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ORIGINAL ARTICLE

ASPECTS OF NURSING CARE IN THE INTENSIVE CARE UNIT

ASPECTOS DA ASSISTÊNCIA DE ENFERMAGEM EM UNIDADE DE TERAPIA INTENSIVA

ASPECTOS DE ASISTENCIA EN ENFERMARÍA EN UNIDAD DE CUIDADOS INTENSIVOS

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ABSTRACT

Objective: to understand the feelings of patients attended in ICU. ***Method:*** a descriptive exploratory study, qualitative, conducted through semi-structured interview, recorded with MP3 player, with ten patients. Then there was a transcript of the speech with detailed reading, identifying the meaning units. Two thematic groups were emerged from its contents: feelings of patients during shift change at the bedside, and relevant aspects of the ICU stay. The study was approved by the Research Ethics Committee, CAAE 0118.0.051.000-11. ***Results:*** the speeches are referred to tough times experienced by patients during hospitalization, reporting discomforts and noises generated by people, lack of attending of their basic needs for staff, lack of privacy, and the reality of frustration before being admitted to ICU. ***Conclusion:*** patients have identified ICU as an uncomfortable environment and it often does not provide the comfort and privacy of the patient. ***Descriptors:*** Humanization; Nursing Care; Intensive Care Unit.

RESUMO

***Objetivo*:** compreender os sentimentos de pacientes internados em UTI. ***Método*:** estudo descritivo exploratório, de natureza qualitativa, realizado por meio de entrevista semiestruturada, gravadas com aparelho de MP3, com dez pacientes. Em seguida houve a transcrição das falas, com leitura pormenorizada, identificando as unidades de significação. Emergiram de seus conteúdos, dois grupos temáticos: sentimentos de pacientes durante a passagem de plantão à beira do leito, e aspectos relevantes da internação na UTI. O estudo teve a aprovação do Comitê de Ética em Pesquisa, CAAE 0118.0.051.000-11. ***Resultados*:** as falas se reportam a momentos difíceis vivenciados pelos pacientes durante o processo de internação, relatando desconfortos e barulhos gerados pelas pessoas, falta de atendimento das suas necessidades básicas pela equipe, falta de privacidade, frustação diante da realidade de estar internado numa UTI. ***Conclusão*:** os pacientes identificam a UTI como um ambiente desconfortável e que muitas vezes não proporciona o conforto e a privacidade do paciente. ***Descritores*:** Humanização; Cuidados de Enfermagem; Unidade de Terapia Intensiva.

RESUMEN

Objetivo: comprender los sentimientos de los pacientes de la UCI. ***Método***: estudio descriptivo exploratorio, de naturaleza cualitativa, realizado a través de entrevista semi-estructurada, grabada con aparato de MP3, con diez pacientes. Luego, hubo una transcripción de los discursos, con la lectura detallada, identificando las unidades de significación. Dos grupos temáticos surgieron de sus contenidos: los sentimientos de los pacientes durante el cambio de turno en la cabecera del lecho y los aspectos relevantes de la estancia en la UCI. El estudio fue aprobado por el Comité de Ética en Investigación, CAAE 0118.0.051.000-11. ***Resultados***: los discursos se refieren a los tiempos difíciles que experimentan los pacientes durante el proceso de hospitalización, relatando molestias y ruidos generados por las personas, falta de atendimiento de sus necesidades básicas, falta de privacidad, frustración por estar internado en una UCI. Conclusión: Los pacientes identificaran la UCI como un ambiente incómodo y que a menudo no proporciona la comodidad y la privacidad del paciente. ***Descriptores***: Humanización; Ayudas de Enfermería; Unidad de Cuidados Intensivos.

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INTRODUCTION

At the level of high complexity attention, the place which concentrates the largest technological arsenal is represented particularly by the Intensive Care Unit (ICU). The Intensive Care Units (ICUs) are commonly closed and separate, physically and functionally, from the remaining areas of the hospital. They were created about 50 years ago to gather, in the same place, seriously ill patients or at imminent risk of death patients, qualified staff and complex equipment, to optimize the treatment of serious diseases and reduce mortality.[1]

Nursing, part of the healthcare team, is responsible for direct and comprehensive patient care in these units as well as the handling of equipment, appliances, lights, sensors, and alarms, among others. However, we must sharpen our sensitivity for not being distant from patients, and not only being delighted to machines. These ones should be at the service of the human being, so they must be all scientific knowledge making the practice in health better, more human, more supportive.

The patient is not just a being with purely biological needs, but a bio-psychosocial and spiritual agent with rights to be respected. Thus his ethical dignity must be guaranteed, because it is fundamental to start walking towards the humanization of health care.[2] Caring in a humane way is a continuing and current need whereas sometimes it ends up being the application of a technique in Nursing. And by realizing that the being for who these techniques are applied is a bio-psychosocial agent is important to humanize.[2]

The ICU has been characterized as specialized environment due to the increasing use of technology that aims to better serve the patient. The treatment implanted in this environment is considered aggressive and invasive, resulting in a high complexity of events and situations. Another feature of this unit is the depersonalization of the human being, because the patient is not in their family, social and professional environment, so he shall face the unknown.

The essence of nursing in intensive care should not be in environments or special equipment, but in the decision-making process based on sound understanding of the physiological and psychological conditions of patients.[3] However, the discussion implemented by the National Humanization Policy (Política Nacional de Humanização-PNH), about the ambience, shows that aspects which can consider it as an enabling tool for functional work process, facilitating the optimization of resources and humane, warm and effective care. The hospital ambience refers to the treatment of the physical place understood as social, professional and interpersonal relationships environment that should provide warm, human and resolute attention, considering some elements that act as catalysts of the interrelationship man x environment.[4]

Hospitalization in the ICU usually happens in an acute and inadvertently way, leaving little time for family adjustment. When facing this stressful situation, family members may feel confused and forsaken.[5] The feelings involved in this process are diverse: there are moments of apprehension, despair, relief, fear, mistrust towards the team, fear, worry, anger, exhaust, among others. We also added to this the difficulty of clearly understand the information given to them by the health team. Generally, families wish to clear and accurate information about the patient's condition.

Hospitalization causes psychological and physical changes in the patient who sees himself outside their natural environment, away from family and being cared for by strangers. The combination of these factors results in feelings of fear, anxiety, insecurity and discomfort that interfere in the pathological process.[6] The maintenance of patient's vital conditions is part of intensive care provided by professionals, so that, the search for fast recovery, or even aiming the cure for some more serious pathology.

For being a special environment in which gravity, the invasiveness and risk of death are frequent, it seems that it was created a stereotype that UTI is a negative and hostile environment that produces little health, predominating the imagery of death, pain and the suffering.[7] The hospital environment transmits, inside, the feeling of isolation and decrease, which coupled with the vulnerability caused by the underlying disease triggers a process of physical and/or mental stress that weighs negatively on the individual's recovery. In addition, health professionals seem to dehumanize gradually favoring the dehumanization of his practice.[8]

Discussing humanization of medicine leads to two questions: Is the humankind no longer a part of the human being? Does the inhumanity arise as a result of what? [4] Human nature is contradictory and ambiguous and that humanity should not be seen as a something given, fixed, but as a product of a becoming, always ambivalent.[9]

Regarding the dehumanization, Morin's ideas show the two sides contained in the

human being when he says that "torture is human, but also the fight against torture is… War is human, but also the struggle for justice and peace is". He adds: "misery of man: only humans can be inhuman. Greatness of man: only they can - and should - become human".[10:17]

There is need for innovative actions that express the lack of humanization of our hospitals and which involve not only the physical aspects, but also the emotional and social aspects of patient, since the individual recovers better being in a pleasant environment, where he feels himself as a valued and well maintained person. Thus, the hospital humanization as an expression of ethics requires the prior formulation of fair organizational and social policies that consider humans and their rights.[11]

In a study conducted in a private institution in Porto Alegre (RS), where 18 nurses and nursing technician active in the ICU were interviewed, it was possible to infer that: empathy, respect and appreciation are essential elements, and that the nursing professionals believe do the difference in the humanizing process in order to improve care practices based on ethics, dialogue and autonomy of the patient, his family and his own staff.[12]

The many years of experience make us to recognize that, despite the great effort that nurses may be performing towards humanizing care in the ICU, this is a difficult task, as it demands individual attitudes against an entire technological system, commonly, little humanizing. The dynamic of work in ICU difficult moments of reflection so that professionals can be better orientated; however, it is for these professionals use strategies that enable humanization, rather than a mechanical and biologicist view that prevails in places of high technology as in the case of ICUs.

The human aspect of nursing care is certainly one of the most difficult to implement. The complex daily routine that involves the ICU environment contributes to the professionals, in general, and include members of the nursing staff who sometimes forget to touch, talk and listen to the human being who is nearby.[1]

This thought can be evidenced by research conducted in a pediatric ICU through open interview with five nurses in order to meet their beliefs regarding humanized care. With this study, we understand that the nurse, even finding it difficult to provide humanized care, appears to be abandoning the belief that UTI is a technical unit, looking for strategies to provide more humanized assistance.[13]

In order to contribute positively, the trajectory of humanistic ideals has involved a variety of sectors and especially the health care.[14] Emphasis is given to the participation of human resources within the hospital, aiming to make them promising in providing a quality service with an eye toward the humanization of health user.

With the intention to implement humanistic actions in health, especially in hospital care, the Ministry of Health created the National Program for Humanization of Hospital Care (Programa Nacional de Humanização da Assistência Hospitalar-PNHAH) in 2001/2002 which was replaced from 2003/2004 through a broader policy, encompassing all levels of care.

In PNHAH, in the "frame of reference and justification" item, humanization was understood as a value, in that it rescues the respect for human life. It encompasses social, ethical, educational and psychological circumstances present in every human relationship. This value is defined in terms of their complementary nature to technical/scientific aspects that emphasize objectivity, generality, causality and expertise of knowledge.[15]

When wishing to promote humanization of health services, the need to include all dimensions of subjectivity user (psychological, familial, cultural and social) is reasonably recognized and discussed by the medical community. The PNHAH proposed a set of integrated actions with the goal of changing the pattern of user assistance in public hospitals in Brazil, improving the quality and effectiveness of services provided by these institutions.[1]

Humanization is understood as opposition to violence, either physical or psychological, which is expressed in the "mistreatment", symbolic, that represents the pain of not understanding their demands and expectations. In this sense, communication is fundamental and must be designed not only on the health professional-patient relationship, but in all organizational structure and culture.[16]

Needs verbalized by patients, family and the interdisciplinary team should indicate directions for interventions of humanization.[1] So, in the PNHAH manual, communication is placed as the centerpiece. Currently, they are added to the previous considerations of humanization about the understanding that humanizing is also to ensure the quality of communication between patient, family, and

staff, and to ensure the quality of communication in organizational culture, which today it is a challenge.[17]

In our career we had the opportunity to experience care in several dimensions. By working in the ICU, we live the greatest conflicts of our professional life because we faced situations of great suffering, anguish, impotence and death, and also where we spend most time working in our professional life.

In everyday practice, we have noticed that the professional were a little worried about the patients' feelings, which indicates little interaction between them and the team of health professionals. The role of the nurse in ICU becomes clearer in some respects when he opts for caution and for healing when he does not become a "slave" of technology, but learning to use technology in favor of harmonizing the patient, their welfare, he shall cherish the technique for it to be an "ally" in an attempt to preserve the lives and well-being of paciente.[18]

The ICU care also involves an interactive action based on the values and knowledge of the caregiver toward the cared patient; it activates an attitude of compassion, solidarity, and help, to promote the welfare of the patient, their moral integrity and dignity as a person.[19]

Ignoring the ethical status and commitments in relationships between nurses and their clients will create conditions that lead to violence and disrespect for human dignity and condition, which could be understood as "careless".

Considering this aspect of nursing care, the study aims to understand the feelings of ICU patients.

METHODOLOGY

Article elaborated from the dissertation << **At the hospital bed: feelings of patients during shift change in the Intensive Care Unit** >> submitted to the Graduate Program in Nursing, Center for Health Sciences, Universidade Federal do Rio Grande do Norte/UFRN. Natal- RN, Brazil. 2011.

This is an analytical study, with qualitative approach and exploratory descriptive. The study involved the participation of 10 patients who were admitted to the ICU during the period of data production, six women and four men. The study participants were selected according to the following criteria: minimum age of 18 years-old; having been hospitalized in the ICU for at least 24 hours, to be fully aware, and to present vowel and respiratory conditions to answer the questions proposed. Exclusion criteria were patients with dementia and who had episodes of disorientation during the ICU stay.

To facilitate the study, we used the methodological use of semi-structured interview technique with a script containing the following open questions: Did you hear what was said during the shift change? If positive: Was it possible to hear something about other patients as well? If positive: what did it mean to you? How did you feel during the nursing shift change?

The research happened in a general hospital in the private health system of Natal/RN. It is a medium-sized unit with 126 hospital beds distributed in medical and surgical clinic, intensive care units, hemodialysis unit, and emergency unit care sectors in the areas of: medical clinic, cardiology, neurology and orthopedics. The place was chosen due to easy access as the researcher worked at the institution for nine years and six months, having little time off before the start of data collection.

Data collection was initiated after approval of hospital institution where the research was developed, as well as the issue of assent for the study protocol, in opinion No. 290/2011 and CAAE 0118.0.051.000-11, by the Committee of Ethics in Research of Universidade Federal do Rio Grande do Norte/ CEP/UFRN. The period of realization passed during the months of July and August, 2011.

This process was guided by the following sequence: patients were approached after ICU discharge, in their target sector (private room). For the first contact it was made a summary presentation of the objectives of the study, we chose a day and time for the interview, according to the convenience of the patient. At this time, we also gave them the Term of Free and Informed Consent Form (ICF), so that the patient had time to read and make a decision regarding their participation in research.

On the day of the interview, the patient was asked to consent in participating in the study by signing the consent form, what was made after some clarifications of doubts if they existed, always making clear their entire freedom in participating or not. After signing a statement, the interviews were recorded with MP3 device to facilitate subsequent treatment.

After this stage of speech transcription, we continue the study with detailed reading, identifying the meaning units. Two major thematic groups emerged from their content: feelings of patients during shift change at the

hospital beds, and relevant aspects of the ICU stay.

Humanization was elected as the carrier of the study, therefore, the analysis of the speeches was anchored by authors dealing with the humanization, as: Leonardo Boff, André Comte-Sponville, others working humanization in health as Elizabeth Kübler Ross, Maria Julia Pais da Silva, Suely Ferreira Deslandes, Vera Regina Waldow, and even Elias Knobel which addresses the issue of ICU.

To ensure the anonymity of respondents and their speeches, we identified by the codename of gemstones demonstrating the scale of importance and values they have to the construction of our investigation.

RESULTS AND DISCUSSION

It was seen that the ICU is a unit in the hospital characterized as a complex environment due to the increasing use of technology that aims to better serve the patient. The common understanding of the ICU characterizes it as an impersonal and inhuman environment for patients who are seriously ill; and it connotes coldness and insensibility to the professional who is active there.[20]

The ICU has positive and negative aspects in the view of those who once needed this care. For some patients in this study, humanization with good professional and quality service was very important in their recovery, overcoming the negative aspects present in this phase.

> *Below God it is the ICU. They pick up the machine for hemodialysis; they did this twice, any time of day or night. He calls a nurse on standby. She stays there all the time, she does not get away. Okay, I'm saved! (Jade)*

> *I even joked that I did not want to leave, I preferred to stay there. Because every time there is movement of staff, we have direct contact with several nurses, practical nurses, with physicians. Each time there was one doctor. I even joked when I spoke thus: I am in prison hospital, now I'm going to solitary (referring to the hospital room where I was). But, nevertheless, I think the attending there is very good. (Citrus)*

The reliability is developed starting from an unconscious mechanism in which there is a transfer of trust learned in previous significant relationships, transported to the present caregivers.[20]

In contrast we can record some statements that expressed moments of pain, suffering and anger about the events experienced during the ICU stay.

> *There the service is very efficient, very strict, but there are few people to attend us. It is not to speak against it [...] but there we were never attended (pause) immediately, no. This is not possible. You got all dirty underneath, because of poop and piss [...] (silence). There were some nurses who wanted to close the door, and the curtain they did not close because I used to say 'no', and the first one I saw in the hallway I used to call her [...] Then they said: "What happened, Mrs. Diamond?", And I said: "my dear, I am all dirty, here everything is dirty" [...] Then they came and bathe me like a 'cat bath'. (Diamond)*

> *The ICU is so disorganized, because it should be like this: you stay there and rest… But it's not… The volume of TV is very loud, popping ears, and they used to joke. So I think, "What is it?" And then I asked the guy who came to change my diaper and he said that they were joking because there was an armadillo there. You know it's a bad behavior, because I think it was really a bad joking. Because you're sick there and have to see that joking [...] (Emerald)*

Reports reveal that large and troublesome noises are generated by people, not by machines as often it is referred in the literature. Thus, we must always be well aware of our strategy for patients. We cannot admit we are providing them careless, what is most valued by clients regarding the care provided is attention.[21]

Another type of suffering flagged for gemstones is the lack of attending their basic needs by the nursing staff.

> *To stay all night within the urine is horrible. They just say: 'Wait! I'm going, I'm coming'. This is like that all night. I had already peed six times in the diaper, and nothing. Then a guy came near me, you know? Then I said: you do me a favor and give me a clean diaper to change. Then he gave me it. I know they're so busy, but they had to put ten nurses to take care of ICU, right? (Emerald)*

Patients admitted to an ICU are mostly dependent and they feel helpless about the lack of autonomy and control, which contributes to anxiety.

> *I had no time to think. When I perceived it, I was already in that bed, as I had not move from one side to the other. It's hard. I thought: "what am I doing here?" So [...] you can't do anything. But there I stayed [...] (pause) the way is that I have to stay here, I could not do anything anymore. (Diamond)*

The perception of deprivation of autonomy, freedom, lack of command of the situation allied to physical weakness and dependence, leads to a state of inactivity and comes to the

patient as part of a hard reality to accept, especially in the acute phase of the disease.[22]

Professionals in the Intensive manifest commonly that is normal, in their care activities, sometimes invading the privacy of the patient who they care. However, this position of neutrality, indifference, may be simply a means of accommodation, or a position adopted in a specific situation, but it is used when the ideals of those involved do not coincide, i.e., the professional feels obliged to realize the prescribing of the procedure or care, while the patient feels that their privacy is being physically invanded.[23]

Diamond's speech, about the routine of examinations collection in ICU, reveals her feelings about the lack of privacy:

> *Oh my dear, it was hard to sleep in the ICU. It was 4 a.m., 3 a.m., and then a men came to collect blood. It was like carnage. Look how my arm is now (he showed us the arterial puncture marks on both members), because they collect from here. And then another one comes and puts a plate in my lung. I thought it was so weird, it seemed that the slaughterhouse came [...] he seemed [...]. (Diamond)*

> *I said: 'boy, I will not take a bath today because I have a horrible sore throat. They bathe me at five and a half in the morning. Hey [...] this is nonsense! They do not care about us. (Emerald)*

The sector of ICU is complex because it involves many procedures and many professionals from various categories in order to ensure quality care to patients. However, we often forget that the patient is a human being with feelings, desires, routines, expectations, limitations, beliefs. Thus, when the focus of care is exclusively for the machinery, procedure and pathology, the environment and care become impersonalized and unwelcoming, since the human dimensions are not highlighted.[24]

It is important to warn that the humane care needs to be understood as the responsibility of each person and it is not only responsibility of a professional category because no category can take all the responsibility for the customer, in their total amplitude, within the health-disease process. [8]

During the interviews, we inquired about the feeling of the participants about the news of being admitted to the ICU, so we obtained the following results:

> *I was sad. It's just because I was tired, a very strong cough and my cardiologist has said that when I feel it I must go to the hospital because it is about twenty minutes for dying. That's the problem. (Jade)*

> *I felt nothing. It is normal for me. It is something that there is no emotion. They said I had to go, needed to go, so let's face it. And I really had to go because I'm going to say I made examinations that I've never had done in my life. (Emerald)*

> *It's the first time I go to the ICU and I hope it is the last! (Diamond)*

The statements presented demonstrate a set of expectations and conflicts among patients, due to the culture of common sense on the ICU. If, on the one hand, they indicate the possibility of receiving a better, specific and attentive care, on the other, they seem to reveal their personal difficulties, as well as grief and sorrow over the complication of the clinical picture.

We can infer that Diamond did not have a good impression of her/his experience in being hospitalized in the ICU. Thus, when asked about what to say to someone who will be hospitalized in the ICU, she/he has maintained the same posture and answered emphatically: Don't go. We have added further statements that show different feelings related to the discussed question in previous speeches:

> *For a person that I have proximity, who is my friend, I tell… (pause) I tell the truth. It's not for the health treating is wrong, it worked. But the professionals are desperate to do the work, and then you cannot ask for much time. (Emerald)*

> *What I can say is that it is a relief. If I did not get there, I would not be here. When I got there I had all help. (Jade)*

> *I'd say you can go because you do not have to be afraid. They do everything right. (Topaz)*

We know that the patients want to let him talk, they also want that we show us interested in what he is talking about and have time available to hear what he says; in this way, tensions are controlled and the patient feels more relaxed.[25] The Emerald's speech makes it clear that the time allocated to it was not enough to meet her needs.

The nursing staff consists of mid-level professionals (nursing auxiliary and technical) and upper level (nurse) and the largest contingent is mid-level; precisely for this reason, they are in direct contact with the patient in achieving most nursing actions. Moreover, although the midlevel professionals perform most procedures involving patients, but they are not able to receive a more complete training in relation to humanity study.

There was a great evolution of nurses and health professionals, however, according to the ethical issues, we cannot always keep the humanization in small things as looking in the eyes, smile, sit, listening and shaking hands.[25] We understand the relevance that the nursing professional devote to training the staff to have a humanized care, because part of his training was devoted to the study of the humanities and social sciences (psychology, sociology and anthropology) which are significant for understanding the human being in essence and wholeness.

It is sad to hear the revelation of Emerald:

> The simplest girls (referring to nursing technician) played a lot with me, they said I was healed. But the upper women didn't (referring to nurses) because they are more important.

We have understood in this testimony that the stance adopted by the nurse may suggest a situation of approaching or distancing. We corroborated the thought that the way in which the nurse's body is positioned reveals her accessibility to the touch, and also, the degree of concern for others, so it is a valuable way for verbal and non-verbal information.[25]

The busy daily life at ICU often makes the nursing care is hit by several tasks to be accomplished. All activities seem to be essential in intensive care, where nursing care is not only that assistance provided directly to the patient, but it is also a range of activities that indirectly end up favoring care.

Another perspective is referred to the involvement of staff with the patient, because the nursing staff of ICU lives daily with situations involving emergencies, suffering and, frequently, with the loss of patients. These situations lead to professional suffering and frustration, whereas in some cases for more to be done, the outcome is death.

The sense of loss leads to frustration for the dedication and effort often is not enough to keep the patient alive. Nurses show the fear of suffering because of the pain of others when they are engaged with patients and families. This approximation provides the creation of linkages and knowledge of experiences and feelings. The longer the time of admission of the patient, the greater seems to be the link and suffering because of what may happen.[26]

According to what was exposed, it seems essential that a psychological support for the health care team who works in ICU is offered by the institution. A professional who understands better himself is able to perceive in the other a reflection of their soul and becomes more sensitive, more caring and, therefore, more human.

CONCLUSION

The theme of humanization of health care shows to be relevant in the present context, since the establishment of a service trampled on principles such as comprehensiveness of care, equity, ethics, social user participation, among others, demand revision and reassessment of daily practices. That involves more emphasis on creating workspaces less alienating, highlighting the dignity of workers and especially of users.[27]

The scientific and technological advances that have occurred in health have contributed to the reduction of morbidity and mortality, increased life expectancy and optimization of technical activities in the ICU, but despite the importance of this fact, this progress has not secured a care focused on human values.

By considered as one of the factors that triggers the devaluation of values centered in human care, medical education has focused in specialization of these factors and, thus, the better staff training happens; more and more empowered and enabled to offer the best treatment and consequent recovery or cure of the patient. However, this training has left the uniqueness of the patient (their values, beliefs, feelings and emotions) in low priority, instead of the "diseased liver" or "impaired renal function", which has compromised significantly the humane care and good quality in health care institutions.

The human aspect of care is one of the most difficult to be implemented, especially in ICUs, where the daily routine and the complexity of the environment, both physical and functional, make the staff forget the importance of touch and communication with the human being who nearby.[28] We must remember that the object of nursing work is care, and humanization is an intrinsic factor.

We know that some characteristics are peculiar of ICU: environment permeated by technology, impending emergencies, and constant need for agility and skill in customer service, which sometimes difficult this care.

The humanization of care depends on the working conditions of professionals in this area as well as their competence and technical skills, including the sphere of human relations. Therefore, the humanization of nursing care is essential to establish interaction and relationship with users of health services, including family members and health professionals.[29] Accordingly, humanization becomes a process that involves all members and the actions of the staff in the

ICU. The responsibility of the staff extends to the assessment of family needs, the satisfaction of these on the care provided, and preserving the integrity of the client as human being.[30]

The humanization in environments which are considered hostile and aggressive, such as ICUs and emergency services, has been a concern of professionals who works in these scenarios daily. Whereas, in most cases, people are not prepared to face hospitalization in these units, professionals must strive to help in patient's acceptance and compliance, and support the family.

Thus, when the essence of caring and humane is present in the actions of professionals, the patient realizes that the feelings of satisfaction compensate dissatisfaction in fighting the disease and the mechanisms employed to defeat it. The humanization in intensive care arises in trying to improve the care provided to critical ill patients and their families and also the working conditions of the multidisciplinary staff who works in the ICU.

To implement the care to humanizing actions we need to value the subjective and the social dimension in all practical care and management of institutions offering services in healthcare such as hospitals. It is important to strengthen the work of multi-professional staff, to encourage the construction of autonomy and participation of the subjects, strengthening social control, to democratize labor relations and to valorize health professionals.

We emphasize that this multidisciplinary team is united by one goal and to achieve it, you must work in harmony, complementing their actions, discussing and reaching, whenever possible, a consensus among peers.

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