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Experience Report

# The Occupational Therapy in adult Intensive Care Unit (ICU) and team perceptions[1]

**Tatiana Barbieri Bombarda[a], Ana Luiza Lanza[b], Claudia Aline Valente Santos[a], Regina Helena Vitale Torkomian Joaquim[a]**

[a]Departamento de Terapia Ocupacional, Universidade Federal de São Carlos – UFSCar, São Carlos, SP, Brazil.
[b]Unidade de Reabilitação para Deficientes Visuais – URDV, São Paulo, SP, Brazil.

**Abstract:** Introduction: The National Health Surveillance Agency (ANVISA), on 24 February 2010, adopted resolution number 7, which makes mandatory the presence of an occupational therapist as an active member of the Intensive Care Unit professional team. It is believed that the ICU scope is a small professional practice in Occupational Therapy due to the small number of publications in the literature. Objective: To describe the experience and actions developed by occupational therapy in an adult ICU and report the staff awareness reagrding this practice at a state hospital, located in the state of São Paulo. Method: This is an experience report in which we conducted document analysis to obtain data regarding actions taken by occupational therapy, as well as the application of a questionnaire with the team to understand the professionals perceptions regarding the care provided. The data obtained was processed through thematic content analysis. Results: We identified that the occupational therapy intervention transited by functional aspects and support for coping, with the recognition of these actions by the team. Conclusion: The described action consists of practices derived from the occupational therapy insertion process in an adult ICU and meets the desire to encourage the research development in this area for the promotion of debates to promote technical improvement of the profession in the care of critically ill patients.

**Keywords:** *Occupational Therapy, Intensive Care Unit, Hospitalization.*

## Terapia Ocupacional na Unidade de Terapia Intensiva (UTI) adulto e as percepções da equipe

**Resumo:** Introdução: A Agência Nacional de Vigilância Sanitária (ANVISA), em 24 de fevereiro de 2010, aprovou a resolução de número 7, que dispõe sobre a obrigatoriedade do terapeuta ocupacional como profissional integrante da equipe atuante em Unidade de Terapia Intensiva. Acredita-se que, na terapia ocupacional, o âmbito da UTI se constitui como um local de reduzida atuação profissional, visto o escasso número de publicações encontradas na literatura. Objetivo: Descrever a experiência e as ações desenvolvidas pela terapia ocupacional em uma UTI adulto, bem como relatar a percepção da equipe em relação a esta prática realizada em um Hospital Estadual, localizado no interior do Estado de São Paulo. Método: Trata-se de um relato de experiência em que se realizou análise documental para obtenção de dados referentes às ações desenvolvidas pela terapia ocupacional, assim como a aplicação de um questionário à equipe para compreensão das percepções dos profissionais em relação à assistência prestada. Os dados obtidos foram trabalhados por meio de análise de conteúdo temática. Resultados: Como resultado, foi identificado que as intervenções da terapia ocupacional transitaram por aspectos funcionais e de apoio ao enfrentamento, sendo possível constatar reconhecimento dessas ações pela equipe. Conclusão: A atuação descrita consiste em práticas provenientes do processo de inserção da terapia ocupacional em uma UTI adulto e vai ao encontro do desejo de se estimular o desenvolvimento de pesquisas neste âmbito, para o fomento de debates que promovam aprimoramento técnico da profissão na assistência a pacientes críticos.

**Palavras-chave:** *Terapia Ocupacional, Unidade de Terapia Intensiva, Hospitalização.*

**Corresponding author:** Tatiana Barbieri Bombarda, Universidade Federal de São Carlos, Rodovia Washington Luis, Km 235, CEP 13565-905, São Carlos, SP, Brazil, e-mail: tatibb_to@yahoo.com.br

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# 1 Introduction

The Intensive Care Unit (ICU) is characterized as a service of immediate actions and prioritization of technical activities, involving technological complexity, disease severity and specialized professionals (MACIEL; SOUZA, 2006). Due to this constitution, the ICU seems to offer one of the tensest, aggressive and traumatizing environments of the hospital (PROENÇA; AGNOLO, 2011), also seen as a space related to suffering and death (GUIRARDELLO et al., 1999).

The intensive care patient is characterized as the individual with a severe and recoverable condition, requiring permanent and specialized clinical care, considering the imminent risk of death and instability of vital functions (CONSELHO…, 2012), indicating the need for an intensive care unit to be offered by a specialized multi-professional team. The professionals working in this unit should be prepared to deal with instabilities in the clinical setting, as well as having theoretical knowledge related to the specific area of intensive care (PAIVA et al., 2002).

Regarding Occupational Therapy, it may involve actions of prevention, promotion, protection, education, intervention and rehabilitation of the patient to prevent deformities, dysfunctions and physical and/or psychosocial and affective problems, and to promote the occupational performance and the quality of life of the individual (CONSELHO..., 2012).

For Galheigo (2007), the incorporation of the occupational therapist as an essential professional in the hospital's health team is a concept that it has not yet been consolidated. However, it is important to highlight the advances in the hospital area, considering the approval of the specialty of occupational therapists in Hospital Contexts (CONSELHO..., 2013), as well as the approval by the National Health Surveillance Agency - ANVISA, on 24 February 2010, of Resolution 7, which deals with the assistance resources for the operation of the ICU, including the Occupational Therapist as a mandatory professional in the composition of the multi-professional team (AGÊNCIA…, 2010).

Nevertheless, the Assistance Parameters were established in 2012 for the various modalities provided by the occupational therapist, and it is indicated the estimate of eight visits per shift of six hours of work for the operation in intensive care units, whether this pediatric or adult, stipulating 45 minutes of each consultation (CONSELHO..., 2012).

Despite believing that the occupational therapist has skills and techniques that favorably help the treatment of the critical patient, scarce studies have been scientifically found with this theme in Brazil and the international scenario.

The article of "Occupational Therapy and Critical Patient" can be pointed out among publications with a focus on the adult population, which expresses data from an exploratory research related to a survey of characteristics of critical patients of an intensive unit of a Chilean hospital and the possibilities of approaching the occupational therapist, evaluating the pertinence of the implementation of an Occupational Therapy program at this place (CELIS et al., 2014).

As a sample of the study, there were characteristics such as high presence of edema in the hands; decreased joint amplitude of hands and fingers; high frequency of use of mechanical ventilation; subject to sedation; compromises on the level of consciousness; exposure to stimuli of the in-hospital environment, and lack of stimuli that evoke the external reality. The authors pointed out that, based on the context and characteristics presented, the Occupational Therapy intervention is a contribution to treatment, since it has theoretical and practical bases that help in the prevention of most of the deficits presented, especially through the precocious intervention, and the occupational therapist assumes the role not developed by other professionals of the team. Also, it is emphasized the importance of assisting the individual in the present time considering all their dimensions and context, starting from the assumption of integral care (CELIS et al., 2014).

In another published study, Dinglas et al. (2013) evaluated the association between patients, ICU and hospital factors with temporality for the first intervention of occupational therapy of patients with acute lung injury, noted that only 30% of these patients received occupational therapy intervention during ICU stay. Worsening of the organic function, continuous hemodialysis and uninterrupted infusion of sedation were variables associated with the postponement of the beginning of occupational therapy care.

Another important publication to be highlighted is research by Alvarez et al. (2012) showing a randomized clinical trial comparing the effectiveness of standard non-pharmacological treatment with non-pharmacological enhanced treatment (standard care and occupational therapy) on the incidence of delirium in hospitalized elderly in an intensive care unit in Chile. Participating subjects were 70 elderly

patients, divided into a control group, who received standard care, and a group that received standard care together with occupational therapy. As a result, it was possible to verify that the group that received occupational therapy interventions had a lower incidence of delirium, less hospitalization time and a better level of motor functional independence at discharge (ALVAREZ et al., 2012). These factors demonstrate significant indicators of the relevance of occupational therapy work and the need for this professional to be part of the ICU multi-professional team.

According to Santos and De Carlo (2013), the studies showed that the occupational therapist´s performance with hospitalized patients provides better coping with hospitalization, better levels of independence, functionality, and quality of life, as well as facilitating a return to daily life and the social participation of individuals. Occupational therapy intervention is indicated as a promoter of the recovery of daily life impacted by illness and hospitalization.

In this way, it is believed that occupational therapy can effectively contribute to the care provided in the adult ICU. However, it is necessary to develop technical-scientific knowledge in this area to foster debates, exchanges of experiences and dissemination of the specificities of professional activity, given the reduction of existing publications.

In this context, aiming to share the experience of the first nine months of occupational therapy in the ICU, this article describes the experience and practical actions developed by the sector and reports the perception of the ICU care team regarding the work performed by the Occupational Therapist.

## 2 Method

This is an experience report based on the experience of the occupational therapy sector in the ICU of a state hospital of secondary level, medium complexity, located in the interior of the State of São Paulo.

The occupational therapy sector in this hospital has four professionals distributed as references by seven wards: general, surgical, infectious diseases, palliative care, semi-intensive and intensive unit. It is important to highlight that the reference occupational therapist does not stay full-time in the ICU, moving to an intensive clinic through for consultations, as well as for participation in a weekly team meeting.

Methodologically, there was a documentary analysis of medical records and specific forms of the sector regarding the notes of the period of the initial nine months of occupational therapy in the ICU to enable the sampling of the actions of the occupational therapy service provided.

At the end of the ninth month of insertion of occupational therapy in the ICU, the professional carried out a questionnaire to the team, with institutional consent, to understand the professionals' perceptions regarding the assistance provided, aiming at investments in educational actions with the care team about the practice of occupational therapy. Two physicians, two psychologists, a nutritionist, a physiotherapist, a nurse, a social worker and a speech therapist were subjected to this stage. The application of the questionnaire was carried out in loco, after the multi-professional meeting, explaining the character of voluntary participation and all signing the Free and Informed Consent Form.

The questionnaire had three questions that sought to understand aspects correlated to the previous experiences of professionals with occupational therapists, to the understanding of the actions practiced and to the visualization of possible contributions of the occupational therapist in the ICU from the perspective of the team.

The data obtained regarding the interventions and the perceptions of professionals were thematically analyzed. The analysis of thematic content consists of a technique in which a floating reading is performed, until all the information is recorded to verify the repetition of themes exhausted, a factor that facilitates the organization of the data into categories and interpretation of these data based on theoretical references (MINAYO, 2007).

## 3 Results and Discussion

### 3.1 Insertion of Occupational Therapy in the ICU

The insertion of the occupational therapist in the adult intensive care unit of a general hospital was initially through weekly participation in multi-professional meetings focused on clinical case discussions. Such participation allowed using this space for exchanges and contributions in the treatment to explain the intervention possibilities and competencies of the occupational therapist to the other specialties.

During these nine months of work, it was verified that the care performed involved patients with a mean age of 54 years old (the minimum age assisted was 16, and the maximum was 84 years old) and with equal representation of the genders (50% male and 50% female). Considering only the primary diagnosis, the most frequent clinical manifestations were respiratory (50.95%), renal (20.75%) and cardiac (11.32%) problems.

It is noteworthy that during the first three months of practice in this unit, there were reduced requests for consultation (n=4), a factor that may be associated with the low appropriation of the team in the interventions developed by the occupational therapist. Therefore, during this period, the services provided came from the active search of the occupational therapist or the demands visualized in the clinical discussions.

According to Carvalho and Lustosa (2008), an interconsultation can be considered as a way of applying the concept of interdisciplinarity, which meets the definition of interconsulence as an interprofessional and interdisciplinary activity of Schmitt and Gomes (2005).

It was verified that, from the consultations carried out in the first trimester and from the exchanges developed with the team about the intervention actions carried out in this period, there was an increase in requests for evaluation by occupational therapy, which culminated, in the period of the following six months, in the execution of 20 requests for consultation. This is an average care of three patient evaluations per month, in a unit with ten beds, thus 129 consultations in the semester.

## 3.2 Occupational Therapy practices

The evaluation process of the occupational therapist was based on an evaluative guide for the sector including the collection of information about the patient´s family structure, occupational profile, understanding and acceptance profile of the disease, the main complaint and the implementation of the Katz[2] scale.

In the identification of the actions given by the occupational therapist, the registered interventions were categorized in reception, coping, communication, functionality, and family, as described in Table 1.

The category *reception* consisted of registered actions related to the active listening of the emotional instability of patients and also of family members, an action that allowed the understanding of the configuration of anxieties and problems delineated by the patient and his/her caregivers, conceptions that sometimes were perceived as an influence on the exacerbation of symptoms. The reception as a guideline of the National Humanization Policy – HNP is the professional attitude in welcoming differences, pain, ways of living and feeling life. It consists in the accomplishment of qualified listening and in the capacity of agreement between the evaluated demands and the possibility of the response to the service (BRASIL, 2010).

In another category called *coping*, actions were taken by the occupational therapist because of difficulties related to hospitalization, neglect of treatment and acceptance of temporary or permanent limitations. For Botega (2002), the disease causes the feeling of loss of control over the patient, being the reactions experienced by each one in the illness and hospitalization, manifested differently. Interventions linked to the *coping* category consisted of general guidelines (clarifications about the clinical picture and functional prognosis, minimization of doubts and deconstruction of fantasies); reflexive propositions (identification of factors and times of greater intensity of symptoms for management strategies, incorporation of co-responsibility and stimuli to assertive postures); visualization of the use of activities of interest as a resource to minimize complaints, as well as the presentation of services available in the network as support for the post-discharge (encouragement and structuring for investment in self-care).

**Table 1.** Actions used by the Occupational Therapist in the adult ICU.

| CATEGORIES | DEVELOPED ACTIONS |
|---|---|
| Reception | Active listening, agreement |
| Coping | Guidelines, Reflections, Activities of interest |
| Communication | Alternative communication boards, writing adaptation, body language training |
| Functionality | Expressive, handmade activities, adapted games, ADLs, mobilizations, positioning |
| Family | Welcoming, mediation of conflicts, expressive activities, strategies for Routine organization and support for mourning |

In *communication*, actions related to the difficulties of expression of the patients were included, a factor assisted through the use of an alternative communication board, as well as the use of alternative resources such as adapted writing and body or facial signs.

Kleinpell et al. (2009) show that many of the patients in intensive units have expressions by gestures and lip movements to communicate, but due to the subjectivity in these attempts, there are sometimes mistaken interpretations by the professionals, generating frustration and anguishes to the patient. In this sense, the use of alternative communication resources of low complexity, especially in intensive centers, tends to favor an effective interaction if there are systematic understanding and applicability by all members of the team (BEUKELMAN; MIRENDA, 1992).

According to Luzo, Mello and Capanema (2004), there is a lack of specific training for professionals to become providers of assistive technology. In this context and in the lived experience, it was possible to perceive that the effectiveness of the alternative communication resources did not only consist in the elaboration and intervention of occupational therapy, but also in the instrumentalization offered by the occupational therapist to the team in how to use the prescribed resources, positioning, simplification of questions, the response time, among others.

The use of expressive activities, crafts and the use of adapted games, as well as the approach to activities of daily living (ADLs), was also used by the occupational therapist, giving rise to the *functionality* category. In the analyzed records, it is stated that at the beginning, the occupational therapist effected articular mobilizations, positioning and, when necessary, adaptations to favor functional performance, interventions that meet the description of the performance at the hospital level, as referred by Carvalho (2004). It is important to report that the choice of manual activities and games was based on information about the patient´s life context and interests. Also, there were medical records of the perception of patients' perceptions regarding the use of activities, as well as the facilitation effect for emotional regulation.

In the ICU, there are patients with severe complications, in which factors such as mechanical ventilation, sedation, tracheostomy, pressure ulcers, edema, disorientation and low level of consciousness may complicate interventions, often generating feelings of anguish and impotence to professionals, including occupational therapists. Therefore, it is necessary to consider all the factors of this environment and to understand the course of the disease and its implications.

From the appropriation of the routine of the ICU and the understanding of its equipment, the occupational therapist develops greater practical security, identifying strategies for applying their technical resources in the midst of the instability of the clinical conditions in the critical pictures.

It is relevant to reflect that, when thinking about the ICU environment, factors such as equipment noise, the level of proportionate stress and the need for invasive practices lead to a characterization of a cold, harsh place, which does not favor stimuli, especially concerning the reception. Therefore, the humanization proposal recommended by the SUS should cover and be established also in this scope.

It is necessary to invest in physical, technological, human and administrative structures to consider a hospital as humanized, in which the individual is valued and respected by placing himself at his or her service, ensuring a high-quality care (MEZZOMO, 2001).

The understanding of qualified care should involve criteria such as the composition of a multi-professional team, adequate physical structuring and the availability of technologies for usufruct.

Passos et al. (2015) report that one of the great challenges of the health team is to combine the technological resources of the ICU with humanitarian values since routine involves constant interaction with the technicity of care, an essential factor for the assistance to critical staff.

These factors are perceived as beneficial in the practice of this hospital, since this institution provides extended hours of visits for family members and it has the performance of multi-professional staff, televisions in each room, electronic medical records, and the physical space of the ICU has ten individual rooms, where half of them have a view of the hospital's external area.

The aforementioned resources are perceived as facilitators in the care process contributing to an adequate care for the patient, sometimes reducing part of the emotional exhaustion by allowing family support in a long time, stimulating the notion of temporality considering an external view in half of beds and privacy because the rooms are individualized, a factor that facilitates the approach about existing sufferings and minimizes external stimuli that hinder the level of attention of the patient during the intervention.

Such an openness to the family remaining for a longer time within the ICU environment may lead to the ambivalence of feelings since there are reports of a present and willing safety, but also of expressions such as impotence and yearning for the poor understanding of the monitoring equipment, and perceptions of patient limitations.

In this section, the *family* category emerges, which consists of interventions performed with the supporting figures of the patient's social network. From the unique identification of each mode of reaction adopted by the caregivers, there were correlated orientations to facilitate communication with the patient; aid in the organization of the family dynamics, because of the dismantling of the illness of an entity, as well as reception in front of the expression of feelings and expectations focused on the prognosis, which involves manifestations of anticipatory mourning.

According to Pettengill and Angelo (2005), the relatives of patients hospitalized in ICU tend to present defensive posture and difficulties of relationship with the health team, being able to adopt distances, factors linked to the experience and experimentation of feelings, such as impotence and insecurity to the unknown, which reinforces the need for interventions with the family.

In this context, it was verified that the interventional resources used by the occupational therapist varied between assistive technology training for interaction between the family and the patient; provision of qualified listening space for reception; conflict mediation; activities focused on expressiveness to support the emotions emerged by hospitalization and on reflexive actions to (re) organization of roles performed, and identification of support figures and potential resources for coping. There was also participation in some reports of death made by the doctor to the relatives, to help in supporting the manifestations coming from the mourning, given the established therapeutic link.

## 3.3 Perception of the multi-professional team on Occupational Therapy

Regarding the multi-professional team, the occupational therapist participates weekly in the clinical case discussions, contributing to his holistic vision to elaborate behaviors that involve minimization of suffering and assistance to the professionals in the identification of care mechanisms that can favor its performance.

Through a brief questionnaire applied to two physicians, two psychologists, a nutritionist, a physiotherapist, a nurse, a social worker and a speech therapist, it was sought to verify the perception of the multi-professional team about the work of occupational therapy in this area.

From the professionals' point of view, there was an approach to the work initiated and recognition by the team was observed to the actions developed by the occupational therapist. It should be noted that 88.9% (n=8) of the respondents stated that they had contact with the work of occupational therapy in the ICU for the first time, in this institution.

The answers were worked through the analysis of thematic content, and the participants described the therapeutic actions that match the work performed, as shown in Figure 1.

In Figure 1, the categories listed from the analysis of the answers given by the team and denoting the perception regarding the performance of the occupational therapy are explained. Among the most cited actions, there is the assistance to coping and the use of activities related to the possibility of doing and consequently favoring a positive posture and a greater commitment of the patient to the treatment. Rehabilitation and approach actions were also mentioned in the activities of daily living - ADLs, related to the stimulus of functionality and independence, often linked to the adaptations and the use of alternative communication. The resignification of life was manifested by the team's perception that the resources employed to promote the awakening of new meanings in the fragile experience of hospitalization and the feeling of the patient´s lack of control over himself. The assistance to the team was reported by placements, such as occupational therapy adds subsidies to the quality of care and favors a more humanized care, as well as helps the team in providing care to the patient, considering the use of a plurality of therapeutic resources.

Specifically, in the activities of daily living (ADLs), the professionals expressed their occupational therapy actions aimed at functional stimuli in activities, such as bathing, clothing and food, a factor that is sometimes linked to the elaboration of adaptations. Rehabilitation was indicated through visualizations of mobilizations and placements.

The use of activities was perceived as conducive to coping with hospitalization and functional recovery, since the possibility of doing reminds the team and

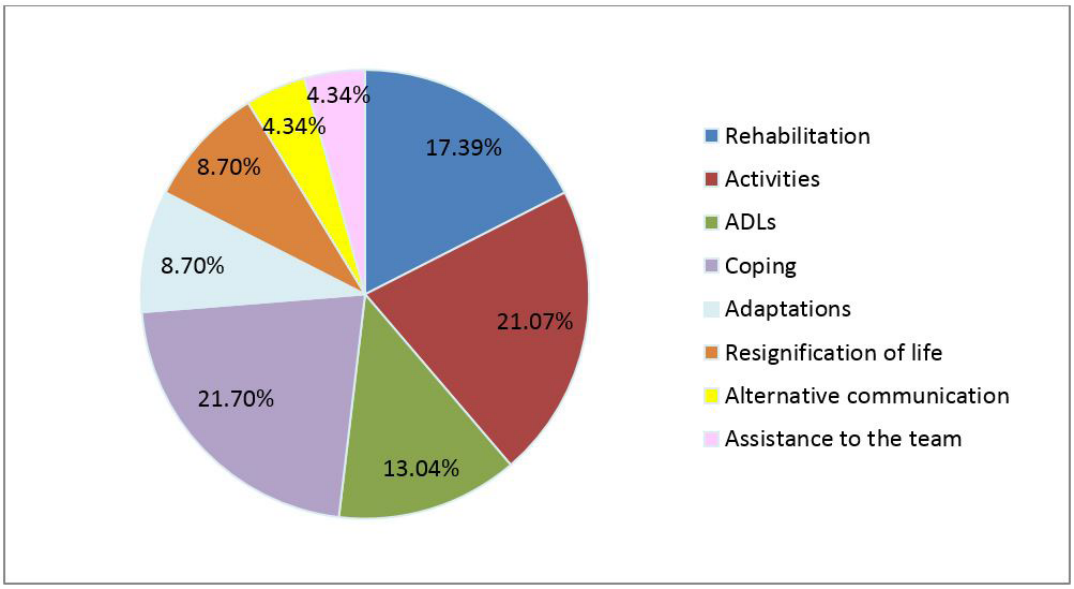


**Figure 1.** Visualized actions by the team through the O.T. work.

the families of the patient, the functional and clinical improvement, minimizing unfavorable feelings.

The alternative communication was reported, being perceived to be linked to the use and training of boards developed by the occupational therapy sector together with the speech therapy to facilitate interaction with the patient, as well as the recognition of the use of other resources such as thickening agents, and the temporality guidelines, to obtain answers. The positioning feature was also perceived to favor the patient´s visual field for lip reading to facilitate writing movements or gestures.

In the *coping* category, the team reported that occupational therapy interventions assist patients in positive perceptions, visualization of support resources and stimuli to their development. Considering the clinical trajectory and the experience in the ICU, some professionals refer perceptions of (res) signification throughout the interventions manifested by the patients.

These signs demonstrated that, during the contact with the practice of occupational therapy, during the first nine months of the insertion of occupational therapy in the ICU of this hospital, the team manifested an understanding of the intervention possibilities, a statement that is possible to be made from the association of the perceptions reported by the team professionals consistent with the actions carried out and registered by the occupational therapist.

Obtaining the team's perceptions in a way that is consistent with the actual work is based on the presupposition of an interdisciplinary practice, which, according to Matos and Pires (2009), allows a better understanding of the multidimensionality of the work object in health, obtaining more satisfactory results.

Therefore, the occupational therapist is configured as a matrix supporter, that is, a specialist who presents a knowledge base that aggregates knowledge resources and contributes with interventions that increase the capacity to solve health problems of the reference team responsible for the case (CAMPOS; DOMITTI, 2007).

In this perspective, the trajectory of occupational therapy in hospital settings, in the Brazilian scenario, shows advances and challenges, both regarding the development of professional practice as well as technical-scientific production and the organization of associations (PALM, 2016).

## 4 Conclusion

Although the work of Occupational Therapy in the Adult ICU is not yet widespread, this experience report highlights about some actions that have been developed in the unit of this report, with the perception of recognition of them by other members of the care team.

It was verified that the actions employed in this hospital have gone through functional aspects and support to the confrontation, with diversified resources used, which demonstrates the amplitude of the repertoire of Occupational Therapy.

However, difficulties related to the dissemination of knowledge about occupational therapy among specialties were observed, which required joint efforts for greater inclusion in clinical discussions and the development of educational actions, considering the constraints related to human resources (number of occupational therapists × number of wards).

It is believed that, in less than a year, important spaces were reached in this hospital, such as the intensive care unit, and the barriers were related to the lack of appropriation of the team on occupational therapy, a factor that gradually diluted with the proposed exchanges of knowledge. However, this is an arduous path, considering the turnover of professionals in the hospital context.

The proposal to share the actions of the occupational therapy work performed at this hospital meets the desire to stimulate the development of research in the context of the ICU to see what has been developed, as well as to encourage debates that promote technical improvement and consolidation of the work of the occupational therapist in this area.

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## Author's Contributions

Tatiana Barbieri Bombarda was responsible for the material review, article design, organization of sources and analysis. Ana Luiza Lanza was responsible for the article's conception and analysis. Regina Helena Vitale Torkomian Joaquim and Claudia Aline Valente Santos were responsible for the analysis and material review. All authors approved the final version of the text.

## Notes

[1] This is an experience report elaborated from the science and consent of the hospital's clinical director, respecting the ethical aspects of this construction.

[2] The Katz scale is an instrument for assessing the level of independence in activities of daily living (LINO et al., 2008).