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PALLIATIVE CARE TO THE ELDERLY IN INTENSIVE CARE: THE PERSPECTIVE OF THE NURSING TEAM

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ABSTRACT

Objective: discover the meaning of palliative care for the elderly for the nursing team and identify how the family interacts with the elderly at the intensive care unit.

Method: descriptive research developed at the intensive care unit of a public hospital in Fortaleza-Ceará-Brazil. The sample consisted of 58 professionals from the nursing team. The data were collected in the second semester of 2015 by means of a semistructured and recorded interview.

Results: the results appointed three thematic categories: palliative care, particularly the relief of pain and suffering; interaction between relative and elderly; in which communication stood out as the most important; and inappropriate environment for palliative care, emphasizing orientation for care.

C**onclusion:** the team has knowledge on palliative care and acknowledges the family as a link between professional and elderly. In addition, intensive care is not considered an appropriate environment for palliative care.

DESCRIPTORS: Aged. Nursing. Palliative care. Family. Critical care.

CUIDADOS PALIATIVOS AO IDOSO NA TERAPIA INTENSIVA: OLHAR DA EQUIPE DE ENFERMAGEM

RESUMO

Objetivo: conhecer o significado de cuidados paliativos ao idoso para a equipe de enfermagem e identificar como ocorrem as interações da família com o idoso na unidade de terapia intensiva.

Método: pesquisa descritiva, realizada unidade de terapia intensiva de hospital público em Fortaleza-Ceará-Brasil. Amostra composta por 58 profissionais da equipe de enfermagem. Fez-se a coleta de dados no segundo semestre de 2015 por meio de entrevista semiestruturada e gravada.

Resultados: os resultados apontaram três categorias temáticas: cuidados paliativos, com destaque para alívioda dor e do sofrimento; interação familiar e pessoa idosa, sobressaindo comunicação como mais importante; e ambiente imprópriopara cuidados paliativos, com ênfase em orientação para o cuidado.

C**onclusão:** conforme o estudo mostrou, a equipe tem conhecimento sobre cuidados paliativos e reconhece a família como elo entre profissional e idoso. Considera-se, ainda, que a terapia intensiva não é um ambiente apropriado para cuidados paliativos.

DESCRITORES: Idoso. Enfermagem. Cuidados paliativos. Família. Cuidados críticos.

CUIDADOS PALIATIVOS PARA EL ANCIANO EN TERAPIA INTENSIVA: UNA MIRADA DEL EQUIPO DE ENFERMERÍA

RESUMEN

Objetivo: conocer el significado de los cuidados paliativos del anciano para el equipo de enfermería e identificar cómo ocurren las interacciones de la familia con el anciano en la unidad de terapia intensiva.

Método: investigación descriptiva realizada en una unidad de terapia intensiva de un Hospital público en Fortaleza-Ceará-Brasil. La muestra está compuesta por 58 profesionales del equipo de enfermería. Se realizó la recolección de datos en el segundo semestre del 2015 por medio de una entrevista semiestructurada y grabada.

Resultados: los resultados mostraron tres categorías temáticas: cuidados paliativos con destaque para el alivio del dolor, interacción familiar y el anciano. Se destacan, como más importantes, la comunicación y el ambiente impropio para los cuidados paliativos, enfatizando la orientación para el cuidado.

Conclusión: conforme ha demostrado el estudio, el equipo tiene conocimiento sobre los cuidados paliativos y reconoce a la familia como un eslabón entre el profesional y el anciano. Además, se considera que la terapia intensiva no es un ambiente apropiado para los cuidados paliativos.

DESCRIPTORES: Anciano. Enfermería. Cuidados paliativos. Familia. Cuidados críticos.

INTRODUCTION

Illness often generates in the affected people, professionals and families an intense desire that, during this process, treatment alternatives and cure be found. The proper response to treatment confirms the success of a battle against a biological enemy that triggers heavy discomfort to human life. When the positive response is not achieved, however, feelings of frustration and impotence develop in view of the possibility of loss and/or continued maintenance of care in palliative care.

Palliative care, understood here as the care that provides the patient whose illness no longer responds to curative treatment with comfort, relief of pain and suffering, as well as improvement in the quality of life in the physical, psychological, social and spiritual aspects, with emphasis on protecting the family during the process of illness, death and mourning, according to the Palliative Care Manual.[1]

The palliative care concept is used to designate the action of a multiprofessional team for patients beyond therapeutic possibilities of cure. The term palliative originates in the Latin word palliun, which means mantle, protection, that is, to protect those whom curative medicine no longer welcomes.[2]

In this sense, considering that the demographic growth of the elderly population is a reality around the world and in Brazil, the concern with this group is considered relevant because, in general, they are people affected by chronic non-communicable diseases that lead to conditions of chronicity. These conditions may make the elderly fragile due to the association between chronic illness and the alterations of old age, although technological advances, linked to the knowledge and competence of the treatment professionals, in some cases does not modify the condition determined by illness. Then, the possibility of the process of death and dying emerges, which is maintained in the imaginary of the elderly person and the relative.[3-4]

In addition, most of the time, the elderly persons who have to undergo a long treatment permeated by complex and painful procedures and their family will spend a long time together in the hospital environment, when there is no indication or chance of returning home. This fact allows the establishment of ties of interaction between the family and the multidisciplinary team, especially nursing, based on trust, hope and respect, enhancing a relationship of responsibility and commitment for the elderly throughout the palliative care period.

Palliative care is a recent term in the vocabulary of the multidisciplinary team and some questions emerge with regard to nursing, namely: how does the nursing team consider palliative care for the elderly in intensive care and how do they perceive the interactions of the family with the elderly hospitalized there?

The knowledge produced will serve as a reflection for the sake of a new perspective on the elderly person in end-of-life conditions and, consequently, broadens the modes of caring, and also permits the apprehension of strategies that contribute to better interact and guide the family at that moment, especially when the elderly person is hospitalized in an intensive care unit.

In this perspective, this study aimed to discover the meaning of palliative care for the elderly according to the nursing team and to identify how the interactions of the family with the elderly person occur in the intensive care unit.

METHOD

This is a descriptive study, carried out in an intensive care unit of a public hospital in the city of Fortaleza, Ceará, Brazil in the second semester of 2015.

While the study population consisted of 75 professionals, the sample consisted of 58 nursing team members, being 23 nurses and 35 nursing technicians. Inclusion criteria were: to be part of the nursing team at the intensive care unit; and exclusion: nurses who carried out management activities, those working in pediatrics and technicians working in the unit's material and equipment control, as well as those with shifts in pediatrics, on vacation or leave for any reason.

Data were collected through a semistructured interview and recorded in a digital audio device with the respondent's consent. The instrument consisted of two parts. The first considered the identification of sociodemographic data (age, length of work in intensive care and experience in elderly care in palliative care); The second part was related to knowledge about palliative care for the elderly and communication / interaction with the family. The interviews were recorded with an average duration of 30 minutes and transcribed in order to maintain the reliability of the statements. The interview was chosen because it permits knowing and interacting more intensely with the participant and observing reactions. All interviews were programmed with the participants and were held in an appropriate room.

After collecting the participants' sociodemographic data, these were submitted to statistical treatment using simple and percentage frequencies. For the interview data, thematic content analysis was applied, which is a set of analysis techniques that describes the contents of messages. The analysis included the following phases: pre-analysis by skimming the corpus, aiming to identify the potential categories and preparation of the material for new evaluation; exploration of the material to decompose the corpus, identification of the categories and description of the categories (analysis itself); and composition of the analysis unit, represented by the immersion and definition of the empirical categories based on the corpus.[5]

In the research, the following units of analysis were identified: the phrase as a recording unit (RU) and the paragraph as a context unit. The discussion of the results obtained involved the phases of significance of and inference about the themes. The results were discussed in light of the relevant literature.

As determined, the study received approval from the Research Ethics Committee of Universidade Estadual do Ceará (CEP/UECE), opinion 078796/2014 and CAAE 31577014.2.0000.5047. Participants signed the Free and Informed Consent Term after reading and explaining the full content of the research.

RESULTS

Characterization of participants

All professionals are female 58(100%); the age ranged from 37 to 58 years, with predominance of 31 professionals between 40 and 47 years (53.4%). Regarding the duration of intensive care work, 52(89.6%) were between 5 and 24 years old and 6(10.7%) were older than 25 years. All the professionals of the team had experience in care for elderly persons in palliative care, either at the research institution or in other places where they carry out professional activities. All participants affirmed experiencing care for adult and elderly people in severe conditions in their daily practice and the elderly in general compose this group of patients.

Thus, as admitted, when the professionals present their opinions about what they consider to be palliative care, they bring the specificities of a care that has been improved and executed in their daily reality throughout their experience shared with the relatives and patients in clinical care practice.

Table 1 shows the distribution of the categories and subcategories elaborated based on the analysis of the participants' interviews, which reveal the contents of the messages and their meanings, through logical deductions and justified by the participants' discourse.

Table 1- Distribution of categories and subcategories elaborated about palliative care for elderly people in intensive care. Fortaleza-CE, Brazil, 2016. (n=58)

Categories	Subcategories	Coding	Recording unit
Palliative care	Relief of pain and suffering	ADS - 25	PC - 110
	Maintain comfort	MC - 19	
	Taking care of frailty	CF - 16	
	Impotence due to loss	RPI- 15	
	Proximity of death	PM – 11	
	Kindness and protection	CPR - 8	
	Continuous hygiene	HC- 7	
	Safety of the elderly	SI - 6	
	Family suffering	SF - 3	
Interaction relative and elderly	Communication required	CN – 45	IRE - 123
	Family participation	PF-37	
	Care orientation	OC- 41	
Improper environment for palliative care	Improper location for palliative care	DRCP- 31	IEPC - 31

Thematic categories

Using the content analysis technique, 264 recording units were identified, constituting three categories and 13 subcategories.

The Palliative Care (PC) category concentrated the largest number of subcategories with emphasis on maintaining comfort; taking care of fragility; relief from pain and suffering; impotence due to the loss and proximity of death, totaling 110 recording units. In this category, the importance of palliative care for the participants is highlighted, emphasizing the concepts of relief, comfort and respect for the human being in the face of the imminence of death.

The Relative and Elderly Interaction (IRE) category concentrated only three subcategories, but with a higher number of records, namely: communication required, family participation and care orientation. According to the above, communication / interaction with the family is one of the palliative care philosophies and its purpose is to promote the quality of life of the patient, in this case the elderly, who are in a condition of illness that threatens the continuity of life. The recording units were predominant in this category, amounting to 123. The idea of communication and interaction with family members is observed in this category, in order to guide them concerning the conditions of the elderly and the importance of sharing care.

In the Inappropriate Environment for Palliative Care (IEPC) category, only one subcategory was identified: difficulty in interactions among professionals, family and elderly. The necessary interaction between the professionals and the elderly's relatives is emphasized, considering the clinical conditions of these people and the indispensable presence of relatives to accompany and perform basic activities with the elderly, which begin in the ward and continue at home. As revealed, the environment does not favor effective communication between professionals and family members.

DISCUSSION

Palliative Care

The professionals' discourse evidenced the emphasis on the relief of pain and suffering as a prerequisite to provide high-quality palliative care. For the professionals, there is a disease and a human being, but the latter is no longer able to react and respond to the therapeutics implemented. So the alternative is palliative care, because it favors the continuity of life for the elderly, involving physical, emotional, social, spiritual and cultural aspects, in order to improve the quality of life, reducing the signs and symptoms of the disease.[3-4] In line with the participants' discourse, the quality of life mentioned is to improve well-being and offer

a better standard of living to the elderly, according to the conditions allowed. As revealed in the following discourse:

I understand that palliative care is provided to the person, in this case to the elderly, when there is no possibility of cure. This generates pain, suffering for all. It is impotence in the face of illness. It means being close to death (...) *so it is time to relieve pain and avoid physical and psychological suffering. It is to be close, to accommodate well and to leave the elderly comfortable. Avoiding injuries because they increase suffering ...* (E43).

The term palliative care still causes fear because of the possibility of death and suffering, through ignorance. Here, comfort is considered important, safety in the sense of avoiding more risk for the elderly, knowing that he or she is frail like a child, and trying to avoid the pain for the family, explaining in detail the conditions of the elderly or any patient, but sometimes I see that they do not accept it, which leads to suffering... (E12).

When death is inevitable, the most visible sensation is the fragility of this healing power, causing in many professionals the idea of failure. Nevertheless, death triggers noteworthy feelings, not only for the dying person, but also for the multidisciplinary health team, especially nursing.[6] Therefore, the understanding of health professionals in the process of finitude is fundamental, mainly because it permits the recognition of the human being who is part of this process. Thus, the construction of this understanding allows for the understanding of the disease for the patient who is confronted with a situation of coping and acceptance. Therefore, patients need assistance from a professional capable of sharing this coping.[7]

In the development of palliative care, situations always occur that are permeated by feelings of suffering, pain and death as constant and present elements. For the professional and patient, these feelings generate an emotional burden that makes the provision of this care more painful. Hence, according to the professionals, they need to perform their initiatives well in order to overcome the vicissitudes deriving from the patients' conditions of illness and suffering, especially the elderly, in order to maintain their balance in the face of the family members' suffering.[8]

According to the professionals' report, the image elaborated about the meaning of palliative care makes it difficult to determine when to start this moment and, also, it generates discomfort in the relatives when communicated. Thus, it is known that the lack of continuous information on the conditions of the elderly, as well as the lack of understanding can arouse hardly realistic feelings in the relatives about the elderly's health condition. Then, the professionals should invite the patients and family members to participate in the treatment established and the care modes, with a view to building a relationship based on trust vested in the team.[9]

In a study involving family caregivers, it was observed that appropriate palliative care practice recommends individualized care for the patients and families, together with the health team, aiming for the bio-psycho-socio-spiritual health of all.

Hence, the family members' particular acceptance of the death process can be understood and they can welcome the professionals' care orientations, specifically considering the complexity of the treatment. As proposed, professionals who are guided by the premises of palliative care can provide attentive and humane help to the family.[10-11]

Interaction Relative and Elderly

In the hospitalization process of the elderly, the family is important, especially because they experience illness and understand the need for hospitalization, based on the pain the illness causes and the distancing from the loved one. The presence of the family supporting and offering comfort reduces the worries deriving from the environment where the elderly person lives. Therefore, the family develops an expressive bond with the nursing team that cares for the elderly person in the hospitalization phase. This fact is observed in the following statements:

When a nurse lets a family member stay longer with the patient, we soon see the difference, both for the patient and the family, especially if it is an elderly person, because the family feels much calmer because they are seeing from nearby what happens to their relative... (E20).

The daughter came in and when she arrived, she hugged her father and said that she loved him very much and that everyone was waiting for him to celebrate his birthday the following week. He was still, but when she started to talk to him a tear ran down his face and he squeezed her hand a little. This is very good for me, so I understand that the families want to be close and know everything in detail. I think it's our obligation... (E33).

The family is the reference and is seen by the elderly as fundamental protection. Considering their historical background and strong family ties, the relatives have the affective components needed to protect the family at this moment. Therefore, the

presence of the family helps the elderly person to accept the hospitalization, and helps in bonding with the health team.

Care for the human being requires the understanding of various types of communication, either verbal or through the perception of bodily gestures or expressions and facial dynamics. Thus, it is fundamental to exchange information or care between health professionals and family members in order to identify the professionals' actual role.[12]

As the statement shows, the family is essential. When the family can get close to the elderly patient in the ICU, we realize that he seems to recover faster. Thus, he responds to stimuli, even skin contact and so-called weak stimuli (E1).

Palliative care for the elderly requires professional interaction with the family to provide care guidance in the most comprehensive way possible. This communication and family orientation occur through qualified listening to perceive their concerns, doubts and anxieties regarding the behaviors the team adopts in care for the elderly person, as well as the moments when family intervention is required. The team also perceives the affective relationship between the elderly and the family, and sometimes seeks strategies to minimize distress and strengthen affections[8], as shown in the following discourse:

Sometimes, even when the nurse expands the visiting hours, one can observe the distancing of the family, the children themselves, in relation to the hospitalized elderly, even when his health is very weak. At first, during the first moments of hospitalization, they are afflicted to get news, to know if the elderly will recover. Then they disappear, and even at the idea of discharge, they no longer visit. They call to hear news. That is very bad, because we wonder what it will be like for us one day (E33).

Overall, the presence of the family at the hospitalized elderly person's side is intended to share affection, security and support with him. However, in the speeches, as has often been observed, the family role in this environment is not seen in this way. Repeatedly, difficulties occur for the family to adjust their time and tasks to the needs to stay next to their loved one, and at other times the non acceptance of the discharge to the infirmary, out of fear of complications that would put the old person at risk again, as well as the non-availability of another family member to maintain this care.

Palliative care proposes to the multidisciplinary team, particularly nursing, in intensive care, the challenge of caring with scientific competence without, however, forgetting the valuation of the human being, independent of his life in the family. In order to be attended to, and for the sake of comprehensive care, the team urgently needs to rescue the empathic interpersonal relationship. It is essential to listen and to be sensitive to the needs of the elderly, rather than technical skills to diagnose and treat. These people expect the relationship with professionals to be based on compassion, respect and empathy, in order to assist them in the process of death, valuing their experience.[13]

In this sense, humanized care needs to go beyond the care focused exclusively on the disease or the possibility of death. To go beyond is to perceive this elderly person as a being who has a life history, feelings, memories, desires and who finds himself in a strange and aggressive environment, with serious commitments of organic and psychological manifestations. As observed in the statement:

For me, I consider the family, at all times, very necessary for the elderly. So if the family could stand beside her patient in the intensive care unit, I think that all patients, including the elderly, would recover much faster (E4).

Of course, empathy should be an established characteristic of the inpatient, the family and the professionals. The exchange of information and the possibility to provide guidance on the elderly's actual needs should occur through dialogue. A harmonious relationship needs to exist in the communication process. It is up to the practitioners to become available to improve the family's understanding of the elderly's health conditions. Sharing the care for this person with the family should be natural and beneficial regardless of where it happens.[10]

For palliative care to be effective, it is essential that the health team, especially nursing, finds strategies for the control of physical symptoms. But it is also necessary to value the need to relieve the psychological and spiritual suffering present in this situation. As emphasized, care focused on individual need and an empathic relationship among professionals, the elderly and the family, promote a better quality of life for all people involved.[10]

In the interviews, yet another important aspect about the family's presence was perceived; besides providing more satisfactory emotional conditions for both, a number of other advantages exist: it creates a closer and more intense relationship with the team; it prevents accidents at the ward by maintaining patient vigilance and permits active participation in care for the elderly. Thus, as understood,

the elderly can be more readily attended and the hospitalization period can be shortened, making the discharge and continuation of care possible.

I think it is important... for him it must be a scary place, full of terrifying apparatuses, unknown people circulating all the time, invading his privacy, invading his decency which for him is so pure. For all these reasons, there are enough motives to frighten an elderly patient admitted to the ICU (E29).

The old man would also be calmer, even though he was sedated, but when he woke up he would see that there was a family member at his side, helping to take care of him. Another important point is the exchange of information with the family, because they should be there, at all times (E58).

Strengthened by the presence of the relative, the elderly can better elaborate their feelings and emotions, such as anxiety, fears and fantasies, generated by the intensive therapy environment, sometimes by the alarms of apparatuses or by the movement of professionals in dealing with the most severe cases, sometimes by the movement of the visitors or the fear of expressing their feelings. As exposed in the professionals' discourse, the family can be a mediator among the elderly, the professionals and the environment.

It should be noted that the exchange of information between relatives and health care personnel regarding the care provided to the elderly during their hospitalization period has not been an easy task, neither for the staff, who are not clear as to what palliative care should be provided in this process, nor for the companions, as they do not know what their role in the intensive care units is.

As the presence of the family is not frequent accompanying and questioning the care, conflict can occur with the nursing team, which is not always prepared to cope with some situations experienced at the unit.

Improper environment for palliative care

Accordingly, the interviewees perceive that the intensive care environment makes it difficult to perform palliative care with quality. According to them, technological devices, noise and environment, as well as visiting hours or lack of privacy, among other factors, contribute to the improper care in the end-of-life conditions, besides deviating from the recovery proposal even in severe conditions.

During the hospitalization of the elderly in this environment, he and his family become part of the routine. In this place, the family assumes new roles, where care becomes more necessary. Therefore, the more oriented the diagnosis, treatment and clinical practice of the elderly person, the greater the possibility for the family to observe and identify the changes early. Another aspect to be considered in intensive care is the short visiting time, which makes the family powerless to maintain the desired relationships with the patient and, hence, causes complaints and annoyances.

Different barriers are appointed in the studies when it comes to palliative care in intensive care. These include the daily practice of the multidisciplinary team, especially nursing, regarding palliative care for the elderly, as they do not properly embrace the meaning of the word and work in an environment with objectives that do not correspond to end-of-life care.6 It was observed, in the reports, that the participants mentioned the intensive care team's lack of preparation for palliative care, a fact that triggered conflicts. At other times, the difficulty to reach a consensus in the actions of the multiprofessional team was perceived, when performing procedures that may not benefit the elderly person already in palliative care.[13]

As is well known, although the central axis of care for the team is the patient's well-being, spending more time at the bedside, and early observation of changes in patient severity, lack of availability to meet the actual needs of the elderly and their family members, and effective communication/interaction. As they emphasize, in the intensive care setting, the nursing professionals experience difficulties in providing palliative care. Despite their experiences and knowledge, there are demands at the unit that require nursing's continued look at the other patients hospitalized there.[14-15]

Studies on the experience of nursing with palliative care in an intensive care unit have shown nurses as the most experienced professionals acknowledged in relation to the other members of the multidisciplinary team. They attribute this experience, generally because they are professionals who facilitate more qualified listening, seek to establish a comprehensive language with the family and identify weaknesses in their knowledge about the clinical conditions of the elderly, as well as the need to start palliative care.[16-17]

Thus, nursing professionals are fundamental in the palliative, that is, multiprofessional care team, due to the essence of their training, whose basic premise the science and art of care, focused on wellbeing. These aspects are evidenced since the early thinking about nursing; quality of life in the last days of the human being.[17]

As observed in the following statements:

I have no idea, because I do not see how the family could help with the elderly patient at the ICU, here. There are many procedures only the unit's staff knows how to do, and the surrounding family might not understand and disrupt it. I do not know if is good to have the family in the intensive care unit, I think they should be prepared first because it is a place of many procedures, sometimes great rush the family will never understand, because the family wants attention upon demand and here, because of the dynamics, it is not possible (E11; E17).

As for the family in the unit, I do not know, because in my opinion I think it is a very closed, very reserved place, full of appliances and the family would not understand all those procedures that are necessary in their patient (E19).

The family can also help us by taking care of the elderly in the small things and observing greater care when necessary; such as changing a bandage that is very dirty, warning when a serum needs replacement and other things a good companion knows how to do, it even helps us (E18).

The family's participation is very important to learn to take care of simple things like giving comfort, not leaving wet and preventing that arms and legs get deformed or that lesions appear. It would be a good way to stay together at those moments, but here, at the ICU, it is not possible, the family does not understand much and is restless due to the environment (E27).

The contemporary death philosophy is marked by the professionals' commitment to making the end of a person's life a dignified moment, giving him a voice, permitting choices, especially concerning the place where he wishes to die, taking care until his last sigh.[18-19]

Thus, family care is more affectionate care, of being together, of protection, and also of hygiene, of observation and even of problem identification, a care that shows to be as essential as the others. For this to take place effectively, the health professionals should offer guidance and instruction on how they can develop these actions, preparing them to better cope with adversities in the natural course of the elderly person's illness, in order to take care according to their capacity and potentials.

In research on the meaning of death and terminality, as it turned out, when the professionals have contact with people who are experiencing the situation, they usually experience anxiety, anguish and fear. They often report that they are unable to cope with the situation. Although they often have knowledge about the characteristics and procedures of end-of-life care, this knowledge is not necessarily tied to the perception of having gained competence to cope with terminal situations.[20]

Yet, as other research shows, although the professionals master the knowledge of palliative care and know how to talk about terminality issues, they believe that they do not provide emotional support to patients and do not feel sufficiently prepared for this task.[21]

The nursing team is responsible in care for people, especially elderly in palliative care, to prepare family members to cope with the process. Palliative care requires in-depth discussions by the group, with a view to better preparation for care.

CONCLUSION

The study revealed the different perspectives involved in palliative care, emphasizing that a comprehensive and interactive perspective on family and patients permits the best care for the patient, especially the elderly.

We could also understand the dilemmas of a team that, when dealing with the circumstances of finitude, guided by palliative care, expresses and reveals negative images on the subject, but emphasizes that the objectives of the work environment are strengthened by possible survival actions, although deaths occur. It also expresses the lack of experience, especially because intensive care actions do not match those required for palliative care. As they explain, the demands are different and the time to practice this care is short at the unit.

The nursing team's communication/interaction with the family should always remain open, in view of the need for the family to inform, guide and understand the whole process, in order to prepare it for discharge and care at home.

The limitations of the research are justified by the nursing team's difficulty to be sensitive to the families' demands, trying to understand the need to respect the elderly person's autonomy, when (s) he is conscious.

The research results are expected to contribute to the planning of actions that favor the understand-

ing of palliative care at the intensive care unit, revealing the importance of the nursing team.

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