelo Conceitual de Horta. Rev Bras Enferm 2006; 59(4): 556-9. Availabe from: http://www.scielo.br/readcube/epdf.php?doi=10.1590/S0034-71672006000400016&pid=S0034-71672006000400016&pdf_path=reben/v59n4/a16v59n4.pdf

17. Santos TCM, Faria AL, Barbosa GES, Almeida PAT, Carvalho P. Unidade de terapia intensiva: fatores estressantes na percepção da equipe de enfermagem. J Nurs UFPE on line. Jan-Feb; 2011 [cited Aug 7]; 5(1): 20-7. Availabe from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/1158/pdf_272

18. Maestri E, Nascimento ERP, Bertoncello KCG, Martins JJ. Avaliação das estratégias de acolhimento na Unidade de Terapia Intensiva. Rev Esc Enferm USP. 2012; 46(1): 75-81.

19. Brasil. Ministério do Planejamento, Orçamento e Gestão. Instituto Brasileiro de Geografia e Estatística. Contagem Populacional. 2010. Availabe from: http://www.ibge.gov.br/home/estatistica/populacao/estimativa2010/default.shtm

20. Alves EF. O cuidador de Enfermagem e o cuidar em uma Unidade de Terapia Intensiva. UNOPAR Cient: Ciências Biológicas e da Saúde. 2013 May; 15(2):115-122.

21. Rodrigues DP, Athanázio AR, Cortez EA, Teixeira ER, Alves VH. Estresse na Unidade de

Terapia Intensiva: revisão integrativa. J Nurs UFPE on line. 2013 May [cited Oct 1]; 7(esp): 4217-26. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/4651/pdf_2631

22. Nascimento KC, Backes DS, Koerich MS, Erdmann AL. Sistematização da Assistência de Enfermagem: Vislumbrando um Cuidado Interativo, Complementar e Multiprofissional. Rev Esc Enferm USP. 2008 Dec; 42(4).

23. Araújo HSP, Morais IF, Valença CN, Santos MM, Germano RM. The dimensioning of the nursing staff in an intensive care unit. J Nurs UFPE on line. 2012 Feb [cited Oct 1]; 6(2): 252-7. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/2214/pdf_1020

Submission: 2014/02/21
Accepted: 2015/07/25
Publishing: 2015/08/15

Corresponding Address

Priscilla Tereza Lopes de Souza
Avenida Agamenon Magalhães, S/N
Bairro Derby
CEP 52010-040 – Recife (PE), Brasil