Objective: To discuss through literature about palliative care as well as the performance of the nursing team facing these patients in the intensive care unit. Method: This is a study of integrative review to search for articles in the databases BDENF, LILACS, SciELO, MEDLINE. In order to establish the guiding question used the strategy of research peak. Were included articles are available in their entirety, electronically and published between 2007 and 2017. Results: There were found 133 articles of which only 10 were analyzed by addressing the process of terminality, palliative care, the inclusion of strategies and contributions of the communication. Among some care identified stood the comfort and hygiene of the patient, pain management, reception room, communication between the professional/patient/family, among others. Conclusion: it is concluded that the final pathway of life of those hospitalized in the ICU is triggered a multitude of feelings, which require the nursing team adequate assistance that minimize the suffering.
It is worth pointing out that the intensive therapy environment brings some meanings attached to the process of Live/die, a fact that consequently the family becomes responsible for decisions relating to the treatment and the type of therapy that will be established in the patient. Due to this fact, it is necessary to maintain a proper communication, to promote information about the patient’s prognosis and avoid feelings of frustration and suffering for the family. And, therefore, in this moment that there should be adequate communicative measures between the professionals and the team to alleviate suffering and provide comfort and encourage them in the face of situations that threaten the life.

Thus, this study is justified by the fact that the need to know the possible nursing care to patients palliative care in the ICU, since the nursing constantly experiences the process of death/dying in the process of palliative care. Another fact is that these professionals seem to ignore their role to these patients, often forgetting that his care as comfort, hygiene and communication/interaction among others, are indispensable in the finitude of life palliative. This is identified several times at the moment in which some nursing professionals are absent from basic care or avoid interacting with these patients.

Once that nursing has knowledge of its relevance in the paliativistas actions in ICU, can promote these patients a dignified and humanized care with continuous measurements during the process live/die. In addition this study aimed to discuss through literature about palliative care as well as the performance of the nursing team facing these patients in the intensive care unit.

Methodology

It is an integrative literature review that aims to gather and synthesize the results of research on a theme, in a systematic and orderly manner; contributing to a thorough understanding of the subject (5).

Six steps were followed for the elaboration of this revision: 1) identification of the theme or research question; 2) the establishment of criteria for inclusion and exclusion of studies; 3) definition of the information to remove the selected studies; 4) Assessment of studies included; 5) interpretation of results; 6) presentation of the review (5).

Thus, the guiding question of the study was first defined by means of the strategy peak. The population (P) restricted in palliative care patients admitted to the intensive care unit. The interventions (I) reported to general nursing care to these patients. The control or comparison (C) does not apply to this study. The outcome expected [Outcomes (O)] was the knowledge of the nursing care to patients who are in palliative care in the ICU. So the question followed as: what nursing care can be imposed to the patients in palliative care admitted to the intensive care unit described in literature? To search the articles were selected terms used in “Descritores em Ciências da Saúde (DeCS)”. Select the keywords in Portuguese “palliative care” “intensive therapy units” and “critical care”. For the screening of articles, the descriptors were combined among themselves using the Boolean operator “AND”.

The inclusion criteria were: scientific articles with full text available in its entirety; published in the last 10 years (2007-2017); and address the central theme “palliative care”, specifically in Intensive Care Units. The exclusion criteria were in complete articles, Proceedings of events, brief comments, text of sites, dissertations, theses, and publications prior to 2007.

The exploratory research was conducted in February 2017 through consultations on the basis of the Nursing Database (BDENE), literature of Latin America and the Caribbean (LILACS), Scientific Electronic Library Online (SciELO), and Medical Literature Analysis and Retrieval System Online (MEDLINE).

After the search, the authors have compiled articles by means of variables: the title of the article, identification of authors and journal, Year of publication, objective, subjects of research, main results and conclusions. Then, we proceeded to the assessment and interpretation of the results, which were summarized and organized to guide the discussion and preparing the final document.

Results

Initially, 133 articles were identified, and after filter the search to inclusion and exclusion criteria, the remaining 79 publications. Then performed exploratory reading of articles (title and abstracts). After reading the title of each publication, the remaining 17. Your abstracts were read in their entirety and passed through a reading of scanning of the whole body of the study, in order to identify which of them addressed the issue investigated, and thus fulfilled the inclusion criteria established. At the end of this step, 10 articles selected previously remained in the study because they were judged consistent with the proposed revision.

As to the origin of the studies, the United States concentrated the majority of publications (78.6%). The population studied in articles included patients who were in the postoperative period of CABG. The scenario of research was hospitals that carry out cardiovascular surgeries. Regarding the methodological design there was a predominance of quantitative studies. Table 2 presents the identification, authors, title, year of publication and periodic studies. From the analysis of the studies revealed various complications of myocardial revascularization in the postoperative period. These complications have been described almost always so grouped according to area or organ affected.

The main care for the patients in palliative care in the ICU found in literature selected were grouped and described in a table (Table 1). The selected articles were identified by the letter “A” and by Arabic numbers that correspond to the order of reading (A1 and A10) according to Table 1 below.

| Table 1: care for the patients in palliative care and their families. |
|---|---|
| Articles | Care addressed |
| A1 (6) | Keep the patient clean, neutralize odors, unpleasant, aspire bronchial secretions, look for peripheral and pulmonary edemas, prevent and/or treat the lesions by pressure. |
A1 (6) Keep the patient clean, neutralize odors, unpleasant, aspire bronchial secretions, look for peripheral and pulmonary edemas, prevent and/or treat the lesions by pressure.

A2 (7) Comfort, establish good communication, to orient the patient and the family in the care to be performed, explain about the medications and the procedures to be performed.

A3 (8) Establish verbal and non-verbal communication with patients and their families.

A4 (9) Comfort to the patient, dialog with family.

A5 (10) Alternative care medicated or not.

A6 (11) Communication with the patient, guidance on the care, deployment and implementation of the systematization of nursing care (SAE).

A7 (12) Care of hygiene (bathroom, oral hygiene), Reception, verbal and non-verbal communication, foster care and the autonomy of patients, comfort, well-being and psychological, inclusion of the family in care.

A8 (13) Communication and dialog.

A9 (14) Effective treatment of physical and psychological pain, comfort and well-being of the patient and his family, care with hygiene, monitoring, feeding, change of decubitus, so as not to increase or cause pain, hydration to the skin, always maintain a dialog, even if the patient is unconscious and whenever possible, meet your personal needs and desires.

A10 (15) Optimization of the quality of life, reduce the suffering of the patient, family-centered care in all phases of the disease, communication with patients and families, comfort to the patient, therapy or massage for relaxation and reduction of discomfort/pain, care with the mouth, repositioning and/or supplemental oxygen to relieve dyspnea in hypoxic patients, use of opioids for pharmacological treatment of neuropathic pain, and associates them with benzodiazepines, for the treatment of dyspnea, anxiety or other symptoms.

After reading the articles found that the same converged in the affairs terminality, palliative care and nursing. And that the majority of articles addressing the patient’s comfort and the verbal and non-verbal communication between the professional/patient/family as the most common care environment for patients in intensive palliative (2-10). However basic care such as hygiene, feeding, prevention of injuries caused by pressure (LPP), and promotion of family care and patient also form remembered in some articles (6-7; 11-14).

Figure 1: Intensive care unit: life, terminality and palliative care.

Discussion

The process of Terminality in ICU awakens in the human being a multiplicity of feelings, which trigger significant fear of family members before the finitude of life; the patient in the terminal phase requires a qualified assistance provided for the care offered, the aim is to provide dignity and decrease the suffering until the final moments of life.

This topic generates a vast amount of feelings to nursing professionals. These feelings related to the process of death may vary in accordance with the concepts of each professional on terminal patients in the ICU, as in the case of religion that can be interpreted and understood in various angles; death at different stages of life (beginning, middle and end) and their possible difficulties in acceptance of the interruption of life; the difficulty discussing the news of the death of the patient to the family and the preparation of the body, among others. Are procedures that bring profound impacts for nursing professionals, such as feelings of professional involvement, empathy, compassion, and failure in the face of death, where the professional may feel impotent, generating a possible feeling of anguish (16).

There is a certain difficulty by the nursing team in acting before patients in the terminal phase, which causes the professional a sense of failure. Therefore, it is necessary that the nursing team learn lead appropriately these situations by emphasizing the importance of a psychological preparation of these professionals and prevent possible psychic conflicts and avoiding situations of impotence professional (6).

As regards the practice of palliative care, this brings important concepts and attitudes for a more humane approach to the situation of Terminality pain experienced by patients. And that the involvement of different spheres of knowledge, of different cultures and personalities in a moment such as this can often make it even more complicated the experience of bringing death to all involved, mainly in cultures that try to avoid contact with (6).

Therefore, palliative care is essential in the context of the ICU, you must establish therapeutic measures for pain relief of critical patients, thus enabling a better quality of life for the patient and their family in end-of-life situations (7).

The family is the fundamental link in the process of patient care and that, in order to gain the trust of these, it is essential to a good interaction between professionals, patients and relatives (8). However there are some difficulties of professionals faced with situations where the family does not accept that your patient is in terminal stage and somehow pushes the professionals to continue investing in the treatment for healing through technological means, and instead of the team working understanding of family members they just opt for the easier it is to accomplish what the family asks, i.e., the therapeutic obstinacy. Therefore in consequence of this attitude the team feels distressed and frustrated, by introducing unnecessary therapies causing greater suffering to the patient, while that in line with the family should provide the patient for the relief of suffering by means of palliative care (9,17).
The ICU'S are not suitable places for the development of the process of dying, because they are sectors of the hospital of high complexity. Features high technology with the aim of providing curative care giving support to life, while palliative care is set to provide the patient with a terminal illness better quality of life by means of pain relief, with the aim of achieving a death with the minimum of suffering as possible (18).

So, after review of publications, you may realize that palliative care and ICU are intimately linked, because the ICU is a place where you can find many patients beyond the therapeutic possibilities which require the implementation of palliative care, where there should be a link between the curative care which are the patients with chance of survival and palliative care patients who are "out of therapeutic possibilities", being essential in nursing the perception regarding the natural process of death always preserving the autonomy of the patient so as to ensure the most appropriate care.

It is essential in the ICU’S, a multidisciplinary team with the aim to meet all the needs of the patient, be they biological, physical, social and psychological, providing the patient and their family a humanized care in all dimensions.

Therefore, it is essential that this issue will be further discussed in the training of health professionals in particular the nursing, because the curricula of undergraduate nursing courses are insufficient in relation to the theme. And that such inadequacies directly impact the quality of care provided by these professionals who are not properly trained (10).

Communication is a process of involvement which should provide with the establishment of a bond between the nurse and the patient terminal, verbal and non-verbal way. Therefore, it is an active process, attention and active listening (8.19).

A relationship of efficiency of the nursing team configures the communication as the main element in the preparation and delivery of a broader care assisting on a large scale in the relation between team members/patient/family, can identify problems early, and become an important ally in integration and aid of care to be provided (11).

Communication is an essential tool in nursing practice. It is through it that you get greater efficiency in the quality of care provided to the patient, being that communication can be both verbal and non-verbal, where this can be expressed in gestures, in expressions and emotions, i.e., a simple look. Therefore it is perceived that communication involves several elements that allow the patient interaction, this role in evolution (13).

A proper communication with the professionals of a team is an essential tool in the provision of care. The communicative process has as focus to build bridges where professionals seek to share information and discuss actions in conjunction with the objective of facilitating the relations among themselves and in the middle of the living reality, thereby offering greater sailing team learning, this being a facilitator for the resolution of problems and a foundation in the interaction of interpersonal relationships (13).

Because the patient hospitalized in an ICU is commonly with feelings of loneliness, isolation, insecure, feeling helpless. At this moment it is essential that the nursing staff perform a communicative process with the patient, developing ability to understand future messages (12).

Therefore, nurses who work in palliative care with patients in the imminence of death and with your family should enhance the use of verbal and non-verbal, as well as qualified listening as instruments for the promotion of effective therapeutic modality of care, although not always, make use of them (8).

This causes the communicative process provided to patients hospitalized in the ICU has a focus on patient/professional interaction, aiming at a foundation which can be of great importance in the quality of assistance offered. With this, the communication is the central axis in the care offered to patients, showing that the care of nursing, is a practical complex, which not only involves techniques and technologies, but also the history of the patient's life, which can be obtained through an effective communication, with the establishment of bond of trust with the patient and his family, that sustain this situation (12).

It is emphasized that, in the case of palliative care in the ICU, communication, orientation and training should permeate the actions of the professionals, which favors the care provided to patients and family, with a view to better results (14).

It is of great importance that the nursing team members develop communication skills, both verbal and non-verbal which excites the sensitivity of the professional to know how to deal with patients during the provision of care or procedures that are performed even when this is sedated, because this process of communication conveys security and improves the interaction (12).

The treatment performed with the patient in an ICU is invasive and triggers a different situations, being full autonomy of nursing develop skills in communication with patients and their relatives, giving greater clarity in information, promoting a planned and structured assistance (20). Thus, the communication is seen not only as an exchange of messages between the nursing staff and patient, but it is an action that must be planned and individualized, not being held by pulses or intuitive way (11).

There are various guides and techniques that can be used to make this therapeutic communication. With this, the nurses from the communication developed with the patient identifies their needs, informs about procedures or situations that he wants to know, promotes the patient's relationship with other patients, with the multi-professional team or with family, promotes health education, exchange of experiences and change behavior, among others. These are some of the functions of communication in which nurses are involved, which does not mean that the patient cannot also be active subjects of these actions (11).
Conclusion

The act of caring in the provision of palliative care enables us to recognize, respect the cultural values and beliefs of each patient, ensuring greater security and privacy for him and his family. Provide palliative care in nursing is to experience and share moments of love, compassion, offer a holistic manner; a humanized care, authority with adequate management and control of pain, with a reduction of suffering, with the aim of preventing undesirable complications.

Proper communication in situations of Terminality in Intensive Therapy Unit provides an essential foundation in the structuring of palliative care, and should be implemented efficiently and active among the members of the multidisciplinary team to awaken the patient and family feelings as positivity and confidence.

References
