THE ELDER CARE IN INTENSIVE CARE UNIT: NEW PARADIGM APPROACH

O CUIDADO À PESSOA IDOSA EM UNIDADE DE CUIDADOS INTENSIVOS: NOVA ABORDAGEM PARADIGMÁTICA

EL CUIDADO DE LOS ANCIANOS EN UNIDAD DE CUIDADOS INTENSIVOS: ENFOQUE PARADIGMATICO NUEVO

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RESUMO
Objetivo: refletir sobre o cuidado desenvolvido à pessoa idosa no contexto de uma unidade de cuidados intensivos (UCI) e apontar o Cuidado Transdimensional como uma nova abordagem paradigmática na área.

Método: estudo de abordagem reflexiva com base numa revisão bibliográfica. Resultados: enunciam-se as especificidades que caracterizam uma UCI, focando alguns aspectos relativos à admissão e peculiaridades do internamento da pessoa idosa. Destacam-se algumas contradições do cuidado, a recente consciencialização dos profissionais de saúde pela humanização em UCI e a aplicabilidade do cuidado paliativo como abordagem complementar. Diferencia-se a conceção de cuidado na perspetiva médica e de enfermagem, esclarecendo a forma como o seu saber e atuação é diversa e complementar. Evidencia-se o desafio do Cuidado Transdimensional que aponta para a necessidade de novas formas de consciência e de expressão, assim como, uma participação mais ativa dos profissionais nas transformações requeridas. Conclusão: o cuidado à pessoa idosa em UCI requer novas formas de pensar-sentir-agir congruentes com a interdependência e complementaridade das ações médicas e de enfermagem através de uma atenção diferenciada e comprometida com a experiência de ser e viver da pessoa idosa internada em UCI.

Descritores: Cuidado Intensivo; Pessoa Idosa; Cuidado Transdimensional.

ABSTRACT
Objective: to reflect on the care developed the elderly person in the context of an intensive care unit (ICU) and point the Transdimensional Care as a new paradigmatic approach in the area. Method: study of reflective approach on the basis of a literature review. Results: are the specificities that characterize a UCI, focusing on some aspects concerning the admission and peculiarities of the hospitalization of elderly person. There are some contradictions of caution, the recent awareness of health professionals by humanization in UCI and the applicability of palliative care as complementary approach. Differentiates the conception of care in medical and nursing perspective, clarifying how their knowledge and expertise is diverse and complementary. It is evidenced the Transdimensional care challenge that points to the need for new forms of conscience and expression, as well as a more active participation of professionals in the required transformations. Conclusion: the elderly person care at UCI requires new ways of thinking-feeling-taking action congruent with the interdependence and complementarity of the medical and nursing actions through a differentiated attention and committed to the experience of being and living of the elderly person patient at UCI.

Descriptors: Intensive Care; Elderly Person; Careful Transdimensional.

RESUMEN
Objetivo: reflexionar sobre el cuidado desarrollado al anciano en el contexto de una unidad de cuidados intensivos (UCI) y señalar el cuidado Transdimensional como un nuevo enfoque paradigmático en la zona.

Método: estudio del enfoque reflexivo sobre la base de una revisión de literatura. Resultados: son las particularidades que caracterizan a una UCI, centrándose en algunos aspectos acerca de la admisión y las peculiaridades de la hospitalización del anciano. Hay algunas contradicciones de precaución, la reciente toma de conciencia de profesionales de la salud por la humanización en UCI y la aplicabilidad de los cuidados paliativos como enfoque complementario. Distingue el concepto de atención médica y de enfermería desde una perspectiva, aclarando cómo sus conocimientos y experiencia son diversas y complementarias. Se pone de manifiesto el problema de la atención Transdimensional que apunta a la necesidad de nuevas formas de conciencia y expresión, así como una participación más activa de los profesionales en las transformaciones necesarias. Conclusion: el cuidado de personas mayores en UCI requiere nuevas formas de pensamiento-sentimiento-tome acción congruente con la interdependencia y la complementariedad de las acciones médicas y de enfermería a través de una atención diferenciada y comprometida con la experiencia de ser y vivir del paciente anciano en UCI.

Descritores: Unidad de Cuidados Intensivos; Persona de Edad Avanzada; Cuidado Transdimensional.
INTRODUCTION

As an integral part of human life, the care represents a deep commitment to life in society and the planet, respecting the most varied forms of expression. Consequently, its concept cannot be exclusive to a particular area of knowledge or a particular professional category. When the context of care is an Intensive Care Unit (ICU), dominated the technology and technical knowledge-biological, this evidence assumes a complexity and specificity. The careful developed can only be fruit of subtle meeting between different powers, all useful, in time, the process undertaken.2-4

Despite advances in the field of research, there are still guidelines imprecise, particularly as regards the subject of elderly person in critical condition. This fact leads us to deepen the look on its contemporary professional practice, of environment and of interpersonal relationships in this context. Given the above, this article aims to reflect on the care developed the elderly person in the context of an intensive care unit. To undertake this reflection, it becomes essential to revisit the past, focus on the present and unveiling horizons of possibility.

In this sense, we started by offering specifics of a UCI, highlighting the complexity of the human being and the mastery of technique, present in this environment of care. Then given the pressure of the health system in relation to scarcity of resources and rationalization of expenditures, focus on some aspects concerning the admission of elderly person at UCI. We point out, also, some contradictions, in which care is part of the enhancement of the technical and scientific competence to the detriment of human competence, depersonalization and verticality of relations. However, at the present time we have a greater awareness of health professionals by humanization in ICU, as well as the applicability of palliative care as complementary approach.

Subsequently, we demonstrate the complementarity and distinction of the conception of care in medical and nursing perspective. The total dependence of the elderly person and the heterogeneity of endogenous and exogenous factors that characterize the aging process makes necessary the articulation of the knowledge and skills provided by the different fields of knowledge to an act Integrator. However, for this to happen, are required new forms of conscience and expression, as well as a more active participation of professionals in this transformation. In view of the above, we finish with the Transdimensional care challenge, which allows you to contemplate the interior/exterior, subjective/objective, the individual/universal, the intuitive/rational.5 So we invite all professionals to assume the commitment to learn and share the wisdom of care supportive, creative and selfless to the elderly person at UCI.

♦ Specifics of an Intensive care unit

In the hierarchy of the UCI hospital services is considered a service of greater complexity. Is intended for the care of patients with actual or potential impairment of vital functions, due to the failure of one or more organ systems, as a result of disease, trauma or poisoning.6 the practices are characterized by the application of cutting-edge technologies and the implementation of procedures with high degree of “invasion” of the body.7 however, for which the etiology that precipitated the pathological situation can be reversed, it professionals need to develop intellectual capacity that favors the speed in decision-making, an established technical capability and a manual dexterity enough.8 Consequently, these units require a differentiated logistic support and a qualified human support so that it can be afforded a permanent attention and specialized care.

However, the incorporation of technology and therapeutic procedures burdensome raises the costs of the internship on a UCI. This generates conflicts and unpopularity by hospital administrations, there is a risk of disruption of the ethical commitment to excellence in care.5,6 When experiencing in our daily lives, the threat of the limitations and budgetary constraints becomes essential to the definition of acceptance criteria and high of people admitted to ICU.5 Consequently, some sick people can be deprived of technology that need to be handled. Particularly, the access of older persons to these units in the future may be compromised.6 Understand that insufficient vacancies at UCI and the scarcity of resources implies the need to make choices. However, we cannot disregard the criteria established for the selection of those patients need to be effective and the pragmatic point of view, whether from the moral point of view. Will this effectiveness is achieved in decisions that professionals take regarding the admission of elderly person?

♦ The admission of elderly person at UCI: Morality in the application resources
The literature presents important subsidies to highlight that with an ageing population, the average age of patients hospitalized in ICU have increased in recent years.\(^1\) by individualizing the UCI, approximately 70% of U.S. hospitalizations correspond to people over the age of 60 years.\(^1\) when it restricts the age group for people older than 70 years, the figures are also significant (25% -30%).\(^3\) With the aging associated with co-morbidities, the loss of muscle mass and strength, to the decrease of physiological reserves pulmonary and renal, cardiovascular, there is an increased risk to develop progressive organ failure.\(^7\) in this sense, some data are evidence of the high mortality rate of the elderly person patient at UCI.\(^3\)

This scenario justifies the concern with the logistical support, economic management and the real effectiveness so intensive in this population size. It is undeniable that the intensive treatment of the elderly is always associated with the idea of cost-benefit little rewarding.\(^3\) however, there is some controversy in the literature, as regards age as a Predictor for prognosis of isolated element at UCI and, consequently to the application of available resources. Some studies revealed that age per se does not determine a worse prognosis, but yes, the associated factors.\(^7,8\) Are elements worthy of consideration in the decision-making process: the pregnant of acute dysfunction, functional capacity and the degree of independence of elderly person prior to the internment camp in the ICU, the presence of terminal illness the number of organic dysfunctions, the pre-existing sequel the proposed treatment and likely results, and the risk of complications inherent to the internment camp at UCI.\(^7,8\)

The chronological age does not necessarily reflect accurately, and uniform, the wide range of functional alterations in several organs. The reaction capacity of the elderly person in the face of acute requests can vary widely, making it unworkable and dangerous any attempt at generalization of functional behavior, within this extremely heterogeneous group.\(^3\) Several elderly people aged over 80 or 85 years contradict the common Census and statistics available to manage to overcome all difficulties and complications, leaving the UCI in stable conditions to everyone's surprise.\(^3\) in view of the foregoing, the decision of admission of an elderly person at UCI determines the understanding of their medical needs, emotional, spiritual, social and psychological.\(^8\) an exploration of these needs with compassion and sensitivity, allows you to verify if the UCI is the best response to the goals of care, or whether, on the contrary, are conservative approaches that reflect more closely the values and preferences of an increasingly elderly population.\(^8\) thus, the therapeutic conduct be used requires overcoming the merely technical discussion and engage the elderly person and their family, respecting their wishes, their choices, making them part of the decision-making processes.\(^4\)

The age, like any other criterion, should be judged only by the negative influence that might have on the proposed objectives for the use of a particular technique. Delete a list for a heart transplant candidate with 80 years isn't a discriminatory form of rationing, but only the acceptance of the fact that the therapeutic results and the benefits of this procedure would be disastrous.\(^6\) in this way, it is reasonable to assert that rationing must be based on objective information and in the best interests of the elderly person sick. The knowledge of this reality implies an analysis of representing for the life of the human being technical and scientific advances and the Tec relations, uniting the dispersed fragments to see the whole.\(^9\) in this sense, it becomes essential to describe some contradictions present in the care of the elderly person hospitalized in the ICU which remains similar to any adult person. Despite the increase in hospitalizations in this age group there is no consideration for its peculiarities, its organic, psychological and social changes.\(^10\)

\(\blacktriangle\) Relocation of an elderly person at UCI: Contradictions in the care

Typically, the relocation of elderly person in a UCI occurs abruptly and assumes a particular slant, the likelihood of increased fragility and vulnerability that characterizes it.\(^11\) Any assault on his integrity, even though minimal, can result in a global imbalance and irreparable damage. This finding makes it imperative the attention and commitment of health care professionals with its objectivity and subjectivity. However, the practice of care to the elderly person at UCI is still guided by the positivist paradigm, which assumes the existence of a reality that can be seized through natural mechanisms and laws immutable, whose basic approach is reductionist and deterministic.\(^10\) in the opinion of some authors, impersonality, the lack of privacy, social isolation, technology, organization of work centered on the biomedical model and the rigidity of the hierarchies are some aspects that influenced the way of living and care developed at UCI.\(^11\) the knowledge and handling of sophisticated equipment by health professionals has led to
the gentrification of this group that controls many times with arrogance that technology to others is startling. These professionals may submit a more technical approach, aimed at making the procedures and the execution of tasks.

Organic disorders, present and potential, as well as hemodynamic instability put the elderly person's life at risk and underlie the need to administer hypnotics and sedatives that alter your state of consciousness. After reduction or suspension of sedation, the elderly person awakens and runs into an unknown environment and impersonal when everything happens and changes quickly. In an inflexible and sometimes careless experience the depersonalization of your body. Is laid bare and permanently connected to tubes and machines, being subjected to technical procedures that often doesn't understand or doesn't realize, given its critical condition. Loses its intimacy and privacy since both vary in inverse ratio of quality of surveillance.

In parallel, imposed certain moral values, behaviors, therapeutic procedures, norms and institutional routines. These changes do not recognize the individuality of the older person, his life story, and their emotional needs and, above all, limit the possibility of developing strategies that encourage the adaptation to unfamiliar surroundings. Thus, in a phase of life in which requires tranquility and warmth, is isolated, in an environment that can generate suffering and anxiety. Apart from the physical pain caused by the disease and therapeutic techniques, is also subject to the pain caused by the distance from family and friends. This experience demonstrates that not every pain can be alleviated by analgesics. To the extent that this thought would remove the intimate and personal meaning of suffering turning pain into technical problem, stripping her of her existential subjective dimension.

Due to a greater awareness and concern of health professionals, the humanization of care at UCI has been quite an issue addressed in recent years. It is evidenced that in intensive care prioritization and identification of futile care as a therapeutic approach in this context have become a necessity.

For a competent, consistent and responsible act, inserted in an environment of this sophisticated technology, you need to associate with the technical and scientific competence human competence and ethics. Need to be present in full, give the best of himself, attended the experience and the knowledge of the other. Humanized Care encompasses the ability to perceive and embrace the human being in its entirety and understand how you build your identity and life story. However, we realize that some professionals are more geared for caring elder whose healing is possible, compared to that in which the hope of recovery is null. However, we must not forget that when the cure run skills and knowledge of the human being, the care encompasses actions that allow you to alleviate the suffering and provide some comfort. In this way, the expression still widely used by some professionals 'there's nothing more to see and do-', need to be overcome in the healthcare practice at UCI. So that this change of thought occurs, palliative actions are fundamental to permit to demonstrate that there is always something that can be done for the welfare of the sick person.

Palliative care actions to the elderly person at UCI

A person is considered in terminal condition when his illness, regardless of the measures adopted, will evolve inexorably to death. However, the focus on curative approach in ICU demand actions obstinate in help to earn more lifetime, underestimating the comfort of the patient terminal and imposing a long and painful agony. Death is postponed at the expense of the senseless suffering, inappropriate control of pain and of omission in providing quality of life to its end. For these purposes in the process of dying are minimized, the implementation of palliative care as a therapeutic approach in this context has become a necessity.

When the cure is unattainable, the therapies are unsuccessful and the suffering of the elderly person becomes unbearable, and the professionals do not always have the lack of edge of life. Learn to accept the moment that death conquers the human knowledge and technical abilities is to respect the right of the elderly person to die with dignity. At this stage, interventions should be directed to the full comfort, in which the main objective is to relieve the discomfort of physical symptoms and alleviate the distress. Palliative care prioritization and identification of futile
measures should be established by consensus by the health team in line with the sick person (if able) and their families. The continuity of futile measures only slows the inevitability of death, a high financial, social and psychological cost to all parties involved in the process.

During a moment so unique as the approach of death, it is important that professionals know live with the finitude of human beings. In this way, the palliative care does not compete or are incompatible with the curative care at UCI. Only accompany the elderly person until the last moments of his life so that the denouement in a sphere of peace and harmony. This philosophy of care in addition to complement the curative treatments of modern medicine, provides professionals with dignity and meaning to treatments chosen. In any event, the elderly person cannot be viewed just as a sick body, but rather as a singular being with feelings, desires, needs, concerns, values and beliefs built from its subjective and social world. All these aspects need to be embedded in the process of care. Require a look and an act capable of overcoming the sensitive corporate of the different professional categories for the benefit of the complementarity of the actions on health.

To take care of the human being in its entirety, exerting a preferred share in relation to their pain and suffering, with technical and scientific competence and extent of instruments being human life. Who cares and let it ring for human suffering on the other if the proceedings and humanizes, apart from scientific knowledge, has the privilege to grow in wisdom, in this regard, we are experiencing a major change, which has ceded space to a merger between curative care and palliative care. Despite this progress, there is still much to be done in a context in which the disease destroys the integrity of the body, and the pain and suffering can be factors of disintegration of the unity of the person. It is still necessary to transform some aspects such as: resource usage for prolongation of situations and not of life itself; inaccurate models for prediction of death; great variability in the practices to the bedside; vague knowledge of the preferences of sick people; problematic communication between teams and families; professional terminology imprecise and poorly trained crews for callous; completion; incomplete medical records.

Palliative practice at UCI should include assistance to families as an extension of the life of the elderly person and the professionals who accompany a person in terminal condition. These should not be recognized only as providers, but also as human beings who need to be cared for. Need their dignity and human conditions are met so that they can develop a humanized care. Considering the above, we were able to seize that despite scientific and technological development is essential for the maintenance of people's lives, too, increased exponential manner, the asymmetry of power and knowledge, making totally unequal relations. In this regard, care of the elderly person at UCI puts the challenge of breaking with the attitude of passivity, with the silence and denial of a standardized, often fragmented assistance and reductionist in different forms of intervention. This awareness makes it necessary for a genuine dialogue between medicine and Nursing about how the different knowledge and actions differ and complement each other.

Medical care and nursing care: Distinction and/or Complementarity

Understanding the care ' derives from the way is perspective and the sense given to it. The caregiver perspective, according to Honoré, consists in the way care opens to thought and to the activity of someone, from their current representations, variables as the domains of activity and the particular circumstances. As to the sense of an action of careful, the author states that this is always singular, own of every one who lives and experience evolves with time and situations. In the same way that there is only one direction for care, also is useless and dangerous to try define a perspective of care authentic and valid for all. At UCI, the practice of care to the elderly person implies questioning the sense caregiver that cleaves around the medical perspective and from the perspective of nursing. In this sense, we must recognize and understand the different ways of being, and do, how they can be convergent or divergent.

Because of its history, the professional discipline of nursing proclaims maturing in the construction of knowledge around the nature of care, of beings who care and who are cared for. According to Watson, the watch continues to be the dominant concept, unifying and central focus of nursing practice. For this reason, the author mentioned sustains the idea that care developed by nursing is ' person-centered ', while the ' medical care centered on the cure'.

The Act caregiver centered on person involves a commitment to human beings, values, will and conhecimento. Requires...
personal involvement, social, moral and spiritual. Conversely, the Act caregiver centered in healing has as objective the recovery and treatment of a disease. In this Act, the organic and rational aspects are privileged to the detriment of existential aspects through which reveal our human possibilities.

In fact, we cannot claim that an action taken in a technical-scientific medical perspective is not authentically care. This action is caregiver within the limits of this perspective, since it allows for mitigating the harmful effects or cure a particular disease. However, even if it is very important, is not sufficient, since the human being is not confined to a body-object, a form of machine, in which we can apply our knowledge and our techniques for brighter than they are. It is while body-subject, different from its component parts, that need to sense, which requires particular attention. Because it’s made of desires, pleasures, risks, joys, sorrows, sources of motivation, disappointment and hope, the body-subject cannot be dominated by systematic approach, nor to submit entirely to the rationality of the other, nor match perfectly to theories and to instruments used by professionals. In this way, an act only for a cure-oriented caregiver of a pathology from a bio life science approach, not fully exhaust its meaning, nor for those who care, even for those who are care and live this experience. This thought reflects the practice of care involves two dimensions: the affective dimension/expressive and technical dimension/instrumental. Depending on the situation and the context of caution there are moments where one of the dimensions is more important than the other. The diagnosis and treatment of the disease caregiver’s activities domain of medical character, the technical dimension/instrumental is more evident in view of the fact that there is more easily perform the technical-scientific activities with effectiveness, than in exercising the intersubjective relations.

Eminently Practical techniques, standardized and distant, can lead to impersonality and stiffness of the relationship, with little show of sensitivity. Often, the elderly person is known for its number of bed or by his diagnosis. Oblivion in explaining the procedures will be submitted and its purpose is current. Naturalize-if prescription habits, procedures, determinations about your live and does not recognize their decision-making ability. On the contrary, it is perceived as an obedient and passive, with no opportunity to express themselves. The development of this vision has contributed to an immoral expression of care, in so far as it deprives the person cared for the richness and diversity of their subjective experiences, isolating it from their midst and denying its own live and know.

To develop an effective care that includes the totality of being, producing well-being and harmony, there is a need for an interconnection between who cares and who’s care, through the intentionality and the presence. In this perspective the elderly person is recognized for its uniqueness and individuality, as someone who lives a particular situation and requires attention to a better coexistence with the environment that surrounds them. When that happens, the affective/expressive dimension is present. Health professionals and recognize the benefits and I though the importance of technology in your know-how, are aware that the use of the same can never replace the presence of your touch, your look, your sensitivity, your dedication, your interest in realizing and understanding each other. On from the above, we can conclude that both dimensions are part of the completeness of the human experience. The great challenge of the practice of care at UCI lies in their combination, i.e. find a synergy between the technical and scientific improvement and a more humane mode of being in relation caregiving.

To achieve this purpose and overcome the entrenched perspective separatist who still predominates, it is urgent a theoretical-practical approach jointly between the most varied disciplines and professions, in order to promote a convergence of actions. No professional alone can give full attention to the needs of the elderly person and his family. This condition requires the emergence of new ways of thinking-feeling-Act in the world, congruent with less competitive attitudes that emphasize the integration of disciplines and professions. However, there seems to be difficulty in operating a large part of the theoretical knowledge developed by the disciplines of medicine and Nursing in the context of clinical practice. Despite the progress achieved in knowledge still shares thrive from the perspective of the traditional model of science. This observation poses the challenge of creating structural conditions so that a new vision of the elderly person care at UCI can effect.

New paradigmatic approach for the care of the elderly person at UCI
Considering what's been exposed so far, namely care and intervene with the elderly person patient at UCI is one of the priorities at the present time. In this sense, you are prompted the development of new and varied theoretical and practical concessions which are accompanied by new perspectives of direction and action on this reality. Within the various emerging approaches, careful Transdimensional points new horizons of possibilities to enlarge the reality that is set, toward a more comprehensive vision of totality. This reference to encompass the characteristics of Transformative nursing Unit and paradigm Was III of medicine, brings in itself a perspective of integration and transdimensionalidade of being and his environment, overcoming the reduced dimension of the health-disease process.

Transdimensional care has as a priority the life in its most diverse forms of expression, and as a goal to increasing complexity of expression of consciousness and quality of life on the planet. is characterized by an innovative way to feel, think and develop the care, which should be built on the basis of interaction by the ongoing dialogue between professionals, individuals, families, groups, communities and societies, without losing sight of the reality of transdimensional.

Consequently, requires new skills and capacities of caregivers, which extrapolate the intellectual and rational capacities, such as: love, wisdom, compassion, solidarity, intuition, creativity, sensitivity, imagination, as well as multi-sensory forms of lack.

Transdimensional care focuses on the essential process of death and rebirth, two concepts simultaneously and complementary opposites. this process as an integral part of human existence can be experienced in the most diverse situations, in a cyclical movement, with a view to the renewal, for diversification and complexity of the creative life. in this way, the daily practice of UCI suggesting death and simultaneously the rebirth of new forms of care, new patterns of action and interaction in this context. Daily occur small isolated acts that may go unnoticed but that are multiplying in the direction of a more comprehensive process. Such as: the need among health professionals to share ideas about certain therapeutic decisions; the prevalence of mutual understanding and cooperation in relation to subjection; the acceptance of diversity of every being and every act professionally; the easing stance vis-à-vis the rules and routines of the unit; the desire to transform and humanize the UCI care environment; the proximity to significant and engaging with the human being careful, and not just the concern to comply with therapeutic actions. However, the experience of the process of change is difficult, especially when the road is permeated by uncertainties, fears, institutional and personal limitations. Abandon old habits, ways of being, being and acting, to make way for new patterns of thought and action, imposes great challenges and some aptitude in conflict management.

A service in which technology seems to have supremacy, in which everything is ceiling, walls, lights, machines and noises, keep the focus on elder care, requires an attitude of constant interior alert. The complexity of care at UCI if evidence by the effort of health professionals to ensure harmony in moments of encounter with the elderly person, a movement of complementarity of feelings, actions and reactions. Of course, this meeting cannot be random, impersonal, devoid of affection and emotion. Pursues the aim of creating bonds of trust and of being a genuine presence in the environment of care. in this perspective, the Transdimensional Care constitutes an eminently participative and reflexive process, in that the caregiver and be careful, through a dynamic, intuitive and creative interaction, create opportunities a walk towards new experiences, in which, so original and unique, if auto known and autotransform.

Arguably the situation of internment in the ICU leave the elderly person and their fragile family, full of uncertainties, with feelings of loneliness, fear and abandonment. this event requires that the caregiver develop skills and talents to be careful in the rediscovery of their potential to transcend its present form of expression. however, we couldn't dismiss the importance of the participation of the elderly person in this process. Their ability of expression as being careful will determine, in large part, the pace and the potential of care. in this regard, the promotion of confidence of elderly person herself is central to who believes in the possibility of recovering many of its capabilities and begin to participate actively in the process of care.

Before the exposed, professionals and elderly person become participants in a process of discovery and mutual learning. Careful actions are privileged moment of Exchange, in which beings involved receive and donate. As such, the effectiveness of care cannot be considered only in terms of results, but as an experience full of meanings, which is vital in the evolution of beings. care as shared process can only make sense in terms
of total unit, implying that if you activate the complex wishes-thought-feeling for purposes of love, help, bringing itself a commitment to life.¹

The events in practice of care at UCI are private, singular and unique, and therefore cannot be rigidly structured or adopt a mechanistic approach, or of absolute certainties. Each elderly person in every moment is unique, making it virtually impossible to predict their behavior based on their past reactions, or based on the behavior of other elderly people in similar situations. Thus, living care Transdimensional “implies changing the old conditionings, openness, flexibility, confidence in the process and the admission that the human being is an eternal apprentice in the art of caring”.¹ ¹³ This learning requires a continuous care practice revisit the elderly person at UCI, in order to enhance, expand and meet its multiple dimensions. Only a careful practice that focuses on nature and the sacred dimension of being and of life can emerge in conjunction and in harmony with the technologies.¹

◆ Opening a space for dialogue

Throughout this text we reflect on certain situations that they anticipate that there is still a long way to go in the context of the care of an elderly person at UCI. On this path of convergences and divergences, the past, present and future coexist and are interrelated in the everyday practice of care. The past reveals disregard between the disciplines of Medicine and nursing for an integrated perspective of actions, in the process of care to the elderly person at UCI. At present, despite the effort still predominates the approach of healing and reductionist vision and traditional science model separatist. However, some transformations begin to gain space, as awareness for the need for humanization and importance of palliative care in practice actions at UCI.

In this evolution, it seems that the word completeness in an ICU starts making sense at will a and receptivity on the other, dialogical relations, on horizontality of knowledge, in appreciation of the human condition of being careful and being a caregiver.¹ ¹⁵ there is at the present time the recognition that the construction of knowledge is an unfinished process and does not occur in isolation, and that a discipline only has real meaning when integrated with others and to society.¹ this thought paves the way for the emergence of Transdimencional care paradigm which may lead to a new form more congruent thinking-feeling-Act in intensive care. Given the complexity of the issues addressed, it wasn't our intention to put an end to this reflection, but open a space of dialogue. We hope that this space can contribute to the development of new forms of expression of care to the elderly person and their family, at UCI.

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