



THE ELDERLY PERSON IN CRITICAL CONDITION: BARRIERS TO INTEGRAL CARE

A PESSOA IDOSA EM ESTADO CRÍTICO: BARREIRAS AO CUIDADO INTEGRAL LA PERSONA ANCIANA EN ESTADO CRÍTICO: BARRERAS AL CUIDADO INTEGRAL

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ABSTRACT

Objective: to know the barriers to the development of integral care for the elderly person hospitalized in an intensive care unit, in the perception of health professionals. **Method:** this is a qualitative, exploratory-descriptive study of the type of land survey performed in an ICU of a Public Hospital of the Central Region of Portugal. Intentional non-probabilistic sampling is used, for convenience, with 24 health professionals. The data were collected through participant observation and semi-structured interview and analyzed with the support of Minayo's hermeneutic-dialectic reference and the WebQDA program. **Results:** five intimately interrelated categories emerged: lack of qualification for gerontogeriatric care; normalization of care practice; intense and exhausting work pace; disarticulation and conflicts in teamwork; and distant management of the ICU care practice. **Conclusion:** It has been shown that although the developments of integral care for the elderly, it is a path permeated by uncertainties, fears, institutional and personal limitations, it is not a utopia. New patterns of action, interaction, will and thought can be constructed to subsidize the interdependence between health professionals and guide to a differentiated practice committed to human dignity in ICU. **Descriptors:** Intensive Care Unit; Critical care; Integrality in Health; Elderly Person; Patient Care Team; Interpersonal Relations.

RESUMO

Objetivo: conhecer as barreiras ao desenvolvimento do cuidado integral à pessoa idosa internada em uma unidade de cuidados intensivos, na percepção de profissionais de saúde. **Método:** estudo qualitativo, exploratório-descritivo, do tipo pesquisa de terreno, realizado em uma UCI de um Hospital Público da Região Centro de Portugal. Utiliza-se a amostragem não probabilística intencional, por conveniência, com 24 profissionais de saúde. Os dados foram coletados através da observação participante e entrevista semiestruturada, e analisados com o apoio do referencial a hermenêutica-dialética de Minayo e do programa WebQDA. **Resultados:** emergiram cinco categorias intimamente interligadas: falta de qualificação para o cuidado gerontogeriatrico; normalização da prática de cuidado; ritmo de trabalho intenso e desgastante; desarticulações e conflitos no cuidado em equipe; e gestão distanciada da prática de cuidado em UCI. **Conclusão:** demonstrou-se que embora o desenvolvimento do cuidado integral à pessoa idosa seja um caminho permeado de incertezas, receios, limitações institucionais e pessoais, não é uma utopia. Novos padrões de ação, interação, vontade e pensamento podem ser construídos de forma a subsidiar a interdependência entre profissionais de saúde e orientar para uma prática diferenciada e comprometida com a dignidade humana em UCI. **Descritores:** Unidade de Terapia Intensiva; Cuidados Críticos; Integralidade em Saúde; Pessoa Idosa; Equipe de Assistência ao Paciente; Relações Interpessoais.

RESUMEN

Objetivo: conocer las barreras al desarrollo del cuidado integral a la persona anciana internada en una unidad de cuidados intensivos, en la percepción de profesionales de salud. **Método:** estudio cualitativo, exploratorio-descriptivo, del tipo investigación de terreno. Fue realizado en una UCI de un Hospital Público de la Región Centro de Portugal. Se utiliza la muestra no probabilística intencional, por conveniencia, con 24 profesionales de salud. Los datos fueron recogidos a través de la observación participante y entrevista semi-estructurada, y analizados con el apoyo del referencial, la hermenéutica-dialéctica de Minayo y del programa WebQDA. **Resultados:** surgieron cinco categorías íntimamente ligadas: falta de calificación para el cuidado gerontogeriatrico; normalización de la práctica de cuidado; ritmo de trabajo intenso y desgastante; desarticulaciones y conflictos en el cuidado en equipo; y gestión distanciada de la práctica de cuidado en UCI. **Conclusión:** se demostró que aunque el desarrollo del cuidado integral a la persona anciana sea un camino permeado de incertezas, recelos, limitaciones institucionales y personales, no es una utopía. Nuevos padrones de acción, interacción, ganas y pensamiento pueden ser construídos de forma a subsidiar la interdependencia entre profesionales de salud y orientar para una práctica diferenciada y comprometida con la dignidad humana en UCI. **Descriptor:** Unidad de Cuidados Intensivos; Cuidados Críticos; Integralidad en Salud; Persona de Edad Avanzada; Grupo de Atención al Paciente; Relaciones Interpersonales.

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INTRODUCTION

It is considered that in recent decades, the practice of care in an intensive care unit (ICU) seems to show profound changes due to scientific and technological developments. In this process of change, reception, care and humanization in the intensive context have been subjects that are much discussed in the literature. Effectively, these concepts are interconnected in the daily life of the health services and together, they construct the integrality of the care.¹ The integral care or integrality principle are terms that have the same meaning and are currently a huge challenge for the health sector.^{2,3}

Integrality is sought for qualified, expanded, transforming care centered on the person as a whole, respecting his values and rights, not accepting the reduction to the disease and the biological aspect.¹ The integrality of health actions favors responsible action of the professionals involved in the care/treatment/cure.⁴ It is the foundation for achieving a better quality of actions and services aimed at health promotion, prevention, and rehabilitation.¹

In a service where technology and technical-biological knowledge seem to have supremacy, maintaining a focus on the person in need requires a constant inner alertness.⁵ When this person is elderly, the attention and commitment of health professionals with their objectivity and subjectivity must be greater, by the probability of intensifying the vulnerability that characterizes it.

This finding hinders to infer that for a competent, coherent and responsible action, professionals inserted in an environment of sophisticated technology need to associate with the technical-scientific competence a human and ethical competence. They need to be able to perceive and welcome the human being in its entirety and to understand the way in which his identity and his own life history are constructed.⁶

Currently, the great challenge in a service such as the ICU is to view the elderly person as a population with different needs, understanding the relationship between their chronic diseases and the factors that promote clinical decompensation to allow greater survival.⁷ However, studies have shown that, despite the increase of the elderly person's hospitalizations, the practice of care is still guided by the positivist paradigm and continues to be similar of any adult person.^{8,9} They emphasized that the planning and implementation of health actions elderly people do not consider their peculiarities and

changes inherent to this age group: aging of organs and systems, functional impairment, comorbidities, potential complications to which they are subject, psychological and social changes.^{8,9}

It is perceived that although each health care provider performs a portion of care to meet the needs of the sick person, there is an interdependence in the integral practice and their actions must be articulated in search of the same purpose: caring for the human being.¹⁰ Thus, the organization of the care system must be based on the shared action and knowledge of the various professionals and on teamwork, pointing to interdisciplinary practices to reach the integrality of the human being.⁴

However, although healthcare professionals strive and recognize the importance of developing integral care, they still live in their daily work with numerous difficulties to make it work. One study highlighted the theoretical-conceptual model of biomedicine with emphasis on biological aspects; the fragmentary and fragmented perspective; the hierarchy of knowledge; and sectoral policies among the barriers to proposals for integrality in health practices and policies, which do not address the complexity and multidimensionality of health care.⁴

Often, professionals perform their actions in an isolated and fragmented way, around the parts of the human body and not the singularity of the person, which can result in the ignorance of the whole process.¹⁰ The technician view favors detachment, indifference, the incomprehension and the insensitivity of human relationships, leading to the predominance of a rational form of care.¹¹ A mechanistic stance, self-control and certainties constitute a barrier to the process of care, considering that the events are unique, particular and singular, and cannot be rigidly structured, with predictable results.¹²

The challenge for integral care practices is a great one, given that in the ICU, certain forms of relationships such as knowledge-power are privileged, constituting an obstacle to the perspective of a change in the forms of health care.² These relationships of know-how are present, can be viewed subtly or expressly and permeate all spaces, generating asymmetric relationships between the different actors involved in the care process.² Usually, the elderly person has difficulty exercising their rights or to make informed decisions, underestimating their rights.¹⁴ Since their knowledge of the clinic is limited, the field of professional discourse supported by

medical science prevails, and all that they say is true².

When ICU admission is unavoidable, a study pointed out that the elderly person needs to feel that beyond technique there is compassion, companionship, wisdom, and respect for their human condition.⁹ All the changes that have occurred in the course of their existence, make it unique, different, and meaningful for itself and for others.¹⁴ Consequently, the reaction of the elderly person to the lived things is particular and dependent on their view of the world and their previous experiences.

In this perspective, integrality must be perceived as a professional commitment that considers the aspects that relate and influence the dimensions of the sick person, that is, of an ethical action, having the emancipation of the professional subjects and users in search of the qualification of their lives as a proposition.² In view of the constant changes that take place in the field of health, it is expected that this study may contribute to the awareness of the need to construct integrative, dignified and humanized approaches to care for the elderly person in a highly technological environment, as is the UCI.

OBJECTIVE

♦ To know the barriers to the development of integral care for the elderly person hospitalized in an intensive care unit, in the perception of health professionals

METHOD

This is a qualitative study, of the exploratory-descriptive type, using the field survey as method. It was performed in an ICU of a Public Hospital of the Central Region of Portugal. An intentional non-probabilistic sample consisted of 24 health professionals: 14 nurses, 6 operational assistants, and 4 full-time physicians. The following criteria were adopted for the selection of participants: professional experience in ICU over two years; full dedication of professional practice time to the UCI; active participation in elderly care in the ICU. The participant observation and semi-structured interview were considered the techniques indicated for data collection, which ran from January 2015 to December 2015.

The participant observation covered the subjective aspects of social life in ICU to provide an approximation to their daily life and the apprehension of their historical and socio-cultural dimension. For a better

systematization of the annotations, a field diary was used. At a later stage, the semi-structured interview was held, since it allows participants to speak freely on a topic, and the questions, when formulated, seek to increase the depth of the reflections and open the interviewee's field of explanation of the interviewees.¹⁴ For the interviews directed to health professionals, a roadmap was elaborated, consisting of two distinct parts. The first part referred to the characterization of the participants and aimed to gather information on sociodemographic data. The second part consisted of general questions with predefined items guided by the general objective of the study.

The interviews were scheduled according to the disposition and availability of the health professionals and were conducted in the nursing office. They had an average duration of sixty to ninety minutes. The interviews were coded according to the professional class to which the participants belonged, by the sex and the order of their accomplishment to maintain the anonymity of the participants and the confidentiality of the data. Thus, for the medical profession, the M coding was used for the physicians, E for nurses and AO for the operating assistants, followed by M or F, corresponding to the male or female gender, and the number corresponding to the order of the interview. The data were recorded by a recorder and making notes.

The WebQDA specific software and the hermeneutic-dialectical frame of reference proposed by Minayo were used to carry out a serious, creative, flexible and committed qualitative data analysis.¹³ It was necessary to have two levels of interpretation present to undertake this analysis of the data: the field of fundamental determinations and the encounter with empirical facts. The field of fundamental determinations means placing the object of study (historical socio-historical context) in time and space, constituting a fundamental theoretical reference for the analysis of data obtained in field research.¹³

Bearing in mind the first level, it was sought to analyze the historical trajectory of the ICU as a specific context. Several health professionals share the same environment of care and are conditioned by a historical moment, they can have both collective interests that unite them and specific interests that distinguish and counter them. The encounter with the empirical facts, that is to say, the second level of interpretation, was the biggest challenge of the analysis phase. Minayo suggests three phases for its

operationalization: 1) data ordering; 2) classification of data; and 3) final analysis.¹³

Participants received information about the research project and the Free and Informed Consent Form authorizing their participation in the study. The research project was authorized by the institution's ethics committee under number 021846.

RESULTS

Of the total of 31 health professionals who make up the ICU team, fourteen nurses, six operational assistants and four full-time physicians participated in the study. Considering that one of the criteria for selection of health professionals was the total dedication of professional practice time to the ICU, the universe of doctors and operational assistants was contemplated. The same did not happen in the universe of nursing professionals. In the distribution of health professionals according to the Age, there was not a very significant variation, being the minimum age of 33 years old and the maximum of 59 years old. Regarding to Sex, in all the professional categories the female sex predominated, compared with five male elements, being four nurses and one doctor. In relation to the Marital Status, the marriages with eighteen participants were highlighted, followed by three singles (one from each professional category), two divorced women (one doctor and one nurse) and one widow (operational assistant). Regarding academic training, a small number of nurses with post-graduate specialization and only one master's degree in Gerontology were observed. All the doctors had a specialization. The low level of education in the category of operational assistants was highlighted. As a type of Institutional Link, twenty health professionals worked in the Public Employment Contract (CTFP) for an indefinite period and four in the Individual Work Contract (CIT) modality. Most of them had a rotating Working Hours of 40 hours per week, except for four professionals who worked 35 hours and two who had a fixed schedule. The Time of Professional Exercise ranged from 7 to 36 years, with an average time of 21 years. However, regarding the Time of Exercise in the ICU, there was not a great variability. Fourteen participants, nine nurses, three operating assistants and two physicians, had been working in the ICU for 15 years, which corresponded to the number of years the service was founded. All the participants confirmed the passage through other services before starting the activity in the ICU. The double job was reported by nine nurses and one doctor.

The thematic categories that emerged in this study were: lack of qualification for gerontogeriatric care; normalization of care practice; intense and exhausting work pace; disarticulation and conflicts in teamwork; and distant management of the ICU care practice. These categories resulted from a dynamic and interactive structuring process and presented below.

♦ Lack of qualification for gerontogeriatric care

Besides being a constitutive factor of daily practice, ICU care is also inscribed in the bodies of different professionals, outlining relationships and world views. Each profession uses its specific knowledge and know-how to develop this care, culminating in a multiplicity of manifestations. Since care for the elderly person is a reality present in the professional career of all health professionals in this study, thirteen nurses, six operational assistants, and four physicians revealed that *they did not have specific training in this field*.

However, the experience of life and the contact with these people in clinical practice made these participants acquire knowledge and discover many specific characteristics of this population, constituting "a great school" (EF3). Thus, the process of acquiring competence for elderly care in ICU was not the result of a specific training, but rather of a professional course that reconciled the experiences that these professionals had from the past to the present moment, as exemplifies the testimonial below.

I have no specific training, but I cannot forget that the past influences the present moment. We are a result of what we are experiencing and the experiences we are living. I learned how to take care of the elderly, sometimes alone, others with the support of my colleagues. (EF8)

♦ Standardization of care practice

It was observed that health professionals were awakened to the affective deficiency presented by most of the elderly people, their "physical, psychological and social weakness" (MF1), the need for "comfort and attention" (EF2), the "respect for their rhythm" (EM10) and the inherent limitations of age. However, it was also noticeable that some of their daily activities were organized in a standardized way and programmed within bureaucratically established schedules, essentially aiming at the efficiency and requirements of the various health professionals.

The problem was not in the fulfillment of the routine, but in the non-recognition that there are other possibilities of being in the

practice of care. As an example, an excerpt from a participant observation is given that demonstrates how health professionals, despite receiving information that an elderly person was exhausted because they were unable to rest during the night shift, they made the decision to perform care of hygiene. These professionals did not question the meaning of their act for the well-being and comfort of that person. On the contrary, the performance of hygiene care in a certain period of time is so incorporated that there was no sensitivity of health professionals to break this routine.

On the morning shift, it was reported that Mr. H. had not been able to rest anything during the night. Any approach to his bed was presenting, any alarm, any noise. One of the elements of the evening commented: "I was even sorry, those eyes always so wide open, I looked scared even though we told him we were always here." It is 9 am and your facies reveals exhaustion and desire to fall asleep. However, the blinds of the internment room were raised and each professional category was organized to start the activities of the morning. One of these activities was body hygiene, which regardless of Mr. H.'s willingness to rest was performed. (Participant observation)

Given the need to perform several activities that are interrelated among the different professionals, it was found that in the ICU environment, it is impossible for each patient to fall asleep or wake up at night at their own pace. This unequal power relationship happens in a subtle and transfigured way, through the laws, norms, rules, habits, customs, routines that are fixed and reproduced by professionals in their daily lives. However, some discourses have demonstrated the subjectivity and the change of posture of health professionals regarding the normalization of procedures and attitudes.

I recognize that I have grown in the way I respond to the needs of our patients. I wonder where they would like to sleep. When you start dieting, I try to know the food of your choice. It has happened to offer some delicacy that existed in the service to an old man and to get the feeling that it was the best that I did while observing his smile of thanks in the middle of all the technological support. (EM11)

♦ Intense and exhausting work rhythm

Although the speeches of health professionals have demonstrated the ability to develop human care and are attentive to the various dimensions of the elderly person, they also recognized that at certain times this did

not happen or was not possible. In this sense, the results from the data analysis led to the thematic category "intense and exhausting work rhythm" consisting of two subcategories: *the extremely severe clinical situations* and *the limitation of the time for care*.

The first subcategory, clinical situations of extreme gravity, was highlighted by ten nurses, three physicians, and three operational assistants to justify the focus on the disease and unavailability to attend the appeals of the elderly person, who were not considered important at a given moment. Consequently, as a doctor pointed out, "water supplies are being postponed, a trainer is being put on the table, or simply handing over to a deprived elderly person" (MF1). Situations such as the admission of patients at high risk, the carrying out of diagnostic tests abroad, or the unit's fulfillment, with unstable patients subject to various organ support techniques, require priority responses.

In situations of extreme gravity, which require total focus on the disease, attention to the elderly is compromised. Their needs, their limitations are forgotten, and sometimes we want immediate answers when the elderly person cannot give them, as a result of their condition of life. But there is always someone who remembers these limitations. (EF3)

The discourses of health professionals revealed that the elderly person's inability to communicate by changing their state of consciousness due to the need for sedation and the lack of knowledge about their life course are conditions that sometimes favor the treatment of the disease. It privileged the clinical knowledge about the treatment of the disease installed in a body and not the care of a person in the integral perspective.

We have limitations by altering the communication that the elderly person has with us and by the knowledge that we have of it. Often we restrict ourselves to his condition of being sick and not to what he is as a person. Only later with the improvement of the clinical picture and with the coexistence with the relatives is that person begins to reveal. (EF8)

The overload of the work process in the ICU associated with the indirect activities was mentioned in the discourse of nine nursing professionals who assumed to have a determining role in the articulation of the multidisciplinary team and preservation of the organization of the environment of the ICU. Although the identification of the problems involved all health professionals, it was the nurses who took the necessary steps to resolve it.

It is the nurses who have to respond to all the problems that arise with the equipment. We have to track progress and know how to handle all new equipment that comes up. If the nurse did not exist, few doctors would know how to respond to some situations. We know all this, but we still have time to pay attention to the person we care. (EF6)

The second subcategory, time limitation for care, was the argument put forward by all health professionals for not immediately satisfying the patient's wishes and devaluing less urgent situations. However, one nurse stressed that "sometimes the lack of time at one point becomes a forgetfulness of long minutes" (EF4). This lack of time also extended to the lack of patience to try to understand the message that an elderly person intended to convey in an insistent way between tubes and delirium. After several unsuccessful attempts, they gave up because "there are activities that cannot wait" (AOF3). The previous discourses prove that time was considered a limiting factor of efficient communication. One doctor emphasized that "the decline of medicine at the head of the patient is noticeable. It is critical in all patients that this is important in providing care for the elderly" (MM2).

♦ Disruptions and conflicts in the process of teamwork

Given the complexity of care developed in the ICU, no professional can overcome the biological model, working in isolation, which makes it imperative to recognize the complementarity of the actions of the different elements that integrate the team. In this study, it was highlighted the feeling of joy and satisfaction of all the health professionals as positive for being part of a team that pursues the objective of taking care of a scientific, creative and human way. They had the idea that each class has its own functions, with autonomous actions and other interdependent ones that complement each other to consider the diverse needs of the elderly person.

However, it was realized that although health professionals recognized the effort and value of the team, they also showed limiting aspects that led to the fragmentation of care and compromised integral care. Some reports denoted individual practice over collective doing, and this was perceptible through statements that agreed to flaws in interdisciplinary dialogue, the passage of information, and clarity in the goals set for the elderly.

I believe that obstacles to the provision of adequate care are lack of interdisciplinary dialogue, lack of clarity in the goals set for the patient, fatigue, demotivation, non-recognition of the good performance of a particular professional. (MF1)

The speeches of three nurses, two physicians, and two operational assistants allowed understanding that the performance of some professionals could be significantly altered depending on the professionals who made up the team in a certain shift. They demonstrated that when the cohesion and understanding between the professionals were stronger, the difficulties and demands of the more complex clinical situations were almost immediately overcome by a more fluid communication and a more equitable relationship. However, for some of them, there were also moments in which collaboration in the care process and the interaction between professionals did not go so well, and they were considered disarticulating aspects of an integral care practice. Thus, depending on the staff that was on duty, the care process might not be facilitated. Some elements were more easily exalted, more stressed, impatient, and inflexible to change or to certain situations.

There are days when collaboration between different professionals is better than others. It may be a lighter shift, but when one or another element is not in tune, we are exhausted. (AOF3)

Health professionals questioned about the type of interaction they had with each other, nine nurses, four operating assistants, and three doctors answered: "we are a professional family." However, the ICU has also been understood as a space where due to the "dominant personality of some professionals, the disagreements happen" (EM10), interfering in the service dynamics. Consequently, difficulties of relationship and conflicts arose as elements incorporated in the daily practice of care, with which they needed to live and interact.

Frequently, the different perspectives of action and decision in the practice of care were generating difficulties in the relationship and conflicts between elements of the same professional class or elements of different classes. Eleven nurses highlighted the attitude of supremacy of some colleagues and admitted that sometimes there was no consensus in the nursing team regarding aspects that should be valued in the care of the patient. Although they did not specify the professional class, six operational assistants mentioned - "there are people who like to command, to be greater than others" (AOF3).

Among the members of the medical team, there were also internal conflicts, both regarding the elaboration and fulfillment of the work scale, and due to different perspectives of action. There were some situations of disagreement, latent or manifest, *“regarding the therapeutic decisions, criteria, and timing of admission of some patients, as well as the degree of investment to be made”* (MF1), in the face of poor clinical prognosis. It was possible to perceive that the medical team did not always discuss the different therapeutic options that certain clinical conditions of the patients demanded.

In the conflict regarding the different perspectives of action in the practice of care, it was highlighted what happened between the professional nurse and the medical professional. As one operating assistant pointed out, *“the most visible conflict occurs when the medical staff and the nursing staff do not understand each other”* (AOF4). This type of conflict passed freely in the underground of the relationships between these professionals. Even though it was not expressed or perceived by its subtlety, it was related to power and was revealed as a threat to the position that these professionals occupied in the space of the ICU.

Four physicians showed that the stress and conflict relationships that existed on certain occasions were caused by stress, work overload, and the difference of opinion between the nursing team and the medical team regarding prioritization. However, for seven nursing professionals, relationship difficulties and conflicts resulted from two situations. The first one was related to the lack of communication for the planning of the different activities or procedures to be carried out during a work shift: an external examination; the admission of a patient to the ICU; the reduction of sedation in an elderly person who usually gets very agitated; or performing an invasive procedure such as a tracheostomy or change of a central venous catheter. Given that these procedures implied changes in the usual organization of work, they required a joint planning for a better articulation of the activities of the professionals involved. The second situation was because some doctors did not accept their suggestions, opinions, or questions. These statements were mainly emphasized in the continuity of invasive and therapeutic procedures in elderly people with little or no probability of survival.

Although in the ICU the distance between the different professional classes was not so

evident, in the opinion of a nurse, the superiority of the medical class is still culturally very present in our society, so it is necessary to *“grow and evolve in a way to understand that all professions are important, have their rights and duties, and deserve the same respect and gratitude”* (Eph. 9).

♦ Distant management of care practice in ICU

The speeches of the health professionals pointed to a management that was increasingly distanced from the reality of the practice of care and the difficulties experienced, which did not facilitate the resolution of problems more quickly and effectively. Usually, corrections and completely unadjusted requirements were made that revealed incomprehension and devaluation by the work developed.

I feel that bosses are increasingly distant from the sick, the work of the teams and more centered on numbers and computers, creating a false illusion of presence. (EF4)

When health professionals were questioned about the transformations related to hospital organization and management from the beginning of ICU implantation, the intensive care physicians underlined the fact that there were no conditions for early signaling of critical patients in the emergency department or in other services of the institution. This problem is still present in daily practice and has repercussions on ICU outcomes in the vital and functional prognosis of patients. From the medical perspective, improving the response to the critical patient and developing integrated and timely care requires:

A greater knowledge of the pathophysiology and teams dedicated and trained for this type of approach, preventing dysfunctions and deterioration that compromise its recovery. (MF1)

Full-featured bosses. We have leaders who are not, nor have they ever been and do not seem to want to be 100% integrated in this reality, which is critical patient care in ICU. (MM2)

In this perspective, the constant absence of the head of nursing and its ineffective and ineffective management were highlighted as barriers to the integrality of teamwork, since it affected the dynamics and the connection between the different professional classes. It was evident in the statements of the health professionals that there was no part of this boss *“the concern to know the way of working*

already internalized by the team” (AOF5). By imposing changes in an abrupt way, without the involvement and participation of the team, revealed a lack of knowledge about the dynamics and operation of a service with such specific characteristics. He took a vertical stance in the relationship established with the professionals, “he only transmits orders, there is no room for dialogue” (AOF6), nor interest in hearing other opinions for the construction of a new way (EF6). For the most part, he did not perceive “the problems and difficulties that his decisions cause in the practice of care” (EM11).

Particularly nurses and operational assistants were subject to hierarchical rigidity and a vertical nursing management model since decisions were made based on the authority of the position, without the effective participation of the other professionals. This attitude discouraged, had a reductive action, generated insecurity and fear, led to the regression of creativity and the capacity to innovate, compromising the development of an intensive care of quality.

The presence of this head was only marked by *“calls for attention, criticism, talks about compliance with standards, protocols, training, interests of the institution and department” (EM7). It was completely indifferent to the demanding work conditions and the overtime resulting from the increase in the number of weekly hours and reduction of the number of elements of the nursing team, as well as to the difficult situations of the personal life of these professionals. They seldom complimented, thanked, or positively reinforced the team’s performance. These attitudes were highlighted by twelve nurses, six operational assistants and two physicians, revealing a lack of recognition and motivation of the head of nursing.*

DISCUSSION

The discourses of health professionals in this study demonstrated that care for the elderly has been viewed as a process of continuous, evolving, dynamic learning, both individually and collectively. Caring for the elderly is not an assignment of the second category, much less an innate competence. It is acquired through training, experience, personal search, and a desire to create, to fulfill, to accept challenges.¹⁴ in particular: maturity and adaptability, empathy and sensitivity, objectivity and critical thinking, social sense and community sense, flexibility, versatility and, above all, creativity. However, studies have shown that the hospital institution tends to have difficulty in

conceiving a specific and dignified intervention, both on the part of the services, as well as of the health professionals.^{5,6,8} Evident worrying, considering that the insufficient number of professionals and the lack of geriatric competencies are associated with an increased risk of adverse events and poorer health outcomes for the sick elderly person.¹⁶

It was verified in this study that care for the elderly in the ICU needs to be differentiated, since, due to the process of illness, there are important organic and psychosocial changes.¹⁷ However, in some situations, the unique organization of the ICU and the requirements of the environment did not always favor human dignity in the practice of care and led to the disregard of the subjectivity of the elderly person during hospitalization. This reality has shown that the stability of the person in critical situation, through the agility that the high technology provides, in addition to the professional qualification, is considered a priority, which means that often the relation, the dialogue and the listener are placed in the background, giving rise to a care centered on the protocols and procedures.¹⁰

In some speeches, it was found that health professionals made the decision to perform a certain action or act of care at a time established for that purpose. This decision privileges only the body that the person has, that is, the object body, because the objective of the professionals is limited to the repetition of an act that they perform in their daily life.¹⁹ Thus, it is affirmed that, in this situation, the care constitutes an accessory act.¹⁹ A different approach would be to see this act from the point of view of the essential, the body that the sick person is, or the subject-body that needs meaningful action, a particular attention, an accompaniment singular.¹⁹

Given the above, it was found that there is still a strong tendency of health professionals to level their actions and behaviors in the practice of care, through the so-called care routines, assuming that, just as one cares for one, care must be taken of all.¹⁸ These routines are considered as an almost automated way of doing and are an important resource for the organization of the assistance space.¹⁸ However, it should be borne in mind that although standardizations are devices aimed at disciplining procedures, they depend on several elements, in particular the behaviors, training and subjectivities of each professional.² In this way, some health professionals demonstrated a change of

attitude regarding the normalization of their actions and was seen as a positive advance. Effectively, the problem is not in the routine itself, but in the way it is carried out in the form of closure and disclaimer when not reflected and questioned.¹⁸

In the ICU, the intense and exhausting work pace experienced by the participating professionals is a reality described in several studies that highlight: the specificity of the service dynamics; the complexity of care developed; the constant coexistence with the severity and unpredictability of clinical situations; the difficulty in dealing with the death and suffering of the other; the presence of confused and agitated patients with difficulty in understanding what is happening to them; the particularities of the care of patients with infections by multiresistant microorganisms; the realization of the various activities with initiative, speed and without any error.^{5,20}

The mentioned characteristics, together with the high degree of responsibility and the need for permanent attention for fear of the consequences of an error that could compromise the life of the sick person, constitute a physical, mental and emotional burden for the health professionals who work in this area. context.^{2,26} From the speeches, it was noticed that the overload of the work process in the ICU involved not only the activities related to direct care to the critical patient, but also the indirect activities, particularly highlighted by the nurses. This varied range of activities performed by nursing professionals is referred to in a study as the quasi-silent role of nursing practice for the success of coordination in the logic of care.²¹

The severity of clinical situations and the need to provide a rapid response by performing certain invasive procedures require these professionals to have an efficient and rigorous time control. In this way, it was highlighted that in these moments the creation of a link related to dialogue, listening and attention to attend physical and non-physical needs with agility so that there is trust and credibility in the team⁹, was compromised. The reality experienced by these professionals goes to the literature that identifies the limitations of time as a critical aspect and as the main reason for not providing quality care.²²

The integral approach in the daily practice of care requires a teamwork, that is, the multidisciplinary work shared and dialogued among the various actors involved in the care of the sick person^{1,3}. In this perspective, the

union, the sharing of experiences and knowledge, the spirit of interaction and support were qualities given by health professionals. These results are supported by a study, highlighting that collaboration or inter-professional cooperation presents itself as a strategy of teamwork and is related to an ethics of care, approaching participatory practices and mutual and reciprocal personal relationships among professionals of health.¹⁰

However, some shortcomings in interdisciplinary dialogue, in the passage of information and clarity in the objectives outlined were identified, which sometimes had strong repercussions on the dynamics of work and the effectiveness of care for the elderly. The relevance of these aspects is supported by an exploratory descriptive study, which considered it fundamental, communication and information exchange among the professionals that integrate the team, to allow a uniform knowledge of the clinical condition of the sick person, avoiding the occurrence of distortions and failures in the their care.²³

Contrary to what is observed in internment services, in this ICU, a functional interdependence between the work of the different professional classes was highlighted. When there is harmony among the different agents, when they emphasize cooperation more than competition, when they work by flexible norms and horizontally, the quality of care developed is higher.¹² It was observed, however, that the relationship of interdependence among health professionals was a condition experienced with duality. On the one hand, there was a process of care for the elderly person permeated by relations of cooperation, complementarity and permanent dialogue. On the other hand, there were different perspectives of action and decision in the practice of care that were generating conflicts and difficulties in the relationship, mainly between the medical class and the nursing class. The study points to the overload of health professionals' functions, the stressful environment of the ICU and the type of interpersonal relationships, as factors impeding open, clear and continuous communication between the different elements of the team.²³

Some medical professionals did not recognize nursing professionals' knowledge and practice as legitimate, but rather subjugated and complementary to medical knowledge.²⁴ They devalued nursing attention calls for certain drug prescription failures or for the clinical condition of one patient avoiding the occurrence of complications. In

this way, some medical professionals understood that their prescriptions were to be fulfilled by a professional class that owed them obedience, which was subordinated to them in the work process. In this sense, these physicians suffer marked influence from the biomedical model that is oriented almost exclusively by a technical-scientific, structured, regulated, linear action, built within an objective rationality.²⁴

However, daily practice in the ICU has demonstrated that the assiduous presence of nursing professionals in the critically ill elderly person gives them the privilege of making the decision to report any abnormality that is occurring. In order to make such a decision, the nursing professional is undoubtedly scientifically aware of the philosophical basis of their training.²⁴ Due to the instability of the sick people, the medical team feels the need of the collaboration of the nursing professionals in the accomplishment of their goals of care. His knowledge and his healing work is only successful because there is another professional who continues his practice, which has a more specific, specific character and, because no sooner than medical diagnosis, care.²⁴ evidence that care / care happens without cure, but healing does not happen without care, which establishes a dependence on medicine in relation to nursing, sometimes denied by the medical community.²⁴

It is noteworthy that although some differences were found, the team's maturity allowed collective and responsible conflicts to be managed through dialogue, aiming to improve the practice of care for the elderly. The word overcoming was the one that best defined the purpose of the struggles of these health professionals. In this perspective, the nursing professionals revealed an evolution and change of attitude when trying to mark their position in a constructive way, not being submissive to the medical orders. Similarly, some physicians were already struggling to listen carefully to the arguments of nurses and operating assistants and to plan certain activities together. This conduct is validated by a study, noting that the conflict generated in the work process between two professional categories can be solved with changes of postures, coexistence and dialogue between the teams, given that the objectives of all walk in the same direction, that is, for the quality of care, highlighted by humanization.³

The way in which the leadership and leadership function is exercised has a marked influence on the operationalization of new competencies by the professionals, in the

dynamics that are generated, in the mobilizing incentive or not for the necessary formation, motivation and confidence.²⁵ This description is not congruent with the results of this study that demonstrate an ineffective management, far from the practice of care and the difficulties experienced in improving the response to the critical patient.

It was verified that the vertical management model adopted by the head nurse was based on the scientific and classic principles of administration, with practices based on centralization of power, control, impersonality of interpersonal relationships, obedience, submission to routines and emphasis on techno-bureaucratic work.²⁶ This chief nurse did not understand or respect the sharing of information, decisions, as well as the relationship between doctors and nurses, built during the time of coexistence. He disregarded that the best form of management is one that values, respects, involves and attends to the needs of the various professionals so that they can continue to develop good care and give their best. In any cohesion strategy and success in achieving the objectives of the organization, it is essential to understand the reaction of people in the context of organizations; promote their motivation; perceive their aspirations and problems, provide opportunities and encourage them.²⁵ People interact in a dynamic way and therefore need guidance, correction, applause, and recognition, especially in moments of reflection on their performance and conditioning factors of the same.²⁵

The management problems mentioned have shown that integral care of the sick person needs to be planned collectively, in a cooperative and shared way among the actions of all the professionals of the health team.²⁶ For this to happen, it is essential to find a balance between good (more flexible and democratic) and the practice of care (human and integral) .²⁶ The interest in creating healthy professional ties was highlighted in a study as an important strategy to make the working environment a harmonious place and provide therapeutic care for quality.²⁷ In the light of the above, it was evident that management as part of the work process is considered dynamic and interdisciplinary since it involves not only technical but also political, economic and social activities.²⁶ In this way, dialogue and interaction between team members are elements that also constitute the materialization of integral care.

CONCLUSION

It was allowed to unveil with the course undertaken in this study that the practice of care of the health professionals to the elderly person in the ICU seems to break with the biomedical model and with the stereotype of the technical rationality, whose objective is the cure and not the care of the human being. These professionals considered that the care developed in the ICU should include objectivity, but transcend it to be a true presence, creating bonds and respecting the feelings, perceptions, and intersubjectivities that permeate the elderly person's life.

This study allowed knowing some barriers to the development of integral care, which was configured in five thematic categories: lack of qualification for gerontogeriatric care; normalization of care practice; intense and exhausting work pace; disarticulation and conflicts in teamwork; and distant management of the ICU care practice.

It was noticed that the process of acquiring competence for elderly care in the ICU was not the result of a specific gerontogeriatric training, but of a process of continuous, evolutive, dynamic, individual and collective learning. Although health workers were sensitized to the specific needs of the elderly, some daily activities were standardized and programmed within bureaucratically established schedules. This dynamics of work sometimes led to the disregard of the particular conditions of each elderly person during hospitalization and did not always favor human dignity in the practice of care.

The ability of health professionals to develop a human care and attentive to the different dimensions of the elderly was evidenced, but it was also emphasized that at certain moments this did not happen due to the intense and exhausting work pace. The extremely serious clinical situations and the limitation of the time for care were considered conditions that favored the focus on the illness installed in a body, and not the care of a person in the integral perspective.

It is emphasized that the team care process is constituted by the relationship of interdependence and moments of solidarity, companionship, complicity, and involvement in the various actions. However, some limiting aspects of collaboration and interaction between professionals that led to the fragmentation of care were also expressed: individual practice over collective doing; the failures in interdisciplinary dialogue; in the passage of information; and clarity in the goals set for the elderly person.

Despite the effort, the relationship of interdependence among professionals was a condition experienced with duality. There were circumstances in which the asymmetry of knowledge and power led to relations of force and conflict. The different perspectives of acting, prioritizing, deciding and planning the different activities or procedures in the practice of care were mentioned as situations that promoted the main divergences and conflicts between elements of the same professional class or different elements.

Finally, ineffective management centered on the power, control, and impersonality of interpersonal relationships, distanced from the reality of care practice, from the needs and difficulties felt were considered a barrier to the integrality of teamwork since it affected the dynamics and the link between the different professional classes.

It has been shown that although the development of integral care for the elderly is a path permeated by uncertainties, fears, institutional and personal limitations, it is not a utopia. New patterns of action, interaction, will and thought can be constructed in order to subsidize the interdependence between health professionals and guide to a differentiated practice committed to human dignity in ICU.

REFERÊNCIAS

1. Fontoura RT, Mayer CN. Uma breve reflexão sobre a integralidade. Rev Bras Enferm [Internet]. 2006 Aug [cited 2017 Mar 24]; 59(4): 532-6. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S003471672006000400011&lng=en.
2. Oliveira R, Maruyama SAT. Princípio da integralidade numa UTI pública: espaço e relações entre profissionais de saúde e usuários. Rev Eletr Enf [Internet]. 2009 [cited 2017 Sep 8]; 11(2):375-82. Available from: <http://www.fen.ufg.br/revista/v11/n2/v11n2a19.htm>.
3. Azar FS. A integralidade do cuidado em UTI: um estudo com foco no trabalho em equipa multiprofissional do Hospital Cemetron-RO [Dissertação]. Porto Velho-RO: Universidade Federal de Rondônia; 2014.
4. Santos KM, Backes DS, Sousa FGM, Erdmann AL. A emergência da integralidade e interdisciplinaridade no sistema de cuidados em saúde. Enfermería Global [Internet]. 2009 [cited 2017 Sep 8]; 17:1-11. Available from: <http://revistas.um.es/eglobal/article/viewFile/75291/73151>
5. Fernandes MJC, Silva AL. Significados do Cuidado de Enfermagem à Pessoa Idosa em

Cuidados Intensivos. In: Silva AL, Gonçalves LHT. Cuidado à Pessoa Idosa: Estudos no Contexto Luso-Brasileiro. Porto Alegre: Editora Sulina; 2010. p. 49-109.

6. Bettinelli LA, Waskiewicz J, Erdmann AL. Humanização do cuidado no ambiente hospitalar. Mundo da saúde [Internet]. 2003 [cited 2017 May 12]; 27(2): 231-9. Available from: [http://bvsmms.saude.gov.br/bvs/is_digita/IS23\(4\)111.pdf](http://bvsmms.saude.gov.br/bvs/is_digita/IS23(4)111.pdf)

7. Schein LEC, Cesar JA. Perfil de idosos admitidos em unidades de terapia intensiva gerais em Rio Grande, RS: resultados de um estudo de demanda. Rev Bras Epidemiol [Internet]. 2010 [cited 2017 Oct 12]; 13(2): 289-301. Available from:

<http://www.scielo.br/pdf/rbepid/v13n2/11.pdf>

8. Martins JJ, Nascimento ERP. Repensando a tecnologia para o cuidado do idoso em UTI. ACM arq catarin med [Internet]. 2005 [cited 2017 Mar 23]; 34(2): 49-55. Available from:

<http://www.acm.org.br/revista/pdf/artigos/284.pdf>

9. Furuya RK, Birolim MM, Biazin DT, Rossi LA. A integralidade e suas interfaces no cuidado ao idoso em unidade de terapia intensiva. Rev Enferm UERJ [Internet]. 2011 [cited 2017 Mar 23]; 19 (1): 158-162. Available from: <http://www.facenf.uerj.br/v19n1/v19n1a26.pdf>

10. Pirolo SM. Atuação interprofissional na terapia intensiva: a integralidade do cuidado e o agir comunicativo de Habermas [Tese]. Ribeirão Preto: Escola de Enfermagem de Ribeirão Preto da Universidade de São Paulo; 2008.

11. Martins JJ, Nascimento ERP, Geremias CK, Schneider DG, Schweitzer G, Mattioli Neto H. O acolhimento à Família na unidade de terapia intensiva: conhecimento de uma equipe multiprofssional. Rev Eletr Enferm [Internet]. 2008 [cited 2017 Sep 8]; 10(4): 1091-101. Available from:

http://www.fen.ufg.br/fen_revista/v10/n4/v10n4a22.htm

12. Silva AL. Cuidado transdimensional: um novo paradigma para a saúde. São Caetano do Sul (SP): Yendis; 2007.

13. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 12ª ed. São Paulo: Hucitec; 2010.

14. Berger L, Mailloux-Poirier D. Pessoas idosas: uma abordagem global. 2ª ed. Lisboa: Lusodidata, 2008.

15. Freitas EEC, Schramm FR. A moralidade da alocação de recursos no cuidado de idosos no centro de tratamento intensivo. Rev Bras Ter Intensiva [Internet]. 2009 [cited 2017 Sep 8];

21(4): 432-6. Available from: <http://www.scielo.br/pdf/rbti/v21n4/v21n4a14.pdf>

16. Beeckman D, Defloor T, Schoonhoven L & Vanderwee K. Knowledge and Attitudes of Nurses on Pressure Ulcer Prevention: a Cross-Sectional Multicenter Study in Belgian Hospitals. Worldviews Evid. Nurs [Internet]. 2011 Sep [cited 2017 Oct 8]; 8(3): 166-76. Available from:

<https://sigmapubs.onlinelibrary.wiley.com/doi/epdf/10.1111/j.1741-6787.2011.00217.x>

17. Leite MT, Schons VF, Silva LAA, Muller LA, Pinno C, Hildebrandt LM. A hospitalização em unidade de terapia intensiva na voz de idosos e familiares. Estud interdiscipl envelhec [Internet]. 2015 [cited 2017 Oct 14]; 20 (2): 535-49. Available from:

<http://www.seer.ufrgs.br/RevEnvelhecer/article/viewFile/46060/35456>

18. Aneas TV, Ayres JRCM. Significados e sentidos das práticas de saúde: a ontologia fundamental e a reconstrução do cuidado em saúde. Interface - Comunic., Saude, Educ [Internet]. 2011 [cited 2017 Oct 14]; 15 (38): 651-62. Available from:

<http://www.scielo.br/pdf/icse/v15n38/03.pdf>

19. Hesbeen W. Cuidar no Hospital: Enquadrar os Cuidados de Enfermagem numa Perspetiva de Cuidar. Loures: Lusociência; 2000.

20. Ferrareze MVG, Ferreira V & Carvalho AMP. Percepção do estresse entre enfermeiros que atuam em Terapia Intensiva. Acta paul. enferm [Internet]. 2006 Sep [cited 2017 Oct 24]; 19 (3): 310-15. Available from: <http://www.scielo.br/pdf/ape/v19n3/a09v19n3.pdf>

21. Cecilio, LCO, Merhy EE. A integralidade do cuidado como eixo da gestão hospitalar. In: Pinheiro R, Mattos RA, organizadores. Construção da integralidade: cotidiano, saberes e práticas em saúde. Rio de Janeiro: IMS ABRASCO; 2003. p.197-210.

22. Teng CI, Hsiao FJ, Chou TA. Nurse-perceived time pressure and patient-perceived care quality. J Nurs Manag [Internet]. 2010 Apr [cited 2017 Oct 24]; 18(3):275-84. Available from: <https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1365-2834.2010.01073.x>

23. Araujo Neto JD, Silva ISP, Zanin LE, Andrade AP, Moraes KM. Profissionais de saúde da unidade de terapia intensiva: percepção dos fatores restritivos da atuação multiprofissional. Rev Bras Promoç Saúde [Internet]. 2016 [cited 2017 Oct 24]; 29 (1): 43-50. Available from:

<http://periodicos.unifor.br/RBPS/article/view/4043/pdf>

24. Florentino FRA, Florentino JÁ. Relações sociais profissionais entre enfermeiro e médico no campo da saúde. Revista Travessias [Internet]. 2009 [cited 2017 Oct 24];3 (2): 1-17. Available from:

<http://saber.unioeste.br/index.php/travessias/article/viewFile/3354/2646>

25. Correia MCB. Processo de Construção de Competências nos Enfermeiros em UCI [Tese]. Lisboa: Escola Superior de Enfermagem de Lisboa- Universidade de Lisboa; 2012.

26. Fernandes MC. Identidade profissional do enfermeiro na atenção básica: enfoque nas ações de gerência do cuidado expressa nas articulações do campo e habitus [Tese]. Fortaleza - Ceará: Centro de Ciências da Saúde da Universidade Estadual do Ceará, 2016.

27. Gomes CB, Noguez PT, Thofhern MB, Amestoy SC. Competência gerencial para com conflitos na equipe de enfermagem. J Nurs UFPE on line [Internet]. 2012 Dec [cited 2017 Mar 16]; 6(12):2911-7. Available from:

<https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/7697/7756>

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