ISSN 1695-6141
Revista electrónica trimestral de Enfermería
Nº47
Julio 2017
www.um.es/eglobal/

ORIGINALES

Life stories and photographs of sedated patients in the ICU: a possible humanization strategy?

Relatos de vida e fotografia de pacientes sedados em UTI: estratégia de humanização possível?

Relatos de vida y fotografía de pacientes sedados en UCI: ¿estrategia de humanización posible?

Cristina Aparecida Pereira da Silva Ribeiro[1]
Monica Martins Trovo[2]
Ana Cláudia Puggina[2]

[1]Registered Nurse. MSc from UNG. Professor of the Nursing graduation course of São Francisco University, Bragança Paulista (SP).Brazil.
[2] Registered Nurses. PhDs in Sciences. Professors of the Nursing Post-graduate Program of UNG, Guarulhos (SP). Brazil.

E-mail: crisapsribeiro@hotmail.com

http://dx.doi.org/10.6018/eglobal.16.3.257291

Received: 28/04/2016
Accepted: 08/08/2016

ABSTRACT:

Aims: (1) To identify the influence of the contextualization of sedated patient, by means of life reports and photographs, from the perception of care of the nursing team and (2) to evaluate the proposed intervention as a strategy for humanization in the care for sedated patients.

Method: Qualitative intervention study, with 43 professionals of the nursing team of an Intensive Care Unit. Data collection consisted of a prior interview, the intervention (fixing of pictures and life reports of sedated patients to the bedside and orientation for the professionals to read them, with the intervention lasting 10 days) and a post-intervention interview. Three frames were fixed and these contained a photograph and life reports of the patients collected through their family members.

Results: In the pre-intervention, the discourses showed that verbal interaction provides more security during the care, there are reasons for preferring to care for unconscious patients, such as the challenge of the complexity and the reward with recovery, as well as the unavailability to attend to frequent requests of the conscious patient. The care was valorized independent of the level of consciousness, knowledge about aspects of the patient's life increased involvement and there was a concern not to judge the patient and to rescue the best of the other. In the post-intervention, it was observed that the contextualization of the patient rescued important elements for the care, such as emotion promoting sensitization, the awakening of empathy with the contextualization, and the involvement and commitment to the care. In addition, a conflict between change of attitude and being defensive was apparent.

Conclusion: The proposed intervention was validated as a strategy for humanization in the care for sedated patients.

Keywords: Intensive Care; Nursing; Nonverbal Communication; Humanization of Assistance.

RESUMO:

Objetivos: (1) Identificar a influência da contextualização do paciente sedado por meio de relatos de vida e fotografia na percepção do cuidar da equipe de enfermagem e (2) avaliar a intervenção proposta como uma estratégia de humanização para o cuidado ao paciente sedado.
Método: Pesquisa qualitativa e de intervenção com 43 profissionais da equipe de enfermagem de uma Unidade de Terapia Intensiva. A coleta de dados consistiu de uma entrevista prévia, intervenção (fixação de quadros de pacientes sedados à beira do leito e orientação para que os profissionais os lessem; a intervenção teve duração de 10 dias) e entrevista pós-intervenção. Três quadros foram fixados e estes continham fotografia e relatos de vida dos pacientes levantados por meio de seus familiares.
Resultados: Na pré-intervenção, os discursos mostraram que a interação verbal traz mais segurança durante o cuidado, há razões para preferência do cuidar de pacientes inconscientes, como o desafio da complexidade e a recompensa da recuperação, como a indisponibilidade para atender solicitações frequentes do paciente, o cuidado é valorizado independentemente do nível de consciência, conhecimento sobre aspectos da vida do paciente melhora o envolvimento e há uma preocupação de não julgar o paciente e resgatar o melhor do outro. Na pós-intervenção constatou-se que a contextualização do paciente resgatou elementos importantes para o cuidar, como a emoção promovendo sensibilização, o despertar da empatia com a contextualização, o envolvimento e o compromisso com o cuidado, além disso foi aparente um conflito entre mudar de atitude e sair da defensiva.
Conclusão: A intervenção proposta foi validada como estratégia para humanização no cuidado de pacientes sedados.

Descritores: Terapia Intensiva; Enfermagem; Comunicação não Verbal; Humanização da Assistência.

RESUMEN:

Objetivos: (1) Identificar la influencia del contexto del paciente sedado a través de las historias de vida y fotografía en la percepción del cuidar del personal de enfermería y (2) evaluar la intervención que se propone como una estrategia de humanización para cuidar al paciente sedado.
Método: Investigación cualitativa de intervención con 43 profesionales del equipo de enfermería de una Unidad de Cuidados Intensivos. La colecta de datos consistió en una entrevista previa, la intervención (fijación de los cuadros de los pacientes sedados en la cabecera y orientación para que los profesionales los leyesen; la intervención duró 10 días) y entrevista posterior a la intervención. Tres cuadros fueron fijados, que contenían las fotos y las historias de vida de los pacientes planteadas por sus familias.
Resultados: En la pre-intervención, los discursos mostraron que la interacción verbal aporta una mayor seguridad durante el cuidado, hay razones para la preferencia del cuidado de los pacientes inconscientes, como el reto de la complejidad y la recompensa de la recuperación, como la no disponibilidad para cumplir con las solicitudes frecuentesdel paciente, la atención se valora independientemente del nivel de conciencia, el conocimiento sobre los aspectos de la vida del paciente mejora el compromiso y existe la preocupación de no juzgar al paciente y rescatar lo mejor del otro. En la post-intervención se encontró que el contexto del paciente rescató elementos importantes para el cuidado como la emoción, promoviendo sensibilidad, el despertar de la empatía con la contextualización, la implicación y el compromiso con el cuidado, por otra parte era evidente el conflicto entre el cambio actitud y salir a la defensiva.
Conclusión: La intervención propuesta ha sido validado como una estrategia para humanizar la atención de los pacientes sedados.

Palabras Clave: Cuidados Críticos; Enfermería; Comunicación no Verbal; Humanización de la Atención.

INTRODUCTION

The National Humanization Policy (NHP) was created in 2004 by the Ministry of Health and, since it was proposed, care must be taken not to trivialize the theme, since initiatives are generally vague and associated with humanitarian, philanthropic, voluntary attitudes that reveal kindness and not the right to health inherent to the citizen. Furthermore, the target of the NHP is not just the user, with health professionals and managers also needing to be considered in this process[1].

The NHP presents a set of transversal guidelines that direct all institutional activity involving users or health professionals, in any instance of implementation[1]. The expected result is the valorization of people in all practices of care and management, with the integration, commitment and responsibility of all for the common good.

The humanization of healthcare presupposes considering the essence of the person, respect for individuality and the need to construct concrete spaces in the health institutions that legitimize the human essence of the people involved. Humanized care implies, on the part of the caregiver, the comprehension of the meaning of life, the capacity to perceive and comprehend oneself and the other[2].

Considering the complexity of the theme, humanizing care in the Intensive Care Unit (ICU) is a great challenge and means caring for the patients in their entirety, considering their personal, family and social context. For this, the active practice of the nursing team and the use of interpersonal communication as an instrument for care are fundamental. In this sense, humanized care is performed with simple actions, based on verbal and non-verbal communication[3]. Good interpersonal relationships between the nursing team, the patient, and their family members should be associated with advanced critical care technology to ensure quality care from an ethical, psychosocial and spiritual point of view.

Mainly because of the altered level of consciousness of sedated patients, humanized care in ICUs has been the subject of discussions by specialists. Based on the assumption that health care should consider the essence of the person, respect for the individuality and the people involved in this process, the nurse needs to evaluate the physical, mental, psychic, social, cultural and spiritual state of sedated patients and that of their family nucleus, in order to focus on the recovery and promotion of the health[4].

Proposals for action for the humanization of the patient sedated in the ICU are necessary, essential and often simple. Examples include addressing the patient by name, placing identifications at the bedside, at the foot of the bed or near the entrance of the room; explaining the procedures that will be performed in advance regardless of the patient's level of consciousness; paying attention to the nonverbal signals emitted by the patients and developing the perception of when something pleases or bothers them; preserving the privacy and confidence of the patients by avoiding personal comments in the unit or in the elevators about them or others; using an appropriate tone of voice to question the patients about their intimate aspects; taking care not to invade the patient's space without asking for permission; and always looking into the eyes before beginning a conversation or procedure[5].

However, with no change of attitude in the relationship with the other, it is impossible to humanize care. The professionals needs to be aware of the words they use in the conversations, to pay attention to the other, listen to what the patients say without letting their thoughts wander, greet them with a smile or shake hands and perceive the feelings and needs of the patient. In addition, it is also necessary to increase the perception for all dimensions of care: the patients, the family members and the team, in their biological, emotional, spiritual and social aspects[5].

The humanization strategy proposed in this study refers to the action of contextualizing the sedated patient, using photographs and life reports made available by the family of

the patient. Its purpose is to improve the quality of the interpersonal relationship, through the strengthening of the bond with the professional that performs the care.

The photograph has the power to impress, move, disturb and provoke different feelings. It is a message that processes through time, the constituent units of which are cultural, with it assuming functions with different meanings, according to both the context in which the message is conveyed and the non-verbal languages exposed and recorded[6]. Through the photograph there is a visual memory that is thought and felt, collectively or individually, historically constructed in a context. It is perceived as a message composed by systems of nonverbal signals, socially and individually understood through codes, the interpretation of which makes the analysis of certain socially determined actions and human relationships possible[7-8].

Through life reports, a group or an individual can be characterized, bringing to the fore the values, definitions and attitudes of the group and of the context to which the individual belongs[9]. Life reports show the temporality of the cultural and social relationships; that is, they historically construct the way of life and relationships established, providing the possibility to understand the experience and context of the individual. They allow the discovery, exploration and evaluation of how people understand their past, link their individual experience to their social context, interpret it and give it meaning[10].

AIMS

1- To identify the influence of the contextualization of the sedated patient on the perception of the care of the nursing team.

2- To evaluate the proposed intervention as a humanization strategy for the care to the sedated patient.

METHOD

This a qualitative intervention study. The study was carried out with the nursing team of a General Adult ICU, in a public hospital in the state of São Paulo. The ICU has 16 beds and the population is made up of 43 nursing professionals: 20 nursing assistants, 13 nursing technicians and 10 nurses.

Only the nursing team was studied, as the length of time spent with the patient, the type of care and the formation of the bond are biases that can be considered in the analysis of the results.

The criteria for the inclusion of the nursing professionals in the study were: to be a nurse, nursing technician or nursing assistant of the selected ICU and to be directly caring or have already provided care at least once for a patient included in the study.

After approval of the research project by the Research Ethics Committee (authorization number 663.343/2014), the professionals were individually recruited to participate in the study during moments of their workday in which they were available or making their notes. The research objectives were presented and, after signing the consent form, the participant was asked about the best moment to perform an interview, with the researcher remaining available.

The data collection consisted of a prior interview, the intervention and a post-intervention interview. The data collection period was from July to August 2014.

First, the professionals responded to the pre-intervention interview. These were recorded and contained questioned about the gender, age, profession, education, and religion of the participant, as well as three questions: Do you prefer to take care of conscious or unconscious patients? Why? Do you think that knowing about the lives of sedated patients would change your way of caring?

After all the participants were interviewed, the intervention began. This consisted of fixing frames at the bedside of the sedated patients and guidance for the professionals to read them. Three frames for each patient were designed in this study. The frames contained a photograph and life reports of the patients collected through their family members. The criterion of the choice of family member was made by means of a genogram. The aim of the use of the genogram was to identify the family member with a stronger bond with the patient, trying to avoid any type of undue exposure or embarrassment for the sedated patient.

The family member was asked to choose a current photo of the patient, framing half the body, doing something they liked or in a moment of happiness. Pictures framed close to the face or from a great distance were not considered, as they made it difficult to view the subject properly in the given context. The family sent the photo by e-mail to the researcher. Thus, in possession of the photo, a picture was elaborated with this, followed by information about the patient and the daily life, including the name, education, outstanding characteristics, religion, profession, hobbies, musical taste and a moment of happiness.

The inclusion criteria for the patients were: to be in deep sedation (Ramsay Sedation Scale 5 or 6), with no prospect of a change in the sedation pattern within the following few days, so that the frames could remain fixed for at least 48 hours, giving the team time to see them; and to be aged 18 years or older, due to the use of the photograph in the study.

At a 10-day interval, the sedated patients were included in the study or had their pictures removed. This period was chosen so that professionals had the opportunity to visualize some pictures and get used to the intervention. As this study assessed the perception about care, time was needed so that this could be modified and/or incorporated.

After the intervention, a structured post-intervention interview was conducted with the nursing team participants, and two questions were asked, the responses to which were recorded: What feelings came up when you saw the frames with the life reports and photographs of the patients? Has knowing something about the lives of the sedated patients changed your way of caring for them? The responses were transcribed in full and analyzed according to the methodological framework of Content Analysis[11].

RESULTS

A total of 43 professionals from the nursing team participated, with a mean age of 33.33 (±7.3) years. However, in the post-intervention phase, 5 (11.63%) participants did not respond to the interview due to vacation, resignation, medical leave or sector transfer.

The majority of the professionals were female (n=32; 74.42%), with technical education (n=24; 55.81%) and of the Catholic religion (n=27; 62.79%). Concerning marital status, the majority were married (n=21; 48.84%). With regard to the professional category, the majority were nursing assistants (n=20; 46.51%), followed by nursing technicians (n=13; 30.23%) and nurses (n=10; 23.26%).

Pre-intervention categories

Through the analysis of the pre-intervention discourse of the participants, five thematic categories and two subcategories were identified (Figure 1).

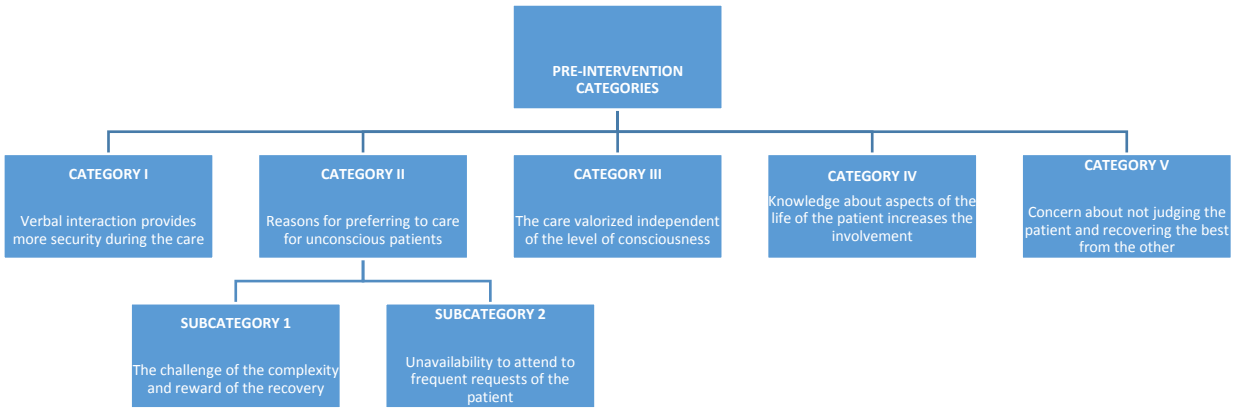

Figure 1 - Thematic categories found in the pre-intervention interview. Guarulhos, 2014.

Category I - Verbal interaction provides more security during the care

This category evidenced the verbal expression of the conscious patient as a facilitator of the relationship and predictive for the care, because, in this situation, the professional has the opportunity to get to know the patient better, obtain feedback about the care provided and be more assertive.

"Conscious, conscious, conscious because we have contact and can converse with him, is he feeling better, what he is expecting from the treatment, we can tell him ... why he is in the ICU, we can clarify why he is here, how many days he'll stay, how likely recovery is for him..." (professional No. 1).

"Conscious, because they are aware, we can analyze, verify their real needs, to provide better care, quality in the care" (professional No. 10).

"The conscious patient helps more, we know what he has, understand? If he is in pain, we know what to do" (professional No. 12).

Category II - Reasons for preferring to care for unconscious patients

Subcategory 1 - The challenge of the complexity and reward in the recovery

In this subcategory the preference of the nursing professional to care for unconscious patients arises from the satisfaction with the monitoring of the patient's recovery and the complexity involved in this care. The recovery of the sedated patient provides a recognition of the work of the professional.

"Unconscious. Because I do not know how to say, I prefer unconscious patients because I think it's more complex, you have to perceive more ... more in depth, you try to discover pain, these things... you perceive more... I prefer it... because of the complexity" (professional No. 5).

I prefer to take care of unconscious patients, it is already a habit here in the ICU, I like to monitor the evolution of the condition, so when he comes in unconscious for me, in most cases they leave here conscious. It is gratifying for me" (professional No. 11).

"Ah! I prefer to take care of the unconscious patient, I like it because it is very beautiful! Very beautiful! When he becomes conscious again, seeing him leaving the bed and go away, understand? It is very gratifying for me" (professional No. 31).

Subcategory 2 - Unavailability to attend to frequent requests of the patient

This subcategory denotes the dissatisfaction and discomfort of the participating professionals with frequent requests, complaints and participation of the patients in their own care. These reports diverge from the ethical and professional responsibility of nursing, however, there is often an inadequate number of professionals in the ICU and a overload in the work, both physical and emotional, of the nursing team.

"Ah ... [pause] *unconscious to be honest... [pause] Ah, because, just because it's easier to manipulate them, understand? In my opinion, it's that... they don't keep calling you all the time... [pause]. In my opinion it's this" (professional No. 2).*

"Oh! Generally here in the ICU we end up getting used to the patient... [stuttering] unconscious right, because it actually takes little time, they give more work in terms of preparing the drug, these things, but once you medicate them... do all the care that has to be done, protect the patient from ulcers, these things, then it's finished. He will not keep saying, 'oh I want water', 'oh come here, it hurts here'! Understand? It's like that" (professional No. 14).

"It's.... [pause] in fact, I do not have a preference, I am in this profession to promote care, so I do not have a preference, I like both because the patient when he is sedated, is.... [pause], he does not have, a... [pause], he doesn't try to interfere with the service, these things, but I don't have any preference" (professional No. 41).

Category III – The care valorized independent of the level of consciousness

In this category the interviewees reported that the state of consciousness of the patients was not important, what really mattered was the care. The nursing professionals reported pleasure and affection in providing the care to the patients, important elements for humanized care.

"I like to take care of both types of patients because in an ICU I exist with the two moments, the first moment that he is unconscious and the second moment conscious, so I think the two moments are very important, so I value them both" (professional No. 20).

"Ah! I like what I do so I do not have any preference, I provide care and I try to take the best care of both types, I have no preference" (professional No. 22).

"Look... I take care of both with the same affection, so I do not have a specific choice, for me it doesn't matter! The care and affection will be the same" (professional No.23).

Category IV - Knowledge about aspects of the life of the patient increases the involvement

In this category, the professional reports greater involvement in the care provided when knowing positive aspects of the patient's life. Knowing the other involves the insertion of that person into the memory and consciousness of a person; thus, the statements of the participants indicate that once the professional knows some aspects of the patient's life, involvement becomes easier.

"I think so... Yes, because this gives more... [pause] I think that... [pause] more involved in the... [pause] you tell stories of life... You get more involved... [pause] to take care of the patient, you understand? Most of the time you do not know anything at all, if you just do what you have to do and that's it, understand? But... I think so" (professional No. 2).

"Yes, because... [pause] it seems that it isn't, but it is, sometimes the reason is even cultural, is of the patient, the lifestyle, it impacts directly and indirectly in the care" (professional No. 10).

"Yes, of course it helps. Clearly, [pause] the more you know the patient the better you can take care of him" (professional No. 13).

Category V - Concern about not judging the patient and rescuing the best of the other

The discourses of the participants in this category show that regardless of knowing aspects of the patient's life, that may be positive or not, the care provided would be the same. However, the concern with not judging the patient is denoted between the lines.

"No, I would not change because regardless of what he was or did, or what happened to him for him to be here, it would not change my care. I'm indifferent... We have to treat everyone here the same" (professional No. 6).

... from the moment the person is here, he is cared for like any other person, regardless of religion, color, sex, or anything. It's indifferent, it may be an ex-convict, or a prisoner, he's here for us to take care of. So, we go into the health area ... I already have knowledge of this, that we would have to take care of the person himself, the client himself, regardless of what he was out there or what he is out there (professional No. 17).

"I don't think so, I think... [pause], regardless of the life history of each one, my care will always be the same, so for the good of the patient, I would not change" (professional No. 26).

Post-intervention categories

After the intervention, three thematic categories and two subcategories were identified (Figure 2).

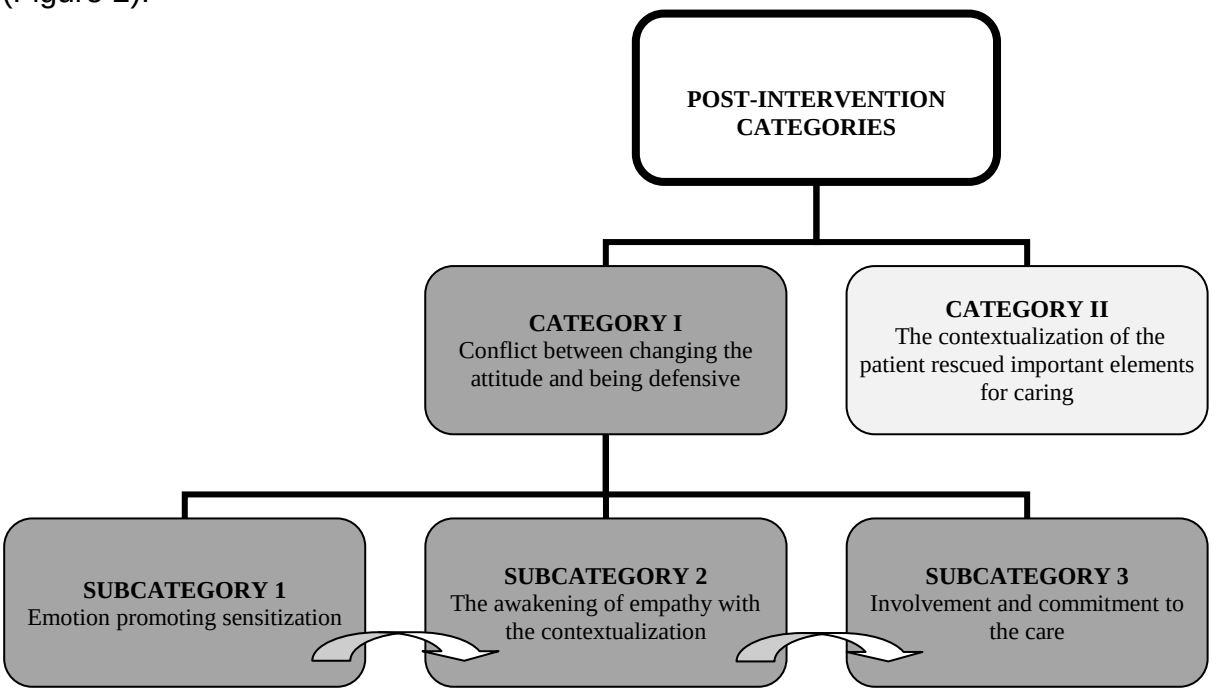

Figure 2 - Thematic categories found in the post-intervention interview. Guarulhos, 2014.

Category I - The contextualization of the patient rescued important elements for the care

This category shows that after the intervention of exposure to the photograph and life reports the professionals mentioned fundamental aspects for the care: emotion, empathy and strengthening of the bond with the patient. This denotes the rescue of the basic elements for humanized care, involving feelings in doing and promoting greater sensitization of the nursing collaborator, increasing the commitment and involvement with the care for sedated patients.

Subcategory 1 - Emotion promoting sensitization

It was possible to perceive that after the intervention the professionals were sensitized, expressing several types of emotion when responding to the interview, such as compassion and affection.

"Ah! Very emotional! Very nice to know that our work is rewarding, right? And that can help the healing of those who come here" (professional No. 3).

"I think it made us more sensitive, not that I am not, but as you have the day to day habit, how can I put it, you think of that person, the active life he had before he got sick, and that makes us more sensitive and helps in the care, yes, positively" (professional No. 11).

"A moment of sensitivity, I think we got closer ... it somehow touched the human and was less technical" (professional No. 13).

Subcategory 2 - The awakening of empathy with the contextualization

This subcategory shows that the previously described sensitization of the professionals allowed the awakening of empathy, with reports of a greater understanding of the other, putting themselves in the place of the patient and the family members.

"What kind of feeling? Ah! Very sad because I put myself in the place of the family members, especially those of bed 12, I do not know if you saw that his wife is pregnant with twins, it was very sad to see... (professional No. 15).

"Ah! It's a great pity, right? A pity, we put ourselves in his place and see that out of here he has a life, a family, has a life out there, right? It gives a lot of pain..." (professional No. 34).

"Ah yes, it changes because you start to respect even more, [stuttering] the patient as a human being, right? So the view, it shakes you up, makes you think, not to act in that mechanical way that sometimes we end up doing. That's it!" (professional No. 10).

Subcategory 3 – The involvement and commitment to the care

The participants reported improved commitment, individualization and motivation in the care after the intervention and consequent sensitization and awakening of empathy. This strengthening of the commitment and greater involvement allows the development of strong bonds with those being cared for, as the following statements exemplify.

"Ah! It improved a lot more, so [pause] for us to take care of them, and to have more contact with the family too, to know what... [pause] when it is time to act, to know a little more about the way that the family is feeling, you deduce a little more, it was good, great, I liked it" (professional No. 12).

"I think the commitment becomes greater, when we get to know the personal life of the patient, the service gets more intense, we are more motivated to do better every time" (professional No. 19).

"There is a feeling that he is really integrated into a family, he has a life, he is a person who has a name, an address, has an entire context of a history. He is not just a number, a bed where he is lying. He is a person who has a whole history, a life and this sensitizes us so that we can help him recover, so that he can return to live with the family that is so worried about him" (professional No. 20).

Category II - Conflict between changing the attitude and being defensive

In this category the difficulty of the nursing professionals to become aware of and to assume a change of attitude in the care after the contextualization of the patient is evident. This difficulty can be perceived by the contradiction in the course of the discourse. The professionals begin the discourse by saying that the intervention did not change the way of caring, however, soon afterwards they report new facts and positive factors in their practice, due to the contextualization.

"It has not really changed, you know? We provide care as we always did, but it's in the more psychological part, I like to know a little more about their lives, at least a little bit" (professional No. 2).

"The way to take care didn't change, but it was very important to know what he did, because sometimes we see the patient and make up a totally different idea of his life and there we had to see and know what he does, it's very interesting" (professional No. 9).

"I would say that my way of taking care of my patient is very difficult to change. Because I am a human person, I look at my patient and I see him that, due to some circumstance, health reason, or accident, is in that situation. But it's always good to know a little more about the people. This makes us understand better, and we can improve the care for that person, because it is very good to know them" (professional No. 20).

DISCUSSION

In the pre-intervention categories evidenced by the discourses, it was possible to identify contradictions that permeate the care actions of the professionals, who refer to valuing care equally with conscious and unconscious patients, yet show a predilection for unconscious individuals and little availability for interaction and listening, fundamental elements for the humanization of the care. Despite reaffirming their commitment to the care and the need to feel active and useful in this, the participants denoted in their statements, replete with pauses, little reflection on the theme and predominance of the technicist view.

The false illusion that care for the critical and sedated patient is less labor intensive was highlighted in the context. The complexity of the physical care actions with these patients requires expert technical knowledge and responsibility to maintain basic functions and to fulfill primary physiological needs. Thus, there are guidelines for the care involved in the maintenance of permeable airways, neurological evaluation, and control of hydroelectrolyte balance, maintenance of intact oral mucous membranes, cutaneous integrity and strict control of vital signs. Even knowing the complexity of the procedural actions involved, the interviewed professionals denoted that the human relationships and communication are the most difficult parts of the care.

Caring for critical patients becomes rewarding because the professional feels useful and able to ease the suffering of the people through individualized care. Respecting the singularity of the patients and their family members at this critical moment in their lives means deeply respecting their human condition. The equipment used in intensive care, such as hemodynamic monitors, contributes to better quality of care, however, elements, such as empathy, receptivity and availability to listen, dialogue and touch are essential for humanized care[12].

It is possible to identify that the intervention aroused positive aspects and feelings, such as emotions, empathy and bonding, in the participating professionals. However, some professionals denoted difficulties in assuming a change in care after the contextualization of the patient, a situation that was evidenced by contradictions in the discourse. Thus, it was inferred that the intervention contributed to the participants perceiving and reflecting on individual aspects of the sedated patient, which may favor more humanized work in the care of these people.

Care involves responsibility, interest and moral commitment, exclusive human characteristics, being an expression of humanity, care is essential for the development and realization of people as better human beings[13]. In nursing care this signifies a moral ideal, which involves the recovery of human characteristics during the act of caring, placing oneself in the place of the other in order to better understand the experiences of this other, with responsibility and ethics[14].

The use of the photograph in the process of humanization has an immediate association with the reality of the individual. The photograph functions in the human mind as a kind of preserved past, memories of certain moments, frozen against the march of time, providing the revival of positive or negative feelings, depending on the image that is visualized[10].

Knowing aspects of the lives of the patients individualizes them, because it narrates their memory of important moments, contributing to show the importance of the person in his/her context, strengthening the bond between the caregiver and patient. Life stories also provide an individual view, because they provide information about the society in which that person is inserted, about their social and cultural values, enabling a better understanding of these processes and the relationships involved[9].

A qualitative study affirmed that information about the life of an individual has a fundamental role in the relationships between people, as it influences the consciousness that the person has of him/herself and of the others. This perception is expressed by language, enabling the perception of the social past in the life of the deponents and readers, who come to understand the historical sequence and to feel part of the context[15].

Emotion is a subjective experience, associated with temperament, personality and motivation, which happens in all relationships that arouse interest in the person[16]. It is the awakening of emotion in relationships that enables the formation of bonds, these being essential in the process of interaction. Thus, it is relevant to highlight the importance of the emotional commitment of the professionals with those who require help, recognizing and considering their manifestations of suffering, fear, anguish, despair, and other feelings[17].

It is considered that to carry out an intervention like this, without emotional preparation of the professional, can be worrying, because it can awaken emotions that need to be recognized and worked with. Reflecting on the other linked to the consequences and the limits of the work of the professionals and the reflection about themselves can bring their suffering and frustration to the surface, as they deal with complex situations daily. Not knowing how to deal with a difficult situation can have as an immediate consequence, with the detachment of the individual as a defense. In this way, it is fundamental to think of strategies to receive and take care of the team emotionally once it is sensitized and involved in the history and image of the sedated patient.

It was not possible to differentiate the perceptions related to the intervention in the different professional categories (nurses, nursing technicians and nursing assistants) and the participants were not characterized in relation to the length of experience. This could form a limitation of the study, because the function and time since formation can influence the involvement. However, it should be emphasized that emotional intelligence is different from intellectual intelligence; that is, emotional development is not linked to age and does not necessarily accompany the level of education. The development of emotional intelligence is increasingly important for good performance in the workplace and may be related to the fact that people with better management of their own emotions are possibly more successful at work and have higher quality of life[18].

CONCLUSIONS

The contextualization of the sedated patient improved the perception of the care of the nursing team, as it aroused positive and important feelings for the care.

The proposed intervention was validated as a strategy for humanization in the care of sedated patients, and can be considered effective in that it proposes sensitization of professionals to the need for humanization and provides a first step to changing attitudes.

REFERENCES

1. Brasil. Ministério da Saúde. Política Nacional de Humanização. Brasília: Ministério da Saúde, 2004.
2. Pessini L, Bertachi L. Humanização e cuidados paliativos. São Paulo: Loyola, 2004.
3. Lobo LF, Puggina AC, Trovo MM. Estratégias de humanização para o atendimento do idoso hospitalizado. Rev Enferm Atual In Derme 2014. 70(8): 12-18.
4. Silva MJP. Qual o tempo do cuidado? Humanizando os cuidados de enfermagem. São Paulo: Loyola; 2004.
5. Silva MJP, Araújo MMT, Puggina AC. Humanização em UTI. In: Enfermagem em UTI: cuidando do paciente crítico. Org Katia Grillo Padilha, Maria de Fátima Fernandes Vattimo, Sandra Cristine da Silva, Miako Kimura. Barueri (SP): Manole, 2010.
6. Erwen P. O significado nas artes visuais. 3ª ed. São Paulo: Perspectiva; 1991.
7. Oliveira GVV. Flashes do passado: o fotojornalismo como fonte de história. Revista Eletrônica de História do Brasil. 1997 1(2). [online] [acesso em 2015 Abr 5]. Disponível em: http://ppghistoria.academia.edu/GilVicente
8. Samain E. O fotográfico. 2ª ed. São Paulo: Hucitec; 2005.
9. Gonçalves RC, Lisboa TK. Sobre o método da história oral em sua modalidade trajetórias de vida. Revista Katálysis. 2007; 10(esp):83-92.
10. Bosi E. Memória e sociedade: lembranças de velhos. São Paulo: Cia das Letras; 1994.
11. Bardin L. Análise de Conteúdo. Lisboa: Edições 70; 2011.
12. Ashworth P. Care to Communicate. London: Royal College of Nursing; 1980.
13. Waldow VR. Cuidar e Humanizar: relações e significados. Acta Paul Enferm. 2011; 24(3):414-8.
14. Waldow VR. Cuidar: expressão humanizadora da enfermagem. Rio de Janeiro: Editora Vozes; 2006.
15. Lima AFC, Gualda DMR. História oral de vida: buscando o significado da hemodiálise para o paciente renal crônico. Rev Esc Enferm USP. 2001; 35(3):235-41.
16. Ekman P. A linguagem das emoções. São Paulo: Ed Leya; 2010.
17. Silveira RS, Lunardi VL, Lunardi Filho WD, Oliveira AMN. Uma tentativa de humanizar a relação da equipe de enfermagem com a família de pacientes internados na UTI. Texto Contexto Enferm. 2005; 14(Esp.):125-30
18. Goleman, D. Inteligência emocional – a teoria revolucionária que redefine o que é ser inteligente, Editora Objetiva, 1995.

ISSN 1695-6141