Esc Anna Nery 2015;19(4):629-634

The family-centered care practices in newborn unit nursing perspective

As práticas do Cuidado Centrado na Família na perspectiva do enfermeiro da Unidade Neonatal

Prácticas del Cuidado Centrado en la Familia desde la perspectiva del enfermero de una Unidad Neonatal

Allana Reis Corrêa[1]
Ana Cláudia de Andrade[1]
Bruna Figueiredo Manzo[1]
Débora Lara Couto[1]
Elysângela Dittz Duarte[1]

1. Universidade Federal de Minas Gerais. Belo Horizonte, MG, Brazil.

Abstract

Objective: To understand the practices of family-centered care (FCC) in the newly born hospitalized care that have been incorporated by nurses. **Methods:** A descriptive study of qualitative approach, developed in the Intermediate Care Unit and Neonatal Intensive Care Unit of a public hospital in Belo Horizonte. Data collection was conducted through semi-structured interviews with 14 nurses, and the data were subjected to content analysis. **Results:** Three topics were originated: nurses' understanding about practices that contribute to a care guided by the FCC; FCC practices: benefits for staff of nurses and Family indicate the child's well-being and the kangaroo mother care; Difficulties in understanding of the targeted care practices by FCC. **Conclusion:** The applicability of the FCC is wrongly understood, and portrays the unpreparedness of professionals to deal with the family as co-responsible in the healthcare process of hospitalized children disease.

Keywords: Nursing Care; Family; Intensive Care Units, Neonatal; Child Care.

Resumo

Objetivo: Apreender as práticas do Cuidado Centrado na Família (CCF) no cuidado do recém-nascido hospitalizado que têm sido incorporadas pelos enfermeiros. **Métodos:** Estudo descritivo de abordagem qualitativa, desenvolvido na Unidade de Cuidados Intermediários e Unidade de Cuidados Intensivos neonatais de uma maternidade pública de Belo Horizonte. A coleta de dados foi realizada por meio de entrevistas semi estruturadas com 14 enfermeiros, e os dados foram submetidos à análise de conteúdo. **Resultados:** Foram originados três eixos temáticos: Compreensão do enfermeiro acerca das práticas que contribuem para um cuidado orientado pelo CCF, Práticas do CCF: benefícios para equipe de enfermeiros e família indicam o bem-estar da criança e o cuidado mãe canguru, Dificuldades na compreensão acerca das práticas do cuidado orientado pelo CCF. **Conclusão:** A aplicabilidade do CCF é erroneamente compreendida, e retrata o despreparo dos profissionais em lidar com a família como corresponsável no processo de saúde doença da criança hospitalizada.

Palavras-chave: Cuidados de Enfermagem; Família; Unidades de Terapia Intensiva Neonatal; Cuidado da Criança.

Resumen

Objetivo: Conocer las prácticas del Cuidado Centrado en la Familia (CCF) incorporadas por enfermeros con el recién nacido hospitalizado. **Métodos:** Estudio descriptivo, con enfoque cualitativo, desarrollado en las unidades de Cuidados Intermedios y de Cuidados Intensivos Neonatales de un hospital público de Belo Horizonte. Los datos fueron colectados a través de entrevistas semiestructuradas con 14 enfermeros y sometidos al Análisis de Contenido. **Resultados:** Emergieron tres temas: Comprensión de los enfermeros acerca de las prácticas que contribuyen para una atención guiada por el CCF; Prácticas CCF: beneficios para el equipo de enfermería y familiares indican el bienestar del niño y de la madre canguro; Dificultades en la comprensión de las prácticas de atención orientadas por CCF. **Conclusión:** La aplicabilidad de la CCF es erróneamente entendida, retratando la falta de preparo de los profesionales en lidiar con la familia como co-responsable en el proceso de atención médica al niño hospitalizado.

Palabras clave: Atención de Enfermería; Familia; Unidades de Cuidado Intensivo Neonatal; Cuidado del Niño.

Corresponding author:
Débora Lara Couto.
E-mail: deboralcouto@yahoo.com.br

Submitted on 07/01/2015.
Accepted on 11/24/2015.

DOI: 10.5935/1414-8145.20150084

INTRODUCTION

Family-centered care (FCC) is an approach that recognizes the importance of the family as a care client, assuring its participation in the planning of actions to be taken. This reveals a new form of caring, offering an opportunity for the family to define problems and consequent actions[1]. In nursing of newborns, professionals, following this philosophy, have to recognize its family as care unit besides taking care of the newborn, In this perspective the family is considered as an integral part of the child's life[2,3].

Caring of newborns in hospitals has seen much advance over the past decades, with relevant technological support as to diagnostics and treats. This, however, is does not suffice to meet demands beyond maintaining the patient's life. Care has to be oriented towards fortification of the family involved, who has to be considered a partner in the assistance. The family, in spite of being inserted in the care context of Newborn Intensive Therapy Units (NITU) is little considered as subject of care in the sense of the FCC approach[2-4].

Inserting the family in the care for the hospitalized child, considering its rights and obligations, has been subject of investigations of nursing as referring to dimension and form in which the participation occurs in assistance practice. Since 1990 with the regulation of the Statute of Children and Adolescents (SCA) guaranteeing the full-time permanence of companion during the infant hospitalization where newborn units go through a process of reorganization of daily practices. Beyond integral care of the newborn its becomes inevitable for the health team to turn attention to the necessities of the family as well, extending the object of nursing care to the pair of newborn and family[4,5].

Establishing a relationship with the family makes it possible for the health professional to obtain a broader view of the problems, understand the necessities and priorities of the family, contributing and facilitating the development of an effective health plan for the child and its parents[6].

The nurses play a fundamental role during hospitalization, taking care of the newborn and family and moreover lead a nursing team that develops the major part of this care. Handling in this way, these professionals minimalize damage done by admission and inform the team and the family on the FCC principles and how the care might be re-orientated.

The philosophy if family centered care requires nursing attention towards not only clinical but also emotional, affective and social necessities, making a wider range of caring possible, which demands change in the ways of caring of the hospitalized child and adolescent[7]. In this way, the care team has to hear the company and establish an interactive relation and attention for necessities he/she expresses on a daily basis[8].

In spite of the existence of the FCC approach and of the Statute for the Child and Adolescent deliberating the legal right of family accompaniment that lends to parents or responsible parties' active participation in the process of treatment, these normative instrument are not fully and effectively translated into the practices of newborn nursing.

It has to be observed that no matter the desirability of incorporating of FCC within the context of newborn caring, professionals demonstrate little preparation to do this, be it for the lack of the opportunity to apprehend this during professional formation or even for no having been subject of permanent education when they entered health service. One observes a restricted comprehension by the team towards family participation, contributing to a stress during submission or exclusion from the care process.

In spite of the deliberation of the statute for the Child and Adolescent and the recommendation do from the family centered care model, it is possible to see the nursing team, and especially the nurses, seem to not have succeeded in apprehend the importance and significance of caring for the family, the change generated by its insertion in care and hospitalization has not succeeded in reorganizing its working processes with the amplification of the object of work. At the same time a practice is observed that corroborates with the biomedical model, centered in proceedings, based on control and vigor, leading the professionals to maintain technical and fragmented care practices.

Various studies demonstrate the importance and benefits of family centered care in newborn and pediatric units[3,6,9]. There are, however, scarce references to nurses' dealing with family insertion into care, showing a scientific gap between the exposed theories and professional practice. Thus, the question arises: do nurses incorporate FCC practices into the caring of hospitalized newborns?

Discussions of this nature are necessary within the actual conjunction of pediatric hospitalization since, being pediatric lodging facilities a legal right, their implementation caused various ways of practical organization of nursing having o be debated o generate an integral attention for the hospitalized newborn and its family.

This study may lead to the emerging of applicable reflections to the teaching and practice of nursing, visioning changes of paradigms related to the way the nurse cares for the hospitalized newborn and its family, further than to contribute to the consolidation of FCC in newborn units.

This way, this study aims to learn the practices of FCC within the care of the hospitalized newborn, incorporated by the nurses.

METHODS

This is an descriptive study with an qualitative approach, developed in the Unit of Intermediate Care and the Unit of Intensive Care of newborns in a maternity hospital in Belo Horizonte, reference in neonatology in the State of Minas Gerais.

The research was held under 14 nurses who gave assistance to newborns in the respective units and are more than one year in service. The saturation criteria were used to define the sample, which means the suspension of inclusion of new participants where date showed redundancy or repetition[10,11]. The collection of data was realized through semi-structured individual interviews held by two authors of this study over the period of April to June of 2014, in the working areas during the respective shifts of the participants.

The bioethical prescriptions of Resolution Nº 466/2012 of the National Health Board were respected so the participants were requested to sign the terms of consent before participating and on voluntary basis The study was submitted for evaluation by de Ethics and Research Committee of the Minas Gerais Hospital Foundation (ERC/MGHF) and was approved under number 580.437, before data collection.

Participants accepted to voluntary participate in this study and were oriented as to the possibility of having their inclusion withdrawn at any time, without consequences for them or their institute. There were no professionals refraining from participation in this study nor demands for interruption of the participation.

The interview script consisted of four questions referring to the nursing tem's care in relation to the newborn and its family whilst caring for the hospitalized newborn, namely: What do you think of the way in which our work evolved as to assistance to hospitalized children and adolescents and their families? How do you perceive family members in the context of hospitalized children and adolescents? Which cars have you realized in the assistance and which cares did the family realize? What are the implications of your care for the family and for the hospitalized child or adolescent?

The interviews were recorded through previous and posterior authorization, integrally transcribed by the researchers and submitted to the interviewees for validation of the declarations before realizing analysis of the collected material. To maintain anonymity, the fragments of each interviewed nurse appear coded with the letter E, followed by a numeric algorithm representing the order of participation, de 1 to 14, e.g. E1 (Nurse 1).

Analysis of data was founded on contents analysis in three steps: pre-analysis; exploration of the material, treatment of results[10]. During pre-analysis data were organized after transcription in full and the material was organized to determine the units of registers and the way of categorizing them. The second phase consists of exploration of the material for the proceedings of codification, classification and aggregation of the results and the third phase, finally, consists of comparison of the results to the found theoretical framework[11].

RESULTS AND DISCUSSION

The sample includes 14 nurses, all of the female sex and aged between 25 and 45 years. They had 2 to 6 years of experience in intensive newborn therapy units.

Establishing the family centered care in the investigative perspective context of the nurses, it was possible to apprehend units that originated the following thematic axes: *Nurses' comprehension of practices contributing to a FCC oriented care; FCC practices: benefits for the nursing team and family indicate the well-being of the child and mother care; difficulties in the comprehension of care practices oriented towards FCC*.

Nurses' understanding of the practices contributing to an FCC oriented car

Nurses operating in the Intermediate and Intensive Newborn Care Units related they realize the reception of the family on admission of the newborn into these units as a practice contributing to an FCC oriented assistance. At this moment, the families are informed about the general state of the child, and about the rights and duties of the family within this context.

To begin a good relationship, the reception is relevant as a good communication is its structural basis. This communication, however, has to be conducted in a clear and objective way, benefitting the quality of care and contributing to the establishment of trust and respect[7]. The following participant puts the reception in the following context.

> *Reception of the parents normally takes place with the arriving children, so we perform an initial reception, explaining the general care the NB (newborn) will experience within the unit, explain to them some general aspects of the assistance, about the equipment to be connected to the newborn. (ENF 3)*

At this moment the nurse's function is to offer clear information about the health of the child to the family, about the diagnostics, treatment and prognosis, not forgetting to evaluate the comprehension abilities of the family with respect of the submission of the child. Inform about norms and routines within the sector may offer an opportunity to create a first bond between child and family, and may mean the beginning of a participating care relation[7]. This adds to the importance of the nurse in practice acknowledging the forces and individuality of the family and respect the methods of confrontations, without judging or censuring behavior[4].

In the following fragment, the interviewee underlines the importance of language used by the nurse at reception.

> *[...] there are lots of people that come here without any knowledge whatsoever, so look at the child, that little work, who has no idea of what is going on, so we use a more appropriate language [...] we talk and try to explain in a way they will be able to understand better. [...] They are very worried about the baby and sometimes do not listen. (ENF 4).*

Besides, the nursing team recognizes the importance and necessity of an effective interaction between the team and the family of the submitted child, however, this knowledge is not accompanied with a satisfactory attempt to improve this reality. The participants permit evidencing the nurse's understanding of the importance of this practice that contributes to the FCC, but emphasize the necessity for the team to prepare for the reception and acceptation of these parents in the unit.

> *Who works in neonatology cannot separate this, I work with the baby and the family. [...] I think this family-issue, we need to have a much larger involvement then we see today.*

I think interaction is good. Like I said, I think that at times the team shows some slack when involving the family a little bit more, they could involve more [...] and I think the team has not a lot of this culture yet (ENF 6).

A significant structural change of organization of the working proceedings was perceived with the full time insertion of the family in the hospital environment, demanding a clear understanding of the dynamics of interpersonal relations by the health professionals. Thus, a nursing team should not abstain from the care delivered to the children of their families[9]. Contributing to this situation an international study indicates a larger permanence of parents and family members in the assistance units together with the children an de health team to facilitate the interaction and effectivity of FCC in newborn units[4].

Acting in the pediatric and neonatology area requires of the health professional to relate his actions in fortifying and protection of the relation built between him and/or the team and the family members. In this respect, maintaining a dialog interaction is of fundamental importance for the construction and maintaining of a bond between the family and the nursing team[7,12].

In this context an international multi centered study demonstrates that educational programs for nurses are essential to guarantee the effective implementation of FCC, as it supplies the processual base and support, indispensable for the reflection of the practice as well as to the modification of behaviors and improvement of interaction between professionals and family[13]. The same study points out that the larger the professional's experience the better ease and expertise he will have to unlock the FCC. This argument may help to explain the difficulty of this team when executing FCC, as the interviewed have moderate experience in the newborn area[13].

FCC Practices: benefits for both nursing team and family indicate the well-being of child and mother care

Nursing assistance to the hospitalized newborn and its family presents peculiar characteristics towards the presence of parents in the units. Nurses recognize the importance of family during hospitalization of the children and believe the interaction is not gained solely in benefit of the family and the child, but also for the team.

Inserting this mother into this care at the earliest possible moment I believe is a benefit for the team as well as for the mother and the patient (ENF5).

International study demonstrated that when the family contributes to the caring of its children, they feel rewarded, less stressed and valorized, improving even the relation between them and the health team[13]. The interviewees also talk of the care for the family as implicating in the well-being of child and family, favoring bonds and softening the damage of hospitalization.

I think this care, focusing mainly on the family and the proper patient, this is, the bay, I think this lessens the stress for the bay, as stress is very strong in newborn units, diminishes pain and I believe it has much influence in the prognostics of the child, especially contacting the mother (ENF 4).

The moment the child has the possibility of having the mother do with it, of the mother performing certain care and the mother already learning to perform some care with it, there is a very important bond between mother and baby, between mother and family and this bond strengthens whenever possible (ENF 7).

The care team has to understand that recognizing the family as being fundamental for the recuperation of the child, it is important to the extent that the integral presence with the child brings benefits for both, when providing interactions that minimalize stressing factors, favoring the rebalancing of the health-sickness process the value is significant in family care[12].

It was also observed that some professionals established a strong relationship between the realization of Kangaroos Care, understood as a practice that contributes to the family centered care and its implications for the newborn and its family.

I perceive that an interaction between the mother and the newborn is very favorable for the peace of both mother and child [...] and that the baby remains much better adapted to mechanical ventilation, we get to do a more gentile maintenance, isn't it, with less sensations of pain, mainly if we succeed to prolong the kangaroo period (ENF 3).

It accelerates the de-hospitalization of the child, I think it also diminishes the submission time, these children interact better, when succeeding a longer kangaroo isn't it, these children I think leave IC more quickly (ENF 3).

The method of kangaroo care brings innumerous benefits to the newborn, especially if it is underweight. Scientific evidence points to a reduction of hospitalization time, the humanizing of assistance. Among all the benefits, one of the mote expressive is the affirmation of the mother-child bond, since this method gives the mother the essential function of caring of the newborn[12].

Difficulties in understanding of FCC oriented practices

Following declarations brought to light a distortion of the understanding of family participation in the submission context. The nursing team, as a whole, does not seem to apprehend the philosophy of family centered care.

I see that when a mother remains a long time within IC, this represents a challenge for the professional, because with her there, she constantly questions everything that

is being done with her baby, so you have to have agility to live with that [...] there are moments in which the overload of work causes some errors and with the parents close, they will be detected. (ENF7).

This fragment of speech permits evidencing a perception of the team in relation with the family as a controlling agent with provided care, and not as partners in child care. An American study points out that effective strategies of involving parents/families can be very useful in securing the patient by means of physical, emotional behavioral security and in clinical treatment[14]. Thus it is important that nurses rethink the way they see this family, aiming to find FCC effectiveness, as well as generating improvements of security.

The interviewees also approach family care as propitious, molding according to the necessity of help for the team, combined with the family's desire to participate.

And this is also propitious, when the father is available, if he wants to interact, then we make use of the opportunity, but as I said, it is not that thing, it still is not very much interjected in the minds yet, like it is not part of the culture and so we still have to work on it. (ENF 3).

Another interviewee refers to the FCC actions only should take place in the period before hospital leave.

I think this family centered care is to be with stable patients. A patient ready to leave. In the beginning of a submission the patient should indeed receive only visitors (ENF 7).

The conceptions of the nurses picture a lack of professional preparation towards the inclusion as co-participants of families in care and evidence a superficial approach towards FCC in newborn units.

Due to the lack of theoretical and practical knowledge during professional formation, the nurse is still unprepared to receive families in the hospital unit[15].

It is not simple to insert and involve an accompanying person in the therapeutic process as it implicates reorganization of working procedures as well as understanding of the dynamics of interpersonal relations between the subjects involved in the care process[16].

In the practice of assistance, the interviewee assumes that the family is not contemplated within newborn care that remains for the team to be executed.

The nurse performs the proceedings, like passing catheters, change bandage, organize beds and all that is administrative in the unit, we are taking care of. The nurse participates in the administration of medicine, changing of diapers and vital data, all that has to do with the care of the little one, that in my opinion is also part of the family's care and the family remains somewhat on the outside (ENF 2)

The following discourses suggest that the considered specialist or complex proceedings have to be done by the nursing team as they demand technical knowledge. On their turn, in their vision, the families undertake the more simple care.

We take attention when changing a bandage perform a physical examination, urgent attendance, vascular and epi-cutanic catheters. With the family, we try to incentive the mother to draw milk for the baby, we try to promote this care skintight, this fixed contact of the mother laying her hand on the baby, making that contact as to maintain the hand so that it is felt, even without manipulating he child too much (ENF 4).

During procedures that demand more techniques, this [FCC] is put aside. In basic care, as they think, as the professional esteems as less important, the family participate more, isn't it, diaper change, bathing, but even so, I think I participate little. Should have to participate more (ENF 2).

The care that was specific for the nursing team now is divided with the family, or delegated, suggesting a process of disresponsabilization of the team for cares often despised by nurses, like diaper change, bathing and diet. This process characterizes a obvious division of tasks, between scientific abilities performed by nurses and popular abilities, at charge of the family[7,17]. Caring of the child has to occur conjunctively, multi-professional team and parents, integrating the team's ability with that of the parents. Meanwhile, the opportunity for a collaborative care does not concretize since the team perceives that the family is not included in the decisions on the care for the child.

Look, the family is primordial here, especially in questions of reduction of professionals as we see today. A mother here, a father here, they help us a lot (ENF 14).

At some moments the professional demonstrates a false expectation of the family, understanding as they represent working force for the care that is the sole benefit that family presence offers to the team[18].

So that the family is not seen only as an executer of care, it becomes fundamental to involve it in the assistance an participation of the therapeutic process as a whole, to the extent that emotional limits and abilities to realize the care of their children during submission are respected[7]. More studies suggest that nurses praise and valorize families competence and effort in planning and performing care, so it no longer is expecting but supporting assistance[12,13].

FINAL CONSIDERATIONS

It is important to emphasize that in spite of the information and reception of the family constitute fundamental elements for the relation of deciding and co-responsabilization between the nursing team and the family such elements may not be

understood by nurses as the only concept of practices that contribute to a FCC oriented care.

The benefits of a family centered care, both for child and its family, as to the nursing team, are recognized by the nurses participating in this study, however, they demonstrate a little consistent understanding of family centered care that remains at distance of its real concept. It can be perceived that the team still sees family presence as a form of control of care delivered to the child, or even as "work force" for tasks considered to be less important. Thus, the applicability of FCC is wrongly understood and pictures a professionals lack of preparation do deal with families as responsible in the health sickness process of the hospitalized child.

Referring to the present study, it is important to underline its limitation od not using other information sources as to guarantee the internal trustworthiness of the study, like data triangulation.

We believe that the FCC approach, if well understood, may be incorporated in the reality of caring of the hospitalized child in the perspective of orienting the professional practice possibly implicating in the identification of actions to be realized and even the priorities in they may assume in the care context.

In this sense, new studies are needed to sustain the importance of FCC in the practice of care of hospitalized children and to spread the understanding of nurses involved in this care.

REFERENCES

1. Barbosa MAM, Balieiro MMFG, Pettengill MAM. Cuidado Centrado na Família no contexto da criança com deficiência e sua família: uma análise reflexiva. Texto Contexto Enferm. 2012; 21(1):194-9.
2. Pinto JP, Ribeiro CA, Pettengill MM, Balieiro MMFG. Cuidado centrado na família e sua aplicação na enfermagem pediátrica. Rev Bras Enferm. 2010; 63(1):132-5.
3. Pacheco STA, Rodrigues BMRD, Dionísio MCR, Machado ACC, Coutinho KAA, Gomes APR. Cuidado centrado na família: aplicação pela enfermagem no contexto da criança hospitalizada. Rev. Enferm. UERJ. 2013; 21(1):106-12.
4. Hiromi ASAI. Predictors of nurses'family - centered care pratices in the neonatal - intensive care unit. Japan Journal of Nursing Sciense. 2011; 8:57-65.
5. Brasil. Ministério da Saúde. Estatuto da Criança e do Adolescente. Brasília: Ministério da Saúde; 1990. 110p.
6. Cruz AC, Angelo M. Cuidado centrado na família em pediatria: redefinindo os relacionamentos. Cienc Cuid Saude. 2011; 10(4):861-865.
7. Lima AS, Silva VKBA, Collet N, Reichert APS, Oliveira BRG. Relações estabelecidas pelas enfermeiras com a família durante a hospitalização infantil. Texto Contexto Enferm. 2010; 19(4):700-8.
8. Strasburg AC, Pintanel AC, Gomes GC, Mota MS. Cuidado de enfermagem a crianças hospitalizadas: percepção de mães acompanhantes. Rev. Enferm. UERJ. 2011; 19(2):262-7.
9. Pimenta EAG, Collet N. Dimensão cuidadora da enfermagem e da família na assistência à criança hospitalizada: cencepções da enfermagem. Rev Esc Enferm USP. 2009; 43(3): 622-9.
10. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 1977.
11. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 10.ed. São Paulo: Hucitec; 2010. 406p.
12. Souza TV, Oliveira ICS. Interação familiar/acompanhante e equipe de enfermagem no cuidado à criança hospitalizada: perspectivas para a enfermagem pediátrica. Esc Anna Nery. 2010; 14(3):551-559.
13. Mc Pherson G, Jefferson R, Kisson N, Kwong L. Toward the inclusion of parentes on pediatric critical care unit rounds. Pediatric Critical Care Medicine. 2011; 12(6):255-261.
14. Lyndon A, Jacobson CH, Fagan KM, Wisner K, Franck LS. Parent's perspectives on safety in neonatal intensive care: a mixed methods study. BMJ Qual Saf. 2014; 23(11):902-909.
15. Côa TF, Pettengill MAM. A experiência de vulnerabilidade da família da criança hospitalizada em Unidade de Cuidados Intensivos Pediátricos. Rev Esc Enferm USP. 2011; 45(4):825-32.
16. Quirino DD, Collet N, Neves AFGB. Hospitalização infantil: concepções da enfermagem acerca da mãe acompanhante. Rev Gaúcha Enferm. 2010; 31(2):300-6.
17. Yamamoto DM, Oliveira BRG, Viera CS, Collet N. O processo de trabalho dos enfermeiros em unidades de alojamento conjunto pediátrico de instituições hospitalares públicas de ensino do Paraná. Texto Contexto Enferm. 2009; 18(2):224-32.
18. Facio BC, Matsuda LM, Higarashi IH. Internação conjunta pediátrica: compreendendo a negociação enfermeiro-acompanhante. Rev. Eletr. Enf. 2013; 15(2): 447-53.