ORIGINAL ARTICLE

NURSES' POTENTIALITIES AND DIFFICULTIES IN IDENTIFYING CLINICAL DETERIORATION

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Highlights: (1). A reflective space on care practice and commitment to improvement. (2). Appreciation of the professionals who detailed the factors during the identification of CD. (3). Effective communication among the nursing team as a care potentiality.

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ABSTRACT

Objective: to analyze the strengths and challenges faced by nurses in identifying clinical deterioration in adult patients in a general medicine unit. **Methods:** a qualitative and descriptive study conducted at a university hospital in southern Brazil between March and June 2024. Sixteen nurses, selected through purposive sampling, participated. The data for this article were collected through participant observation and semi-structured interviews and analyzed using discursive textual analysis with the aid of IRAMUTEQ software. **Results:** The strengths identified included effective communication among the nursing team, the use of handover tools, early detection of clinical changes, and teamwork. The difficulties, on the other hand, were related to the absence of care protocols, structural and logistical limitations, a diverse patient population, high staff turnover and professional inexperience, failures in interprofessional communication, and demotivation at work. **Conclusion:** The identification of clinical deterioration is influenced by organizational and communication factors, as well as by nurses' professional experience, highlighting the need for institutional strategies that strengthen patient safety.

Keywords: Clinical Deterioration; Nursing Care; Hospital Care; Communication.

INTRODUCTION

Clinical deterioration (CD) is a condition of high severity for the health status of patients admitted to general medicine wards, as it involves hemodynamic changes in the body and physiological imbalances, in addition to changes in clinical and neurological parameters. Such changes may precede major adverse outcomes, such as unexpected death, cardiorespiratory arrest, sepsis, or the need for transfer to intensive care units. In this context, the timely recognition of clinical deterioration is a priority in the care provided by the nursing team[1].

Among the serious complications often preceded by CD, sepsis stands out; it is defined as a potentially fatal organ dysfunction resulting from a dysregulated host response to infection. This condition is associated with high mortality rates in Brazil, estimated at around 55% in intensive care units, making it a significant public health problem. This scenario underscores the need for continuous and qualified clinical monitoring in the hospital setting[2].

Meanwhile, early identification of CD in the hospital setting is crucial to ensuring rapid interventions and, consequently, minimizing mortality rates. To this end, the nursing team needs technical and scientific knowledge and experience to act effectively[3].

However, there are several challenges in this process, such as the lack of care protocols for assessment, institutional culture (including hierarchical relationships and inefficient management), lack of team cohesion, errors in vital sign documentation, communication difficulties, professional inexperience, and even inappropriate behavior for healthcare professionals. These obstacles can hinder the rapid and effective identification of CD, negatively impacting nursing practice and patients' clinical outcomes[4]. These factors can interfere with nurses' assessments, their recognition of signs of worsening disease progression, and their ability to make appropriate clinical judgments to establish priority strategies for directing patient care, thereby preventing complications and improving health indicators.

Therefore, given that the institution under study does not use early warning protocols or scales in this setting, the following research question arose: What strengths and challenges emerge in the process by which nurses recognize clinical deterioration in adult patients in an internal medicine unit? Thus, the present study aims to analyze the strengths and challenges nurses face in identifying clinical deterioration in adult patients within the setting of the medical clinic unit (UCM- in Portuguese) at a university hospital in southern Brazil.

METHOD

This is a descriptive qualitative study conducted to gain a more profound understanding of the opportunities and challenges present in the care setting for the identification of CD, with the aim of improving the quality of care and positively changing practice. In addition to highlighting existing shortcomings related to the phenomenon under study and fostering collective discussion with key stakeholders in the UCM's healthcare practice, the study sought to transform and contribute to the current reality within the work context[5].

The study was conducted at a medium-sized University Hospital located in southern Brazil, which serves as a referral center for infectious and contagious diseases, between March and June 2024. Sixteen nurses participated in this study, representing 73% of the nursing staff in the medical clinic unit. The inclusion criterion was having worked in the unit for at least one

month, and the exclusion criteria were nurses who were on vacation, on leave, or had been employed in the unit for less than one month.

During data collection, two nurses were on vacation, and four declined to participate in the study. Participant observation and semi-structured interviews were the strategies used to collect data for this article, which began after approval by the Ethics and Research Committee and the participants' signing of the Free and Informed Consent Form. Thus, anonymity, confidentiality of information, and the freedom to withdraw at any stage of the study were guaranteed, without any adverse consequences for the participants.

Observations of daily care routines at the UCM took place over a 15-day period, totaling 70 hours. The researcher's strategy was to begin observations before the start of the shift handoff for each shift (morning, afternoon, and night), a crucial moment for communication among nurses regarding significant changes in patients' conditions. Notes were recorded in a field journal to facilitate data documentation, ensuring the accuracy of the collected data.

The interviews were conducted with the aim of encouraging the staff to participate in this study; a rapport with the nurses was established even during the observation phase. A total of 16 interviews were conducted, guided by a structured interview guide; they were recorded on video and audio (using a cell phone for the recordings), with an average duration of 25 minutes each. The interviews took place in a private setting (the hospital's study room) and online; all were recorded to ensure the reliability of the collected data and were subsequently transcribed using Reshape software.

Discourse textual analysis (DTA) was used to analyze the data with the aid of the IRAMUTEQ software, which generated five classes based on analysis of text fragments from the corpus. It should be noted that DTA employed four focal points: dismantling the texts (deconstruction and unitarization), establishing relationships (categorization process), capturing emerging insights (expressing the understandings achieved), and a self-organized process (active learning)[6].

All provisions established in Resolution No. 510 of April 7, 2016, of the National Health Council were adhered to regarding the ethical aspects of research in the Humanities and Social Sciences field. The study was approved by the Research Ethics Committee of the Federal University of Rio Grande under opinion No. 5,829,209.

To ensure participant anonymity, an alphanumeric code (E—nurses) was used, based on the order of participation.

RESULTS

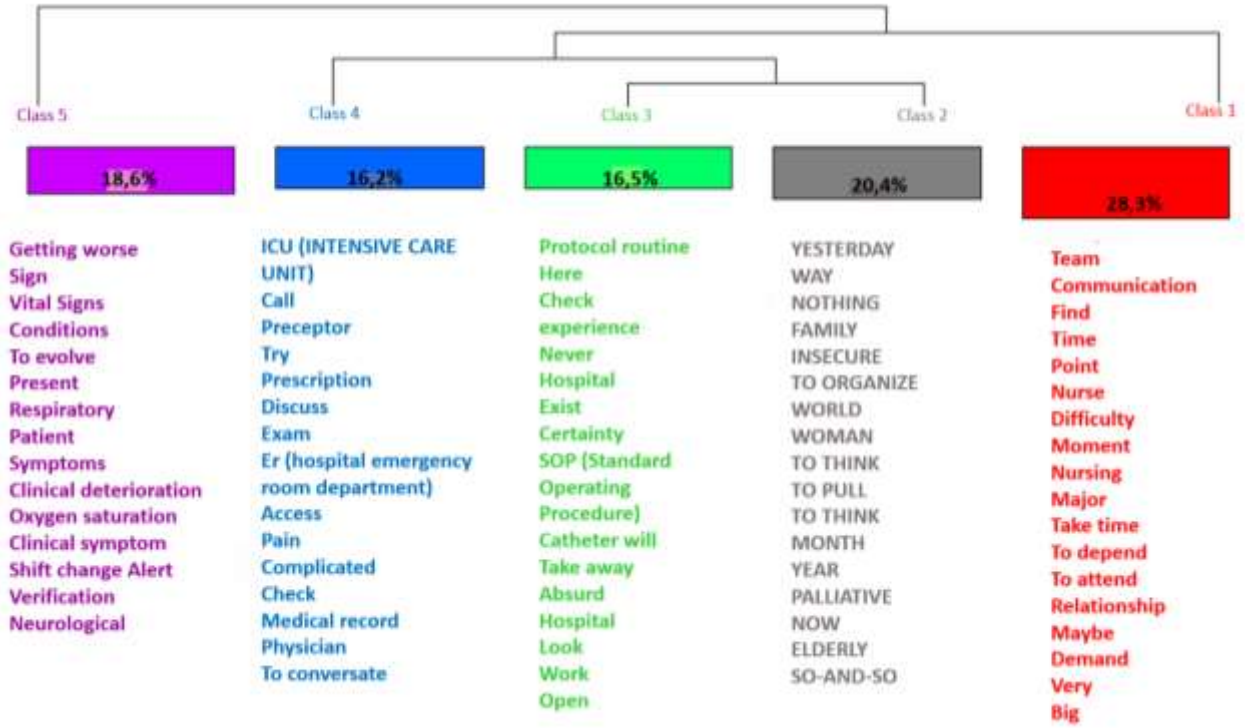
Regarding the participants' characteristics, ten nurses were female (62.5%) and six were male (37.5%); the mean age was 33.43 years, ranging from 28 to 46 years. Regarding the time since graduation, the average was 8.4 years, ranging from 4 to 20 years since completing the undergraduate nursing program; and the length of experience as nurses ranged from one year to 20 years, with an average of 7.6 years.

Among the participants, four nurses (25%) reported that their first experience providing care in a hospital setting occurred at UCM, and 100% of the nurses stated that they had not received any training or courses offered by the institution before beginning their work in the sector. However, 13 (81.3%) took the initiative to enroll in a course or training program shortly after beginning their nursing duties at UCM.

Between three months and one year after joining UCM, 14 nurses (87.5%) reported having completed training offered by the University Hospital; only one nurse noted that they had not received any training offered by the hospital. The nurses' length of service at UCM ranged from five months to three years.

The IRAMUTEQ descending hierarchical classification subdivided the operationalization into five classes, resulting in a total coverage of 89.19% derived from the 759 text segments (Figure 1).

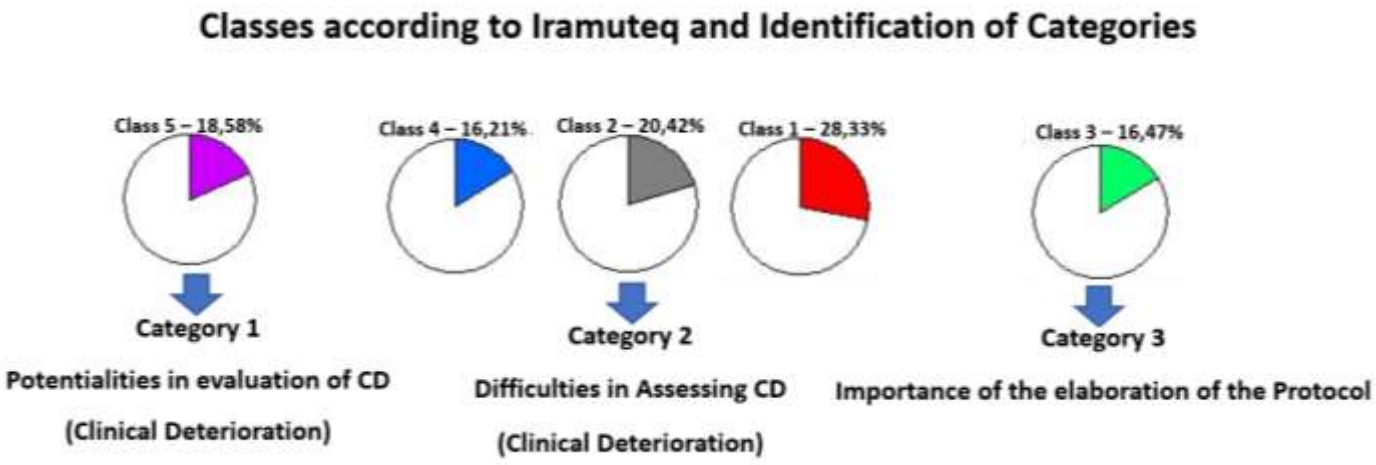
Figure 1- Classes generated by IRAMUTEQ. Rio Grande do Sul, 2024.



Source: study authors.

Three final categories emerged through DTA, following an analysis of the units of meaning generated from the text segments in the IRAMUTEQ dendrogram. Class three addresses points regarding the development of the protocol, which constitutes the category on "Importance for Protocol Development." The text segments that gave rise to the other two categories, meanwhile, address the potential and challenges involved in identifying CD, which are present in classes one, two, four, and five, and will be detailed in this article (Figures 1 and 2).

Figure 2- Classes generated by IRAMUTEQ and determination of categories. Rio Grande do Sul, 2024.



Source: study authors

Potential in the identification of clinical deterioration

Among the strategies for identifying CD, it was observed that communication among nurses is very effective during shift handoffs, facilitating the assessment of patients admitted to the UCM.

> During this shift handoff, some colleagues are great at pointing this out, and you can see exactly which patient you need to prioritize as your main patient. (N3).

> When we take over the shift, if this has already been identified by the previous team, it serves as a warning sign for us on the next shift. (N5).

One of the tools used by nurses in the process of assessing the CD is the shift handoff form, a spreadsheet containing patients' names, diagnoses, tests performed or pending, and the main changes that occurred during the shift. This is a strategy used by nurses to aid in the process of identifying CD, since its use during the shift handoff highlights information relevant to CD or possible complications.

> Because during the shift handoff, you note the things you consider essential [...], but the most important thing is the shift handoff chart. (N8).

The shift handoff is a priority; it's one of the most decisive moments. (N13).

There is greater collaboration between the nursing team and effective communication regarding nursing technicians' observations of deteriorating vital signs and changes in level of consciousness, just as nurses alert technicians to warning signs in patients who require closer attention—factors that may also indicate that the patient is beginning to experience CD.

> When the staff (nursing technicians) notice a change, they report it quickly; they come back to the station and let us know right away […] it's usually very fast, immediate […] that's really positive. (N11).

> I do a sort of triage among those who are in worse condition or at risk, and I identify which nursing technicians are responsible and let them know as well. (N8).

Evidence of hypotension/hypertension, hyperthermia, changes in heart rate patterns, as well as changes in respiratory patterns and a drop in oxygen saturation levels, are indicative of CD in patients. All of these observations are relevant to clinical decision-making, as well as to the need for oxygen therapy, to prevent potential complications.

> In cases of severe bradycardia or severe desaturation, the team steps in to monitor the patient because these patients are not being monitored; with the monitor, it becomes easier to identify the issue, and this is generally the standard approach. (N9).

> The patient is experiencing some difficulty, presenting with hypotension, a persistent fever, and respiratory distress. (N11).

The nursing team's assessment of changes in urine output, the risk of seizures, and precordial pain are key clinical indicators for the early detection of the CD process in patients.

> A patient with low urine output—you look at their actual waste products to get an idea of their renal deterioration, to see if their kidney function is worsening. (N6).

> There's no protocol for chest pain, and we have numerous patients. Even though we don't have a cardiology department here, we don't use protocols, so the team is left to its own devices and acts based on what we know, but there comes a point where we can't go any further. (N10).

Upon noticing signs of clinical deterioration, the team immediately springs into action and expedites the monitoring of this patient, a factor that directly aids in identifying and resolving the CD.

> In more severe cases, the nurse immediately brings the monitor [...] if the monitor isn't available, they try to get one from a neighboring clinic or use whatever they have [...] but they never leave the patient completely unattended. (N9).

> I see that the nursing staff is also quick to act when a patient shows signs of deterioration, stepping in to monitor that patient. (N5).

The pursuit of team-based care—working together with the multidisciplinary team to share information about patients' critical conditions, with respect and trust, where each member acts according to their specialty and contributes to the patient's care—enables complementary care and minimizes the risk of adverse events in patients with CD.

> I don't really have any complaints; whenever there's a complication, we're always able to call on the nursing assistants and even our fellow nurses as well. (N8).

> We have a very close working relationship with the physical therapists [...] we call them, discuss the blood gas results, or they'll come in to provide their care, then return to the clinic, call the nurse, and say, "Let's talk to the doctor to request a blood gas test because I think this patient might develop complications." (N3).

For the effective assessment of patients with CD who are at high risk of progressing to cardiopulmonary arrest, it is essential that the team collectively and responsibly establish the procedures to be followed, teamwork practices, training, care protocols during cardiopulmonary resuscitation, and the team's response during this emergency.

> We had these training sessions quite frequently, and the team had been working together for a long time already [...] there was very good team chemistry. (N11).

> One positive aspect of the UCM is that, since we have more nursing colleagues compared to other departments—we have three or four nurses, when a complication arises, one of the benefits is that we help each other a lot. (N2).

Difficulties in Identifying Clinical Deterioration

Among the difficulties observed, the characteristics of the unit and the hospital directly impact nurses' planning of interventions, such as the unit's physical structure and logistical support, as well as the shortage of backup intensive care unit (ICU) beds (an adult ICU with only six beds, some of which are occasionally out of service due to structural problems).

> Sometimes there are issues related to the unit itself; sometimes the patient is in a bed that lacks a gauze partition or the partition isn't working—these are logistical issues specific to the unit. (N8).

> During the last three shifts, we've had to care for at least one intubated patient because there were no available beds in the ICU. (N4).

The UCM is characterized as a critical care unit; it treats patients with a wide range of clinical conditions, comprising a mixed profile of inpatients with a high percentage of those susceptible to social vulnerability factors. Also noteworthy is the complex daily routine involved in caring for this patient population, which requires careful monitoring to maintain their physiological conditions within normal parameters.

> The ICU is different; it's unique, and to manage a ward where you have 41 inpatients, 26 or 27 of whom are bedridden. (N4).

> Difficulties in identifying clinical deterioration were sometimes masked by the patient's diagnosis […] sometimes the patient's oxygen saturation drops, and we assume that this saturation level is simply part of their clinical condition, and the patient then progresses to CPR (cardiac arrest) as well. (N9).

Every day, the nursing team's activities begin with the arrival of staff at the scheduled times for shift changes across the different shifts: morning (7 a.m.), afternoon (1 p.m.), and night (7 p.m.). Thus, the shift handoff involves the exchange of information between nurses and between nursing technicians. After the shift handoff, adjustments are made to the daily nursing schedule, causing disorganization at the start of activities. This affects the organization of nursing activities and the ability to assess the patient's condition more accurately during the first hours of the shift, indicating a lack of operational efficiency for the team until the daily schedule is finalized.

> Another issue that causes disruption is the delay in finalizing the daily nursing schedule [...] due to changes in patients and their clinical status or changes in the number of nursing technicians; we have to make adjustments, which takes a lot of time at the start of the shift, while meanwhile, the nurses handle the demands. (N12).

During this observation period and while conducting the interviews, we observed high turnover among the nursing staff, a factor that compromises daily care, staffing levels, team cohesion, and, consequently, the attention required to identify the CD.

> Because it's a sector with high staff turnover [..] new employees end up arriving, and some of the team chemistry that was there gets lost. (N11).

> And right now, here at the UCM, we have a smaller team than we used to have. It's still a large team, but it's smaller than it was before. (N4).

In addition to the impacts caused by staff turnover, there is a lack of protocols at the facility, a lack of established procedures, and the absence of an early-warning system that alerts staff to critical vital signs. These factors increase the risk of adverse events and influence the process of assessing the level of care, as staff members end up acting solely based on their experience. One must also consider the professionals with little or no clinical experience who are admitted to the UCM, a fact that hinders an effective assessment of patients' CD, creating uncertainty during the initial encounter—especially given the complexity of the field.

> We don't have protocols; the tools we use are the Braden and Morse scales, along with other assessment tools […] we don't have a protocol that provides the tools to help us recognize when a patient isn't progressing well. (N4).

> Occasionally the lack of experience, [...] when I arrived at the ICU, I was coming from 12 years of primary care [...] and knew next to nothing about what hospital care actually entailed. (N3).

> I had no experience; I have a bit of difficulty. (N13).

The different attitudes and behaviors exhibited by professionals joining UCM negatively influence the CD assessment process, a situation that arises due to the lack of a tool to guide their actions.

> The team is left to its own devices and does things based on what we know, but there comes a point where we can't go any further […] each of us relies more on our clinical experience, on what we've been through, on our experience. (N10).

> Because no matter how much experience a person has, sometimes things go unnoticed. (N11).

Inconsistencies in information, missing or incomplete entries in medical records, and the need to improve communication between the nursing staff and the multidisciplinary team are ongoing issues in the daily routine of the UCM. Problems related to communication directly affect the quality of care, a fact that can cause harm to patients undergoing CD.

> There's a difficulty in passing on information [...] and also a lack of communication [...]. Is this written down? Was it discussed with the family? So even when this recommendation exists, nothing is documented. (N4).

> We need to improve this interdisciplinary communication among all team members so that we can understand what each person is saying. (N10).

Updates to protocols and changes to the treatment plan must be properly communicated, made available, and easily accessible to the nursing staff, since direct patient care is provided by nurses and nursing technicians.

> Communication between doctors and nurses is a problem, because they identify an issue, request something—an urgent procedure or something—and we sometimes don't even know [...] the lack of communication from the medical team is a problem. (N13).

> [...] if there were more effective communication between the nursing team and the medical team, I think it would help a lot to predict when a patient's condition is worsening and to identify this clinical deterioration early on. (N11).

The lack of respect and professional recognition for nursing on the part of some members of the medical team can lead to feelings of hopelessness, fear, and insecurity. The difficulties experienced by nurses in caring for patients' CD due to this disharmonious relationship are negative factors for the professional routine, which generates a feeling of devaluation, fear, deviation of function, abandonment, limitation, shame, dissatisfaction and impotence. All these factors corroborate professional demotivation.

> And what about the patient's medical history? It's those connections—you know, I really miss that here. People don't piece the information together to guide care, but no, it's just an isolated piece of information [...] you can't establish a basis for diagnosis and treatment—it's simply so absurd; it scares me. (N1).

> I keep feeling quite helpless; I think the feeling is definitely one of helplessness—of not being able to be decisive. (N11).

Such conditions, which affect the physical and mental health of nursing professionals, also come to light when the team observes or experiences inappropriate and inconsistent care practices, such as delayed actions and prolonged decision-making during CD.

> But I think the most difficult challenge is taking action in the moment, in a more skillful way—you know, sometimes I get the feeling that they delay things, take too long to take action, and you have nowhere to run. (N6).

> Our biggest problem is intervention, so we've been communicating […] I think that's precisely the biggest problem—being able to intervene at exactly the right moment so that the situation doesn't get worse. (N10).

The insecurity of the team and the speed of intercurrences to adopt a conduct at the time of CD is a factor that worsens due to the lack of protocols.

> So there's a serious lack of medical guidance and reassurance from the colleagues we work with as well […] a lot of people are just left there, at a loss, not knowing what to do during CPR […] in my experience, the general lack of protocols is what makes providing care the most difficult. (N1).

> When we have a protocol, we don't just wait for the doctor; we're able to move more quickly during the intervention […] we don't use protocols, so the team is left to their

> own devices and acts based on what we know, but there comes a point where we can't go any further. (N10).

Another challenge highlighted by the nurses is the lack of established procedural protocols and care guidelines for cardiopulmonary resuscitation, as well as a lack of coordination among team members during emergencies.

> […] I think CPR is extremely important […] it's a recurring event in the UCM; it's an event that gives advance warning, yet few people are prepared to act […] if you have a CPR situation there, a CPR protocol—stop and ask, "What does a CPR protocol look like?" Most won't know how to answer; everyone is at a loss, including the doctors. (N1).

> I think that during a CPR, team coordination is a challenge […] so they have a theoretical component, a very high level of theoretical knowledge, but I think the difficulty in coordinating with the entire team sometimes results in two or three people unnecessarily repeating the same activity. (N11).

Teamwork must be a priority in a medical clinic with a mixed and complex patient population, as is the case at the site of this study, serving as a strategy to address this complexity and the challenges it entails. To achieve this, effective communication among team members is essential, as is maintaining respectful relationships, valuing the potential of each professional working in the sector, and developing a treatment plan that addresses patients' needs.

> "Because the team needs to be a little more aligned and cohesive […] the lack of alignment among the team is one of the things I still struggle with." (N3).

> "First, I look at the team as a whole; if the team isn't cohesive and the entire team doesn't share a common understanding of things, it doesn't matter if you have the best doctor or the best nurse there." (N4).

DISCUSSION

The professional experience of nurses working in the UCM was reported as a facilitating factor during the identification of CD, as was their assistance in supporting professionals with less clinical experience. In addition to professional experience, it is emphasized that having

complementary training that broadens their scientific knowledge, along with an ethical commitment to their profession—enabling them to make clinical judgments supported by signs of deterioration—facilitates and expedites action during the CD[7].

Thus, strategies such as providing a guide with instructions for novices and less experienced professionals could aid in this process, as suggested by studies already published in the literature. It should be noted that the proposal to adopt institutional protocols also takes the form of a strategy that can positively facilitate the adaptation of new professionals[8-9].

Something that complements improvements in the workplace is the adoption of effective team communication; even in health care settings, communication is a key resource for establishing safe and high-quality care measures. However, communication breakdowns within the multidisciplinary team, particularly between nurses and physicians, were identified during the observation and widely described by nurses as a cause for concern, which can lead to administrative problems and adverse events, such as incorrect procedures or misdiagnoses[10].

Despite communication gaps within the multidisciplinary team, an area of strength was observed in the identification of CD through more robust communication among the nursing staff. The nursing assistants, who are on the front lines of patient care, relay key changes in patients' conditions to the nurses, enabling targeted and prioritized care for patients requiring the closest monitoring—a practice that enhances patient care, quality, and safety. These communication arrangements and their effectiveness are crucial for optimizing the time spent on patient care, thereby increasing the time available in the care setting[11].

The shift handoff, medical rounds (known at UCM as "rounds"), and the briefing on shift events (vital signs, complaints, changes in urine output) between technicians and nurses are key moments for exchanging relevant and important information regarding the continuity of care, complications, and changes in treatment. When conducted in an organized and structured manner, these activities facilitate communication that helps prevent gaps in the care process, promoting continuity and safety of care. It should be noted that gaps in team communication are directly related to challenges in preventing cases of cardiopulmonary arrest[12-13].

In addition, the use of the shift handoff chart is a tool used by the nursing team that flags changes consistent with the CD and enhances patient safety measures. It is understood that the pursuit of standardization, with the help of tools or protocols, supports and provides greater

safety for the nursing team's management and actions, which improves the quality of continuity of care focused on the priorities of patients who require more attention[14].

Both communication among nurses and the handoff between shifts for the early identification of CD are factors that align with findings in the international literature, which highlight continuous monitoring and structured information exchange as fundamental elements for the timely recognition of clinical complications. Furthermore, the use of tools—such as early warning systems and escalation protocols—that are integrated into daily work routines contributes to greater responsiveness and effectiveness in managing CD[1].

As for hindering factors, issues related to the facility's physical structure, the lack of protocols, logistical limitations, and insufficient equipment emerged, all of which directly interfere with care planning and continuity during hospitalization.

Care processes, as well as their quality and safety, are directly influenced by the physical space of hospital units, negatively impacting care practices and staff satisfaction, in addition to affecting patient safety[15]. Evidence suggests that a lack of standardization, variability in clinical practices, and exclusive reliance on individual experience can delay the identification of and response to clinical deterioration, in addition to increasing staff insecurity[1].

Another characteristic noted about the UCM was the mixed profile of its inpatients; in addition to serving as an extension of the hospital's emergency department, it is the destination for surgical patients who develop complications. There is also a predominance of socially vulnerable patients suffering from infectious and contagious diseases who require recurrent hospitalizations. The hospital, the setting for this study, is a regional referral center for the treatment of infectious and contagious diseases and their complications. This patient profile is associated with a higher probability of mortality, a fact corroborated by a study indicating a higher proportion of deaths among patients hospitalized for infectious and parasitic diseases[16].

Consequently, there is heightened vigilance among professionals working in the UCM, particularly among nursing staff, as this team plays a key role in monitoring complications. Measures such as greater monitoring of vital signs and the development of strategies to prevent healthcare-associated infections are necessary, with an emphasis on measures backed by scientific evidence, such as the use of protocols and *bundles*. The scale used to assess CD is based precisely on increased monitoring of vital signs, highlighting the importance of the protocol from this study for the UCM[16].

One issue frequently raised by nurses was the time required to prepare the daily nursing task assignment schedule and workload for the UCM, a task that takes up a significant amount of nurses' time—both in preparing it in advance (beginning the previous afternoon) and in finalizing it the following morning, right at the start of their shift. This staff allocation is also directly related to the potential to minimize costs, reduce the risk of complications associated with healthcare, and improve patient safety measures—reasons that further justify its complexity[17].

As for the workload in patient care, due to the number of critically ill, bedridden, or dependent patients, there is the potential for psychological and physical distress among the staff. It is necessary to analyze the degree of dissatisfaction and satisfaction among professionals in the sector regarding working conditions, as this may reflect a greater burden of emotional and functional factors affecting the team[17].

Staff turnover is another characteristic of the study setting; this factor hinders efforts to achieve progressive improvement in the sector, interferes with the continuing education process, and affects the safety culture, thereby increasing the responsibilities and demands on the professionals who remain on the team. Data on the employment profile of the study participants indicate significant turnover, as evidenced by the fact that 77.3% of UCM nurses had been working at the institution for one to three full years[18-19].

Studies addressing the impacts of turnover and professional inexperience on the identification of CD show that collaboration among professionals and teamwork among nurses with different levels of training and experience influence the ability to obtain a comprehensive view of the problem, as well as to recognize signs of worsening conditions, particularly in the context of an internal medicine unit. This evidence reinforces the need for institutional strategies for onboarding and continuing education to reduce variations in the assessment of clinical cases and strengthen clinical judgment[9].

The contributions of this study to clinical practice revolve around the need for investments in continuing education strategies (discussion of clinical cases or practical exercises involving simulations); the implementation of protocols tailored to the institutional context, with a focus on staff adherence and training; the strengthening of shift handoffs and tools that standardize information on patients' clinical conditions; and, finally, strategies for improved communication among the multidisciplinary team. Such strategies, combined with clear implementation policies, integration into work routines, and institutional support, can

positively influence nursing practices and the resolution of chronic disease and its complications[9].

This study expands our understanding by presenting the reality of a UCM that does not adopt standardization strategies or use early warning scales to identify CD, highlighting how opportunities and challenges intertwine in this process. By demonstrating the importance of communication among the multidisciplinary team and of shift handoff protocols, as well as the impacts of the absence of protocols, staff turnover, organizational limitations, and communication breakdowns among team members, the findings elucidate how these factors interact and correlate within the nursing team's work process. Thus, the study provides a basis for planning viable interventions, particularly those related to standardizing care and continuing education, thereby contributing to the improvement of clinical monitoring and the escalation of care in similar healthcare settings[1].

A limitation of the study is that it was conducted at only one university hospital. However, it is believed that the contributions of this study to the context under investigation go beyond the development of a care protocol as a care-and-education tool, as the research facilitated moments of integration, free expression, active listening, acceptance, reflection, and appreciation, as well as care-related actions, such as health education. It was a moment in which the participants were encouraged to expose their perceptions and feelings, under the guarantee of anonymity and exemption from judgment. In addition, the debate around the themes and the contact with the perception of the other made it possible to mobilize reflection on one's own life, health and work.

CONCLUSION

Understanding the challenges and opportunities experienced by nurses when identifying clinical deterioration in a general practice setting, through observation and interviews, was essential, as it provided a space for reflection on care practice and a commitment to improvement and positive change, as well as an opportunity to listen to and support these professionals.

The study demonstrated that the identification of clinical deterioration in general practice settings is shaped by opportunities related to communication and teamwork, as well as

by challenges associated with the lack of protocols, structural limitations, and organizational challenges.

These findings support the need for institutional investments in strategies that promote standardized care, professional training, and effective communication among teams, thereby contributing to patient safety and improved clinical outcomes.

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NURSES' POTENTIALITIES AND DIFFICULTIES IN IDENTIFYING CLINICAL DETERIORATION

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