

# PERCEPTION OF NURSING PROFESSIONALS AGAINST HUMANIZATION IN INTENSIVE CARE UNITS

## PERCEPÇÃO DOS PROFISSIONAIS DE ENFERMAGEM FRENTE À HUMANIZAÇÃO NAS UNIDADES DE TERAPIA INTENSIVA

**Deylane Abreu dos Santos** - deylane.abreu.santos@gmail.com

Enfermeira, formada pela Faculdade Adventista da Bahia (FADBA), Cachoeira, Bahia, Brasil.

**Giselle Oliveira Azeredo** - giselle.azeredo@hasilvestre.org.br

Enfermeira, pós-graduada em Cardiologia pela Faculdade Unyleya, Rio de Janeiro, Rio de Janeiro, Brasil.

**Thais Batista dos Santos** - thathabatista13@outlook.com

Enfermeira, formada pela Faculdade Adventista da Bahia (FADBA), Cachoeira, Bahia, Brasil.

**Daiane Alves de Carvalho** - daianealcar11@gmail.com

Enfermeira, formada pela Faculdade Adventista da Bahia (FADBA), Cachoeira, Bahia, Brasil.

**Luzia Lima dos Santos** - luziaenfermagem@gmail.com

Enfermeira, formada pela Faculdade Adventista da Bahia (FADBA), Cachoeira, Bahia, Brasil.

**Abstract:** **Introduction:** The humanization of care in Intensive Care Units involves all health professionals who make up the working team, providing care to the patient and family, seeking to preserve the integrity of the patient as a human being and not just focusing on the patient-disease, encompassing -o as a person who has his own needs. **Objective:** To know the perception of nursing professionals regarding humanized care in intensive care units in a private hospital in the year 2021. **Methodology:** This is a cross-sectional study, which aims to assess the perception of nursing professionals working in Intensive Care Units, through a descriptive design in a qualitative perspective. **Results and discussion:** After analyzing the speeches of Nursing professionals, the answers were classified into five categories, namely: the concept of humanization, the actions that characterize humanized care, the difficulties encountered in performing humanized care, non-humanized situations and strategies for a humanized assistance. Through the analysis of all categories, it is understood that professionals feel humanized, is a contributing factor for them to practice humanization with their patients. **Final considerations:** Given the perceptions presented, the reports provided knowledge of how professionals provide humanized care to patients hospitalized in the Intensive Care Unit, leading us to reflect on the difficulties for humanization from the demands of the sector, the number of professionals, structural difficulties and the accumulation of functions that can become a predisposing risk for the performance of dehumanized care.

**Keywords:** Humanization; Intensive care unit; Nursing Professionals.

## INTRODUCTION

The humanization of care in the Intensive Care Units (ICU) involves all the health professionals who make up the active team, providing care to patients hospitalized there. In this care process, it seeks to understand suffering ethically, in addition to knowing its specifications and not just focusing on the patient-disease, encompassing him as a person who has his own needs (1-2).

Humanization is characterized as the search to obtain the greatest possible comfort for the patient and his family (3). In addition, to humanize is to offer quality in the care to users of the health system, providing comprehensive care, in a holistic way, respecting human life and the environment where this care is provided (4).

ICUs emerged in the 1950s, due to the need to care for patients in acute or critical condition, becoming traumatizing environments, due to the procedures performed there for an effective recovery of assisted patients (5). In these places, the patient who needs biomedical care, for the treatment of pathologies, and also psychological, that interfere with the process of the disease, spend most of the time alone. It is noteworthy, in this sense, that the physical environment and all the resources that the ICUs have are very important for patients, however, the most significant in this space is the human essence (6).

The act of touching, listening, watching the patient in a humanized way, understanding his fears and desires, among others, are actions that go far beyond procedures performed and medications administered, because humanized care is essential for quality care (6). Many point out that professionals think about all the processes carried out, but end up forgetting the main thing, which is humanization, pointing out the importance of communicating with the patient and the importance of this moment for the patient (7).

However, studies show that not only the patient who is hospitalized there needs humanized care, but also the family inserted in this context, because he is in a period of fragility, preventing a negative impact regarding the care of the team towards the patient (6). The family is considered a very important component, since, in the same way that the patient/family member, is with fears and longings in the face of the condition, the nurse should always seek to solve doubts, bring coherent and clear information, explaining the routines of the unit and, above all, passing the information of the clinical condition, seeking to welcome and treat in a holistic way(6).

Given this context, this study aims to: Know the perception of nursing professionals in the face of humanized care in intensive care units in a private hospital in 2021. In turn, it adopts as specific objectives: to describe the sociodemographic profile of professionals according to the speech answered in the questionnaire; to identify the main humanized care provided to patients in Intensive Care Units, from the discourses of the professionals; to identify the main difficulties faced in the assistance to provide humanized care.

The present study is justified, given that the theme is of great relevance to the nursing team, because they are the professionals who are most often exposed to direct care with patients who are in situations of greater dependence, fragility, insecurity and anguish. For this reason, it is believed that this study will contribute to the reflection of professionals who work in the ICU, providing better performance in the care provided to patients and thus contributing to greater social and professional performance.

## METODOLOGY

This is a cross-sectional study, with an exploratory descriptive design and a qualitative approach. To carry out this study, 15 nursing professionals were interviewed, seven nurses and eight nursing technicians who worked in a Private Hospital in Rio de Janeiro in 2021. The professionals were invited to participate in the research through an explanatory approach to the research, carried out by the main researcher, being clarified of the objectives of the study. After agreeing to participate voluntarily, they signed the Free and Informed Consent Form (TCLE). The study was approved by the Research Ethics Committee of the Adventist College of Bahia (FADBA), under CAE number 49337021.1.0000.0042 and opinion number 4,897,856.

The inclusion criteria used were: professionals who had from two months of experience and who worked in the ICU. As exclusion criteria: professionals on leave or on vacation during the period of data collection and professionals who did not work in care areas. It is important to remember that the professionals participating in the survey were assured about the right of withdrawal at any time of the study, if they so wished, however, the importance of their participation from the answers to the questionnaire was emphasized, always respecting their limitations and freedom of choice. They were assured: privacy, confidentiality and protection of the image, ensuring that the information collected will not bring harm to the community from the reading of the work, because the terms used in the format: Enf1, TecEnf1.

As risks, in this research there may be: discomfort due to the time spent filling out the questionnaire, omission of information related to the exposure of the data provided, the breach of the

reliability of the data and invasion of privacy. However, possible measures have been adopted so that such risks do not become real, ensuring the zeal for the confidentiality of information, ensuring that the data collected will be used only for the realization of this study and kept confidential, committing us not to publish the names of the participants, not even the initials or any other form of identification, as determined by Resolution of the National Health Council (CNS/MS) nº 466, of December 12, 2012 (8).

As benefits, the study does not bring direct benefit to the participant, however, it presents general benefit for all nursing professionals in relation to the look of humanized care to the critical patient. This collective benefit also extends to the scientific environment, since the study will provide greater visibility on the subject, enabling the implementation of preventive measures focused on the problem encountered.

The instrument used for data collection was a questionnaire, prepared by the researchers, obtaining guiding and pertinent questions to the participants, which were formulated with the purpose of knowing the perception of nursing professionals in the face of humanization. It was developed using Microsoft® Word software, in the case of a questionnaire with 13 questions, three of which are multiple choice and 10 discursive, with a filling time of approximately 20 minutes.

The questionnaire was divided into two parts, which are: the characterization of the participants, composed of multiple choice questions which were constituted by sex, marital status and training, within this category also had discursive questions about age, training time, working time in the institution and in the ICU; the second part of the questionnaire was related to the perception of nursing professionals, seeking answers about the concept of humanization, main humanized care provided, the main difficulties faced, the strategies used in the face of limitations, situations experienced understood as non-humanized and the humanized care for the family.

From the data collected through the answers obtained in the questionnaire, they were described and structured in pre-analysis, exploration of the material and treatment of the results. The method of content analysis was used for data analysis, which, according to Bardin (9), began by choosing the documents that were analyzed. In the case of the questionnaire answers, they have been transcribed and will constitute the corpus of the survey. This analysis was carried out in three phases, starting with the floating reading, soon after, we move on to the choice of indexes or categories, which arose from the guiding questions or hypotheses, and the organization of these into indicators or themes (9).

From the analysis, five thematic categories of the research were defined, being assigned from Records Units (UR) as shown in Table I.

Theme	Total UR	%UR	Category	Total UR	%UR
Humanization involves empathy, benevolence and being sociable.	7	9,6%	Humanization Concept	21	28,76%
Humanization related to actions that promote quality in care.	4	5,5%			
Humanization with a focus on patient well-being.	1	1,36%			
Humanization related to care.	9	12,32%			
Listen and talk as a humanized action.	17	23,28%	Actions that characterize humanized assistance	22	30,13%
Some functions restrict humanized assistance actions.	4	5,47%			
Perform change of decubitus.	1	1,36%			
The leadership as a difficulty in humanization	1	1,36%	Difficulties for Humanization	14	19,17%
Mechanism at work as a difficulty in humanization.	1	1,36%			
Time and demand as a difficulty in humanization.	5	6,84%			
Work overload as a difficulty for humanization.	5	6,84%			
Difficulty in requesting patient feeding as a difficulty for humanization.	1	1,36%			
The system as a difficulty for humanization.	1	1,36%			
Delay in service as non-humanized situations	2	2,73%	Non-Humanized Situations	4	5,47%
Rude attitudes on the part of the patient.	1	1,36%			
Breach of secrecy as non-humanized situations.	1	1,36%			
Provide comfort for the patient.	2	2,73%	Strategies for humanized assistance	12	16,43%
Know the patient and his family as strategies for humanization.	10	13,69%			

**Table I** - Definition of Categories from Registration Units.

**Source:** Results of this study.

## RESULTS AND DISCUSSION

### Participant Profile

According to survey data, 86.7% of respondents were female and the highest frequency age was

26 years (21.4%), and in the total sample it ranged from 25 to 39 years. It is noteworthy that 66.7% declared themselves single.

## Qualitative analysis of the data

After the analysis of the discourses of Nursing professionals, the answers were classified into five categories, namely: the concept of humanization, the actions that characterize a humanized care, the difficulties encountered to perform a humanized care, situations experienced categorized as non-humanized and strategies for a humanized care.

After the exhaustive reading and based on the theoretical framework, the following categories that emerged from the analyses are discussed.

### Category-01: Humanization concept

In this category, nursing professionals reported that there are different interpretations and understandings about the concept of humanization. Empathy is highlighted, that is, and put in the other's shoes, seeking to understand their weaknesses, needs, thoughts and perform a care based on their needs. The interviewees, in their speeches, point out these aspects as basic requirements for humanized assistance. In the reports, the respondents highlighted:

*I understand that being human is to have empathy, to put yourself in the other's shoes, to watch how you would like to be watched. (Enf 3)*

*Humanization is a differentiated look of the patient as a whole. (Enf6)*

When talking about empathy, one automatically thinks about humanization, due to the fact that when the individual seeks to put himself in the other's shoes, it is easier to understand him and act according to the expected expectations. This allows a connection of values and conceptions<sup>(10)</sup>.

However, the difficulty of transmitting empathy for limitations or even personal reasons can contribute unfairly to the relationship between professional and patient, causing unworthy and disrespectful assistance. This situation can bring suffering and anguish to the professional or even compromise his posture, precipitating attitudes that impair the patient's autonomy<sup>(11)</sup>.

It is worth mentioning that, by putting yourself in the patient's shoes, we seek to perform care in the way you would like to receive it, however, this action can cause the occurrence of several problems, due to the fact that there are several cultural differences that can make this action

impossible. This is because what can serve as a positive reference in the care for the professional, in the perception of the patient can be understood as inhuman or even offensive (11). However, being empathetic should not be considered as a natural gift, but as a skill to be developed and achieved (11).

Other participants pointed out that to humanize is to take care in a holistic way, seeking to understand the patient in an integral way, through a specific care for each subject.

*It is a differentiated look at the patient welcoming as a whole and offering better conditions in the patient's rehabilitation. (Enf 4).*

*Any action aimed at the integral care of the individual, respecting his culture, morals, integrity, level of consent. (Enf 5).*

*Look at the patient as a unique being and focus on their needs individually, understanding their perceptions, feelings and expectations. (TecEnf 7).*

For a humanized assistance with users who need care in the health system, active professionals need to put themselves in the shoes of the patients they are attending, seeking to be sensitive to listen to their needs, reflecting on the way they would like to be treated, causing many attitudes to be abolished because they are not consistent with humanized holistic care (12).

For Chernicharo, Silva and Ferreira (10), holistic vision is understood as a way to identify the needs of the other and meet them, maintaining the vision of the individual as a whole.

## Category-02: Actions that characterize humanized assistance

In this category, the actions that characterize a humanized care, by nursing professionals, are related to a humanized care for the patient, being them: demonstrate attention, listen, perform their hygiene preserving parts of the body, call it by name, perform change of decubitus. They point to these actions as a means of the patient's trust with them and means of dignified care for every human being:

*Attention to the patient in their hygiene preferences, preserving their body during hygiene. (Enf 4).*

*The main care provided was to listen, to care about the patient, seeing him as a human being who has his dimensions. (Enf1).*

*Pay attention to the complaints and doubts they have; call by your preferred name or surname. (TecEnf 3).*



Demonstrating attention and listening are concepts of humanization and welcoming and for this it is necessary that there is an openness of the professional, moving with the history of the patient, understanding his need to dialogue, demonstrating a commitment far beyond the technique (11).

It is also understood that humanization does not only encompass the patient, but also the family that is inserted in the same context of fragility, dependence and care of the team:

*Whenever I come into contact with a family member of patients, her fragility is evident, she is valued, for example, I have already found myself in situations of offering psychological support to the family member, when I realized that my support was not enough, I sought a psychology professional to give better support. (Enf 3).*

*[...]Passing on to him all the care that is given to his family, the good conversations we have and how he spent the day. With this, the family member leaves the place feeling well. (TecEnf 1).*

The family, as well as the patient, has fears, longings, uncertainties, in the face of the delicate moment they are living. The nurse, in turn, has the duty to comfort and support this family, carrying out the appropriate guidelines, updating the patient's health status, explaining the routine of the unit, actions that will make the family members feel supported in the process of illness, treatment and rehabilitation, making it safer that the person hospitalized there will receive quality care (6). It is worth mentioning that it is important that, when the family member enters a complex environment such as the ICU, he is welcomed and received with a respectful treatment by the professionals who are there. This treatment will strengthen ties, making a scary and stressor environment in a welcoming place (12).

In addition, as mentioned above, the family identifies the welcome as an essential piece to meet their needs, in addition to feeling supported by the team at the moment of fragility, having support and attention, even if at the moment the past information is not a desired information (13-12).

From this, the reception allows the strengthening of ties, creating a closer relationship between the professionals and the family, being necessary that this practice is constant, so that the focus does not become only the disease, this practice being indescribable within the ICU (13). However, not all professionals can contact the patient's family member, to provide humanized care, because of the demands of the sector:

*Not always, therefore, there are some functions that restrict this contact. (Enf6).*

*Few times I can speak [...]), during the visit I talk to some specific relatives, but with the demands of the sector, it is difficult to pay attention to everyone. (Enf 2).*

Studies show that, when thinking about humanization, one should think about humanized care



for the patient and his family. It is important that professionals are fully aware of this, however, often this assistance is not carried out because they are overloaded, leading them to perform mechanistic care and, consequently, causing a distance between the professional and the family of the hospitalized patient (14).

Due to this distancing, nursing professionals end up becoming forgotten for family members, although they are contributing in a timely manner to the care and rehabilitation of the patient (15). Because of his absence at the time of the visit, many families are unaware of the role of this category in health care, mentioning the doctor frequently, presenting him as the main member of the team, making him the main responsible for rehabilitation for having a more direct contact with families at the time of the visit (15).

From this, the need for greater involvement of the nursing team with the families of hospitalized patients is identified, presenting the importance of their function for carrying out care. It was noticed that families cannot spontaneously detect the care provided by nursing, and for this to happen professionals must know how to deal with work tasks and manage communication with family members (15).

However, it is not enough to think about humanization with a focus only on the patient and the family. It is also necessary to think about the professionals who are responsible for performing this care, because if they do not feel humanized, valued, motivated, it will be impossible to feel protagonists of this process within the ICU (14).

### Category-03: Difficulties for humanization

In this category, most of the professionals interviewed pointed out the difficulties of providing humanized care for patients. In their perception, what leads to dehumanized care are: the demands of the sector, the number of professionals, structural difficulties and the accumulation of functions. Respondents point out these aspects in their speeches:

*The demand of the sector without a doubt and the lack of professionals is a very big barrier, because it takes a lot of time and this sometimes prevents us from giving full assistance. (Enf 5).*

*Because it does not have a satisfactory number of employees, the service becomes busy. (TecEnf 3).*

*Structural difficulties, accumulation of functions (overload)). (Enf 3).*

According to Calegari, Massarollo and Santos (11), work overload is a factor that hinders the practice of humanization, because it prevents the dedication of professionals to patients. Nurses end up being forced to solve demands of the sector, paying more attention to the demands than by providing care according to the patient's need, or even a non-service of this need. However, it is emphasized that this hinders dedication, but does not incur negligence or lack of assistance, because the necessary care remains.

The overload is also related to the amount of the number of nursing professionals for the number of patients, causing an increase in the risk for the increase in hospital infections in hospitalized patients, related to the non-adherence of hand hygiene practices; to the increase in openings of injuries, related to the failure to make changes in decubitus; the increase in falls and other adverse events in Consequently, this risk, if it is realized, increases the days of hospitalization (16).

The overload is also considered an obstacle to education actions, making it difficult to be available and participating in training, highlighting the need for the proper dimensioning of this professional category (16). In addition, it is important to point out that nursing professionals do not only have the function of hospitalized patient care, because they also have the responsibility to train and train their team, manage all the inputs and matters in the sector, articulate with other professionals of the multidisciplinary team and administration, and it is up to him to guide patients and the family. All this in search of promoting multi-management for the benefit of the patient (16).

Therefore, the overload of nursing professionals should be understood as a consequence of many factors and it is up to the human resources managers together with the nursing coordinators to diagnose this problem, promoting the development of strategies at various levels to solve this situation when detected, so that there is humanization towards professionals and consequently for patients, also reducing related adverse events (16).

## Category-04: Non-humanized situations

In this category, the professionals interviewed reported some non-humanized situations. Among them, the ones that stood out the most were: carelessness with the aesthetics of the patient, non-humanized procedure and patient without care for a long time. The interviewees in their speeches point out:

*Patient discovered, dirty with blood and wet sheet. (TecEnf 8).*

*Performing a bath in the bed, where two professionals performed inappropriate comments to the patient. (Enf 2).*

*Patient without care or assistance for more than 6 hours. (Enf 7).*

Hospitalizations in an environment such as the ICU can generate discomfort and, especially, loss of the patient's privacy, whose autonomy and possibilities of choices are lost, because they have no way to express or even decide, causing the patient to drift from the professionals who are there to perform care <sup>(17)</sup>. Nursing is known as the art of caring, however, the complexity of patients and units has transformed many nursing professionals, causing them to stop providing humanized care <sup>(18)</sup>. With this, concerns arise regarding humanized nursing care within the ICU, because the care model ended up taking this proportion, and has left something to be desired regarding the humanization offered in care <sup>(19)</sup>.

## Category-05: Strategies for humanized assistance

In this category, nursing professionals use strategies in the face of the limitations found to provide humanized care. In the reports, the ones that stood out the most in the speeches of the professionals were: knowing the patient and his history and being available to the patient and the family.

*Treat patients by name and remember their history outside the hospital. (Enf 2).*

*Even in the rush of everyday life I try to give the maximum attention [...] so that you feel welcomed. (TecEnf 3).*

*I always introduce myself to the patient and the family, I show myself present for any questions or care. (Enf 7).*

Nursing professionals still encounter numerous difficulties, especially with regard to the reception and the relationship with the family, because it is a relevant issue because it influences the recovery of the patient admitted to the ICU <sup>(19)</sup>. However, for this reception to happen, it is necessary for nursing professionals to invest time and actions of care, interest, showing sensitivity to the patient and his family, listening to their complaints, identifying concerns, anxieties and fear, causing a relationship based on empathy, favoring a relationship of trust between professionals, patient and family <sup>(18-20)</sup>.

## FINAL CONSIDERATIONS

From this study, it was possible to know the perception of ICU nursing professionals about the humanized care provided to hospitalized patients, providing information about the profile, the main care performed and the difficulties faced by such professionals to provide humanized care.

In this way, it is understood that the demands of the sector, the number of professionals, structural difficulties and the accumulation of functions can become a predisposing risk for the realization of dehumanized care. For this reason, the present study is of great value to the field of knowledge, because it brought reflections in relation to the factors presented and evaluated, leading to the understanding of the beginning of the problem and to think about viable and effective strategies for the improvement of the quality of care provided by the population studied.

However, the present study presents some limitations for the application of the research, which were related to the number of professionals achieved, the difficulties in the answers, because many were short and succinct and the lack of time of the professionals to respond during the shift, causing many to take the material home and, consequently, forget to return it answered or even missing the questionnaire. However, these limitations found did not devalue the results obtained and the achievement of the proposed objectives. Therefore, it is of great value to carry out more in-depth research on the subject, since the study itself shows as a relevant subsidy for future studies.

## REFERENCES

1. Magalhães, SGS; Silva, JSLG. O Cuidado Humanizado na Unidade de Terapia Intensiva Neonatal. *Revista Pró-UniverSUS*. 2019 Jan-Jun.; 10 (1): 129-132.
2. Rodrigues YSRS, Santana RPSP, Pinheiro CPO. Humanização na Unidade de Terapia Intensiva Adulta. *CORPVS*. 2019; 1(1):9-24.
3. Dias DM, Barreto JC, Silva JHR, Barbosa CES, Santos WABV, Morais MGC, *et al.* Humanização do cuidado na unidade de terapia intensiva: revisão integrativa da literatura. *Pes Soci Desen*. 2022; 11(4):e53911427852.
4. Ministério da Saúde (Brasil), Secretaria de Atenção a Saúde, Departamento de Saúde Básica. Política Nacional de Humanização. MS. 2010; 1(1):1-247.
5. Silva FD, Chernicharo IM, Silva RC, Ferreira MA. Discursos de enfermeiros sobre humanização na Unidade de Terapia Intensiva. *Esc Anna Nery*. 2012 out - dez; 16 (4):719- 727
6. Ouchi JD, Lupo APR, Alves BO, Andrade RV, Fogaça BM. O papel do enfermeiro na unidade de terapia intensiva diante de novas tecnologias em saúde. *Saúde em Foco*. 2018; 10: 412-428, 2018.

7. Evangelista VC, Domingos TS, Siqueira FPC, Braga EM. Equipe multiprofissional de terapia intensiva: humanização e fragmentação do processo de trabalho. *Rev Bras Enfer.* 2016; 69(6): 1099-1107.
8. Guerriero LCZ. A resolução 510/16: diretrizes éticas para pesquisas em Ciências Humanas e Sociais. *Cad Bras Ter Ocup.* 2016; 24(3): 429-433.
9. Bardin L. *Análise de conteúdo.* 4. ed. Lisboa: Edições 70; 2011.
10. Chernicharo ÍM, Silva FD, Ferreira MA. Caracterização do termo humanização no cuidado por profissionais de enfermagem. *Esc Anna Nery.* 2014; 18(1):156-162.
11. Calegari RC, Massarollo MCKB, Santos MJ. Humanização da assistência à saúde na percepção de enfermeiros e médicos de um hospital privado. *Rev Esc Enfer USP.* 2015; 49(Esp2): 42-47.
12. Luiz FF, Caregnato RCA, Costa MR. Humanização na Terapia Intensiva: percepção do familiar e do profissional de saúde. *Rev Bras Enfer.* 2017; 70(5): 1095-1103.
13. Passos SSS, Silva JO, Santana VS, Santos VMN, Pereira A, Santos LM. O acolhimento no cuidado à família numa unidade de terapia intensiva. *Rev Enfer UERJ.* 2015; 23(3): 368-374.
14. Ribeiro KR A, Borgues SP, Baldunino JAS, Silva FA, Ramos TMST. Dificuldades encontradas pela enfermagem para implementar a humanização na unidade de terapia intensiva. *Rev Enfer UFPI.* 2017; 6(2): 51-56.
15. Araújo EJM, Ponte KMA, Araújo LM, Farias MS. Satisfação dos familiares com a humanização da assistência em UTI. *Rev Poli Publ.* 2019; 18(1):6-11.
16. Novaretti MCZ, Santos EV, Quitério LM, Daud-Gallotti RM. Sobrecarga de trabalho da Enfermagem e incidentes e eventos adversos em pacientes internados em UTI. *Rev Bras Enfer.* 2014; 67(5): 692-699.
17. Souza PTL, Ferreira JÁ, Oliveira ECS, Lima NBA, Cabral, JR, Oliveira RC. Necessidades humanas básicas em terapia intensiva. *Rev Fun Care Online.* 2019 jul/set; 11(4): 1011-1016. DOI: <http://dx.doi.org/10.9789/2175-5361.2019.v11i4.1011-1016>.
18. FIGUEIREDO, Maria do Carmo Clemente Marques et al. Cuidado humanizado ao paciente crítico: uma revisão integrativa. *Rev Saú Cien.* 2018; 7(1): 94-101.
19. Nascimento EA, Lima LNF, Pereira CS, Fonseca SCT, Silva DO, Neves AF, et al. As dificuldades da equipe de enfermagem frente à assistência humanizada na unidade de terapia intensiva. *BJDV.* 2021; 7(2): 17262-17272.
20. Mercês MO, Carvalho BF, Silva DR, Passos SC. O acolhimento da família na unidade de terapia intensiva. *Rev Enfer Contem.* 2019; 8(2): 182-189.