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BEST PRACTICES IN NEONATAL NURSING CARE MANAGEMENT

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ABSTRACT

Objective: to build a theoretical matrix of care system/organization of Nursing in a Neonatal Intensive Care Unit based on the meanings attributed by the Nursing Team professionals and other involved actors in the relationships and interactions of care in dealing with the fragility of living/surviving newborn.
Method: a qualitative study adopting the theoretical framework the Complexity Paradigm and the Grounded Theory as research design. The participants were 22 subjects divided into four sample groups. Data was obtained from interviews and analyzed through comparative analysis, performed from May to August 2012.
Results: nursing care practices management is based on the experience of the relationships/interactions with the family members and other health team actors, aiming to incorporate best practices. Thus, nursing care practices management seeks to address the fragility that surrounds prematurity, minimizing the sequelae when seeking newborn's survival.
Conclusion: the organization of nursing care system in a Neonatal Intensive Care Unit is complex, dynamic, interactive and interdependent with other health systems, mobilized by a management process of care and/or good care management practices that enables pre-term and his family a care focused on the fragility and uncertainties of living/surviving in singular conditions of life. The nurse stands out with the fundamental role of articulation in the light of the relationships/interactions in the care and organizational daily routine.

DESCRIPTORS: Nursing. Healthcare management. Hospital administration. Neonatal intensive care units. Newborn.

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MELHORES PRÁTICAS NA GERÊNCIA DO CUIDADO DE ENFERMAGEM NEONATAL

RESUMO

Objetivo: construir uma matriz teórica do sistema/organização de cuidado de Enfermagem em Unidade de Terapia Intensiva Neonatal a partir dos significados atribuídos pelos profissionais da Equipe de Enfermagem e demais atores envolvidos sobre as relações e interações do cuidado no lidar com a fragilidade do viver/sobreviver do neonato.
Método: estudo qualitativo que adotou como referencial teórico o Paradigma da Complexidade e como desenho de pesquisa a Teoria Fundamentada nos Dados. Participaram 22 sujeitos divididos em quatro grupos amostrais. Os dados foram obtidos a partir de entrevistas e analisados mediante análise comparativa, realizadas no período de maio a agosto de 2012.
Resultados: a gerência das práticas de cuidado de enfermagem está fundamentada na vivência das relações/interações com os familiares e demais atores da equipe de saúde, com vistas à incorporação de melhores práticas. Assim, a gerência das práticas de cuidado de enfermagem busca contemplar a fragilidade que envolve a prematuridade, minimizando as sequelas ao buscar a sobrevivência do neonato.
Conclusão: a organização do sistema de cuidados de Enfermagem numa Unidade de Terapia Intensiva Neonatal é complexa, dinâmica, interativa e interdependente dos demais sistemas de saúde, mobilizada por um processo gerencial de cuidados/boas práticas gerenciais de cuidado que possibilita ao pré-termo e sua família um cuidado voltado à fragilidade e incertezas do viver/sobreviver em condições singulares de vida. O enfermeiro se destaca com o papel fundamental de articulação frente às relações/interações no cotidiano assistencial e organizacional.

DESCRITORES: Enfermagem. Gestão em saúde. Administração hospitalar. Unidades de terapia intensiva neonatal. Recém-nascido.

MEJORES PRÁCTICAS EN LA ADMINISTRACIÓN DEL CUIDADO EN ENFERMERÍA NEONATAL

RESUMEN

Objetivo: construir una matriz teórica del sistema y/o de la organización del cuidado de Enfermería en una Unidad de Cuidados Intensivos neonatales a partir de los significados atribuidos por los profesionales del Equipo de Enfermería y demás actores involucrados sobre las relaciones e interacciones del cuidado en cuanto a lidiar con la fragilidad de la vida/supervivencia del neonato.
Método: estudio cualitativo que adoptó al Paradigma de la Complejidad como referencial teórico y a la Teoría Fundamentada en los Datos como resultado de la investigación. Participaron 22 sujetos divididos en cuatro grupos muestrales. Los datos se obtuvieron a partir de entrevistas y se los analizó mediante un análisis comparativo; las entrevistas se realizaron en el período de mayo a agosto de 2012.
Resultados: la administración de las prácticas del cuidado de enfermería se fundamenta en la vivencia de las relaciones/interacciones con los familiares y demás actores del equipo de salud, con vista a incorporar mejores prácticas. De este modo, la administración de las prácticas del cuidado de enfermería pretende contemplar la fragilidad que envuelve a los nacimientos prematuros, minimizando así las secuelas al buscar la supervivencia del neonato.
Conclusión: la organización del sistema de cuidados de Enfermería de una Unidad de Cuidados Intensivos Neonatales es compleja, dinámica e interdependiente de los demás sistemas de salud, a la vez que se ve movilizada por un proceso administrativos de cuidados/buenas prácticas gerenciales de cuidado que hace posible que ofrecer al bebé prematuro y a su familia un cuidado enfocado en la fragilidad y las incertezas de la vida/supervivencia en condiciones vitales singulares. El enfermero se destacada con el rol fundamental de articulación frente a las relaciones/interacciones del cotidiano asistencial y organizacional.

DESCRIPTORES: Enfermería. Gestión en salud. Administración hospitalaria. Unidades de cuidados intensivos neonatales. Recién nacido.

INTRODUCTION

The scientific and technological advances associated with a better understanding of newborn physiology have contributed to a significant increase in pre-term newborn survival rate in Brazil, resulting in the change of the infant mortality profile. These scientific and technological advances provide a noticeable improvement in care, contributing to the increase in survival of these newborns, especially from the implementation of Neonatal Intensive Care Units (NICUs).[1]

In this sense, there is currently a growing worldwide concern to combine the technological advances with a sensitive and individualized neonatal care. There is a movement towards birth humanization, and the health professionals have been constantly encouraged to seek the interface between the technical and affective aspects necessary to administer a therapy that promotes not only the survival of organically healthy infants but also their neurological development and their integration into family life.[1]

In the movements and undulations of human relations and interactions in the hospital environment, the nursing and health professionals build, in their care practice, a set of meanings which result in a reference structure of mutually collective care process. It is understood as relational, procedural and stimulated by constant movements and undulations arising from the interactive processes in the hospital setting and outside it.[2]

Thus, the complexity view broadens the perspective on the nursing management process and starts to conceive care from a network or processes and products that involves relationships, interactions and associations among the professionals, users and managers as subjects who compose the health system.[3]

Complex thinking, which considers unity in diversity, emerges in the health field, in the NICU space, as a possibility of horizontality in decisions, effective and active participation of all involved subjects in its organizational process, granting new meanings when dealing with the newborn's living/surviving fragility, as regarding the professionals working in this sector, as well as the reflection of it in all the links resulting from this complex system.

Seen in the light of complexity, NICU care practice management can/should be understood as a product and service in its multiple dimensions/relationships/spaces, that is, as a service production system unique in its way of being and in its existence. It obeys and follows orders, routines in its everyday, while constituting the place where random encounters are born, permeated by situations of order/disorder/interactions/organization.

The *Interactive Domain Model* (IDM*)* defined best health practices as the set of processes and activities that are consistent with health/public health promotion values, goals and ethics, theories and beliefs, evidence, and environment understanding, and are most susceptible to achieving health promotion/public health objectives in a given situation.[4] In the field of neonatology, for example, research brings the implementation of best practices in the interaction between caregivers and parents of children with complex health conditions, chronic and life-threatening diseases,[5] as well as best practices in neonatal nutrition.

The challenging proposal to consider the transformations needs in the work process in a neonatal intensive care unit, signaling the incorporation of best practices, broadens the object of action in neonatology, aiming at acting in a coherent and transdisciplinary way between the actors and services, envisaging family insertion as one of the fundamental points in newborn care, thus qualifying the dimensions and interactions that already exist.

Thus, some concerns arose: how do the nursing and health professionals exercise their care practices within the NICU? How do they experience the do-better-quest facing the specifics of pre-term infants' life and health situations and their families in the NICU?

Thus, the initial formulations of the research problem centered on the organization object of care practices in the NICU were the following: How do the nursing and health professionals experience the relationships and interactions in the organization of nursing care in dealing with the fragility of newborns' living/surviving in NICUs? What are the meaning s of these experiences, which they consider as best practices for these pre-term infants and their families?

Therefore, this study aimed to build a theoretical matrix of the Neonatal Intensive Care Unit in the Nursing Care system/organization on the relationships and interactions of care in dealing with the fragility of newborn's living/surviving.

METHOD

A qualitative study adopting as research design the Grounded Theory (GT) as a way to understand the phenomenon under investigation. Two main features of this model are the constant data comparison with emerging categories and the theoretical sampling of different groups to maximize similarities and differences between information.[6]

The study setting was the neonatal unit of the Polydoro Ernani de Sao Thiago University Hospital, opened in 1995, totally free for the public. This unit is a national reference center of the Kangaroo Method by the Ministry of Health and has a philosophy of humanistic care principles. This choice was due to the fact that this location evidenced the needs and justifications for the research.

For data collection, the semi-structured interview, individually performed, fully transcribed, and inserted in the *NVIVO*® software. It took place in the workplace or in other setting of the participant's choice, from May to August 2012. The theoretical sampling consisted of four sample groups, having the following as inclusion criterion: the participants who experience the problem under study in NICU care. Other pre-established factors were considered: working at least six months and participating in newborn care practices in the institution. The only exclusion criterion was withdrawal of participation, since the subject was given the right to decide to be a subject of the study, as well as to abandon at any stage of the study. Thus, a total of 22 participants were obtained: 1) management and care nurses (E1 - E6); 2) six technical professionals and nursing assistants (T1 - T6); 3) five health professionals (doctor, psychologist, speech therapist, social worker, nutritionist) who work directly in the NICU (I1 - I5); and 4) five family members (M1 - M5). The guiding questions were the following: how do you experience the relationships and interactions of the nursing and health professionals in the organization of nursing care in dealing with the fragility of newborns' living/surviving in neonatal intensive care units? What are the meanings of these experiences, which you consider best practices for these pre-term infants? The interviews lasted an average of 30 minutes.

The methodological strategy used for data analysis was the Comparative Analysis. Therefore, as soon as data collection began, they were coded or analyzed. Data substantive analysis was performed through open coding (interviews microanalysis, line by line), axial coding (data and category connections grouping) and selective coding (performed the systematic analysis that subsidized the development of the central phenomenon).[6]

At the end of the analysis process, six categories emerged that support the phenomenon of "Nursing care management: incorporating best practices in a neonatal intensive care unit", them being: "Understanding the specificities of NICU care", "Identifying attitudes/behaviors in NICU care management", "Sharing care with the family by inserting it in the NICU", "Seeking professional qualification to deal with the complexity of NICU care", "Promoting teamwork: limits and possibilities" and "Caring for the repercussions of pre-term baby care in critical and technological environment". Thus, it was decided to approach them separately, giving visibility to their respective subcategories.

RESULTS

From the data coding and categorization process, the central phenomenon is highlighted: Nursing Care Management: incorporating best practices in a neonatal intensive care unit, supported by six categories and their respective subcategories, presented in Chart 1.

Chart 1 – List of categories and their respective subcategories. Florianópolis, SC, Brazil, 2014.

Categories	Subcategories
Understanding the specificities of NICU care	- Involving attitudes of affection and sensitivity in caring - Considering pre-term baby language as peculiar, difficult and complex - Identifying care particularities in a closed setting - Having to deal with the threshold between life and finitude
Identifying attitudes/behaviors in NICU care management	- Considering or not the attitudes/personal aspects in the professional performance - Acting (or not) as a care manager - Valuing the systematization of the nursing care
Sharing the care with the family by inserting it in the NICU	- Involving the family in the care measures - Assessing the needs and priorities of each family - Establishing links as a result of long hospitalization periods
Seeking professional qualification to deal with the complexity of NICU care	- Seeking update on the scientific and technological advances - Performing scientific research from everyday care
Promoting teamwork: limits and possibilities	- Sharing the decision-making processes - Identifying divergences in the adoption of care conducts
Caring for the repercussions of premature care in a critical and technological setting	- Considering the importance of sequelae and damage prevention - Reconciling technology and issues with sensitive/fragile/delicate care

Understanding the specificities of caring in a NICU that implies understanding the NICU environment as a unique, differentiated care setting. Seeing wires, mechanical respirators, infusion pumps, probes and catheters connected to a fragile and weak baby, the first touch of parents, first skin-to-skin contact, evolving day by day into breastfeeding process, shows that care is surrounded by unique attitudes of affection and sensitivity.

Based on this reality, the health team increasingly seeks to develop skills in dealing with the severity/fragility of pre-term infants, even in the face of emergencies, recognizing their language as peculiar, difficult and complex. This process is part of the everyday care in neonatology; identified by the professionals working in this reality and reiterated by the recognition of the parents of infants who needed NICU care.

I see the relationship of caring along with affection, [...] *the baby is taken care more carefully, more lovingly, more humanly, but I think not only that, it's also how the team sees the patient* (E2).

The study scenario serves severe, extremely premature infants who inspire particular and individualized care. Simultaneously with the immediate and precise care that severity demands, the professional needs to consider the fragility that the newborn has, reducing the risk of often-irreversible sequelae, and even the risk of death.

With the Ministry of Health policy that sought a new paradigm of attention to neonatology, we came to see him as a subject. And seeing him as a subject, we come to look more at him and to understand how these answers he is giving us are, what he needs, and offer it to him. One of the pillars of this humanized situation is individualized care, each infant has a behavioral response that differs from the other (I2).

Consequently, the relationship with other support services (laboratory, pharmacy, radiology) becomes distant, limiting their knowledge of their routines and realities. The NICU staff confesses that they are not seen as intensive care by the support services, as they observe the slowness of exams, medication dispensation, which generates conflicts and work overload, and it is up to the nurse to divide between serious infants care cases and bureaucratic matters solutions.

Many sectors here at the UH think neo are a nursery, it doesn't have the complexities it has, they don't know what it's like (T1).

We didn't need to move there [pharmacy]*, because this is an ICU, the ICU is a priority, got it?! And sometimes we even let them think we are a nursery and we are not! Then maybe we start to change and make them see that we are dealing with serious things and that we need their support, right?!* (T4).

The data reveal that each infant is considered as the subject of care, as well as the efforts and commitment of the team towards the continuous improvement of care provided. In an inseparably way, the professional experience brings personal values, beliefs and, above all, sensitivity and expertise in this field of knowledge.

Dealing with the problems that result in the infant's death goes through feelings of helplessness and frustration. In this situation, the extreme, the opposite and the undesirable are configured in the NICU scenario, manifested in different ways and attitudes, as they reflect the involvement and individual confrontation of each actor involved in this process.

From that condition it certainly mobilizes her, not only the pain of seeing another's pain, but her own pains are evoked there, right?! I think we have to work in such an environment where fragility rules and risk is imminent, we have to supposedly be fine, working with our personal stories out here (I2).

This reality points out to the transformations that happen in the professional practice of Nursing and are configured as a process of resignification of his professional identity, in a gradual and not always homogeneous and linear way. Data indicate that these changes need greater involvement and appreciation, since his formation, in view of the need to seek critical-reflective basis in his actions and decisions within the management of his practice, considering his commitment to the management aspects that his role grants.

We have to be an example for all the situations, so I believe that maybe some things we had to rescue in the training too (E1).

The nurse is seen as an articulator by his team and/or in his work shift and by the other professionals that make up the interdisciplinary service, An attribution that is conferred and not always perceived or declared, giving rise to the need for a better instrumentalizing and commitment of his role as a care manager.

The conducts taken or not by the nurse interfere with health care, whether to develop a critical analysis, or to identify problems around them, make decisions, plan and implement care and motivate the health team professionals. Likewise, these processes, as they are intrinsically linked, interfere with being a nurse as a human and professional being, influencing the construction of their professional autonomy in the care process.

I think the leader has a major role in helping to tell people what this institution is, the difficulties in the institution, the difficulties in managing the institution, [...] *in my evaluation, the leadership has a very important articulation role, and then the internal articulation, both in the service, between the various shifts,* [...] *and then the articulation with the other services, this is essential* (E1).

The position of leadership is a leading role, a management role, whether it is working or not working, you have to pull here, I will pull the one that is doing less, that is not doing what we standardized, something like that, but I see that the group itself has to believe, the whole group, especially the nurses (E2).

In the researched institution, the systematization of nursing care (SNC) is implemented, enabling the planning of care based on scientific knowledge, enabling nurses to exercise their professional autonomy.

Respecting the reality and specificity of each sector, by means of the SNC, the nurse has the tools to perform the planning, organization, coordination, execution and evaluation of the nursing care services, providing individualized care focused on the case of neonatology and in the needs of each pre-term infant and his family.

The respondents also signal the importance of parental participation and involvement in neonatal care at the institution investigated. Increasingly, the fear and obstacles of inserting parents in their daily work has been in the past. Nowadays, parents who are absent or who do not interact with their child and/or team immediately draw attention to facing the critical care environment and possible difficulties in bonding.

The NICU in question stands out for providing ways of allowing/favoring/encouraging family presence, which enables them to see the infant within his family context, starting there, the first lines of his life history, in the most humanized way possible, putting, for the parents, the severity of their child and technology aspect in the background.

We work hard on this family issue, on the support network to humanize and to check with the team what the possibilities are for this family to be inserted in the care of this newborn (I1).

They [nursing staff] *give us peace of mind, give support, and take care, because in the beginning when we are in the ICU, in the incubator, they are the ones who take care. We have no contact, so, they give us peace of mind, you know?! That affliction; that anxiety of not knowing what will happen in a moment, right?! They reassure us and we see that we are well cared for, you know?!* (M2).

Most of the time, it is up to the nurse to assess the families' needs/priorities in their initial contacts with the NICU setting. The data reveal that there is a sensitivity exercise in the team towards parents, providing welcoming and giving information that is easy to understand.

It is also up to the nurse to evaluate and provide the necessary referrals to the parents throughout their child's stay in the NICU, in coordination with the other health team members.

The presence of the mother in this connection in the child's neuro-sensorial development, in short, is not only the kangaroo, but the presence itself. The one with a little baby who is in serious conditions, he still can't make skin-to-skin contact, right?! But the mother's voice, her touch, makes the difference, yes, the mother, the father, that reference person (I1).

Here the service is very different and the neonatology nurses try to make us feel different, try to make us not feel inside the hospital (M5).

Team-family relationships are often very close and reflected subliminally in care delivery. They are based on the psychological, cultural aspects of each professional and family individually.

Consequently, long periods of hospitalization allow the parents, because they spend many hours in the neonatal unit, to follow and know part of their routine. The team also sometimes provides closer relationships, to a greater or lesser extent. We observed that this relationship mode often goes beyond the professional/hospital setting, allowing them to enter into personal aspects that go beyond infant-family care.

This is other feature different from the neonatal ICU to the adult ICU, the neonatal ICU has a much longer stay, longer than the adult ICU, so the bonds that build up, they will also reflect on the care issue, and then there is the empathy and antipathy theme (E1).

Nursing, following the technological advances in health, seeks to innovate and re-signify its praxis, adopting new relationships and interactions, whether internal or external, expanding its aptitude in the construction of knowledge.

The NICU in question stands out for implementing scientific thinking as a primordial basis in the search for the best practices in neonatology, a recent field with constant advances in technological innovations. The routine changes and new ways of caring are based on collective discussions and scientific research, appropriate to the particularities and context of the scenario, periodically evaluated, aiming to reconcile the individualization of care with the implementation and offering of good practices to the infant, his family and health team.

It was a fight for us to get that "kitten" oro-gastric probe fixation. One of them put it there, one put it here, one complained. Until, I don't know how things were happening in a way we don't even realize it, that today everyone when they are going to fix an oro-gastric probe, fix that "kitten" one (T6).

The adverse conditions also serve as opportunities for the reevaluation and changes of practices, such as the emergence of nosocomial infections, which implied the adoption of individualization of materials such as thermometers, stethoscopes, diapers and care with dispensation of milked breast milk, conducts that emerged from the team collective construction, which reorganized their care practices.

It's probably because it's a client that really needs attention, they're fragile infants, so I think it makes us want to know more so we can understand a little bit more about baby's language (E3).

It's a peculiar language that is both difficult and complex to know, so maybe that's why they (team) *are so focused on studying* (E3).

Regarding the multidisciplinary work process, some aspects appear as hindering/challenging. One of them, pointed out by the interviews, is the space occupied during the physical structure renovation, which prevented the proximity and privacy for periodic discussions. Added to this is the fact that not all the team members work in the NICU exclusively, limiting their dedication and interaction with the unit's organizational context for collective decision-making, reducing the viability and implementation of best management care practices.

At this moment, we are in a period of renovation, right?! So that broke our improvement process a bit. I'll tell you, because of the working conditions and the space we have today, things that we didn't do before that we considered had expected the return of not so good practices (I1).

In the everyday of this NICU, there are differences of conduct and points of view, acting as obstacles in labor relations, disarticulating the team in such a way that divergences cause conflicts and imply lack of adherence to the proposed changes.

For example: we have an X situation in a baby, let's meet, right?! A technician, a nurse [...], *a doctor, a speech therapist, right?! Whoever has to talk about this situation, let's get together, a more informal meeting* [...]. *So, those who participated lead to everyone together, right?! Speaking the same language, because their parents are very attentive, right?!* (T4)

As we consider the increased supply of intensive care to an increasingly pre-term newborn and therefore at high risk of neurological sequelae, a new reality that is worthy of attention and concern is an increased susceptibility to the development of sequelae due to prematurity and interventions suffered during hospitalization in neonatology.

We are dealing with a very atypical beginning of life that can cause a lot of inconvenience forever, so we are responsible for the result of what we are putting into society and not everyone realizes it... (I2)

I think the responsibility we have for the newborn is much greater and because you have to do real miracles, if you look at the number of premature infants who have been born underweight (E1).

Since they understand the care specificities in neonatology, nurses seek to act as a team, prioritizing professional qualification. In their daily care, when inserting parents/families in the critical and technological setting that composes their practice, there is a need to care about the repercussions that taking care of a fragile pre-term infant implies, avoiding bio-psycho-physiological sequelae. Thus, the articulation representation between the presented categories and subcategories and the phenomenon is illustrated in Figure 1.

Figure 1 – Representative diagram of the articulation between the presented categories and subcategories and the phenomenon. Florianópolis, SC, Brazil, 2014.

DISCUSSION

The issue of prematurity brings with it some specificities, conferring the need for a singular and highly specialized care, requiring a continuous improvement in the professional skills. A number of studies in this area portray the constant search for knowledge deepening about prematurity, such as prevention of skin lesions in newborns and newborn skin,[7] discomfort and pain in newborns,[8] identification and prevention of excessive noise in NICU,[9] as hearing loss in NICU hospitalized newborns related to prolonged noise exposure is one of the most widespread problems in the literature,[10] new neonatal resuscitation strategies,[11] risk factors for intracranial hemorrhage,[12] and NICU patient safety promotion,[13] among others.

Facing this scenario of a care susceptible to constant changes, the study results show that the best practices management in nursing care practice is formed by relationships and interactions in their everyday in micro and macro organizational space and seeks to overcome barriers present in these environments.

A research also reveals that the nurse articulates care and management aspects, not always having control of the demands, because besides the daily responsibilities, still has to count on the characteristic of unpredictability of a NICU. However, as Morin[14] brings about, it is about knowing how to think the unpredictable, the circular, the recursive, that is, what escapes the traditional conceptions of causal determination and linear time; it is a matter of definitively breaking the disciplinary barriers and of building a multidimensional and trans-disciplinary science.

The management of the NICU care practice can/should be understood as a product and service in its multiple dimensions/relationships/spaces, that is, as a unique service production system in its way of being and existing. It obeys and follows orders, routines in its daily life, while constituting the place where random encounters are born, permeated by situations of order/disorder/interactions/organization.

The search to broaden knowledge and skills implies new perspectives on the management of care practices developed, encouraging nurses to discover new ways of acting together, recognizing the value of complexity in the uniqueness of their being and doing. Therefore, nurses open spaces for new health practices that address sensitivity, highlighting the need to use a new framework that addresses the inter-subjectivities and interactions in the NICU environment.[15]

The importance of family insertion, as well as their perceptions and coping assessment, sharing care with the multidisciplinary team is a recurrent theme in national and international literature[16–17] and essential for neonatal care.

Contemplating the sensitivity and fragility that permeates the issue of prematurity, the family appears as a source of essential support, actively participating in this process. The participation of the nuclear family (father, mother and siblings) and of the extended family (grandparents, uncles and cousins) in this moment of fragility, and the support of those who are trusted, whether they have blood ties or not (friends, neighbors), are a valuable emotional support asset.[18]

In this perspective, there is a study that signals that NICU nurses and physicians should be encouraged to reflect critically on whether the type and consistency of support they provide to parents matches the parents' perceptions and needs.[19] Inserting parents in the NICU scenario means not only placing them as spectators where the team defines what care they will perform, but also embracing their opinions and feelings and jointly discussing the actions taken, considering/reconciling technical skill and paternal desires.

Regarding the multidisciplinary work, it was found that its articulation is unanimously valued by all the team members, bringing benefits to promote the search, implementation and evaluation of new care practices, as well as providing good relationships between involved actors in the neonatology

setting. However, there are limiting factors such as the need for a greater frequency in the discussion of the conducts taken, whether in the management or in the care realm, where everyone acts in a committed and responsible manner.

Providing quality care for children and their families requires cohesion among the team, including professional competence, mutual respect, responsibility, effective communication and collaboration.[20] Working in teams is not just about adding functions to achieve a common goal. It represents combining competences, understanding divergences and establishing an integrative and problematizing relational process capable of rescuing truly human feelings.[21]

The actions of the multi-professional actions focus on the concern and commitment not simply to ensure the pre-term infant's survival. The incorporation of care measures that seek to avoid iatrogenic and sequelae to this being is increasing, seeking to integrate it with their family and society with quality of life.

As a limitation, a research study presented the fact that data was collected in a single hospital. A number of research studies including other institutions, inserting a larger number of participants may bring more representative information of the investigated phenomenon.

CONCLUSIONS

The organization of the nursing care system in a Neonatal Intensive Care Unit is complex, dynamic, interactive and interdependent with the rest of the health systems, mobilized by a management process of care and/or good care management practices that enables pre-term and his family a care focused on the fragility and uncertainties of living/surviving in singular life conditions.

In this context, the research showed that the nurse stands out with the fundamental articulation role in daily care and organizational relations/interactions. He involves and is involved by the family members and the other health team professionals, as well as by the support services, to seek solutions and alternatives to the challenges and limitations that emerge in daily intensive care, using autonomy and creativity.

The results showed that the relationships between the multi-professional team are still fragmented, signaling the need to strengthen ties in order to optimize and improve the application of best practices, encompassing the plurality of knowledge, exercising communication, meeting the common goal which is the excellence of newborn and his family caring.

The research also shows that inserting parents in their child care goes beyond allowing/providing their presence in the NICU, but placing them as active and collaborative actors in the decision-making processes in therapeutic behaviors, instrumentalizing them to re-signify the birth process of this unique, fragile, singular being, allowing them to exercise care/bond not only at the onset of hospital discharge, but from the first skin-to-skin contact.

As a proposal for future research studies, it is suggested to broaden the phenomenon study in question in other care settings in neonatology, providing more participants.

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NOTES

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AUTHOR CONTRIBUTIONS

Study Desing: Klock P, Buscher A, Erdmann AL.
Data collection: Klock P.
Analysis and interpretation of data: Klock P, Buscher A, Erdmann AL, Costa R.
Discussion of the results: Klock P, Buscher A, Erdmann AL, Costa R, Santos SV.
Writing and/or critical review of content: Klock P, Buscher A, Erdmann AL, Costa R, Santos SV.
Review and final approval of the final version: Klock P, Buscher A, Erdmann AL, Costa R, Santos SV.

APPROVAL OF RESEARCH ETHICS COMMITTEE

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CONFLICT OF INTERESTS

There is no conflict of interest.

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