




## **INTENSIVE CARE IN NON-CRITICAL UNITS: REPRESENTATIONS AND PRACTICES OF NOVICE GRADUATE NURSES**

Rute de Oliveira Almeida<sup>1</sup>   
Márcia de Assunção Ferreira<sup>1</sup>   
Rafael Celestino da Silva<sup>1</sup> 

<sup>1</sup>Universidade Federal do Rio de Janeiro, Escola de Enfermagem Anna Nery,  
Programa de Pós-Graduação *Stricto Sensu* em Enfermagem. Rio de Janeiro, RJ, Brasil.

### **ABSTRACT**

**Objective:** to analyze the practices of novice graduated nurses in view of their social representations on intensive care to the critical patient provided in non-critical patient units.

**Method:** a qualitative research, based on social representations, with 26 novice graduated nurses at a private university in Rio de Janeiro (Brazil). Data collection made between 2016 and 2017 by a semi-structured interview and lexical analysis by Alceste software.

**Results:** the context of the Intensive Care Unit influences social representations, which mobilizes identity aspects of this environment that stereotype the ward as a disorganized place and that does not have material resources and trained professionals. Thus, when novice undergraduates act and despite the effort and dedication fail to transfer the patient, fear and lack of confidence are exacerbated, resulting in actions that can bring risks to the patient.

**Conclusion:** there are stereotypes in relation to the clinic that limit the care actions of the novice undergraduates in relation to the critical patient, and should be re-signified in generalist education. It is recommended to develop follow-up programs for novice graduated nurses.

**DESCRIPTORS:** Nursing. Intensive therapy. Professional practice. Social psychology. Nursing care.

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# O CUIDADO INTENSIVO EM UNIDADES NÃO-CRÍTICAS: REPRESENTAÇÕES E PRÁTICAS DE ENFERMEIROS RECÉM-FORMADOS

## RESUMO

**Objetivo:** analisar as práticas de enfermeiros recém-formados em face das suas representações sociais sobre o cuidado intensivo ao paciente crítico prestado em unidades de pacientes não-críticos.

**Método:** pesquisa qualitativa, pautada nas representações sociais, com 26 enfermeiros recém-formados em uma universidade privada do Rio de Janeiro (Brasil). Coleta de dados entre 2016 e 2017 por entrevista semiestruturada e análise do tipo lexical pelo *software* Alceste.

**Resultados:** o contexto da Unidade de Terapia Intensiva influencia as representações sociais, o que mobiliza aspectos identitários deste ambiente que estereotipam a enfermagem como um local desorganizado e que não dispõe de recursos materiais e de profissionais capacitados. Com isso, quando os recém-formados agem e apesar do esforço e dedicação não conseguem transferir o paciente, exacerbam-se o medo e falta de confiança, resultando em ações que podem trazer riscos ao paciente.

**Conclusão:** há estereótipos em relação à clínica que limitam as ações de cuidado do recém-formado frente ao paciente crítico, devendo ser resignificados na formação generalista. Recomenda-se desenvolver programas de acompanhamento dos enfermeiros recém-formados.

**DESCRIPTORIOS:** Enfermagem. Terapia intensiva. Prática profissional. Psicologia social. Cuidados de enfermagem.

# EL CUIDADO INTENSIVO EN UNIDADES NO CRÍTICAS: REPRESENTACIONES Y PRÁCTICAS DE ENFERMEROS RECIÉN GRADUADOS

## RESUMEN

**Objetivo:** analizar las prácticas de enfermeros recién graduados sobre la base de sus representaciones sociales acerca del cuidado intensivo del paciente crítico prestado en unidades de pacientes no críticos.

**Método:** investigación cualitativa, pautada en representaciones sociales, con 26 enfermeros recién graduados en una universidad privada de Rio de Janeiro (Brasil). La recolección de datos se realizó entre 2016 y 2017 mediante entrevistas semiestructuradas y análisis del tipo lexical por el *software* Alceste.

**Resultados:** el contexto de la Unidad de Terapia Intensiva influye sobre las representaciones sociales, y crea aspectos identitarios de este ambiente que marcan un estereotipo y estigmatizan a la enfermería como un lugar desorganizado que no dispone de recursos materiales ni de profesionales capacitados. En ese contexto, cuando actúan los recién graduados, y, a pesar de su esfuerzo y dedicación, no logran trasladar al paciente, se exacerbaban el miedo y la falta de confianza, que resultan en acciones que pueden implicar riesgos para el paciente.

**Conclusión:** hay estereotipos en relación a la clínica que limitan los cuidados que el recién graduado presta al paciente crítico y que deben ser resignificados en la formación de grado. Se recomienda desarrollar programas de acompañamiento de enfermeros recién graduados.

**DESCRIPTORIOS:** Enfermería. Terapia intensiva. Práctica profesional. Psicología social. Cuidados de enfermería.

## INTRODUCTION

Currently there is a growing concern about the allocation of patients in the Intensive Care Unit (ICU), in view of limited resources to meet the increase in the volume of patients who demand intensive care, as well as due to the insufficiency of Services. In this direction, discussions about those who need to be in the ICU have been developed in the search for the best evidence on the criteria of admission, screening and discharge, in order to help the intensivist professional in the final decision regarding ICU admission.<sup>1-2</sup>

More recently, to address restrictions on ICU admission, rapid response systems were created in many hospitals, with the objective of teams with expertise in intensive care to evaluate patients at risk of clinical deterioration in wards and implement rapid interventions in an attempt to avoid ICU stay, offering intensive care outside ICU confinement.<sup>3</sup>

Thus, the burden on ICU performance capacity articulated to the limitation of the number of beds available causes in many institutions to have a refusal of patients<sup>4</sup> and, with this, intensive care is performed outside the ICU environment, especially in clinical, surgical, emergency wards, post-anesthetic and outpatient recovery units, in this study called non-critical units.<sup>5-6</sup>

A research that determined the required number of adult ICU beds in Rio de Janeiro (Brazil) to meet the current existing demand showed that considering an average length of hospitalization of 11 days in the regulated ICU would take 595 active beds compared to the existing 268, to ensure the stability of the system and meet the 33,101 requests that were made to the Vacancy Regulation Center in 2010-2011.<sup>4</sup>

The legislation referring to the functioning of the ICU admits the possibility of critical or potentially critical patients being hospitalized in another hospital unit. In this case, the transfer to an ICU should be carried out as soon as possible and, meanwhile, the patient should be assisted by the team of the unit where they are located.<sup>7</sup> In particular, regarding the nursing team, interest in the screen article, the presence of critical patients in units of non-critical patients impacts their work.

An example was perceived in an investigation on the severity and nursing workload of patients applying for the ICU vacancy, according to which, although patients who were admitted to the ICU had a higher severity rate and required a higher nursing workload, those who remained in the ward as candidates for the vacancy had an average nursing workload very close to the national average of patients admitted to the ICU.<sup>8</sup>

In view of this impact, the issue of nurses' performance in intensive care in non-critical units, particularly recent nurses, categorized as beginners, is to light because they did not have experience in the exercise of a practice.<sup>9</sup> This is because in the professional experience of the researcher acting as a teacher it was noticed that students in transition from the end of training to the labor market expressed anxiety, fear and refusal in view of the possibility of providing intensive care as a professional, regardless of whether or not they choose to act in the ICU.

The empirical observations of this phenomenon, which indicated strangeness and behavioral changes of novice nurses, can be contrasted with the analysis of knowledge production on the effect of experience on professional performance. One of the researches differentiated the characteristics and competencies of 49 expert nurses and beginners, to know what characterizes an *expert* nurse. The results showed the following: Broad vision, ability to anticipate, insight, speed in action, definition of priorities competently. Therefore, they have in-depth knowledge by the experience in the nursing clinic.<sup>10</sup>

On the other hand, novice nurses have difficulties due to lack of preparation. Research by novice, experienced and supervising nurses on novice experiences has shown an inability to apply

the knowledge learned in practice due to deficiencies in the fundamentals of care, communication, and management.<sup>11</sup>

When these deficiencies are considered in the specificity of the practice in intensive care, it can be observed that they can affect patient safety, an issue that is problematized in research in this area.<sup>12-13</sup> In one of them, which investigated the organizational factors that contributed to 638 adverse events identified in an adult ICU, it was found that the number of professionals and inexperience were factors more associated with the rate of adverse events than the severity of the patient's disease.<sup>13</sup>

It is evident, therefore, that inexperience influences the professional performance of this novice graduate, bringing to concern the competence of these nurses for intensive care in the current context, outside the ICU. In addition, the unavailability of ICU beds is a reality commonly reported by the media, which produces a discourse about the critical patient's permanence in non-critical units. This generates the need for nurses who will deal with intensive care in these units to process this phenomenon, because it becomes relevant, current and socially important for this group<sup>14</sup> that comes to deal with this new demand for care.

Thus, novice graduated nurses produce and communicate their social representations (SRs), presenting solutions to problems from the social interaction that guides their actions.<sup>14</sup> Objective: to analyze the practices of novice graduated nurses in the face of their social representations about critical care intensive care provided to non-critical patient units.

## METHOD

Qualitative research that applied the theory of social representations in the procedural aspect. By considering it a common sense theory elaborated and shared collectively for the purpose of constructing and interpreting the real, it enhances the way individuals produce and justify behaviors, actions, and interactions with the phenomenon.<sup>14</sup> Thus, SRs, as theory and method, makes it possible to understand how subjects elaborate their thoughts and how it articulates with the practical dimension in which the phenomenon is impregnated.<sup>14</sup>

Its application is based on the defense that intensive care around critical patients hospitalized outside the ICU has social thickness for novice graduated nurses, as it mobilizes their affections, knowledge, dialogues and conversations about this object, based on of which re-signify such phenomenon. So, the interest is to understand how this representation articulates with the practice of care of the novice formed nurse to the patient outside the ICU.

The research was developed with novice graduated nurses from a private university in the city of Rio de Janeiro (Brazil). In this, intensive care is addressed at two specific moments of the graduate nursing course: In the seventh period, when there is the theoretical discipline of ICU Nursing, with theoretical and theoretical-practical activities, and in the last period, when the internship activities occur.

After approval of the project by the Research Ethics Committee in 2016, the researcher was immersed in the stage of the ICU Nursing discipline, to approach the students in the final phase of education, explain about the research and select contacts.

At the conclusion of the course, the researcher contacted the potential participants initially selected, inviting them to the research and scheduling data production. The participants' selection criteria were: Having completed the graduate nursing course at the scenario university during the research period. The exclusion criterion was: Having training and/or acting as a nursing technician.

This exclusion criterion is justified because in SRs the previous experiences of contact with the phenomenon affect its elaboration.<sup>14</sup> In this sense, as in the category of nursing technician there was the possibility of having professionally dealt with intensive care in the field of nursing care, influencing the construction of SR, it was decided to exclude this group.

Data production took place in the school semesters 2016.2 and 2017.1. In December 2016, 39 nurses completed the course, 12 were selected; In July 2017, 62 completed, of which 14 were selected, totaling 26 participants. The end of data production was based on the preliminary analysis, which verified the theoretical and empirical consolidation for the understanding of the phenomenon.

Participants signed the Informed Consent Form and were interviewed in a room of the institution that hosted the research, lasting between 20 and 30 minutes with the application of a semi-structured script with questions that addressed: Intensive care training, intensive care outside the ICU, professional requirements, difficulties, safety risks. Data were also collected characterizing the social belonging of the participants. Data recorded on digital device was transcribed, revised, prepared in single corpus and processed by the Alceste software in the 2012 version.

The program applied statistical procedures to highlight the lexical from which the speaker provided information about the rationality of their speech. This time, the program classified the speech of the novice undergraduates by the similarity and non-similarity of the words used, as well as their occurrence/co-occurrence and textual function.

The analysis was based on the Ascending Hierarchical Classification, in which the level of association of the lexicon with the class imports, as measured by a statistical value expressed in Phi, as well as the neighborhood relations of the lexicons that explain the class dynamics; and the crossing of lexicons in the Elementary Context Units (ECUs), excerpts cut by the program.

The anonymity of the participants was guaranteed, preserving the coding of the ECUs, where Ind = novice graduated nurse, followed by the order of the interview. Interpretation of the meaning of classes at the interface with the study phenomenon was made in light of the Theory of Social Representations.<sup>14</sup>

## RESULTS

The analysis of the program took place from 2841 different words that occurred 33707 times. The division of the *corpus* in 781 ECUs resulted in 6 lexical classes, and the block that is structured by classes 1, 5 and 6 reflects the dimension of the participants' practice. Class 1 consisted of 115 ECUs, representing 22% of the total corpus, as shown in Figure 1.

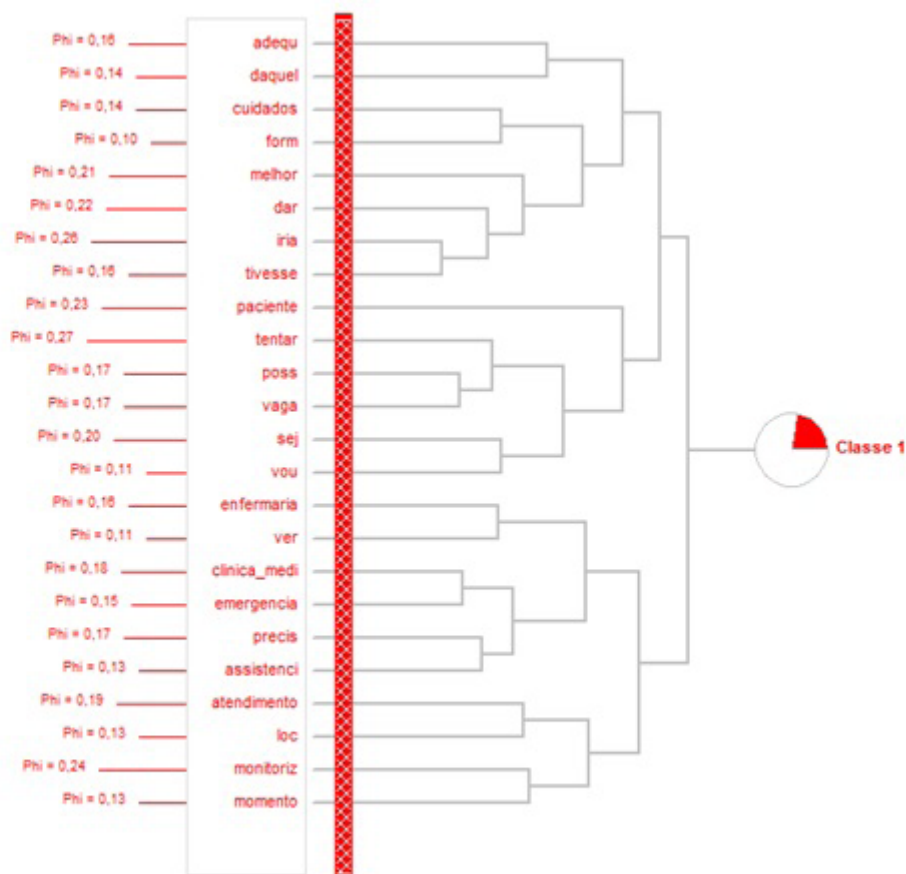
The emergency and medical clinic lexicons, which are linked to the words precise and assistance, show concern with the context of patient care. In addition, the highest Phi lexicons were from the blocks that bring together the words try, can, and vacancy, and would, give, and better, which express the desire to try their best to care for the patient outside the ICU, and of trying to get the vacancy for this sector.

These senses are complemented by the analysis of the ECUs, where the use of the lexicons patient, medical clinic, ward and emergency lexicons configures the evaluation of the novice undergraduates from the context of assisting the patient outside the ICU when they are placed to act in front of this care:

*There is no way to be safe, I can not see safety, because when the patient is medicated he has to be in a quiet place and as I will give a palliative, but I will not be able to provide them with what they need, that is, the cure (ECU No.540, ind.18).*

*A patient who should be inside the ICU and not kept inside the ICU is not treated the same. The ICU is more reserved, quieter, the patient is sometimes monitored in an emergency, but very noisy, very stressful (ECU No.459, ind.16).*

The content of the ECUs emphasizes that the patient should receive intensive care in the ICU, whose image is of a "quiet" place. In the medical clinic they are out of their natural place, which creates tension for being considered unsafe. This assessment leads the novice undergraduates to get a place in the ICU to transfer him, as the lexicons show: Vacancy and transfer.



**Figure 1** - Ascending hierarchical classification (AHC) of the class 1

*Try to give priority and act with priority with this patient, because it is more serious and should try the sector vacancy, try this transfer. I would try to assist you as best I could and try to transfer the sector (ECU No.231, ind.08).*

*I can't even tell you what I would do, because, knowing that I could die at any moment and that I'm responsible for him there, I think I would go to family members to ask for God's sake to transfer him to another place, a private network, I don't know (ECU No.183, ind.06).*

When there is no possibility of transference, the speeches turn to the verbs to try, give and do, when they affirm that they would try to give the best possible assistance to this patient, prioritizing their monitoring, indicated in the best lexicons and monitoring.

*Act with priority, if the patient is critical, would attempt to monitor and take care before transfer is achieved. It is to have a priority in that patient, as others are assisted, have no severity, and assist him as best as possible (ECU No.232, ind.08).*

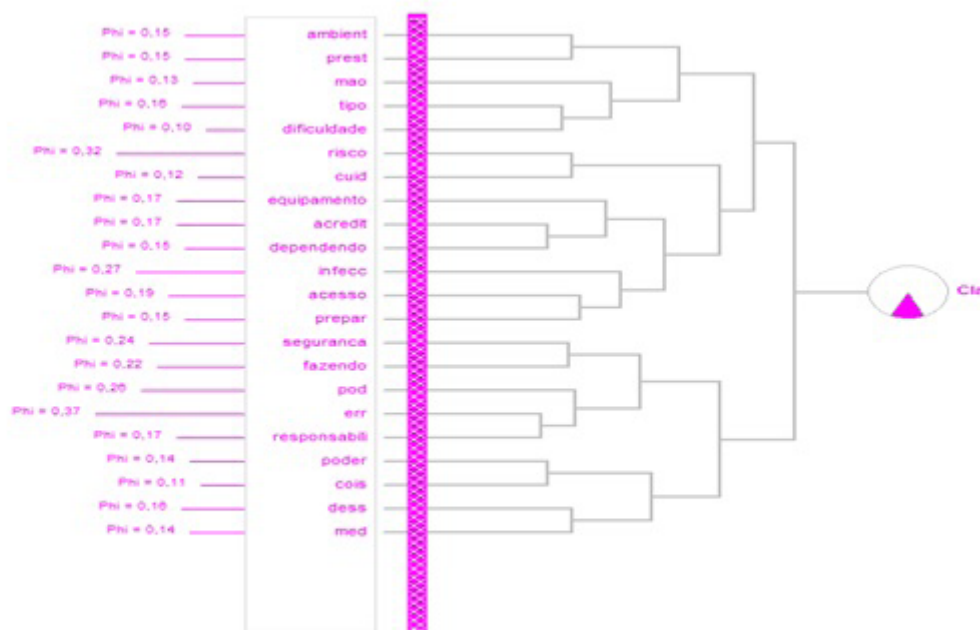
*It would mess with my emotionally, it wouldn't work very well. But I would not shirk responsibility, I would do my best, the goal would be for them to walk away, I would do the possible and the impossible to make them feel better (ECU No.121, ind.03).*

Given this situation of care there emerges in the novice graduated nurse that they will not be able to attend, especially due to the management of technologies associated with intensive care, expressed in the lexicons: Alone, monitoring, pump and appliances.

*The critical patient requires a lot of monitoring, I don't think I'll fit a lot of pumps, all those appliances, I don't think I could handle it, I may be wrong, but I look over there and I don't think I'll handle this (ECU No.226, ind.08).*



Class 5 displayed in Figure 2 brings together 71 ECUs, totaling 14% of the produced corpus content.



**Figure 2** - Ascending hierarchical classification of the class 5

There is an association between risk and care, which has links with the blocks that congregate, on the one hand, the lexical error, can and responsibility, and, on the other, fear, of this and the thing. Therefore, the novice graduate taking care of critically ill patients outside the ICU carries the risk of error in actions, which generates fear and leads to professional responsibility for patient's safety.

The lexicon most associated with this class was error/wrong, which reflects this possibility of the novice graduate for encountering difficulties during patient care and, in the face of this, some wrong procedure, causing damage to the patient.

*Because there is that too, I think this is my biggest fear, doing something wrong and thus making that patient's life worse (ECU No.66, ind.02).*

*You do not know if you are doing right or wrong. If you are doing it wrong, depending on what you are doing, it may damage. Example, a probe will pass, I'm not sure if the probe went to the lung or towards the jejunum, so if the person auscultates and thinks they are right (ECU No.29, ind.01).*

The risks for patient safety care provided by novice undergraduates are expressed in the risk and safety lexicons, whose concern is to generate an adverse event. The main one is the infection, concern of the individual 9 with the damage that can cause to the patient.

*There would be risks, there will be a difficulty. Until the matter of experience, a new nurse, has never been a technician, is not used to the hospital, will feel fear, some difficulty, even without sufficient apparatus to provide care (ECU No.236, ind.08).*

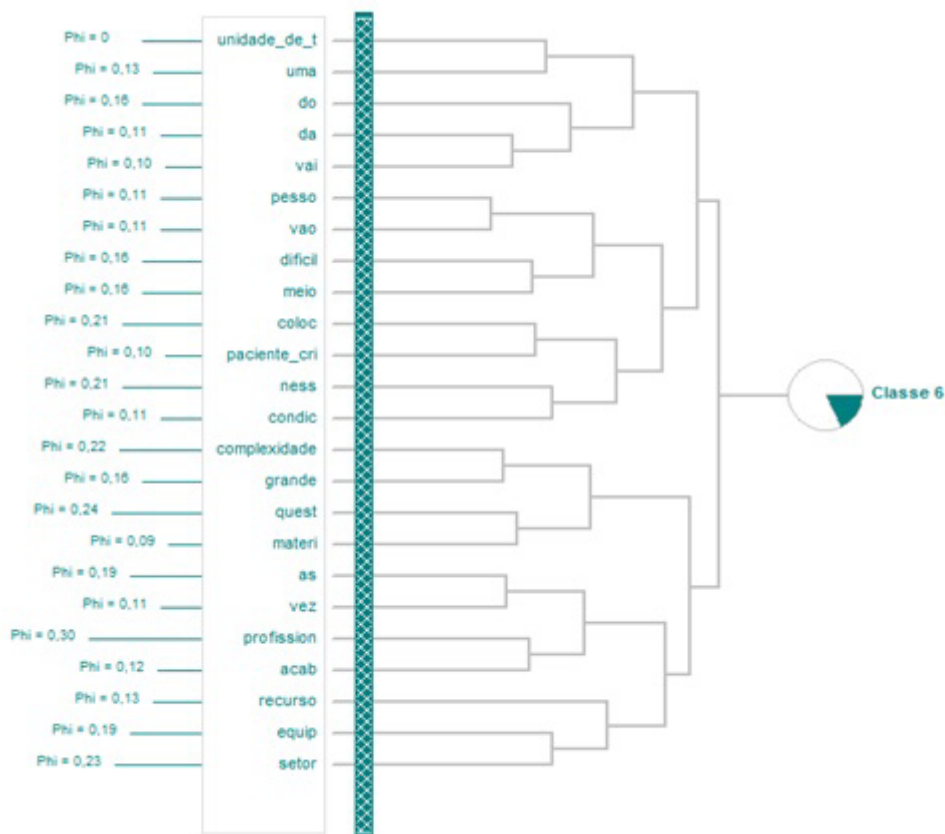
*I think I'm scared, but I think I would take care of it too and I am bot afraid. My concern well, in my mind would be the risk of infection, I think it increases outside the ICU, out of a better prepared environment for this patient (ECU No.261, ind.09).*

These risks imply in liability to the professional, due to the need to have the preparation/qualification being required to provide harmless care. This in the novice graduate is cause for concern, illustrated by the lexical preparation and responsibility.

*I'd rather start in other sectors and if it's one of those, prepare better, do a post or something. Rendering it can, but I don't know if it would be all right, all right, could render, but with some difficulty (ECU N.82, ind.02).*

*The difficulty would be how to act, what to do if something happens, to be in charge of that life in my hands. Any complication, and: 'What to do? My God, where to start from?' Because wrongly placed access, any procedure we do, and a wrong bandage can endanger us and the patient (ECU No.560, ind.19).*

Class 6 is illustrated in Figure 3, consisting of 94 ECUs, 18% of the corpus.



**Figure 3** - Ascending hierarchical classification of the class 6

One of the associations is between large and complexity lexicons, which refers to the characterization of intensive care. In addition, two blocks of words address the resources to address this complexity, which unites issue and material, and what brings together resource, staff, professionals, and sector. In this understanding, the provision of intensive care needs material and human resources in quality and quantity. The links between medium and difficult, in this and conditions, mean that in the clinic there are no resources available, which is considered a difficult condition.

In the analysis of the ECUs, the respondents refer to the intensive care of the patient anchored in the image of the ICU context, evidenced by the use of lexicons: Sector, ICU and complexity. From this perspective, care is categorized as highly complex by the use of advanced therapeutic resources and the idea of death to which it is linked.

*And structure, the team question too, if my technicians will be able to take care of this patient, if they know how to handle this highly complex patient, the devices would have to see the issue of continuing education (ECU No 671, ind. 24).*



*People think there is a high death rate, they are few, because out of ten let's say one or two go out and say they go to the ICU (ECU No.465, ind.16).*

Because it is complex, intensive care performed in a context other than the ICU raises questions about the conditions and resources to implement such care, seen in the lexical question, condition and resource. One of the issues is the availability of material resources, because according to the interviewees in the clinic there is a lack of materials:

*Material would be difficult, because we don't have so many materials, sometimes we don't have photosensitive appliance, a ventilator like in the ICU, there's no professional (ECU No.290, ind.10).*

*In an ICU everything is nicer, everything is cute, there is a probe, everything is there, somewhere else is not like that. In terms of material and personnel, it would be more difficult to coordinate staff to maintain the best care for this patient [...] (ECU No.291, ind.10).*

Another issue addressed in professional lexicons and dimensioning were human resources. This time, there is concern regarding the amount of adequate personnel to provide quality assistance. The deponents consider that outside the ICU the number of staff is reduced and, therefore, would cause damage to care for critically ill patients.

*The materials, not all materials that you have in the ICU you have in the medical clinic, the issue of professional dimensioning within the ICU (ECU No.429, ind.14).*

*I think if you have no material and conditions, you may know, but you cannot interact with the critical patient. I think I would have, from what I saw there, the amount of professionals for the patient, I think of great importance, because it ends up overloading the professional and ends up losing attention, at least in the ICU, the complexity is great (ECU No.393, ind.12).*

Added to the number of staff there is the concern with their quality, in terms of training of the nursing staff. The team lexicon is related to the competencies for intensive care, namely: Dexterity, attention, leadership, mastery of technology. However, they judge the medical clinic staff as unqualified.

*It happens a lot, people are taking, but the professionals are not trained as in the ICU, I stayed in the coronary ICU and the medical clinic with the critical patient. In the coronary ICU, changes in position there hardly opened an ulcer, when it came, it came with the ulcer, but we could recover that wound (ECU No.283, ind.10).*

*I think these would be the two difficulties I would face. Or even the nursing staff that would not be prepared, because a team working in the medical clinic is different from the ICU, the team is different, the routine, the jobs (ECU No.463, ind.16).*

Given the understanding that in nursing ward sectors there are no material and human resources in quantity and quality to support intensive care in these places, such care is difficult, and it is a great challenge to provide care to critically ill patients outside the ICU, as presented by the difficult and challenging lexicons.

*Difficult. Nothing is worse than that psychological pressure, that responsibility, it's all disorganized and you'll have to get over it. Inside a closed ICU, because each unit has a standard, following the protocols I think would have no difficulties (ECU No.413, ind.13).*

The results presented portray the actions of the novice graduate guided by the SRs of intensive care to critically ill patients outside the ICU, built in the light of the image of intensive care in the ICU. This dialectic between the ICU context and outside it is seen when participants address: The work processes - in the clinic it's all "disorganized", in the ICU it's "everything is nice", "everything is cute"; material resources - in the clinic "there is nothing" and in the ICU, "there is everything there" (probe, equipment, mattress, medicine, ventilator); the team - the clinic's professionals "really don't know", "can't handle", while in the ICU the professionals "are trained", "different".

## DISCUSSION

The results reveal identity elements that contribute to the elaboration of the SRs. The identity from the perspective of social psychology can be conceived as a subjective and dynamic phenomenon resulting from the double realization of similarity and difference between each other, the other and other groups. The SRs contribute to such an identity common to individuals, which in turn fosters social identifications and differentiations based on affiliation and belonging to a social group.<sup>15</sup>

In the case of novice undergraduates, learning experiences during graduation lead them to have contact with the characteristics of the clinic and the ICU, from which they apprehend elements of identity and whose identifications are the basis for thinking intensive care outside the ICU.

The sense of identification is seen in the results when participants value ICU care, which has the resources needed to deal with life/death and makes it complex: Process technologies, product technologies and skilled professionals, objectified in the image of a “quiet place”; On the other hand, the feeling of difference in other places devalues and stereotypes the clinic: Where there is nothing, people know nothing, processes are disorganized, and it is an “unsafe place”. Therefore, representation is constructed between “place and non-place”.

Studies on intensive care reinforce such an identity.<sup>16–18</sup> One ratifies the idea of complexity by the need to manage the state-of-the-art computerized and technological resources that are available in the ICU to reverse life-threatening conditions.<sup>16</sup>

In an investigation on the identity aspects found in the social representations of nurses about the care practices of the hospitalized intensive care client, the authors concluded that the representations were permeated, on the one hand, by elements that valued the group of ICU nurses: Their ability to intervene, technology management and level of knowledge. On the other hand, elements that undervalued and created stereotypes about nurses who did not work in the ICU were identified, which was a reason for conflicts between professionals inside and outside the ICU.<sup>18</sup>

Regarding the intensive care performed at the clinic, the study highlights the challenges of the care provided by nurses to critically ill patients in the emergency room of a teaching hospital. The main difficulties were: Insufficient material resources and nursing staff; inadequate physical resources; lack of specialized human resources; and lack of staff training. What most interfered with the routine when the critically ill patient was in the emergency was the staffing.<sup>5</sup>

The SRs are important to everyday life because they guide people in how to jointly name and define the different aspects of daily reality and how to interpret them, make decisions, and eventually stand in front of them.<sup>14</sup> Thus, given the categorization that the clinical sectors do not have technologies, material resources and processes, being therefore unsafe places, the first action of the novice graduated nurse is to try to get the place to quickly transfer the patient to the ICU.

When it is not possible to transfer the patient due to the absence of vacancies, the novice graduated nurses act at their best in this circumstance. However, as they conclude that the professionals in the clinic “do not know how to handle” also evaluate not having the proper preparation to take care of this patient outside the ICU.

Thus, they already experience the feeling of low value and incompetence at the beginning of their insertion in the labor market. Therefore, the SRs of critical patient care outside the ICU show that clinical wards are considered unsafe to perform such care, also qualifying as unsafe the actions of novice graduated professionals to patients who need this type of care.

This result reveals that the problem of the lack of ICU vacancies and the presence of critically ill patients in wards, an institutional (and system) structural problem, may be being welcomed by an individual category, generating their disqualifying feelings about themselves, and the others about them, which reverberates negatively early in their careers, affecting professional identity.

This impact on novice undergraduates is even more pronounced when one considers that there is a paradox between the demand for ICU beds higher than the supply and the process of nursing education, which does not meet this reality of the labor market. This is because, at present, the rapid growth of large urban centers has led to an increase in the rates of social violence and the number of injuries caused by external causes, which has increased the population of critically ill patients in need of hospital beds.<sup>19</sup>

In addition, the problems of the primary and secondary care network, which, due to investment and infrastructure deficiencies, often have low resolution, making situations that could be resolved by preventive care require hospitalization. Such factors lead to the presence of patients in non-critical units.<sup>19</sup>

Despite this political and social context, many higher education institutions have excluded from the minimum graduate nursing curriculum the teaching of intensive care, claiming that this is specialized knowledge, which has resulted in the formation of professionals with weaknesses in the skills to intervene in the face of the prevalent health-related demands of the population.<sup>19</sup>

This paradox of labor market demand for training coupled with the stereotype that non-ICU professionals know nothing further exacerbates the feelings of fear and lack of confidence that come from inexperience. Such dichotomy between nursing education and clinical practice in intensive care settings, as well as its negative impacts, has been addressed in the international literature; however, the transition from novice to competent nurse is seen as a challenge that can be overcome.

An example of this is seen in the study that explored the experiences of nurses who were hired as novice undergraduates and began their third year of practice as competent nurses in intensive care. Results indicate that novice undergraduates may become competent in intensive care and a successful transition requires early exposure to various clinical situations, resilience promotion, self-care, teamwork and mentoring.<sup>20</sup>

Another example is addressed in an integrative literature review of supporting elements to assist the transition of novice nurses in intensive care settings to increase their competence and confidence. Highlighted aspects that can positively support increased confidence and competence include: the allocation of a quality support person; inclusive workplace culture; acquisition of knowledge, skills and guidance based on the learning needs of the novice graduate; positive experience of socialization.<sup>21</sup>

On the other hand, when the challenges of the new formation are not overcome, the feeling of incompetence and lack of exacerbated preparation can compromise the safety of working in the labor market against critically ill patients outside the ICU, with moral, ethical and legal risks. This is because it accentuates the fear that they have to do something wrong and cause harm to the patient.

This context can drive coping and cause wrong actions due to difficulties encountered during care, or paralyze and undermine clinical reasoning for more appropriate decisions. Therefore, the action of the novice undergraduates is limited by inexperience, although they do it in the best way possible, besides being influenced by the symbolic constructions about this care outside the ICU, reflecting difficulties in the handling of techniques and technologies related to intensive care and in conducting clinical reasoning.

The differences that exist in the conduct of clinical thinking and decision making are illustrated by research that sought to understand the decision making of novice and experienced intensive care nurses from Scotland and Greece regarding the management of mechanical ventilation weaning. From an ethnographic research on how nurses collect and use the signs of respiratory assessment to guide their weaning decisions, the authors realized that nurses used patient-centered information (objective and subjective) based on respiratory assessment and prior knowledge of the patient.<sup>22</sup>

Less experienced nurses needed more signals to be sure of the concepts that described the patient's weaning ability from ventilation. Given this, the authors concluded that information categorization strategies for decision making can be taught in educational programs.<sup>22</sup>

The limitations of this research are methodological, as the exclusion criteria adopted and the profile of the chosen institution restricted the number of participants and the scope of the results.

## CONCLUSION

The SR on intensive care in non-critical units is built in the light of the ICU context, which mobilizes identity aspects of this environment that stereotype the ward as a disorganized place and that does not have the material resources and trained professionals to provide intensive care. This symbolic construction interferes with the practices of the novice graduated nurse, as it generates fear and a feeling of unpreparedness that, combined with inexperience and weaknesses in training, limit their actions towards the patient. Therefore, acting at their best when unable to transfer the patient immediately to the ICU faces difficulties, with the risk of errors that may compromise patient safety.

The research shows that training should ensure minimum learning experiences for nurses to safely meet patients in need of intensive care, even outside the ICU, reframing intensive care and minimizing feelings of incompetence that generate fear and limit the actions of the novice graduate. It is proposed as a strategy the realistic simulation in the ICU Nursing theoretical discipline, using high fidelity scenarios in which the student is stimulated to decision making, the analysis of its results and the reflection of its performance. This would make it possible to bring theory closer to practice, considering the interval between them in the study institution.

Even though the training improves, fear and insecurity in the face of novelty are inherent to the people. This time, it is necessary to develop monitoring and development programs for novice graduated nurses, welcoming them and improving their skills. Performing rotation of professionals between sectors, such as in the ICU, can bring these professionals closer and qualify their performance when the patient is present at the clinic.

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## NOTES

### ORIGIN OF THE ARTICLE

Extracted from the dissertation - Novice graduated nurses and intensive nursing care in non-critical patient units: A study of social representations, submitted to the *StrictoSensu* Graduate Program of *Escola de Enfermagem Anna Nery, Universidade Federal do Rio de Janeiro*, in 2017.

### CONTRIBUTION OF AUTHORITY

Conception of this study: Almeida RO, Ferreira MA, Silva RC.

Data collection: Almeida RO.

Analysis and interpretation of data: Almeida RO, Ferreira MA, Silva RC.

Discussion of the results: Almeida RO, Ferreira MA, Silva RC.

Writing and/or critical review of content: Almeida RO, Ferreira MA, Silva RC.

Review and final approval of the final version: Almeida RO, Ferreira MA, Silva RC.

### APPROVAL OF ETHICS COMMITTEE IN RESEARCH

Approved by the Research Ethics Committee of Escola de Enfermagem Anna Nery/Hospital Escola São Francisco de Assis,, opinion No. 1.389.478, Certificate of Submission for Ethical Appraisal 51708615.9.0000.5238.

### CONFLICT OF INTEREST

There is no conflict of interest.

### HISTORY

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### CORRESPONDING AUTHOR

Rafael Celestino da Silva  
rafaenfer@yahoo.com.br