DOI: http://dx.doi.org/10.18569/tempus.v10i4.1966

# Visita humanizada em uma unidade de terapia intensiva: um olhar interdisciplinar.

# **Humanized visit in an intensive care unit: a multidisciplinary look.**

# Visita humanizado en una unidad de cuidados intensivos: una mirada multidisciplinar.

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**RESUMO:** A Unidade de Terapia Intensiva é um setor de alta complexidade onde os pacientes críticos passam por períodos de observação contínua em um ambiente frio e pouco acolhedor e, por vezes, assustador na visão dos pacientes e familiares. Nesse sentido, a visita humanizada multidisciplinar busca promover melhor compreensão deste contexto e esclarecer as dúvidas e inseguranças geradas por esse ambiente garantindo assim, uma assistência de melhor qualidade. Buscou-se, portanto, relatar a experiência da visita humanizada multidisciplinar em uma unidade de terapia intensiva. A visita humanizada ocorre com a participação, em conjunto, do médico, enfermeiro, psicólogo e fisioterapeuta. Inicialmente, a equipe recebe os familiares na sala de espera da UTI: em seguida, realiza acolhimento, avaliação psicológica e intervenção breve de apoio e orientação, e preparo psicológico para a visita. Quando necessário, a equipe multidisciplinar acompanha o visitante beira-leito, para proporcionar o acolhimento das dúvidas que surgem ao ver o paciente. Ao final do horário de visitas, realiza-se o boletim médico com a participação interdisciplinar, onde o médico informa a evolução clínica do paciente, discute o caso com a família e a equipe, a fim de_propiciar que o paciente receba a melhor terapêutica. A visita humanizada interdisciplinar é finalizada após o boletim, quando o psicólogo realiza o atendimento com a

família, com o objetivo de compreender a percepção do familiar sobre o momento atual e o impacto emocional reativo ao momento vivenciado. Encerra-se o processo com a evolução no prontuário do paciente, onde são informados os principais pontos que são identificados no momento da visita.
Palavras chave: Terapia Intensiva, Humanização da Assistência Hospitalar, Relações Profissional-Família.

**ABSTRACT:** The Intensive Care Unit is a highly complex sector where critical patients go through periods of continuous observation in a cold and unfriendly environment, and sometimes frightening in the eyes of patients and their families. In this sense, the multidisciplinary humanized visit seeks to promote a better understanding of this context and to clarify the doubts and insecurities generated by this environment, thus guaranteeing a better quality assistance. We therefore sought to report on the experience of the multidisciplinary humanized visit in an intensive care unit. The humanized visit takes place, with the participation of the doctor, nurse, psychologist and physiotherapist. The team receives the family members in the waiting room of the ICU, hosts, psychological evaluation and brief intervention, support and guidance, and psychological preparation for the visit. When necessary the multidisciplinary team accompanies the visitor to the bedside, to provide the reception of the doubts that arise when seeing the patient. At the end of the visitation hours, the medical bulletin is made with an interdisciplinary participation, where the physician informs the clinical evolution of the patient, discusses the case with the family and the team, in order to provide the patient with the best therapy. The interdisciplinary humanized visit is completed after the bulletin, when the psychologist performs the care with the family, in order to understand the family member's perception about the current moment and reactive emotional impact to the moment experienced. The process with the evolution in the patient's chart closes, where the main points that are identified at the time of the visit are informed.
Keywords: Intensive Care, Humanized Care, Professional-Family Relationships.

**RESUMEN:** La Unidad de Cuidados Intensivos es una industria altamente complejoenel que los pacientes críticos pasan por períodos de observación continua enun ambiente frío y pocoacogedor, y, a veces aterradora a losojos de los pacientes y sus familias. En este sentido la visita humanizado multidisciplinar busca promover una mejorcomprensión de este contexto y aclarar lasdudas y las inseguridades generadas por este ambiente garantizandoasí una mejoratención médica. Se trató, por lo tanto, para informar de laexperiencia de la visita humanizado multidisciplinarioen una unidad de cuidados intensivos. La visita humanizado se lleva a cabo, conlaparticipación conjunta del médico, enfermera, psicólogo y fisioterapeuta. El personal da labienvenida a lasfamiliasenla sala de espera de la UCI, lleva a cabo larecepción, evaluación psicológica y laintervención breve, apoyo y orientación, y lapreparación psicológica para la visita. Cuando es necesario, el equipo multidisciplinarioacompaña a lacabecera visitante a proporcionar a lagrancantidad de preguntas que vienen a ver al paciente. Al final de las horas de visita, llevado a cabo el registro médico conlaparticipacióninterdisciplinaria, donde el médico informa a laevolución clínica del paciente, se analizael caso de lafamilia y elpersonalconelfin de establecer que el paciente

recibeelmejortratamiento. Interdisciplinario visita humanizado se completa después de laliberación, cuandoel psicólogo realiza elservicioconlafamilia, conelfin de conocerlapercepción de lafamilia sobre lasituaciónactual y el impacto emocional reactivaexperimentóel momento. Termina elproceso de laevolucióndel paciente que se informa a lospuntosprincipales que se identificanenel momento de la visita.
Palabras clave: Cuidados Intensivos, Humane Cuidado hospitalario, profesional-familia Relaciones.

## INTRODUCTION

The Intensive Care Unit (ICU) is a highly complex sector in the hospital environment, it is aimed at critical patients who need continuous monitoring of their organic functions, with state-of-the-art technological resources and high complexity care, with a qualified team, and the purpose of restoring the state of health of those who are hospitalized. It is a cold, unwelcoming place; full of appliances that ensure the maintenance of life and that are sometimes frightening in the eyes of patients and their families[1].

The need for hospitalization of a family member in an Intensive Care Unit causes a high level of stress, insecurity, fear, and emotional imbalance for both the patient and the relative. This condition is experienced as a real crisis by the family, due to the conditions of uncertainty and insecurity that they experience during the patient's hospitalization process, in the face of difficult and complex prognoses that characterize the most serious situations. In addition to having significant repercussions on family daily life, since this change usually occurs suddenly and unexpectedly[2].

The main stressors that affect relatives are: emotional impact due to the need of transferring to the ICU; deprivation of the caregiver role; behavior of the patient and their reactions; change in the looks of your beloved one and invasive devices; sounds and noises of the environment; emergency procedures to the patient at the time of the visit; difficulty in communication between the team and the family; simplified understanding of the patient's clinical condition; difficulty in understanding the reason for hospitalization in the unit; and therapeutic behavior that is often invasive[1].

The ICU is seen as a place where death is most likely, as a desperate situation of isolation from family and friends; such a view is due to the lack of knowledge or the embracement provided by the ICU staff[3].

Thus, it is verified that understanding what the ICU is, the equipment connected to the patient and the procedures performed is of paramount importance for the therapeutic advancement, and it promotes the humanized assistance to the family and patients[3,4].

Thus, it is evident that in order to handle the difficult situation, the family needs guidance; and the visit is the moment for the multidisciplinary health team (physician, physiotherapist, nursing team, psychologists, among others) to contact the family, preparing and accompanying them during

the visit, identifying their needs, expectations and clarifying their doubts; but, above all, having the sensitivity to observe their reactions and to understand their feelings[6,7].

The routine that the multiprofessional team is used to is to take advantage of the moment of the visit to update the information in the patient's chart and/or rest. It is necessary for the health team to recognize the inpatient family and to include it as part of the healthcare universe, which requires attention and care. It is necessary for the team to put themselves in other people's shoes (patient/family member), in order to value their experiences, to recognize that each person has different coping tools, and to provide a relationship of trust and empathy[4].

The involvement among the healthcare team, patient, and the family is an essential prerequisite for humanization. Psychology plays a fundamental role in this context, by bringing the family closer to the ICU environment and promoting a better interaction between the ICU and the other team members (physicians, physiotherapists, nursing staff, among others)[1].

In order for the care of the family to be humanized, it is of fundamental importance that the nursing team participates in the embracement by including the family member in the in-hospital care; therefore, it is up to the nurse and the nursing team to listen to the needs and to the opinion of the family in order to include it in the care plan. However, it is observed that although the nursing team considers the task of guiding families important, it rarely takes on this task, which is usually carried out by the psychologist and the social worker[7].

The concept of multidisciplinarity arose in the twentieth century, and it was only after the 1960s that it began to be emphasized as a need to transcend and to pass through fragmented knowledge, although there has always been, to a greater or lesser extent, a certain aspiration to the unity of knowledge. In this way, health as integrity does not allow fragmentation in physical, mental and social health and, therefore, it starts from a holistic vision that supposes to understand it in the interface of great diversity of disciplines. This diversity becomes more complex when the reality of health goes beyond the individual dimension and passes into the collective sphere[9].

The physical environment, with several devices connected to the patient, including invasive mechanical ventilation, and monitoring, with constant alarms of the infusion pumps; in addition to the instability and severity of the other patients, make it necessary for the team, especially the physiotherapist, to act in the care of the patient and the family, in order to minimize the impact of the ICU stressors; in this way, they can act explaining about the devices and their functionalities. In addition to considering in their work the assistance to a human being who is going through a difficult time, what can be included in the care and assistance of those who are hospitalized[4].

In this way, the comfort that the family and the patient receive from the multidisciplinary team enables them to channel energy for the solution of conflicts and problems, which may occur during the hospitalization period. This way of treating the family guarantees the comprehension of care in its integrality, guideline that guides the consolidation of the Unified Health System (SUS)[3,4].

In this sense, some strategies have been created, enabling and encouraging the change in customer service, such as the National Program for Hospital Humanization (NPHH) and the Resolution of the Anvisa Collegiate Board No. 7, of 2010. The Program proposes the implementation of interventions aimed at humanizing and improving the bond between health workers, patients, and their families. The resolution, in turn, reaffirms the importance of the subjective and social dimension in the care and management practices in the ICU.

Currently, allying humanitarian values with ICU care with its high technology is a big challenge. This challenge, as an ethical practice, is understood in this study as the act of welcoming, so that valuing the embracement becomes a way for professionals who wish to rescue the humanistic care in health. In this context, the family emerges as well as its present need for care and acceptance, based on interpersonal relations, since it enters into a process of illness due to the deep bond with the critical patient, which generates emotional shock and uncertainties about the future[10].

In this sense, the multidisciplinary humanized visit seeks to promote a better understanding of this context and clarify the doubts and insecurities generated by this environment; thus, guaranteeing a better quality care and the execution of the NPHH. In this way, this study aims at reporting the experience of the humanized multidisciplinary visit, with the presence of the nurse, physiotherapist and psychologist, in an intensive care unit.

The interest in this experience report arose with the intention of reporting that it is possible to carry out a humanized interdisciplinary visit, and that most of the material necessary to carry it out is the technical/scientific knowledge of the multidisciplinary team. But, above all, the desire to put oneself in the other's shoes, to recognize this moment as crucial for the well-being of both the patient and their relatives and, if performed in a satisfactory way, it can help in the recovery of the patient in a significant way. In addition, this study aims at contributing to the scientific community by disseminating the methods and procedures used to carry out this instrument, as a form of embracement and support for the relatives of patients hospitalized in the ICU.

## METHOD

This is a qualitative study, through the report of experiences with a critical-reflexive approach of the experience in the field of performance of the Multiprofessional Residency in Adult Intensive Therapy with the humanized and multidisciplinary visit performed daily in the Intensive Care Unit of a hospital of infectious and contagious diseases.

The Hospital has 145 beds, of which seven are for the adult ICU. This, in turn, relies on the performance of a multidisciplinary team prepared to serve critical patients who need intensive care. The team consists of physicians, nursing staff, physiotherapists and general services, as well as hosting the Integrated Multiprofessional Residency in Adult Intensive Care (IMRAIC), which has a team of nurses, physiotherapists and psychologists.

The routine of the ICU meets the criteria of the humanization policy by offering care to patients with quality, dignity and confidentiality about their diagnosis and medical information, which are passed on only to family members and people who are responsible for the hospitalization. Family members and friends have the opportunity to visit the patient every day for an hour, at an established time; they are welcomed in a waiting room, and after the visit they receive a medical bulletin in a room to be respected the privacy of each patient/family. In addition, the family members can participate in the therapeutic group "Acolher", of psychological support to relatives of patients hospitalized in the ICU, which occurs once a week, with the conduction of the psychology service.

The multidisciplinary humanized ICU visit program has been in place since 2014, with the inclusion of the Multiprofessional Residency in Adult Intensive Care (IMRAIC). It aims at embracing and providing the family members with differentiated and crisis care by reducing their doubts, providing guidance about the ICU procedures and equipment, emotional support in order to reduce anxiety, emotional discomfort and stresses that are triggered by the ICU environment and the patient's clinical situation, and provide the acquisition of adaptive behaviors to this environment.

The visit was carried out with the participation of a nurse, two psychologists and a physiotherapist. The humanized visit took place daily (from 4:00 p.m. to 5:00 p.m.), as well as exceptions in which visits are extended, according to a multidisciplinary team evaluation in the hours before the visits.

The team (1 nurse, 1 physiotherapist, and 2 psychologists) welcomed the family members in the ICU waiting room, hosted them, proceeded with a psychological evaluation and brief intervention, support and guidance, and made the psychological preparation for the visit. The embracement took place individually and in a group; individually, on the first visit of the family to the patient in the ICU, where they received an informative folder by a member of the team, with guidelines on procedures, routines and schedules, and appropriate attitude in the ICU. The embracement in-group occurred when the family members arrived at the ICU waiting room, and received advice from the nursing tram about hand washing, probes, change of position, and the general state of how the patient was; and from the physiotherapist about the devices that were attached to the patient, and their importance. Psychology was responsible for the psychological assessment, brief support intervention, counseling, and psychological preparation for the visit.

When necessary, the multidisciplinary team accompanied the visitor to the bedside to provide clarification of the doubts that emerged upon seeing the patient, and encouraged their participation in care and communication with the patient. At the end of the visit, a medical report was made with the participation of the doctor, nurse, physiotherapist, and psychologist, where the physician informed the clinical evolution of the patient, discussing the case with the family and the multidisciplinary team, in order to provide the patient with the best treatment, having the participation of the family and the multidisciplinary care team.

The multidisciplinary humanized visit program was finished after the bulletin, when the

psychologist performed the care to the family, in order to understand the family member's perception about the current moment and reactive emotional impact to the moment experienced, besides the compression of the diagnosis and prognosis of the patient. If necessary, brief focal support psychotherapy was performed in order to reduce the anxiety generated by the moment of crisis, and if this was the case, the anticipatory mourning therapy was begun, with the purpose of helping to strengthen the confronting resources in difficult situations. The process was finished with the annotation in the patient's medical record, where the main points identified at the time of the interdisciplinary humanized visit were informed.

## RESULTS AND DISCUSSION

Since its creation in April 2014 until June 2016, care and follow-up have been given to family members during the Multidisciplinary Humanized Visit Program and the result has been satisfactory. During this time, the effectiveness of communication, quality in the team-family-patient relationship, full patient and family care, breaks with the biomedical model and considers the biopsychosocial, cultural and spiritual aspects of the users, as recommended by the WHO (1999) and the PNHS (1999)[9].

It is possible to perceive that the relatives seemed satisfied with the embracement, feeling integrated to the team and participative regarding the treatment of the patient, in the care and decision making throughout the visit from the moment of arrival to the health unit, during the period of the visit, medical bulletin and post bulletin.

The affirmation is due the observation of the family members from the externalization of the feelings of contentment, satisfaction and security in both verbal and nonverbal language, in the moments of embracement before the ICU entrance, during the visit, medical bulletin and embracement post bulletin.

It is observed that the embracement performed by the multiprofessional team before seeing the patient provides: minimizing of the impact of hospitalization, reducing the possibilities of psychological decompensation, stimulating adaptive and resilient behaviors, and strengthening the internal coping resources of family members. A study carried out in 2008 pointed out that the previous moment of the visit is an important requirement for humanization, since it is a time to keep the family informed and prepare them for the visit, by offering adequate information in simple words that are consistent with the sociocultural level of the family members[7].

In addition, it is possible to identify these behaviors during the therapeutic group of psychological support to the relatives of patients hospitalized in the ICU, "Acolher", a moment in which the family members feel at ease to expose their feelings, share their experiences, report the suffering experienced during the hospitalization, receive guidance and support from the psychology service. Oliveira (2014) emphasizes that the formation of groups in an ICU enables the family to have

a therapeutic value by providing an account of their experiences; helping them to change their understanding of the facts of life and in acquiring healthier attitudes towards coping with the hospitalization, as well as being an important instrument for the embracement and humanization of health[8].

The presence of one or more professionals of the multiprofessional team (nursing technicians, nurse and physiotherapist) at the bedside, side by side with the family member, gives the family and the patient a sense of security, acceptance and makes them more comfortable to ask the doubts that arise from the hospitalization. In addition to being a time for each professional to present to the family the care provided to the patient, which allows each companion to perceive the quality of the service and assistance offered to the patient[10].

It is also verified that when presenting themselves as available to the family, the professionals open space so that doubts and concerns are attenuated, leaving no opportunities for gaps, thus reducing the discomfort and emotional stress due to doubts or lack of information.

At the time of the medical bulletin, it is possible to see that the family feels part of the team and participant in the care of the patient. When the family members discuss the best treatment for the patient, they clarify their doubts regarding the clinical condition and have the opportunity to be embraced after the bulletin, in order to minimize the impact of the hospitalization and favor a better understanding and organization of the information obtained.

The multidisciplinary action throughout the visit and the activities of the "Acolher" group are of great relevance, considering that, with this participation, it is possible for each nurse, physiotherapist and psychologist to clarify their role regarding the patient/family member and clear doubts related to it with more ownership and clarity of information. In addition to emphasizing the importance of the teamwork for the goal in common, which is the quality of care and reestablishment of health or the minimization of the pain, whether physical or emotional, caused by the process of illness.

Therefore, it is possible to verify that the care to the families during the humanized visit is based on the concept of extended clinic, in order to produce health and increase the autonomy of the subject, the family and the community, with the recognition that the experience that every family member has is unique[4].

## FINAL CONSIDERATIONS

Based on the report of the humanized multidisciplinary visit, it is possible to perceive that it seeks to promote a better understanding of this context and to clarify the doubts and insecurities generated by this environment, thus guaranteeing a better quality care in guaranteeing the execution of the NPHH. In addition, it is possible to carry out a humanized multidisciplinary visit, and that most of the material necessary to carry it out is the technical/scientific knowledge of the multidisciplinary team. But, above all, the desire to put oneself in the other's shoes, to recognize this moment as

crucial for the well-being of both the patient and their relatives, and that if it happens satisfactorily, it can help in the recovery of the patient in a significant way.

During the humanized visit, it was noticed that the families feel welcome, participative in the care, and confident in the team, as they verify the quality of the care provided, and clarify their doubts. At this moment, we experience the effectiveness of communication, quality in the team-family-patient relationship, we provide integral assistance to the patient and the family, breaking with the biomedical model and considering the biopsychosocial, cultural and spiritual aspects of the users, as advocated by the national humanization policy.

However, it is possible to perceive that the family members are satisfied with the embracement; they feel integrated to the team and participative regarding the treatment of the patient, in the care and in the decision making in all the course of the visit, from the moment of the arrival to the unit health, at the time of the visit, medical bulletin, and post bulletin.

Therefore, the present study evidences the interdisciplinary humanized visit as an important instrument of humanization and embracement, and support to the relatives of patients hospitalized in the ICU.

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Article submitted on 19/01/2017
Article approved on 26/09/2017
Article posted in the system on /03/2018