

Experience report

Implications for Nursing Technicians in Palliative Care within Intensive Care Units: A Practice Report

Implicações dos técnicos de enfermagem em cuidados paliativos na terapia intensiva: relato de experiência

Implicaciones de los técnicos de enfermería en cuidados paliativos en la terapia intensiva: relato de experiencia

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Abstract

Objective: to report encounters with Nursing Technicians (NTs) during shifts in an adult Intensive Care Unit (ICU), aiming to provoke reflections on the professional, affective, and ideological implications in palliative care practice. **Method:** a practice report conducted between June and July 2024 with 42 Nursing Technicians, totaling seven encounters, using the conversation circle modality. **Results:** the encounters highlighted the participants' implications related to the perceived low effectiveness of care practices, a hospital environment structured by rules and norms, and the NTs' limited knowledge regarding the implementation of palliative care practices. **Conclusion:** through the collective analysis of their libidinal, ideological, and professional implications in the care environment, participants were able to express experiences and needs, bringing to light unspoken aspects and fostering deeper reflection on palliative care practices.

Descriptors: Palliative Care; Licensed Practical Nurses; Education, Nursing, Associate; Intensive Care Units; Institutional Analysis

Resumo

Objetivo: relatar os encontros com Técnicos de Enfermagem (TE) durante os plantões na Unidade de Terapia Intensiva (UTI) adulto, visando provocar reflexões sobre as implicações profissionais, afetivas e ideológicas na prática em cuidados paliativos. **Método:** relato de experiência, realizado entre junho e julho de 2024, com 42 Técnicos de Enfermagem, totalizando sete encontros, na modalidade roda de conversa. **Resultados:** evidenciou-se, nos encontros, as implicações dos participantes relacionadas à pouca efetividade na prática assistencial, um ambiente hospitalar instituído com regras e normas e o desconhecimento dos TE no desenvolvimento das suas práticas em cuidados paliativos. **Conclusão:** ao colocarem em análise

coletiva suas implicações libidinais, ideológicas e profissionais no ambiente de cuidado, possibilitaram a expressão de vivências e necessidades, revelando os não ditos e favorecendo a reflexão sobre a assistência em cuidados paliativos.

Descritores: Cuidados Paliativos; Técnicos de Enfermagem; Educação Técnica em Enfermagem; Unidades de Terapia Intensiva; Análise Institucional

Resumen

Objetivo: relatar los encuentros con Técnicos de Enfermería (TE) durante los turnos en la Unidad de Terapia Intensiva (UTI) de adultos, con el fin de provocar reflexiones sobre las implicaciones profesionales, afectivas e ideológicas en la práctica en cuidados paliativos. **Método:** relato de experiencia, realizado entre junio y julio de 2024, con 42 Técnicos de Enfermería, totalizando siete encuentros, en la modalidad de círculo de conversación. **Resultados:** se evidenció, en los encuentros, las implicaciones de los participantes relacionadas con la poca efectividad en la práctica asistencial, un entorno hospitalario instituido con reglas y normas y el desconocimiento de los TE en el desarrollo de sus prácticas en cuidados paliativos. **Conclusión:** al poner en análisis colectivo sus implicaciones libidinales, ideológicas y profesionales en el entorno de cuidado, posibilitaron la expresión de vivencias y necesidades, revelando los no dichos y favoreciendo la reflexión sobre la asistencia en cuidados paliativos.

Descriptor: Cuidados Paliativos; Enfermeros no Diplomados; Graduación en Auxiliar de Enfermería; Unidades de Cuidados Intensivos; Análisis Institucional

Introduction

The development of society has pointed to the need for the continuous updating of humanized healthcare for the population. This context has paved the way for the development of Palliative Care (PC), which constitutes a multidisciplinary and interdisciplinary approach—arising from healthcare actions and services from the primary to the tertiary level—that cares for patients with life-threatening diseases in order to alleviate suffering and other symptoms through pharmacological and non-pharmacological means. This approach aims to improve the quality of life of patients, their families, and caregivers through the prevention, early identification, comprehensive assessment, and management of physical, psychological, spiritual, and social issues.¹⁻³

The nursing team plays a privileged role in healthcare. They are the only professionals who remain at the patient's side twenty-four hours a day, creating a bond among the patient, family, caregivers, and the healthcare institution. This connection enables the integral development of Palliative Care principles.⁴

According to data from the Federal Nursing Council, the largest number of professionals in the field is composed of Nursing Technicians (NTs, equivalent to

Licensed Practical Nurses in Brazil), with 1,847,700 registered professionals throughout Brazil, followed by 752,567 nurses and 473,260 nursing assistants. It is worth noting that 70% of the nursing team in hospital units is composed of technicians, and—despite this extremely significant number—there are no studies on PC directed at this group.⁵

Thus, it is urgent to promote qualified training for these professionals in order to provide quality healthcare. In December 2023, the National Palliative Care Policy was approved through Resolution No. 729⁶, consolidating all efforts undertaken through specific financial allocation and regulations for the provision of comprehensive, compassionate, and effective Palliative Care. On May 7, 2024, the National Palliative Care Policy (PNCP) was officially instituted within the Unified Health System (SUS) by GM/MS Ordinance No. 3,681.²

These initial considerations are added to the first author's concerns while working as a nurse in an Intensive Care Unit (ICU), where she observed the insecurity and lack of preparation of the nursing technician team in providing care for patients in palliative care. Added to these concerns is her engagement with the theoretical frameworks of Institutional Analysis within the scope of the Professional Master's Program in Health Education at Fluminense Federal University, understanding that health professionals and those in training are shaped by affective, social, ideological, and professional dimensions inherent to institutions, and that such influences affect each professional's care practice.⁷⁻⁸

In this sense, this article aims to report encounters with nursing technicians during shifts in an adult Intensive Care Unit, seeking to provoke reflections on the professional, affective, and ideological implications in palliative care practice.

Method

The study uses the qualitative method of a Practice Report, which, in the academic context, aims not only to describe the lived experience (close experience) but also to value it through a critical-reflective academic effort, with theoretical-methodological support from Institutional Analysis (IA) (distant experience).⁹⁻¹⁰ According to IA theorists, its purpose is to understand social reality based on the actions and discourses of its subjects. Regarding the method, it consists of an articulated set of

concepts, among which the concepts of institution, instituted, instituting, and implication stand out for this report.¹⁰

In IA, it is important to bear in mind that institution is not a descriptive concept; therefore, it does not designate solid and concrete entities—capable of being seen—but constitutes a “contradictory dynamic building itself in (and into) history or time.”^{11:11}

In this report, education, health, teaching, and professional practices are understood as institutions, highlighting that all institutions have the following characteristics: “coerciveness and moral authority,” as they exercise a pattern of control over individuals; “historicity,” which marks the existence of institutions before the individual’s birth and their continuity after death; and “exteriority,” which emphasizes that every institution is situated outside the individual and is independent of their will.^{12:193-199}

The concept of implication refers to our constant and often unconscious involvement in everything we do. That is, we are continually influenced by our affective, ideological, and professional dimensions, whether in relation to our professional practice or to the institutions to which we belong, such as family, religion, health, and education.¹¹

Regarding the activities of this RE, they were conducted in an adult intensive care unit (ICU) at a public hospital in the state of Rio de Janeiro. This ICU has 30 beds and is supported by a multidisciplinary team comprising 33 nurses, 96 nursing technicians, 33 physicians, 33 physical therapists, 2 psychologists, 1 nutritionist, 2 social workers, 4 dentists, 1 music therapist, and 1 occupational therapist.

The experience began in June 2024, when the first author took the initiative to hold weekly encounters during shifts, totaling seven encounters, the last taking place at the end of July 2024. The encounters were conducted in the conversation circle modality, with spontaneous participation. This modality is aligned with the assumptions of IA, as it favors horizontality among participants and positions them as co-investigators of the studied reality. Furthermore, it privileges dialogicity by encouraging interaction and debate, in which the speeches intertwine and confront one another, generating reflections that would hardly emerge in individual interviews. As a result, the conversation circle constitutes an environment conducive to the collective construction

of knowledge, in which the focus is not restricted to individual reports, but to the production of new meanings through sharing and group reflection. Consequently, it was configured both as a listening tool and as a space for training and collective analysis.

Regarding the participation of nursing technicians, it was observed that, in the first meeting, 3 professionals were present; in the second, 4 professionals participated; and in subsequent meetings, the participation of 7 professionals per session was recorded, totaling 42 participations over the analyzed period. As for their experience in intensive care, they had between 8 and 20 years of practice, which already indicated greater experience in the care of critically ill patients. All were part of the first author's team.

Participation in the meetings was open to all nursing technicians, with no inclusion or exclusion criteria, aiming to involve as many interested individuals as possible. The meetings took place at the nursing station, in the afternoon—considered a quieter period in the unit, after the completion of care routines—ensuring at all times the availability of the team for patient care. Those who did not feel comfortable participating in the discussions continued with their professional activities.

In the first meeting, the session lasted 30 minutes, and from the second meeting onward, the sessions already exceeded one hour in duration. The discussions also gradually changed and took place more spontaneously, allowing the nursing technicians to express their doubts and topics of interest to the group. Those who were participating for the first time came with great expectation. Throughout all the meetings, an environment conducive to the externalization of anxieties, fears, barriers, and doubts was formed, as there were bonds of trust among them.

At the beginning of each new encounter, a retrospective of what had been addressed in the previous week was conducted. In this way, participants who had already attended could offer new opinions, propose topics for discussion, or update those who had not had the opportunity to participate. This practice, known as restitution, is part of the propositions of the IA framework of AI and must be carried out at each new meeting.⁸

The weekly encounters were completed in July 2024 and constituted a starting point for informal dialogues about palliative care. It is noted that the analysis of the encounters was guided by the IA framework, focusing on the identification and problematization of the implications emerging from the participants' discourses.

It is important to clarify that these meetings are linked to a research project approved by the Research Ethics Committee in Human Sciences of the Federal Fluminense University (CAAE: 79317024.8.0000.8160, Opinion No. 7,027,687).

Results

The results of the debates highlighted critical aspects regarding the NTs' perceptions and knowledge of palliative care within the ICU, as well as its professional, affective, and ideological implications for the development of their practices. From the encounters, it was possible to group the findings into pathways that reveal the different implications for subsequent analysis and discussion:

1. The affective, professional, and ideological implications reported in the debates regarding the limited recognition of NTs' contributions by other health professionals working in the ICU;
2. The affective and professional implications revealed in the difficulties of dealing with intense emotions and the lack of hospital-level strategies to mitigate stress in the work environment;
3. The libidinal and ideological implications evidenced in the debates about difficulties related to religiosity/spirituality and in welcoming the physical, psychological, social, and spiritual suffering of patients in palliative care and their families or caregivers;
4. The affective and professional-organizational implications highlighted in the desire to promote changes in the care of patients and families, evidencing nuances of instituting practices in palliative care within an environment structured by ICU norms and rules;
5. The ideological and professional implications consistently highlighted in the debates regarding the absence of the palliative care theme during training, leading to difficulties in the development of this type of care at the hospital level.

These combined elements intensify the challenges faced by nursing technicians in caring for patients in palliative and end-of-life care. Although it is known within hospitals that nursing technicians constitute an expressive and indispensable group, they are often undervalued in the hospital environment, with little participation in multidisciplinary team meetings—this being one of the aspects highlighted in all meetings.

It is important to bear in mind that, since nursing technicians are the professionals with the closest proximity to patients in the ICU and are part of the multidisciplinary team, it is to be expected that they should be included in team meetings to participate in decisions regarding therapeutic plans. Such teamwork would enable them to feel more secure and more efficient in their actions.¹³

During the meetings, it was also observed that many nursing technicians demonstrated discomfort when caring for terminally ill patients. This is not uncommon and occurs because the hospital is often perceived as an environment focused on preserving life. This finding reinforces the need for nursing technician training in palliative care, as well as the issue of dealing with death and not only with life within the hospital setting.¹⁴

By discussing the issues raised by the nursing technicians during the meetings, using the theoretical-methodological framework of institutional analysis and implication analysis, we sought to confer greater scientific rigor to this research event, in addition to highlighting the importance of broadening reflections on palliative care in intensive care units based on the analysis of the nursing technicians' implications in the development of this care. For the discussion, three axes were elaborated, in which we sought to condense the challenges and difficulties considered most relevant during the collective debates.

Discussion

The limited effectiveness attributed by Nursing Technicians to Palliative Care, its implications, and over-implications

To speak of implication is to draw on the theoretical contributions of institutional analysis, which highlight that, with the introduction of the concept of implication into IA, institutionalists reject scientific neutrality in their interventions by collectively analyzing their affiliations, problems, and desires, thereby overcoming positivist illusions and the distance between researcher and participants. It can be said, therefore, together with the authors, that implication is an element always present in the conscious or unconscious actions of subjects and that it must always be analyzed individually and/or collectively as a strategy for elucidating the dialectical conditions in which we live.^{7-8,11,15}

During the encounters, it was possible to identify “psycho-affective or libidinal, structural-professional or organizational, and historical-existential or ideological” implications.^{7:108} This aspect became clear when participants perceived that working in an ICU shapes one’s way of behaving and caring. Over the years, this environment reinforces the belief in a caregiver who saves lives and fights the “villain” called death. Furthermore, there is a belief that “good care” is capable of making people “reborn,” even when there is no further hope for life. In contrast, the insertion of Palliative Care (PC)—whose objective is to offer quality to the process of illness and death in a more natural way—challenges everything these professionals believe and questions what is familiar to them.¹⁶

The “superhero” identity often attributed to health professionals provides validation for their work. However, this definition generates additional tension, as “superheroes” do not fail, do not give up, and do not allow themselves to become exhausted.¹⁶ Thus, they assume the duty to serve and save at any cost, even if it implies sacrificing their own health. This posture, very present in the ICU, raises important questions: how can the relevance of PC be highlighted to those who view “saving” as the

only essential value of their work? What implications emerge from this “superhero” feeling, produced and reproduced by intersections with the institutions of religion, family, and health?

Another aspect highlighted by the Nursing Technicians (NTs) refers to their limited recognition by other professionals and the excessive workload in hospital environments, which reduces the time available for humanized care, generating anguish and frustration. Many NTs report being unable to dedicate the desired attention to patients due to the fast pace of work and high demand. The lack of time to provide emotional comfort and meet subjective needs leads some professionals to perceive their care as having low effectiveness. Additionally, the nature of PC itself—focusing on relief rather than cure—may be perceived as having limited efficacy. In this context, the feeling arises that these actions do not produce visible or immediate results, reinforcing the perception of ineffectiveness.¹⁷

From the perspective of IA, these aspects prompt reflections on hierarchical and power relations in the hospital environment. NTs receive tasks to fulfill within established quality standards, but these hierarchical relations promote actions governed by rules that distance them from their “superhero” ideal. Thus, the work scenario contributes to these professionals not perceiving themselves as implicated in PC practices. On the contrary, they find themselves “over-implicated,” which prevents them from analyzing their affective, professional, and ideological implications with the institutions present there, such as the practices of care, health, and education. By being over-implicated, they respond naturally to verticalized demands and, even when dissatisfied, continue to execute tasks with a “participatory illusion” in PC practices.^{8,15,18}

The encounters provided a space for NTs to rethink care practices, specifically in the context of palliative care. In this environment, the participants were able to verbalize feelings and perceptions about palliative care, reveal contradictions and *unspoken aspects of their daily routine*. Conflicts and discontentments also emerged regarding their way of acting as nursing technicians. Through this collective analysis, individual implications became evident.

The findings indicate that the debates helped NTs externalize perceptions, understand their role in the hospital organization, and recognize their importance within the health institution. It proved crucial that NTs receive continuous training and be integrated into a culture that values PC and their role in different care practices.

Libidinal and ideological implications evidenced in debates on religiosity/spirituality in the context of suffering

Libidinal and ideological implications manifest in different ways during care, depending on how each individual is influenced by institutions. They can impose challenges on PC practices, especially in palliative care.

Often, nursing professionals face personal difficulties in dealing with these issues because they lack the habit of discussing their feelings. These difficulties, which go beyond technical care, involve high sensitivity and the patient's religious or spiritual dimension.

Regarding religiosity/spirituality, a major challenge is the lack of preparation to address patients' beliefs effectively. The absence of specific training in ecumenical spirituality and religion during formal education is one reason why professionals feel unprepared. This limitation can generate discomfort and anxiety, especially when delivering difficult news or dealing with end-of-life situations.¹⁹

Regarding the embracement of physical suffering, the challenge goes beyond pain control and the management of physical symptoms. Suffering is a multidimensional experience, encompassing emotional, psychological, social, and spiritual factors. Many professionals feel powerless when facing patients' suffering, especially when there is no longer any possibility of cure and medical treatments cannot provide the expected relief. This situation can generate frustration, sadness, fear, loneliness, anguish, and feelings of inadequacy in professionals, who need to deal both with the patient's suffering and with their own emotions.²⁰

When space was opened for speaking and listening about the difficulties of nursing technicians in palliative care, it became possible to highlight and bring into debate the libidinal and ideological implications of these professionals. Ideological

implications refer to 'the ways in which each individual thinks, represents, and believes, based on the different scientific, religious, political, and philosophical perspectives through which individuals relate to institutions.' Libidinal implications, in turn, are more closely linked to desire, affection, and embracement, in a sense of mutual affectation. They may also indicate "an emptiness, a lack, an incompleteness, or a will to power, a force of striving as a desire for production."²¹ When working with IA, it is necessary to seek different methods to analyze and highlight the implications present in a given context. It is essential to go beyond the environment of professional practices and also investigate the different positions that each nursing technician occupies in social relations in general, in their daily lives, and in each one's life history.¹¹

The literature highlights that, to overcome difficulties in addressing religiosity/spirituality and in embracing physical suffering, it is essential that professionals receive emotional support and continuous training on topics such as suffering management. It is also important to promote a work environment that fosters self-care and psychological support to deal with the emotional demands of the profession.⁴

The establishment of a bond of trust and care among the professional, the patient, and the family or caregiver is fundamental to providing an environment of embracement and safety. However, this connection can be impaired if the professional lacks adequate emotional and communicative tools, which generates frustration for all involved.

This axis highlighted the importance of addressing in collective debates the feelings of nursing technicians, their fears and anxieties regarding religiosity/spirituality, and the lack of training for embracing and relieving pain in patients receiving palliative care. It enabled them to bring to light their implications with care practices that are often understood as ineffective and inadequate, which may prevent them from recognizing their potential as nursing professionals.

Structural-professional implications: instituting palliative care practices and the absence of this theme during training

The analysis of structural-professional or organizational implication is one of the main theoretical tools used in the investigation of professional practices. In this report, professional implication is understood as a social practice crossed by health institutions and care practices, reflecting the way each professional relates to these institutions and is affected by them in their activities.^{8,15} This dimension of implication highlights the elements that give meaning to the social work of the subjects.⁷

In other words, it refers to the relationships that nursing technicians establish with health institutions and with care practices in the context of palliative care.

In Brazil, palliative care is still relatively recent, although it is already recognized as a science that emerged in the early 16th century, with the creation of hospices.²²

Many professionals had no contact with this topic during their training, especially nursing technicians, for whom there is little research recognizing the importance of their work in healthcare. This lack of knowledge regarding approaches centered on the needs of patients with no possibility of cure leads these professionals to state that they do not feel prepared to offer humanized assistance to patients in this condition and to their families or caregivers.

The ICU environment is often perceived as impersonal and technocentric, focusing on continuous surveillance and complex interventions, which hinders the creation of a welcoming and humanized atmosphere.

Rigid rules, such as limited visiting hours and the restriction of physical contact, negatively impact the bond between patients, families, and the healthcare team. These norms, which aim to ensure infection control and maintain an efficient workflow, distance families from the care process, increasing isolation for the patient and their loved ones. Consequently, the combination of emotional distance and technological coldness makes PC in the ICU appear as a fragmented rather than an integral experience, be seen as a fragmented experience rather than an integral and welcoming one.²³

Furthermore, the physical structure of the ICU is generally not adapted to provide emotional comfort. Even in specialized units, there is still much to be improved in welcoming family members who experience pain the process of losing a loved one. Family members often experience feelings of pain, fear, sadness, insecurity, anguish, loss, frustration, and loneliness—feelings that are intrinsic to the human being.²⁴ This physical inadequacy compromises the process of communication and emotional support, which are essential for palliative care, where active listening and the presence of family members are fundamental, resulting in a minimally humanized coexistence with patients and families, determined by the very hospital organization in the ICU.

When debating these aspects with the nursing technicians, the structural-professional or organizational implications related to the care practices of patients in palliative care became evident. During the meetings, the debates stimulated the exchange of experiences, and this interaction brought real everyday problems to the surface, revealing nuances of instituting movements in palliative care practices that are rarely discussed in the work routine. In this sense, it becomes necessary to destabilize instituted social arrangements, allowing the emergence of instituting forces.¹⁵ *It can be said that, by proposing new forms of relationship between the nursing team and the healthcare team in general, palliative care introduces practices that disrupt “the already instituted arrangements of power and control in the care environment.”*^{25:97}

For humanized interaction to be possible within the ICU, it is necessary that institutional rules and the spatial configuration be reconsidered, in order to allow greater flexibility and integration among the healthcare team, patients, and their families. A welcoming environment can reduce suffering, facilitate communication about the patient's condition, and enable palliative care to be practiced in a compassionate manner.

It is necessary to emphasize that, due to the challenges related to the lack of knowledge about palliative care and the fact that they do not feel theoretically and technically prepared to deal with the person with no possibility of cure, the analysis of implications made it possible to highlight the urgent need for training of nursing professionals in this area.

Analyzing the structural-professional and organizational implications allowed the nursing technicians to rethink the organizational structure of the workplace. This process led them to evaluate the difficulties related to the lack of space, materials, and task overload. In this way, they understood that instituted and bureaucratic aspects of care distanced them from the care they wished to offer to patients and their families.²⁵

It can be stated that this axis allowed for the understanding of implication analysis as a 'device for transforming the health work process.' This resource stimulates reflection on the necessary change in educational and healthcare institutions regarding palliative care, highlighting the importance of nursing technician training for the practices of this care.^{21:132}

When discussing the results, a cut is always made of what is intended to be analyzed. In this case, we chose to address the implications of nursing technicians, constantly present in the development of their practices in palliative care. Therefore, it is considered a limitation of this report that it focuses on only one aspect of the situation—that which seeks to understand what is sometimes not revealed in the daily work routine: the unspoken aspects that hinder relationships and communication among professionals—aspects that are amenable to problematization in light of Institutional Analysis. Another limitation refers to the fact that, although the results are relevant, as this is an experience report conducted in a single setting, the question arises regarding the generalizability of these findings.

However, such limitations do not invalidate the contributions of this experience report. Among them, we highlight the possibility for readers to broaden their reflections on palliative care and, above all, on the relevant role that nursing technicians occupy in care settings. Understanding their fears, doubts, and the need for recognition of their role by the healthcare team within the scope of care undoubtedly constitutes an important contribution of this study to nursing and to healthcare practice.

Conclusion

This experience report revealed that the collective analysis of the implications of the first author and the nursing technicians, conducted during the meetings, broadened the understanding of the diversity and complexity of daily relationships in the practice of palliative care. The analysis of the libidinal, ideological, professional, and organizational implications of all participants made it possible to rethink potential changes in intensive care units, making them more welcoming, with appropriate environments and specific rules to care for patients in palliative care. In this way, it seeks to provide care that values life and ensures a dignified death.

This effective implementation, as it consists of often innovative practices, requires a cultural, organizational, and educational change in nursing practice. This is essential to advance and overcome the challenges inherent in implementing new care practices that have a humanized approach, centered on the patient and the family.

Thus, this study reaffirms the need to insert palliative care in a structured way into the training and daily life of healthcare services, recognizing the nursing technician as a central subject in the production of care.

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