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RESEARCH

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Transition from COVID-19 ICU to general ICU: experiences in the internalization of intensive nursing care[a]

Transição da UTI COVID-19 para UTI geral: vivências na interiorização dos cuidados intensivos de enfermagem

Transición de UCI COVID-19 a UCI general: experiencias en la internalización de los cuidados intensivos de enfermería

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ABSTRACT

Objective: to analyze the experiences of nursing staff during the transition from a general Intensive Care Unit (ICU) to a COVID-19 ICU in a rural municipality. **Method:** descriptive qualitative research conducted with 20 nursing staff. The setting was a general ICU of a philanthropic hospital located in a rural region of southern Brazil. Data were collected through semi-structured interviews and then subjected to thematic content analysis using NVivo software. **Results:** nursing staff reported challenging experiences in the COVID-19 ICU, marked by aspects of internalization. The transition to general beds was abrupt, marked by a lack of trained human resources, staff inexperience, and infrastructure deficiencies. However, the general ICU was considered a victory for the municipality and region, streamlining the availability of intensive care and addressing network deficits. **Final considerations and implications for practice:** this study contributed to understanding the transformation of intensive care in the years following COVID-19. Aspects inherent to interiorization were experienced in the implementation of intensive care beds. However, this phenomenon is seen as a step forward in the care of critically ill patients in rural municipalities.

Keywords: COVID-19; Hospitals; Intensive Care Units; Nursing; Nursing, Team.

RESUMO

Objetivo: analisar as vivências dos trabalhadores de enfermagem na transição de uma Unidade de Terapia Intensiva (UTI) geral a partir de uma UTI COVID-19 em município interiorano. **Método:** pesquisa qualitativa descritiva, realizada com 20 trabalhadores de enfermagem. O cenário foi uma UTI geral de um hospital filantrópico localizado em região interiorana do Sul do Brasil. Os dados foram produzidos por meio de entrevistas semiestruturadas. Após, foram submetidos à análise de conteúdo temática com auxílio do *software* NVivo. **Resultados:** trabalhadores de enfermagem relataram vivências desafiadoras na UTI COVID-19, marcadas pelos aspectos de interiorização. A transição para os leitos gerais foi abrupta, marcada pela carência de recursos humanos capacitados, inexperiência da equipe e deficiências de infraestrutura. Porém, a UTI geral foi considerada uma conquista para município e região, agilizando a disponibilidade de cuidados intensivos e suprindo *déficits* da rede. **Considerações finais e implicações para a prática:** este estudo contribuiu na compreensão da transformação da terapia intensiva nos anos subsequentes à COVID-19. Aspectos inerentes à interiorização foram vivenciados na implementação de leitos intensivos. Porém, este fenômeno é entendido como um avanço para a linha de cuidado ao paciente crítico nos municípios interioranos.

Palavras-chave: COVID-19; Enfermagem; Equipe de Enfermagem; Hospitais; Unidades de Terapia Intensiva.

RESUMEN

Objetivo: analizar las experiencias del personal de enfermería durante la transición de una Unidad de Cuidados Intensivos (UCI) general a una UCI COVID-19 en un municipio rural. **Método:** investigación cualitativa descriptiva realizada con 20 personal de enfermería. El escenario fue una UCI general de un hospital filantrópico ubicado en una región rural del sur de Brasil. Los datos se recopilaron mediante entrevistas semiestructuradas y luego se sometieron a análisis de contenido temático utilizando el software NVivo. **Resultados:** el personal de enfermería relató experiencias desafiantes en la UCI COVID-19, marcadas por aspectos de internalización. La transición a camas generales fue abrupta, marcada por la falta de recursos humanos capacitados, la inexperiencia del personal y las deficiencias de infraestructura. Sin embargo, la UCI general se consideró una victoria para el municipio y la región, agilizando la disponibilidad de cuidados intensivos y abordando los déficits de la red. **Consideraciones finales e implicaciones para la práctica:** este estudio contribuyó a comprender la transformación de los cuidados intensivos en los años posteriores a la COVID-19. Se experimentaron aspectos inherentes a la interiorización en la implementación de camas de cuidados intensivos. Sin embargo, este fenómeno es visto como un paso adelante en la atención a pacientes críticos en los municipios del interior.

Palabras-clave: COVID-19; Enfermería; Grupo de Enfermería; Hospitales; Unidades de Cuidados Intensivos.

INTRODUCTION

Critically ill individuals often require complex clinical care, which demands hospital infrastructure with high technological density and support from specialized teams in sectors known as Intensive Care Units (ICUs).[1] ICUs care for critically ill patients who are particularly prone to complications and adverse events. In these sectors, nursing work is essential for the provision of high-quality healthcare services.[2]

The disease known as Coronavirus Disease 2019 (COVID-19), due to its high variability and infectivity, became a pandemic and a public health problem, requiring ICUs worldwide to expand in order to meet the growing number of individuals in need of intensive care.[3,4] In Brazil, although there was an adequate average proportion of ICU beds, their availability was insufficient in the pandemic scenario, mainly due to regional disparities across the national territory. Regions distant from major Brazilian capitals were characterized by a lack of specialized beds.[5]

During this period, nursing workers became a limited resource in the face of the challenge of meeting increasing demand, which required the reallocation of the nursing workforce to work in these new units. The pandemic highlighted the importance of a robust and qualified intensive nursing workforce for health systems worldwide.[4]

The expansion of ICU beds during COVID-19 occurred especially in rural regions, due to the historical shortage of these services in such areas. This occurred in a context of several challenges, including difficulties in recruiting specialized human resources.[6]

From 2022 onward, with the end of the most severe phases of the pandemic, a process of reorganization of health systems began in Brazil and worldwide. In some regions of Brazil, COVID-19 ICUs were closed; however, in others, these beds were converted into general ICUs, particularly in areas where there were gaps at this level of care. Thus, a process of post-pandemic internalization of intensive care began, driven by the intention to correct an insufficient Brazilian hospital care structure, geographically unevenly distributed, irregularly integrated into local and regional systems, and severely affected by chronic underfunding.[7]

Particularly in rural municipalities, which face geographic and budgetary adversities, the introduction of intensive care beds emerges as a post-COVID-19 phenomenon that should be investigated from different perspectives, including nursing work. What is currently known is that the internalization of intensive care has not eliminated inequality. National and international scientific evidence has highlighted regional disparities in access to intensive care, especially for populations living in rural areas.[6,8]

Focusing on the experiences of nursing professionals in this process is relevant, as this professional category provides complex and continuous care in the hospital setting, being responsible for complex activities in care, management, and education domains.[9] After overcoming the COVID-19 pandemic, research focused on analyzing the nursing workforce in ICUs in the post-pandemic scenario is essential, due to the transformations of these services,[4] especially regarding experiences in the internalization of intensive care.

Finally, it is noteworthy that this study is aligned with Sustainable Development Goal 3 (Good Health and Well-Being), proposed by the United Nations, particularly the specific objective of expanding health coverage, including access to essential healthcare services for the population. Therefore, the objective of this study was to analyze the experiences of nursing workers during the transition to a general ICU from a COVID-19 ICU in a rural municipality.

METHOD

This is a descriptive qualitative study conducted in accordance with criteria for methodological rigor and transparency from the COnsolidated criteria for REporting Qualitative research. The study was carried out in an adult general ICU in a rural municipality in the northwest region of Rio Grande do Sul, Brazil. This service is a reference for a population of 52,575 inhabitants, including municipalities in the region with a predominance of rural populations.

In 2021, the hospital responsible for this general ICU submitted a request to the State Health Department of Rio Grande do Sul to convert the existing COVID-19 ICU into an adult general ICU. The unit had ten beds (the same number as the COVID-19 ICU), equipped and staffed with a multidisciplinary workforce to care for critically ill patients admitted through the State Bed Regulation Center. Most hospitalizations involved individuals from the local rural population.

Data collection took place in May 2023, with nursing workers from the unit serving as key informants. Both professionals who had worked and those who had not worked in the COVID-19 ICU were included, as all were experiencing elements related to the transition process at the time of data collection. During this period, the ICU nursing staff consisted of 28 professionals. Nursing workers at both technical and higher education levels who were part of the staff at the time of the study were included. Professionals on vacation, leave, or any work-related absence during the interview period (May 2023) were excluded.

One worker was excluded due to being on vacation, another due to work leave, and five declined to participate. Thus, 21 professionals were initially included in the study.

Data collection was conducted by a nurse enrolled in a master's program, supervised by a PhD nurse. Semi-structured interviews were used to obtain information.

Invitations for the interviews were previously communicated at the workplace and scheduled according to each participant's availability. Interviews were conducted individually during work shifts, in a private room within the hospital, and guided by a script developed by the researcher. Initially, sociodemographic and occupational data were collected (gender, age, professional category, graduate education, time working in the unit, and prior experience in intensive care). Subsequently, the interviews were guided by the following topics: the COVID-19 context preceding and influencing the accreditation of the general ICU; experiences in the transition process from COVID-19 ICU to general ICU; and experiences in the general ICU within the context of internalization.

Interviews lasted approximately 30 minutes. A pilot interview was conducted to adjust the interview script, which required no modifications and was therefore included in the analysis. Interviews were audio-recorded with participants' consent using a digital device and transcribed in full. To validate the data, transcripts were sent to participants via text message, with a seven-day period allowed for review and feedback. No repeat interviews were necessary. One interview was excluded at the participant's request; therefore, the final corpus consisted of 20 interviews.

Interview transcripts were subjected to thematic content analysis, conducted in three stages: pre-analysis; material exploration; and treatment of results, interpretation, and inference.[10] In the pre-analysis phase, material aligned with the research objectives was organized and carefully read. During material exploration, content was divided into recording units using NVivo software. These units were then grouped according to semantic logic, forming thematic categories.

Finally, in the stage of treatment of results, interpretation, and inference, theoretical frameworks were revisited and national and international evidence was consulted. Based on this, conclusions and inferences were developed.

The study complied with Resolutions 466/2012 and 510/2016 of the Brazilian National Health Council. The project was approved by a local Research Ethics Committee on April 22, 2023, under Opinion 6,015,275. Excerpts from participants' statements are presented in the results, identified by the acronyms NUR (nurse) or NT (nursing technician), followed by a number corresponding to the order of participation in the study.

RESULTS

A total of 20 nursing workers participated in this study. Most were women (n=19). The majority were between 22 and 42 years old (n=15), while a minority were between 49 and 55 years old (n=5).

Most participants were nursing technicians (n=15), and the remainder were nurses (n=5). Most had worked in the COVID-19 ICU and remained in the general ICU (n=12). The others were reassigned to different sectors due to staff turnover within the institution. Most had more than one year of experience in the unit (n=13). Regarding training, three had specialization or additional training in intensive care, and three had prior experience in intensive care before joining the institution.

Experiences of nursing workers in the COVID-19 ICU: aspects related to internalization

The trajectory of many participants in this study began during the COVID-19 ICU period. Experiences during the pandemic were frequently mentioned throughout the interviews. These experiences were striking for these professionals, who recalled the complexity of the unit and the difficulty of clinical management of patients.

> *When I arrived, it was a COVID-19 ICU. It was something totally different. The patients, mostly prone, on* [infusion] *pumps,* [...] *many seriously ill* (NT12).

> [...] *during the COVID-19 pandemic, you would sometimes leave the patient feeling well; when you returned the next day, the patient was ill. It was very fast, a matter of hours for them to worsen. The patient is doing great, saturating very well, and then a little while later they would start to desaturate.* [...] *the COVID-19 period was very much like that: very unstable* [...] (NT04).

The implementation of the COVID-19 ICU in the rural hospital was marked by numerous challenges, especially the lack of technical knowledge among the team (as most had never worked in an ICU) and the lack of experienced professionals.

> [...] *we didn't know. It was the very basics. We learned there* [COVID-19 ICU]*. I learned inside the hospital, because I had never worked in a hospital before. I went from home care to the hospital* [...] (NT03).

> *It started down there* [inpatient unit]*, without any idea, because it wasn't every day that we had intubation, it wasn't every day that we had central catheter insertion. Our routine was very calm, very quiet. Until the COVID-19 patients arrived. Then the intubation thing started to become routine, and we thought it was a monster... how to prepare for an induction* [...] (NT10).

Nursing staff had difficulties organizing the physical structure of the COVID-19 ICU, given the speed at which it was implemented.

> *When we went up to the COVID-19 ICU, we had nothing in place. There was no counter.* [...] *it was a very painful and rushed adaptation phase* (NT10).

> [...] *it was difficult because of the lack of infrastructure. We didn't have much. At first, the materials were on a stretcher; on the next shift, they were on the other side. This greatly hampered the emergency response.* [...] *we worked hard until we started to organize the structure. We had a small school desk, a laptop with a cracked screen, and a computer. The computer kept freezing, the system didn't work, there was no internet inside* (NUR03).

As a way to cope with the adversities faced by the nursing team—such as lack of procedural knowledge and limited time for training—workers developed collective strategies to improve preparedness for COVID-19 ICU work.

> [...] *we had a group* [...] *we would download the video we wanted from YouTube®; watch the video and send it to the group; and study together* [...] (NT10).

> [...] *so, I had already been studying with the girls before, I had already been reading. It made things easier. We were able to hold each other's hand.* [...] *we started from scratch* (NUR03).

The COVID-19 ICU contributed to the development of the general ICU, especially regarding procedures and the way the team organized itself in the search for knowledge:

> *We learned. What we learned in the COVID-19 ICU, we applied to the general ICU and improved upon. We didn't have that way of organizing ourselves, of researching what the patient had. Now I'm very much into research. The patient arrives with an illness; I go to Google® and look up what that illness is. Why they have that illness* […] (NT04).

Therefore, it is evident that experiences in the COVID-19 ICU were relevant for participants, as they provided contributions that influenced both individual and collective organization for work in the general ICU.

Transition to the general ICU: challenges experienced by nursing workers

Issues related to general ICU accreditation were described as a bureaucratic and politicized process, marked by significant effort from hospital leadership.

> *It was a struggle. They moved around a lot, sought help from people quite a bit.* [...] *we saw the nurse and other people looking for paperwork and trying to show that a general ICU could exist, that it had all the necessary facilities. And thank God, they succeeded* [...] (NT04).

With the decline of the pandemic, the transition from the COVID-19 ICU to the general ICU was perceived as a sudden event, filled with novelty, lack of information, and insufficient knowledge and skills to deal with the new clinical profile of patients.

> *I think it was very impactful because, one week we were a COVID-19 ICU, the next week we were a general ICU. The change was very sudden. It was something totally different. The COVID-19 ICU had specific cases; normally it was always the same thing. In the general ICU, no, there are various cases!* (NT13).

The transition to the general ICU was accompanied by many of the same problems that persisted, such as a shortage of qualified human resources, which caused overload and an accumulation of functions.

> [...] *there was one physiotherapist for the entire hospital, so they couldn't keep up, they couldn't handle working with everyone.* [...] *I had to know how to adjust* [the mechanical ventilator]*; I had to master both the ventilation part and the medication pump part, sedation, everything* [...] (NT08).

During the transition process, COVID-19 and non-COVID-19 patients coexisted at various times in the same ward, which added complexity to the nursing work process. In May 2023, when the data for this research were collected, this coexistence was still common:

> *We are still dealing a lot with this post-COVID-19 adaptation, even after the end of the pandemic. Our isolation ward was intended for other illnesses, but we are receiving* [severe cases of COVID-19] [...] *we are in this adaptation phase, trying to move on from COVID-19* [...] (NUR04).

One factor that facilitated the internalization of intensive care in this context was telemedicine:

> *There were many things we didn't know much about, but the rounds at Albert Einstein [hospital] helped us a lot to clarify many doubts.* [...] *if we have any questions, we ask them, the doctors too* (NUR02).

Despite all challenges, some nursing professionals highlighted that experiences in implementing the general ICU, although full of adversity, were catalysts for transformation, growth, and learning.

> [...] *it was a huge challenge to look at each patient in a different way. You look at the patient in bed one: one clinical approach. You look at the patient in bed two: another! It's very challenging, but it's good because we get out of our comfort zone. We were practically knowing the same things, reading the same things. Breaking that barrier, we start to challenge ourselves, to learn about other clinical approaches, to lead the team in a different way. With different perspectives for each patient.* [...] *there comes a point when we really don't know* [something] *because it's new. So, I sit down with them* [the team]*, download an article on the computer, we read it, I bring a book the next day, seeking to improve the care* (NUR03).

Therefore, it is observed that the transition to the general ICU, although desired by the institution and team, was permeated by difficulties inherent to the rural context, such as lack of resources, supplies, and infrastructure. Participants highlighted that the arrival of other patient profiles was abrupt, but also noted the coexistence of COVID-19 patients in the general ICU. Despite the challenges, telemedicine and studies were strategies that strengthened nursing staff in the face of the challenge of recognizing themselves as an intensive care team.

Accreditation of the general ICU as an achievement for rural municipalities

It became evident that the accreditation of the general ICU was a necessary response to the high demand for critically ill patients, in light of which the hospital had to adapt its infrastructure and care delivery model.

> [...] *there was a shift, before the ICU opened, where we had a very significant event at the ward* [inpatient unit] [...] *there were many seriously ill patients... 90% really seriously ill. We had three intubations that night, and I was the only nurse. One patient was extubated and then reintubated, so we had four complications, and we didn't have a doctor. That was the breaking point. I texted the head in the morning,* [saying] *that I wasn't up to it. They were already working on it* [general ICU accreditation]*, and on the next shift, we arrived here with the name ICU* (NUR03).

In this regard, the opening of the general ICU occurred in a context of high expectations from both the institution and the rural municipality. Nursing workers understood this event as an achievement for hospital users and the region, who previously had to face long care pathways to access intensive care beds:

> *I think it's very important because sometimes* [patients] *would stay here in the hospital waiting for a bed* [...] *now, with our ICU, we have that security.* [...] *even patients who came from cities in the region had to wait to get a bed. So, with the ICU here, it's much easier for family members too. There's no cost for transportation* [...] *for our region, it was a wonderful thing* (NUR02).

> *There were patients who would stay in the emergency room for days until they could get a bed* [in another municipality]. *Now, no! The ICU is a breakthrough!* [...] *we had a room in ward one* [inpatient unit] *... it was room 24, which had two beds and was a semi-ICU. The* [critical] *patients stayed there. They stayed in the emergency room; after two days, when they didn't go outside, they went there* [...] (NT12).

One of the professionals reported her personal experience involving her mother, describing the delay in accessing an ICU bed. Her account highlights the fragility of critical care management in rural contexts, marked by long-distance transfers:

> *It happened to me, to my family. My mother got sick and needed an ICU. We didn't have an ICU here, and my mother ended up in* [name of another city]*, 300 kilometers* [away]. *They accepted her there at 7 p.m.; we left here at 1 am because she needed an ICU ambulance. We didn't have one. The SAMU can only transport up to 200 km, exceeding SAMU's limits. We arrived there, my mother stayed for two days and passed away.* [...] *now you don't need to leave, do all that. Your family member got sick, they're already in the ICU, being cared for, being medicated* (NT04).

Furthermore, professionals reported that the ICU strengthened the hospital's identity, addressing deficits in other sectors and reinforcing its problem-solving capacity in the eyes of the community. Many professionals expressed satisfaction and pride in being part of this setting.

> [...] *I think the institution is now seen as a hospital because, whether we like it or not, the ICU has become the face of the hospital, because our hospital was very poorly regarded, very badly spoken of. Our emergency room is still quite outdated. But the ICU, you know? It got an upgrade* (NT10).

> [...] *for me, it's wonderful; learning that I will carry with me for the rest of my life. Everything I learned here.* [...] *is a dream come true. I always felt very insecure about working in the hospital, not just in the ICU. So, when they invited me to come, I was very happy* [...] *the best thing is being able to provide a good service to others, whether they are intubated, on a ventilator or not, treating them with love, with care and respect* [...] *I hope to live many more years working in this area* (NT08).

The results show that ICU accreditation was both a response to an important demand and the fulfillment of an expectation regarding the care pathway for critically ill patients in rural regions. Participants perceived this process as beneficial and as a catalyst for positive changes in the hospital and in patient management in the region.

DISCUSSION

The first analytical category presents the experiences of nursing workers during the pandemic, highlighting memories of the complexity of nursing work with critically ill patients in the COVID-19 ICU. Studies have shown that frontline nursing workers experienced complex challenges in their daily work, impacting both their professional experiences and personal lives, including increased care demand and patient unpredictability and instability,[11,12] which is consistent with the findings of this study.

A lack of technical knowledge and team inexperience were also highlighted. An Australian study showed that the organization of COVID-19 ICUs was hindered by difficulties in recruiting nurses with training and experience in intensive care. The study, conducted in 24 ICUs, found that nursing shortages persisted, especially during infection peaks, when additional beds were opened and workforce reallocation was necessary, though not always sufficient.[4]

Physical and environmental disorganization in the COVID-19 ICU was mentioned as a challenge during these experiences. Infrastructure is reported as a significant barrier in rural ICUs.[8] It is known that organizational characteristics of the work environment and the availability of adequate materials can facilitate or limit nursing practice in intensive care,[13] which corroborates the perception that nursing experiences were impacted by this reality.

As coping strategies for these challenges, participants resorted to studies and the pursuit of knowledge in the workplace, especially collectively, in order to mitigate doubts and find ways to meet the clinical demands of the sector. Intensive care nursing staff recognize the importance of ongoing training and qualification for the care of critically ill patients, especially after the pandemic, and it is essential that the work process facilitates these movements.[14] These professionals stand out by finding innovative ways to provide care, even in adverse situations. During the COVID-19 pandemic, in particular, nursing staff integrated innovative, evidence-based practices to ensure quality of care in the face of the disease's complexity and unpredictability.[15]

Based on experiences in the COVID-19 ICU, it was identified that the nursing team became prepared, resilient, and strengthened for critical care. A qualitative study conducted with nursing professionals showed that, for them, the pandemic spurred nursing teams to acquire new knowledge and create new routines. The team's engagement favored the reorganization of work.[16] Therefore, it can be considered that the experiences of this period contributed to strengthening the professional identity of nursing.

In the second analytical category, the challenges experienced by nursing staff in the transition process to the general ICU were described. The interviewees indicated that the accreditation of this service was desired and the result of management efforts. In Brazil, the opening of new ICU beds within the public health system is regulated by Resolution Ordinance 03 of September 28, 2017.

The interested hospital must meet a set of criteria such as: having updated registration data; possessing at least 60 active or operational general beds (or 30 beds in the case of specialized hospitals); complying with a set of regulations from the Brazilian National Health Regulatory Agency; meeting criteria related to organization and workforce, services and equipment; and having a prior plan demonstrating the need for ICU beds in the respective region. The process of analyzing the situational assessment follows a ritual that involves different instances of public power.[17] Therefore, it is observed that it is a careful procedure that explains the efforts expended by management.

Once these beds were accredited, the transition to the general ICU was immediate and felt as sudden by the participants. The first experiences were marked by a feeling of increased complexity, especially clinical complexity of the patients, who had multiple pathologies. Nursing in intensive care presents a unique complexity, due to the clinical severity of patients.[18] Patient morbidity and mortality rates and clinical severity impact nursing and can lead to feelings of increased workload.[19] Furthermore, it is important to consider that, as the clinical picture of patients changes, new efforts are required to retrace various learning paths acquired during the COVID-19 ICU phase.

Another element that marked the experiences of nursing staff during the transition to general ICU was the limited availability of human resources, contributing to overload and the accumulation of functions. There is limited information on the costs of maintaining intensive care beds in rural regions worldwide.[1] It is known that, in rural regions, challenges to retaining the health workforce may coexist, compromising care and health outcomes.[20]

Another fact that marked the participants' experiences was the prolonged coexistence of COVID-19 patients and other critically ill patients in the general ICU, even after the end of the pandemic. In Brazil, the acute phase of COVID-19 was marked by political instability and weaknesses in public policies. For this reason, the results of the pandemic response fell short of those obtained in most Latin American countries. Furthermore, the control of transmission and long-term effects of the disease was also delayed, so that morbidity and mortality persisted in Brazil for years after the official end of the pandemic.[21]

The interviewees listed factors that facilitated their experiences in this scenario, such as telemedicine, which is an emerging reality in many ICUs, a phenomenon driven by the COVID-19 pandemic. This resource has the potential to improve the provision of critical care.[22] In the context of the decentralization and geographical distance of large hospitals, the importance of this resource for strengthening evidence-based practice and the quality of care stands out.

Working in the ICU is challenging and motivates nursing professionals towards professional growth, a process that primarily occurs within the work collective. A qualitative study conducted with ICU nursing professionals showed that they employed coping strategies in the face of work challenges. However, the best opportunities to improve the work experience lay in strategies undertaken collectively, mainly through teamwork and collaboration.[23]

The last analytical category shows that the ICU accreditation was perceived as an achievement for the participants, the hospital, and the community. This event was conceived as a response to the pressure of critically ill patients in this territory. A study conducted in ICUs in rural regions of an African country showed that, despite the challenges, these sectors had the capacity and potential to absorb a large demand for critically ill patients, highlighting their importance to the health system.[8]

Based on the experiences of nursing staff, the general ICU was perceived as the realization of an expectation held by the inhabitants of the municipality and region, accustomed to facing long lines of care before reaching an intensive care bed. A Brazilian ecological study showed that there are significant weaknesses in the provision of public health facilities, especially in regions that concentrate black populations with precarious income and low levels of education.[24] Therefore, the decentralization of ICUs is justified as an expectation of these regions, already historically weakened by inequalities in the provision of intensive care beds.

One of the consequences of the difficulty in directing critically ill patients to ICUs is their prolonged stay in emergency departments. The presence of critically ill patients in these units imposes an additional burden on these sectors, both from a care and management perspective. Critically ill patients in emergency departments can suffer multiple health setbacks. Managing this problem is complex, and one solution is precisely the expansion and better geographical distribution of intensive care beds.[25]

At one point, there were accounts related to family experiences, recalling loved ones who had died in the past due to barriers to obtaining intensive care in rural areas. It is known that rural regions face significant challenges in organizing intensive care services, such as a low number of beds for large populations, precarious infrastructure, and difficulty in obtaining supplies.[8] This situation can weaken the patient care pathway and impact morbidity and mortality.

The ICU was understood by nursing staff as a service that provided improvements and visibility to the hospital, making it more effective, more efficient, and respected by the community. A Brazilian qualitative study conducted with hospital nursing professionals investigated the meanings they attributed to their work. The following elements were highlighted: status of recognition and visibility; efficiency and production of results; importance to the institution; sense of capability to perform complex activities; social utility; and excellence in the care provided.[26] Therefore, by recognizing the importance of the general ICU for the hospital, the municipality, and the community, it can be considered that these experiences contribute to the very sense of belonging that the participants have been building with intensive care.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR THE PRACTICE

The results highlighted important experiences in nursing work, firstly in the COVID-19 ICU, marked by complexity, unpredictability, inexperience and a search for knowledge, and subsequently in the general ICU, whose implementation process was abrupt, weakened by the scarcity of human resources and the coexistence of patients with COVID-19, but faced with the help of telemedicine and collective efforts.

Despite the difficulties and barriers faced, professionals understood the general ICU as an achievement for the rural region, as it represented the possibility of mitigating the deficiencies in the care pathway for critically ill patients, who suffered long waiting periods for intensive care beds. The aspects inherent to the decentralization were experienced in the transition of intensive care beds. However, this phenomenon was understood as an advance for the care pathway for critically ill patients in rural municipalities.

This study was limited by the fact that interviews were conducted at the respondents' workplace and during their working hours. Although this strategy was fundamental for obtaining participation and access, the urgency to return to work may have impacted the duration of interviews at times. However, it was never necessary to interrupt the interviews. The possibility of memory bias, which can limit the production of information, should also be considered.

It is suggested that further research be conducted on the topic of internalization of intensive care post-COVID-19. Once the pandemic is over, it is necessary to gather evidence on the transformations of ICU services and the new challenges faced by nursing. Regarding qualitative studies, it is suggested that other research be conducted from the perspective of other actors, such as managers and multidisciplinary teams, in order to incorporate different perspectives on the phenomenon under discussion.

This study is believed to have contributed to understanding the expansion of intensive care in the coming post-COVID-19 years, providing insights for analyzing the new challenges faced by nursing teams in rural ICUs, an emerging and under-researched phenomenon.

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DATA AVAILABILITY RESEARCH

The data will be available upon request via email to the corresponding author, due to the fact that the database contains sensitive and confidential data for the institution.

CONFLICT OF INTEREST

No conflict of interest.

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