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REFACS

Dimensions of quality of life at work: representations of nursing teams in a hospital environment

Dimensões da qualidade de vida no trabalho: representações de equipes de enfermagem em ambiente hospitalar

Dimensiones de la calidad de vida en el trabajo: representaciones de los equipos de enfermería en el entorno hospitalario

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This is a qualitative research carried out in a federal public hospital in the interior of the state of Minas Gerais, Brazil, in 2017. The study aimed to analyze the representations of nursing teams in a federal teaching hospital about the constituent dimensions of quality of life at work. A sociodemographic questionnaire and interview with semi-structured evocation test were used. In data exploration and analysis, descriptive statistics and content analysis were used. 45 nursing workers were surveyed, most of which were women - nurses (17.8%), nursing technicians (57.8%) and nursing assistants (24.4%). Participants made it clear they knew actions aimed at quality of life at work and highlighted individual search and in external contexts to take care of their health. The paradox that arises for workers in general, and hospital nursing teams in particular, lies in the representation that work can produce illness and suffering, an important space for the performance of workers' health.
Descriptors: Quality of life; Occupational health; Job satisfaction. Nursing, Team

Esta é uma pesquisa qualitativa realizada em um hospital público federal do interior de Minas Gerais em 2017, com o objetivo de analisar as representações de equipes de enfermagem de um hospital federal de ensino acerca das dimensões constituintes da qualidade de vida no trabalho. Utilizou-se questionário sociodemográfico e entrevista com teste de evocação semiestruturado. Na exploração e análise de dados foram empregadas a estatística descritiva e análise de conteúdo. Pesquisou-se 45 trabalhadores de enfermagem, na sua maioria mulheres – enfermeiros (17,8%), técnicos de enfermagem (57,8%) e auxiliares de enfermagem (24,4%). Os participantes explicitaram conhecer ações voltadas à qualidade de vida no trabalho e destacaram a busca individual e em contextos externos para cuidar de sua saúde. O paradoxo que se coloca aos trabalhadores em geral, e às equipes de Enfermagem hospitalar em particular, reside na representação de que o trabalho pode produzir adoecimento e sofrimento, o que se constitui em importante espaço para a atuação da saúde do trabalhador.
Descritores: Qualidade de vida; Saúde do trabalhador; Satisfação no emprego; Equipe de enfermagem

Esta es una encuesta cualitativa realizada en un hospital público federal del interior de Minas Gerais, Brasil, en 2017, con el objetivo de analizar las representaciones de los equipos de enfermería de un hospital universitario federal de las dimensiones constitutivas de la calidad de vida en el trabajo. Se utilizó un cuestionario sociodemográfico y una entrevista con una prueba de evocación semiestructurada. Se utilizaron estadísticas descriptivas y análisis de contenido en la exploración y el análisis de los datos. Se investigó a 45 trabajadores de enfermería, en su mayoría mujeres - enfermeros (17,8%), técnicos de enfermería (57,8%) y auxiliares de enfermería (24,4%). Los participantes dijeron conocer las acciones centradas en la calidad de vida en el trabajo y destacaron la búsqueda individual y en contextos externos para cuidar de su salud. La paradoja para los trabajadores en general, y para los equipos de Enfermería hospitalaria en particular, radica en la representación de que el trabajo puede producir enfermedad y sufrimiento, un espacio importante para la acción de la salud del trabajador.
Descriptores: Calidad de vida; Salud laboral. Satisfacción en el trabajo; Grupo de enfermeira.

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INTRODUCTION

Quality of Life (QoL) is intrinsically related to the well-being and satisfaction of each person. It reveals how, in each socio-cultural context, members of society assess the standard of well-being and comfort they have[1,2].

Since the 1990s, academic production on quality of life has intensified, mainly due to the work of the World Health Organization Quality of Life Assessment (WHOQOL)[2]. The consolidation of studies on QoL contributed to the resumption of research on Quality Working Life (QWL), which is a concept originated in England, in the 1950s, when a study took place on the existing relationships between individual-work-organization that resulted in the so-called sociotechnical approach of organization of work[3].

Since then, approaches to QWL have taken place with contributions from different sciences and under strong influence of social and economic contexts in which they developed. There was an increase in academic production and, also, its sedimentation in management[4].

Although QWL is a polysemic concept, the common factor among approaches seems to be the recognition of the importance of the workers' perspective in understanding work in organizations and the impacts of QWL on work and organizations[4-6]. QWL is related to issues concerning new technologies and forms of organization and dialogue, among others, with notions of health and safety at work, satisfaction and motivation[7].

The QWL approach has taken place in research involving different professional categories[4,5,8]. This approach explores the potential of nursing professionals due to its magnitude as a workforce in health services[9,10] and the impacts of QWL on the health and work of these workers[11] and, consequently, on the service provided to users.

The Instituto Brasileiro de Geografia e Estatística[9] - IBGE (Brazilian Institute of Geography and Statistics) of 2015 estimated that the health area would be composed of 3.5 million workers, including active and retired professionals, of which approximately 50% worked in nursing. Of these, 80% were nursing technicians and assistants, and 20% were nurses.

In a review work[12] on Brazilian nursing production, there was an indication on the use of seven different instruments in research, among which the Professional Satisfaction Index stood out. Although there was no consensus on the conceptualization of QWL, professional satisfaction was highlighted in the approaches[12].

In order to contribute to the consolidation of studies with hospital nurses, the Instrument for the Evaluation of Quality Working Life of Nurses in Hospitals (IEQWLN) was reduced to four domains: *Identity and professional image*; *Working conditions, safety and remuneration*; *Institutional appreciation and recognition*; *Integration with the team*[11]. Thus, it is important to ensure that subjective and objective aspects present in the context of practice and in the perception of workers are addressed, which contributes to apprehending the specificities of the QWL of the profession[11].

In the light of the contributions of academic production, to explore representations of professionals from nursing teams who work in a hospital environment, this study considers QWL as a set of dimensions: social, cognitive, emotional, structural, economic and health conditions.

The option of not adopting a QWL assessment instrument is related to the interest in approaching social representations of nursing team workers in their own terms, with a critical perspective on the quality of life at work and with the sedimentation of studies in the field of workers health.

Thus, this study aims to analyze representations of nursing teams from a federal teaching hospital about the constituent dimensions of quality of life at work.

METHOD

It is a descriptive research developed with a qualitative method[13]. The study scenario was a large federal teaching hospital in the state of Minas Gerais, a reference in an expanded health region whose care is provided by the Sistema Único de Saúde - SUS (Unified Health System).

Nurses, technicians and nursing assistants participated in the study, according to the Código Brasileiro Ocupacional - CBO (Brazilian Occupations Code), which provided direct care to users and were assigned to the Medical Clinic infirmary of that hospital.

Participants were recruited along their respective work schedules (morning, afternoon and evening), obtained from the hospital management sector. The inclusion criteria were: to be a professional on the nursing team in the Infirmary of the Medical Clinic sector; regardless of age, gender, education and work shift. Exclusion criteria consisted of: being on vacation or being away for health reasons.

Aiming at the socioeconomic characterization of the study participants, a questionnaire was prepared with questions related to age, gender, self-declaration of color, marital status, education, number of children, family income, amount of time working in the health area, employment relationships, weekly workload and work shift. The team performed double data entry using Microsoft Office Excel® software.

The constitutive dimensions of QWL were outlined as follows: *social* (work relationships, quality of services provided, impacts of work on community life); *cognitive* (personal and technological knowledge); *emotional* (satisfaction, personal fulfillment, professional growth); *structural* (working conditions that promote the development of cognitive and emotional aspects); *economic* (better income, consumption of comfort items) and *health conditions* (physical and mental health of professionals).

For the construction of data on the constitutive dimensions of QWL, the team prepared a Evocation Semi-structured Test (*Teste de Evocação Semi-Estruturado - TESE*) as proposed by Brabo and Gomes[8]. The TESE is considered as a technique "of identification and characterization of social representations" whose questions are designed to capture evocations of "components of the structure of possible social representations", which are[8]:

i. *Conceptual* (has to do with; is; are): words that, theoretically, can explain the concepts and/or stereotypes directly associated with the term inducer;

ii. *Attitudinal* (it is important for): words that, theoretically, explain values (positive or negative) that the term inducer awakens in the individual;

iii. *Prescriptive* (need/s): words that, theoretically, explain the gaps/flaws perceived by individuals in relation to the term inducer.

Following this proposal, the TESE employed in the research was composed of three guiding questions: *What is QWL?* (conceptual); *What to do to obtain QWL?* (attitudinal) e *What can be done to obtain QWL?* (prescriptive). The application of the questionnaire and the interview guided by TESE lasted, on average, 25 minutes. The analytical process of the data obtained with TESE is exemplified in Table 1.

To ensure confidentiality and privacy regarding participants, numbers were assigned in order to collect data. In evocations, abbreviations are used (N. for nurses; N.T. for nursing technicians and N.A. for nursing assistants), followed by the number assigned to the participant.

Table 1. Examples in the analytical process of the data obtained from interviews to detail the dimensions of the QWL. Federal teaching hospital in the interior of Minas Gerais, 2017.

Part.	Profession	Gender	Answer to question	Codes	Dimensions of QWL
17	N.T.	F	**1 – Concept of QWL** For quality of working life, the first thing the person has to be is in good health, really good. If there is a health issue, there is no productivity. Having good communication with colleagues, having a good relationship, having good material to work with, this is very important.	Infrastructure; Team work; Material resources; Safety.	Social; Emotional; Health conditions.
10	N.T.	F	**2 – Attitude towards QWL** Yes, the person has to have a good balance on a daily basis, eat well, sleep, have a good relationship.	Balance; Food; Rest; Good relationships.	Social; Emotional; Structural; Economic.
11	N.A.	F	**3 – Prescriptive for QWL** More exchanges of ideas in the work sector itself. You know, it's innovating things. Today I think there is a lack of updating techniques, procedures, communication, patient assessment and information.	Communicability; Create; Update – techniques; Ability to evaluate.	Social; Cognitive; Structural; Economic.

Key: Part. – Participant; N. – Nurse; N.T. – Nursing Technitian; N.A.- Nursing Assistant

This article explores how dimensions of QWL (social; cognitive; emotional; structural; economic and health conditions) are related by participants to the conceptual, attitudinal and prescriptive components obtained with TESE. Data exploration and analysis occurred with descriptive statistics and content analysis[14].

To visualize the quantitative results of the study, we used the Radar type chart, also known as "spidergram", of a star or Kiviat diagram[15]. This graphic strategy demonstrates high potential for showing the distribution of data among dimensions, observing the development of dimensions in terms of solving a problem; compare different categories with each other and observe their scope, without hierarchizing them[16], as they all make up the constitutive scenario of QWL for the participants.

In an attempt to apply this strategy to the context of this study and based on a review that analyzes characteristics of QWL and health of nursing professionals[12], the following dimensions were outlined: social, cognitive, emotional, structural, economic and health conditions.

The social dimension presents the importance of interactions between participants, both in professional and family context. This dimension had as agglutinating themes: teamwork, meetings, family life, activities outside of the hospital, socializing, interpersonal interaction and team unity.

The cognitive dimension seeks to highlight the place of importance of continuing education for nursing teams and explores topics such as education, information update, training, courses, qualification, access to postgraduate education and improvement.

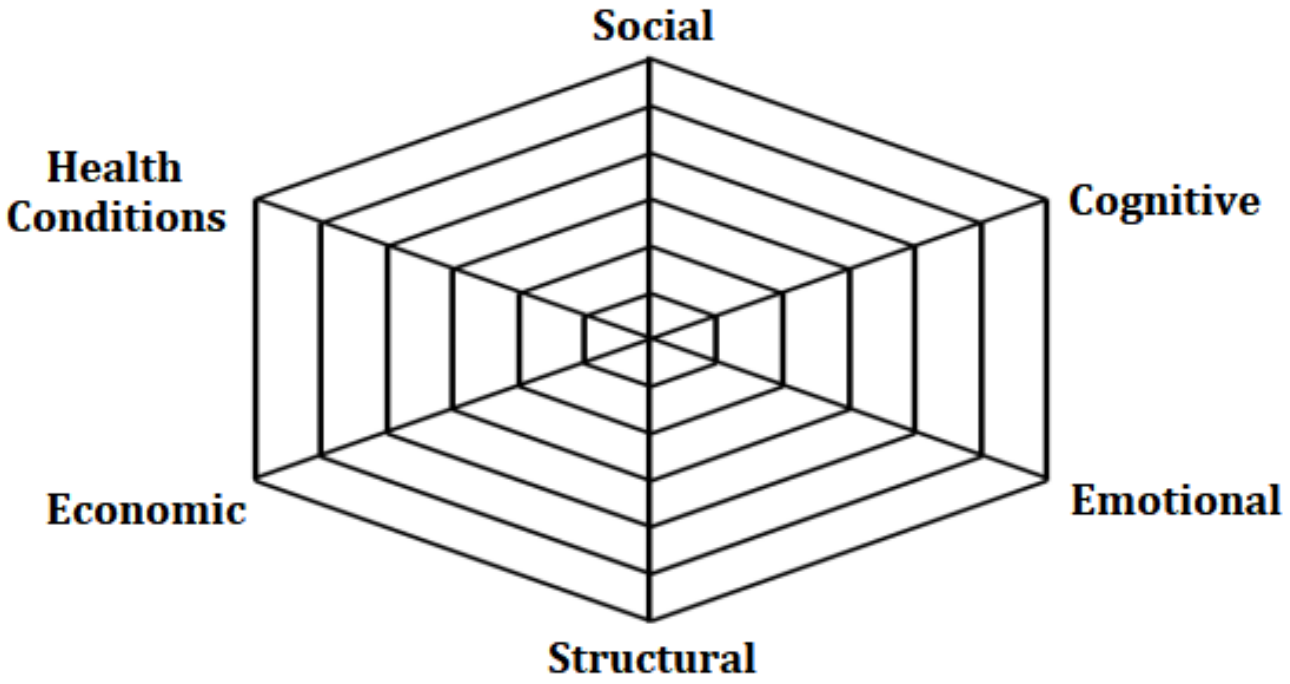
The emotional dimension is related to the teams' self-perception in situations that promote all sorts of feelings that influence QWL, such as: satisfaction, well-being, appreciation of the profession (incentives), welcoming, therapeutic monitoring, stress and promotion of self-esteem.

The structural dimension focuses on those aspects that directly influence QWL, the cause of which is generally beyond the reach of professionals, although they affect the performance of their activities in the work environment. In this dimension, they are contained: assistance to the worker, scarcity of inputs, undersizing of the teams, equivalent remuneration and reduction of the workload.

The economic dimension refers to the possibility of immediate consumption of individual

and/or family comfort items, remuneration/wage appreciation. And the health conditions are related to the work environment, which risks (chemical, physical, biological, environmental) are placed in situations that affect workers in their health-disease process, individually or collectively. Access to various materials for carrying out the activities, without improvisation, provision of resources, maintenance of equipment, safety and ergonomics make up this dimension. In Figure 1, the axes start from the center towards the edge of the graph, and these are the constituent dimensions of QWL.

Figure 1. Constitutive dimensions of Quality of Life at Work. Teaching Hospital in the interior of Minas Gerais, 2017.



The lines that will form a polygon will be determined by the number of citations of the participants to that question/category, composing a line; and the same lines connect to each other[16]. The evaluation of QWL is observed by approaching the ends of the polygon formed on the Radar. Thus, the larger the area of the figure built towards the extremities, the better the hospital's performance regarding the characteristic under analysis.

At the same time, an asymmetric polygon reveals that the hospital, in the participants' understanding, has performed better in one of the characteristics of the QWL, since one of its ends is closer to the Radar edge than the other.

Based on the analytical process, three network graphs were built, one for each TESE question. Here, the analysis reflects the strengths, weaknesses and priorities of the dimensions displayed in the graphs for the research participants and allows to assess, for example, which aspect deserves more attention when conducting participatory processes in decision making[15]. The research was approved by the Research Ethics Committee under CAAE 67537917.5.0000.5154.

RESULTS

Sixty professionals were eligible to participate in the study. After individual contact and invitation, 45 professionals joined the research, of which: nurses (17.8%), nursing technicians (57.8%) and nursing assistants (24.4%). Table 1 shows the sociodemographic and professional characterization of the nursing teams members in the Medical Clinic sector who participated in the study.

Among the study participants, the majority were female (86.7%), self-declared white

(51.1%), married (55.6%), with children (71.1%), with a specialization course (44.4%), working in the health field for 11 years or more (48.9%), with only one statutory job (84.4%) and with a weekly workload of 40 hours; family income between 4 to 6 minimum wages (57.8%). Regarding age, workers predominated in the age group between 41 and 60 years (42.4%), varying between 25 and 63 years (Table 1).

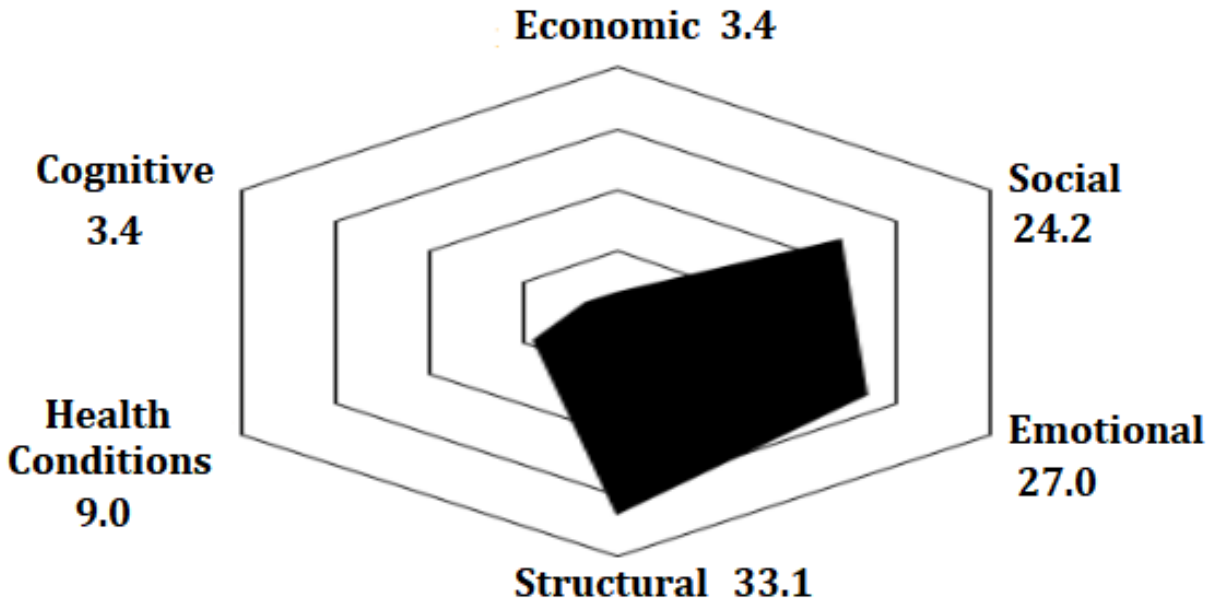
Table 1. Sociodemographic characterization of nursing teams from a federal teaching hospital in the interior of Minas Gerais, 2017.

Variables	N	%
Gender		
Female	39	86.7%
Male	06	13.3%
Self-declared color		
White	23	51.1%
Black	10	22.2%
Brown (mixed raced)	10	22.2%
Yellow (Asian)	02	4.4%
Age		
Up to 30 years old	05	11.1%
Between 31 and 40 years old	18	40.0%
Between 41 and 60 years old	19	42.2%
61 years old or more	03	6.7%
Marital status		
Married/civil union	25	55.6%
Single	12	26.7%
Separated/divorced	06	13.3%
Widowed	02	4.4%
Education		
High school	03	6.7%
High/technical school	12	26.7%
Higher education	06	13.3%
Specialization	20	44.4%
Masters	04	8.9%
Family income (in minimum wages)		
Up to 3	07	15.6%
Between 4 and 6	26	57.8%
Between 7 and 8	08	17.8%
9 or more	04	8.9%
Time working in the health field		
Up to 3 years	03	6.7%
Between 4 and 6 years	15	33.3%
Between 7 and 10 years	05	11.1%
11 years or more	22	48.9%
Employment links		
One	38	84.4%
Two	06	13.4%
Threes	01	2.2%
Work shifts		
Morning	19	42.2%
Afternoon	12	26.7%
Night	14	31.1%

With the use of network graphics, the 459 codes referring to the elements that make up the notions that make up the QWL identified in the TESE analysis were distributed, as described in Graph 1. In all questions, the most cited element was structural , followed by emotional; this being the second most cited only in the 1st Question, which evokes the Concept of QWL, as shown in Graph 1.

Graph 1, referring to the conceptual component of QWL and its relationship with the dimensions that compose it according to the participants' evocations, demonstrated the relevance of the structural dimension (33.1%) related to working with pleasure, work infrastructure, administration, assistance . It was followed by the emotional dimension (27%), which involves interpersonal interaction and satisfaction; social (24.2%), related to interpersonal interaction and community environment; health conditions (9%), involving worker health, favorable environment, time to rest; cognitive (3.4%), how to know the integrality, training, updating, training; and, finally, economic (3.4), which obtained only six statements (salary, investment, remuneration)..

Graph 1. Dimensions involved in the concept of Quality of Life at Work according to study participants. Municipality of the interior of Minas Gerais, 2017.



The way in which participants conceptualized QWL can be learned in the following excerpts:

Quality of working life is a physical, emotional, spiritual, social well-being among people, between work groups and in the family. (N. 4)

Quality of working life means having a decent salary, working in an accessible workload. (N. T. 16)

Well, I think that quality of working life is to have fair shifts, enough breaks to be able to rest too, respect, I think that's it. (N. A. 9)

It means working without stress, with peace of mind, with training and safety. (N. A. 11)

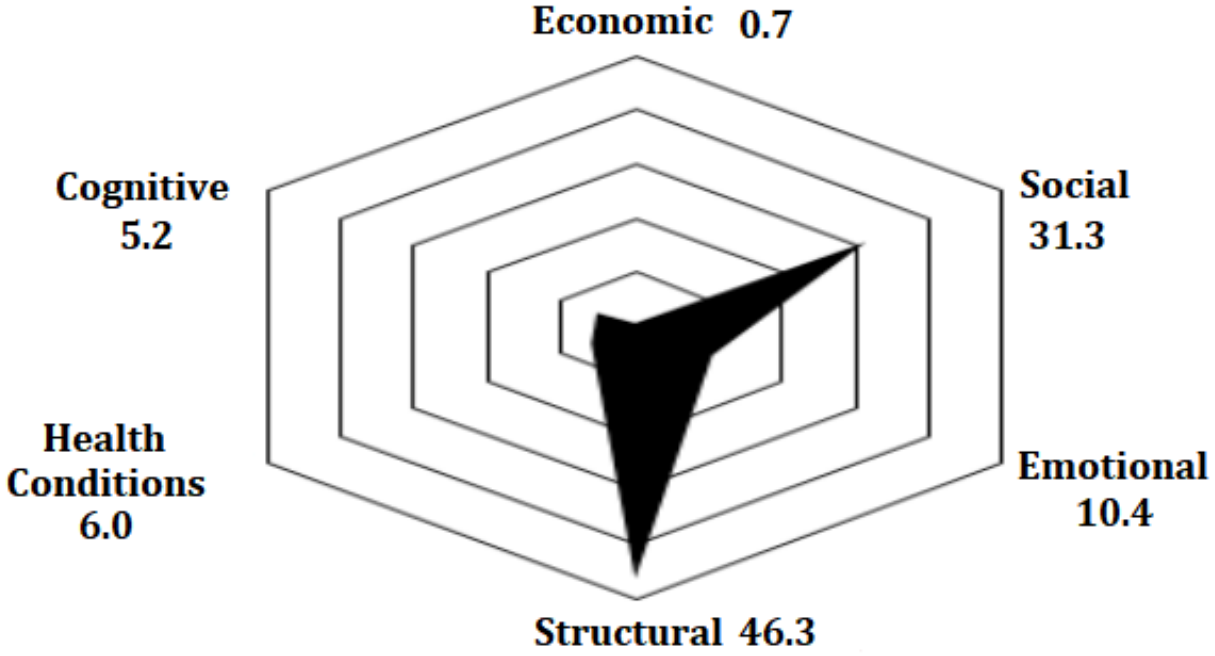
[...] *is to work in a place that provides you with the minimum conditions for you to perform your job well, to know that you are doing it safely, with quality.* (N. 5)

Quality of life working is [...] *having good qualifications, a good remuneration for that job, guarantees of work proposals that are sustainable, that are not volatile, that do not change all the time* [...]. (N. 8)

Graph 2 demonstrated the relevance of the structural aspect, with 62 statements and evocations referring to management shock, the goal plan and reduction of workload. The social dimension had 42 mentions, among which: teamwork, harmony in the team and participating in meetings. The emotional dimension was enunciated 14 times, with aspects such as: pleasure at work, appreciation, support, hospitality, respect from colleagues and clients; health

conditions were mentioned 8 times, such as: safety at work, fair scales, material resources, training. The cognitive dimension had 7 statements, the most cited of which was training. And the economic had only one mention.

Graph2. Dimensions involved in attitudes to obtain QLW, according to study participants. Municipality of the interior of Minas Gerais, 2017.



The ways in which the members of the Nursing teams show their representations on the attitudinal issue can be learned in the following excerpts:

[...] *you need to improve some points in the institution, right? Increase the number of employees to have more time to do these trainings, more time to do the activities with ease. I think so.* (N. 1)

It is necessary for us to be satisfied, doing our job in the best way, but for that we have to be satisfied in the sector where you are working. (N. T. 21)

I believe that today [...] *what is lacking is financial support on the part of the government to be able to, that is, to better equip the hospital and not to lack material* [...]. (N. A. 7)

The codification of responses to the prescriptive question of TESE is systematized in Graph 3. As seen in Graph 3, the structural dimension predominated, with 54 evocations; followed by social, with 48; emotional, with 16; cognitive, with 15; health condition, with 12 and economic, with 1 evocation.

Regarding the six dimensions of QWL adopted in this study, it is observed that the structural one was the most cited (38.1%) in the total of the three questions of TESE. The social dimension corresponded to 29.0% of the evocations. Its relevance was expressed in the three questions of TESE, being more expressive in the Prescriptive Question for QWL (32.7%). This dimension exposes working relationships among professionals, between professionals and managers, as well as the quality of the service provided and the impacts of work on community life.

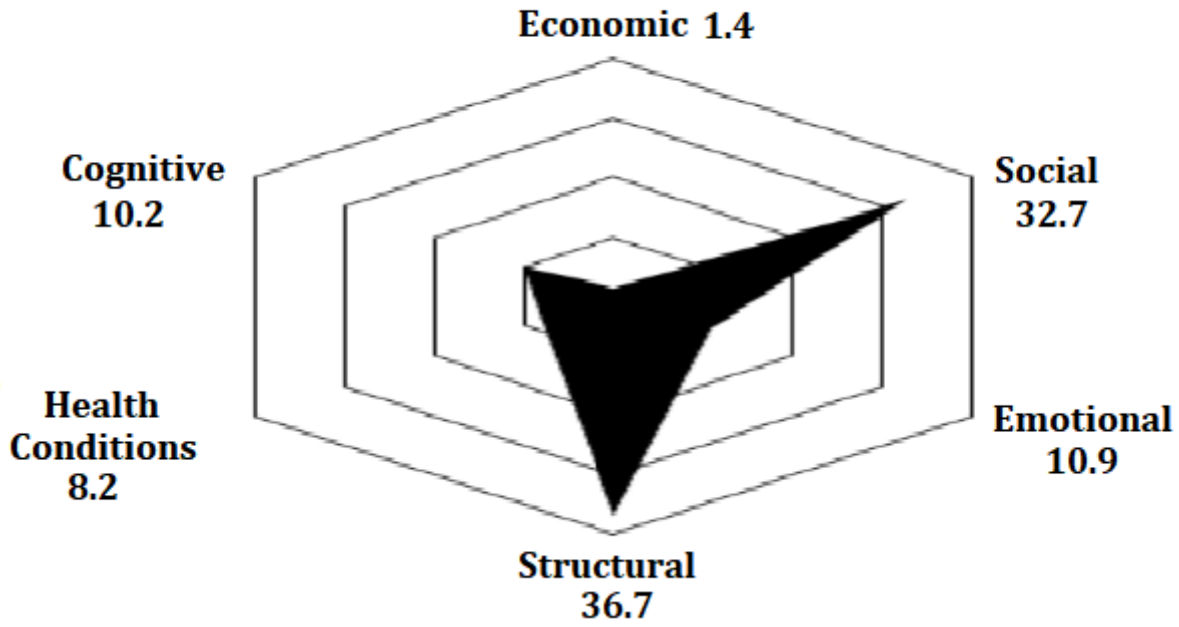
The emotional dimension was the third most cited in TESE (17.0%). This dimension includes security, appreciation, satisfaction and respect. This dimension was considered relevant only in the Conceptual QWL Question (27%), in which it appeared as the second most mentioned.

The health condition dimension represented 7.8% of the evocations, being more expressive in the Conceptual Question (27.0%). This dimension is related to the mentions directed at work aspects that are explicitly related to the illness of the worker.

In turn, the cognitive dimension accounted for 6.1% of responses in the TESE. In the

prescriptive question for QWL, it appears with 10.2%. It refers to personal and technological knowledge, as well as access to continuing education. The economic dimension was present in 2% of the evocations. The question on which it was most frequently mentioned was the Conceptual of QWL (3.4%). It is related to factors such as financial income and the dimension it occupies in the lives of professionals.

Graph 3. Strategies for achieving QWL according to study participants. Municipality of the interior of Minas Gerais, 2017.



The representations referring to the Prescriptive Question of QWL were apprehended in evocations such as the following::

My God! So, depending on the institution, we don't have much to do, right? The management of structure, of material, that part is up to them. We have to look for ways to learn how to deal with absences: lack of material, lack of structure, lack of time [and] *as we cannot cope with these absences here,* [we have to] *seek care outside, therapy, do physical activity to be able to clear your head. Being able to take care of our health because we stay here sometimes we barely drink water* [...] *we have to learn how to deal with these shortages and organize ourselves in a way that the absence that the institution imposes on us does not harm us physically.* (N. 5)

Improve communication between professionals [...] *and communication with patients as well.* [...] *There is so much humanization in the hospital, but there is not, there is no humanization of professionals or patients* [...] *due to overcrowding, we are not able to provide humanization* [...] *This affects not physically , but emotionally* [...]. (N. 6)

Freedom of speech, meetings, leadership listening to their employees, a good policy that includes a good harmony at work [...] *that is good for both the institution and the people who are working* [...]. (N. T. 4)

The main point would be this approximation between boss and employee so that we would have more satisfaction, so that we would be happy for work knowing that we are going to work and have support [...] *leave with a cool head* [...]. (N. T. 10)

What is really needed here is [...] *physical exercise* [...] *it helps to de-stress people who may be stressed with each other, it helps a lot.* (N. T. 15)

I would like to stress [that] *the reduction in the workload would be a big step up to raise quality of life of professionals.* [...] *there should be some dynamics aimed at professionals, a psychologist to prepare them for the demands of day-to-day life, to listen to them, to nurture them* [...] *and one more thing: to have the necessary material, inputs.* (N. A. 5)

DISCUSSION

The predominance of female professionals (86.7%) among the study participants is consistent with the results of research undertaken by the Conselho Federal de Enfermagem - COFEN (Federal Nursing Council)[17], in which it was identified that 85.1% of the workforce is female.

The majority women was also pointed out in another study[18]. This phenomenon is not exclusive of Brazil. An international survey[10] explored the reality of 25 countries in the period from 2006 to 2014, and pointed out relationships between the feminization of health workforce with wage differences, especially in low and middle-income countries. Such findings[10] point to the importance of the gender approach in studies and in the discussion of health policies and human resources management.

The particularities of the study undertaken here rest on employment ties and the education of the participants, given their insertion in a federal institution. Although a single employment tie prevailed, due to the majority are civil servants, the study points to a growing reality in federal institutions, which is the existence of other types of employment ties that also impact the performance in other institutions, as reported by 15.5% of participants. Such a phenomenon is important in understanding the increase in weekly workday and the relationship with low remuneration of workers[19], which, in turn, can impact QWL.

Regarding dimensions of QWL analyzed by TESE, according to participants, its conceptualization would require the consideration of the structural dimension that encompasses daily relations with management, improvements in infrastructure as well as in the work environment. This finding brings the breadth of the representation of the members of the nursing team about QWL, taking a look at structural conditions of work and also of health. It is in line with the critical reflections of another work[7] that suggests an understanding of the "quality of work(ing life)", placing at the center of the reflections the fact that the conceptualization of QWL requires an understanding of work and the possibilities of workers' control over the environment, organization and security, among others.

The polygon formed in Graph 2, referring to the attitudinal approach of TESE, revealed aspects similar to the conceptualization of QWL because the structural and social dimensions predominated, which reinforces the importance of the organization of work, the environment and relations with/of/between professionals and managers. The emotional dimension is present, given the importance of issues involving feelings, conflicts and events related to the work routine[20]. As for the cognitive dimension, it was evoked as a need for "improvement" and "planning".

The analysis of this attitudinal question of TESE revealed the need for greater participation of professionals in decision-making and administrative management processes, which also requires training and investment processes in the social dimension.

The prescription of actions for QWL, according to participants, demonstrates the importance of acting on the structures of the hospital organization, but in a planned way, built with the participation of workers and that they are trained to evaluate practices.

In this sense, "participating" and "managing" focus on the social and structural aspect of QWL, respectively. However, it is a matter of problematizing the way in which the hospital institution in which they operate conducts work organization and management, since, from the perspective of Occupational Health adopted in the study, the participation of workers in decisions and the possibility of their organization in the workplace are essential conditions for the promotion of their health[7]. Otherwise, the limit of decisions to "administration", to managers would imply the concealment of control over work[7].

The hegemonic conception of QWL has three striking characteristics: focus on individuals, assistance and emphasis on productivity. The focus on individuals ensures the reproduction of concrete work conditions and the organizational environment and it is expected that each worker can develop "resistance to organizational adversities"[6]. The assistance character is revealed in the fact that, although initiatives of the programs understood as QWL initiatives are "valid in themselves", they do not have synergy with the questions posed by the work and its contexts, thus assuming a compensatory and curative character. In turn, the productivity desired by the management models aims at productivism despite the healthy character that work should assume[6].

In research[21] with federal public service managers in the executive, legislative and judicial spheres that developed the Programa de Qualidade de Vida no Trabalho - PQVT (Quality of Life at Work Program), it was demonstrated that QWL projects can suffer from conceptual, ethical and methodological support, especially in terms of focus on the individual as if they were able, on their own, to obtain all the conditions to experience QWL in the work environment, full of asymmetrical relationships, with a diversity of situations.

The proposition of activities under the eyes of the study participants focused on physical-bodily activities, such as "work gymnastics", stimulating "physical activities" outside the work environment; “group dynamics” or actions for “motivation”, including obtaining higher “remuneration” and actions of a preventive nature to health problems such as performing “periodic exams”.

This set of recommendations for QWL does not mention the institutional causes of stress, fatigue, physical and mental exhaustion; neither the reasons for the overload that lead to leave from work[21,22]. Factors that can harm the health situation of workers such as the worsening of Chronic Non-Communicable Diseases (NCDs), such as diabetes, hypertension or cardiovascular diseases, and even obesity and the abuse of alcohol or tobacco that affect NCDs[23] and, still, redound in motivation to abandon the nursing profession[19].

In some situations, nursing professionals, whose work is characterized by caring for life, neglect their own care and do not always realize that professional illness can be linked to conditions and workloads[24]. This reality requires a structure in which the professional is assisted both as a worker and as a user of health services.

The performance of professional activities impacts the worker's health-disease process. Among these impacts are physical, psychological and mental overload that promote emotional/occupational stress, resulting from strenuous, extensive and exhausting work routines[25]. This scenario of exhaustion of the Nursing teams will be responsible for professional dissatisfactions, for injuries and illnesses that affect, thus, the QWL in all its dimensions to a greater or lesser degree.

Among the dimensions of QWL, the economic aspect was investigated, mentioned a few times by the participants: six times in the conceptual question, one in the attitudinal and two in the prescriptive. The researched group considered low importance of this dimension in QWL. However, when the statements of the other dimensions are considered, such as, for example, lack of material and personnel, lack of maintenance of the physical structure, salary issues, we see the relationship of these factors with the economic.

In general, the representations of hospital nursing staff professionals about QWL touch what can be considered as the main challenge/limit of this approach: “*learning to deal with these shortcomings and organizing in a way that the lack that the institution imposes do not harm us*”. The practices that seek QWL [...] aim to increase the resistance of workers to continue living in an adverse work environment[21].

Such conditions are aggravated in the contemporary political context, in which neoliberal policies have been opposed to health reform, with significant impacts on work in public institutions and in serving the population in general[26,27].

CONCLUSION

The study allowed an approximation to the participants' social representations about QWL. When they were prompted to conceptualize QWL, to outline what is necessary to achieve it, and then to suggest actions for the context in which they work, as recommended by the TESE method, the narratives of the members of nursing teams allowed an expanded look at representation of the work and health of the worker in a hospital environment.

The paradox that arises for workers in general, and hospital nursing teams in particular, lies in the representation that work can produce illness and suffering. Thus, the representation of QWL is deeply related to the quality of the work performed. Such paradox was explicit in the

enunciation of actions developed, individually, aiming to manage the "shortcomings" that refer to the infrastructure, conditions and work organization.

The workers demonstrated to recognize the limits of the actions, generally present in programs for the promotion of QWL and coming from the superior administration, they force the individual search for QL and in external contexts to take care of their health, as absence of illness. Thus, the representation of QWL requires emphasizing the expansion of communication channels, listening and greater participation in the elaboration of actions related to the totality of the work.

The exploration of the representations of workers in the nursing team allowed a first approach to the theme and may contribute to the understanding of the hospital in which they work, but the results are not generalizable.

A limitation of the study is that it did not detail the analysis of the specificities of the representations of assistants, technicians and nurses in view of their different attributions. It is considered that techniques for the collective construction of data, such as the focus group combined with photovoice, can expand the process of listening to workers and sensitize them to the development of collective strategies aimed at worker health and promotion of QWL in the hospital context .

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