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Patient advocacy in valuing social and family being in times of COVID-19

Advocacia do paciente na valorização do ser social e da família em tempos de COVID-19

Defensa del paciente en la valoración del ser social y la familia en tiempos de COVID-19

Mayara Souza Manoel[1]
Fábio Silva da Rosa[1,2,3]
Elizabeth Peter[4]
Carolina da Silva Caram[5]
Kely Regina da Luz[2]
Mara Ambrosina de Oliveira Vargas[1]

1. Universidade Federal de Santa Catarina. Florianópolis, SC, Brasil.

2. Hospital de Clínicas de Porto Alegre. Porto Alegre, RS, Brasil.

3. Universidade do Vale do Rio dos Sinos. São Leopoldo, RS, Brasil.

4. University of Toronto, Lawrence S. Bloomberg Faculty of Nursing. Toronto, ON, Canada.

5. Universidade Federal de Minas Gerais. Belo Horizonte, MG, Brasil.

Corresponding author:
Mayara Souza Manoel.
E-mail: mayarasmanoel@gmail.com

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Abstract

Objective: to understand the strategies used by intensive care nurses in the face of situations that required patient advocacy, involving the appreciation of social and family being during the COVID-19 pandemic. **Method:** this is a qualitative, descriptive and exploratory study, carried out in the five regions of Brazil. A total of 25 intensive care nurses participated in the study. Data were collected through a semi-structured interview and subsequently subjected to discursive textual analysis. **Results:** nurses advocated before the health team and for the family's presence within the Intensive Care Unit. With the COVID-19 pandemic, new strategies were established to advocate, promoting virtual rapprochement between nurses, patients and family members as well as the permanence of family members in intensive care environments when necessary so that nurses could know patients better and integrate the family into care. **Conclusion and implications for practice:** the strategies used to act on behalf of patients were carried out for rapprochement between nurses and family members; for instructing family members to advocate for patients; and for the defense of family presence within the Intensive Care Unit.

Keywords: COVID-19; Family; Health Advocacy; Intensive Care Units; Nursing.

Resumo

Objetivo: compreender as estratégias utilizadas pelos enfermeiros intensivistas diante das situações que demandaram a advocacia do paciente, envolvendo a valorização do ser social e familiar no cenário da pandemia de COVID-19. **Método:** estudo qualitativo, descritivo e exploratório, realizado nas cinco regiões do Brasil. Participaram do estudo 25 enfermeiros intensivistas. Os dados foram coletados por meio de uma entrevista semiestruturada e, posteriormente, submetidos à análise textual discursiva. **Resultados:** os enfermeiros advogaram perante a equipe de saúde e pela presença da família dentro da Unidade de Terapia Intensiva. Com a pandemia de COVID-19, foram estabelecidas novas estratégias para advogar, promovendo a aproximação, de forma virtual, entre enfermeiros, pacientes e familiares, bem como a permanência dos familiares no ambiente de terapia intensiva, quando necessário, para que os enfermeiros conhecessem melhor o paciente e integrassem a família ao cuidado. **Considerações finais e implicações para a prática:** as estratégias utilizadas para agir em prol do paciente se deram por meio da aproximação entre enfermeiros e familiares; por meio da instrução de familiares para que advoguem pelo paciente; e pela defesa da presença familiar dentro da Unidade de Terapia Intensiva.

Palavras-chave: Advocacia em Saúde; COVID-19; Enfermagem; Família; Unidades de Terapia Intensiva.

Resumen

Objetivo: comprender las estrategias utilizadas por los enfermeros de cuidados intensivos frente a situaciones que exigían la defensa del paciente, involucrando la valorización del ser social y familiar en el escenario de la pandemia de COVID-19. **Método:** estudio cualitativo, descriptivo y exploratorio, realizado en las cinco regiones de Brasil. 25 enfermeras de cuidados intensivos participaron en el estudio. Los datos fueron recolectados a través de una entrevista semiestructurada y posteriormente sometidos al análisis textual discursivo. **Resultados:** los enfermeros abogaron ante el equipo de salud y por la presencia de la familia en la Unidad de Cuidados Intensivos. Con la pandemia del COVID-19, se establecieron nuevas estrategias para abogar, promoviendo el acercamiento virtual entre enfermeros, pacientes y familiares, así como la permanencia de los familiares en el ambiente de cuidados intensivos cuando sea necesario, para que los enfermeros puedan conocerse entre sí. mejorar al paciente e integrar a la familia en el cuidado. **Conclusión e implicaciones para la práctica:** las estrategias utilizadas para actuar en nombre del paciente se llevaron a cabo a través del acercamiento entre enfermeras y familiares; instruyendo a los familiares para que defiendan al paciente; y por la defensa de la presencia familiar dentro de la Unidad de Cuidados Intensivos.

Palabras clave: COVID-19; Defensa de la Salud; Enfermería; Familia; Unidades de Cuidados Intensivos.

INTRODUCTION

The term advocacy comes from the Latin *advocatus*, which means "the one who provides evidence". In nursing, these signs are used to promote patient advocacy, i.e., for health advocacy, a fundamental competence for nurses to provide evidence with the aim of empowering patients and their families so that they can make informed decisions about health treatments.[1-4]

Health advocacy is closely linked to human rights and the right to health. It can be said that the idea of patient defense, later called patient advocacy, began with the draft, by the United Nations (UN), of the Universal Declaration of Human Rights, in 1948.[5] Internationally, patient advocacy practice by nurses was only recognized in the 1970s; however, even today, it portrays a relatively new role in nursing practice, especially in some countries, such as Brazil, where investigations into the exercise of patient advocacy by nurses are still incipient.[6,7]

In Brazil, health is a right for everyone and a State's duty, guaranteed by the Federal Constitution of 1988. Likewise, patients have their rights guaranteed by law following the Brazilian Health System (SUS – *Sistema Único de Saúde*) regulation through Organic Law 8,080 of 1990.[5] From this perspective, nurses can defend users' interests and well-being by ensuring that they are aware of their rights and have access to information for decision-making.[1,3] Therefore, nursing advocacy practice is expressed with the aim of ensuring patients' rights and contributing to their autonomy.

However, it cannot be denied that, in Intensive Care Units (ICU), advocacy becomes essential due to the complexity of the environment, the vulnerability and severity of patients' clinical situation and, above all, continuous use of sedatives and painkillers, which makes it impossible for patients to advocate for themselves.[2,8-10] Disadvantage situations caused by social inequalities, the worsening of the disease process and the need for specialized care due to critical condition in ICU and associated with great influence of technologies, increase vulnerability, which can be caused by different factors or conditions.[2,8]

Bearing this in mind, nurses become a reference for care for both patients and their families, due to their proximity, representing their wishes and being responsible for their defense before the health team and the institution.[1,2,8] In practice, they exercise autonomy as a strategy, used even in the face of barriers that may hinder or impede the practice of law. When exercising their autonomy, nurses seek to help patients obtain the necessary health care, ensuring the quality of this care and the presence of their family.[7]

By promoting the presence of family members with patients admitted to hospital, boosting this presence also at critical moments of care, nurses become active agents in promoting patient advocacy.[11-17] Therefore, when it is not possible to identify patients' wishes, nurses use the family as a reference to defend themselves before the multidisciplinary team, encouraging family members to help in decision-making.[13,15,17,18]

However, as a result of the COVID-19 pandemic, it was necessary to reconfigure the ICU work process, preventing family members from accompanying patients' hospital admission as a measure to prevent the spread of the disease, generating, among other repercussions, the lack of family members in the sector to advocate on behalf of patients. This aspect made patients even more vulnerable, which required nurses to play the role of patients' main defender before the health team, the institution and the health system itself.[9]

Patient advocacy is the nurses' ethical and moral duty, and has political and professional importance.[1,3] Even so, the barriers imposed by the health care system, institutions and the health care team itself, such as the absence of family members in the ICU during the pandemic, made this task even more complex, which justifies the interest of this research.[3,5,19]

Considering that the COVID-19 scenario has highlighted both the ICU and nurses in the role of advocates for their patients, there is a need to clarify possible ways of advocating in nursing, also considering the current changes in the context of pandemic.[10] Therefore, the question emerged: what were the strategies used by intensive care nurses in situations that required patient advocacy and appreciation of social and family being during the COVID-19 pandemic? To this end, this study aimed to understand the strategies used by intensive care nurses in situations that required patient advocacy and appreciation of social and family being during the COVID-19 pandemic.

METHOD

This is a qualitative, descriptive and exploratory study, whose writing was guided by the COnsolidated criteria for REporting Qualitative research (COREQ),[20] supported by the conceptual framework regarding patient advocacy, which allowed the main researcher to establish the exercise of interpretation and reconstruction of meanings with an emphasis on participants' perspective, considering their contexts and subjectivities.[21]

The study was carried out with 25 intensive care nurses from the five regions of Brazil (North, Northeast, Central-West, Southeast and South), selected intentionally, who worked in adult ICUs dedicated to caring for patients with COVID-19. This amount considered data saturation, which occurs when no new elements are found among the data obtained and the addition of new information is no longer necessary, as there are no changes to the understanding of the object of study.[22]

Data production took place from July to October 2021, through individual online interviews, carried out by the main author, using a semi-structured script prepared by the authors containing questions about participant sociodemographic characteristics and perceptions about strategies involving advocacy patient and appreciation of social/family being. The questions were previously tested by the authors, aiming to improve interview conduct, and the script was developed so that it included the relevant aspects to understand the phenomenon studied.

Nurses with more than six months of care work in intensive care in public and/or private sector institutions during the COVID-19 pandemic period were included. This period of time was established because it is assumed that six months is the minimum necessary for nurses to become familiar with the ICU environment and institutional routines, thus being able to act autonomously in situations that require patient advocacy. Nurses who did not care for patients with COVID-19 were excluded.

The invitation to participate was sent via electronic mail (email), and, upon acceptance, each participant was taken to a virtual room, maintaining their privacy. Prior scheduling was made, depending on each participant's availability. It is important to highlight that data were produced during the COVID-19 pandemic, which is why the interviews were conducted online.

The interviews were transcribed to form the *corpus*, and the data obtained was subjected to discursive textual analysis, which establishes the exercise of interpretation and reconstruction of meanings with an emphasis on the perspective of subjects involved in the research.[21] However, it should be noted that understanding seeks to transform reality from the perspectives of the subjects participating in the investigation. In this regard, an interpretation that does not come from outside the phenomenon investigated is required. Thus, analytical development occurred in three fundamental stages: text unitarization; categorization; and communication.[21]

In the unitarization stage, the interviews were thoroughly examined and fragmented until units of meaning were obtained. In categorization, relationships were established between units of meaning so that responses were grouped into two categories: (1) Strategies used to practice law with the aim of valuing social and family life before the pandemic; and (2) New strategies used to practice law in order to value social and family life throughout the pandemic and their respective descriptions. In the communication stage, the understanding of the phenomenon investigated was explained, which presents itself as the product of a new combination of elements constructed during the previous phases.

The study complied with Resolution 466/12 of the Brazilian National Health Council, and was approved by the Research Ethics Committee of the *Universidade Federal de Santa Catarina* (UFSC), under Opinion 2.620.178 in April 2018. Participants signed the Informed Consent Form, and had their identities preserved, with the identification made up of the region of the country in which they reside (North, Northeast, Central-West, Southeast and South), followed by the sequential number of the interviews, which were recorded upon consent.

RESULTS

Participant characterization

Among the participants, 17 (68%) were female; nurses' age range was 28 to 47 years old; 22 (88%) had specialization, of which 20 (80%) in the intensive care area; 12 (48%) had a master's degree; and three (12%) had a doctoral degree. Furthermore, 11 (44%) of nurses are linked to a public institution, ten (40%) to a private institution, and four (16%) to a mixed institution. Furthermore, 21 (84%) stated that they had an effective relationship with these institutions; and 24 (96%) were in a highly complex ICU. Professional training time ranged from two to 25 years, and professional experience in ICU ranged from nine months to 25 years.

Categories organized based on analysis of results are presented below

Based on data analysis, two categories were defined, *a priori*: (1) Strategies used to practice law with the aim of valuing social and family life before the pandemic; and (2) New strategies used to practice law in order to value social and family life throughout the pandemic and their respective descriptions.

Strategies used to practice law in order to value social and family life before the pandemic

Nurses' actions to preserve social beings and family involved understanding patients' singularities and paying attention to affective and emotional needs. The strategies used before the COVID-19 pandemic consisted of encouraging family visits and the presence of a companion as well as making visiting times more flexible, as necessary. Furthermore, the family member was encouraged to act as an active agent in the care process, and family member and patient were prepared and guided throughout hospital admission for autonomy after hospital discharge.

It was noticed that nurses practice advocacy on behalf of patients when there is a close family member within the unit, being a way of exchanging the necessary information about patients and their clinical situation.

> *Before the pandemic, we had family members very close in the ICU. We would bring the family member close to explain and even transform them into a caregiver.* (SOUTH/1)

> *Having an information-based relationship with family members, a more frank, more open dialogue, building clinical knowledge, explaining, taking time to explain the clinical picture to the family.* (SOUTH/4)

Furthermore, sharing between nurse and family member causes involvement in patient care, especially with regard to clear and objective information so that this family member can claim access to medications in the health system, participate in their therapeutic plan and prepare for patient discharge and return to home.

> *We talk, we meet with family members to resolve some issues, such as giving instructions for family members to obtain some medications that are made available by the State, such as Eprex.* (NORTH/3)

> *The strategy I use in law, especially involving the family, is precisely to approach the family, introduce myself, explain what my job is, my role in caring for that patient, make that family feel safe about my position and, likewise, clarify their doubts. I make families fully aware of patients' clinical issue, that we are there to collaborate, try to reassure them, because many are anxious and fearful when leaving their loved ones inside the ICU. So, my strategy is to always embrace this family, talk, be as objective and clear as possible, as confident in my role so that they feel comfortable, knowing that patients are being cared for, are being looked after.* (SOUTHEAST/4)

> *Family members close to patients help provide care,* [...] *I think nurses have this role of bringing families closer, especially because patients are family members, they are not ours, they are not part of the institution. There comes a time when they need to return home, so I worked a lot on this aspect of family members staying with patients in the ICU.* (SOUTH/5)

> *Within our proposed philosophy, focusing on patients and families, we bring families into care and provide information in a clear and honest way, with understandable language. I usually say that families are extremely important, because the people who are there on the bed have a history, a family, friends, and they are important beings for those people, and they, therefore, are important within this process.* (NORTHEAST/1)

> *We begin to see an improvement in care results when patients/families are truly placed at the center of care, valuing their role and decision-making for the therapeutic plan.* (SOUTHEAST/2)

Another nurse advocacy strategy in defending, before the team, patients' right to have a companion in the ICU, refers to the perspective of valuing the self and the family, focusing on humanization of care and its therapeutic possibility, promoting quality care.

> *Here, in the North region, it is very complex to have a companion. For example, patients aged 14 to 19 stay in the adult ICU and* [there] *they cannot be accompanied, even though they have the right to do so, or chronic patients who stay in the ICU for a long time. Sometimes it's difficult for us to convince some people on the team* [that] *this is therapeutic for patients.* (NORTH/2)

> *We have excellent results with the family present. We observed that the process of treatment and healing and improvement with the family is extremely evident. We were able to understand the evolution and see how much patients benefit from this, and those who didn't have family nearby, we ended up playing this role.* (NORTH/5)

> *Promote family interaction with patients, informing them about their rights, humanizing treatment so that companions to ICU patients are in accordance with their psychosomatic needs, and adapting, on the other hand, to family members' emotional conditions.* (SOUTHEAST/5)

Finally, nurses highlight the strategy of maintaining a reliable and partnership relationship with the family, involving them in activities, such as rounds and dehospitalization of patients and, also, providing company and affection when it is not possible for family members to be present.

> *Family is priority number two after patients. We are rarely left out of issues that need to be resolved with the family. We are sued directly, many times. Therefore, the best strategy is to make family members understand that we are there to cooperate and add value.* (CENTRAL-WEST/2)

> *Increasingly, we need to value social/family being in all ways: valued presence in the ICU, participation in rounds, effective communication and insertion of the family member throughout the patient dehospitalization process.* (NORTHEAST/5)

> *At the hospital, we have daily contact with the family to find out how patients would like to be treated. We also have those patients who, after a few months, progress to palliative care, so, together with the family, we build how to treat this patient and guarantee their rights.* [...] *this part of valuing social and family being is easier to work on. During visits, at the hospital, we have the possibility for these family members to bring belongings, photographs,* [...] *leaving it exposed and promoting a more familiar environment. When a patient does not have a family, the team takes care of them and each day a professional is responsible for going there. Even if this patient is unconscious, talk a little, maintain a supportive spirit* [...]. *We have the affective record, which is a way of knowing this patient's preferences, when possible, helping in this part.* (CENTRAL-WEST/5)

New strategies used to practice law in order to value social and family life throughout the pandemic

To reduce the spread of COVID-19, families were physically removed from intensive care environments. With this, nurses became patients' main advocate.

> *Today, in the COVID era, there is no family member, it is a nurse and a patient.* [...] *without family, nurses practically advocate 100% of the time for patients, because they are alone. Today, we don't even know our family members and, before the pandemic, there was closeness.* (SOUTH/1)

With the pandemic, we had to develop more advocacy, because there was a very limited number of visits, so we ended up having to be patients' advocate, as we couldn't get in touch, it wasn't possible to have that bond between family member and patient as close as before. [...] *now, we are starting to return with reduced visits. We try to pass the information on to family members. If contact is difficult, we assess whether it is necessary or not,* [...] *especially because we have a large number of patients and beds.* (SOUTH/2)

Patients, even in the ICU, had the right to visit, depending on the situation, including a companion at all times. With the pandemic, this right was taken away from patients, and they were left completely without a family member, without a visitor. Those who were lucid spoke to their families via video conference; the others, who were intubated, did not even have this communication. And we know that, even if patients are sedated, their hearing is maintained, so family members there, constantly present, help a lot in treatment. There are already studies that prove this. (NORTHEAST/2)

Faced with this situation, the need arose to implement new measures to advocate for patients, especially in order to rescue and guarantee the presence of a family member. To achieve this, strategies were used such as: organization of physical space to accommodate companions; particular analysis of each case; making video calls; passing on bulletin information externally to the unit; proper clothing for companions, with signing of a commitment form for the visit to take place; and reinforcement of technology as a means of promoting rapprochement.

We had three one-hour visiting times, with the presence of three family members, who took turns one at a time. Now, we have a thirty-minute schedule with just one family member. Of course, each case is analyzed individually. There were times when we left family members present with patients 24 hours a day in a well-planned and organized manner, leaving these patients in the end beds so that family members were not in the middle of others. But this also depends on the structure, so it was rarely possible to leave a family member together. Nurses have a lot of autonomy where I work. (SOUTH/3)

The pandemic has greatly harmed patients' rights to receive visits from family members and each individual's personal issues of respecting their wishes. During the pandemic, I noticed patients being very alone in intensive care, so, when I identified which patients needed it, or I realized it would be good for them or their family members, one of the strategies I used was to make video calls, even when working at night. It was a way for patients to have their moment, so I tried to give them that. (SOUTH/5)

The pandemic made the issue of humanization difficult, because the distance from the family of patients admitted to the ICU was complex, so the units had to develop strategies. Among them were: having a team that provided the bulletin outside the ICU; teams that transmitted the bulletin via phone calls; teams that called patients to speak to the family; etc. (NORTH/2)

Nurses, where I work, are very active in the extended visit decision. Our ICU has extended visits. And, in the second wave, we began to allow visits with proper clothing for all visitors and within a limited time [...]. *Then, the family members signed a commitment form and an analysis was also carried out on these family members, whether they were part of the risk group or not. We conquer patient visits.* (NORTH/3)

With the pandemic, family members could often not be with patients, there were some internal rules of the institution, [...] *even though patients are seniors, we were resistant to leaving companions, and the strategy we used to family to become closer, involved in the care process, was via videoconference or calls, both from the nursing and medical staff, to provide medical reports, or families would go to a reception room for doctor to give all the information and give patients' report. The difficulty was adapting the companion issue, because, when patients are seniors, they have the right, by law, to have a companion, so getting around this situation was a little more delicate.* (CENTRAL-WEST/1)

It changed with the pandemic as the family moved away from the hospital and our communication is through virtual contact or by telephone. (NORTHEAST/1)

The human component was cited as a way to strengthen patient advocacy, referring to the importance of empathy in this time of pandemic.

I already practiced, in my life and in my assistance, empathetic spirit, always trying to put myself in patients' and family members' shows, and this intensified a lot during and after the pandemic. (NORTH/4)

DISCUSSION

The study demonstrated the importance of family presence and participation in the ICU as a way of valuing self and family. The family's stay in the ICU is very important, so much so that, in 2005, the Brazilian National Critical Patient Policy was established by the Ministry of Health, which defends family-centered care with the aim of providing quality care for family members and patients who are admitted to the ICU.[2]

Research participants emphasized the importance of family members staying in intensive care as a strategy used to practice law in order to value social and family life throughout the pandemic.

In this regard, it was noticed that nurses played a fundamental role in making this stay possible, instructing patients' families to also practice advocacy on behalf of patients. The literature corroborates the results found in this research by highlighting nurses as a defender of patients' and family's rights as well as articulators and intermediary actors between the health team and patient and their family members. The role of these professionals as an advocate for patients is clear by providing subsidies for empowering patients and families, providing autonomy so that they can make conscious decisions about their health-disease situation.[8]

Furthermore, advocacy stands out as an element of holistic care in nurses' work, i.e., care that considers patients as a whole, involving not only the health-illness situations that led to the worsening of clinical condition and, consequently, admission to intensive care, but also the surrounding biopsychosocial issues. Therefore, advocacy is considered comprehensive to this holistic care, not restricted only to patients, but also extending to their family.[12]

Patient advocacy carried out on behalf the family is evidenced through daily actions carried out in nurses' assistance that include including the family to provide well-being and welcome patients during hospital admission, among other aspects, such as: encouragement of family as active care agent; provision of information about the real clinical condition and prognosis; and guidance on the procedures to be performed, the possibilities of treatments offered, the equipment and invasive devices. Privacy must be promoted for both, confidentiality of information entrusted to nurses, advocacy before the team regarding end-of-life procedures, considering non-resuscitation, seeking medical assistance, living wills and advance directives.[2,8,12]

Another important finding of this research refers to advocacy practice in intensive care with the inclusion of families in the care process, thus preparing them for hospital discharge, helping patients and their families adapt to facing new daily adversities, enabling the process of reintegration into society when necessary.[10]

Regarding the issue of interaction and communication between nursing team and patient and their family members, nurses assist in establishing values and meanings regarding hospital admission in the ICU, acting by advocating for patients' and families' needs before the clinical team, establishing a plan family-focused care, in addition to traditional individualized care plan for each patient.[13]

Nurses' action as an intermediary between patient, family and multidisciplinary team, especially the medical team, must be valued as an advocacy action, as nurses become mediators between parties, often translating clinical information into a language suitable for clients as well as taking on the role of expressing to the clinical team the wishes and desires of patients and their families, seeking to ensure the best possible care and treatment.[8,17]

In the context of work during the pandemic, the restriction of the presence of family members in ICU was highlighted due to the need to minimize the spread of COVID-19. Considering the results of this study, in which the presence of the family was one of the patient defense strategies most valued by professionals, it was noticed that this restriction of family members' access to the ICU was the most reported situation in the interviews, making new strategies necessary for nurses to exercise patient advocacy, since, to exercise it through involvement with family members, it is necessary to establish a bond and interaction with the family. Therefore, patient advocacy needs change drastically when there is a change in the dynamics of this involvement with the family.[8]

The absence of family members with patients during the COVID-19 pandemic was the greatest dilemma faced by the health team, and it was constantly up to nurses to inform family members that they could not be in person in the ICU.[23-29] The suspension of in-person visits led to a reformulation of this process in health institutions, meaning that the use of digital platforms allowed contact between patients and their families through virtual visits, a strategy implemented to mitigate the negative effects of isolation and to improve the quality and results of communication between family members, patients and ICU professionals. The previously mentioned components contributed to ensuring that patients' rights in relation to the Brazilian National Humanization Plan guidelines were preserved.[26-29]

Virtual visits allow the multidisciplinary team to bring them closer to the families of patients admitted to hospital, enabling the clarification of doubts about the clinical picture and the interaction between patient and family.[26] It is worth noting that patients with severe COVID-19 were treated, in most cases, in the prone position (pronated) for long periods, using devices for feeding, ventilation, monitoring, among others, which alter body image, allowing nurses, through the exercise of patient advocacy and using a virtual approach, to present the physical space of the bed and patients' situation, providing security to the family and building a space of trust and understanding.[26]

Corroborating the results of this study, among the strategies found for establishing communication with family members, it was possible to identify, in the literature, that the use of technology enabled more interactivity, leading the team to carry out a new process of learning, reflection and reconfiguration about communication.[27] Furthermore, to ensure the meeting between patients and their families, even with the restrictions imposed by the COVID-19 pandemic, it has become essential to minimize the distance between them by carrying out virtual visits as well as providing psychological support during hospital admission.[26-29] Regarding the issue of operationalizing communication, more investments are needed in the acquisition of devices for making video calls.[27] However, study participants reported difficulties and that this is not the reality of all Brazilian hospitals, as interaction with family members was restricted to calls via the unit's landline telephone.

It was also noted that providing dignified and safe care, with the moral commitment to inform patients so that they can participate in treatment decisions, is a characteristic of patient advocacy. These factors led nurses to pay attention to the values, cultures and beliefs of those admitted to intensive care during the COVID-19 pandemic.[29]

This new way of advocating involves ethical aspects, such as prior consent from patients or their guardians prior to carrying out virtual visits. Hence, nurses provide quality care while maintaining patient privacy and protection. Respecting patients' values is one of the main attributes of their defense, therefore providing an opportunity to advocate for them.[29]

Another issue highlighted in the literature was the prolonged period of hospital admission of patients affected by COVID-19, who were longing to see their family members again, with virtual visits offering the possibility of receiving honest, intelligible and timely information, capable of providing comfort to both patients as for family members, who also need support, comfort and closeness.[26,29] In this regard, study participants mentioned that increased workload due to overcrowding caused by the pandemic meant that the provision of direct assistance to family members, through virtual contact as a way of guaranteeing convey of information, and the implementation of virtual visit became a challenge for nurses.

However, even though Brazilian hospitals have opted for the absence of in-person visits in the ICU, with the intention of defending life and protecting their own family members from contagion by COVID-19, study participants stated that regulations in this regard were becoming more flexible over time, especially after the start of vaccination. Thus, the results of this research are in line with other studies, which reiterate the benefits of an expanded policy on visiting family members in the ICU as well as highlighting the harm that the absence of a family member can cause to patients.[24,25,29]

Considering the risks of contamination, nurses needed to ensure that guidelines regarding protective measures to prevent the spread of COVID-19 were followed by family members, making it possible to provide a companion during the period of hospital admission in the ICU, especially in cases of terminal illness, aiming at end of life comfort.[27] Thus, patient advocacy by intensive care nurses can ensure a humane process of death and dying, providing emotional and spiritual support and a peaceful, calm and peaceful environment for patients, with the presence of their family.[17]

Regarding the achievement of objectives and expectations to understand the strategies used by intensive care nurses in situations that required patient advocacy during the COVID-19 pandemic, it was possible to identify those nurses experienced an unpredictable moment, with rapid deterioration of the health system, high number of patients, contamination among colleagues and prolonged daily contact with infected patients. These factors, associated with the high number of patients admitted to the ICU, the shortage of nursing staff and an environment with complex decisions and cumulative patient losses, created many new challenges for nurses, causing them to face severe stress.[28] But despite these challenges, nurses demonstrated that patient advocacy is part of the daily ICU context, because neglecting patient advocacy has consequences for both patients and nurses.

Finally, the patient advocacy exercised by intensive care nurses during the pandemic allowed reducing harm to patients, enabling the appreciation and information of them and their families and also allowing participation in care and treatment decisions. Advocacy by nurses plays an important role in ensuring safe health practices, reducing risks in the hospital admission process and also correcting possible errors, being able to avoid harm.[28]

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

The nurses participating in the research, from all Brazilian regions, reinforce that valuing self and family is essential in patient advocacy. Therefore, it was possible to understand that the strategies used to act on behalf of patients occurred: through bringing nurses and family members together to better understand patients and advocate on their behalf before the health team; through instruction to family members so that they could also advocate for patients; and defending the presence of family members within the ICU, promoting comfort and improving the clinical condition and making the family a comprehensive part of care.

However, it was found that, with the COVID-19 pandemic, the family was physically removed from the ICU area, with the intention of protecting them, avoiding contamination by the coronavirus. As a strategy, the virtual approach to family members of both nurses and patients was highlighted. Therefore, new strategies were implemented to bring the family closer, in order to enable nurses to know their patients better and maintain contact between these patients and their loved ones, valuing the self and the family.

Even though the number of participants in qualitative research does not constitute the possibility of limiting the study, it is noted that developing the research with participants from the five regions of Brazil may have triggered a limitation bias. In other words, even considering participants from public and private institutions, delimiting five per region required researchers to carry out a rigorous prior assessment in the process of attracting potential participants. Even though they come from different regions, there was some similarity in the results analyzed.

Finally, there is a need for future research with patients to understand the changes caused by the pandemic and the consequences of restricting the physical presence of family members in intensive care environments. It is also necessary to determine family members' and patients' perception regarding the new advocacy strategies implemented by intensive care nurses.

AUTHORS' CONTRIBUTIONS

Study design. Mayara Souza Manoel. Mara Ambrosina de Oliveira Vargas.

Data acquisition. Mayara Souza Manoel. Mara Ambrosina de Oliveira Vargas.

Data analysis and interpretation of results. Mayara Souza Manoel. Mara Ambrosina de Oliveira Vargas. Elizabeth Peter. Carolina da Silva Caram. Kely Regina da Luz. Fábio Silva da Rosa.

Manuscript writing and critical review. Mayara Souza Manoel. Mara Ambrosina de Oliveira Vargas. Elizabeth Peter. Carolina da Silva Caram. Kely Regina da Luz. Fábio Silva da Rosa.

Approval of the final version of the article. Mayara Souza Manoel. Mara Ambrosina de Oliveira Vargas. Elizabeth Peter. Carolina da Silva Caram. Kely Regina da Luz. Fábio Silva da Rosa.

Responsibility for all aspects of content and integrity of published article. Mayara Souza Manoel. Mara Ambrosina de Oliveira Vargas. Elizabeth Peter. Carolina da Silva Caram. Kely Regina da Luz. Fábio Silva da Rosa.

ASSOCIATED EDITOR

Rafael Silva

SCIENTIFIC EDITOR

Marcelle Miranda da Silva

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