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ORIGINAL ARTICLE

THE MEANING OF NURSING CARE FOR THE FAMILY IN AN INTENSIVE CARE UNIT

OS SIGNIFICADOS DO CUIDADO DE ENFERMAGEM À FAMÍLIA EM UMA UNIDADE DE CUIDADOS INTENSIVOS

LOS SIGNIFICADOS DEL CUIDADO DE ENFERMERÍA PARA LA FAMILIA EN UNA UNIDAD DE CUIDADOS INTENSIVOS

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ABSTRACT

Objective: to know the meanings of nursing care to a family in ICU of a hospital in the Central Region of Portugal, from the experiences of nurses. ***Method***: study based on the qualitative approach in hermeneutic phenomenology. Experiential descriptions were obtained through open interviews. The meanings of the phenomenon under study emerged through content analysis, with the support of qualitative analysis program QSRNvivo7. ***Results***: five themes were highlighted: The social representation of the UCI as a coping factor; Reception and orientation of the family in the ICU environment; Reaction of the family lived moment; the positive transformation of the family living in the ICU; Difficulties in the care of the family in ICU. ***Conclusion***: a technologically complex environment, nursing professionals recognize the importance of the family in the care process to critically ill patients. This was considered a breakthrough in care humanization. ***Descriptors***: Intensive Care Unit; Nursing Care; Family.

RESUMO

***Objetivo*:** conhecer os significados do cuidado de enfermagem à família em uma UCI de um Hospital da Região Centro de Portugal a partir das vivências de enfermeiros. ***Método*:** estudo de abordagem qualitativa fundamentado na fenomenologia hermenêutica. As descrições experienciais foram obtidas através de entrevistas abertas. Os significados do fenômeno em estudo emergiram através da análise de conteúdo, com o apoio do programa de análise qualitativa QSRNvivo7. ***Resultados*:** destacaram-se cinco temas: a representação social da UCI como fator de enfrentamento; Acolhimento e orientação do familiar no ambiente da UCI; Reação dos familiares ao momento vivido; Transformação positiva da vivência do familiar na UCI; Dificuldades no cuidado ao familiar em UCI. ***Conclusão*:** num ambiente de alta complexidade tecnológica, os profissionais de enfermagem reconhecem a importância da família no processo de cuidado ao doente crítico. Este fato foi considerado um avanço na humanização do cuidado. ***Descritores*:** Unidade De Cuidados Intensivos; Cuidado de Enfermagem; Família.

RESUMEN

***Objetivo*:** conocer los significados del cuidado de enfermería a la familia en una UCI de un Hospital de la Región Centro de Portugal, a partir de las experiencias de enfermeros. ***Método*:** estudio de enfoque cualitativo fundamentado en la fenomenología hermenéutica. Las descripciones experienciales fueron obtenidas a través de entrevistas abiertas. Los significados del fenómeno en estudio surgieron a través del análisis de contenido, con el apoyo del programa de análisis cualitativo QSRNvivo7. ***Resultados*:** se destacaron cinco temas: La representación social de la UCI como factor de enfrentamiento; Acogida y orientación del familiar en el ambiente de la UCI; Reacción de los familiares al momento vivido; Transformación positiva de la experiencia del familiar en la UCI; Dificultades en el cuidado al familiar en UCI. ***Conclusión*:** en un ambiente de alta complejidad tecnológica, los profesionales de enfermería reconocen la importancia de la familia en el proceso de cuidado al enfermo crítico. Este hecho fue considerado un avance en la humanización del cuidado. ***Descriptores*:** Unidad de Cuidados Intensivos; Cuidado de Enfermería; Familia.

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INTRODUCTION

The intensive care units (ICU) are services in the hospital that are designed to care for critical patients, whose condition is potentially reversible, and require complex and specialized care. In intensive care, the technical dimension is highly valued. However, the use of technology only makes sense if it is integrated in the relational process and are safeguarded the technical principles and human indispensable to the maintenance and enhancement of life.[1] Studies show that some aspects of the work of everyday life in the ICU, as eminently practical techniques, standardized and distant, the lack of privacy, social isolation, orientation to the biomedical model can lead to the detriment of comprehensive care.[1-3] Inevitably, a mechanistic approach to self-control and certainly is a barrier to care process, considering that the events are unique, special and singular and cannot be structured in a rigid, predicting the results. [4]

Hospitalization in a UCI is a key factor of anxiety and suffering not only to the sick person but also for his family. Consequently, care in this context should include the patient´s family, building bonds that help to face moments of anguish, loneliness, and fear.[5] The literature shows that the construction of a protective, warm and supportive environment, able to stimulate the recovery of the sick person and follow their respective family, is a desire and a goal in everyday practice of many professionals.[6] However, in a space dominated by hard technologies and the frequent dichotomy life/death, it is possible that the family is not always welcome in a humane way by nursing professionals. In this perspective, the relationship established between health professionals, person in care and family tends to be vertical, fragmented and focused on structured knowledge, rules and routines.[7]

Considering the health status of each person influencing the way the family works, it appears that the family is a central institution that can collectively experience the whole process of pain and suffering in ICU.[8] In general, families have the strength to face it, but also, it is up to health professionals to make them explicit, and if necessary, to encourage the emergence of new strengths.[5] Therefore, nursing professionals should know and understand each family, identify and act on their needs, making it easier to adapt to this new phase of life or mobilizing strategies to maintain balance or to recover from a crisis situation.[9] They need to provide an effective human care, enhancing sensitivity, faith, hope, help, trust, and noted seeing the other with the physical eyes and the eyes of the heart, including intersubjectivity.[5] It is necessary to be open to expressions of each person respecting beliefs, values, and continuously dialoguing.[5]

Given the above, we can conclude that the great challenge of care practice in UCI is to find a synergy between the technical-scientific development and a more human way of care relationship.[6] This thinking underlies the desire to discover the lived reality and the uniqueness of the experience in the care of the family in this context. For these reasons, as a central objective, it is defined: To know the meanings of nursing care to a family in ICU of a hospital in the Central Region of Portugal, from the experiences of nurses.

The interest and relevance to this study come from the fact that this issue requires a deeper look at the exercise of contemporary nursing in relation to the family, to give visibility to their different characteristics and contribute to a more humanized care and higher quality. Thus, the following objectives were determined:

- To know the meanings of family nursing care in an ICU of a hospital in the Central Region of Portugal, from the experiences of nurses.

METHODOLOGY

This is a qualitative study based on hermeneutic phenomenology. This approach favors the symbology that covers the phenomenon of care, providing access to the rationales that determine the affections that involve and emotions that characterize it. Based on the six steps that define the structure of the hermeneutic phenomenological method proposed by Max Van Manen[10], we will need the methodological approach guiding this study.

♦ Selecting the phenomenon of interest

The phenomenon chosen was nursing care developed in a service with complexity and specificity. We want to give visibility to the diverse experiences of nursing professionals

who carry out their activity in an ICU. We believe that new insights, thoughts and ways of doing can contribute to the construction and improvement of knowledge of care in this context.

♦ **Selecting the study perspective of the phenomenon**

In this study, the nursing care perspective is a family in an ICU. Describing and interpreting the family care as a lived experience of the nurses in an ICU, is a priority at this time because the need to reshape behaviors and attitudes aimed at family integration in the care process. In this sense, the focus of this study is directed to the question: *What significance attribute nurses/nursing care give to the family in an ICU of a hospital in the center of Portugal?*

♦ **Selecting the context of the phenomenon**

The context chosen to conduct this study was a level II ICU of a hospital in the Central Region of Portugal, which started its activity in 2001.

♦ **Selecting the study participants**

As a method of participants selection, a purposive sample was used. Ten nurses were selected. In the inclusion criteria was defined that the participants should exercise activity in the ICU for more than two years and wish to participate in the study.

♦ **Respecting ethical principles**

For the development of the research, authorization was requested by formal letter to the Board of Directors of the Hospital of the central region of Portugal. Also, the study project together with the Consent and Informed Form were referred to the Ethics Committee of the institution involved for approval. Throughout the study, it was sought to maintain a climate of kindness and understanding, respecting the four principles established for research with human beings.[11] In this sense, each participant acted free of any kind of institutional coercion or psychological (autonomy); the participants have been clarified and they felt good to be able to contribute to improving the quality of care in the ICU (beneficence); anonymity and confidentiality of information obtained was assured (non-maleficence); the right of each participant without distinction or inferences was respected (justice).

♦ **Obtaining the experience descriptions of care**

The open interview is the data collection instrument suitable for understanding by interpreting what is fully lived by all those involved. The interviews took place between October and December 2014. Looking for customize testimonials and remain anonymous, the interviews were coded in the order of performance, using different names of flowers.

♦ **Developing a phenomenological hermeneutical reflection**

We chose the analysis proposed by Van Manen, to facilitate understanding and the systematic process of organizing the content of the transcribed interviews.[10] This step was developed after a vision of the descriptions as a whole, which is achieved by reading and rereading the descriptions to grasp the meaning of the participant´s expressions. Subsequently, free of preconceptions or prejudices, we tried to identify paragraphs or sentences showing aspects linked to the family care. Paragraphs and sentences identified were rewritten to capture the essence of phenomenological meanings. The process of writing and rewriting paragraphs and sentences led to the identification of the sub-themes that reflect the most significant moment of the speech. Subsequently, the sub-themes were reorganized and grouped into core subjects, always focused on the central question of the study. This whole process was developed with the support of QSRNvivo7 qualitative analysis program. The capture of the main themes and the preparation of reflective analysis was the final step.

RESULTS

♦ **Characterization of the Participants**

There were ten nurses participating in this study, 7 female and 3 male. The average age is 39.2 years old, with a minimum age of 28 years old and a maximum of 48 years old. Regarding marital status, six participants were married, three divorced and one single. In addition to the degree as academic training, only one held the specialization course in the medical-surgical area. The distribution by professional category showed that six had the category of nurses graduates and four had the category of nurses. As a kind of institutional link, seven belonged to the

institution team and three had a contract. All of them work on rotating schedules. The Professional exercise time varied between 5 and 25 years, with an average time of 15 years. Regarding the exercise time in the ICU, five participants exercise activity for 14 years. The remaining were included between eight and three years. Nine participants confirmed have worked for other services before starting the activity in the ICU.

♦ Revealing the Meanings of care to the Family in the UCI

Based on the descriptions of the participants, five main themes emerged: The social representation of the UCI as a coping factor; Reception and orientation of the family in the ICU environment; Reaction of the family at the lived moment; Positive transformation of the family living in the ICU; Difficulties in the care of the family member in the ICU. We then proceeded to their presentation.

♦ The social representation of the ICU as a coping factor

ICU is a hospital environment in the social imaginary, either by personal experience, by the experience of a family member, a friend, neighbor, or the image conveyed by the media. The social representation of an ICU is culturally linked to the suffering, the gravity, and death. This representation is not unknown to the nurses in this study, who live in daily life with this condition of life, which is “to be or have someone admitted in ICU”. They reported that a family member, after knowing that one of their loved ones are hospitalized in the ICU, starts a new journey impregnated by an aura of uncertainty and mystery. Consequently, feelings ambivalent and conflicting emerge, in a constant tension between the hope of recovery and the fear of loss. Participants say that family members are aware of the risk of life and the severity of the situation. However, they also visualize the UCI as a space that has the resources to provide a careful and specific care. The successful experiences of other patients who have recovered announce a new hope and reinforce the belief in the recovery of their loved one.

> *When family members enter the unit, they bring the idea that society, in general, conveys about these services, who is hospitalized in an ICU is because it is very bad and so his life is in danger. But also, they have the example of others who have recovered. The curious thing is that many have the idea that they will not be able to see their family while hospitalized in the ICU. They are looking forward to this idea. (Tulip)*

♦ Reception and orientation of the family in the ICU environment

To reverse the representation the family has about a UCI, they consider that their care practice must understand the value of family as an extension of the sick person´s life. In this sense, valuing the family means to welcome it and integrate it within the constraints imposed by an intensive care environment. *Only realizing the need to welcome the family is that you can humanize an environment historically marked by coldness, aggression, and technicality.* Thus, it was expressed that *"the concern of the team for a more humanized care, united them with the creation of a host protocol to the families visiting the sick person"* (Iris). In the view of these professionals, how this process of reception is conducted and the humanizing nature that characterizes it is crucial for the reaction of the family during the hospitalization. The time of the visit is considered a family approach opportunity to strengthen ties and to demonstrate that they are not alone in that moment of anguish and anxiety. There is someone who recognizes their worries, their suffering and is committed to the support and help.

> *Despite the insecurity and anxiety visible on the face of the family, there is a team effort to not feeling lost or alone. We meet them before entering the hospital room. The first contact is always with people who are there to help and not with the technological apparatus. (Carnation)*

The preparation of the family for the meeting with the patient is not seen as one more routine, in which only transmit the rules and service standards. However, it constitutes the initial stage of a relationship that is intended to be successful, allowing strengthens them for the time ahead. Emotions, feelings, and shared information may not reduce the family´s pain, but minimize their insecurity and negative expectations, giving meaning to the existence of being a nurse and the essence of caring.

> *The way I host the family member is decisive for his reaction over the hospital. I cannot decrease his pain, but I can give some comfort and be sensitive*

to his suffering. I do my best so that my relationship with the family is not regarded as a routine where I pass rules and service standards, but above all, I give support. (Camellia)

At the moment the family member enters into the inpatient unit, he is faced with an unfamiliar, depersonalized and threatening the environment. The specifics of the service inherent to their physical and structural features, sophisticated technology and the very sick person´s condition have a strong impact on the family member. For these reasons, the *approach of the family* to their loved one requires monitoring and constant encouragement. Nursing professionals strengthen for this meeting is not only for a physical encounter marked by the patient´s condition and the apparatus that surrounds them. Encouraging interaction is a way to reach the sick person, the family affection and a little piece of their personal environment, giving a sense of continuity to their life.

Family members are prepared for the time of the visit. We explain all that will find and help to meet the sick family member and how to interact with him. (Violet)

The process of adapting to different situations is constant in the course of human life. However, experiencing the reality of an ICU can be an event for which a family at that time and context does not have resources to enable to overcome this situation. In this sense, *the orientation of the family during the reception* procedure can help to answer questions and promote an adequate response to the sick person´s condition. Together, access to medical information is also facilitated at the end of each visit. According to participants, family members were satisfied with the information provided by nurses. They justify this preference for the close relationship they have with the family, which strengthens the affective links and mutual understanding. In this relational process, they seek to arouse the attention of the family to the little signs on the severity of the clinical picture often unnoticed. Thus, technical terms are not used that impose rationality, but words that in their simplicity, reveal small signs that can help overcome feelings of ambiguity and uncertainty. When they leave the unit, the family easily forget the technical terms, but the revealing words of affection will carry with them. They remain in their thinking because they gave them some serenity.

At the end of the visit, the family always has the opportunity to speak with the doctor in attendance to receive information. But, I feel they are quite when nurses say things they like, today he managed to open his eyes, already seems to understand some orders already asks for water. (Daisy)

♦ Reaction of the family to the lived moment

Some participants describe that family members react very differently to this lived moment. Some of them are terrified when facing with the environment and with the noise. They approach slowly, remain standing beside the bed, watching the face of the sick person before touching him. They seem to forget all that they have been passed on before entering and do not know how to proceed, they are pale and weep. Others have difficulty recognizing their loved one for his swollen and sometimes deformed aspect. There are still those who feel an immediate need to touch as if to make sure it really is their loved one who is lying in that bed, apparently indifferent to his presence. Driven by a strong curiosity, they observe and question everything.

The families react differently. Some are terrified by minimal noises, with the reaction of the patient, then look for a clarification, a help. Others are very curious, they want to see everything, to raise the sheet to peek. (Tulip)

Many times, there are relatives doubting to see at the right person because this is so different from what usually is. The swelling of the face, the hands, the tube and the presence of yarn jumps on them. (Narcissus)

Considering the uniqueness of each family and their ability to adapt to a crisis-situation, participants identify changes in the way of reacting family members, throughout the hospitalization of their relatives. With the passage of time, the ICU represents a new space in the family every day. Therefore, the strangeness decreases, expressions of fear and anxiety present in their face lose the rigidity of its contours. This sense of familiarity with the care environment takes place in a slow and gradual way, being more evident when the evolution of the clinical picture is positive.

I'm glad when that insecure family member, tense, will lose fear and passes to enter the unit, directing his gaze to our counter, greeting us and

> *expecting us to say something new. They make comments on the hair arranged and well-shaven. I admit that this is more visible when the trend is positive. (Hyacinth).*

♦ Positive transformation of the family living in the ICU

The testimony of the participants allows us to apprehend the transmitted orientation that can transform the experience of a family in the ICU as a positive experience. However, this transformation is only fully done by integrating the family into the care of the sick person. Therefore, it is essential to develop actions that allow knowing the sick person through the family and seeing the family as an indispensable participant in the care process. These actions assume a particular highlight when a family is facing their loved one unable to interact due to their natural state of unconsciousness or drug-induced. Apparently, for the family, there is no exchange ratio for the lack of dialogue and manifestation of the sick person. The speeches of the participants reveal their effort to make the family recognize the contribution of their presence to the recovery of the sick person. They are encouraged to interact with their loved one through their daily presence, words of support, expressed in touch care in handling their hands.

> *I like to demystify the idea that family members have that the patient under the influence of sedation cannot see, hear, which is not worth talking to him or play, that are not aware of their visit. I try to show how important it is for them to recovery, making their presence felt. (Poppy).*
>
> *When patients cannot express what they want, what distinguishes them, I need to ask family collaboration for this information. (Dahlia).*

♦ Difficulties in the care of the family member in the ICU

In the speeches of the participants, it is possible to learn the family as the focus of attention of their care in a technologically complex environment. The recognition of its importance has been seen as a positive development, bearing in mind that this is not a condition present in other ICUs. The gestures and attitudes expressed by the participants reveal the importance of family involvement in the care process. They also provide *a balance between doing and knowing, between live and be with the family*. However, in this process emerge difficulties related to dealing with emotionally intense experiences and the lack of time. The nurse/family relationship, although enriching, is also a source of personal difficulties to deal with intense emotional experiences. Some situations such as difficult to convey information, the irreversibility of the clinical picture, admissions for organ donation potentiate this difficulty. Thus, five participants conceive to be with family implies sometimes in living with the limitations.

> *I am a concern when I meet with the family and have to say the patient keeps the same situation. Unfortunately, I have nothing new to tell you. This makes me sad. I feel sorry. I have difficulty in supporting the family in these moments. (Violet)*

The lack of control over the situation affects their actions, raising doubts and a sense of anguish. In care practice, they cannot develop a complementary process to the other, but, they absorb the reality if it were the part of their life. At a time when the family needs a more differentiated and individualized listening to it does not. The removal is one of the resources used to not having to deal with the pain and suffering of families and ensure control of their emotions by not being confronted with their fragility.

> *There are situations that I do not know how to get the family, how to approach, how to be by their side. I am distressed by the situation and recognize that often I pull away and keep me busy with other things to not have to answer their questions, so often repeated by the longing to hear something different, something I cannot convey. (Poppy)*

The involvement with the family is a complex process. There are the satisfaction and gratitude of the family member, but also the painful feelings, accompanied by impotence and nonconformity. This finding leads these professionals to admit that they still do not dispense the desired attention to the family member, given the short time visit.

> *The time we have to get the family is very short and so we limit to the needs of that family immediately, we never go beyond. All other factors that may influence that family are not considered. (Daisy)*

We can learn that the valorization of the family was highlighted in nursing professionals in this study. This value is related to the family of the host process for

meeting with their loved one and recognizing the importance of family involvement in the recovery of the person in care. They express their limitations and difficulties in the relationship with the family.

DISCUSSION

The hospitalization of a person in the ICU usually occurs unexpectedly and abruptly, leaving little time for family adjustment.[12] Faced with this situation, it is not only the sick person who is vulnerable both physically and psychologically, but also their family.[9] Hospitalization in the ICU seems to be one of the most difficult and important events in the family dynamics, because the relative is away from his conviviality, by the imposition of service routines and rigid times.[2] At this time, taking care of the person in critical condition as a whole does not imply neglecting his family, so their reception by nursing professionals becomes imperative. Attitudes such as dialogue, listening, presence, co-responsibility, commitment, appreciation of each other, sharing experiences are basic conditions to effect the host are essential.[12]

In this study, nurses demonstrated a care practice that understands the value of family as an extension of the sick person´s life. Valuing the other is characterized by forms of affection and attention and is evident in pleasure attitudes to be with each other and be able to do with the other.[4] In this sense, they developed a humanizing host protocol to family member determinant to strengthen ties and minimize the impact to the ICU environment. However, the literature shows that despite the efforts of nursing professionals to humanize care in the ICU, this is a difficult task because it requires individual actions against a whole technological system, commonly little humanizing.[8] In the daily life of the ICU, the health team uses more time to develop their technical skills (hard technology) and cognitive (soft-hard technology) and little time for the use of technologies of relationships, as the host of the sick person and his family.[12] The technical vision favors the detachment, indifference, misunderstanding and insensitivity of human relationships, leading to the predominance of a rational form of care.[12]

Countering this trend, the statements of the participants of this study revealed that the care developed in the UCI also involves a partnership with the family. Being the entity that best know the person in critical condition, their habits, their customs, their needs and their fears, the family constitutes an important link between the sick person and nursing professionals.[9] They assume a vitally important role in issues related to health and disease process of their hospitalized family member.[12] The unique way the family deals with the internment situation depends on the family history and the defense mechanisms they use in the scenario.[8]It is observed that at the beginning there is a moment of shock, denial, of feeling despair, which can be gradually replaced by a greater capacity to withstand and deal with the reality.[8] Information is a dominant need, so the family should be informed in a clear, objective and realistic way, the operation of the dynamic of unity and health of the person in critical condition.[9] Some family members have difficulty understanding the information given to them by the health team.

In this sense, the data from this study are not consistent with some studies showing that the needs of families and patients hospitalized in ICUs are not being met and communication between professionals and family seems inadequate, which constitute problems to be solved.[13,14,15] When there is not a previously established relationship between work and family, the meetings can be difficult and complex.[16] Usually in the UCI, the main transmitter of communication on the sick person is the doctor who should provide clear and realistic information but compassionate and solidary.[17] Despite the specific environment of an ICU, care cannot be reduced to the axis of technical and biological unresponsive for the care of the sick person in its complexity, and the family member hosting. When approaching a family, the nursing professional is entering a universe of values, with personal meanings and experiences, which should be considered in the course of dialogue and listening process.[8]

The presence of the family can alleviate feelings of insecurity and fragility of the patient before an environment full of appliances and unknown people, contributing to an improvement in their clinical course.[8] The visit of the family is as

a source of emotional support for the patient admitted to the ICU.[18] However, this direct dedication to family happens to a limited extent given the lack of time for integral involvement.[8] Often, some standards, such as determining the orientation visits and time can be formatted by health professionals as one more task to be accomplished in an authoritarian logic. This authority comes from the domain-specific knowledge by the professional, based on the current clinical model.[19] The nursing staff must be the link between the patient and family member, favoring the interaction between them and at the same time taking care of both.[12] Creating links can happen in times of visits or alternative schedules, which can be provided according to the needs of the family and the hospitalized person.[8] Thus, they may contribute to a full, humanized and welcoming family care in the UCI.

The gestures and attitudes expressed by the participants reveal that deal with the pain and suffering of family promotes often their removal to protect from suffering, distress and disruption that these interactions generate. This behavior is consistent with the literature that shows that to minimize the feelings of uncertainty, sadness, anger, confusion, anxiety, and discomfort experienced by the family when informed about the approaching death of their loved one, health professionals must assume a welcoming and develop communication skills posture.[17] However, often the team ends up not realize the need to host the family, in and out of the ICU, the visiting hours without receiving the attention they need to face the situation.[8] There are also nursing professionals who appropriate time visiting hours, as a period of escape, to relieve their own stress and gather the team.[20] The visit time as a time of rest of the nursing team may be a defense mechanism, consciously or not, to resist the daily sufferings of work in an ICU.[8] Sometimes, the difficulties in family care are related to fear of emotional involvement and the unpreparedness of the professionals dealing with situations of the family crisis as coping with the death news.[12]

Although some situations experienced in the ICU may be in unrest scenario and insecurities and coexistence be limited to the short period of the visit, the family is perceived as care focus of attention developed by these participants in a technologically complex environment, and seen as a positive development. However, we cannot forget that any professional alone can give full attention to the sick person´s needs and his family. Care in the ICU results in dialogue, sharing of experiences and knowledge of different professionals to new ways of thinking-feeling-action be built.[6] Only in this way it will be possible that health professionals in the ICU a way safer and close family, strengthening the necessary changes in interpersonal relationships and daily practice of the team.

CONCLUSION

Understand the reality in which nursing professionals of this study are inserted involved in diving in subjectivity and in essence, without disregarding the objectivity. From different looks, it was possible to uncover the meanings of family care in the ICU, which are configured in five core subjects. The route undertaken in this study demonstrated that these meanings seem to break away from the traditional practice guided by the biomedical model and the stereotype of technical rationality. These professionals consider the care developed at ICU is a response to a call for help that is through a sense of understanding and empathetic approach to the family world. During hospitalization, they seek to go to meet and establish a relationship that allows creating bonds of trust and being a real presence.

It was clear that there is still much to do to continue to build a humane environment and protection that favors the family monitoring. However, the daily practice of the ICU seems to show new ways to care, new patterns of action and interaction. Every day, there are small isolated acts that may go unnoticed but which are multiplying in the direction of a more global process. For example a more flexible attitude towards the rules and routines of the unit; the desire to transform and humanize the ICU care environment; meaningful and engaging proximity to the care human being, not just a concern to comply therapeutic actions.[6] However, the experience of the process of change is difficult, especially when the road is riddled with old habits, ways of being and acting,

uncertainties, fears, institutional and personal limitations.

We hope an approach to the experiences of nursing professionals to provide support for a reflection on practice that integrates the family as a caring focus on the ICU. This implies rethinking the relationship established with the family, working conditions, involving political and institutional management and the formation of professionals.[19] Because we are continuously apprentices of care, any perspective that is adopted for the study or practice it is a reduction reality.[4] Sharing this vision, we suggest that further studies be conducted in different ICUs to improve, expand and meet the multiple dimensions involving family care.

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