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NURSING SUPPORT FOR PATIENTS WITH PALLIATIVE CRITERIA IN THE INTENSIVE CARE UNIT

Assistência do enfermeiro frente a pacientes com critério de paliatividade em Unidade de Terapia Intensiva

Asistencia de enfermería a pacientes con criterios de cuidados paliativos en la Unidad de Cuidados Intensivos

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ABSTRACT

Objective: to describe the support provided by nurses to patients with palliative care criteria admitted to an intensive care unit. **Method:** this is a literature review on the Virtual Health Library and PubMed databases. **Results:** there are criteria for palliative care for patients in intensive care units, and nursing provides comfort and respect for the patient, taking care not only of the body, but also of the psychosocial aspects and those of their families. **Conclusion:** palliative care has proven to be a comprehensive care for people with terminal illnesses, with emphasis on the physical, psychosocial and spiritual aspects of the individual and the family; quality of life; care based on a humanistic approach; priority of care over cure and bereavement support. Nursing is the one who always supports the patient and provides the care to be taken to improve their quality of life.

DESCRIPTORS: Patients; Palliative care; Intensive care units.

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RESUMO

Objetivo: descrever a assistência do profissional de enfermagem frente a pacientes com critérios de paliatividade internados em Unidade de Terapia Intensiva. **Metodologia:** trata-se de uma revisão da literatura nas bases Biblioteca Virtual de Saúde e PubMed. **Resultados:** existem critérios para os cuidados paliativos de pacientes que se encontram em Unidades de Terapia Intensiva, e a enfermagem proporciona conforto e respeito para o paciente, levando cuidados não somente focados no corpo, mas nos aspectos psicossociais e de seus familiares. **Conclusão:** o cuidado paliativo evidenciou-se como cuidado integral voltado para indivíduos em condições terminais, com ênfase no aspecto físico, psicossocial e espiritual do indivíduo e família; qualidade de vida; cuidado baseado em uma abordagem humanística; a prioridade do cuidado sobre a cura e o apoio ao luto. Sendo a enfermagem quem assiste o paciente a todo o tempo e propicia os cuidados a serem feitos para melhorar sua qualidade de vida.

DESCRITORES: Pacientes; Cuidados paliativos; Unidades de terapia intensiva.

RESUMEN

Objetivos: describir la asistencia que brindan los profesionales de enfermería a los pacientes con criterios de cuidados paliativos ingresados en una Unidad de Cuidados Intensivos. **Metodología:** se trata de una revisión bibliográfica sobre la Biblioteca Virtual en Salud y las bases de datos PubMed. **Resultados:** existen criterios de cuidados paliativos para pacientes que se encuentran en Unidades de Cuidados Intensivos, y la enfermería brinda comodidad y respeto al paciente, cuidando no solo centrado en el cuerpo, sino en los aspectos psicosociales y de sus familiares. **Conclusión:** los cuidados paliativos demostraron ser cuidados integrales dirigidos a personas en condiciones terminales, con énfasis en los aspectos físicos, psicosociales y espirituales del individuo y la familia; calidad de vida; atención basada en un enfoque humanista; la prioridad del cuidado sobre la curación y el apoyo al duelo. Enfermería es quien asiste al paciente en todo momento y le brinda los cuidados que debe tener para mejorar su calidad de vida.

DESCRIPTORES: Pacientes; Cuidados paliativos; Unidad de terapia intensiva.

INTRODUCTION

The World Health Organization (WHO) defines Palliative Care (PC) as an approach that promotes quality of life by preventing and relieving suffering in patients and their families facing illnesses that threaten the continuity of life.1 However, it is known that if the process were effectively implemented, most patients would continue to receive no palliative care because of the lack of professionals and services to care for this population.

Intensive Care Units (ICUs) provide sophisticated therapies for critically ill patients. Patients with chronic diseases, who are exposed to exacerbations during their disease, are living longer, but with worse living conditions, due to the additions available to their respective treatments.[2]

The assistentialist model generally adopted in these units is based on intervention and cure and does not allow for care in all its dimensions.[3] In addition to the inadequate training of health professionals and the difficulty of understanding that they no longer have the ability to work toward a cure, there is also the difficulty of dealing with impotence in the face of inevitable death.[2]

There are still several barriers to the effective delivery of PC, especially in intensive care. However, based on good medical practice and evidence-based medicine, science has turned to PC.[2] In addition to their technical responsibilities, nurses play a critical role as a liaison between the team and the family.[3]

It is believed that an integral and adequate approach to the end of life requires effective preparation in palliativism or the practice of the art of caring for the dying, thus combining scientific knowledge with the alleviation of suffering. It should be developed in parallel or complementary to the biomedical paradigm of curing and extending life.[4]

In this process, the nurse assumes a primary role in anticipating and providing the resources necessary for care, as well as in assessing the needs of each patient, in planning and implementing actions that allow the individual to pass through the end of life without suffering. In short, to offer palliative care in nursing is to experience and share moments of faith, love and compassion, understanding that it is possible to die with dignity, accompanied by professionals, family members and spiritual support.[4]

The conditions listed as chronic do not initially require ICU care, although the care that such patients require is intensive in the sense of close proximity to the professional. On the other hand, patients who meet the criteria for intensive care can evolve into an irreversible situation and need to have their pain alleviated.[2] Therefore, the study aims to describe the assistance of the nursing professional to patients with palliative criteria admitted to the ICU.

METHOD

This is a literature review. The selection of articles was carried out in the databases of the Virtual Health Library (BVS) and PubMed, for those that deal with the care of patients with palliative criteria admitted to an intensive care unit (ICU) in the period between 2011 and 2021. A total of 12 articles and 1 manual were selected, referenced by the descriptors: Patients AND Palliative Care AND Intensive care units.

The inclusion criteria are related to those that met the cited descriptors, as well as full articles, in Portuguese, English and Spanish, published between 2011 and 2021.

RESULTS

The articles present different characteristics in terms of the listed points of view, the people involved, and the methodological design. These characteristics are shown in Chart 1 below.

Chart 1 - Characterization of the scientific production on the palliative care of patients in ICU.

Author/ Country / Year	Title	Key results
Santos, RJLL et al / Brazil / 2019	O enfermeiro e os cuidados paliativos proporcionados ao idoso terminal internado em UTI [The nurse and the palliative care provided to the terminally ill elderly who are hospitalized in the intensive care unit.]	As a result, the authors found that nursing professionals need to provide humanized care to patients, using strategies recommended by the Systematization of Nursing Care (SNC).
Luiz MM et al / Brazil / 2018	Cuidados paliativos em enfermagem ao idoso em UTI [Palliative Care for the Elderly in the ICU]	In their studies, the authors identified as results the main nursing interventions and actions for elderly patients under PC in the ICU, but emphasized that it is essential to create new strategies to improve the care of such patients.
Zeferino MGM et al / Brazil / 2019	Cuidados Paliativos: Percepção de enfermeiros que atuam em Unidade de Terapia Intensiva [Palliative care: Perception of nurses working in the ICU]	the authors identified as results the main nursing interventions and actions for elderly patients under PC in the ICU, but emphasized that it is essential to create new strategies to improve the care of such patients.
Silva,TM/Brazil / 2014	Cuidados paliativos em UTI: elaboração de cartilha para a orientação para a prática de enfermeiros no cuidado a pacientes com DCNT [Palliative Care in the Intensive Care Unit: Development of a Practice Guide for Nurses Caring for Patients with CNCD]	The author created a booklet to help the ICU nurses of a given hospital to identify and admit patients with chronic non-communicable diseases, in terminal conditions, under PC. Generating as a result the confirmation that it is extremely difficult to follow a single standard of care due to the requirement of mobilization of the multidisciplinary team.
Santana, JCB / Brazil / 2012	Cuidados paliativos nas unidades de terapia intensiva: implicações na assistência de enfermagem [Palliative Care in the Intensive Care Unit: Implications for Nursing Practice]	The author discussed the importance of the role of the nurse in PC for patients hospitalized in the ICU, highlighting the effectiveness of the role of this professional who must be constantly updated in theory and practice, without losing the essence of humanized treatment to patients.
ANCP / Brazil / 2012	Manual de Cuidados Paliativos ANCP [ANCP Palliative Care Handbook]	Guidelines for PC therapy were found in its different areas, with emphasis on the respective criteria for patients in the ICU.

Source: The author, 2021.

The purpose of palliative care is to ensure the quality of life of both patients and family members, seeking to cope with diseases that cause threats to the continuation of life, also seeking to adjust the precautions and the relief of suffering.[5] Another study noted the importance of deepening and publishing new strategies for providing good care regarding palliative care in the ICU, in order to develop the methodology of care in the work environments.[6]

There is an evolution in the therapy provided for the control of the death process, which will provide the proper care in a humanized way to the users. The absence of a PC protocol to guide professionals on what to do with these patients is perceived as an advance in humanized care and not just technical knowledge.[7]

Through the creation of a booklet that directs the steps to be followed for the care of patients in terminal situations, it has been verified by practice: the removal of the team in the process of terminality; the indication of palliative care in the ICU; the responsibility of the nurse and the difficulty of communication between the team and the family members. It concludes that the care provided by the multidisciplinary team creates difficulties for those involved.[8]

The complexity of the ICU for the care of patients requiring PC is high, requiring differentiated care with the intention of balancing advances in technology, humanization and palliative care.[9]

In terms of specific criteria, the National Agency for Palliative Care2 highlights criteria for ICU PC for: patients with HIV: Persistent diarrhea for one year; serum albumin less than 2.5; persistent use of illicit drugs; age > 50 years; absence of retroviral therapy, chemotherapy, and other drugs related to HIV disease prophylaxis; advanced dementia due to HIV; toxoplasmosis; and symptomatic congestive heart failure at rest.[2, p. 66]

Patients with Long-Term Neurological Disease: Their respective neurological conditions have a protracted course of development and it is rarely possible to identify the beginning of the final phase of the disease. The symptoms of these patients vary, and many of them have cognitive, behavioral, or communicative dysfunction in addition to their physical deficits.[2, p. 66]

Patients with Mental Disabilities: Patients with mental illness die prematurely compared to the general population. Yet there is little research on end-of-life care planning for these patients.[2, p. 67]

Stroke patients: The main criteria include nutritional assessment and functional capacity. Palliative Performance Scale - PPS less than or equal to 40%; level of ambulation: mostly confined to bed; activity/significance of illness: unable to work; unable to self-care; decreased food and water intake; level of consciousness: drowsy/confused; weight loss > 10% in the last 6 months; weight loss > 7.5% in the last 3 months; serum albumin < 2.5 g/dl; current history of pulmo-

nary aspiration with no effective response to speech therapy interventions.[2, p. 68]

Patients with dementia: If there is confirmation of Alzheimer's disease and other related diseases, if some structural changes and functional impairments are identified, in addition to comorbidities, they will serve as the basis for intervention and PC planning. Ultimately, in the terminal phase of the disease, the combined effects of Alzheimer's disease (FAST stage 7) and any other comorbid or secondary condition (delirium, pressure ulcers, aspiration pneumonia) should be such as to characterize a prognosis of 6 months or less.[2, p. 68]

Patients with ALS: Decreased respiratory capacity according to criteria: 1. Vital capacity less than 30% of normal; 2. Significant dyspnea at rest; 3. Need for supplemental oxygen at rest; and 4. Patient refuses mechanical ventilation. B. Other Criteria for Indication of PC: 1. Progression to wheelchair--dependent ambulation; 2. Speech difficulty: unintelligible or unintelligible speech; 3. Progression from normal to pasty diet; 4. Progression to dependence in most or all major activities of daily living (ADLs) or need for assistance with all ADLs. C. Critical Nutritional Impairment: 1. Insufficient intake of nutrients and fluids to sustain life; 2. Progressive weight loss; 3. Dehydration or hypovolemia; and 4. Absence of artificial feeding methods. D. Life-threatening complications: 1. Recurrent aspiration pneumonia; 2. Upper urinary tract infection; 3. Sepsis; 4. Recurrent fever after antibiotic therapy.[2, p. 69]

DISCUSSION

The International Council of Nurses (ICN) states that early assessment, identification and management of pain and physical, social, psychological, spiritual and cultural needs can reduce suffering and improve the quality of life for patients with PC and their families.[2]

It reflects that PC does not bring a cure to the patient, but should be provided by professionals with comfort and respect to make the patient's life as bearable and meaningful as possible without hastening death. The care is not only focused on the care of the body, but also the psychosocial aspects of the patients and their families, as well as the emotional pain, anguish and psychological malaise experienced by the patient.[10]

For many health professionals, the impossibility of cure is a justification for providing limited care, which is contrary to the principles of PC, which should offer a support system that allows the patient to live as actively as possible until the moment of death, and a system that helps family members.[10]

In this sense, it is necessary for multidisciplinary teams to make decisions together with the patient and his family, respecting the autonomy of the individual and the principle of non-maleficence.[11] However, the literature still reports difficulties in making the decision to switch from curative treatment to PC.[12]

Adequate communication between professionals, patients and families should be prioritized, as it is one of the main barriers that generate conflicts in the care of terminally ill critical patients.[11] And this difficulty is also reflected in the communication with the family and the patient.[12]

Communication is mainly between physicians and families, and is usually delayed and fragmented. When meeting with families, physicians often do not have time to share their perspective on the patient's goals and values or to express their own concerns. This results in missed opportunities for empathetic responses and leaves families too distressed to absorb or integrate the information they need to make a decision.[13]

Because of the complex, multidimensional, and dynamic nature of the disease, palliative care is a therapeutic approach that necessarily requires a multidisciplinary team.[11] To organize and guide this team, it is necessary to implement PC protocols in the ICU environment, which are important for reducing suffering and improving the quality of care offered to the terminally ill.[11]

This protocol will help professionals to decide how to deal with users who do not wish to be treated with extraordinary measures. It also aims to establish criteria for more systematized care during the dying process, which is necessary to make care more human and of higher quality.[7]

Systematized practice favors the identification of care needs expressed and/or indicated by patients and families, allowing the caregiver and the person being cared for to face this phase of life together, making use of appropriate strategies and resources.[4] Systematization brings a methodical and scientific approach to the care of people with PC and their families by collecting data, identifying problems, planning, implementing and evaluating interventions (pharmacological and non-pharmacological), and proposing changes based on evaluations.[5]

Another aspect identified in the literature is the daily barriers faced by ICU patients that prevent optimal care. The lack of consensus on the goals of each member of the team is highlighted. The nurse is concerned about the patient's well-being because he or she has a more holistic view, being the one at the bedside.[12] It is widely accepted in the literature that every critically ill patient in the ICU should be the focus of PC and that it is the responsibility of the entire team: to ensure comfort at the end of life; the decision to allow death to occur naturally should be made by the team, the patient, and the family.[3]

The principles that guide the practice of PC require specific training, as they are not yet transversal to the content and paradigms with which health professionals are taught. In the ICU environment, where patients at the end of life are usually found, these principles should be widely worked and disseminated[3], so that the care of palliative patients is always done in a humanized way.

CONCLUSION

Finally, the care of patients with PC who are beyond therapeutic cure is important, with the care process as a priority in the treatment process. It is clear that the results have contributed to the improvement of the care provided by the nurse to the patient with PC, at the same time as providing scientific evidence that can be put into daily practice.

As well as, in a comprehensive way, to be tested through the NCS and its relationship in the respective categories and subcategories of the Model of Care for the Preservation of Dignity (MCPD), including exploring the subsidies of nursing practice to promote a dignified death.

It was also noted that the valorization of life and the understanding of death as a natural condition, centered on the individual and the family, has a multidisciplinary character, with the aim of containing and alleviating not only the physical, but also the psychosocial and spiritual suffering of the patient, with the intention of achieving comprehensive care, guided by ethical principles of human rights.

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