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RECEPTIONAL AND EDUCATION PROCESS IN HEALTH TO FAMILY MEMBERS PATIENTS BOARDING IN ADULT ICU

Elizângela Santana dos Santos*
Andréia Bendine Gastaldi**
Mara Lúcia Garanhani***
Juliana Helena Montezeli****

ABSTRACT

This study aimed to analyze the family member's perceptions of Intensive Care Unit (ICU) patients after care and health education process. This is a study descriptive, exploratory with a qualitative approach, using interviews with 13 family members of patients in the adult ICU of a university hospital who were entering in the unit for the first time. Data collection occurred from August to October 2015. First, the family members underwent an intervention in health and were subsequently conducted the semi-structured interviews with three guiding questions. The interviews recorded, transcribed and submitted to thematic analysis. The research followed all ethical procedures. Data grouped under three categories: conceptions of family members of ICU; feelings experienced by the family members to step into the ICU for the first time and health education as a facilitator for the reception family. Observed the lack knowledge of family members about the ICU enclosure, and stress and shock to find the serious hospitalized parent. It concluded that the reception and health education were decisive factors for the visitors, they granted security and are actions that according to the family members themselves, should be routinely performed.

Keywords: Health Education. User Embracement Professional. Family Relations. Intensive Care Units.

INTRODUCTION

The educational practice is a competence of the nurse must mobilized in the most different areas of professional performance, with emphasis on health education. This can be set to the channel in which scientific knowledge of the area reach the daily life of the population, brokered by health professionals, providing improved health and quality of life[1]. Is a set of knowledge and practices that should be more than inform, but, considering the subjectivity of the subject, their beliefs and history, you can direct to the reflection of changes[2].

Health education is not neutral, permeated with intentions that considers not only health as absence of disease. Therefore, to empower the population, should not target only the memorization of concepts and knowledge, and Yes, allow the individual to develop skills and competencies to decode and manage the knowledge on health[3].

According to the law 7,498/86, which provides for the exercise of nursing, is the private nurse education with the goal of improving health of the population, and the implementation of these actions should have the participation of all the nursing staff (nurses, and nursing assistant)[4].

Therefore, the nurse in addition to being leader, empower the team and systematize the nursing care must also carry out health education. However, despite being, something laid down in law, often during the daily life and the work process, guidelines, and health education not practiced, including the intensive care environment.

The environment of the intensive care units (ICU) characterized by continuous assistance to patients, the presence of qualified staff, high-tech gadgets and the need for agility and rigorous attention on assistance. Due to these particularities, the actions of health promotion can be devalued and unlinked from the professional practice[5].

Considering the UTI in all its complexity of

*Nurse. Intensive care to the adult resident of the Universidade Estadual de Londrina (UEL). E-mail: ss.elizangela@hotmail.com
**Nurse. PhD student of the graduate program in public health at the UEL. Lecturer in the Department of Nursing at the UEL. E-mail: gastaldi@sercomtel.com.br
***Nurse. Doctor in nursing. Lecturer in the Department of nursing and the graduate program in public health at the UEL. E-mail: maragara@hotmail.com
****Nurse. Doctoral candidate in nursing graduate program at the State University of Maringá (UEM). Lecturer in the Department of Nursing at the UEL. E-mail: jhmontezeli@hotmail.com

devices, high prevalence of bacteria and tension by the clinical picture of patients, health education activities are damaging themselves similarly health promotion practices, therefore, the very intensive environment hinders this process.

In this context are the family members of critically ill, which, in addition to the tension of having a loved one in the hospital, experience uncertainties regarding the evolution and prognosis of the patient who is hospitalized in a unit intended for critical patients. In addition, hospitalization in intensive care often unexpectedly and acute, and this situation can generate clutter, helplessness and stress to the family[6].

Therefore, it is important that nursing professionals especially nurse, to invest in care actions demonstrating interest, consideration and sensitivity to the patient and his family. Interaction and support team with the family generate well-being and comfort, therefore, can minimize this difficult moment and disgusted to the same[7].

Specifically on the role of the nurse in the relationship with the family, this professional is the guarantee of the right of the family to be with the patient in the process of care and hospitalization, regardless of whether it is as an escort or visitor. The nursing staff must see the family as company for the sick and ally in teamwork, as well as a facilitator of the accession process and collaboration in the treatment[8].

Finally, pondering the lack of information to the family, the environment impact of the ICU and the familiar sight as a visitor, it was observed that not always the familiar is oriented with respect to invasive procedures, or even why the prepping to enter the required sector. Considering this information being part of an educational process that it is also the nurse and aims to share knowledge with the user, the present study aimed to know the perceptions of family members to step into for the first time in the ICU; perform a host process and health education with family members on the first visit to the patient in the hospital in ICU and; analyze the perceptions of these families about health and educational process developed.

METHODOLOGY

It was a qualitative, descriptive and exploratory research conducted in adult INTENSIVE CARE UNIT at the University Hospital of Londrina (HU/UEL), whose participants were 13 relatives of inpatients in this sector. Inclusion criteria were be over 18 years old, have interned in ICU adult family and be entering the INTENSIVE CARE for the first time. Data collection took place during the period from August to October 2015.

Family members, upon arrival to the ICU for visiting hours, questioned about entering for the first time or not. To those included in this criterion and inclusion criteria of the study, explained the purpose of the survey and how would your participation if sign an informed consent (TFCC). The people who agreed to participate were accompanied by a student of the last year of graduation in nursing to its familiar and, in this first moment was explained about all invasive procedures (orotracheal tube drains, catheters, etc.) connected to the patient, as well as on the equipment (infusion pumps, mechanical ventilator, monitors, etc.). The student also clarified doubts, however, without providing any information about the condition of the patient, because only the team of the unit would perform this function later. After being held this educational process, the students retreated and guarantee the privacy of visiting hours, however, was still around and available to the family.

The second part of the research happened shortly after visiting hours, which consisted of a new approach to visitors from the first moment of the study participants. He given a folder dealing with explanatory information about the ICU, on specifics for the visiting hours and an illustration about invasive procedures. At this time, it explained about the interview and the questions that carried out by signing the FICS. Semi-structured interviews has recorded from the following main issues: 1) *as (a) you felt upon entering the ICU*. 2) *you (a) on entering the ICU was oriented (a) with regard to equipment, invasive procedures and medications*. *As you (a) felt about this guidance?* 3). *What degree of importance that you (a) gives these guidelines*

that you were given? Somehow, they were useful? If Yes, in what ways?

Was made by sampling for saturation, which means the establishment of a sample, suspending the new components when the data begin to be replayed[9],and for the treatment of the data using the content analysis, which suggests the following steps: pre-analysis, material exploration and processing of results[10].

The interviews carried out in a room next to the ICU, which ensured the confidentiality and privacy while interview, recorded and transcribed in full. The lines of respondents coded with the letter F (family) and an Arabic number (1 to 13) because of participation.

The research approved by the Research Ethics Committee of the Universidade Estadual de Londrina, with opinion registered CAAE, 46538615.3.0000.5231 and obeyed the ethical criteria of research involving humans.

RESULTS AND DISCUSSION

Participated in these study 13 relatives of patients who were entering the INTENSIVE CARE for the first visit. In relation to the degree of kinship, seven were children/stepchildren, two grandchildren, a brother-in-law, a father-in-law, a brother and another, son-in-law.

The results organized in three empirical categories: 1*) conceptions of the family about the ICU;* 2) *feelings experienced by family members to step into in intensive care for the first time*, and 3) *health education as a facilitator for the host of the familiar*.

Category 1: Conceptions of the family about the UTI

The first category dealt with the family over the conception of UTI, since it was the first time they enter in the unit. In the reports, it is clear ignorance of the relatives regarding such ambience. They did not know where they were and what they did for the appliances and invasive procedures. In addition to admit their own ignorance, something that became clear in the analysis was the concern of respondents with other relatives. Respondents perceive also the ignorance of other family members during the same time, imagining that their own doubts might be the same from other visitors, as seen in the following report:

> (...) Is ... for example, I did not know she fed, over there [by nasoenteral catheter]. I thought it was just serum; He explained it was a food that goes in one location. The device that takes air so she can breathe. Showed me also the heartbeat. I think it is important, because ... There ismany people who do not know. Myself, I did not know about some equipment there. (F3)

The ignorance has nothing to do with the interests of family members to know the purpose of the apparatus and equipment. A similar study conducted in the city of João Pessoa (PB) pointed out that family members have noted the absence of prior presentation of the unit and the lack of clarification on the equipment, getting without knowing what they would find next to the patient[11].

At the time of admission of the ICU, family delves into an environment very weird and unaware of the unit, equipment and invasive procedures, therefore, it is important that the nursing staff prepare for the visits, making this time less stressful and enabling a closer contact with the patient[11].

For many of the relatives, the ICU urged fear and anguish, and seen as a last choice, after hospitalization in this unit there was no more possible resources to restore the health of patients. It also been pointed to its complexity and that is a sector different from the others, characterized by a greater accuracy and control over the care provided, as can be seen in the following snippet:

> I know this is more rigorous because they have to be on top. A no, of course, but here. (...) so we know it's one of the last features, which no longer exists (F4)

> Because when you are in the ICU is not good. So, why give that bad business! When you are in the room is different, simpler, and more normal. You sit beside the bed, you talk with the person, the person responds. There, there ... was asleep, because of the strong remedies. Why, I do not know, give that weird on us, our ... feel bad (F8)

> We see how all those connected devices, people

> breathing forced. I, in my point of view, I think the person got there in intensive care ... only God, see.(...) to get her out of there I only believe in God (F11)

The concern with the patient is potentialized by UTI be mythologized as a place to die[12]. In a survey conducted with patients, it reported that their vision prior to hospitalization in intensive care was an environment connected with death, linked to feelings like anxiety, uncertainty and discomfort, despite the human and technological resources. Therefore, corroborating the line F8, there is a cultural relationship of the ICU with a critical and rigorous environment, which can be associated with the possibility of death[13].

According to a study in Neonatal Intensive Care Unit, was also noticed by family members who, after a certain time, the ICU was the ideal place for the treatment of the patient, given its complexity, as was reported by talk of F4(14).

The belief in God reported by F11 also described in other research, which explores the spirituality for relatives of inpatients in ICU, and, in this process of hospitalization of a loved one, approximation with God produces a beneficial and positive effect on the family, which can result in better quality of life[15].

It is up to point out that the ICU is a closed unit and one of its features is the restriction of access to other people. Therefore, in several hospitals, including at the institution where the study conducted, no presence of escorts for patients, and that the family only enters as a visitor in timetables established as routine.

Still about the perceptions, it noted how the families tuned around, since the environment, other visitors and family members to staff and equipment, according to exemplify these excerpts:

> It is a completely different environment. In addition to the person that you come to visit, there are other people in the same situation, which in my case was my mother. In addition, there are people who sometimes relatives cannot come because of work, because she lives in another city. So, we get up to shocked because a person has not received any visiting side, so we are thinking, "I wonder if this person has no one who can come visit". And also the situation of the work that people are over there ... dedicating his life for another life (F3)

> The Lady [employee] was there and said, "Oh, we're going to shave". Is detail, you say that "our, even that!" Like brushing your teeth, also thing that you can't do, so they have all the care of clean, has the shower that is something too that they are there, doing the daily needs that you have they are supplying (F5)

> Then help the heart, the heart rate. I was seeing there too where is showing that little heart there, there is heartbeat, isn't it? She went from 110 to 88, I saw there (F11)

Category 2: Feelings experienced by family members to step into in intensive care for the first time

This category explored entrance in ICU and how was the experience of first visit. Clear the tension, shock and anxiety of being at the same time entering this sector for the first time and find her in serious condition. However, for some respondents also represented the joy and relief to see the patient in the best conditions:

> Oh, it is very uncomfortable because you see the person you love so, in that situation is very difficult, because we know how it is, that is embarrassing. Shocked me a lot when you see the person in that situation ... is impressive so you have to have a good kind of psychological, otherwise, you get desperate. Then you see that piece of wire, you do not know that serving (...) a unit will beep you ever gets desperate [laughs]. You say, "What's going on?" [Laughs]. Therefore,it iscomplicated. It is shocking to see it like that;it is not easy (F5)

> Oh, I got a little scared. Thinking that I was going to find a picture worse. However, I was happy the way he is. The way people meet, I found it very good (F9)

Speaking of F5 translates an important point that has addressed in another study on the optics of the patients themselves, which is the embarrassment, the exposure of patients and lack of privacy during the visit, generating nuisance[16]. Infer, therefore, that the nursing care must resound just technological issues and techniques, valuing the aesthetics of presentation of the patients, in order to minimize the negative perceptions of family

members during the visit.

Feelings have also emerged a loved one hospitalized in intensive care that for all visitors represented sadness, fear and apprehension:

> I felt a little bad because I never saw my mother like that. Then I was calming down ... crying is normal because you never saw his mother like that, so I was a little nervous, apprehensive about the situation. Nevertheless, with the minutes that I have been getting there I was calming down a little more (F3O

> Oh, I think it is an agony every day so for us. Why just yesterday we received word of the tests were bad. Today's good thing, bad thing tomorrow, another day that is good. So it's always like that, we never have a certainty, we get very nauseous (F7)

> Felt bad. Very badly. Is a business that we are accustomed to the good person there you see the person in that State there, a lot of appliance, intubated. It feels bad (F8)

The feelings of grief and sadness experienced by the family who has a loved one in the hospital in ICU was also explored in another study, that understands the hospitalization in intensive care as a difficult time for the family structure. Family members interviewed, and impotence described feelings like pain, anguish and fear by the separation caused by hospitalization[12].

The line above the familiar F7 represents the uncertainty of tomorrow and anxiety arising from the fact of having a family member in the hospital in ICU, so similar to the accounts of relatives of inpatients in Santa Catarina, who reported his anguish in the face of uncertainty and possibility of death[12].

About the uncertainty, a survey conducted in Bahia also demonstrated the discomfort experienced by families due to possible non-recovery of the familiar hospitalized, were also reported feelings of anxiety, distress and agony[17].

On the findings it is possible to conjecture that the nursing, by adding science and art, is the Professional category that has ballast to minimize such negative feelings described by the families in this and other studies cited, through several strategies, among them, we highlight the educational processes as welcoming the action, central theme of this research.

Category 3: health education as a facilitator for the family hosting

In the last category, the statements clarified the importance and the need of foster care and health education in the ICU. The participants highlighted how the actions undertaken were relevant to them and, because they are essential, they should done routinely. Raised also the knowledge of staff shortage and that the reception and the health education should carried out only on the first visit, as shown by these clippings:

> Is a trust to have someone there leading you, explaining why I had never been here, I did not know what it was like inside. If I were to go, I would go and went there and was going to see him and just! He [Nursing Student] arrived, guided me ... asked me to put the glove. Then I thought it was very useful (F1)

> You need to have a person to guide, because not everybody knows (...) andyou had better have someone to clarify everything, guide, because it requires. Therefore,it isgood; it takes a person to do this often. I know they do not have many employees to be seeing all this, but it is good to have someone to follow. Everything is good (F4)

> Oh, I think it is essential. I think if every time someone walked into the ICU, not first or second, because I think that each time, each person is different. So, if you have someone to guide as you did, I think much better. Because you feel more comfortable, you see the person in that situation with that piece of apparatus you already think. "My God, you're going to die ' [laughs]. Therefore, you see it is not that, it is not that way. You understand what is, it is a lot easier. Much more quiet. I was quieter [laughs] (F5)

Similarly, to the present study, family members also pointed out the importance of clarification and guidance to ease the suffering of the family and let the environment less dark and creepy, making it cozy[6].

On the other hand, other research has shown what we see in daily life: intensivist that empirically the information given in the ICU are passed on informally and only when

they are requested, as well a lack of commitment of the professionals[18].

Lee, in a study conducted in an ICU in southern Brazil with family members and patients after host strategies adopted by nurses, family satisfaction has been detected in relation to attendance[19], in line with the findings of the present research. The process of hospitalization in intensive care generates in the family many uncertainties and the host was marked as essential and extremely important, providing bond and trust. Still on the subject, it emphasized that, in spite of the environment being critical and often hostile, there must be dialogue, information and attention to the familiar, because he always will exist and will have its importance in patient recovery[19].

In addition, emphasizes that distribution of information leaflets on the family unit before the entrance in the ICU addressed for the first time as care that can provide more security and information, and has been included in this research[18].

FINAL CONSIDERATIONS

The ICU, mythologized as a place of last resort therapy to their patients, generates negative feelings to the families. It was in the investigation now terminated, that feelings like fear and tension were quite present in the visitors ' routine and the understanding that family members are passive participants in the care routine is anachronistic and ineffective to the recovery of the patient.

The family must considered as integral element in process of caring for the individual critically ill and, to this end, it of the upmost importance that health professionals are aware of these people's perceptions about the drive on which your family member hospitalized and they understand the difficult position of having a loved one admitted to an ICU.

Despite the work process in this sector be characterized as complex and insightful, it was highlighted the importance of welcoming, actions that are often simple, do not capture as much staff time and which are essential to visitors. Thus, the educational activities carried out in this study, as well as the words of the participants, are converging with the related literature and is a practice should regarded as one of the pillars of intensive nursing care.

Another point that was present in the lines of the family was the unfamiliarity of the visitors about the materials and equipment. However, you do not know its function and utility meant that visitors ignoring the presence of these devices, the note as another relevant theme raised in the survey.

This study has limitations because it held only in an institution and for checking the phenomenon only from the perspective of one of his protagonists – the family – it claimed that the host and health education are decisive factors for visitors, provide security and are actions that, according to their own family members, should carried out routinely. It is understood that, despite the setbacks the process of work influence and hinder the occurrence of activities like these, one must consider the visitor as end element of patient care and understand how these practices are crucial during visiting hours.

Far from remedy discussions on the subject, it expected that the constructs presented here could promote in intensivistas nurses concerns resulting in the implementation of the health education to the family members of hospitalized care essential critical environment welcoming.

ACOLHIMENTO E PROCESSO EDUCATIVO EM SAÚDE A FAMILIARES DE PACIENTES INTERNADOS EM UTI ADULTO

RESUMO

Os objetivos deste estudo foram:conhecer as percepções dos familiares ao adentrarem pela primeira vez na Unidade de Terapia Intensiva (UTI); realizar um processo de acolhimento e educação em saúde com familiares na primeira visita; analisar as percepções destes familiares acerca do acolhimento e processo educativo em saúde desenvolvido.Trata-se de um estudo descritivo, exploratório, qualitativo,foram entrevistados 13 familiares de pacientes internados na UTI adulto de um hospital universitário que estavam adentrando a unidade pela primeira vez. A coleta de dados ocorreu de agosto a outubro de 2015. Primeiramente, os familiares foram submetidos a uma intervenção educativa em saúde e posteriormente

foram realizadas as entrevistas semiestruturadas com três questões norteadoras. As entrevistas foram gravadas, transcritas e submetidas à análise temática. Os resultados foram organizados em três categorias: concepções dos familiares sobre a UTI; sentimentos vivenciados pelos familiares ao adentrarem na UTI pela primeira vez e educação em saúde como elemento facilitador para o acolhimento do familiar. Observou-se o desconhecimento dos familiares sobre a UTI e a tensão ao encontrar o familiar grave. Concluiu-se que o acolhimento e educação em saúde foram decisivos para os visitantes, concederam segurança e são ações que, segundo os familiares, devem ser realizadas rotineiramente.

Palavras-chave: Educação em saúde. Acolhimento. Relações profissional-família. Unidades de Terapia Intensiva.

RECEPCIÓN Y EL PROCESO EDUCATIVO EN LA SALUD DE LOS PARIENTES DE PACIENTES HOSPITALIZADOS EN LA UCI ADULTO

RESUMEN

Este estudio tuvo como objetivo analizar la percepción de los familiares de pacientes hospitalizados en la Unidad de Cuidados Intensivos (UCI) después delrecepción y proceso de educación para la salud. Se trata de un estudio descriptivo, exploratorio con enfoque cualitativo, mediante entrevistas con los 13 miembros de la familia de los pacientes hospitalizados en la UCI de adultos de un hospital universitario que estaban entrando en la unidad por primera vez. La recolección de datos ocurrió entre agosto y octubre de 2015. En primer lugar, la familia se sometió a una intervención en salud y posteriormente se realizaron las entrevistas semi-estructuradas con tres preguntas de orientación. Las entrevistas fueron grabadas, transcritas y sometidas a análisis temático. La investigación siguió todos los procedimientos éticos. Los datos se agrupan en tres categorías: las concepciones de los familiares acerca de la UCI; sentimientos experimentados por las familias para entrar en la UCI por primera vez y educación para la salud como un facilitador para recepción de la familia. Fue observado la falta de conocimientode la familia sobre el recinto de la UCI, y el estrés y el shock de encontrar la pariente hospitalizada grave. Se concluyó que la educación en salud fueron factores decisivos para los visitantes, que otorgan seguridad y son acciones que, según los propios miembros de la familia debe ser realizada de forma rutinaria.

Palabras clave: Educación em Salud. Acogimiento. Relaciones Profesional-Familia. Unidades de Cuidados Intensivos.

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Corresponding author: Elizângela Santana dos Santos. Rua Sérgio Romano Macaxeira, 326, Bairro Santa Madalena. CEP: 86073-190, Londrina-PR, Brasil. E-mail: ss.elizangela@hotmail.com

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