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ARTIGO ORIGINAL

NURSING CARE TO PEOPLE AT THE END OF LIFE DUE TO COVID-19 IN THE INTENSIVE CARE UNIT: EXPERIENCES OF PROFESSIONALS

CUIDADO DE ENFERMAGEM ÀS PESSOAS EM FINAL DE VIDA POR COVID-19 NA UNIDADE DE TERAPIA INTENSIVA: EXPERIÊNCIAS DE PROFISSIONAIS

CUIDADO DE ENFERMERÍA A LAS PERSONAS AL FINAL DE SU VIDA POR COVID-19 EN LA UNIDAD DE CUIDADOS INTENSIVOS: EXPERIENCIAS DE PROFESIONALES

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ABSTRACT

Objective: To know the experiences of nursing professionals caring for people at the end of life due to COVID-19 hospitalized in an intensive care unit. **Methodology:** For this, we undertake a qualitative, descriptive research, which approaches the interpretative paradigm. Between May and June 2022, we interviewed 12 nursing professionals working in an intensive care unit of a philanthropic hospital in southern Brazil. The data were managed in the Atlas.ti program and submitted to thematic analysis. **Results:** Presented in this article concern the thematic unit Nursing care at the end of life due to COVID-19 in Intensive Care Unit, constituted by the subunits: The possibility of death: "Unfortunately we didn't have much to do to reverse that situation"; "We were aware that the patient was going to die": communication between care teams; "We did everything for everyone"; "We did not have much contact with the family": the distancing of the nursing team and, finally, "It was them with themselves": experience of patients in ICU from the perspective of

professionals. **Conclusions:** Experiences described reinforce the need for education to nursing teams, especially in ICU, for palliative care. Although they are not restricted to the final stage of life, they can make the difference between dying with dignity and dying with suffering and loneliness, especially in periods of health emergency marked by high mortality.

Keywords: Critical Illness; Intensive Care Units; COVID-19; Nursing Team; Palliative Care.

RESUMO

Objetivo: Conhecer as experiências de profissionais de enfermagem no cuidado às pessoas em final de vida pela COVID-19 hospitalizadas em unidade de terapia intensiva. **Metodologia:** Para isso, empreendeu-se uma pesquisa qualitativa, descritiva, que se aproxima do paradigma interpretativo. Entre maio e junho de 2022 foram entrevistados 12 profissionais de enfermagem atuantes em unidade de terapia intensiva de um hospital filantrópico do Sul do Brasil. Os dados foram gerenciados no programa Atlas.ti e submetidos à análise temática. **Resultados:** Apresentados neste artigo dizem respeito à unidade temática O cuidado de enfermagem diante do final da vida por COVID-19 na Unidade de Terapia Intensiva, que se constituiu pelas subunidades: A possibilidade da morte: "infelizmente não tinha muito o que fazer, com relação a doença, pra reverter aquela situação", "A gente ficava ciente de que o paciente ia morrer": a comunicação entre equipes assistenciais, "A gente fazia tudo para todos": cuidados com o corpo na fase final de vida pela COVID-19, "A gente não tinha muito contato com a família": o distanciamento da equipe de enfermagem e, por fim, "Era eles com eles mesmos": vivência dos pacientes em UTI sob a perspetiva dos profissionais. **Conclusões:** As experiências descritas reforçam a necessidade de educação das equipes de enfermagem, para os cuidados paliativos, especialmente em UTI. Embora eles não se restrinjam à fase final da vida, podem fazer a diferença entre um morrer com dignidade e um morrer com sofrimento e solidão, sobretudo em períodos de emergência sanitária marcados por grande mortalidade.

Palavras-chave: Estado Terminal; Unidades de Terapia Intensiva; COVID-19; Equipe de Enfermagem; Cuidados Paliativos.

RESUMEN

Objetivo: Conocer las experiencias de profesionales de enfermería en el cuidado a las personas en final de vida por COVID-19 hospitalizadas en Unidad de Terapia Intensiva (UTI). **Metodología:** Para ello, se emprendió una investigación cualitativa, descriptiva, que se aproxima al paradigma interpretativo. Entre mayo y junio de 2022 fueron entrevistados 12 profesionales de enfermería, actuando en UTI de un hospital filantrópico del sur de Brasil. Los datos se gestionaron en el programa Atlas.ti y se sometieron al análisis temático. **Resultados:** Presentados en este artículo se refieren a la unidad temática El cuidado de enfermería ante el final de la vida por COVID-19 en la UTI, que se constituyó por las subunidades: La posibilidad de la muerte: "desafortunadamente no había mucho que hacer para revertir esa situación", "Nos dimos cuenta de que el paciente iba a morir": la comunicación entre equipos asistenciales, "Hicimos todo por todos": el cuidado del cuerpo en la fase final de la vida por COVID-19, "No teníamos mucho contacto con la familia": el distanciamiento del equipo de enfermería y, por último, "Eran ellos mismos": vivencia de los pacientes en UTI desde la perspectiva de los profesionales. **Conclusiones:** Las experiencias descritas refuerzan la necesidad de educación de los equipos de enfermería, especialmente en UCI, para los cuidados paliativos. Aunque no se limitan a la fase final de la vida, pueden hacer la diferencia entre un morir con dignidad y un morir con sufrimiento y soledad, sobre todo en períodos de emergencia sanitaria marcados por gran mortalidad.

Palabras clave: Enfermedad Crítica; Unidades de Cuidados Intensivos; COVID-19; Equipo de Enfermería; Cuidados Paliativos.

INTRODUCTION

COVID-19 is characterized by respiratory and/or systemic impairment due to infection with Severe Acute Respiratory Syndrome coronavirus 2 (SARS-Cov-2). This impairment can range from mild (when involving the upper respiratory tract) to severe pneumonia, which can progress to acute respiratory failure and, sometimes, death.[1] The disease has become a global health problem, having caused a high number of deaths in a short period, prevailing in people with chronic diseases.[2]

The severity and acute complications resulting from COVID-19 increased the bed demand in intensive care units, especially during the period before vaccinations. The intensive care unit (ICU) is characterized by the clinical complexity of its patients, the performance of invasive procedures, and technological density. In Brazil, the hospital beds available to the population have been historically scarce. This situation worsened during the pandemic, which led to the adaptation and creation of new intensive care beds, faced with the collapse of public and private services.[3] The increase in the number of severe cases and beds impacted the work process of ICU teams, which was marked by overload, distress, and exhaustion.[4]

Nursing teams in ICUs care for patients and their families, ensuring with their constant presence that comprehensive, affective, and effective care is provided within this technological space.[5] The COVID-19 pandemic meant these teams faced challenges they had not previously experienced. Although nursing has historically worked during epidemics and pandemics, the COVID-19 pandemic made teams gain prominence due to the demand that arose for nursing care in primary and hospital care.[6]

Professionals cared more intensely for their own safety and the use of personal protective equipment became essential to their practice, which made providing care a more complex task.[7] Furthermore, they recurrently witnessed deaths, which impacted their mental health, as caring for someone at the end of their life means being exposed to the vulnerabilities that are inherent to the human condition.[8]

End of life is a period that begins with the diagnosis of a disease as advanced, progressive, or with a limited prognosis, and ends with death, and can vary from twelve to six months, or less.[9] Although there are instruments that can estimate the probable time when death will occur, professionals use their clinical experience to determine this period.[10] For COVID-19, this estimate was based on health deterioration, especially the worsening of lung, circulatory, cardiac, and kidney functions.[11]

People at the end of life can benefit from the palliative care approach, considering the multidimensionality and multidisciplinary work that characterizes it. During the pandemic, at an international level, the presence of palliative care teams in the ICU allowed the care teams to have better decision-making processes to promote comfort for patients and their families.[12] The use of technology, such as tablets and cell phones, made farewell or aggregation rituals possible.[13] In Brazil, professionals at an ICU created a “Memory Box”, where the patient's belongings were placed together with flowers, and were given to bereaved family members, as a more humane strategy to support them, return the body, and preserve the memory of the deceased.[14]

During the pandemic, recommendations were developed regarding how palliative care could be offered to patients with COVID-19, from actions to manage symptoms to guidelines for decision-making.[15] Despite this, the teams experienced limitations to their self-care and the care of their patients and family members. Therefore, this study aims to understand the experiences of nursing professionals when caring for people at the end of life due to COVID-19, hospitalized in an intensive care unit.

METHODOLOGY

This is a descriptive study, with a qualitative approach, within the interpretive paradigm, developed in the ICU of a philanthropic hospital in Southern Brazil. The participants were nursing professionals who worked in the ICU caring for patients with COVID-19. The inclusion criteria were nurses and nursing technicians with more than three months of experience in the ICU, who provided care to patients with COVID-19, as well as nurses and nursing technicians who worked in the COVID-19 ICU during its existence in the institution. The exclusion criteria were professionals who were on some type of leave during the data collection period.

Snowball sampling was used, starting with a key informant who referred other possible ones, working in different shifts.[16] We sought to select at least two nursing technicians and one nurse from each team. Thus, 12 professionals were invited to participate in the research, all of whom accepted the invitation.

Data collection took place between May and June 2022, through semi-structured interviews, with a protocol that included questions about the professionals' performance with patients at the end of life due to COVID-19 in the ICU.[16] The interviews were recorded in audio, varying between 23 and 45 minutes. The audio files were then transcribed into text using Google Docs, in Arial, size 12, and 1.5 cm line spacing. The text files were managed using Atlas.ti and subjected to thematic analysis.[17]

The first stage involved organizing and preparing the data for analysis. This stage took place, firstly, on Google Drive, in specific folders, in which the audio files, and later the text files with the transcriptions, were organized. The second stage involved reading the data, and consequently reflecting on the information, which in this research occurred at the same time as the data collection, with the interviews being read and re-read during data management with the Atlas.ti program.[17]

The third stage concerns coding, which, in this research, was operationalized using Atlas.ti, resulting in 43 codes that were extracted from the interviews and distributed in 679 excerpts. In the fourth stage, categorization, the codes and excerpts were grouped by similarity, resulting in two large thematic units. In this article, only data relating to one of them, titled “Nursing care at the end of life due to COVID-19 in the Intensive Care Unit”, are shown. The fifth stage consisted of presenting the results and the sixth involved their interpretation. The results are presented with a narrative format, based on the sub-units that make up the thematic unit, and interpreted with the help of literature relevant to the topic.[17]

This study respected the ethical aspects of research on human beings, as set out in Resolution No. 466/2012, of *Conselho Nacional de Saúde* (National Health Council) of Brazil, and was approved by the Research Ethics Committee under report No. 5,372,917. The participants signed two copies of the Free and Informed Consent Form, one remaining with them and the other with the researcher. Anonymity was guaranteed, using names of superheroes, chosen by them, for the interview excerpts.

RESULTS

Of the 12 participants, eight (67%) were nursing technicians and four (33%) were professional nurses. As for the technicians, five were female, aged predominantly between 30 and 40 years old. For their part, men were aged between 23 and 40 years old. Regarding the professional nurses, two were female and two were male, with ages ranging from 27 to 49 years old.

Below are the five thematic sub-units that are part of the unit titled “Nursing care at the end of life due to COVID-19 in the Intensive Care Unit”, as follows: The possibility of death: “Unfortunately there wasn’t much to do in terms of the disease to reverse the situation”; “We were aware that the patient was going to die: Communication between care teams; “We did everything for everyone”:

Physical care during the final stage of life through COVID-19; "We didn't have much contact with the family": the distancing of the nursing team, and, finally, "They were only with themselves": The experience of patients in the ICU from the professionals' perspective.

They summarize the type of care that was prioritized by the nursing professionals: The methods to identify, name, and register people at the end of life; physical care, especially hygiene, and mobility; family care; and care regarding loneliness and fear of death.

Thematic sub-unit 1: The possibility of death: "Unfortunately there was not much that could be done in terms of the disease to reverse the situation".

According to the participants, when patients were admitted to the ICU, they already were in an irreversible condition or were progressing toward it, which made the measures to prevent death insufficient.

"There are other patients who have reached a very serious level, who often go to the ICU to have a place to die" (Batman).

"Patients who came in at noon and at night were already intubated. The next day we arrived, and they had already died" (Wonder Woman).

The irreversibility of the cases was detected through signs that were observed during hospitalization. The frequency and continuity of these signs resulted in a pattern of identifying severity and imminent death.

"It took over the whole lung. Then you saw that even with ventilation, the lung did not expand. [...] Drugs too, always in high doses" (Spider-Man).

"[...] the kidney function as well, I at least noticed that the patients' kidney function started to decline and they would go on hemodialysis, and it was practically certain that they wouldn't be saved" (Black Widow).

In the attempts to reverse the condition, mechanical ventilation and hemodialysis were the predominant therapies used.

"We began to notice that patients stopped having diuresis, and became very edematous, and then they started to undergo hemodialysis" (Black Widow).

"A patient with COVID, came in fine, but in the early hours of the morning their saturation started to worsen, then they had to call the emergency room and the doctor was already intubating" (Invisible Woman).

Some drugs have also been linked to the possibility of imminent death.

"Oh, when we came in with the vasopressors you knew they weren´t going to get out of there" (Spider-Man).

"Drugs, both sedatives and vasopressors, are increasingly at higher doses" (Thor).

Thematic Sub-Unit 2 - "We were aware that the patient was going to die": Communication between Care Teams.

The participants explained that most of the information was transmitted verbally, during shift handover.

"We took over the shift, and the doctor came. He came, sat next to me there, we would be there together, talking and he would say 'Oh, this bed, and that bed, these are patients for whom there is nothing else to do.' And often, often a colleague, the nurse from the previous shift, would already say during the shift handover, during

the shift change they would already warn us, communicate that there wasn't anything left to do for the patient" (Batman).

"Usually, the doctors did a kind of round for us. They presented all the clinical pictures to us. [...] The nursing handover was also done with us, the technicians, it was all done together" (Spider-Man).

Regarding how information was recorded, the means were digital and written.

"Yes, we had progress notes. We had digitalized progress notes. [...] So in them we said: 'The patient is in serious condition, it is a critical case, a decision was made by the medical team that from that moment on we would take comfort measures.' In the book words were a little more aggressive, so to speak" (Batman).

"It was more like word of mouth. As if a wireless telephone was being used like that, you know" (Iron Man).

"No, it wasn't recorded. It was just verbal" (Catwoman).

In irreversible cases, the teams used specific terminology aimed at classifying and determining the type of care for each patient.

"There were patients who took a long time after we 'switched to comfort'" [virar a conforto] *(Thor).*

"There was a patient who was not, how can I put it, 'a case to invest in'" [pra investir, no caso] *(Supergirl).*

"Popularly, we say that the patient is 'SPP' which is 'If it stops, it stops'" [Se parar, parou] *(Batman).*

Thematic Sub-Unit 3 - "We did everything for everyone": Physical Care during the Final Stage of Life due to COVID-19.

It was observed that there was no difference between the care provided to patients at the end of life and other patients in the unit, for whom recovery was possible.

"Oh, I didn't do anything different regarding care. I did what I generally do for everyone" (Storm).

"Until the end, regardless of whether the patient is a patient who is well or a patient who is at the end of their life, a patient who will die in hours, minutes, the care is the same, it has always been the same" (Batman).

"Usually, care does not change from a patient who is in recovery to the patient who is only palliative. We maintain care" (Thor).

Regarding nursing care, they were related to hygiene, depending on tolerance, in addition to other measures that enhance well-being.

"Usually, when patients were very seriously ill, we couldn't do much work, because it could lead to death" (Black Widow).

"I placed them in the prone position, offering oxygen as needed. Many times, I would feed them, I would give them bean broth in their mouth, because they were unable to feed themselves, or water with a syringe. [...] I would wash them, do oral hygiene, change shoelaces" (Wonder Woman).

Participants also mentioned appearance-related care, in addition to skincare.

"What I liked to do, and what I generally did to everyone, was shave the men, that kind of thing. My colleague even messed with me: 'Oh no, you're going to shave him, he's going to die, this one is about to die' (laughs). But I did I anyway.. [...] Only for those who really weren't able" (Storm).

"If there was a bedsore, I took care of it as prescribed by the doctor" (Wonder Woman).

"We repositioned them according to protocol" (Iron Man).

Pronation was a measure repeatedly used to improve lung expansion.

"[...]patients who were a little better, you pronated and so on, and it improved the patient's ventilation pattern" (Cat Woman).

"[...] we had to prone this patient and when taking him out of the prone position he was in really bad shape" (Spider-Man).

As cases worsened and patients' physical conditions deteriorated, care such as repositioning and bed baths were no longer prioritized. This was due to the fear of hastening death.

"It's usually very complicated to mobilize, they will generally destabilize and [pass away]…" (Thor).

"Usually, when the patients were in a very serious condition, we couldn't do much, you know, because it could lead to death right there" (Black Widow).

When death occurred, some practices were adopted to prepare the body before the arrival of the funeral homes.

"The contact, the call was requested, and the doctor contacted the family, informing them of the death. Then we prepared the body and left it ready for the funeral home to take" (Thor).

"They [the family members] were at the door, but they couldn't come inside" (Invisible Woman).

Thematic Sub-Unit 4 - "We didn't have much contact with the family": Distancing in the Nursing Team.

Regarding care provided to families, participants reported ways in which they helped bring them closer to the hospitalized person, even with distancing measures.

"We kept in touch by phone, via WhatsApp, sometimes we would open it to see the messages. They asked for information, we talked to some of them. They sent audio messages, asked us to play it for the patient and we did so" (Black Widow).

"The only contact we had was when we got in touch with them, so they could bring some, uh, personal hygiene items, something like that" (Batman).

One form of caring for families was communicating through video calls and app messaging.

"We also made an exception for patients who we saw were in very bad shape, who we saw were going to be put on ventilation, who perhaps, we didn't know whether or not they would come back from ventilation, so we made an exception. I would video call during the morning shift" (Iron Man).

"When we had the possibility, we would do a video call with the patient, in this case with the family, the patient would see the family member and talk, within their possibilities" (Supergirl).

Some patients refused this type of contact, as they did not want family members to be aware of their critical condition.

"There were some patients who didn't want to be seen in that state. So, they didn't want to call because they didn't want their family to be worried" (Superman).

"We offered to video call family members, and sometimes some of the patients didn't want to. And those who agreed, cried" (Invisible Woman).

Thematic Sub-Unit 5: "They Were Only with Themselves": Experience of ICU Patients from the Perspective of Professionals.

The patients' fear of death was made evident during the interviews, where the professionals reproduced their statements.

"'I don't want to be intubated, I don't want to die, I don't want to lose my family'" (Iron Man).

"' Don't let me die, I want to see my children'" (Thor).

"'I don't want to be intubated'" (Hulk).

One of the aspects that caused the most anxiety was intubation.

"Some changed, signs changed, pressure, heart rate, they changed especially because they were away from their family. They wanted to see them; many didn't know if they were going to get out of there. They were unable to see their family again. So, yes, some suffered a lot and were really destabilized" (Supergirl).

"There was a cardiac arrest, the patient in the next bed, we handled it right there, and we looked to the other side and the patient was crying, thinking it would now be him" (Hulk).

"And they knew there wasn't much escape other than ventilation" (Iron Man).

The participants also noticed the patients' loneliness, reporting how they tried to alleviate this.

"This helped them because they were literally alone. It was them with themselves. As much as we were there, and the team went back and talked to them, we couldn't pay them full attention, or stay by their side talking. The few who were lucid...but we couldn't just pay attention to the more lucid people. I think it wasn't satisfying, but it gave them a boost" (Storm).

"[...] They went in there, many left and just saw us there, every day. And those who didn't leave, their last contact was us, there was no family, there was no funeral afterward, there was no wake, there was no wake really. So, their last contact would be us" (Supergirl).

"Usually, we tried to talk to them, we tried to calm them down, to show that each situation was different, that each case was different. Maybe I would ask the doctor for some medicine to calm the patient, to try to keep them calmer" (Thor).

DISCUSSION

During the most serious phase of the pandemic, despite using machines, medicines, and invasive procedures, vital organs were hardly able to recover their functions, which made the irreversibility of the cases evident to professionals.

When facing worsening, resuscitation measures were not always adopted, given the critical condition of the patients. The decision to resuscitate needs to involve the patient, their family, and the team, the latter being responsible for the clinical evaluation of the patient, advocating for their quality of life, dignity, and lessening of their suffering.[18] With regard to renal function, the increase in creatinine levels resulted in acute renal failure, which was treated using hemodialysis. Furthermore, high levels of Troponin I contributed to cardiac injuries.[19] As for technological interventions, non-invasive and invasive mechanical ventilation was used, with invasive ventilation being predominant in ICUs, and consequently, associated with higher mortality rates due to COVID-19.[20]

Medications such as Midazolam and Fentanyl were widely used within ICUs due to the significant number of patients under mechanical ventilation, who consequently needed to remain sedated. Anesthetics such as Midazolam were in short supply at the peak of the pandemic, revealing a shortage of this medication in ICUs in several Brazilian states. This brought attention to the fragility that exists in the production of these supplies, and it is evidence that countries with greater organizational and financial resources have better possibilities to face public health emergencies.[21]

Regarding the records kept during this period, some contradictions were found. It is highlighted that one of the speakers mentions the existence of a notebook to record objective information when the irreversibility of the cases was confirmed. Another participant asserts that this information was only transmitted verbally. It is clarified that, at a certain point, the notebook was used as a recording method. However, the increase in demand for care in the unit made it impossible to continue using it. Thus, information began to be transmitted verbally, and progress notes were recorded using a digital system.

The use of specific terms to identify patients in irreversible clinical situations was predominantly linked to the decision not to perform cardiopulmonary resuscitation, for example, "if it stops, it stops" [*se parar, parou*], and the expression "comfort" [*conforto*], understood as pain management and limiting or suspending drugs. In this sense, it is worth pointing out that such terminology contradicts what is proposed by palliative care institutions, which advocate for the use of "life-threatening illness" or "illness that does not respond to modified treatment" to refer to the condition or disease that affects the person. This prevents reducing the person to their pathology, as well as removes the idea that there is nothing more to be done.[22]

Bed bathing was seen as promoting comfort, as well as a form of skincare, maintaining its integrity by improving blood circulation. Moreover, it helps prevent infections and improve the feeling of well-being. However, it is a complex procedure, which in many situations becomes unfeasible given the severity of the patients' condition. Hemodynamically unstable patients may experience a drop in saturation, as well as changes in body temperature and heart rate, and it is the nurse's responsibility to evaluate and adapt hygiene care in each case.[23,24]

Some reactions from professionals regarding physical care and the identity of patients, such as the moments of laughter, or when mentioning that some colleagues believed that patients at the end of life did not deserve certain types of care since they would die, can be interpreted as denial or defense.

Regardless of the stage of illness, people who no longer respond to modifying treatment need to be assisted per the objectives of care, through adequate communication, constant assessment, non-abandonment, and care for the family.[25] The ICU stands out from other sections of hospitals because it houses technologies that are at the center of the healthcare team's professional actions. However, it is necessary to restore ethics and respect for the bodies of patients, whose privacy is invaded in this setting, and whose identity, morals, and values are made invisible. Their bodies deserve and must be considered with their individuality and their history should be respected, aiming for dignity in the last moments of their life.[26]

Care actions like repositioning were also highlighted. End-of-life patients experience organ failure as their disease progresses, and this includes the skin. At this stage, the use of certain covers should be considered and nutritional aspects reviewed, as well as their positioning in bed, which must be adapted to the patient's tolerance, both in terms of frequency and type of position.[27] It is clear that, in the context where the participants worked, the high flow of patients made it difficult to adapt their care to each patient's needs, leading to the homogenization of care.

The prone position was mentioned by professionals as an important part of care. It was adopted in COVID-19 ICUs in the face of respiratory failure, in an attempt to avoid mechanical ventilation or improve lung expansion in patients already using these devices, who could remain in said position for a period between 12 and 16 continuous hours.[28]

Pain management was also emphasized, especially during bathing and repositioning. In a study carried out with 19 ICU patients, it was found that after bed bathing, the level of pain increased significantly. For patients in induced coma, it is recommended to pay attention to poor sedation and analgesia, which can be corrected by combining drugs such as Midazolam and Fentanyl.[29]

In the face of death, the teams prepared the bodies following national guidelines, stopping secretions from injuries and the insertion of devices, removing secretions from orifices and blocking them to prevent extravasation, and placing the bodies in waterproof bags.[25] These bags symbolized death and the depersonification of rites of passage at the end of life, due to the potential risk of contamination by SARS-Cov-2. Suppressing these rites directly impacted the mourning process of families.[30]

The participants acknowledged that the care provided to families was deficient since they needed to stay away. There was physical contact only in the moments in which they delivered hygiene products. Despite this, the participants reported having tried to bring the families closer to patients using digital technologies such as video and telephone calls. This is how they informed the families about the health status of the patients, and in many cases, it was a strategy to make the last goodbye possible.

In the urgency of organizing a work front during the pandemic that had physical spaces, trained professionals, supplies, and equipment, the communication between teams and families was weakened, limiting humanized assistance. In many situations, the notification of death was performed at the ICU door, without proper support.[31]

Consequently, the participants did not consider the bond between families and the team to be strong, considering the lack of support, especially at the time of loss. There are immediate and long-term strategies that can be used by teams to deal with the damage caused by bereavement. Immediate strategies are those in which families are provided with the experience of anticipatory bereavement, through telephone calls, audio recordings, and/or letters. Long-term strategies are those that will last for an extended period, until there is relief from suffering. This includes continuous accompaniment through rehabilitation and specialized counseling.[32] In this research, it was observed that the professionals used predominantly immediate support strategies.

In this scenario, according to the perception of the participants of this research, palliative care and comfort were focused exclusively on pain relief or prevention. Nonetheless, palliative care extends to families, as it aims to reduce suffering beyond that experienced by the patient, especially when addressed through therapeutic communication and support. During the COVID-19 pandemic and in the COVID-19 ICU, offering palliative care was challenging given the high hospitalization rates, demand for procedures, overload of professionals, and lack or displacement of practitioners who specialize in palliative care. Therefore, it becomes evident that there is a need for training aimed at further disseminating this philosophy of care, in order to favor its distribution between services, even in the context of a pandemic.[33]

Finally, faced with the anxiety and fear of death expressed by patients, the professionals in this study felt like they were the only and final support in the face of pain, loneliness, dying, and death, and recognized presence and listening as important parts of healthcare. In agreement with this, a study[34] found that, with the absence of families during hospitalization during the pandemic, professionals became an extension of the patient's family, leading to an understanding that they should develop empathy and humanization during care.[34] In contrast, another study showed that when identifying feelings of fear of death in patients with COVID-19 in the ICU, health professionals hid their feelings and used emotional distancing with patients as a defense mechanism, generating an emotional overload for themselves.[35]

CONCLUSIONS

This study allowed us to understand the experiences of nursing professionals when caring for people at the end of life due to COVID-19, who were hospitalized in the ICU. It was found that this was an overall complex type of care, requiring physical and psychological efforts from professionals to perform their duties.

This fact made it impossible to consider the patients' biographies, resulting in the standardization and depersonalization of some of the care provided and in essence limiting the provision of palliative care. Despite this, there were moments when it was possible to listen to patients, offer them attention, and care for their appearance and identity, which made professionals feel this was the unique and exclusive way of supporting patients during hospitalization, until their death.

Regarding the limitations of this research, the fact that the first author was an employee of the institution at the time of data collection stands out, as this may have interfered with some of the answers. Furthermore, the interviews took place during work shifts, which may have influenced the time availability of the professionals. In addition, the study was carried out in a single ICU and only with nursing professionals.

Despite this, the experiences presented here reinforce the need to train nursing teams in palliative care, especially in ICUs. Although their work is not restricted to the final stage of life, they could make a difference between dying with dignity and dying with suffering and loneliness, especially during periods of health emergencies marked by high mortality. Therefore, we believe in the importance of public policies to institutionalize and promote palliative care (teams) in different contexts and health services, in order to make this a consistent practice for living and dying.

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MVMK, FRC: Conceptualization, Data curation, Project management, Programs, Original draft writing.
MVMK, FRC, HDCC: Formal Analysis, Research, Methodology, Resources, Validation, Visualization.
FRC: Supervision.
FRC, HDCC: Writing and Review, Editing.

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