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ORIGINAL ARTICLE

FEELINGS OF PATIENTS WHILE STAYING IN INTENSIVE CARE UNIT SENTIMENTOS DO PACIENTE DURANTE A PERMANÊNCIA EM UNIDADE DE TERAPIA INTENSIVA SENTIMIENTOS DEL PACIENTE MIENTRAS QUE PERMANECE EN LA UNIDAD DE CUIDADOS INTENSIVOS

Fátima Maria da Silva Abrão¹, Edivania Felix dos Santos², Raquell Alves de Araújo³, Regina Célia de Oliveira⁴,
Aurélio Molina da Costa⁵

ABSTRACT

Objective: describing the feelings of the patient related to the stay in the intensive care unit. **Methodology:** an exploratory study with a qualitative approach performed in a teaching hospital with twelve patients who were discharged from the sector in the period from December 2010 to April 2011. It was performed a semi-structured interview recorded for data production and analyzed according to the technique of content analysis. The study was approved by the Research Ethics Committee, CAAE 0040.0.102.000-10. **Results:** the analysis resulted in four categories: << Fear of death and insecurity >>; << Anxiety and stress >>; << Isolation and loneliness >>; << Faith and religiosity >>. **Conclusion:** it is essential to pay attention to the feelings of the patient, as they promote further reflection and discussion of nursing care process, focusing upon the whole human being. **Descriptors:** Nursing; Adult Health; Intensive Care Units.

RESUMO

Objetivo: descrever os sentimentos do paciente relacionados à permanência em unidade de terapia intensiva. **Metodologia:** estudo exploratório, com abordagem qualitativa, realizado em um hospital de ensino com doze pacientes que receberam alta do setor, no período de dezembro de 2010 a abril de 2011. Foi utilizada a entrevista semiestruturada gravada para a produção dos dados e analisadas segundo a Técnica de Análise de conteúdo. A pesquisa foi aprovada pelo Comitê de Ética em Pesquisa, sob o CAAE 0040.0.102.000-10. **Resultados:** a análise resultou em quatro categorias: << Medo da morte e insegurança >>; << Ansiedade e estresse >>; << Isolamento e solidão >>; << Fé e religiosidade>>. **Conclusão:** é imprescindível atentar aos sentimentos do paciente, visto que promovem uma maior reflexão e discussão do processo de cuidar em enfermagem, visando a uma compreensão do ser humano integral. **Descritores:** Enfermagem; Saúde do Adulto; Unidades de Terapia Intensiva.

RESUMEN

Objetivo: describir los sentimientos del paciente relacionados con la estancia en la unidad de cuidados intensivos. **Metodología:** un estudio exploratorio, con abordaje cualitativo, realizado en un hospital universitario con doce pacientes que fueron dados de alta del sector en el período de diciembre 2010 hasta abril de 2011. Se utilizó la entrevista semi-estructurada registrada para la producción de los datos, y se analizaron según la técnica de análisis de contenido. El estudio fue aprobado por el Comité de Ética en Investigación, CAAE 0040.0.102.000-10. **Resultados:** el análisis resultó en cuatro categorías: << Miedo a la muerte y la inseguridad >>; << La ansiedad y el estrés>>; << El aislamiento y la soledad >>; << La fe y la religiosidad >>. **Conclusión:** es esencial prestar atención a los sentimientos del paciente, ya que promueven una mayor reflexión y discusión sobre el proceso de atención de enfermería, centrándose sobre todo el ser humano. **Descritores:** Enfermería; Salud del Adulto; Unidades de Cuidados Intensivos.

¹PhD in Nursing, Coordinator of the Postgraduate Associate Program in Nursing, University of Pernambuco/Paraíba State University/PAPGenf/UPE/UEPB. Recife (Pernambuco), Brazil. Email: abraofatima@gmail.com; ²Nurse, University of Pernambuco/School of Nursing Nossa Senhora das Graças/UPE/FENSG. Recife (PE), Brazil. Email: edivaniafelix@hotmail.com; ³Nurse Master. Recife (PE), Brazil. Email: raquellcatunda@gmail.com; ⁴PhD Professor in Nursing, Associate Postgraduate Program in Nursing, University of Pernambuco/Paraíba State University/PAPGenf/UPE/UEPB. Recife (PE), Brazil. Email: reginac_oliveira@terra.com.br; ⁵Physician, Professor, Associate Postgraduate Program in Nursing, University of Pernambuco/Paraíba State University/PAPGenf/UPE/UEPB. Recife (PE), Brazil. Email: aumolina55@gmail.com

INTRODUCTION

The Intensive Care Units (ICUs) are intended to care of critically ill patients with ongoing care needs and who are at risk of dying.¹ These locations are characterized often as generators of feelings such as fear, as well as causing anxiety and stress to the patient, these fruits of the manifestation of feelings of fear of death.

The ICU is a place marked by the complexity of care, wrapped certainties and uncertainties about the health situation/inpatient disease, where the patient becomes oblivious to their social and familial situation.² Although considered to be the best environment for recovery of patients in critical or serious condition, the ICU environment is seen as cold, aggressive and traumatic involving the patient, the family and this is also the multidisciplinary team. In this regard, it is noteworthy that *"The highly technologized structure of intensive care units much favors the maintenance of vital functions and physiological balance for the maintenance and survival of patients."*³

Such technological resources lead professionals to take actions and postures mechanized⁴, making them forget there's a human being in need of exchanges, communication, whether verbal or not, directed with simple actions, such as a word of comfort, a smile or even a shake of hands, which can give sense of security and confidence to the patient.

In the ICU, professionals turn for the body only, technical procedures, equipment use, and organic manifestation of the disease. The feelings and aspects related to spirituality end up being ignored, which contribute, directly or indirectly, to meet the most important needs of the patient.⁵ Thus, the patient who has the experience of hospitalization in intensive environment may present with feelings denoting shame and embarrassment by the lack of privacy and loss of identity and autonomy experienced with living in the unit.⁶ In a survey conducted in the ICU, it was found that among the negative aspects generated by the unit was the state of sadness in which patients perceive themselves in unity.⁷

It is necessary to understand the care beyond the technique, considering the patient more than a biological being, it is needed to give holistic care, they experience feelings such as respect, affection and use dialogue⁸, because life is composed of cultural representations, common sense, and of the elements that provoke feelings and emotions, in which the treatment becomes worthy as to

make effective patient care. Therefore, knowing the feelings of patients related to their stay in the ICU, it is relevant for professionals who deal with these people, especially the nursing staff, because there is a reflective-humanistic contribution of their character about holistic care and unique to the patient.

OBJECTIVE

- Describing the patient's feelings related to the stay in the intensive care unit.

METHOD

This is an exploratory study with a qualitative approach using semi-structured interviews as a technique, carried out in a teaching hospital, characterized as a public, general, large and high complexity hospital in Recife - Pernambuco, in the adult ICU sector. This is located on the second floor of the hospital and has 28 beds distributed in wards (A, B and C), aimed at serving coming from various clinical hospital patients.

The research population was composed of adult patients admitted to the ICU who were discharged. A total of 62 patients have been raised. However, only 12 patients participated in this study, those who met the following inclusion criteria: having been admitted to adult ICUs remained conscious and walked for at least 48 hours, be in hospital at the time of the interview; able to communicate verbally and be in hemodynamically stable condition.

The production data was conducted during the period from December 2010 to April 2011. As instrument was used a guide for semi-structured interview, with the following question: "How did you feel during the period of ICU stay?"

The visits of researchers to search for patients discharged from the ICU were held three times a week during the survey period. The search duration was three hours on average, a total of nine hours a week. Through the records of admission and discharge from the ICU was possible to carry out a survey and identify patients, noting the inclusion criteria of the search.

The interviews were recorded by means of electronic device (MP₅) and later transcribed. A careful reading of the statements of individuals was taken in order to seek a higher fidelity of the descriptions reported by them, ie, their feelings ICU.

Empirical data were analyzed using content analysis Bardin.⁹ This technique shows how some pillars phases: preparation of material or description; inference or deduction, and

interpretation. Before the analysis itself, a floating reading was performed as first contact with the reporting units, which made the first contours emerge from the analysis. Thus, after the content analysis of empirical data emerged four categories: fear of death and insecurity, anxiety and stress, isolation and loneliness, and faith and religiosity.

To ensure the confidentiality of the patients involved, it was decided to designate them by codes for names of flowers.

The data production was initiated after approval of the Research Ethics Committee of the Hospital da Restauração of Pernambuco, under CAAE 0040.0.102.000-10, on May 25th, 2010, respecting the ethical standards recommended in Resolution n. 196/96, the National Board of Health, which regulates research involving humans in Brazil. This research involved minimal risk and those involved had the confidentiality of information provided by the researchers. The recordings were destroyed at the end of the collection.

RESULTS AND DISCUSSION

Of the 12 hospitalized patients, 33% were aged 45-49 years old; the majority was male with 58%, and length of hospital stay between 2-18 days.

The testimonies of the patients are presented and discussed in the categories that emerge from the participants' speech, expressed the significance of their feelings during their hospitalization.

♦ Category 1 - Fear and insecurity

In this category, fear and insecurity were identified as intensifiers of great feelings, with a character almost synonymous with the social-familial relationships cuts to the patient, being away from family means the beginning of the end, to be a time of isolation, which seems creating uncertainty and fear, especially of death, as shown in the following quote:

I felt fear SO, because I was with a very high frequency, right? And came to take, there, I felt bad. Likewise I got sick at home. Then I was afraid because I thought there was going to die [...] ICU! Going into the ICU! Take to the ICU [...] [thoughtfully nodded].
(Glass of Milk)

Another highlight that same approach, demonstrates these sentiments thus expressed:

I felt very afraid, alas, of the guy's worse there, my family there, all [...] (Rose)

In turn, another guy betrayed in his speech that:

I was afraid of contact with people who had not [contact] and I get there and did not [pause] anyone to talk to me, no one to do what I wanted to do. (Cactus)

By speeches, one realizes that the feelings of fear and insecurity are influenced by the stigma of the name ICU carries, as culturally preconceived intended for people near death and felt by patients or reported by those who passed the ICU or even repeated exacerbated by the common sense of fashion. Important to put that environmental factors also affect the ICU to those responsible for implementing care.⁸ Its reveal, too, the presence of the feeling of fear and insecurity of the unknown, both in relation to the environment as compared to human contact with professionals present there. We notice that these, particularly the nursing staff, despite their experience, have not needed to deal with the patient who experiences this process emotional support. In this sense, it is noted that there is a multitude of feelings of nursing staff on the status of the patient, especially when it is near death, such as sadness, fear and impotence¹⁰.

As much as we know, with certainty, that the human being is finite, few accept the idea of finitude, causing insecurity and anxiety due to the possibility of the death process. Care for the patient in his finitude also requires a decision of the profession, particularly in regard to the final stage of the intervention of caring for these patients in the critical stage process. With this, the health team performs a special role in intervention and decision making, which are generated in specific challenges and tensions.¹¹

The nurse must act understanding that simple actions, such as touching, dialogue and information, empathetically, can contribute significantly to mitigate the harmful effects of ICU admission. Thus, it is believed that the process of relocation in this environment eventually become less negative to its users.¹²

♦ Category 2 - Stress and Anxiety

This category lists the feelings of anxiety and stress, mainly due to dissatisfaction related to the generator room noise and the behavior of the staff, especially nursing, as demonstrated in the following statements:

On the second day [at the ICU], I felt the environment strange. I felt a little "unquiet". (Margaret)

The patient goes on revealing his concerns about the environment, which, in principle, should be calm:

I felt a little uneasy, because I could not sleep right, because I was conscious and the other were not. Sleeping was a hard time!

Too much noise. Left the lighted [...] I needed rest, had to take sleeping pill. (Rose)

Ah, I got [nervous], because a lot of time there, lying in that bed! [...] It was a lot of noise [...] It was because of noise, another came, make test [examinations] passing medicine with awareness [action] the remedy you slept [...] But you cannot realize that you wanted to sleep. (Cactus)

Besides the aspects experienced by patients about the physical structure of the ICU, there are also aspects that betray their stay with nostalgic feelings and to share with other patients many situations, this cause anxiety and seizures. The statements below denote this statement:

I wanted to go home to see my daughter, kill the longing of her [...] (Sunflower)

The side that I turned there was a patient, on the other side was a tubed one. So I did not sleep; did not. (Iris)

The people, when letting on their feelings of stress and anxiety, even if not reported exactly in those words; in a survey conducted with 106 ICU patients about stressors in the unit, the top three cited were related to the disabled living with the fear of dying and also about the lack of time in the ICU, it is perceived that the feelings of stress and anxiety permeating the inpatient.¹³

Regarding the stress generated by the nursing staff, it was noted its occurrence by not promote a peaceful environment, and also for not seeking to establish almost any kind of communication with the patient, as evidenced by the following statements:

Ah, I got [stressed], because it was a long time there alone. Do not talk with anyone there [...] ah, professionals not approach me, no! (Sunflower)

Sometimes they wrangled, there is [...] complicated for me, a lot of noise. They wrangled, nurses, there is that atmosphere. Becomes difficult for the patient, the patient has nothing to do with what is happening, is that you are listening, have standing [...] even more in the ICU. Have to take rest, have to have a lot of peace to improve. (Rose)

Is apprehended, by reports, the professional attitude before the patient does not meet the fundamental ethical principles required by the Code of Ethics for Professional Nursing as these should "respect the life, dignity and human rights in all its dimensions".¹⁴ We need to take professional humanized positioning using existing technologies in the ICU to promote health care, combining the best technological devices with host, ethical and cultural respect.¹⁵

The patient care performed acceptably by the nursing staff makes him feel confident and comfortable in the relationship with the team, and with it, this is reciprocated with feelings of warmth and empathy. These feelings position persons in equal levels of importance and dignity.¹⁶

The lack of communication and creating a bond between the professional and the patient was evident when analyzing the statements of the subjects in this study. Often it is perceived that there was no approach to dialogue, focusing on nursing actions in technical procedures, forgetting the human need for social interaction, which causes stress to the patient. Therefore, it can be seen that the joint interaction between professional and patient is an important way to reassure him, and link building in which there can be more interaction and reliability of this by facilitating adherence to treatment. Enhancing communication, subtracting spaces doubts, desires and anxieties generated by the lack of dialogue.¹⁷

To have an effective relationship is not sufficient to consider communication as a tool but as an essential basis of competence and also the interpersonal ability.¹⁸ this sense, we believe that should be a strong interrelationship between nursing and assisted customers a since the success of the recovery will be faster and more effective because of the good performance of the work of the nursing team depends on communication and cooperation, which takes advantage of improved health inpatient.

♦ Category 3 - Isolation and loneliness

This category includes testimonies of how patients felt for spending too much time alone, away from family, somewhere other than their daily living environment, having to live with strangers are presented.

Here are some reports:

I had visits. Every day there are visitors; but, during the night, not. Then, it did not give me sleep. (Rose)

I missed my mother, my cousin [...] I [feel like going out], because it was a long time there, lying in that bed, alone. (Cactus)

'd stay away from my family, going away from me. (Glass of milk)

Once again, the family has been instrumental in supporting the recovery process. This is unveiled in the following statement:

Ah, the husband, two sons, cousin, sister, neighbor, there, each gave a word and went out [...] I felt very happy, I was not forgotten in there [at the ICU]? Because

there are many who are going to stop there [ICU] and the family forgets. (Tulip)

It is noted that the visits of family and friends were portrayed as positive to alleviate the isolation and loneliness that were submitted in the ICU factor. The influence that family support seems to have the recovery of patients should be taken into consideration by the nursing staff. It is the visit that the patient is seen, expresses and acts naturally. For some authors, the family is seen as part of the sick person, experiencing anxiety, fear, separation and behavior change.¹⁹⁻²⁰

The speech below, exemplifies this observation:

And I get there and did not [...] Nobody can talk to me. Anyone do what I wanted to do. (Narcissus)

We see from this that there is exaltation of the patients' feelings about being remembered and treated like people in that environment conducive to many moments of emotional conflicts.

It was observed that with the welfare generated by family and friends in the business, professionals who work in this environment little interfered positively with regard to decreased feelings of isolation and loneliness experienced by patients. Right now, which could be observed was the lack of interaction, as seen in the following quote:

I had visit [...] but, at night, no [...] was difficult [to be in the ICU], because I did not know when going out. And any song that we'll either know first when will it come out, and there, I did not know. (Narcissus)

Establishing a stronger link with the professional the patient and family is necessary in order to establish interactions for their benefit.

♦ **Category 4 - Faith and religion**

This category is represented by spirituality and religion, which permeated the patients interviewed during their ICU stay, especially as regards the rehabilitation and care delivery. In fact, they are important because they lead us to believe in faster recovery, with the belief prime factor for success in recovery and discharge from the ICU.

Study in ICU, on religion and religiosity with terminal patients, families, physicians and nurses, showed that the person to have a religion, facing situations of disease and treatment with greater hope, unlike those for whom religion is not configured as something decisive in their lives.²¹ In this regard, it is worth mentioning the issue of spirituality that permeates religious issues, and factor to be considered to understand man as a holistic

being. There are studies showing the need for nursing sensitive to this issue and recommends that there be courses that give distinct connotation between spirituality and religiosity.²²

In the statement below, the presence of the sacred, with the mention of "God" and "Jesus", indicates that the patient assigns to them a large part of improving their health.

I asked God to give me much courage and health, since the operation I did was very dangerous, I have seen death [...] I asked Jesus very much [...] I converted, in the name of Jesus, there, ready, I'm here. (Iris)

The speeches emphasized the divine, the sacred, in the relationship to be patient in the ICU, what is highlighted in the following statements:

I was well received, thank God, I have no complaints. (Gardenia)
I was extubated and, thank God, I was fine, thank God. (Jasmine)
Thank God everything was fine; then I left [...] (Tulip)

In content analysis, the evocation of "God" refers not only to the experience of the moment of their stay in the ICU, but to their leave from the sector:

I really wanted to go home [...] kill the longing [of the daughter], God willing [...] (Sunflower)
God shall not want me back [...] [to the ICU]. (Cactus)

With the above statements, it is noticed that the presence of a "higher" authority causes patients to have a reference of strength, control over their lives, the decisions on the direction, which is permeated by positive aspects to his departure from ICU. Also, go through the experience in ICU means that if the patient develops a sense of gratitude to God, and this clearly shows in their testimonies.¹²

In the case of professionals who provide care to critically ill patients, there are still compelling science-related issues in health, trying to control aspects of spirituality. It is believed to be due to a denial of the sense of finitude of being.

FINAL REMARKS

In this study, it was possible to see the various expressions of feelings in patients, such as fear of death and the uncertainty related to the stigma of the term ICU, which carries the proximity of death. Furthermore, we see the influence of environmental factors in the ICU (noise, excessive light, bed rest), which generates feelings of anxiety and stress were also caused by the nursing staff, due to

not promoting a peaceful environment. Associated with this, there is the expression of loneliness and isolation on the absence of the family and the lack of interaction between the professional and patient.

In turn, it is understood the importance of the presence of the symbolic and sacred as the positive stimulus factor in the recovery process of the hospitalized person and reference to spirituality, as the defining criterion that man is a being with feelings, so that nurses should pay attention to it, listening, respecting and valuing these expressions. Thus, it is considered that nursing, as a profession of care, should pay attention to these feelings and these expressions, so you can provide holistic care aimed at a more humane and effective care for human beings who experience the ICU stay.

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REFERENCES

1. Proença MO, Dell Agnolo CM. Internação em unidade de terapia intensiva: percepção de pacientes. *Rev gaúcha enferm.* [Internet]. 2011 June [cited 2012 Mar 05];32(2):279-86. Available from: <http://seer.ufrgs.br/index.php/RevistaGauchaEnfermagem/article/view/16953/12772>
2. Backes MTS, Backes DS, Erdmann AL. Relações e interações no ambiente de cuidados em Unidade de Terapia Intensiva. *Acta paul Enferm* [Internet]. 2012 [cited 2013 Dec 22];25(5):679-85. Available from: <http://www.redalyc.org/pdf/3070/307026618001.pdf>.
3. Bettinelli LA, Erdmann AL. Internação em unidade de terapia intensiva e a família: perspectiva de cuidado. *Av enferm* [Internet]. 2009 June [cited 2013 Dec 22];27(1):15-21. Available from: http://www.enfermeria.unal.edu.co/revista/articulos/xxvii1_2.pdf.
4. Moura KS, Araújo LM, Araújo LM, Valença CN, Germano RM. A vivência do enfermeiro em terapia intensiva: estudo fenomenológico. *Rev RENE* [Internet]. 2011 June [cited 2012 Nov 20];12(2):316-23. Available from: <http://www.revistarene.ufc.br/revista/index.php/revista/article/viewFile/159/70>.
5. Correia JN, Rosa K. Os sentimentos e a espiritualidade identificados nos familiares de pacientes terminais em terapia intensiva. *J Nurs UFPE on line* [Internet]. 2011 Dec [cited 2012 Oct 25];5(10):2391-7. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/1990/pdf_716.
6. Bettinelli LA, Pomatti DM, Brock J. Invasão da privacidade em pacientes de UTI: percepções de profissionais. *Rev bioethikos* [Internet]. 2010 [cited 2012 Apr 20];4(1):44-50. Available from: <http://www.saocamilo-sp.br/pdf/bioethikos/73/44a50.pdf>.
7. Tavares AT, Pawlowytsch PWM. Percepção dos pacientes sobre sua permanência em uma Unidade de terapia intensiva. *Saúde Meio Ambient.* [Internet] 2013 Dec [cited 2013 Dec 26];2(1):32-43. Available from: <http://www.periodicos.unc.br/index.php/sma/article/view/434/391>.
8. Backes MTS, Erdmann AL, Büscher A, Backes DS. O cuidado intensivo oferecido ao paciente no ambiente de unidade de terapia intensiva. *Esc. Anna Nery Rev Enferm* [Internet]. 2012 Dec [cited 2013 Dec 23];16(4):689-696. Available from: <http://www.scielo.br/pdf/ean/v16n4/07.pdf>.
9. Bardin L. Análise de conteúdo. Lisboa: Edições 70, 2009.
10. Souza e Souza LP, Ribeiro JM, Rosa BR, Gonçalves RCR, Silva CSO, Barbosa DA. La muerte e el proceso de morir: sentimientos manifestados por los enfermero. *Enferm glob* [Internet]. 2013 Oct [cited 2013 Dec 22];32:222-9. Available from: <http://revistas.um.es/eglobal/article/view/global.12.4.163241/153151>.
11. Coombs MA, Addington-Hall J, Long-Sutehall T. Challenges in transition from intervention to end of life care intensive care: a qualitative study. *Int J Nurs Stud* [Internet]. 2012 [cited 2012 Oct 8];(49):519-27. Available from: http://ac.els-cdn.com/S0020748911004160/1-s2.0-S0020748911004160-main.pdf?_tid=be0d1b98-6e7d-11e3-a332-00000aab0f02&acdnat=1388097389_a0e3342a3c4a32f532db6e8999f4b4fa
12. Silva AJS, Souza GGM, Leda KCM, Brasileiro ME. Assistência de enfermagem na UTI: uma abordagem holística. *Revista Eletrônica de Enfermagem do Centro de Estudo de Enfermagem e Nutrição* [internet]. 2010 June [cited 2012 Oct 25];1(1):1-16. Available from: http://www.ceen.com.br/conteudo/download/4552_53.pdf.
13. Rosa BA, Rodrigues RCM, Gallani MCBJ, Spana TM, Pereira CGS. Estressores em Unidade de Terapia Intensiva: versão

brasileira do The Environmental Stressor Questionnaire. Rev Esc Enferm USP [Internet]. 2010 Sept [cited 2013 Dec 22];44(3):627-35. Available from: <http://www.scielo.br/pdf/reeusp/v44n3/11.pdf>.

14. Conselho Federal de Enfermagem. Código de Ética dos Profissionais de Enfermagem [Internet]. Rio de Janeiro: Cofen; 2007 [cited 2012 Oct 21]. Available from: <http://www.portalcofen.gov.br/sitenovo/nod/e/4158>.

15. Marques IS, Souza AR. Tecnologia e humanização em ambientes intensivos. Rev. bras. enferm. [Internet] 2010 Feb [cited 2013 Dec 26];63(1):141-4. Available from: <http://www.scielo.br/pdf/reben/v63n1/v63n1a24.pdf>.

16. Araújo NRA, Monte CL, Freire FAG, Silva EL, Torres AL, Bezerra SMM. Ética e humanização na unidade de terapia intensiva: relato de experiência. J Nurs UFPE on line [internet]. 2012 Mar [cited 2012 Oct 25];6(3):685-9. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/2145/pdf_1039.

17. Aguiar ASC, Mariano MR, Almeida LS, Cardoso MVLML, Pagliuca LMF, Rebouças CBA. Percepção do enfermeiro sobre promoção da saúde na Unidade de Terapia Intensiva. Rev. Esc. Enferm. USP [Internet]. 2012 Apr [cited 2013 Dec 26];46(2):428-35. Available from: <http://www.scielo.br/pdf/reeusp/v46n2/a22v46n2.pdf>.

18. Nascimento DD, Correia DMS. A percepção do cliente hospitalizado na interação interpessoal com os profissionais de saúde. J Nurs UFPE on line [internet]. 2011 Apr [cited 2012 Oct 25];5(2):238-47. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/1528/pdf_293.

19. Silva RS, Campos AER, Pereira A. Cuidando do paciente no processo de morte na Unidade de Terapia Intensiva. Rev. esc. enferm. USP [Internet]. 2011 June [cited 2013 Dec 26];45(3):738-44. Available from: <http://www.scielo.br/pdf/reeusp/v45n3/v45n3a27.pdf>.

20. Freita KS, Mussi FC, Menezes IG. Desconfortos vividos no cotidiano de familiares de pessoas internadas na UTI. Esc. Anna Nery Rev. Enferm. [Internet]. 2012 Dec [cited 2013 Dec 24];16(4): 704-11. Available from: <http://www.scielo.br/pdf/ean/v16n4/09.pdf>.

21. Henrik Bulow H, Sprung CL, Baras M, Carmel S, Svantesson M, Benbenishty J, et al. Are religion and religiosity important to end-of-life decisions and patient autonomy in the ICU? The Ethicatt study. Intensive Care Med. [Internet] 2012 [cited 2013 Jan 09];38:1126-33. Available from:

http://download.springer.com/static/pdf/485/art%253A10.1007%252Fs00134-012-2554-8.pdf?auth66=1388271265_53ee06f0311a3f2e6ebb5bfae1b503f1&ext=.pdf.

22. Sessanna L, Finnell DS, Underhill M, Chang Y, Peng H. Measures assessing spirituality as more than religiosity: a methodological review of nursing and health-related literature. J Adv Nurs. [Internet] 2011 Mar [cited 2013 Jan 22];67:1677-94. Available from: <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2010.05596.x/pdf>.

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Corresponding Address

Fátima Maria da Silva Abrão
Rua Arnóbio Marques, 310
Bairro Santo Amaro
CEP: 50100-130 – Recife (PE), Brazil