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The Nursing Team Approach When Facing the Feelings of Relatives of Patients Undergoing Intensive Therapy

Atuação da Enfermagem Frente aos Sentimentos dos Familiares de Pacientes em Terapia Intensiva

Actuación de la Enfermería Frente a los Sentimientos de los Familiares de Pacientes en Terapia Intensiva

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ABSTRACT

Objective: The study's purpose has been to describe the feelings experienced by the relatives of patients hospitalized in the Intensive Care Unit, and also to know how the nursing professionals deal with those feelings. **Methods:** It is an integrative literature review that was carried out over the period from 2012 to 2016 in the Virtual Health Library (VHL) database. The following descriptors were used: nursing, patient family support, welcoming, communication, professional-family relationships, adult intensive care unit. **Results:** A total of 139 articles were obtained, nonetheless, only 32 articles met the inclusion criteria and were analyzed. The feelings experienced by the relatives were evidenced, as well as the nursing action based on these feelings. Furthermore, the orientations and information given to the relatives were also observed. The negative factors that influenced the performance of nursing professionals with the family were still evident. **Conclusion:** The results allowed a reflection about both the perceptions and performance of the Intensive Care Unit nursing professionals when facing the feelings experienced by the family members.

Descriptors: Nursing, Welcoming, Communication, Intensive Care Units.

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RESUMO

Objetivo: Descrever os sentimentos vivenciados por familiares de pacientes internados em Unidade de Terapia Intensiva e conhecer como os profissionais de enfermagem atuam frente a esses sentimentos. **Método:** Revisão integrativa da literatura realizada nas base de dados da Biblioteca Virtual de Saúde (BVS), utilizando-se os descritores: enfermagem, apoio familiar de paciente, acolhimento, comunicação, relações profissional-família, unidade de terapia intensiva adulto, no período de 2012 a 2016. **Resultados:** Obteve-se um total de 139 artigos sendo que, destes, 32 foram analisados por satisfazerem aos critérios de inclusão. Evidenciou-se os sentimentos vivenciados pelos familiares, a atuação da enfermagem frente a esses sentimentos bem como as orientações e informações prestadas aos familiares. Ainda ficaram evidentes os fatores negativos que influenciaram a atuação dos profissionais de enfermagem com a família. **Conclusão:** Os resultados permitiram uma reflexão sobre as percepções e atuação dos profissionais de enfermagem de UTI, frente aos sentimentos vivenciados pelos familiares.

Descritores: Enfermagem, Acolhimento, Comunicação, Unidade de terapia intensiva.

RESUMEN

Objetivo: Describir los sentimientos vivenciados por familiares de pacientes internados en Unidad de Terapia Intensiva y conocer cómo los profesionales de enfermería actúan frente a esos sentimientos. **Método:** Revisión integrativa de la literatura realizada en las bases de datos de la Biblioteca Virtual de Salud (BVS), utilizando los descriptores: enfermeira, apoyo familiar de paciente, acogida, comunicación, relaciones profesional-familia, unidad de terapia intensiva adulto, en el período de 2012 a 2016. **Resultados:** Se observó un total de 139 artículos, de los cuales 32 fueron analizados por satisfacer los criterios de inclusión. Se evidenció los sentimientos vivenciados por los familiares, la actuación de la enfermería frente a esos sentimientos así como las orientaciones e informaciones prestadas a los familiares. Aún quedaron evidentes los factores negativos que influenciaron la actuación de los profesionales de enfermería con la familia. **Conclusión:** Los resultados permitieron una reflexión sobre las percepciones y actuación de los profesionales de enfermería de UTI, frente a los sentimientos vivenciados por los familiares.

Descriptores: Enfermería, Acogimiento, Comunicación, Unidades de Cuidados Intensivos.

INTRODUCTION

The Intensive Care Unit (ICU) is the hospital unit intended to receive unstable patients bearing hemodynamic instability, who need an environment with advanced and specialized technological support. It is composed of a specialized multidisciplinary team capable of attending critically ill patients and is probably one of the most difficult and stressful places in a hospital institution in terms of anxiety and depression among in-patient relatives.[1]

The illness represents ruptures in the daily life of the hospitalized person and their relatives, is usually an unexpected and distressing event for the whole family and this is due to several factors such as the threat to life, little information about the clinical conditions, the rigid visiting routines, social isolation, factors that can de-structure the family balance.[2]

The lack of information and clarification of the relatives in knowing the purpose of the technological and invasive devices and equipment present in the patient leaves the family insecure and distressed with the situation that they will find next to their familiar, extremely difficult moment, since from the uncertainty of the recovery the family develops and expresses different feelings.[3,4] In this sense, family members who in addition to the tension of having a loved one hospitalized, experience uncertainties about the illness and hospitalization, which often occurs abruptly and unexpectedly, which can lead to disorganization, helplessness, and family stress.[5]

Considering the aforesaid, moments like visiting hours are considered of utmost importance for the professional and family relationship. At this moment it is essential to clarify doubts and provide information to family members when they are requested and in a clear, objective and understandable to all. The needs of the patients' relatives in the intensive care unit show that the receipt of information about the patient is classified among the most important needs of the families.[6]

During the hospitalization period, the family needs to adjust and reorganize itself in order to overcome the difficulties that will arise. In this sense, during the visit, it is important for the nurse to clarify the doubts and questions of the relatives regarding the patient's state of health and the treatment he is receiving, so those negative feelings such as anguish and concern are minimized or even healed. Therefore, the welcoming and the information become essential, because they establish bonds and narrow the interpersonal relationship between the health professional and the family that also needs care because most of the times they feel lost and helpless among this arsenal technological.[7]

Welcoming in caring for the family is linked to listening to attend to their needs, presupposes a set of listening activities, problem identification, and resolution interventions. The actions attributed by the nurses to the welcoming practice should be added to the notion of continuity, since receiving well, listening and meeting the needs of family members are actions to be performed in all contacts with the patients' relatives.[8]

Bearing the abovementioned in mind, the nursing professionals have a fundamental role in the adaptation and recovery of the patient, as well as in the family support. Given this, the nurse must be able to attend the patient and his family, promoting an affective bond that aims at an individualized and quality assistance, minimizing the pain and suffering of all during their stay in the ICU. Promoting an effective interaction with the patient's family in the ICU is a fundamental step in the recovery of health, an aspect difficult to establish in full, since it involves time, consciousness and will.[9]

The feasibility of this study arises from the professional

experience of the authors regarding nursing care developed in ICU. This allowed to identify gaps and limitations of the nursing team in relation to the feelings manifested by the relatives in relation to the unknown and unstable environment of the ICU, as well as the waiting period to visit the patient, especially the delay in the visiting hours, the lack of adequate information and the interruption of the same to perform procedures in the patients, compromising the time of visit as well as the affective bond and familiar conviviality.

Given the aforementioned, this study aims to identify the feelings experienced by the relatives of patients hospitalized in the Intensive Care Unit, and also to know how nursing professionals react in response to these feelings.

METHODS

This study has a qualitative approach and adopted as a research tool the integrative literature review.[10] The six steps indicated for the construction of the method were followed, being these the selection of the research question; the definition of the inclusion criteria of the study and sample selection; the representation of the selected studies in tables format, considering the characteristics in common; the critical analysis of the findings, identifying differences and conflicts; the interpretation of the results and, as the last step, the pointing of the many evidences found.

The method used to classify the strength of evidence proposes three levels, namely: 1- Intervention or diagnosis; 2 - Prognosis or etiology; 3- Meaning, based on the question of the original study. In view of the corpus of this research, we used the classification of evidence of studies with a clinical question directed to the meaning, with the following hierarchy: I - Metassynthesis of qualitative studies; II- Individual qualitative studies; III - Synthesis of descriptive studies; IV- Individual descriptive studies; V- Expert opinion.[11]

In order to guide the review, the following guiding questions were formulated: What are the feelings experienced by the relatives of patients hospitalized in the Intensive Care Unit? What is the approach of nursing professionals with regards to those feelings? The collection of articles was done initially in the Virtual Health Library in the databases: *LILACS*, MEDLINE, BDENF and IBECS. The access was online and occurred during the month of August 2017, using the following descriptors: nursing, patient family support, welcoming, communication, professional-family relationships, adult intensive care unit. The descriptors were associated with each other through the Boolean operators AND and OR.

Previously defined inclusion criteria were used for the selection of articles: publications in Portuguese, Spanish or English, with full text and available in full in the databases selected during the period from 2012 to 2016, restricted to the adult intensive care area, to allow to answer the question of research and, later, to establish links with the nursing professionals' performance; additionally, studies based on methodologies that bring strong evidence to the understanding of the research problem. The time cut adopted aimed at the analytical feasibility in the collection and analysis of the data.

After a previous analysis of the inclusion criteria, and considering the exploratory reading (title and abstract), an initial quantitative of 139 articles was obtained, which were then submitted to the evaluation by means of an instrument elaborated with the objective to analyze to what extent the manuscript could contribute to the understanding of the problematic in question. We excluded studies that did not comply with the proposal, as well as studies related to pediatrics and neonates. This instrument covered the general characteristics of the study, methodological outline, recommendations and level of evidence, and the evaluation process was passed by two independent judges. The disagreements among the evaluators were decided together, which generated a final sample of 23 articles, 15 in Portuguese, 1 in Spanish and 7 in English.

Based on the information collected through the instrument, a synoptic table (**Table 1**) was constructed, in order to allow the analysis of the articles and subsequent apprehension of the evidence. The analysis was based on the content of these bibliographies and on the confluence of topics that were subsequently organized.

RESULTS AND DISCUSSION

The characterization of the studies included in the review indicates that the production on the theme was distributed as follows: for the year of publication, eight studies were published in 2012, four in 2013, five in 2014, four in 2015 and two in the year of 2016. The analysis of the content of the studies presented gave rise to three units that depict the evidence obtained, on the basis of which the respective proposed recommendations are delineated (**Tables 2, 3 and 4**). They are shown as follows: Feelings experienced by relatives of patients hospitalized in ICU; the nursing performance in front of these feelings; and the factors that interfere in the relationship of these professionals with the family.

Table 1 - Description of the studies analyzed after applying the selection criteria. *Santa Maria* city, *Rio Grande do Sul* State, 2017.

*Title/Journal/Year	Objective	Methods	Database	E
Percepción de los familiares de pacientes críticos hospitalizados respecto a la comunicación y apoyo emocional/Revista Cuidarte/ 2016.[12]	Assessing the perception of the relatives of critically ill patients regarding verbal and non-verbal communication, and the emotional support offered by nursing staff during ICU admission.	Descriptive and cross-sectional study.	*LILACS*	IV
O conforto dos familiares de pacientes internados em unidade de terapia intensiva/	Identifying the comfort of the relatives of patients hospitalized in ICU.	Exploratory, descriptive, and cross-sectional	*BDENF*	IV

Revista de enfermagem UFPE on line / 2016.[13]		study.		
O acolhimento no cuidado à família numa unidade de terapia intensiva/ Revista de Enfermagem UERJ/ 2015.[14]	Describing how the nurse takes care of the care of the family in the ICU.	Qualitative and descriptive study.	*BDENF*	IV
Visita de Enfermagem e dúvidas manifestadas pela família em unidade de terapia intensiva/ Revista Acta Paulista de Enfermagem/ 2015.[15]	Understanding the doubts from the relatives of patients hospitalized in the intensive care unit, more than 24 hours, and showed during the nursing visits.	Cross-sectional study.	*LILACS*	IV
Transforming a conservative clinical setting: ICU nurses' strategies to improve care for patients' relatives through a participatory action research/ Nurs Inq / 2015.[16]	Strategies of change generated through a dialogic-reflective-participatory process aimed at improving the care of critical ICU patient families.	Qualitative, participatory action research.	MEDLINE	II
Desvelando competências do enfermeiro de terapia intensiva/ Revista Enfermagem Foco Brasília/ 2015.[17]	Showing the necessary competencies for nurses working in intensive care according to the professionals, enabling the construction of the competency profile of intensivist nurses.	Qualitative, exploratory-action research.	*BDENF*	II
Nursing strategies to support family members of ICU patients at high risk of dying/Heart Lung /2014.[18]	Exploring how family members of ICU patients at high risk of dying respond to nursing communication strategies.	Prospective, qualitative and descriptive study.	MEDLINE	IV
Traditional/restrictive vs patient-centered intensive care unit visitation: perceptions of patients' family members, physicians, and nurses/ Am J Crit Care/ 2014.[19]	Understanding patient-centered UTI perceptions among family members, physicians, and nurses.	Qualitative research.	MEDLINE	II
Percepção da comunicação, satisfação e necessidades dos familiares em Unidade de Terapia Intensiva/ Revista Anna Nery/ 2014.[20]	Identifying and comparing the perception of nonverbal communication expressed during the hospital visit with the degree of satisfaction and importance of relatives in relation to their needs in the ICU.	Descriptive, cross-sectional study.	*LILACS*	IV
Assessment of satisfaction with care among family members of survivors in a neuroscience intensive care unit/ J Neurosci Nurs/ 2014.[21]	Exploring the family satisfaction with regards to the care in an ICU.	Qualitative research.	MEDLINE	II
Informational support to family members of intensive care unit patients: the perspectives of families and nurses/ Glob J Health/ 2014.[22]	Explaining the perspectives of families of patients and nurses ICU on informational support.	Qualitative study.	MEDLINE	II
Conforto de familiares de pessoas em Unidade de Terapia Intensiva frente ao acolhimento/Revista da Escola de Enfermagem da USP/ 2013.[23]	Identifying the level of comfort of family members of people under critical health conditions due to hospital staff welcoming practices.	Quantitative cross-sectional study.	MEDLINE	IV
Perceptions and needs of relatives of patients hospitalized in an intensive care unit/ Revista Cuidado é fundamental Online/ 2013.[24]	Knowing the perceptions and needs of the relatives of patients hospitalized in an ICU.	Qualitative and descriptive study.	*LILACS*	IV
O familiar acompanhante como estímulo comportamental de pacientes internados em terapia intensiva/ Revista Anna Nery/ 2013.[25]	Measuring the verbal and non-verbal expressions present in the patient's behavior before, during the insertion and stay of the accompanying family member in the intensive care unit, and to comparatively analyze the behavioral changes of the patient during those moments of hospitalization.	Qualitative research.	*LILACS*	II
Participation and support in intensive care as experienced by close relatives of patients: a phenomenological study/ Intensive Crit Care Nurs/ 2013.[26]	Exploring participation and support as experienced by close relatives of patients in an ICU.	Reflective Life Research (RLR).	MEDLINE	II
Discursos de enfermeiros sobre humanização na Unidade de Terapia Intensiva/ Revista Anna Nery/ 2012.[27]	Identifying elements of the practice of intensive care nurses that make it difficult to implement the humanization of care.	Qualitative research.	*BDENF*	II
Alterações na dinâmica familiar com a hospitalização em Unidade de Terapia Intensiva/ Revista de Enfermagem UERJ/2012.[28]	Understanding the changes in family dynamics with the hospitalization of a family member in the intensive care unit.	Qualitative and descriptive study.	*BDENF*	IV
O impacto da visita de enfermagem sobre as necessidades dos familiares de pacientes de UTI*/ Revista Escola de Enfermagem USP/2012.[29]	Implementing the Nursing Visit in the adult ICU and verifying and attending to the main information and welcoming needs to be verbalized by the families.	Quantitative study.	*LILACS*	IV
Percepção do enfermeiro sobre promoção da saúde na Unidade de Terapia Intensiva*/ Revista Escola de Enfermagem USP/2012.[30]	Reporting the perception of nurses on health promotion, describe actions to promote health and identify difficulties in carrying out health promotion activities in the ICU.	Qualitative and descriptive-exploratory study.	*LILACS*	IV
Estratégias para o acolhimento dos familiares dos pacientes na Unidade de Terapia Intensiva/ Revista Enfermagem UERJ/2012.[31]	Identifying the welcoming strategies implemented by nurses, to the families of the patients of this unit.	Qualitative research.	*LILACS*	II
Avaliação das estratégias de acolhimento na Unidade de Terapia Intensiva*/ Revista Escola de Enfermagem USP/2012.[32]	Evaluating the implemented welcoming strategies.	Qualitative research.	*LILACS*	II
Conflitos nos relacionamentos interpessoais decorrentes de fatores que dificultam a comunicação Enfermeiro/Cliente durante o cuidado/ Revista Cuidado é Fundamental/ 2012.[33]	Identifying the main factors that cause stress in care in the Intensive Care Center (ICC).	Qualitative and descriptive-exploratory study.	*BDENF*	IV
O cuidado e a comunicação: interação entre enfermeiros e familiares de usuários em uma Unidade de Terapia Intensiva Adulto./ Revista Cuidado é Fundamental/ 2012.[34]	Assessing how occurs the communication between nurses and family members of users of an Adult Intensive Care Unit.	Qualitative research.	*BDENF*	II

*__Note:__ They were kept as in their original language.

Feelings experienced by relatives of ICU patients

The analyzed articles[13,15,18,28] brought feelings experienced by relatives during hospitalization. The intensive care environment commonly causes negative feelings in patients and relatives, as evidenced in **Table 2**; identifying them may favor individualized assistance to this clientele. Feelings such as anguish, anxiety, sadness, despair, lack of information, fear of family loss, social isolation, among others should be considered by the nursing team, in the sense of seeking a rapprochement with family members to help them overcome this difficult moment.

Table 2 – Description of the feelings experienced by relatives of ICU patients. *Santa Maria* city, *Rio Grande do Sul* State, 2017.

Feelings like post-traumatic depression, distress, and stress[28,29]
Anxiety, sadness, suffering, impotence, anger[18,28]
Difficulty in reconciling tasks, work with visiting hours and routine ICU[28]
Family history/loss of identity, feeling alone, lost[28,34]
Lack of information, lack of confidence, dissatisfaction[18,29]
Doubts about the ICU environment, appliances, treatment and recovery[15,28,29]
Apprehensive and distressed to talk to staff, lack of communication[22,29,34]
Nonverbal behaviors of defense and discomfort, approach and comfort[20]
Fear of death, losing the relative[15,17,28,29]
They feel welcomed, secure and confident[13,14,24,33]
Feel satisfied with communication on visits[21]
Comfort, religion, spirituality[13]

Bearing in mind the feelings manifested by the relatives of ICU patients available in the literature, it was important to describe how nursing acts/intervenes to minimize these feelings (**Table 3**).

Nursing approach when facing these feelings

The nurse's action to work out the feelings with the patients and their relatives was revealed in the analyzed studies. This highlights the importance of demonstrating welcoming, communication, and information provided in a clear and objective manner.

Table 3 – Description of the nursing approach when facing the feelings showed by the patients' relatives. *Santa Maria* city, *Rio Grande do Sul* State, 2017.

Talking, calming, relaxing[14,31,32]
Practicing humanization and welcoming the family[14,32,33]
Clarifying doubts[14,15,20,32,34]
Providing clear and concise information with appropriate language that is easy to understand[18,20,28]
Establishing communication, bond and trust[12,19,20,25,34]
Reducing family anxiety, emotional support[12,18,25]
Being present by showing interest and concern[18,28]
Allowing the family member to participate in care[25,26,28]
Welcoming the family members, telephone contact and dialogic relationship at visit time[32]
Dialogic-reflective-participatory process[16]
Having an optimistic view and supporting spiritual practices[18]

Factors that interfere in the relationship of the nursing professionals with the patient's family

The majority of the nurses recognize some type of difficulty or difficulty that limits the accomplishment of activities in the ICU environment, among them: a large number of tasks, excessive work demands, lack of material, lack of commitment of professionals, lack of sensitivity of professionals and resistance to the changes attached to old habits, in addition to the insufficient number of professionals to demand.[31]

Table 4 – Description of the factors that interfere in the relationship of the nursing professionals with the patient's family. *Santa Maria* city, *Rio Grande do Sul* State, 2017.

Work overload/shortage of time[14,31,34]
Institutional Routine/Bureaucratic activity[14]
Technological dynamics, inadequate communication, technical terms[22,24,32-34]
Fear of being emotionally involved, getting involved in the situation[20]

Among the experienced feelings were described feelings such as: difficulty in coping, lack of trust and confidence in care, hesitancy to ask questions, anger, and dissatisfaction in response to nurses.[18] It was found that when family members are lovers of a belief, the level of comfort can be established by a social and spiritual support. Faced with the uncertainties of the pathology, future events and situations of the hospitalized relative, religion and spirituality can provide the family with a better control of emotions and acceptance.[13]

One of the studies[24] mentions that relatives believe that the ICU is the place where their relative will be well-taken care since the surveillance is greater, the professionals are closer and in constant alert, a fact that provides security to the relatives. They say that being in the ICU represents being very sick, but that, through the care offered by the professionals within the unit, their families have the opportunity to recover and to leave better than when they entered.

Hospitalization and family separation portray a stressful event for both the patient and the family, caused by an affective-emotional rupture, triggered by the impossibility of staying with the patient and by circumstances imposed by the routine of the ICU, with stipulated visits and reduced. In this context, family members feel lost, apprehensive and powerless, present psychosocial changes, changes in their daily routine and difficulties to be together.[28]

During the visit[20] the family members present nonverbal behaviors of defense and discomfort, identified by a tense facial expression, anxiety, fear, doubt, followed by rapid body movements and rigid and tense body posture. On the other hand, the behavior of approach and comfort was identified in the family with the positioning of the shoulders and trunk curved forward and/or facing the patient, a direction of the feet parallel or still facing the patient and low voice volume appropriate to the ICU context. In this study, the relatives pointed out their main needs, being important to know: what are the chances of improvement of the patient, being able to talk to the doctor every day, having his questions answered frankly, knowing which professionals are caring,

being available information and receive information about everything that relates to the evolution of the patient daily.

Another study[21] points out that families that participated in more than three family visits in the intensive care setting were more likely to be completely satisfied with the communication provided by the health team. While family members who were not living with their relative prior to ICU admission were significantly less likely to be completely satisfied.

Family members described nurses as an important source of information about the ICU environment, treatments and the patient's health status. Having the nurse explain what was happening to her family inspired confidence and allowed them to deal better with the situation.[18]

The ICU is an environment where it is necessary to develop sensitivity and tact to deal with fear and death almost daily; everything is close, fast, which brings an immeasurable emotional overload when considering what is right and wrong, just and unjust. It is enough to doubt faith and spirituality. It is an environment of many sorrows and insecurities, unexpected and unusual situations, where there is a vital need to maintain emotional balance.[17]

Studies[15,22,29,34] show that during the visitation period the relatives express doubts about the patient's health status, clinical conditions, care, and procedures, as well as discharge from the ICU. For some family members, the amount of information that the nurse provides for the family is small, leaving some clarification on account of other professionals in the team.

The satisfaction of the family member, as well as the hope and expectation of improvement, were feelings that emerged in the study.[33] The family perceives the welcoming as essential and of utmost importance, providing bond and trust. When family members receive adequate information about the relative's state of health, they are relieved and confident about the care received, creating a bond of trust between the team and the family. To feel welcomed, for some family members, is to have support and attention from each professional, is to ask and find the answer, even if that is not the desired response.[14]

Regarding the nursing performance in relation to the feelings experienced, some studies[12,18,15,19,20] showed that the information provided by nursing help the family members to understand the care and the environment of the ICU, as well as the regular and structured communication of the nursing team with the family assists in reducing stress and understanding the treatment performed. In this sense, caring for the family implies perceiving the other in the gestures and speeches, in their concepts and limitations, including conversations and information pertinent to what the individual wants to know, sharing interest and responsibilities. The communication should be clear, objective and include clarifications about the diagnosis, treatment, procedures, and equipment in it, communication goes beyond the words being contemplated by gestures, silences, facial expressions, body movements and above all communication becomes important for bonding.

Another related factor in the studies[12] is the emotional support provided to the family as a support for the welcoming and interaction in the care provided by nurses, through a friendly and friendly approach, providing comfort and confidence, demonstrates on the part of the team the concern and interest in calming the anxiety of the family in dealing with this moment of crisis. Emotional support should be understood as a form of care, whose purpose is to provide comfort, care and well-being for the patient and the family.

In the study[18] the nurses exhibited a series of behaviors that showed concern for the physical, emotional, psychosocial and spiritual well-being of the family and the patient. This included ensuring that the patient and family member were comfortable, encouraging family members to express their emotions, take an optimistic view, and support spiritual practices.

For this to happen, family members need to feel the support and empathy of healthcare professionals in helping them cope with the critical situation of their ICU patients. Adequate support from health professionals and empathic behavior establishes a positive attitude among health professionals and family members encouraging them to return to normal life.[22]

Studies indicate that the nurse should help the family to understand, accept and face the disease, treatment, and consequences that this new situation imposes on family life. It is essential to use strategies that can ease the suffering of the family with the incorporation of effective welcoming practices that aim to create a close relationship between the health professional and the one who needs care, so that the focus is not only the illness.[14]

The welcoming implies that each professional participates in the health process assumes its role, be open and value the encounter with the other, with a posture of listening and commitment. Some of the welcoming strategies[32] implemented in the ICU are the following: receiving family members at admission, telephone contact, and dialogue on visits. The telephone or face-to-face information that is given in an enlightening manner can be interpreted by the family as a response of the nurse to their needs to attend to concerns, doubts, and fears.

Providing welcoming to family members[33] is one of the responsibilities of the nurse, because these strategies contribute significantly to the success of improved care. The possibility of flexibility in visiting hours and the number of visitors also appears as a welcoming strategy because the family members feel supported, understood and comforted, having part of their affected needs met. In a moment of anguish and distress, these extra minutes of stay with his relative are related to affective bonds, sensitively overcoming the physical and cold barrier of the ICU to be together not only in those 30 minutes reserved for visiting hours.

Some studies[25,26,28] suggest that the family members participate in ICU care, together with the nursing team, because there are changes in the verbal and non-verbal reactions of the patient after the stimuli generated by the presence of the family, which vary from the absence of speech and movements, passivity in acting, reactions of acceptance of procedures, communication and greater participation in care.

Relatives close to critical patients represent their world of life. They feel a strong concern for patients' situations and want to be involved, suffer from feelings of insecurity where the result is in balance for critically ill patients. While family members are people who protect and support patients, family members also need support and protection. They are sensitive to the professionals' attitudes and approaches.[26]

The nurse's concern with the ICU environment and the interference that this translates into the patient's well-being is observed in the adoption of measures that minimize the sources of stress and benefit the conscious patients in this context. As far as possible, conditions of sleep and quiet rest should be provided, reducing and silencing noises in an attempt to provide a calm and safe environment.[31]

Nevertheless, a study[14] shows that for some relatives of patients hospitalized in the ICU, the welcoming practice is not yet a common condition. The recognition of the nurses investigated on the welcoming of the families in the ICU seems to be unanimous, although they show a certain difficulty in welcoming and guiding the family members.

In this sense, the development of a dialogic-reflexive-participatory process can lead to changes that promote family and patient-centered care, as well as the learning of critical analysis skills that can be widely used in health work.

The strategies identified were: moving from a professional--centered work to a patient-centered perspective; reduction of the hierarchical power between doctors and nurses, change from an individual to a collective posture; the transition from a naive acceptance to a critical attitude. Opportunities for dialogue and reflection were created among professionals who had not shared their concerns about the care of family members until then. Professionals, who had not yet felt capable of transforming their context, began to critically review their clinical work and transform it.[16]

Concerning the factors that interfere in the relationship between nursing professionals and the family, one of the studies analyzed[20] evidenced the team's difficulties in establishing an effective interpersonal communication with the family members, either because they identify with the situation experienced by their own fears emotionally or even unprepared to deal with situations of loss. Another aspect mentioned in the studies is that most patients in the ICU are sedated, which in this way hinders communication.[31]

Another studies[22,24,33,34] point out the failures in communication and the impediments found between the nursing team and the client or family member, and the language can be cited through the excessive use of technical terms. This communication is appropriate for family members as information about the patient's clinical condition is transmitted at the time of visit in a clear and objective manner without technical and difficult terms. In this sense, the information must be complete and comprehensible. Family members need the information provided to meet their level of knowledge, so that they can better understand it, and their interpretations are correct. This can decrease the level of anxiety and family concern.

Complementing this reality a study[24] contributes towards that end, focusing that the greatest needs felt by the subjects were those related to the failures in the communication process with the team, the absence of guidelines and the short period of visitation. Regarding communication, relatives report that there is a lack of clarity in the information passed on by health professionals. A negative factor, pointed out by the family members, was the use of technical language, which made it difficult to understand what was being transmitted to them.

Reorganize the work of the ICU whose actions are still centered on the technicist model, focused on the disease and not on the subject and almost exclusively for the hospitalized person, disregarding their family member is hard work and a challenge for nursing, especially for those that operate in highly complex units.[32]

CONCLUSIONS

From the analysis of the studies, it was possible to recognize the importance of identifying the feelings and needs experienced by relatives of patients hospitalized in an ICU, seeking to identify such needs in order to implement the planning of interventions that meet the needs of both the patient and of the family.

During the discussions of the articles, it was observed that, just like the patients, the family also needs support and care, because when faced with the hospitalization of a relative in the ICU, the family feels disordered and fragile. It was also evidenced that when assisting the family in its specificities and establishing an effective communication, in a clear and objective manner, the nurse provides to the patients' family, the security and confidence in the hospitalization process.

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