cadernos ESP/CE
Revista Científica Escola de Saúde Pública do Ceará Paulo Marcelo Martins Rodrigues
1808-7329 (1809-0893)

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DOI
10.54620/m791t927

Affective medical record as a care device in an ICU in Ceará

Prontuário afetivo como dispositivo de cuidado em uma UTI do Ceará

História clínica afectiva como dispositivo de cuidado en una UCI de Ceará

ABSTRACT

This study aims to report the experience of implementing an affective medical record as a humanization and ambience care device in an adult Intensive Care Unit (ICU) of a regional hospital in the interior of Ceará, Brazil. This is a descriptive study, presented as an experience report, developed through the creation and use of a record containing patients' subjective information, collected from conscious patients or their family members. The experience occurred during an elective multiprofessional residency internship carried out by a psychologist, with presentation and agreement established with the ICU team. The results indicated greater closeness between professionals, patients, and families, enhanced communication, appreciation of subjectivity, and positive changes in the ICU ambience, such as the use of music during care activities. It is concluded that the affective medical record represents a powerful soft technology that strengthens bonds and **c**ontributes to the humanization of care in highly complex environments.

Keywords: *Humanization; Intensive Care Units; Hospital Psychology.*

RESUMO

Este estudo tem como objetivo relatar a experiência de implantação de um prontuário afetivo como dispositivo de humanização e ambiência em uma Unidade de Terapia Intensiva (UTI) adulta de um hospital regional do interior do Ceará. Trata-se de um estudo descritivo, do tipo relato de experiência, desenvolvido com base na criação e implantação de um prontuário afetivo que reúne

informações subjetivas dos pacientes hospitalizados. A vivência ocorreu durante um estágio eletivo de residência multiprofissional realizado por uma psicóloga, com apresentação e pactuação junto à equipe da UTI. Os resultados evidenciaram maior aproximação entre profissionais, pacientes e familiares, estímulo à comunicação, valorização da subjetividade e mudanças positivas na ambiência, como o uso da música durante os cuidados assistenciais. Conclui-se que o prontuário afetivo configura-se como uma tecnologia leve e potente, capaz de resgatar a subjetividade, fortalecer vínculos e contribuir para a humanização do cuidado em ambientes de alta complexidade.

Palavras-chave: *Humanização; Unidade de Terapia Intensiva; Psicologia Hospitalar.*

RESUMEN

Este estudio relata la implementación de un prontuario afectivo como dispositivo de humanización y ambiencia en una UCI de adultos de un hospital regional del interior de Ceará, Brasil. Se trata de un estudio descriptivo, tipo relato de experiencia, basado en la creación y uso de un prontuario con información subjetiva, recogida de pacientes conscientes o de sus familiares. La intervención se desarrolló durante una pasantía electiva de residencia multiprofesional realizada por una psicóloga, con presentación y acuerdo con el equipo de la UCI. Los resultados mostraron mayor cercanía entre profesionales, pacientes y familias, mejor comunicación y cambios positivos en la ambiencia, como el uso de música durante los cuidados. Se concluye que el prontuario afectivo es una tecnología blanda que fortalece vínculos y favorece la humanización del cuidado en entornos de alta complejidad.

Descriptores: *Humanización; Unidades de Cuidados Intensivos; Psicología Hospitalaria.*

INTRODUÇÃO

Humanization in the hospital context has been debated nationally [in Brazil] since the 2000s, with the National Program for the Humanization of Hospital Care (originally Programa Nacional de Humanização da Assistência Hospitalar a.k.a PNHAH). This program aimed to improve health actions and services through the qualification of management, infrastructure, and care and reception practices developed by professionals[1]. Hospital humanization is understood as a responsibility ethics towards users, grounded in ambience and healthy interprofessional relationships. Thus, based on this broad perspective on humanizing processes and practices, the Ministry of Health [of Brazil] launched the National Humanization Policy — HumanizaSUS (originally Política Nacional de Humanização a.k.a PNH), going beyond the focus of a program with a defined deadline to become a health policy with an expanded, integrative, and continuous vision[2].

Within the scope of the National Humanization Policy, ambience emerges as a fundamental strategy, being, beyond a purely theoretical concept, a model of care and management that considers the importance of proper environment for the health of individuals. This model encompasses three axes: the first proposes the provision of comfort, focusing on individuals' privacy and the appreciation of their individuality, emphasizing environmental characteristics that relate to them, such as color, smell, sound, and lighting, in order to ensure comfort for health services' professionals and users. The second refers to proper environment as a facilitator of the production of subjectivity through encounters between individuals, and the third concerns the workflow within health environments, thereby enhancing technical resources as elements that strengthen the health process. These three axes are interrelated and, together, constitute ambience[2].

Intensive Care Units (ICUs) are high-complexity services aimed at providing intensive care to patients with life-threatening clinical conditions. As an intensive care environment intended for patients at risk of death, the ICU relies on technological and human resources, including multidisciplinary teams. That's why it is necessary to provide a welcoming environment, since this is a place in which fear and the unknown actively affect the subjectivity of patients, family members, and professionals. The ICU is a challenging place to apply humanizing processes, as it is a kind of environment that professionals are directly confronted with patient losses and the loss of patients' subjectivity, as well as with intense interaction with machines, which may foster the "care automation" and distancing in human interactions[3].

In this context of high technological density, Merhy[4] defines health technology by encompassing, within his theoretical framework, the care and reception produced in health settings, with an emphasis on valuing human relationships. The author identifies three modes of care: hard, soft-hard, and soft technologies, highlighting soft technologies, which are enabled through contact with others, and producing health through bonding and reception. In this sense, the affective medical chart emerges as a soft technology of care directed toward

patients, family members, and health professionals, promoting changes in the physical environment and contributing to the restoration of subjectivity through reception, autonomy, and mental health.

Furthermore, the present study aims to report the experience of creating and implementing an affective medical chart as a humanizing and ambience device in an adult Intensive Care Unit (ICU) of a regional hospital in Ceará's countryside.

METHODOLOGY

This is a descriptive study based on an experience report by this article's author, in her field practice as a psychologist in a multiprofessional health residency program. The study development stemmed from the creation of an affective medical chart, which is a device that goes beyond the traditional medical chart. The latter consists of a process that gathers clinical and administrative information about the patient to make a medical record that can be later used throughout treatment to support health care; the affective medical chart, in turn, goes beyond merely producing technical and protocol-based records by focusing on the subjective aspects of patients' life histories, such as preferences, affective bonds, beliefs, and elements that promote well-being[5].

The creation of the affective medical chart originated from exchanges experienced within the context of the multiprofessional residency, especially through dialogue with residents working in the field of pediatrics, who reported using a model of affective medical chart as a playful intervention activity with hospitalized children. Based on these shared experiences, a search for references and models of affective medical charts was initiated in the scientific literature and in digital sources, which culminated in the realization of a scarcity of content on this topic. A relevant experience was published by the Health Department of the State of Ceará, describing the usage of the affective medical chart as a humanization strategy in the Intensive Care Units of the General Hospital of Fortaleza (originally Hospital Geral de Fortaleza a.k.a HGF). This institutional experience constituted an important reference and a source of inspiration for the adaptation and development of an affective medical chart suited to the reality of the adult ICU of the Regional Hospital of Iguatu (originally Hospital Regional de Iguatu a.k.a HRI).

During the 30-day experience in the elective internship, the material was prepared and presented to the service's head nurse and to the coordinator of the Patient Quality and Safety Center (originally Núcleo de Qualidade e Segurança do Paciente a.k.a NQSP). After approval, a meeting was held with the ICU staff to present and clarify the purpose and use of the affective medical chart. Only after this meeting was over that the chart was attached on the wall beside each ICU bed.

The chart was elaborated to have the following information: "I would like to be addressed as..., I'm the special one for..., support network, favorite food, favorite track/song, something that makes me happy, religion/belief, favorite

place," which were considered relevant and had the potential to generate affective engagement among patients, family members, and professionals. After the presentation, the instrument was filled jointly with the team and with patients who were conscious and oriented at the bedside, as well as with family members of unconscious or disoriented patients.

Throughout the implementation, five conscious and oriented patients and four family members of unconscious or disoriented patients directly participated in the experience, contributing to the completion of the affective medical chart. This experience took place in September 2025, during the elective internship of the Multiprofessional Residency Program in Family and Community Health of the Ceará School of Public Health (originally Escola de Saúde Pública do Ceará a.k.a ESP/CE), which is part of the National Policy on Health Residencies (originally Política Nacional de Residências em Saúde a.k.a PNRS) and it aims to qualify resident professionals[6].

As this was an experience report, with no identification of participants and no experimental intervention, submission to the Brazilian Research Ethics Committee (originally Comitê de Ética em Pesquisa a.k.a CEP) was not required, in accordance with the guidelines of Resolution No. 510/2016 of the Brazilian National Health Council (originally Conselho Nacional de Saúde a.k.a CNS).

RESULTS

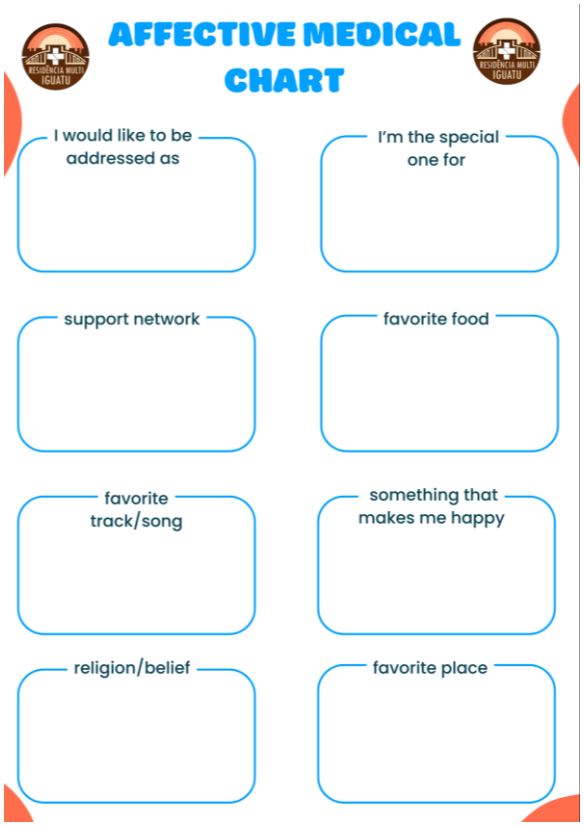
The findings not only describe the experience but also indicate relevant qualitative impacts, such as the strengthening of the bond between the team and patients, better engagement of family members, and the re-signification of the hospital environment. During the implementation phase within the ICU beds, it was possible to observe conversations between two conscious patients in their beds, to whom the swing of the affective medical chart was explained. They were then asked whether they wished to answer the questions, a request they promptly accepted.

Regarding the first question, which referred to how users would like to be addressed, the responses were related to nicknames, most of which differed from the name displayed at the bedsides. When asked about music (their favorite tracks/songs), it was noticeable how much happier they became, and some even hummed their favorite songs. As a result of these responses, the nursing team, upon learning about the patients' musical preferences, began to set background music to play during bathing care.

Given the number of intubated and unconscious patients in the ICU setting, conversations were held with families to complete the affective medical chart. This activity was carried out by the Social Work residency internship professionals, who receive the families before visitation. In this context, it was possible to observe the welcoming attitude of the professionals while presenting and explaining the affective medical chart to family members. It was also evidenced that they became emotional while sharing information and answering questions about their loved ones during a shift handover. In this case, the

emotional person was one family member that answered the chart for a patient who had recently been admitted. This episode suggests that the use of the affective medical chart may have had a positive impact on the family's relationship with the ICU environment.

Figure 1 – Affective medical chart used in the ICU.



Source: Prepared by the author (2025).

Thus, the affective medical chart proved to be a powerful instrument in the daily routine of the ICU, both for patients and their families and for the multiprofessional team. Accordingly, it was possible to observe that its usage favors more individualized care practices, contributing to the humanization of care and to the expansion of communication strategies in the ICU context.

The implementation experience revealed positive impacts on communication, bonding, and the ambience of the service, reaffirming its relevance as a care device. In addition, the affective medical chart became consolidated within the service and began to be effectively used. As the proposer of the initiative, the experience brought satisfaction by showing that interventions grounded in subjectivity can produce significant changes in the way care is provided in a high-complexity environment.

DISCUSSION

Welcoming and ambience are important devices for the process of humanization in hospitals, materializing through the implementation of health actions carried out by professionals and patients[7]. In the development of these actions, it is essential that all individuals be able to contribute as protagonists in building new health strategies. Thus, articulating humanization in the hospital context involves the implementation of integrative strategies that mobilize managers, frontline professionals, family members, and patients[8].

The ICU is an environment that involves the work of various professionals. As it is an environment focused on uninterrupted care for critically ill patients, it is common for some patients to require respiratory interventions that, depending on their degree of complexity, may reduce verbal communication. In this context, the comfort provided by a welcoming environment and by information derived from the affective medical chart enable other forms of communication with the user, such as music, faith, and food[5]. Music, in particular, has been identified in the literature as a resource capable of promoting well-being and supporting psycho-social aspects during hospitalization, as highlighted by Delabary[9].

The ICU environment may be perceived as a cold one, marked by hostility and the absence of human affection. Thus, patients and family members may react to the environment in either beneficial or harmful ways, producing feelings that significantly affect the health process[10].

In this context, the affective medical chart may be understood as both a strategy and an instrument for qualifying care and promoting humanization in hospital settings, especially in Intensive Care Units. The conversation held to fill the affective medical charts proved to be a therapeutic moment for families and patients, who demonstrated feeling more welcomed while sharing more personal information. In this process, it stands out the relevance of the social name as a central element of subjectivity. A social name, such as a nickname or a trans-identity name, is much more than a patient identification protocol; knowing how the patient likes to be called breaks with imposed standards, including gender categories established by cisnormativity.

The possibility that more personal information may become part of daily care practices fosters forms of care that go beyond clinical technique based on method, favoring an approach aligned with the principles of the PNH. The affective medical chart is also a device that brings the health professional team closer to family members, minimizing communication failures and fantasies related to the hospitalization process within the ICU setting[5].

Thus, in light of the available literature and the experience reported in this study, it was possible to observe that there remains a lack of scientific publications specifically addressing the affective medical chart as a care strategy in the hospital context, especially in the ICU. In this sense, the implementation of the affective medical chart is an innovative experience, as it proposes a practice that is still little systematized in literature, contributing to the field of hospital humanization and opening pathways for new investigations and interventions.

FINAL CONSIDERATIONS

This experience makes it possible to reflect on the importance of affective dimensions for humanization in health care settings, as well as on the need to humanize the human being and provide care beyond biological aspects, fostering the appreciation of subjectivity.

In this sense, the development of the affective medical chart met the proposal of modifying the ICU environment and contributing to the health process of patients admitted to the service, configuring itself as a tool for promoting humanization, equity, and the strengthening of socio-family conditions.

Finally, it should be highlighted that the development and implementation of the affective medical chart were not settled on as a one-time action or as an initiative restricted to the internship period, but rather as a contribution with the potential to remain within the service. The device remains implemented in the ICU routine, being incorporated as a continuous strategy of care and humanization, which demonstrates its feasibility, acceptance by the team, and relevance to the hospital context. Therefore, the affective medical chart reaffirms itself as a sustainable and powerful practice for promoting ambience and humanization in high-complexity services.

In addition, it is a strategy with potential for scalability, as it can be adapted and implemented in other Intensive Care Units and in different hospital services across the country [Brazil], while respecting the specificities of each context.

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Author Contributions

Formal analysis: FTOT, ABG; **Conceptualization:** ABG; **Writing – review & editing:** FTOT, ABG; **Methodology:** FTOT; **Writing – original draft:** FTOT; **Supervision:** ABG; **Validation:** ABG; **Visualization:** FTOT, ABG.

How to Cite

Fernandes FTO, Gonçalves AB. Prontuário afetivo como dispositivo de cuidado em uma UTI do Ceará. Cadernos ESP. 2026;20:e2557.

Conflict of Interest

The authors declare no conflicts of interest.

Received: January 29, 2026

Published: July 22, 2026

Funding

This study was self-funded.