Article

The Significance of Intensive Care Unit Stays for Older People, Medellín, Colombia

✉ ***Silvana Hincapié-Rodas***

https://orcid.org/0000-0003-4272-8308
Universidad de Antioquia, Colombia
silvana.hincapie@udea.edu.co

Luz Estella Varela-Londoño

https://orcid.org/0000-0001-7799-2197
Universidad de Antioquia, Colombia
luz.varela@udea.edu.co

Received: 10/07/2024
Sent to peers: 04/09/2024
Approved by peers: 10/03/2025
Accepted: 22/04/2025

DOI: 10.5294/aqui.2025.25.2.8

Para citar este artículo / To reference this article / Para citar este artigo
Hincapié-Rodas S, Varela-Londoño LE. The Significance of Intensive Care Unit Stays for Older People, Medellín, Colombia. Aquichan. 2025;25(2):e2528. DOI: https://doi.org/10.5294/aqui.2025.25.2.8

Theme: Care processes and practices

Contribution to the field: Population aging brings with it an imminent need to conduct more in-depth research with older people to promote measures and policies that contribute to ensuring integral care and attention for them in various settings. From the perspective of nursing, understanding the significance of ICU stays for older people allows nursing professionals to recognize their needs in a timely manner to provide care with a tailored and humanized approach that considers the changes associated with old age, promoting their adaptation and health outcomes in this environment, which they are increasingly likely to enter.

Abstract

Introduction: The increase in the number of older people in intensive care units (ICUs) poses a challenge for care providers, as these patients are more vulnerable and fragile, making them prone to unfavorable outcomes. **Objective:** To understand the significance of ICU stays for older people. **Methodology:** This is a descriptive qualitative study employing ethnographic tools. Following an exploratory study, ten interviews were conducted and complemented by observation in an ICU and a field diary. There was reflexivity and concurrence between data collection and analysis. The interviews were transcribed, and codes were identified through line-by-line reading, which were used to configure the emerging categories. Rigorous criteria and ethical principles were retained. **Results:** The meaning that participants assigned to the ICU setting was that of a respectful, enclosed, cold, special room with personalized care for complex or seriously sick patients. Interactions occurred with family, healthcare personnel, and spiritual figures, with diverse meanings, mediated by respectful, kind, special, and affectionate treatment; however, there were moments of inhumane, distant, and indifferent treatment. Care was defined as special, requested, and timely; at other times, it was defined as not received, not identified, not timely, or with some limitations when provided. **Conclusion:** The meaning of ICU stay for older adults is associated with being cared for and grateful, despite some unfavorable situations in the environment, interactions, and care.

Keywords (Source: DeCS)
Older adult; intensive care units; critical care; Nursing; interpersonal relations; aging; frailty; patient-centered care; ethnography; qualitative research.

El significado que tiene para las personas mayores su estancia en una unidad de cuidado intensivo, Medellín, Colombia

Resumen

Introducción: el incremento de personas mayores en las unidades de cuidado intensivo (UCI) es un reto para el cuidado, en la medida en que tales pacientes presentan un grado mayor de vulnerabilidad y fragilidad que los hace propensos a tener resultados desfavorables. **Objetivo:** comprender el significado que tiene para las personas mayores haber estado en la UCI. **Metodología:** investigación cualitativa descriptiva con herramientas de etnografía. Previo estudio exploratorio, se realizaron diez entrevistas, se complementó con observación en una UCI y diario de campo. Hubo reflexividad y concurrencia entre la recolección y el análisis, se transcribieron las entrevistas y en la lectura línea por línea se identificaron códigos con los que se configuraron las categorías emergentes. Se conservaron criterios de rigor y principios éticos. **Resultados:** el significado que los participantes dieron al contexto de la UCI fue el de una sala de respeto, encerrada, fría, especial y con atención personalizada para pacientes complejos o graves de salud. Las interacciones se dieron con la familia, el personal de salud y figuras espirituales, con significaciones diversas, mediadas por el trato respetuoso, bueno, especial, cariñoso; no obstante, hubo momentos de trato inhumano, distante e indiferente. El cuidado fue definido como especial, solicitado, oportuno; otras veces como no recibido, no identificado, no oportuno, o con algunas limitaciones al momento de brindarlo. **Conclusión:** el significado de haber estado en la UCI para las personas mayores se asocia con sentirse bien cuidados y agradecidos, a pesar de algunas situaciones no favorables en el ambiente, las interacciones y el cuidado.

Palabras clave (Fuente: DeCS)
Persona mayor; unidades de cuidados intensivos; cuidado crítico; enfermería; relaciones interpersonales; envejecimiento; fragilidad; atención centrada en la persona; etnografía; investigación cualitativa.

O significado, para idosos, da permanência em uma unidade de terapia intensiva. Medellín, Colômbia

Resumo

Introdução: O aumento do número de idosos em unidades de terapia intensiva (UTI) representa um desafio para o cuidado, pois esses pacientes apresentam maior vulnerabilidade e fragilidade, o que os torna mais propensos a ter desfechos desfavoráveis. **Objetivo:** compreender o significado, para os idosos, de ter estado em uma UTI. **Materiais e métodos:** pesquisa qualitativa descritiva, utilizando métodos etnográficos. Previamente a um estudo exploratório, foram realizadas 10 entrevistas, complementadas por observação em UTI e registros em diário de campo. As etapas de coleta e análise foram conduzidas com reflexividade e coerência metodológica. As entrevistas foram transcritas e, na leitura linha por linha, foram identificados códigos que deram origem às categorias emergentes. Os critérios de rigor e os princípios éticos foram respeitados. **Resultados:** Os participantes atribuíram à UTI o significado de um ambiente respeitoso, isolado, frio, especial e com atendimento personalizado para pacientes em condição grave ou complexa de saúde. As interações ocorreram com a família, com os profissionais de saúde e com figuras espirituais, com significados variados, mediadas por um tratamento respeitoso, bom, especial, afetuoso; contudo, também houve relatos de tratamento desumano, distante e indiferente. O cuidado foi descrito ora como especial, solicitado e oportuno, ora como ausente, não reconhecido, inoportuno ou limitado em determinados momentos. **Conclusão:** Para os idosos, o significado de ter estado na UTI está associado à sensação de ter sido bem cuidado e ao sentimento de gratidão, apesar de algumas experiências desfavoráveis relacionadas ao ambiente, às interações e à assistência recebida.

Palavras-chave (Fonte DeCS)
Idoso; unidades de terapia intensiva; cuidados intensivos; enfermagem; relações interpessoais; envelhecimento; fragilidade; cuidados centrados na pessoa; etnografia; pesquisa qualitativa.

Introduction

Population aging is a worldwide reality; thus, the social, cultural, and health systems of all countries face challenges to ensure the care of the older population (1). It is important to recognize that older people have a high degree of fragility that makes them more susceptible to illness, which may lead them to require specialized care in environments such as the intensive care unit (ICU) to heal, preserve their functionality, and meet their needs, aiming to allow them to enjoy the best possible quality of life after their discharge (2).

The ICU is considered a highly technical place, with some particular conditions such as restrictions on visits, the use of invasive medical devices, limited interaction and communication with family members, loss of autonomy and role, consequently requiring qualified professionals to provide care (3).

Brunker et al. (4) and Vincent et al. (5) state that within the ICU there is a higher prevalence of older people, which implies a greater care challenge for nursing professionals who perform care with a differential approach, since they must be trained to understand older people, comprehensively addressing their culture, needs, and health problems to provide timely, effective, and person-centered care (6).

These events generated as an objective of this research the interest in understanding the meaning of ICU stays for older people, expressed in their own words and in the stories regarding the meaning this stay had in their lives.

Methodology

This research emerged from the previous approach of the main researcher with older people in research courses and from her interest in delving deeper into the issues of the ICU referred to by them, which configured the assumptions that there, they go through loneliness, discomfort due to noise and light, and that they lose their independence. In addition, there is a lack of knowledge and low tolerance to treat them; in some cases, they are discriminated against.

Qualitative research was conducted with a descriptive approach and supported by some ethnographic tools such as interviews, observations, field notes, and drawings. The participants were ten people who met the inclusion criteria: Age equal to or older than 60 years (7), a stay in the ICU for a period not lower than 24 hours (8), and the desire to participate voluntarily. The study participants presented maximum variability in aspects such as sex, in which the sample was composed equally of five women and five men. The age of the group ranged from 61 to 89 years, while their level of education ranged from no education to postgraduate education. The length of hospital stay ranged from 2 to 105 days, depending on the reason for admission, which included respiratory (COVID-19, pneu-

monia), cardiovascular (valve repair), neurosurgical (pituitary aneurysm clipping, laminectomy), and surgical (nephrectomy, hepatectomy, and herniorrhaphy) pathologies.

One exclusion criterion was having communication and/or language difficulties (language, dysarthria). Purposive sampling by criterion and snowball (9) was applied; no participant refused to participate, nor did they withdraw from the study.

An exploratory study was conducted following the university and institutional ethics endorsement with minutes CEI-FE 2021-38 of January 28, 2022, and DM (02) 002/2022 of February 16, 2022. The researcher, a nurse external to the ICU, with training in research, applied the semi-structured interview guide to three older people who met the criteria; it was not necessary to modify it, and he data were included.

Access to the study site was initiated in 2022 by sending text messages via WhatsApp groups, socializing a brief description of the research. Some older people and their relatives personally expressed interest in participating, so telephone contact was established with them through rapport (10), with the purpose of agreeing on the interview, its modality, time and place. Each participant was approached in a single face-to-face meeting at home, except for two interviews that were conducted, one by WhatsApp, due to the distance, and the other in a shopping mall, at the request of the participant. The interview was conducted in four steps: Greeting; explanation and signing of the informed consent; development of the interview and request for the ICU drawing, and, finally, acknowledging gratitude. In reciprocity, education and nursing care were provided, as well as a gift (non-financial).

The interviews lasted from one to three hours, and the audio was recorded; four participants were accompanied by their caregivers, who in some cases participated with their voice. At all times, the researchers sought to expand the information, probing for new data. Both techniques (interviews, drawings, and observation) and researchers were triangulated, and a cross-analysis was conducted with the advisor and with academic and external peers, until the data were saturated.

For observation access to the ICUs, the coordinating intensivist and the coordinating nurse were designated as *gatekeepers* (11). There were 30 hours of observation at different times and days, and the healthcare personnel also spontaneously provided information for the knowledge acquisition concerning the phenomenon.

The field notes were written in the shortest possible time not to lose data; 132 pages of concrete descriptions of the ICU process and setting were achieved, which were also analyzed. The participants drew the space of the ICU, drawings that were incorporated into the analysis as a strategy of the experimental ethnography (12); only one participant refused to do so.

For the analysis, reflexivity was applied, questioning the effect of the data on the researchers and their interactions with the participants as socially active subjects (13). The interviews were transcribed and carefully and repeatedly reread, capturing concurrent patterns and relationships or differences between them as a coding strategy.

This coding was conducted between the main researcher and her advisor of the interview transcripts in Microsoft Word format; subsequently, they were reorganized in a Microsoft Excel matrix, as follows: Testimonies, *emic* and *etic* codes, which were then grouped into the emerging categories, which responded to the stated objectives. The collection and analysis were concurrent, as proposed by De la Cuesta-Benjumea (14).

With the application of theoretical sampling (15) and constant comparison (11), the researchers arrived at the construction of the categories: *Setting* of the ICU, *interactions* with others, and *care*. Data production ended with data saturation, as no new information emerged or was redundant (16). The variability of participants was considered, as shown in Table 1.

The rigor criteria proposed by Guba and Lincoln (17) were met: Transferability, via the description of the participants and the presentation of the setting; credibility, with the feedback of results to the participants, who resonated with them; reliability, with the preparation of field notes in the shortest possible time, the faithful transcription of the interviews and confirmation by audits in presentations to the academic community and peer evaluators internal and external to the university.

The ethical principles of respect, benevolence, and justice were followed to ensure the well-being of the participants and to prevent harm. Colombian Resolution 8430 of 1993 (18) was applied, which establishes the minimum requirements for research on human subjects, prevailing safety and privacy, through sufficient knowledge of the research, in conjunction with the voluntary and autonomous signature of the informed consent.

Results

The sociodemographic characterization (Table 1) and the description of the participants are presented below.

- *The ambivalence of feeling as an older person or not.* As an age group with particular characteristics, the researchers inquired regarding their self-perception and that of their peers. Some of them perceived themselves as old, but with youthful characteristics such as: young soul, young body, energy, strength, independence, and good health, all of which is reflected in the following testimonies, labeled with alphanumeric codes to ensure privacy: E for interview, in addition to sex and age. For the field diary, the codes were: DC, followed by the acronym ICU.

Table 1. Participants Sociodemographic Characterization

	E1	E2	E3	E4	E5	E6	E7	E8	E9	E10
Sex	Male	Female	Male	Female	Male	Male	Female	Female	Male	Female
Age (years)	63 years	89 years	70 years	63 years	78 years	62 years	77 years	61 years	68 years	71 years
Residence	Caucasia	Bello	Medellín	Medellín	Abejorral	Medellín	Medellín	Medellín	Medellín	Medellín
Stratum	3	3	2	2	1	5	5	2	3	2
Education	Postgraduate	Incomplete	No education	Elementary	Incomplete	Postgraduate	Postgraduate	No education	Postgraduate	Elementary
Occupation	Nurse	Seamstress	Craftsman	Tailor	Builder	Medical doctor/ pensioner	Professor / pensioner	Housekeeper/ pensioner	Electrical engineer and pensioner	Cook and pensioner
Insurance	SURA	SURA	Savia salud	SURA	Salud total	SURA	Red vital	SURA	SURA and pre-paid	SURA
Religion	Catholic	Catholic	Christian	Catholic	Catholic	Catholic	Catholic	Catholic	Catholic	Catholic
ICU stay (days)	9	2	105	5	4	15	2	42	8	60
Reason for admission	COVID 19	Pneumonia	Valve repair	Right nephrectomy	Partial hepatectomy	COVID-19	Cervical decompression	COVID-19	Aneurysm clipping	COVID-19- and peritonitis
Year of admission to ICU	2020	2019	2021	2021	2021	2021	2022	2021	2022	2022

Source: Prepared by the authors, field work, 2022.

I consider myself an older person, but with the soul, body, and life of a young person [...] because nothing hurts me, nothing bothers me, [...] the only thing is that I wear glasses, but anyone wears them, [...] I have never undergone any surgery, thank God, I am a very healthy person. (E1-H63)

I do feel like an old person, but a very strong one... hmm... I consider myself a senior citizen. (E5- H78)

Others reported that they do not identify themselves as older people, as they do not feel it or do not show it.

I do not consider myself an adult, nor do I consider myself old, I still consider myself young, because [...] no, I am not old, [...] and I have been a very happy man. (E6- H62)

[*P: She feels as though she is an older adult?*] Not yet [...] because imagine that [...] to go to claim medication, it says that from the age of 60 onwards, [...] I often took the preferential card, and people stared at me, questioning "why is she using this card?". (E4- M63)

- *Activities and priorities of the older person.* In their daily work, they dedicate themselves to doing only what is necessary and prioritize what they consider to be essential.

I am already at a stage in life where I no longer care about many things; there are already priorities and things that are important and others that are not, and whatever I do not care about, I do not care about. (E7- M77)

No, I do not think about anything, that time, that time goes by, what am I going to give back, or what am I going to do ahead [...] what is happening, onwardly, neither backwards nor forwards. (E10- M71)

- *Perception of other older people.* The perception they have of other older people is that they are old, sick, past their working years, and with reduced energy.

An older adult is a person who is over 60 years old, and who, let's say, has finished their working life cycle, [...] they get sick more frequently, let's say they have reduced their, their energy and their capacity to move fast, to think faster. (E9- H68)

With the disease, with the disease they diagnosed me with, yes, I feel old because I am unable to do things. (E3-H70)

The ICU setting

- *General characterization of the ICU.* The participants defined the ICU as a ward of respect, with special treatment and highly personalized attention, full of several "devices", where visitors are controlled, where they receive seriously ill patients, where they lose their independence, and where there is a lot of loneliness; nevertheless, there are lessons to be learned:

A place of profuse respect and solitude, and with a very special treatment. (E2-M89)

Visits from there are highly controlled. (E4- M63)

One learns to value people more. (E6- H62)

- *Feelings in the ICU:* The feelings in the ICU were diverse, such as: loneliness, desire to leave, fear, anguish, sadness, and closeness to death:

The worst thing there was similar to being lonely. (E2-M89)

I believe it is that... that one is already far beyond here... closer to death. (E4-M63)

In that system, I felt like, let's see, how should I put it, like, like useless. (E3-H70)

- *Healthcare personnel in the ICU:* The ICU healthcare personnel recognized included the intensivist, the nurse and auxiliary, the respiratory therapist, and the general and inter-consultant services. Likewise, they recognized a different standard of patients than other services, since there the professionals work as a team, with established routines and rotating shifts, it is difficult to distinguish them because they wear a similar uniform.

The ratio is three patients per nursing assistant, nine patients per nurse and respiratory therapist. The intensivist must be there for special and intensive care patients. (DC1- ICU)

Because [...] at seven in the morning, one went in and another one came out. (E8- M61)

[The nurses] were just going to do what they needed to do to me. (E5- H78)

You cannot sit down without their permission, or without their supervision, so they [the nurses] are extremely radical in that sense. (E9- H68)

- *Physical, regulatory, political, and cultural setting of the ICU.:* In this aspect, the ICU was characterized by having air conditioning, natural and artificial lighting, as a cold, quiet, and clean place. In addition, it is composed of cubicles, referred to by some as small, and has: hospital beds, monitors, infusion pumps, chairs, auxiliary feeding tables, among others.

Within this space, there were a few *things allowed*.: visits were controlled, as well as the entry of personal items and cell phones, the use of radios and televisions, while other things were *prohibited*, such as getting out of bed, removing medical devices, smoking, recording or taking photos of sedated patients and using social networks; nevertheless, some used strategies to circumvent these rules.

Healthcare personnel have guidelines and behaviors that govern their work, such as wearing a uniform, bathing patients at night or early in the morning, performing two medical inspections during the day, handing over patients at the end of the day, immobilizing sedated patients, dressing them in a gown and diaper.

[It is] a very small space, [...] it has centralized air. (E1-H63)

The place was quiet; [the relative] came in because of my nephew's 'in', who works there. (E7- M77)

Nursing shift changes are nurse-nurse. (DC4- UCI)

Four or five? I was bathed as late as two in the morning. (E8- M61)

Interactions with others in the ICU

- *Interactions with healthcare personnel.* Perspectives were diverse, mediated by the respectful, good, special, affectionate treatment; however, there were moments of inhumane, distant, and indifferent treatment.

All very dear [the nurses] and the medical doctors too. (E8- M61)
There is nothing humane about the nurses who provide care here, nor the intensive care nurses, let alone the hospital nurses. (E7- M77)

- *Relationship with family and spirituality.* Interactions occurred not only with healthcare personnel but also with spiritual figures and family. In this process, older people sometimes choose to remain silent about their needs, while the personnel say things that are difficult for them.

I asked God and the Blessed Virgin to help me a lot. (E8- M61)

I put up with [the pain in my veins] as long as they administered the medication, but I never told it to the intensivist. (E1-H63)

"This patient has only a 10 % chance of survival," and he thought I hadn't heard it. (E1-H63)

- *ICU care.* Patients defined care as loving attention and support in the activities of daily living, being attentive to them and knowing their needs. They described care that was special, requested, and timely, although there was also care that was not received, not identified, or not timely.

The attention they dedicate to you during meals, [...] the care [...] to get dressed, to go to the bathroom, [...] the love they give you. (E6- H62)

Well, for me, care is to be attentive to a person without failing to see what they want, what they need. (E7- M7)

They sent me the laundry, and those things were labeled, [...] they knew me, they knew my tastes. (E1-H63, employee of the institution, who was in the ICU)

I would say to anyone who came in here: take away this horrible pain I have, and so on and so forth. (E4- M63)

I would sit down and cry, [...] then they [the nurses] would tell me: "No, calm down [...] they love you very much here, [...] they are very attentive to you". (E8- M61)

I said to the nurse: "Would you do me a favor and change my diaper," [...] it was eleven o'clock at night and she said: "Yes, I'm coming". She left, and it was two in the morning. I had already peed three times when they took off that diaper; it was leaking. (E7- M77)

- *Limitations on care*. The limitations they perceived from the healthcare personnel to provide care were work overload, lack of skills, not managing the care and the use of cell phones: "Obviously that cell phone became a way to communicate, but I don't like the fact that I saw nurses, especially the younger ones, [...] in video calls with their boyfriends in the ICU." (E3-H70)

Discussion

In the ambivalence of feeling or not an older person, a negative conception of aging is evident, typified by the World Health Organization as ageism (19), which refers to the negative concepts related to age and that can lead to consequences such as lower life expectancy and physical and mental disruption. There is also the paradox of well-being (20), when older people adapt to the situations that arise and focus on what is vital.

The ICU setting

The descriptions of the ICU personnel, as well as their physical, regulatory, political, and cultural setting, are consistent with the minimum qualification requirements for healthcare services defined in Resolution 3100 of 2019 of Colombia (21), according to which the institutions are autonomous to define the ratio according to the complexity of their services. In addition, personnel must be certified in specific competencies to work there.

It is noteworthy that the participants considered the ICU to be a quiet place, when the literature reports that it is a noisy place (60 and 70 decibels, the normal being under 30 decibels) (22); this may be related to the physiological process of aging, in which hearing capacity decreases with advancing age (23).

Additionally, the ICU features the characteristics of the total institution proposed by Goffman (24), where people are in similar conditions for a period, with restriction of visits and stripped of their belongings, with pre-established routines and supervised by an authority, in this case the healthcare personnel; all this in contrast to humanized care (25), as a strategy to improve the care of people.

Similar to the findings of Kentish-Barnes et al. (26), it was found that patients in the ICU have spiritual concerns, feel fear, as well as anguish before death and what it entails, requiring effective communication and special support by healthcare personnel.

Interactions in the ICU

Interactions, as mutual communication actions between two or more people (27), occurred with healthcare personnel, family, and spiritual figures, facilitating communication and decision making for recovery.

There were also contrasts in the interactions. On the one hand, the achievement of therapeutic relationships of respect, special, affectionate, and kind treatment, which allowed the expression of the subculture of both the caregiver and the care recipient; on the other hand, although as exceptions, the treatment was sometimes referred to as indifferent, inhuman, and distant, blurring the process of humanization of the person as the center of care (25).

The interaction referred to with spiritual figures revealed spirituality as an element of transcendence in the search for improvement in the face of pain and illness (28). In turn, the family was considered a source of support and companionship to minimize physiological and emotional alterations, leading to a better adaptation and coping with the situation, as described by Duque et al. (29).

Care in the ICU

Care is considered the essence of the nursing field and encompasses the actions provided to people to maintain their physical, mental, and spiritual functions, factoring in their experiences, values, and behaviors (30).

Neglected care has been defined by Chaboyer et al. (31) as care that is delayed, partially performed, or not performed at all. This condition in hospital settings may be related to work overload, lack of skills or knowledge, insufficient resources, delegation of care, and high staff turnover, among others, which limit comprehensive and individualized care (32). These conditions should be identified and addressed to favor timely patient care.

Invisible care is considered by Gimenez (33) as those undocumented tasks that are part of care management. They constitute a reality that affects nursing, since they are multiple activities that must be fulfilled without the patient identifying them in their favor, consuming time in which direct care is limited, so that for the patient and their family, these are of little value and become invisible.

Finally, the prolonged use of cell phones by the personnel, as reported by the participants, highlights the urgency of having col-

laborators with roles, as proposed by Swanson (34), "competent and compassionate healers", that is, with scientific and technical skills, but also with empathy and compassion towards the care recipients.

Conclusions

Stereotypes regarding old age affect older people, with negative consequences for their health, well-being, and the exercise of their rights. The meaning of ICU stays for older people was related to the setting of the ICU itself, interactions with others, and the care received or not. The ICU was perceived as a rough place, backed by rules and policies, similar to an institution that generates negative feelings contrary to those conducive to humanized patient-centered care. Interactions were both positive and negative; they were not limited to healthcare personnel but transcended to family and spiritual figures as pillars of companionship and support in the illness. Participants defined caregiving as the act of lovingly supporting people's needs and acknowledged the limitations of healthcare personnel in providing it. These results call for highlighting the importance of providing specific and differential care that prioritizes the needs, values, preferences, and autonomy of older people in the ICU and the humanization of care.

Acknowledgements

We would like to thank the older people who were eager and willing to participate voluntarily in this research, *opening their hearts* to share an important experience of their lives through dialogue and drawing. Likewise, to the healthcare institution and its personnel for the welcoming and willingness that facilitated the field work.

The research was funded with the researcher's own resources.

Conflict of interest: There was a conflict of interest due to the direct relationship of the main researcher, as an employee of the institution where the participant observation was conducted, which was overcome as she was not at the ICU nor had she worked in it. The field work was conducted outside working hours, non-institutional uniforms were worn, and there is a written statement that the rights belong to the researcher.

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