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Bedside nurses' care model: challenges and perspectives for an innovative practice

Modelo assistencial do enfermeiro à beira leito: desafios e perspectivas para uma prática inovadora

Modelo de atención de enfermería al lado de la cama: desafíos y perspectivas para una práctica innovadora

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ABSTRACT

Objective: To understand the practice of nurses in the context of the care model at the bedside of the patient in an Intensive Care Unit, in the light of the ethics of virtue.

Method: Qualitative research, carried out in an Intensive Care Unit of a University Hospital MG/Brazil. Data were collected in February 2016 through a semi-structured interview applied to the 12 nurses who worked at the unit. The data were submitted to Thematic Content Analysis.

Results: The "bedside" care model encourages innovative practice, (re)directing nurses in the search for their *telos*, patient care, overcoming the fragmentation of nursing care and reconfiguring professional identity. However, the organization of the model in the scenario raised challenges related to the recognition of nurses by the multi-professional team, generating identity ruptures.

Conclusion: The adopted bedside model interferes in the nurses' relationship with care, bringing together professional and patient, enhancing innovative and excellent practice.

Keywords: Nursing. Ethics. Intensive care units. Nursing care. Nursing, private duty.

RESUMO

Objetivo: Compreender a prática de enfermeiros no contexto do modelo assistencial a beira leito do paciente em Unidade de Terapia Intensiva, à luz da ética da virtude.

Método: Pesquisa qualitativa, realizada em uma Unidade de Terapia Intensiva de um Hospital Universitário MG/Brasil. Os dados foram coletados em fevereiro de 2016 mediante entrevista semiestruturada aplicada aos 12 enfermeiros que atuavam na unidade. Os dados foram submetidos à Análise Temática de Conteúdo.

Resultados: O modelo assistencial "beira-leito" estimula a prática inovadora, (re)direcionando o enfermeiro na busca do seu telos, o cuidado ao paciente, superando a fragmentação da assistência de enfermagem e reconfigurando a identidade profissional. Contudo, a organização do modelo no cenário fez emergir desafios relacionados ao reconhecimento do enfermeiro pela equipe multiprofissional, gerando rupturas identitárias.

Conclusão: O modelo beira-leito adotado interfere na relação do enfermeiro com o cuidado, reaproximando profissional e paciente, potencializando a prática inovadora e de excelência.

Palavras-chave: Enfermagem. Ética. Unidades de terapia intensiva. Cuidados de enfermagem. Prática privada de enfermagem.

RESUMEN

Objetivo: Comprender la práctica del enfermero en el contexto del modelo de atención ao lado de la cama del paciente en una Unidad de Cuidados Intensivos, a la luz de la ética de la virtud.

Método: Investigación cualitativa, realizada en una Unidad de Cuidados Intensivos de un Hospital Universitario MG/Brasil. Los datos fueron recolectados en febrero de 2016 a través de una entrevista semiestructurada aplicada a las 12 enfermeras que laboraban en la unidad. Los datos se enviaron a Análisis de Contenido Temático.

Resultados: El modelo de atención "al lado de la cama" fomenta la práctica innovadora, (re)orientando al enfermero en la búsqueda de su telos, atención al paciente, superando la fragmentación del cuidado de enfermería y reconfigurando la identidad profesional. Sin embargo, la organización del modelo en el escenario planteó desafíos relacionados con el reconocimiento de las enfermeras por parte del equipo multiprofesional, generando rupturas en la identidad.

Conclusión: El modelo de cabecera adoptado interfiere en la relación de la enfermera con el cuidado, uniendo al profesional y al paciente, mejorando la práctica innovadora y excelente.

Palabras clave: Enfermaría. Ética. Unidades de cuidados intensivos. Atención de enfermería. Práctica privada de enfermería.

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INTRODUCTION

Nursing, as a science and profession, has historically been linked and committed to care, involving performance based on scientific knowledge, technical capacity and the ability to produce work models that show their responsibilities and potential[1]. Considering the evolution of care throughout history, contemporary nursing can be analyzed as a private nursing practice, composed of standards of excellence and the achievement by professionals of goods internal and external to the profession.

According to MacIntyre, the internal goods of a profession, denominated *telos*, are those that differentiate practices from one another and can only be achieved by professionals who have technical skills and use virtues in the pursuit of excellence in a particular practice. External goods, for the author, are common to any practice, being considered social consequences, such as prestige, power, money and status[2].

It is important to highlight that acting with excellence involves the action of the professional because he is the best in the search for the internal good of his profession. It therefore means mobilizing attitudes and habits, that is, virtues, whether they are physical (technical competence) or moral (useful for society), in order to reach the practice[2]. Thus, when performing the practice with excellence, the professional at the same time that legitimizes it as technical competence, also reaches its social relevance.

When considering care as *telos* of the nurse's practice, virtue ethics is assumed as an epistemological perspective for the discussion in this article, reaffirming care as the internal good of nursing[3]. Despite the multiple dimensions of care, it is apprehended that the nurse's practice is substantiated by the interaction between care and managerial activities, with the role of this professional in care management being relevant.

Within the scope of the Unified Health System (*Sistema Único de Saúde* – SUS), different challenges related to the achievement of the internal good of nursing stand out in the face of the legal, organizational, philosophical, and paradigmatic premises driven by it. SUS is configured as an ethical call that triggered changes in health practices and in the identity configuration of professionals, with a shift from curative practices to those that produce care, whose focus is on the individual understood and analyzed in their cultural, symbolic and social context[4].

In the field of organization of practices in the hospital context, the reality reveals the adoption of care models that organize the practice of nurses in a fragmented way, which often distances them from care and, therefore, from direct care to the patient, giving focus mostly to administrative activities[5]. In these models, the division of nursing work takes place considering the attributions foreseen for each professional category, so that the activities of direct care to the patient remain mostly developed by mid-level nursing professionals[5]. The term care model, although it is considered a polysemic term, in all its aspects refer, in a given context, to the way in which a health service organizes its practices, as well as the values that guide them[6].

However, recent changes in the work organization of nurses have modified their daily activities, bringing them closer to direct care for the patient. In this regard, it is worth clarifying that some university hospital institutions have been adopting the comprehensive care model as a way of transposing fragmented care, proposing that care to be provided by the same professional in a work shift in order to ensure adequate care to the patient needs[5]. In the institution, the setting of the present study, the comprehensive care model is called "bedside nurse" and was adopted in closed hospital sectors, focused on critical care. Nurses assume the comprehensive care of patients under their supervision, focusing their actions on direct assistance, remodeling the practice in this context.

Given the above, the guiding question of the study arises: How does the nurse practice in an ICU that adopts the bedside care model take place? For the purposes of this study, an Intensive Care Unit (ICU) of a teaching hospital located in Minas Gerais was chosen to analyze the practice of nurses, under the prism of virtue ethics, where they adopted the nurse's care model at the patient's bedside.

It is assumed that the nurse's practice has a potential to transform work and that changes in the care model that centralizes the patient can have repercussions for an innovative nursing practice that rescues the focus on care and reconfigures the identity of the nurse, overcoming fragmentation of nursing care expressed by the division of labor perceived in most scenarios of the nurse's performance. Therefore, this study may contribute to the (re)valorization of nursing practice and the promotion of the protagonism and autonomy of nurses as an agent of care.

The objective of the present study was to understand the practice of nurses in the context of the bedside care model of the patient in the Intensive Care Unit of a University Hospital, in the light of the ethics of virtue.

METHOD

This is a study with a qualitative, descriptive, interpretive, and analytical approach, based on the Ethics of Virtue. The present study followed the guidelines of the Consolidated criteria for reporting qualitative research (COREQ), aiming to ensure the adequacy of the article to the transparency standard for reporting results in qualitative research[7].

Qualitative research is capable of exposing the complexity of human life and highlighting meanings of social life. The dynamic relationship between the real world and the subject is assumed to be the foundation, the interdependence between individuals and objects and the inseparable link between the world and the subjectivity of the subject[8].

The Ethics of Virtue reveals itself as an epistemological reference consistent with the object of the present study, considering that a particular practice has the internal good (*telos*)[2], differentiating it from the others. In this perspective, assuming care as nursing telos allows the analysis of the practice to be deepened in a context that adopts the care model that characterizes it for its internal good, that is, the care.

The study was carried out in the ICU of a University Hospital, located in Minas Gerais, Brazil. The scenario was chosen intentionally considering the changes that the insertion of the Brazilian Hospital Services Company (*Empresa Brasileira de Serviços Hospitalar* – EBSERH) as manager of the University Hospital caused in the hospital. Among them is the reorganization of nursing practice with the proposal of a comprehensive care model that places nurses in a position to act individually in order to consider the patient as a whole, which implies the development of skills, dexterity and values[5]. In the scenario of this study, the comprehensive care model mentioned was called the bedside nurses' care model. In this model, the nurse, together with the nursing technician, assumes the management of care and the direct and comprehensive assistance of the patients under his supervision.

Twelve nurses who met the inclusion criteria participated in the research. The inclusion criteria demanded that the nurses were offered by EBSERH, considering that in the institution different employment relationships coexist and that they worked on day shifts. The exclusion of professionals from night shifts was due to the fact that they have different ways of organizing work, which could cause bias in the investigation. Participants were identified by the code "ENF" followed by chronological numbering from 1 to 12 according to the interviews.

Data collection was carried out in February 2016 through an interview guided by a semi-structured script, conducted by a previously trained researcher. The researcher introduced himself, informed the objectives, ethical aspects and collected the interviewee's consent to participate in the study by signing the informed consent form. The interviews were previously scheduled, carried out in the professional's working environment in a private location and were recorded and transcribed in full. The script contemplated issues related to the work performed and what the professional would like or should perform at the unit; the obstacles and facilities faced to develop the activities; how they deal with the obstacles encountered; the ethical issues that arise in daily work and the way they deal with them; the motivations to continue working as a nurse and the changes proposed to carry out the work. The interviews lasted an average of thirty minutes.

The data were analyzed using the Thematic Content Analysis[9]. The organization of the data took place around the pre-analysis stages; exploration of the material and; the treatment of results and inference and interpretation[9] and were analyzed under the light of the literature. In the pre-analysis, the material was organized and it was carried out a fluctuating reading. In the exploration of the material, the data were coded and categorized, initially being structured three analytical categories, namely: ethical aspects, facilities and fragilities of the practice and meaning of being a nurse. It should be noted that, subsequently, the categories were grouped in order to answer the research question in this article, composing a single category called the bedside care model. In the treatment of results, inference and interpretation consisted of deepening the analysis, establishing connections with the literature and with the theoretical framework of the Ethics of Virtue.

It is noteworthy that all ethical and legal precepts established in Resolution 466/2012 of the National Health Council were fulfilled (Statement No.1,237,831). The participants signed the Free and Informed Consent Form (ICF) and were informed about the terms of confidentiality and the anonymity of the statements, as well as the risks and benefits of the research.

RESULTS

It was observed that the experience of nurses in the bedside care model in the ICU environment, reveals care as a translation of the practice, as *telos* of the nurse's practice. Bedside nurses provide improvements in the quality of care, reallocating them to a space that is their own. Innovative model in allowing care to be provided in its entirety and without intermediaries, through the application of the nursing process with systematic care planning. However, the model also produces strangeness in the nurse's recognition

with the team, given the historically established forms of care, which displaced the nurse to activities of a primarily administrative nature, and often dissociated from care. The movement proposed by the bedside care model aims to reintegrate nurses into the *locus* of direct care, qualified by highly specialized professional training.

This resumption of the nurse's position at the bedside is associated by ENF1 and ENF5 to the nobility. For these nurses, being close to the patient is "noble", enabling specialized and safe care, with the establishment of a trusting relationship between peers.

> *My job is direct patient care. It is very noble to be close to the patient when performing care* (ENF5).
>
> *The dressing is being changed using the correct technique and I know that my colleagues also have this concern. We change the dressing as often as necessary, indicate the best dressing, change the decubitus every 2 hours, and evaluate the patient to change the decubitus. So, I see that the patient is being better cared for* (ENF1).

The testimonies presented reveal the recovery of identity, weakened in situations in which the professional is disconnected from the activities that give meaning to his work. They also reveal the nurses' perception about their potential in transforming the practice, when considering care as part of their practice. In this sense, ENF8 points out that the practice is linked to care, considering it as "the cradle" of nursing.

> *I work directly with the patient, I can rescue everything that nursing places as a cradle, which is care. From the moment that care is established, I automatically put myself connected to the nurse* (ENF8).

Asked about the values that were mobilized to achieve excellence in practice, nurses pointed out:

> *Affection for the patient and respect* (ENF9), *prudence* (ENF3), *scientific knowledge* (ENF1; ENF5; ENF12), *justice* (ENF4; ENF5; ENF6), *commitment* (ENF7), *communication* (ENF8; ENF11), *empathy* (ENF1; ENF8), *humanization* (ENF8), *responsibility* (ENF3; ENF8; ENF12), *patience* (ENF8), *respect for legislation* (ENF6) *and principles of beneficence and non-maleficence* (ENF10).

These values converge with principlist and deontological ethics and, still, with basic human values. In this regard, ENF5 points out the sense of justice (principlist ethics) and professional oath (deontological ethics) as part of its values. Soon, it moves forward, pointing out dignity and nobility in relationships (ethics of virtue).

> *Ethical value is that you treat each patient fairly, to be in accordance with the oath you made and guarantee all that at the bedside. If you make a mistake, you must have the dignity to acknowledge your mistake and be noble to act accurately with the patient and the family. From the moment you are clear with the family and the patient, the relationship improves a lot* (ENF5).

The participant ENF09 reports that, due to the care model adopted, care is being performed by nurses, which gives a high level of technical and scientific competence and prevents the fragmentation of care between professional categories of higher and medium nursing level, thus revealing, the power of this model of organization of practice.

> *The technical capacity of each one is greater, we are not dealing with technical personnel in assistance, we are all of higher education, everyone's capacity for knowledge is greater* (ENF9).

Although the testimonies point out that the nurse recognizes positive aspects of his proximity to the patient and his potential for transforming care in favor of excellence, with direct and beneficial repercussions for the patient, there are inherent fragilities in the organization of the care model in question in this scenario, as well as challenges that still need to be overcome if the full power of the care model to be achieved. The statements of ENF1 and ENF6 refer to the existence of a gap between the prescribed and the real, between the discourse proposed by the incorporation of the new care model and the practice that, in fact, occurs in the daily life of the organization, mostly reductionist, technicist, which does not allow the application of the nursing process in its entirety. Such gaps make emerge the nurses' strangeness and suffering.

> *The transition from technician to nurse was complex because there was no discourse about the qualification of care, but the substitution of the workforce, and this was painful for the nurse. My practice is reductionist. I can do so much more than I do today. And it is not because of the bed bath and the bandages that I make or because of the diaper that I change. But, due to the lack of possibility of in-depth discussion of each case* (ENF1).
>
> *In fact, I believe that the proposal could have been differentiated. Today we work on the scale of 2 nurses to 1*

technician with 4 patients in a ward. We are very restricted to basic assistance. The diagnosis, the prescription, the nursing care, something directed even to the strategic management of the nurse for the patient is a little to be desired (ENF6).

In this field, ENF2 and ENF4 reinforce that the productive capacity of nurses should be better explored, thus enhancing the quality of care and the profitability of the service. In fact, ENF2 relates to the organization the role of enhancing the work of nurses through improvements in the definitions of the roles of members of the multi-professional team.

The work of the nurse, in this management model, could be more profitable if our potential as a nurse were explored. It is little explored due to the lack of definitions of the role of the technician, the assistant nurse, and the manager (ENF2).

In the ICU there are several things that are not implemented, but that should be. We did not assess the BRADEN scale and the nurse's workload at admission. These are things that the nurse should do. Patient care is interconnected with these things that are not done, so indicators fall, and we are unable to evaluate the care itself (ENF4).

Regarding the uncertainty of the team members' roles, the nurse assumed bedside care that was developed by the nursing technicians. ENF12 reports that this new work organization impacted the non-recognition of nurses by the team, emerging identity ruptures.

I think the work I should be doing is bigger. But I see myself as a technician, it requires little thinking. I work mechanically [...] *The multidisciplinary team does not respect the nurse. I think I already had a view that whoever is at the bedside is the nursing technician, with little voice. The nurse has no participation, we try to insert the nurse in the case discussions and the team does not accept it* (ENF12).

DISCUSSION

The adoption of the bedside nurses' care model created opportunities for nurses to rescue care as an innovative practice performed by the patient-centered nursing process. Innovation translates into the model since, when raising diagnoses, implementing interventions, and assessing the patient's evolution are activities performed by the same professional. Furthermore, the model makes it possible to overcome the fragmentation of care between nursing categories, being developed in a multidisciplinary context. The care, manifested in this way, expresses the understanding of the *telos* of the nurse's practice and of the virtues that need to be mobilized in order to reach its excellence. It should be noted that *telos*, based on the Ethics of Virtue, is the proper purpose of the practice, which, due to its historical construction, its specificity, the skills to be mobilized and the virtues to be achieved in pursuit of excellence, it is unique[2].

In this perspective, the participants of the present study assume care as *telos* of their practice, alluding to it as being the "cradle" of nursing. It is necessary to consider the history of nursing and its professional bases, with care linked to proximity to the patient and being a central value for the profession[10]. Furthermore, care refers to actions directed towards the other, in order to meet immediate needs or anticipate actions to intervene in the health-disease process[11].

In Brazil, the fragmentation of care resulting from the technical division of work has been debated in view of the particularization of the care and management tasks provided, which do not offer an integral view of the individual, weakening care[5]. The model that placed nurses at the patient's bedside promoted their approach to care and the development of a comprehensive practice for patients with critical needs. In this way, care is materialized in the relationship between nurses and between them and patients, strengthening the values of practice through the exercise of virtues, since they are the means to achieve excellence[2]. The bedside model facilitates the exercise of the virtues that give excellence to the practice, legitimizing it.

Specifically in the Intensive Care Unit, people are in constant interrelationship, carrying out activities with a high degree of complexity and specialization, which requires the mobilization of different skills to care for critically ill patients[12]. Such movement in favor of providing the best possible care means legitimizing the practice and reinforcing its social relevance, which is what characterizes the reach of a practice considered to be of excellence.

At the moment when the importance of interrelationship in the care delivery is considered, the participants expressed their dissatisfaction with the bedside model. Although the nurses in the present study recognize themselves as competent and capable of providing excellent care, they reported that they were not recognized by the other (multidisciplinary team), which is attributed to the fine line between the work of the nurse and the nursing technician, culminating in the weakening of his identity and the sharing of activities related to care among the team.

Care, taken from a relational perspective, is a significant element in the nurse's identity configuration, given that it is based on relationships that generate recognition, both from the nurse himself in relation to his practice, as well as from the team members, peers and superiors, legitimizing it[2]. It is clear, therefore, the need to move forward in the search for technical and managerial devices that allow reconfiguring the bedside care model, in order to eliminate technical reductionism and fragmentation of care, giving visibility to nurses.

In addition, the results of the present study pointed out to nurses' dissatisfaction when compared to nursing technicians with secondary education. It is inferred that the nurse feels devalued because he perceives himself as a substitute for the nursing technician, despite having higher education and professional specialization. The opposite is true and was demonstrated in a study whose nursing technicians are satisfied when they are not distinguished from nurses, causing a feeling of equality[13].

Such perception of equality between nurses and technicians is strengthened by the way in which the bedside model was implemented in the unit. This is because the activities developed by both were not well defined by the managers so that they are confused, weakening the identification of the nurse's practice. Still, there were reports that the nurses see themself in the position of performing essentially technical and low complexity activities, generating a feeling of frustration for them, who consider themselves apt and competent to perform more complex functions and who are unable to daily develop them. In this regard, a study points to the Practice Environment Scale instrument as an indicator for the quality of nursing practice[13], given that its application can contribute to the definitions of professionals' role.

The frustration experienced by the nurse due to the lack of recognition on the part of the multi-professional team and the nursing technicians leads to the reflection on macro-structural aspects, regarding the organization of nursing work in health institutions. Such aspects refer to the fact that the care models adopted by hospital institutions have historically displaced nurses from care to assume primarily administrative tasks, leading them to delegate activities closer to the patient to the nursing technician. A study carried out in a university hospital points out that the technical division of work prevalent in the institutions, although there are efforts to change this reality, is marked by nurses working in the management of the unit and in performing highly complex procedures while nursing technicians perform most of the tasks directed to patient care[5].

The organization of the nurse's work in the context of the present study makes it possible to reencounter with the patient care at the bedside, bringing him closer to his practice, that is, care. However, this situation was perceived in a negative way by the professionals, generating feelings that refer to devaluation, invisibility, and frustration for realizing that the less complex care work, in the eyes of the other team members, is related to doing "fewer" or less important. This situation reveals a identity rupture experienced by nurses in the face of the lack of recognition of their work by their peers[14].

The reality presented in this study allows a reflection on the identity challenges that nurses experience. This is because the movement for the reappropriation of direct patient care by the nurse, without the fragmentation of care with other professional categories, presupposed putting the nurse in an original, proper identity position. However, this study shows that, even recognizing the importance of direct care practice to the patient, qualified by his knowledge, the nurse feels incomplete, referring to the need to perform more complex and managerial activities to recognize, in fact, as nurses. Such evidence may be related to the model's implementation mode, since the organizational configuration and the way teamwork works must be fundamental elements of analysis so that there are transformations and innovation in daily life, considering the expectations of the authors involved[14].

It is assumed that the implementation of such a model should involve the entire health team, making it possible for the duties of each member of the multidisciplinary team to be clear and to be incorporated by the team so that each professional could mobilize their virtues and values in function of their practice and the common goal that is the patient.

The nurse, in the constant search for the *telos* of his practice, discourse about the importance of finding means in the institution that are compatible with the practice, as well as for the mobilization of the virtues, in the sense that the individual can carry out his practice with excellence, legitimizing it[3]. From the perspective of the Ethics of Virtue, virtues are devices that make the practice intelligible, guiding the individual to achieve the internal good of the profession[2]. Such virtues can be physical, which are related to the development of technical competence, as well as moral, related to the usefulness of this practice for society. In this regard, it should be noted that they are not ontological, being developed as habits and attitudes during training and professional practice[2]. Therefore, it is highlighted the need to reflect on the training processes of nurses in the daily routine of services that encourage the development of virtues compatible with the innovative care practice that reinforces and enhances the role of nursing as a profession, achieving social relevance.

The values cited as important for the performance of the practice by the nurses in the present study go beyond the principlism and deontological ethics, surpassing the morality of duty. It is not intended to deny the importance of morality in the execution of the nurse's practice, but considering the hermeneutics of virtue ethics, one also appreciates the subject's desire and need and accepts it as ethically important to decide and carry out the action for oneself[15]. Hence the importance of considering the whole team in the process of changing care models, as well as in the advent of their implementation.

The interaction inherent to the nurse's practice can be presented in an instructive way, followed by protocols or with a constructive intention that produces subjectivities[12]. Therein lies the power of the nurse in the transformation of care, since, assuming care as relational and as *telos* of practice, attitudes based on technical skills and, above all, on human values are accepted, promoting innovative practices. Such values, in the exercise of virtue, allow the individual to judge the right to be done, in place, at the right time and in the right way, not just being an exercise routinized by the application of rules and codes[2]. It is essential that the institution and service management recognize these issues by creating environments that stimulate and encourage the practice of nurses, since, with conditions to seek the *telos* of their practice, they will provide excellent care and in line with the their moral judgment, in addition to adhering to projects such as changing the care model.

FINAL CONSIDERATIONS

The practice of nurses in an Intensive Care Unit that adopts the bedside care model is related to the constant search for nurses in their *telos*, that is, care. In this sense, the bedside care model, which organizes nursing work, proved to be powerful for reaching the *telos*, configuring itself as an innovative and excellent practice regarding the possibility of directly caring for the patient, applying the nursing process, managing care, and overcoming the fragmentation of nursing care. The care is assumed, by the nurse, as proper to his profession and its implementation assumes the potential for advances in the professional field and in the quality of the assistance provided.

It should be noted that the care model presented in the present investigation when rescuing the bedside nurses' practice reveals contradictions regarding the technical division of work, demonstrating that there is ambiguity between the activities of the technician and the nurse, which are configured as forms of identity ruptures for the latter. This issue being the result of professional conflicts experienced by nurses and the lack of recognition that generates repercussions on their identity, it is demonstrated the importance of defining the roles and competences of each member of the multidisciplinary team in the performance scenarios. Such a gap presents itself as an organizational challenge for the qualification of actions in accordance with the care proposal sought by the institution's care model.

The present study presents as a limitation the choice of Ethics of virtue as an epistemological reference. This is because such a definition mobilizes the researcher not only to analyze the development of a practice, but for the immersion of what comprises that particular practice that differs from any other by its internal good (telos). Still, it stands out the limitation of studies that discuss the adoption of institutional models that guide the assistance and that organize the work of the nurse.

REFERENCES

1. Adamy EK, Zocche DAA, Almeida MA. Contribution of the nursing process for the construction of the identity of nursing professionals. Rev Gaúcha Enferm. 2020;41(spe):e20190143. doi: https://doi.org/10.1590/1983-1447.2020.20190143
2. MacIntyre A. After virtue. 3rd ed. Indiana: Notre Dame Press; 2007.
3. Caram CS, Peter E, Brito MJM . Invisibility of the self: reaching for the *telos* of nursing within a context of moral distress. Nurs Inq. 2019;26(1):e12269. doi: https://doi.org/10.1111/nin.12269
4. Caçador BS, Ramos FRS, Brito MJM. [The process of distress/moral suffering in nurses of Family Health Strategy: subjectivity and identity]. Enferm Foco. 2016;7(3/4):22-6. Portuguese. doi: https://doi.org/10.21675/2357-707X.2016.v7.n3/4.910
5. Gelbcke FL, Sousa VAF, Scherer MDA. From prescribed work to the real work of nursing in in-patient care units of federal university hospitals. Texto Contexto Enferm. 2019;28:e20170508. doi: https://doi.org/10.1590/1980-265x-tce-2017-0508
6. Fertonani HP, Pires DEP, Biff D, Scherer MDA. The health care model: concepts and challenges for primary health care in Brazil. Ciênc Saúde Coletiva. 2015;20(6):1869-78. doi: https://doi.org/10.1590/1413-81232015206.13272014
7. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2017;19(6):349-57. doi: https://doi.org/10.1093/intqhc/mzm042
8. Minayo MC. Scientificity, generalization and dissemination of qualitative studies. Ciênc Saúde Coletiva. 2017;22(1):16-7. doi: https://doi.org/10.1590/1413-81232017221.30302016
9. Bardin L. Análise de conteúdo. Ed. rev. e atual. Lisboa: Edições 70; 2009.
10. Caram CS, Rezende LC, Montenegro LC, Amaral JM, Brito MJ. [Ambiguities in the health team's work in the context of an intensive care unit]. Rev Sanare. 2016 [cited 2020 Jan 07];15(1):15-24. Portuguese. Available from: https://sanare.emnuvens.com.br/sanare/article/view/923/552
11. Santos KCB, Cavalcante TB, Ribeiro ASF, Alencar TRG, Fontenele AMM, Santos DMA. Implantation of the reference nurse model in a university hospital. Rev Enferm UFPE on line. 2019;13(1):268-74. doi: https://doi.org/10.5205/1981-8963-v13i1a236542p268-274-2019

12. Silva RC, Ferreira MA, Apostolidis T, Brandão MAG. A conceptual framework of clinical nursing care in intensive care. Rev Latino-Am Enfermagem. 2015;23(5):837-45. doi: https://doi.org/10.1590/0104-1169.0501.2622
13. Oliveira EM, Barbosa RL, Andolhe R, Eiras FRC, Padilha KG. Nursing practice environment and work satisfaction in critical units. Rev Bras Enferm. 2017;70(1):73-80. doi: https://doi.org/10.1590/0034-7167-2016-0211
14. Vilela GS, Ferraz CMLC, Moreira DA, Caram CS, Brito MJM. Nurse's identity construction in the face of the moral distress process in an intensive care unit. REME: Rev Min Enferm. 2020;24:e-1334. doi: https://doi.org/10.5935/1415.2762.20200071
15. Ferkany M, Newham R. A comparison of approaches to virtue for nursing ethics. Ethical Perspect. 2019;26(3):427-57. doi: https://doi.org/10.2143/EP.26.3.3287351

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