Revista Brasileira em Promoção da Saúde
e-ISSN:1806-1230
Original Article
DOI: 10.5020/18061230.2019.8668

NURSING TEAM'S PERCEPTIONS OF HUMANIZATION IN INTENSIVE CARE

Percepções da equipe de enfermagem acerca da humanização em terapia intensiva

Percepciones del equipo de enfermería sobre la humanización en cuidados intensivos

Ariane da Silva Castro
Uniersity of Cruz Alta (*Universidade de Cruz Alta - UNICRUZ*) - Cruz Alta (RS) - Brazil

Éder Luís Arboit
Uniersity of Cruz Alta (*Universidade de Cruz Alta - UNICRUZ*) - Cruz Alta (RS) - Brazil

Gabriela Zenatti Ely
Uniersity of Cruz Alta (*Universidade de Cruz Alta - UNICRUZ*) - Cruz Alta (RS) - Brazil

Cristiane Appio Motta Dias
Uniersity of Cruz Alta (*Universidade de Cruz Alta - UNICRUZ*) - Cruz Alta (RS) - Brazil

Jaqueline Arboit
Federal University of Santa Maria (*Universidade Federal de Santa Maria - UFSM*) - Santa Maria (RS) - Brazil

Silviamar Camponogara
Federal University of Santa Maria (*Universidade Federal de Santa Maria - UFSM*) - Santa Maria (RS) - Brazil

ABSTRACT

Objective: To get to know the nursing team's perceptions of humanization of care in an Intensive Care Unit. **Methods:** Study with a qualitative approach performed in 2017 in a hospital institution, whose participants were four nurses and eight nurse technicians working in the Adult Intensive Care Unit of a hospital in the hinterlands of Rio Grande do Sul, Brazil. Data collection was carried out through semi-structured interview. Data were analyzed by means of the thematic analysis, which gave rise to a thematic category, namely: The everyday work in the Intensive Care Unit in the context of the humanization of care. **Results:** The findings reveal that the professionals perceive the importance of a qualified care, based on a friendly and humanized practice. They highlight the importance of not only meeting the biological needs of the patients under their care, but also using communication as a practice closely related to the humanization of care. Nevertheless, one can sometimes identify the lack of knowledge of the Brazilian humanization policy. **Conclusion:** This study provides support for nursing professionals to (re)think their health care practice, with a view to combining high technological density with humanization and patient safety in intensive care.

Descriptors: Nurse Practitioners; Humanization of Care; Intensive Care Units.

RESUMO

Objetivo: *Conhecer as percepções da equipe de Enfermagem acerca da humanização da assistência em Unidade de Terapia Intensiva.* ***Métodos:*** *Estudo com abordagem qualitativa realizado em 2017, em uma instituição hospitalar cujos participantes foram quatro enfermeiros e oito técnicos de enfermagem atuantes na Unidade de Terapia Intensiva Adulto de um hospital do interior do Rio Grande do Sul, Brasil. A coleta de dados ocorreu por meio de entrevista semiestruturada. Os dados foram analisados pela análise temática, a partir da qual emergiu uma categoria temática, qual seja: O cotidiano de trabalho na Unidade de Terapia Intensiva no contexto da humanização da assistência.* ***Resultados:*** *Os achados revelam que os profissionais percebem a importância da assistência qualificada, embasada numa prática acolhedora e humanizada. Apontam a importância de atender não somente às necessidades biológicas dos pacientes por eles assistidos, mas o uso da comunicação como prática intimamente relacionada com a humanização do cuidado. No entanto, pode-se identificar, por vezes, a falta de conhecimento em relação à política nacional de humanização.* ***Conclusão:*** *O estudo traz subsídios para que os profissionais de Enfermagem possam re(pensar) a sua prática assistencial, tendo em vista aliar a alta densidade tecnológica com a humanização e a segurança do paciente em terapia intensiva.*

Descritores: *Profissionais de Enfermagem; Humanização da Assistência; Unidades de Terapia Intensiva.*

Received on: *11/27/2018*
Accepted on: *03/07/2019*

RESUMEN

Objetivo: *Conocer las percepciones del equipo de Enfermería sobre la humanización de la atención en la Unidad de Cuidados Intensivos.* ***Métodos:*** *Estudio de abordaje cualitativo realizado en 2017 en institución hospitalaria cuyos participantes han sido cuatro enfermeros y ocho técnicos de enfermería de la Unidad de Cuidados Intensivos Adulto de un hospital del interior de Rio Grande de Sur, Brasil. La recogida de datos se dio por entrevista semiestructurada. Los datos han sido analizados por el análisis temático del cual se identificó una categoría temática: El cuotidiano de trabajo de la Unidad de Cuidados Intensivos en el contexto de la humanización de la atención.* ***Resultados:*** *Los hallazgos revelan que los profesionales perciben la importancia de la asistencia de calidad basada en la práctica acogedora y humanizada. Señalan aún la importancia de atender no solamente las necesidades biológicas de los pacientes asistidos por ellos sino también el uso de la comunicación como práctica íntimamente relacionada con la humanización del cuidado. Sin embargo, se puede identificar de cuando en cuando, la falta de conocimiento de la política nacional de humanización.* ***Conclusión:*** *El estudio señala subsidios para que los profesionales de Enfermería puedan re(pensar) su práctica de la atención para aliar la alta densidad tecnológica con la humanización y la seguridad del paciente de cuidados intensivos.*

Descriptores: *Enfermeras Practicantes; Humanización de la Atención; Unidades de Cuidados Intensivos.*

INTRODUCTION

The Intensive Care Unit (ICU) emerged from the need to intensify health care by improving the quality of human resources and using materials and equipment to treat critically ill patients. It is a complex environment that features high technology, quality human resources and routine systematic and continuous care[1].

In the ICU, there is the constant possibility of dealing with emergency and death situations due to the degree of severity of the patients. Therefore, it can be considered a hostile environment due to excessive and permanent light and noise[2], highly invasive procedures, and restriction for visits by family members[3]. This requires professionals to be aware of any complications, which requires specialized knowledge and technical skills in the ICU[3]. Given this context, ICU patients and relatives sometimes end up being assisted without humanized care.

The National Hospital Care Humanization Program (*Programa Nacional de Humanização da Assistência Hospitalar – PNHAH*) provides for – among other matters – the humanization of public hospital care provided to patients and the improvement of existing relationships between users and professionals, between professionals, and between the hospital and the community with the aim of improving the quality and effectiveness of the services provided[4]. In an attempt to unify policies, the PNHAH and other existing humanization programs were combined into the National Humanization Policy (*Política Nacional de Humanização – PNH*), also known as the *Humaniza-SUS*[5], which also included the Public Health scenarios (primary health care services) to improve the effectiveness and quality of health services.

Nursing work in the ICU encompasses several needs to improve the quality of the care provided to patients and families focused on humanization. Moreover, professionals must combine technical and scientific knowledge to provide safe and better quality humanized care[6]. The actions performed by the professionals, the critical situation of patients and the use of various technologies require specific knowledge to deliver care based on the principle of comprehensiveness[7], one of the principles of the Unified Health System (*Sistema Único de Saúde – SUS*), which considers people holistically, i.e., their biopsychosocial needs are taken into consideration[8].

In this regard, the National Health Promotion Policy (*Política Nacional de Promoção da Saúde – PNPS*) approved in 2006 and revised in 2014 provides for, as one of its transversal themes, the production of health and care, which is aimed at fostering the theme in networks that provide humanized care practices and promote dialog through practices based on comprehensive care and health[9].

Thus, intensive and critical care nursing in the context of humanization seeks to meet the needs of the user and their families by adopting the perspective of the expanded clinic and the co-responsibility for care. It is noteworthy that it is a challenge for health professionals, especially those working in the ICU, given some previously mentioned characteristics of this unit[10].

Humanized care aims to improve patient care[10]. Despite the implementation of PNH several years ago, humanization practices are still incipient in many institutions[11].

Given that, care requires professionals to implement methodologies that enable the delivery of better care to the patient/family member. Therefore, the humanization of care implies the optimization of nursing practice[12].

Thus, this subject was chosen due to academic experiences during the curricular internships in the School of Nursing and, especially, in intensive care, with a view to improving care for ICU patients. It is essential to encourage professionals to express their opinions regarding humanized care. Thus, we chose to conduct the study with professionals who make up the Nursing team as they are the ones who carry out technical activities related to the humanization of full-time care. Given the exposed issues and the relevance of humanized care in the ICU, this study sough to answer the following research question: "what perceptions does the nursing team have of the humanization of care in the intensive care unit"?

This study aimed to get to know the nursing team's perceptions of humanization of care in an Intensive Care Unit.

METHODS

A qualitative approach was used as it is considered the best type of research for achieving the study goals. This type of research investigates the beliefs, perceptions and opinions that result from human interpretation of their experiences and feelings. In this context, the perception of the subjects who experience the phenomenon analyzed is valued[13].

The study took place in an adult ICU of a hospital in the countryside of Rio Grande do Sul, Brazil. It is a private medium-sized hospital with 100 beds that serves about 500 patients per month with a staff of 320 workers and about 100 physicians across more than 25 specialties. In all, 10 beds are in the Adult ICU. Visits by family members in the unit are allowd at two different times in the morning and evening shifts and last 30 minutes. Nurses and other professionals who make up the health care team accompany the visits[14].

The professionals who work in the ICU at this hospital were invited to participate in the study. The researcher directly invited the professionals and explained the purpose of the study to each one of them. A meeting with those who agreed to participate was scheduled for data collection. Participants were nurses and nursing technicians assigned to the three work shifts in the ICU. The study included people working as nurses or nursing technicians for at least six months. Those who were on annual leave or any other type of leave during the data collection period did not participate. Thus, the study sample consisted of four nurses and eight nursing technicians.

Data were collected in August and September 2017 through semi-structured interviews[13]. This technique was chosen to be used in this study due to the possibility of collecting subjective data related to the values, attitudes and opinions of respondents. Such data could not be obtained through a questionnaire.

The interviews were held in two stages: the first stage focused on respondents' identification data (age, marital status, sex, length of time spent on the job and working in the ICU, technicians' level of education, and nurses's graduation degree). The second stage focused on data related to the objective of the study and used the following question: How do you perceive the humanization of nursing care in your workplace? The interviews were held individually in a private room at the health care facility and lasted 20 minutes each. They were recorded in an mp3 format to ensure a reliable material for analysis.

The sampling process was finished after the research objective was reached considering thematic saturation[15]. After that, the interviews were transcribed using a text editing software.

Data were systematized and analyzed the thematic analysis[13] technique, which is performed in three phases: pre-analysis, material exploration, and treatment and interpretation of results. The first phase, pre-analysis, consists in systematizing the initial concepts posed by the theoretical framework and providing pointers for the explanation of the collected information. The material exploration, the second phase, focuses on the constitution of the coding operations and encompasses the transformation of text excerpts into registration units, the definition of evaluation rules, and the classification and association of information into symbolic or thematic categories. The third phase involves the treatment and interpretation of results and focuses on seizing the evident and hidden contents contained in all the collected material (interviews, documents and observation). Given the aspects considered analogous and different, the following category emerged from the thematic analysis: "The everyday work in the Intensive Care Unit in the context of the humanization of care."

This study respected the ethical aspects of research involving human beings and is in accordance with Resolution No. 466/2012 of the National Health Council[16]. To this end, the participants signed the Informed Consent Form and were identified by means of a code using the initial letter corresponding to the profession and a number corresponding to the random order of the interviews: nurse (N1) and nursing technician (NT2).

The study project was approved by the Research Ethics Committee of the University of Cruz Alta Foundation (*Fundação Universidade de Cruz Alta - UNICRUZ*) (Approval No. 2.188.659).

RESULTS AND DISCUSSION

Characterization of the study participants

Twelve nursing professionals - four nurses and eight nursing technicians – were interviewed. Of these, 11 were women. Age ranged from 21 to 42 years old and the mean age was 33 years. With regard to participants' marital status, two were married; two reported common-law marriage; seven were single and one was divorced. The length of time working in the institution ranged from two to 17 years, with a mean of nine years. The length of work in the Adult ICU ranged from 10 months to 11 years. Of the twelve professionals, four had completed higher education; eight had completed technical education; four were in higher education and one was specializing.

The everyday work in the Intensive Care Unit in the context of the humanization of care

This category describes the understanding of humanization in environments of high technological density. Recent research has shown the importance of understanding humanization in complex care environments[17]. It is necessary to understand the dynamics and structure of the institution, resource (material and human) management processes and the users' profile considering the individual a complex unique human being capable of adapting depending on the conditions of the environment and the relationships built[17].

Health professionals are fundamental elements of the hospital organizational structure and thus develop competencies and skills inherent to their core profession. In this context, there is a need to identify the skills of ICU professionals and understand that nursing management and care are paramount functions in the daily routine of nurses aiming at the excellence of care provided to the patient, family and community[18].

The intensivist nurses' competences include: knowledge, interpersonal relationship, leadership, decision making, teamwork, communication, planning, organization and emotional balance[19]. From this perspective, it is evident in the daily routine of health care facilities that some professionals tend to relate technological density and critically ill patiens often based on skills related to knowing/doing. However, it is necessary to invest in the development of sensitive and attentive listening skills in addition to nonverbal expression, observation and embracement in face of the real needs of the subject.

The following statements show the important role of the institution/organization in properly developing the facility's routines:

> *"When we are on call we arrange with the patients, we see who gets whom. At night we rotate, we never get the same patient. From the moment we split, we get organized to see the team routines, one goes to the pharmacy, another to the Sterilization Material Center (Central de Material de Esterilização – CME), another to the linen room. After that, we check the vital signs, change diapers, administrate medications, provide all the care related to that patient." (NT3)*

> *"When I am on call I routinely check the refrigerator, the waste, materials, visit each patient, make the assessment and then use the system to carry out risk ranking. After, during visiting hours, we are always present. Then we supervise the bath, and after midnight I start Nursing Care Systematization (Sistematização da Assistência de Enfermagem – SAE), prescription, chart updating." (N2)*

Given the high demand for care activities and their complexity, specialized care requires specific skills and teamwork skills from nurses to better meet the patient's needs. In this perspective, the articulation between the actions performed by different professionals through teamwork is essential for the provision of quality and effective care in the unit and is in line with the concept of humanized care in the ICU[20].

Systematizing care implies the use of a science-based work methodology. The implementation of SAE in ICUs significantly contributes to improving the quality of care by ensring a better organization and structuring of the unit. These actions seek to ensure greater safety to the patient by planning the health care delivered by the nursing team and other professionals in terms of core actions and professional field. Therefore, by means of a care instrument, it can enable the exchange of information indispensable to the provision of singularized and systematized care, which helps to humanize care[21].

The activities performed by nurses in the ICU are related to care and care management. Management activities include the definition of nursing protocols and routines, the management of technological and material resources, the development of educational activities, and the articulation with the multidisciplinary team and the other units of the hospital institution[22]. The factor that most restricts multiprofessional teamwork in intensive care units is disrespect between professionals. This may be the result of hierarchical relationships, lack of knowledge of each professional's duties, and lack of communication[23].

Thus, care management involves managerial and care aspects in nurses' work process. In the managerial dimension, it promotes actions aimed at organizing work and human resources, which provides the conditions for patient care and for the performance of the Nursing team. In the care dimension, the focus of intervention is on user needs with a view to fully meeting them[24].

It is also evident that nurses' activities are centered on administrative roles and are little articulated with care. However, it is necessary to articulate and integrate other aspects such as management, care, leadership, communication, interaction, decision making and cooperation. These elements are considered essential attributes of nursing care management[25]. In this regard, the interviewees reported some work routines in the ICU but emphasized that the patient always comes first:

> *"Some days are busier. The basic thing is to arrive, start the on-call shift, assess the patient, perform Nursing Care Systematization, solve the pending issues in the sector, and pass on patient information to family members." (N1)*
>
> *"We have a workload of 6 hours, with 15-minute break. The daily work often follows the routines, but sometimes the routine can be different, but we try to do the best for the patient, always working as a team to perform patient care." (NT2)*

The ICU is a complex unit; it is an environment that often leaves patients and families in a fragile condition. In addition, this unit requires the integration between the various professionals that make up the multi- and interdisciplinary team so that the care provided is in line with the real needs of patients considering their clinical condition and needs as subjects. It also aims to provide greater security to family members as they do not have the possibility to stay in the unit full time and often need to travel long distances to visit them[2].

Another aspect that needs to be considered is that these trips to the hospital generate costs and the family member does not often have the financial resources to do so. Given such situation, the nurse also plays an important role in embracing the patient's family member and providing moments that can strengthen the bonds between those involved and assist in the elaboration of strategies so that these bonds can be strengthened[6].

It can be inferred from the participants' statements that they realize the need to deliver a more humanized care in the intensive care unit as they show weaknesses in relation to the theoretical framework of humanization:

> *"I always say 'I chose this profession and I am very happy'. I like what I do, but when I started in the ICU I faced some difficulties because reality is really difficulty here, patients are very critical. But I learned that they are people who need humanized care even more." (NT4)*
>
> *"Humanization is a word that has many meanings. [...] I believe there is a little humanization, but, when it comes to Nursing, there is a lot to be done. Humanization, most people understand one thing, but the context is totally different. You cannot say there is not a little, even a little, you have it in patient care, especially in care. I think it is a beautiful subject to talk about, but it is little practiced." (NT5)*
>
> *"In our experience, a little bit of sensitivity is lost, a little bit of involvement are lost over time. Considering the time I have been working in the unit, we have become colder. But every day we learn what it is to humanize care." (NT7)*

The aforementioned statements are in line with a recent study that found that although health professionals are not aware of the content of the National Humanization Policy, they bring to their daily practice values such as respect, dignity and brotherly love, thus making their daily activities more humane[3].

The loss of sensitivity reported by one respondent in this study may be related to the technology used by health professionals in services to assist in maintaining life, which can sometimes be a positive aspect. On the other hand, it may be negative because technological diversity, especially in ICUs, can weaken the practice of humanization of care by professionals as there is a range of care procedures that require the use of these technologies[10], thereby leading to an increasingly mechanized care and distancing the professional from the patient.

From this point of view, it is necessary to reflect on actions and interactions in the context of health services: what, how and when to speak; what, how and when to look; how to stand and touch. There is a need to reflect on the act that exceeds the mere handling of someone else's body. It is important to try to carefully understand the verbal or nonverbal message the other is trying to pass so that their needs can be met[25].

Another important aspect highlighted in the statements is the communication, which is closely related to the humanization of care:

"It is a very humane team. We manage to talk to the patients, take their hands. Here we can have a more humanized care because it is a more intensive care [...] We are closer to the patient to talk and assist as needed." (NT8)

"It is the communication between the manager/collaborator in the development of work processes." (N4)

Communication is an important tool within the ICU and should involve patients, family members, professionals and the media. Good personal relationships and a tolerant and open communication environment are identified as factors that favor quality and human attention[26]. Such communication must take place and benefit the whole group, which is mainly aimed at the well-being and health of the patient. From this perspective, communication can be directed to the patient, family members and between team members[27].

The statements also showed some issues related to the PNH and patient rights:

"(...) it must happen because it is a unit where most of the times there is much suffering for family members and patients, where we need to embrace them with dedication, respect and professionalism. We need to understand the needs of each one, meet them in the best way possible. The National Humanization Policy is intended to improve the communication skills of different professionals, such as managers, and of the pattients as well so that it can be shared among all people, so that the same way of caring and the same work organization can be followed." (N3)

"(...) I know they are the patient's rights and nothing more." (NT1)

"(...) the patient has to be aware of the rights he has. Just as we have a code of ethics that we have to comply with to provide the service, (...) leave everything in the workplace, not go out talking about what happens inside. So, the humanization policy is something like that, the care we have to deliver to the patient and the obligation to provide everything the patient is entitled to." (N2)

The participants realized that humanization in intensive care permeates the relationship with ethics, embracement of family members and patients and respect for their rights. Although professionals may have difficulty conceptualizing humanization, they bring in their modes of expression and experiences their opinions about humanized or non-humanized treatment. The health professionals analyzed claimed to understand the precepts of the PNH and reported implementing such guidelines in their care practices despite reporting that there are still many flaws in the ideal path to an effective humanization in health services[6].

Research has shown that patient care in the ICU is relevant to the intensive care provided by the professional team. However, this care requires not only the biological dimension of technical care, but the provision of comprehensive care to patients who should be treated as human beings with respect, affection and dedication[28].

Thus, there is a need to invest in the professional-patient-family relationship. The professional should be able to offer the necessary information and demonstrate patience, attention and affection in the interaction with the patient[21]. It was observed that the restricted environment can be beneficial, which can favor the care and more humanized and welcoming actions:

"Closed environment, with fewer patients, direct contact with family members, with the possibility of a better embracement." (NT6)

Recent research revealed that humanizing is not restricted to embracing with sympathy. It also involves the building of relationships, working conditions, and listening spaces for all the actors involved[29]. This allows making choices in a clinical perspective and the subject's life projects, which implies the co-responsibility of the health-disease process. The ICU environment should be well presentable, harmonious, pleasant, organized and clean, thereby providing comfort and well-being to patients, families and professionals, which is in line with the concept of ambience proposed by the PNH, according to which it is important to create healthy and welcoming spaces that provide privacy to those involved in this care process[10].

By wearing the patient's shoes, the health professional can identify with feelings about the disease and recognize that, in addition to the pathological dimension, there are important emotional and social factors:

"(...) identification with the patient can lead us to have feelings such as fear or anguish, which leads us to rethink about our actions of care for the other human being. (...) I understand that there are many elements that contribute to the patient's healing process, such as listening, talking, touching, respecting and committing." (N1)

However, the restricted contact between the professional and the patient and between the patient and the family were considered by the participants a drawback to humanization:

"Restricted contact between the health professional and the family member and little contact between the family member and the patient" (NT1)

Distancing can be a hindering factor for professionals, patients and their families as it generates anxiety and fear. Given this aspect, communication is a strategy to humanize care. This should be directed to patients, whether conscious or unconscious, and their relatives in order to inform them about the context and clinical condition of the relative admitted to the ICU and embrace their anguish, hope and fear[20].

A Brazilian study found that the only moment afforded to patients' contact with family members is the limited interval intended for the visit[30]. At this moment, the family members explain their anxieties and emotions, their doubts regarding the evolution of the disease, their concerns and consequences of the social role break caused by the hospitalization. Most critically ill patients do not respond satisfactorily to stimuli, which makes family members look for health professionals.

In this context, the information given by health professionals at the time of the visit should be clear and provided empathically. This requires good communication skills and an understanding of the aspects that involve the relationship between all the people involved in the care process[30]. Therefore, it is essential to promote the therapeutic relationship produced through contact between the family and the patient.

Some limitations of the present study should be noted, including mainly the fact that it involved only nursing professionals who work in an intensive care unit of a single hospital, which makes the generalization of the results difficult.

Finally, by revealing that respondents believe that the practice should be welcoming and humanized, the findings indicate that the patient should be embraced not only in terms of biological needs, but also in terms of communication, which is relevant as a practice closely related to the humanization of care. However, the professionals reported finding it difficult to recognize, sometimes, some aspects of the National Humanization Policy.

Given that the National Humanization Policy aims to train professionals whose practice should be guided by actions with technical, scientific and human efficiency in an ethical way respecting the individuality of the patient and with a holistic approach[5] and that the National Health Promotion Policy suggests the challenge of reorienting health services to overcome the fragmentation of caring for the disease and move towards the perspective of comprehensive care for people in their needs in a dialogical relationship of caring/being cared for and teaching/learning[31], training courses should be carried out with the entire team of ICU professionals in order to minimize the problems highlighted by them.

Initially, the team should understand that the humanization strategy is a process of interference in health production through the investment in a new type of interaction between subjects to improve the quality of interprofessional bonds and the relationship between professionals and system users, thereby supporting the construction of new institutional devices[32] and facilitating health promotion.

Given this reality, it is important to highlight the importance of systematically humanizing patient care in critical situations since risk ranking and, above all, emcompassing a process of development of ethical-moral skills to guide their future practices[33].

In this context, there is a need for teaching and learning strategies and methodologies that enable the intended actions. Additionally, it is necessary to seek constant feedback from subjects, health team, managers, family and patients in a dynamic process. The impact of humanization of care in the ICU would therefore be assessed in this way to propose improvements in the quality of health care, in the optimization of public resources and in patient safety.

FINAL CONSIDERATIONS

The findings revealed that the interviewed professionals realize the importance of providing quality care based on a welcoming and humanized practice.

They also realized the importance of not only meeting the biological needs of the patients assisted by them, but also of using communication as a practice closely related to the humanization of care. However, it was possible to identify, sometimes, a lack of knowledge regarding the National Humanization Policy.

The study can help nursing professionals to re(think) their care practice in order to combine high technological density with humanization and patient safety in intensive care.

CONFLICTS OF INTEREST

The authors declare that there were no conflicts of interest.

CONTRIBUTIONS

Ariane da Silva Castro and Éder **Luís Arboit** contributed to the study conception and project, relevant critical review of intellectual content, data collection and analysis, and approval of the final version for publication; **Gabriela Zenatti Ely, Cristiane Appio Motta Dias, Jaqueline Arboit and Silviamar Camponogar** contributed to data analysis and interpretation, relevant critical review of the intellectual content and approval of the final version for publication.

REFERENCES

1. Santos ES, Gastaldi AB, Montezeli JH, Garanhani ML. Acolhimento e processo educativo em saúde a familiares de pacientes internados em UTI adulto. Ciênc Cuid Saúde. 2016;15(4):639-46.
2. Escudero D, Viña L, Calleja C. Por una UCI de puertas abiertas, más confortable y humana. Es tiempo de cambio. Med Intensiva. 2014;38(6):337-402.
3. Machado ER, Soares NV. Humanização em UTI: sentidos e significados sob a ótica da equipe de saúde. Rev Enferm do Cent-Oeste Min. 2016;6(3):2342-8.
4. Ministério da Saúde (BR). Manual do Humaniza SUS [Internet]. 2003 [accessed on 2008 Feb 5]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/humanizaSus.pdf.
5. Ministério da Saúde (BR). Programa Nacional de Humanização da Assistência Hospitalar. Brasília: Ministério da Saúde; 2001.
6. Luiz FF, Caregnato RCA, Costa MR. Humanização na terapia intensiva: percepção do familiar e do profissional de saúde. Rev Bras Enferm. 2017;70(5):1095-103.
7. Massaroli R, Gue Martini J, Massaroli A, Delacanal Lazzari D, Nunes de Oliveira S, Pedroso Canever B. Trabalho de enfermagem em unidade de terapia intensiva e sua interface com a sistematização da assistência. Esc Anna Nery Rev Enferm. 2015;19(2):252-8.
8. Souza-Silva JC, Martins CA, Barbosa MA. Rede de atenção à saúde: percepção de usuárias do Sistema Único de Saúde. Rev Bras Promoç Saúde. 2016;29(Supl):44-50.
9. Malta DC, Reis AAC, Jaime PC, Morais OL Neto, Silva MMA, Akerman M. Brazil's Unified Health System and the National Health Promotion Policy: prospects, results, progress and challenges in times of crisis. Ciênc Saúde Colet. 2018;23(6):1799-809.
10. Ministério da Saúde (BR) Secretaria de Assistência a Saúde. Cartilha Humaniza SUS. Política Nacional de Humanização – PNH. Brasília: Ministério da Saúde; 2015.
11. Mongiovi VG, Anjos RCCBL, Soares SBH, Lago-Falcão TM. Reflexões conceituais sobre humanização da saúde: concepção de enfermeiros de Unidades de Terapia Intensiva. Rev Bras Enferm. 2014;67(2):306-11.
12. Pascuci L, Meyer V Jr , Nogueira EE, Forte LT. Humanization in a hospital: a change process integrating individual, organizational and social dimensions. J Health Manag. 2017;19(2):1-20.
13. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14ª ed. São Paulo: Hucitec; 2014.
14. Hospital Regional Santa Lúcia [Internet]. 2018 [accessed on 2019 Feb 14]. Available from: https://www.hospitalsantalucia.com.br
15. Fontanella BJB, Ricas J, Turato ER. Amostragem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. Cad Saúde Pública. 2008;24(1):17-27.
16. Brasil. Ministério da Saúde, Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012: diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Diário Oficial da União; Brasília, 13 Jun 2013.

17. Sanches RCN, Gerhardt PC, Rêgo AS, Carreira L, Pupulim JSL, Radovanovic CAT. Percepções de profissionais de saúde sobre a humanização em unidade de terapia intensiva adulto. Esc Anna Nery Rev Enferm. 2016;20(1):48-54.

18. Soares MI, Resck ZMR, Terra FS, Camelo SHH. Sistematização da assistência de enfermagem: facilidades e desafios do enfermeiro na gerência da assistência. Esc Anna Nery Rev Enferm. 2015;19(1):47-53.

19. Correio RAPPV, Vargas MAO, Carmagnani MAS, Ferreira ML, Luz KR. Desvelando competências do enfermeiro de terapia intensiva. Enferm Foco. 2015;6(1/4):46-50.

20. Evangelista VC, Domingos TS, Siqueira FPC, Braga EM. Equipe multiprofissional de terapia intensiva: humanização e fragmentação do processo de trabalho. Rev Bras Enferm. 2016;69(6):1099-107.

21. Oliveira APC, Coelho MEAA, Almeida VCF, Lisboa KWSC, Macêdo ALS. Sistematização da assistência de enfermagem: implementação em uma unidade de terapia intensiva. Rev RENE. 2012;13(3):601-12.

22. Chaves LDP, Laus AM, Camelo SH. Ações gerenciais e assistenciais do enfermeiro em unidade de terapia intensiva. Rev Eletrônica Enferm. 2012;14(3):671-8.

23. Araujo JD Neto, Silva ISP, Zanin LE, Andrade AP, Moraes KM. Profissionais de saúde da unidade de terapia intensiva: percepção dos fatores restritivos da atuação multiprofissional. Rev Bras Promoç Saúde. 2016;29(1):43-50.

24. Mororó DDS, Enders BC, Lira ALBC, Silva CMB, Menezes RMP. Análise conceitual da gestão do cuidado em enfermagem no âmbito hospitalar. Acta Paul Enferm. 2017;30(3):323-32.

25. Cardoso OP Jr, Pinto JMS. Quando a vida começa diferente: cuidado postural no cotidiano da equipe multiprofissional em terapia intensiva pediátrica. Tempus. 2016;10(4):83-100.

26. Rico LR, Marsans MC, Márquez CM, Borrás AM, Riba LS, Savall DT, et al. Relaciones interdisciplinarias y humanización en las unidades de cuidados intensivos. Enferm Intensiva. 2006;17(4):141-53.

27. Andrade CG, Costa SFG, Lopes MEL. Cuidados paliativos: a comunicação como estratégia de cuidado para o paciente em fase terminal. Ciênc Saúde Coletiva. 2013;18(9):2523-30.

28. Backes MTS, Erdmann AL, Büscher A. The Living, dynamic and complex environment care in intensive care unit. Rev Latino-Am. Enfermagem. 2015;23(3):411-8.

29. Silveira de Carli B, Ubessi LD, Pettenon MK, Righi LB, da Rosa Jardim VM, Fernandes Stumm EM. The humanization theme in intensive care in health studies. Rev Pesqui Cuid Fundam. 2018;10(2):326-33.

30. Félix TA, Ferreira FV, Oliveira EN, Eloia SC, Gomes BV, Eloia SMC. Prática da humanização na visita em unidade de terapia intensiva. Revista Enfermagem Contemporânea. 2014;3(2):143-53.

31. Ministério da Saúde (BR). Política Nacional de Promoção da Saúde: documento para discussão. Brasília: MS; 2002.

32. Deslandes SF. Análise do discurso oficial sobre a humanização da assistência hospitalar. Cienc Saúde Colet. 2004;9(1):7-14.

33. Figueiredo MCCM, Ferreira TN, Almeida FCA, Araújo AM, Araújo PE, Souza KBS, et al. Cuidado humanizado ao paciente crítico: uma revisão integrativa. Rev Saúde Ciênc [Internet]. 2018 [accessed on 2019 Feb 18];7(1):94-101. Available from: http://www.ufcg.edu.br/revistasaudeeciencia/index.php/RSC-UFCG/article/view/513

First author's address:
Ariane da Silva Castro
Universidade de Cruz Alta - UNICRUZ
Rodovia Municipal Jacob Della Méa, Km 5.6
CEP: 98005-972 - Cruz Alta - RS - Brasil
E-mail: arianecastro06@gmail.com

Mailing address:
Éder Luiz Arboit
Rua Protásio Mendes Castanho, 363
Bairro: Sulgon
CEP: 98300-000 - Palmeira das Missões - RS- Brasil
E-mail: earboit@unicruz.edu.br

How to cite: Castro AS, Arboit EL, Ely GZ, Dias CAM, Arboit J, Camponogara S. Percepções da equipe de enfermagem acerca da humanização em terapia intensiva. Rev Bras Promoç Saúde. 2019;32:8668.