QUALITY OF LIFE OF THE NURSING CAREGIVER AND ITS RELATIONSHIP WITH CARE

Qualidade de vida do cuidador de enfermagem e sua relação com o cuidar

La calidad de vida del cuidador de enfermería y su relación con el cuidar

Original Article

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ABSTRACT

Objective: To identify aspects that affect the quality of life of nursing caregivers and their relationship with care in an Intensive Care Unit for Adults (A-ICU). **Methods:** This was a descriptive study with qualitative approach, taking as subjects 21 professionals who constitute the nursing staff of the A-ICU of a school hospital in Maringá-PR. Unstructured interview was used as a strategy to collect data, conducted between May and June 2009. Data analysis was based on the method of content analysis. The categories identified were: overlooking improvement in quality of life related to the resources in an A-ICU; the quality of life influencing the form of care; interpersonal relationships into the health team reflecting on the quality of life and care. **Results:** The analysis of caregivers' speech and the results of the observation showed that there is correlation between the aspects they consider influential in their quality of life and the way of caring for patients in an A-ICU. **Conclusion**: The findings indicate that, among the influential aspects, the stressful factors overlap the enhancing ones. From this perspective, dealing with caregiver's suffering might be the starting point for the improvement in quality of care in an A-ICU.

Descriptors: Quality of Life; Nursing Care; Intensive Care Units.

RESUMO

Objetivo: *Identificar aspectos que interferem na qualidade de vida dos cuidadores de enfermagem e no cuidar em uma Unidade de Terapia Intensiva para Adultos (UTI-A).* ***Métodos:*** *Trata-se de uma pesquisa descritiva, de natureza qualitativa, tendo como sujeitos 21 profissionais que compõem a equipe de enfermagem da UTI-A de um hospital escola do município de Maringá-PR. Utilizou-se como estratégia para coleta de dados a entrevista semiestruturada, realizada entre maio e junho de 2009. A análise dos dados se baseou no método da análise de conteúdo. As categorias identificadas foram: vislumbrando a melhora da qualidade de vida relacionada aos recursos em uma UTI-A; a qualidade de vida influenciando na forma de cuidar; as relações interpessoais na equipe multiprofissional refletindo na qualidade de vida do cuidador e no cuidar.* ***Resultados:*** *A análise dos depoimentos dos cuidadores e os resultados da observação evidenciaram que há correlação entre os aspectos que eles consideram influenciadores de sua qualidade de vida e a forma de cuidar dos pacientes em uma UTI-A.* ***Conclusão:*** *Os achados indicam que, entre os aspectos influenciadores, os fatores desgastantes se sobrepõem aos potencializadores. Nessa perspectiva, lidar com o sofrimento do cuidador pode ser o ponto inicial para a melhora na qualidade do cuidar em uma UTI-A.*

Descritores: *Qualidade de Vida; Cuidados de Enfermagem; Unidade de Terapia Intensiva.*

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RESUMEN

Objetivos: *Identificar los aspectos que influyen en la Calidad de Vida de los cuidadores de Enfermería y en el cuidar en una Unidad de Cuidados Intensivos (UCI-A).* ***Métodos:*** *Se trata de una investigación descriptiva, de naturaleza cualitativa con 21 profesionales del equipo de Enfermería de la UCI-A de un hospital escuela del municipio de Maringá-PR. Se utilizó la entrevista semi-estructurada como estrategia para la recogida de datos realizada entre mayo y junio de 2009. El análisis de los datos se basó en el método del análisis de contenido. Las categorías identificadas fueron: vislumbrando la mejoría de la calidad de vida relacionada a los recursos de una UCI-A; la calidad de vida influyendo en el cuidar; las relaciones interpersonales del equipo de profesionales reflejando en la calidad de vida del cuidador y en el cuidar.* ***Resultados:*** *El análisis de las declaraciones de los cuidadores y los resultados de la observación han evidenciado una correlación entre los aspectos que ellos consideran influyentes en su calidad de vida y la forma de cuidar a los pacientes en una UCI-A.* ***Conclusión:*** *Los hallazgos indican que de los aspectos influyentes lo factores negativos se sobreponen a los positivos. En esa perspectiva, trabajar con el sufrimiento del cuidador puede ser el punto inicial para la mejoría en la calidad del cuidar en una UCI-A.*

Descriptores: *Calidad de Vida; Atención de Enfermería; Unidad de Cuidados Intensivos .*

INTRODUCTION

It has been noted in recent years, the increase in studies involving the subject's quality of life (QoL), which demonstrates the restlessness of researchers attempting to provide what the advancement of technology cannot perform adequately, that is, both caregiver's emotional development and the excellence in care[1].

Such studies are due to the fact that QoL is expressed through the value the individual assigns to every aspect of his life, especially those concerning the welfare dimensions of health, leisure, family and social relationships, goals and objectives he wants to achieve, besides the level of self-esteem and personal and professional development[2,3]. Thus, work is a central element, since it is through it that men have tried to satisfy their aspirations and achieve their QoL[3].

In this sense, it is also important to assess the conditions of QoL of nursing caregivers. The nursing caregiver has been defined as the professional-human with specific training in nursing, who may or may not join a team, whose actions of caring for dependents, in the environment of care to the sick, go beyond the technical and scientific knowledge, based on the humanization, solidarity and respect for the one under care[4].

The QoL of nursing caregivers is influenced by several factors - such as stress, identification with patient's stories of life, beliefs and values, ethical dilemmas, anxiety, technical and scientific knowledge, motivation, accelerated pace, responsibility, job satisfaction and physical wear - that are constantly experienced by caregivers and can be both stressful and a potential enhancer. In the ICU environment where this process occurs, the role of nursing is essential regarding the patient care, a task considered of high complexity[2,3,5-9].

Given that, the work environment of an ICU should be highlighted, as it may become a potential generator of tension and anxiety among nurses. Researches indicate the fast pace, noise, excessive lighting, technology, stress and critically ill patients , some being overweight as a set of factors that negatively impact the QoL of nursing caregivers, since they are continuously with patients, covering various shifts , having to participate in complex procedures, and even deaths. Moreover, nursing is ranked as the fourth most stressful profession, because of the responsibility it demands of its workers towards patients' lives[2,3,6,9,10].

Thus, it is perceived that little has been investigated on the aspects that influence the QoL of the nursing caregiver, while he provides expert assistance and care in an ICU[1]. It is critical to carry out further investigation on that theme, while it becomes a challenge.

In this context, it is considered that this research shall contribute to disseminate, among the nursing caregivers, a relevant and rather unknown content, to broaden research possibilities, assisting in the construction of knowledge related to the nursing caregiver's QoL, to provide elements for implementation of positive changes in the workplace and provide gains in terms of better quality of care offered.

Therefore, this study aimed to identify aspects that affect the QoL of nursing caregivers and the form of care in an Intensive Care Unit for Adults (A-ICU).

METHODS

This is a descriptive study, of a qualitative nature, developed with the nursing staff of the ICU of a university hospital in the city of Maringá-PR. The A-ICU has 29 nursing caregivers (nurses and nurse technicians); of these, 21 participated in the study.

Inclusion criteria were: being part of the nursing staff (nurses, auxiliary and/or nursing technician), to be working at the time of data collection, in the various shifts of A-ICU, and signing the Free Informed Consent Form. The caregivers who were on vacation or leave and those who refused to participate in the study were excluded.

Data collection took place from May to June 2009, by means of an interview, performed in a quiet place within

the institution. The instrument applied during the interviews was a semi-structured form, comprising two parts: a closed one, assessing the caregiver characterization (professional category, sex, age range, civil status, number of children and their age range, work shifts, time in the job, existence of other employment link, shift in the other job), and an open part, consisting of three questions: Thinking about your job, what you think could be done to improve your quality of life? How does your quality of life influence the form of providing care in the ICU? How is your relationship with the other professionals in your workplace?

In data processing, it was employed the guidance of the content analysis, by Bardin[11], that follows these steps: pre-analysis, the material exploration, treatment of the results and the interpretations, which constitute the themes. Content analysis is a set of methodological tools under constant improvement, which is applicable to extremely diverse speeches. This technique oscillates between the two poles of rigor: the objectivity and subjectivity.

The core themes used for the categorization of data focused on words or meanings contained in the statements of the interviews. It was possible to organize the following categories: 1) **anticipating the improvement in quality of life related to resources in an A-ICU**, in which participants show improved QoL conditioned to the expansion of human resources, decreased workload, overtime earnings, acquisition of new technologies and support or qualification programs for the caregivers, 2) **the quality of life influencing the form of care**, in which subjects express some factors influencing their QoL and their way of caring, like the (dis)harmony and the personal work environment, and 3) **interpersonal relationships within the interdisciplinary team reflecting in the caregiver's quality of life and in the care provided.** The aspects mentioned by the respondents in this category are translated into four subcategories: communication failure as an interference factor in patient care, interpersonal relationships influencing the health status of the patient, caregiver's emotional (im)balance, and personality traits reflecting on QoL and influencing care.

The development of the study occurred in accordance with the ethical principles disciplined by the *Resolução 196/96 do Conselho Nacional de Saúde* (Resolution 196/96 of the National Health Council)[12], and the research project was approved by the *Comitê de* Ética *em Pesquisa com Seres Humanos (COPEP)* of *Universidade Estadual de Maringá* (Ethics Committee on Human Research of the State University of Maringa (Opinion 181/2009). Participants were asked to sign the Free Informed Consent Form, and the interviews were recorded and later transcribed verbatim. In data presentation, caregivers were identified by numbers and the letter C.

RESULTS E DISCUSSION

In this study, we sought to present the results and the following discussions. We begin, therefore, with the characterization of the population, and next, continue with the presentation of the categories and subcategories that emerged from the study.

Knowing the caregivers

Interviews were conducted with 21 caregivers: 10 (47.6%) nurses and 11 (52.4%) nursing technicians. Of these, 16 (76%) were female and 12 (57%) were married, 14 (66%) were aged between 30 and 49 years. Regarding the number of children, 16 (76%) had one or more children and from these, 10 (48%) were younger than ten years old. As for the employment link, 12 (57%) had service time over three years, 8 (38%) had other employment; 4 (50%) worked on the night shift.

Anticipating the improvement in quality of life related to resources in an A-ICU

This category refers to the statements expressed by caregivers surveyed on aspects relating to QoL of nursing caregivers in an A-ICU. The subjects interviewed consider the improvement in QoL conditional upon the presence of several features that they regard as necessary for the provision of care in an A-ICU.

It was noticed that caregivers mention the need for **expansion of human resources** in an ICU-A:

> *[...] We do not have a person, a pilot for cover. Every time someone has to cover the shift for an employee that's absent and it so goes, overloading us. There comes a time we can't take anymore. It's like an obligation to work overtime. You say: "I will not take it, because I'm not forced to work overtime," but you think: "My fellow is killing himself there," Then I end up going there [...]. (C6)*

> *[...] If you increase the number of employees, overtime would decrease, then, the service would be better, assistance could even be planned. This is not done because the service is very, very pushed [...]. (C9)*

The caregivers understand the incomplete workforce due to the complexity that the ICU presents and feel obligated to perform overtime. Possibly, they are taking a turn that is not theirs, due to the developed sense of responsibility and, above all, to respect for their profession. However, this selfless dedication can result in a burden, leading to impairment of the care provided through the exhaustion they may be submitted to.

The number of nursing professionals in an ICU who are liable for complex procedures and critical patient is

seen by the caregivers as insufficient, since they need to fill the gaps, covering the missing ones. This yields suffering, because, despite doing the best they can for the comfort and recovery of those who are under their responsibility, they perceive this assistance as inefficient, rendering them feelings of impotence, which affect their QoL and the way they will provide care[8,13].

The availability of workers within the ICU nursing staff may be regarded deficient, in the face of the tasks to perform, because if no one takes into account the type of patient and the type of professional activity performed in that unit, the result translates into burden for those who remain in the position[7,14].

Caregivers express aspects such as the **reduction of workload and performance of overtime** involved in improving the QoL of nursing caregivers in an A-ICU:

> *[...] 30 hours of work would be good. We take 36 hours, but don't always do only that, because there is always some employee who is on vacation, relieved [...] and we have to cover, take overtime, and it takes my quality of life. (C14)*

> *I think the workload is a bit heavy. There should be a way to do a rotation of employees because employees are stressed, exhausted, and that disturbs a lot. There comes a point where the person ends up with depression. (C21)*

It is noticed that the working hours cause an exhausting and stressful climate, leading the caregivers to submit suggestions, such as reduction of workload and system of rotation, which, according to their perceptions, would foster the care of themselves. Possibly, they crave more time to develop other activities that bring them satisfaction, motivation and enable them to admire life under other angles, not just recover the energy through sleep and rest.

The extensive workload takes their motivation away and causes conflicts between team members, with stress to the group and, in particular, to the caregiver. In this sense, free time dedicated for leisure acts like an alternative means for relaxation and relief from everyday problems arising from the nursing staff, fostering interpersonal relationships and aiming, thus, to improve the quality of life of workers and of the service in general[3,15,16].

The features involved in the shifts in an ICU can lead caregivers to physical and emotional exhaustion[5,10,16]. Among the stresses generated by the workload, there is the Burnout Syndrome, which affects those whose professions have a direct relationship with the customer and are exposed to chronic stress, resulting from the constant attention, fast-paced, tension and irregular sleep pattern. The emotional stress can manifest itself physically, characterized by feelings of loss of energy, fatigue and exhaustion of the individual, interfering with the care and decreasing the QoL of these individuals[9,17].

Obtaining new technology is perceived as a really necessary factor for improving the nursing caregiver's QoL and the care provision in an ICU-A:

> *[...] Improving conditions, equipment, for example, The beds are heavy. However there is equipment nowadays that help you a lot in handling (sic) some patients; electric beds for you not to work so hard, so ergometer, assisting in this sense [...]. (C1)*

> *[...] One example is the bed that turns into an armchair because we have morbidly obese patients, so we feel very tired and have no way to handle these patients, understand? For this patient to get seated, one has to get him on the lap, it is infeasible. And if the position change takes a longer period, we strive so much that an injury ends up occurring. So we asked for that bed, to maintain our health and we feel better knowing they are providing a higher quality of care. (C3)*

It is believed that professionals, when referring to the struggle for the best possible care, understand the assistance provided in an ICU as differentiated and, thus, there is a need for extra support to ease the complexity of rhythm and routine they face. They realize that, acquiring new equipment, such as electric beds, they become protected against the risks inherent to such activities, storing forces and maintaining their health, essential to take care with excellence.

The procedures and material resources used in an ICU are always evolving and require further training, for nursing caregivers are in daily contact with critical patients requiring specialized assistance. However, not all ICU take advantage of new technologies, such as monitors, infusion pumps, electric beds and catheters, nowadays considered indispensable for care[5,14].

The speeches related to **support programs and qualification for the caregiver** show their importance for the improvement of QoL and the care provided in an A-ICU:

> *[...] It could take place inside here, also, a motivation to the employees, for them to keep a regular physical activity. This will diminish the stress level and improve the quality of life. Proper diet, also, because we end up eating wrong, making snacks, not eating well. So, a nutritional program and physical activity would be of help. (C9)*

> *[...] Our mood here is shaken, so, I think that, if we had some emotional support, like a social assistant or a psychologist, to help us cope with these situations... (C17)*

The caregivers understand the need for programs and/or actions within the work spaces aimed at the caregiver's health, making suggestions such as physical activities for

improving performance in functions, along with nutritional counseling, and psychological support, through targeted therapies to prepare them emotionally to face the possible conflicts on service. This is, perhaps, a way to express emotional distress they carry within themselves, indirectly, demonstrating the difficulty in dealing with the situations that undermine the psychological domain, essential for the execution of their activities in the environment of an ICU.

They realize the importance of spaces for job training and psychological support, as labor therapies, which are opportunities for discussion of conflicting issues that cause suffering in work, and to find solutions to reverse these factors. Moreover, this strategies would help caregivers to feel respected, valued and able, having them to perform their activities better care and achieve personal and professional fulfillment, reflecting positively on the care and QoL[6,9,13].

The quality of life influencing the form of caring

In this category, the reports reflect the personal (dis) harmony refleting in care as being the way such care provision becomes influenced by the nursing caregiver's QoL in an A-ICU:

> *[...] No matter how hard one tries to be professional, not every day you are fine. Some days you're a little more tired, you've got some problem at home and ends up getting a little distant. Then there are moments that you cannot be one hundred percent to assist the patients [...]. (C2)*

> *[...] If I'm good in all areas, I will provide good care, better than we use to do, because you will have enthusiasm to do that. And if you're having (sic) some point affected in your routine, it will reflect in the work, because this story about 'letting your problem out of service', ah! This is fudge, to me, it's just literature [...]. We do everything to be okay here ... but we always let something show up[...]. (C4)*

Caregivers understand that the issues related to the human aspect, which exist in each caregiver affect, likewise, the individual in the exercise of their professional activities, that is, the care offered, because they do not understand how can separate the personal from the professional area. This demonstrates the sensitivity that exists in each caregiver often suppressed due to the demands that the service imposes.

In some situations, caregivers cannot perform the practices of care as they wish, after all, it is possible that personal problems are interfering with work activities. However, these professionals may not be aware of the obstacles that they are having to deal with, because they cannot look at themselves, because the demands direct his concerns to the other[2,14].

The work environment interfering in care is also revealed as an aspect that influences the QoL of caregivers and nursing care in an A-ICU:

> *[...] If the job is stressful, I will approach the patient in a different way. So, if you're missing employee, if it is too much work, you're busy, it's a stressful environment, it all together causes prejudice to patient care. (C5)*

> *[...] Like it or not, the work, here, makes you tired, not only emotionally but also physically. And if you're like me, you absorb these negative stuff from the work, you get more tired, your face shows it. All this has influence and this will impact on the productivity of your work. (C12)*

Caregivers attach to the workplace a meaning that can influence the care offered. This becomes noticeable when reporting that the emotional and physical wear, originated in the stressful environment of work, affects the caregiver and interfere in the way he will care for the patient as an individual. This is perhaps an appeal from the professional to have his weakness perceived, which often makes him unable to deal with all the problems of an A-ICU.

The space of the ICU becomes complex, not only in relation to matters involving the physical environment, but due to feelings that guide the experiences of the professionals who work there, as hatred, resentment, love, compassion, fear and anxiety. Such feelings impact the caregiver, putting him at risk of incidences of mental health problems. Once health is influenced by the work environment - in the case of ICU, a stressful atmosphere due to the complexity of the technology, to critical patients and the constant expectation the caregivers are exposed to - the professional-patient relationship and, therefore, the care itself suffer interference[3,5,14,16].

The vulnerability of the nursing caregivers in work environment of an ICU, represented by physiological, emotional, cognitive or behavioral changes, stems from the impact of various stressors existing in this environment, namely, the overwork, the constant contact with the suffering of another, the complexity of tasks and the unpredictability of the general state of the patients[18].

Interpersonal relationships of the multidisciplinary team reflecting in the caregiver's quality of life and in care

Informants reveal, in this category, aspects related to the influence of interpersonal relationships on the quality of life of nursing caregivers and the process of care in an A-ICU. While expressing their comprehension about this topic, caregivers focus on the impact that issues related to interpersonal relationships have on themselves and on care for critical patients.

The **communication failure as a factor of interference in patient care** was identified as an obstacle to be circumvented by the team that makes up the A-ICU:

> *[...] even with the doctors, if you don't have a good relationship, there is no communication. And the patient is affected, because the doctor does not have access to all information he could have and, sometimes, he misses some conductions that could be followed to that patient [...]. (C2)*

> *It is very important to have good communication, because the care is not just provided by one speciality. The patient needs the nurse, physical therapist, cleaning staff, doctor ... So, if nobody speaks the same language, each will handle the work his own way and the patient may be harmed, because invasive procedures could be done twice. So, we have to sit down and talk, 'Do you do this? Do you do that?', but with the same goal [...]. (C10)*

The nursing caregiver regards his work as a summation of the actions to be performed together for the benefit of the patient, requiring effective communication between multidisciplinary team existing in an ICU. Possibly, this effective communication they refer to is related to dialogue, understanding and even aid among the surrounding colleagues, regardless of the professional class.

It is known that the interpersonal conflicts among the staff of a multidisciplinary ICU have been perceived by nursing caregivers as stressful and tension generators, since, despite having in common the care for a critical patient care, they have different interests and worldviews. The conviviality in an ICU can become painful when interests are confronted[14,19].

Therefore, to reach an effective communication between the multidisciplinary team, an interaction between the components of nursing and other areas is necessary. However, to permeate the communication process, it is important the establishment of bonds as friendship and trust, in order to ease the tensions and promote the realization of the potential of each caregiver[14,19].

Study participants expressed that **the interpersonal relationships influencing the patient's health status** is one of the aspects that impact the care offered in an A-ICU:

> *[...] If you have a team where (sic) people do not interact, where (sic) there are conflicts, it undermines the work and you will pass it along for the patient, the care will be harmed. I've already witnessed it. (C5)*

> *[...] The interpersonal relationship influences the patient care and, because the team will not have the patience, that tranquility to be taking care of the patient due (sic) some quarrel with his colleague. Sometimes the patient gets anxious and one's got to have enough patience to be dealing with him [...]. (C19)*

The nursing caregivers understand the relationship between the team as an important foundation to establish a harmonious atmosphere and conniving with the patient's evolution. It can be inferred that this professional has possibly had experiences where the patient has not developed positively. Supposedly, due to the fact that human beings, in their weakness, absorb the negative aspects arising from factors that alter the wholesome environment.

The conflicts between members of the healthcare team in an ICU depart, usually, from pressure and stress related to activities that require much of the caregiver. It has been realized the need for harmonious relationships that encourage good patient outcomes and promote the QoL of the individuals operating there. Given that, caregivers have attributed importance to good interpersonal relationships, through which bonds of friendship, trust and mutual aid are established, leading them to communicate and seek to achieve the realization of their potential as professionals, with the responsibility of taking care of patients effectively[5,10].

The good interpersonal relationship assumes importance as a strategy in tackling **the caregiver's emotional imbalance** in an A-ICU:

> *[...] If you do not have a good relationship, it will mess up your emotions, leave you sad or frustrated [...]. You will not work with enthusiasm to care for the patient. Like it or not, you spend a lot of time in the ICU, and if you're not well with friends, you will not be comfortable, and this pressure decreases your concentration [...]. (C1)*

> *[...] The most complicated thing is to work in an environment where people cannot talk to each other, cannot have a relationship beyond the professional (sic). If you work in an environment where you are only there to work, psychologically, that does a lot of harm [...]. (C2)*

Caregivers reveal, in their speech, the realization that there must be integration among the team in an ICU for maintenance of the emotional balance. They emphasize that the professional is affected by the conflicts that may arise between colleagues, and this may interfere negatively in the way of caring. They present the need to rely on psycho-emotional baggage that provides them proper structure to perform their activities and interact with other team members with confidence and support. We realize that is the only way the caregivers understand the opportunity to confront the difficulties and develop their work with more authenticity.

A good team interaction promotes exchanges among professionals that comprise it, that is, the knowledge, understanding and mutual help serve as a mediator among caregivers. Although these aspects may interfere in relations, it is important that those involved in the relationship keep

the dialogue open and expose their perceptions, to avoid distancing and superficiality. It is believed that creating effective links in the workplace becomes a facilitator of the activities to be performed, because a great part of their life is spent there and emotional support is needed to serve as fuel for their journey[20].

Personality traits **reflecting in QoL and influencing on care** is perceived by caregivers as an important aspect of interpersonal relationships in an A-ICU:

> *[...] Sometimes, you're not prepared to get to the person and say: 'Look, let's talk about what happened, excuse me, I shouldn't have said this or that...'. So, well, our ego gets hurt, then, until you get to leave it behind and get to talk, work doesn't come out well done. So, the person's personality influences a lot on the work environment and caring. (C8)*

> *[...] Just today an ICU official has said: 'If you are replacing another patient into boxes, I'll take my name off the shift schedule. So, that's boring. When she rebels, she takes her name from the Sunday shift, which is already missing employee. You have to turn a blind eye to be able to continue working [...]. There are several types of personalities, a lot of 'starlet' people, people do not think that there is a unit, it's a team, then it's useless if you want to stand out, because here everyone is equal [...], but still people don't understand. (C11)*

Nursing professionals realize that the individual's personality traits can be both a facilitator and a complicating factor for the interpersonal relationships in an ICU. They point out that those who cannot work the feelings of pride and/or hurt within themselves might not communicate with other team members and not provide effectively the care for patients. Possibly, the one who cannot communicate effectively has emotional wounds caused by traumatic conflicts that have not yet healed and certainly this will be reflected in the human being dependent on his care, since, from the moment the caregiver does not feel good about himself, he will not manage to maintain focus.

However, it is known that the manner of being and the personal difficulties are inherent to the human condition and that, before being professionals, they are people. The nursing caregivers often fail to maintain good interpersonal relationships due to blockages and/or limitations of his own personality. The way of acting, speaking and expressing themselves occasionally ends up being misinterpreted, creating conflicts between team members and feelings of anguish and suffering. Thus, one should take into account the individuality of each during the formation of bonds, so that it will not interfere with QoL and the way care is offered to another[20].

FINAL CONSIDERATIONS

The perceptions of nursing caregivers working in an A-ICU about the aspects of their quality of life presented correlation with the care offered by them. Without claiming to exhaust the subject, this study has contributed to a greater understanding of the issues involved in the working environment of an A-ICU, which can endanger the health of nursing caregivers and the assistance they provide.

During the study, it was possible to identify some thematic cores. The first central theme focused on improving the quality of life related to the resources of the ICU. Among the aspects considered, these stand out: increasing the number of employees facing the complexity of the ICU; decreasing the workload (fixed workload and overtime), perceived as a cause of exhausting and tense climate; acquisition of new technologies as a strategy for prevention against risks inherent in the activities; programs to support and qualify the caregiver, thus becoming opportunities for discussion of conflicting issues that cause suffering in professional living.

The second core discussion addressed the influence of QoL in the form of caring. Among the factors mentioned, there were the personal disharmony, that is, the problems of life faced by the human being existing in each caregiver, affecting him in the performance of care; and the work environment as an influential agent in QoL and care due to the stress generated, which causes physical and mental wear.

The third core comprised interpersonal relationships within the multidisciplinary team reflecting in the caregiver's QoL and in care. Among the issues that emerged, interpersonal relations were perceived as strongly influential on QoL and care, since they often generate failures in communication among the multiprofessional team, which renders the quality of care being below the expectations.

The interpersonal skills of the nursing staff was expressed as an aspect that reflects directly in the patient, revealing the importance of positive relationships among caregivers in order to establish a meaningful and harmonious atmosphere, conniving with patient outcomes. The satisfactory interpersonal relationship was pointed as a strategy against the caregiver's emotional imbalance; likewise, establishing an emotional bond in the work environment was perceived as a facilitator of professional activities. Furthermore, the caregiver's personality traits were seen as facilitating or complicating factors for interpersonal relationships; hence, they can help or hinder communication between team members.

In summary, QoL of nursing caregivers is expressed by several bio-psychosocial aspects surrounding the work

environment in an A-ICU, which function both as boosters and hinderers of their health. However, the analysis has highlighted that the stressful factors outweigh the potential ones. It is worth remembering that the unit of work cannot be seen in its entirety as responsible for the negative results presented in this study, since QoL involves other areas of life besides work.

Nevertheless, knowing the aspects that are positively and negatively influencing the QoL of caregivers is important for the implementation of an institutional policy that clarifies values and basic interests, supports the qualification of employees and considers investing in better working conditions. It is believed that these findings, by providing guidance for new approaches and a basis for programs targeting the needs of nursing professionals, can contribute to increased productivity within the ICU, having in mind that improved QoL of caregivers provides the necessary welfare to render them capable of offering a higher-quality care.

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