

VALORIZATION OF THE FAMILY IN THE CARE PROCESS: NURSES' ATTITUDES IN A NEONATAL UNIT¹

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ABSTRACT

Introduction: Qualitative, exploratory, descriptive study carried out in a public hospital in the Brazilian Northeast. **Objective:** to understand the attitudes of nurses in care with families in neonatal intensive care and the way their practices and attitudes permeate the care process. **Methodology:** the data were obtained through an open unstructured interview with 11 nurses and supported in Content Analysis. **Results:** Four themes were created, in which welcoming, listening, empathy, bonding and care in partnership were attitudes to take care of the family with the purpose of the therapeutic project and the continued care of the child at home. **Conclusion:** knowledge, technical skills and particular attitudes are nursing practice, in which the time and quality of the presence are challenges that are necessary to combine the care with families with technological and bureaucratic procedures. Competencies will be needed to manage and to generate innovation and renewal of nurses' attitudes and practices, especially the values attributed to acting and not just the availability of time.

Keywords: Nursing. Intensive care. Family nursing.

INTRODUCTION

Health care must embrace the family in a collaborative, autonomous, integrative and family-centered way. It is a way of caring that should value the experience of the family; direct interventions to all members, healthy or sick; considering influences, family relationships, family forces, culture and the environment, implying a process of interaction between the professional and the family⁽¹⁾. In this perspective, the nurse is a promoter of change and his/her knowledge aims at a new level of stability, since the focus is the family functioning, especially in the context of Neonatal Intensive Care Unit (NICU). The inclusion of the family in care requires that nurses be open to interactions and adopt caring attitudes in a dynamic of relationships and interventions that exceed clinical care⁽²⁾. Therefore, attitude is understood as the disposition or behavior that allows making value alternatives of a given situation⁽³⁾ or a psychological evaluation tendency, involving

decision making, favorable or unfavorable, in relation to an object. It means a purpose, a way of proceeding, an organized and coherent way of thinking, feeling and reacting⁽⁴⁾.

Taking into account the assertions that guide the nursing care of families and the delimitation of the object of research, it was assumed that the nurses' attitudes are decisive for the quality of the relationships established with the family in neonatal intensive care, allowing to formulate the question of research: What attitudes are adopted by nurses to value the family in the care of the child in the context of neonatal intensive care? From this questioning we were mobilized to carry out this research in order to advance the production of knowledge on Family Nursing in the context of neonatal intensive care. The objective was to understand nurses' attitudes to care families with neonatal intensive care and how their practices and attitudes permeate the care process.

METHODOLOGY

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It is a qualitative, descriptive and exploratory research with nurses who practiced their professional activities in the neonatology unit of a University Hospital in Northeastern Brazil (10 in the NICU and one (01) in the *follow up*). The participants were included in the criteria: being in full professional practice and having professional experience in the sector for at least six months.

All the interviews were carried out in the physical space of neonatology, in a room designated by the Coordination of the service. We used an open individual interview guided by the question: What attitudes are assumed by nurses to value care with families? Circular questions were needed to facilitate the expression of participants' experiences. The interview data were analyzed with the support of Content Analysis in three phases: pre-analysis; exploration of the material; treatment of results, inference and interpretation⁽⁵⁾. The corpus was defined by 11 interviews and in the pre-analysis hypotheses were formulated that allowed the construction of the indicators of analysis to make the data to be transformed into analytical material and allowed to determine the dimensions and directions of the analysis. The exploration of the material constituted the second phase, by identifying the units of record from the cut (choice of units) followed by the classification and aggregation to choose the themes.

Data collection was performed after the first contact, at a date and time agreed with participants from August 25 to December 19, 2016. To ensure the principle of confidentiality and anonymity, the data source will be presented in a coded way (Enf 1 ... 11). The principle of autonomy was considered, granting for the participants the possibility of refusing to participate in the research.

The study respected the formal requirements of the national and international standards that regulate research involving human beings, with the favorable opinion of the Ethics and Research Committee of the Federal University of Maranhão, number 1,249,885.

RESULTS

Through the careful process of Content

Analysis, it was possible to name four themes: Attitudes of Nurses for Family Care in the Context of Neonatal Intensive Care; Attitudes of Care for Families with Focus on Continuity of Care; Factors that guide the practice of the Nurse in the NICU, and Limitations of the family care, which will be presented descriptively with a cut of the speeches of the participants.

Theme 1. Attitudes of Nurses for Family Care in the Context of Neonatal Intensive Care - in this theme, nurses characterized attitudes of care with families in the Neonatal ICU, for example: the reception, empathy, bonding, listening, dialogue and the quality of the presence:

The attitudes that we try for the family are the welcoming in the admission of the babies in the UTI-NEO (Enf 1).

The attitude of the nurse is to welcome, to receive, to respect, to clarify clearly, concretely, bluntly, without difficult terms and you feel that you are being understood (Enf 11).

Another remarkable attitude was empathy, understood as the ability to become aware of feelings, concerns and needs of others:

Empathy is to know that what the family is going through could be with me. To be empathetic the nurse must be available to the family and emphasize that he is willing to clarify anything and that he will be there to attend to their needs. We have to put ourselves in the family's place. (Enf 6).

Empathy is fundamental in the professional practice of nurses, because it allows them to recognize effectively the needs of the other, and consequently to satisfy them and to find ways to help them in their difficulties. At other times, the participants emphasized the nurse's attitude towards the construction of the mother-child-nurse bond:

In the neonatal ICU there is a situation of frustration between the imaginary baby and the real baby. This can lead to rupture, especially in more extreme cases, such as malformation, extreme prematurity. Nursing plays a fundamental role in helping to form the mother-baby bond (Enf 1).

It is fundamental the bond that the professional

establishes with the family and the family perceive in the professional a person who supports and who can trust. Only in this way there will be an exchange (Enf 4).

Listening and dialogue emerged from the nurses' speeches as necessary attitudes to care for the family based on the quality of presence and communication for the continuity of care, where being present does not only mean physical presence in performing technical procedures:

Attitude that I see is listening, it is necessary to listen, to be near to them, being close and to be close I have to listen. It is important to exercise listening for closeness. It takes quality of presence, getting closer to the other, being closer to the other and giving security to the family, because otherwise we build nothing. (Enf 2).

Listening to what the family has to say, clarifying doubts, questioning, and even calling to participate actively in the process. Giving the family the opportunity for active participation (Enf 4).

These attitudes, together with the communication skills, motivate horizontal relations of care in the NICU and are configured as a tool for integral care.

Theme 2. Attitudes of Care for Families with Focus on Continuity of Care - it reveals how the nurse cares for the family aiming at the continuity of care in the home environment using health education as a strategy for care:

It is no use for the hospital staff to take care of themselves; the hospital staff cares for the family to continue to care at home (Enf 1).

Today you cannot take care of the child without the presence of the family, because they will continue the care at home. Otherwise we are not sure that the family is ready to take care of it at home (Enf 2).

Added to this, the unique therapeutic plan is defined as therapeutic behavior, the result of the collective discussion of the interdisciplinary team with the family from the needs of the child-family dyad. This assertion is confirmed in the following speech:

The Hospital works with the unique therapeutic plan, which understands the patient and his family as essential in the construction and

discussion of treatment, and the family, together with the professionals, decides on the best intervention approaches (Enf 10).

Another important point for the continuity of care is the home visit:

It is necessary to see the family context, so the home visit carried out by the staff here has the role of seeing the social, family context and broadening this approach in guiding the care of these babies and what they need (Enf 4).

The home visit made by the NICU team demonstrates the commitment and availability of these professionals to care, strengthening ties with their families and establishing relationships of trust, as well as reducing insecurity regarding care delivery to the newborn.

Theme 3. Factors that guide the practice of Nurse in the NICU - nurses may be able to describe what it is to be a good nurse and what good nursing care is based on personal values and experiences:

The differential of us, nurses, is in the proximity of making families feel that we are there not only as a professional, but as a person who is ready to welcome, to understand. This is what will make the differential as a nurse. Then nothing more viable than we have this relation of trust, of fellowship, of welcoming. The nurse has the correct attitudes to take care of the family, and she is one of the professionals that most assumes this dimension of care (Enf 11).

However, when analyzing their practices, nurses announced that there is a discrepancy between what they think and what they actually do, revealing a value perspective:

For nurses, care has to be made available, and not everyone has this availability, many nurses are worried about the technique, and they do not think that caring for the family is not important and that it is not part of the routine of the nurse to take care of the family and some nurses have neglected this care. It takes sensitivity to know that the family is part of the care. It is no use being an excellent technique that does all the procedures if I do not have this care at the whole. It is always said that the nurse has the look of the whole, so we have to see the family. But there is religion, politics, culture, there are many things that interfere with care and if we do not have a wide look, we do not take good care (Enf 5).

Nurses need to consider not only their own beliefs to guide their actions, but also the families', other nurses' and other professionals' beliefs, according to the scientific evidence and ethical and moral considerations:

It is necessary to respect, to listen, trying to demystify without the family loses what they believe, but respecting the individuality of each one (Enf 4).

We no longer work in isolation, but in interdisciplinarity... It is a communication between professionals about what is happening. This is paramount for an expanded care for the family. Each one with a glance realizes and changes it with the others. In front of a problem the team sits, talks, discusses and later we sit in the room with the family (Enf 5).

It is relevant to consider the need to combine personal values with professional values that are acquired through reading, observation, reflection and research and are adjusted and reinforced by feedback among colleagues, families and other staff members. At this point, attitudes of care seem to be implicitly related to the sensitivity of each nurse. Thus, caring for the family was gradually becoming the nurse's identity behavior and as a professional choice:

Make it possible, have a time to listen to other people, to exchange ideas, to see how the service is happening in other places, in other sectors. It is an investment that is personal. You need to change and also want that to happen, I think it is a lot of the person's desire and also for you to enable it (Enf 3).

For some nurses, the intervention in the context of the NICU aims to meet the needs of the person in critical situation, in this case, the newborn, deferring the care of the family for a reference professional:

We often tend to share the family care with others. The nursing has contact with the family in the morning and in the afternoon, but at night we don't, there's a lot of demand. We ask that they return in the morning. It is complicated to take care of the family. The nurse's life is very busy; sometimes the doctor can give the assistance to the family when there is a resident doctor because there's too much to do. There are 19 children and their families. The hospital should have a prepared team, who can study each case, understand each situation and take care calmly, without hurry. The quantity of

babies is great and each baby has his family, so it should have a team just for that, just to give attention to the family. We often say that the baby has a syndrome, and we talk, and sometimes we do not have time to sit down and study the syndrome to explain it to the family (Enf 8).

Otherwise, it was revealed that:

Even with the rush, if the professional has a different attitude, he would take care better of the family, it is a matter of organization and see that inside there is a context, which includes not only the sick baby but the family and their needs, weaknesses. (Enf 6)

Therefore, in order to take care of the family, it is necessary to go beyond the technical care and perceive the universe that constitutes each family and interact with it, making this social group a context of care, and not just the newborn.

Theme 4. Limitations of the family care – Family care is intrinsic for the routines of the nurse in Neonatology, it's evident the importance and necessity, due to the benefits for the newborn, health team and family, besides ensuring continuity for home care. However, some professionals reported that despite the importance of family care, they do not do it, claiming unavailability of time and multiple tasks as demonstrated in the speeches below:

Nowadays there is an attempt to keep the family close, but it is not always as effective as it should be. Because of the great demand for services and activities there is no time to stop to actually have that moment as it should be, there is the moment, but it is often shorter than it should be. (Enf 1).

Because of the dynamics of the ICU, this is a little bit to be desired, because the routine is very different, it's a rush, the babies are in a serious case, so you do not have that constant contact with the family (Enf 6).

The routine of the unit determines how the guidelines will be made or even the informal conversations with the family, because the approximation with the relatives is only possible when the demands of the work shift allow the time for it:

We were unable to provide care for family. There are too many babies to take care of, too many tasks. The keys, the papers, the incubator that is not heating, the medication that did not arrive and the family... We give information in the hospital hall. We often end up leaving it to do other tasks. The nurse's problem is the rush, explaining everything very fast and doing things automatically. We talk, "the family participates," but in many things we end up not letting the family really participate (Enf 8).

Likewise, each family has their singularities, and it is up to the nurses to have sensitivity and know how to adapt to the routines of the sector in order to reduce the stress and suffering of family members:

What happens in reality is that we see a barrier. We understand the importance of the family during the hospitalization of the newborn, but the routine and the mechanicity of the procedures distance us from the approximation and appreciation with the family. We ended up not bringing this family close to us and we moved away. (Enf 10).

Sometimes the nurses understand that the relatives come to the Neonatal ICU with the objective of ascertaining the care provided by them, which causes insecurities and consequent remoteness:

Here in our unit, mother and father have liberated entrance, the other relatives don't, and they use to be boring: "Here comes the grandfather, there comes the grandmother, here comes the uncle." We can imagine that a lot of curious people come. We do not see how people are really coming to collaborate. We perceive them as curious and as if they were there to watch over our work (Enf 10)

Another important point emphasized by the nurses who participated in the research is the dimensioning of personnel in the NICU. They refer to deficits in human resources, generating an overload of activities that compromise the quality of care and relationships in which informing, welcoming, and humanizing are neglected by bureaucratic issues and technical demands of the sector, producing poor and limited care:

The nurses have a tendency to receive assignments that are not for them, to do administrative things that are not nurses', and we end up assuming for the child's sake, for the

well-being of the family. The excess of assignments often leads you not to give so much attention to the family (Enf 9).

On weekends, holidays, and the night shift, where the health care team is incomplete and the accumulated demands are divided between nurses, doctors, and nursing technicians, they are postponed to another time or another day. To solve this problem, nurses focus their attention on children with the most serious cases and this can generate detriment in the care of those with a more stable clinical picture and neglect care with families:

When there is a professional who is full of assignments, with many patients, he focuses on patients who have a serious case. And you often have ten patients in your responsibility, but you can only care more the one that is very bad. And some families get a little abandoned. (Enf 9).

It was revealed that the nurses have focused on technical care:

In the context of neonatology, nurses don't have the attitude to take care of the family. We are busy with tasks that will generate roles or some bureaucracy. Sometimes the parents are there next to us, and we think that everything is fine, but that father is distressed and we do not come, we do not have time to come and ask if everything is ok, to communicate, and we cannot supply the needs of the family. (Enf 8)

Some professionals reported inhibiting attitudes towards caring for families. This fact may demonstrate that there is a need for investment in training, but especially in personal development to acquire skills and competencies to take care of families and their complexities:

Some mothers have a refusal attitude, this makes that the care of the family doesn't happen, so this makes that the team is distant. You only go when you are asked for, when you realize that the baby is really in need. Because you have a lot of difficult mothers, who, perhaps because of the situation, who have not understood the real situation yet. They have these attitudes of refusal, of ignorance, and we also take away, as a protection measure. (Enf 7).

On the other hand, some nurses understand the limitations of the sector and other professionals, and seek to adopt attitudes to modify them, so that the family feels welcomed

in the NICU and they are also subject of care:

Most nurses take care of families. As much as possible people take care of themselves. But really, if we had a better working condition, more professionals, that would be better. Sometimes you are very agonized, but you can stop and pay a little attention because the family needs (Enf 11).

The NICU has some situations that make it difficult to take care of the family, but the attitude of the nurse is the key point for this care to happen, and these attitudes will coordinate this relationship, making the family a participant in care or mere spectators.

DISCUSSION

The fact that the research was developed in a single context can be configured as a limitation, a fact that makes us to suggest other studies with a broader scope, so it is possible to visualize different contexts and realities. But the research contributed significantly to the professionals' reflection on their assistance to families and rethinking their way of taking care of a new approach to family members, perceiving them as an integral part of care, which will bring us, in the long term, a change in the reality of care practice.

As caring attitudes, the welcoming was cited as a first step towards the care and beginning of the nurse-family relationship and tool for the expansion and implementation of humanized care. Welcoming is the "act of receiving and attending the different members of the family in the neonatal unit, seeking to facilitate their insertion in this environment. [...] involves an action not only physical but also affective"^(6: 6). It is a humanizing relationship, which involves exchanges and includes, in addition to the subject, the social context⁽⁶⁾, being adjusted as a driving strategy for caring for the family.

Empathy, another attitude toward caring for the family, requires concern for the other, the formation of bonds, the feeling of sharing and the possibility of *putting yourself in someone's shoes*⁽⁷⁾ and involves listening, and, especially, making the family feel understood.

One of the nurses' roles during the hospitalization of the newborn is to maintain interaction with the family so that the

construction and maintenance of the bond takes place and results in well-being and mitigation of the damages caused by hospitalization⁽⁷⁾. The promotion and maintenance of the bond with the family allows the nurse to provide integral and quality care, identifying peculiarities and adjustment capacity in this moment of family fragility, where there is psychic suffering and the possibility of losses and ruptures.

This attitude brings a new perspective on caring, developing with the family mechanisms of adaptation and coping that will result in an attention focused on the subjectivity and individuality of the subjects⁽⁸⁾. For this reason, welcoming and bonding are strategies to improve health care, once it centralizes the work processes in the family, while the participation of the family in the health-disease process develops the capacity of empowerment⁽⁹⁾.

Empathic listening and effective communication attach greater quality to care and are "necessary to build connections and sustain a relationship"^(10: 330). The author emphasizes that to be an attentive listener the nurse must develop skills, be fully present and learn to distinguish the different forms of communication. In the perspective of authentic care, listening and dialogue are presupposed, it presupposes that the nurse has attitudes of interest and willingness to care, and demonstrates the commitment to perceive, to know and to understand the other in their needs and sufferings, in their joys and weaknesses⁽¹¹⁾. Therefore, valuing listening and dialogue stand out as attitudes of respect, while ignoring them is attitude of arrogance.

When communication is effective and timely, nurses perceive a decrease in the level of suffering and anxiety in their families⁽¹¹⁾ and behaviors such as welcoming, empathy, bonding, listening, dialogue and the quality of the presence collaborate for horizontal relations between professionals and the family and conform as positive attitudes of nurses, who facilitate and collaborate for the care of families in the context of the NICU.

NICU care is not restricted only to the neonatal unit, but must be continued by the family in the home environment. In order for continuity of care to be a reality, there is a

need, firstly, for the exercise of partnership care⁽⁹⁾. In this perspective, the NICU becomes a learning environment, sharing of experiences and care⁽¹¹⁾ and will be determinant for home care after discharge⁽¹²⁾. Therefore, family training for home care should be initiated when the newborn is admitted to the NICU through care in partnership. To this end, the nurse must equip the family with knowledge associated with practices, exercising the integration of professional knowledge to the family's knowledge, performing health education actions⁽¹³⁾. Thus, the care that nurses provide to families determines the acquisition of skills, the reduction of fears and insecurities, and consequently the continuity of care at home^(7,8).

The home visit is a tool to take care of the families, since it allows the professionals to know the family context at home and directs specificity to the interventions⁽¹²⁾. The period before hospital discharge is critical and full of insecurities for the family, which makes the home visit important, since it optimizes nurses' performance and promotes the integration of professionals and the family⁽¹¹⁾.

With regard to the work process, excessive hours of work and inflexible routine, nurses tend to move away from their families⁽¹²⁾, because the focus of these professionals' attention is focused on the technological and technical apparatus of the NICU, where despite the understanding that caring for the family is necessary, this assistance is not effective. Therefore, the NICU routines tend to alienate the nurse from the family, and this professional eventually loses the real value of that moment to the relatives⁽¹⁴⁾. This condition produces a fragmented approach to the family, and nurses, attached to the role of caretakers, restrict themselves to answering the questions of family members, without them expressing timely and coherent information and meeting the needs of the family. The haste in answering the questions of the families and returning to the technical activities compromises the bond, the relations of care and generates ineffective communication.

The nurse perceives that the model focused on the biological dimension enhances the distress and stress experienced by the family⁽¹⁵⁾, but some professionals refer to changes in

attitudes to minimize these damages, especially determined by factors and forces that influence nursing practice, including knowledge, professional and personal experiences, policies and intentionality⁽¹⁰⁾. However, when analyzing their practices, nurses announced a discrepancy between what they think and what they actually do, reinforcing the influence of values⁽¹⁰⁾ on professional behavior.

The meanings expressed by nurses in caring for families have a very close relation with the attitudinal determinants which modify the strategies for care with families. Thus, it can be inferred that the personal characteristics of each professional influence the practice of care and reveal an intentionality to meet the family.

In any case, taking care of the family and assuming the attitude of appreciation of this social group as a unit of care was configured as an initiative inherent to each nurse and this revealed two experiences: For some the centrality of care is the family and the child and they take the interaction as required. For others, the intervention in the context of the NICU aims to meet the needs of the person in critical situation, in this case, the newborn, delaying the care of the family for a reference professional. This fact is curious and antagonistic, since attention to preterm and low birth weight newborns is based on caring for the family.

CONCLUSION

Neonatal ICU care is a practice permeated by complex emergency situations, in addition to being surrounded by expectations and risks, where the newborn is subjected to invasive procedures, making it also a stressful environment for nurses and the family. Thus, it is necessary for the nurse to take care of the family, seeing the decrease of anguish and anxiety, showing empathy, interest and concern with them. Establishing a bond and partnership with the family is undoubtedly a guiding principle for the care of families to be adjusted in companionship and reciprocity, resulting in an assistance that benefits both. Assistance should focus on subjective care, as well as technical care, in order to place the family in the center of attention and to have attitudes that

suggest a capacity for partnership with the family, focusing on the continuity of care.

The nurses of the Neonatal Unit revealed that they are always overloaded, because besides the routine care, which is centered in the procedures, they assume innumerable bureaucratic tasks and some attributions that are not of their competence, which reduces and

limits the family care and refers to the necessity to reorganize the NICU scenario, where the actions are still centered on the technical model, focused on the disease and not on the subject and prioritize the newborn, disregarding the family. Family Nursing is still in process, and its path is full of technicality, institutional and personal limitations.

VALORIZAÇÃO DA FAMÍLIA NO PROCESSO DE CUIDADO: ATITUDES DE ENFERMEIROS EM UNIDADE NEONATAL

RESUMO

Introdução: Estudo qualitativo, exploratório, descritivo, realizado em hospital público do nordeste brasileiro. **Objetivo:** compreender as atitudes dos enfermeiros no cuidado com famílias em terapia intensiva neonatal e o modo como suas práticas e atitudes permeiam o processo de cuidado. **Metodologia:** os dados foram obtidos por entrevista aberta não estruturada com 11 enfermeiros e apoiados na Análise de Conteúdo. **Resultados:** foram construídos 4 temas nos quais acolhimento, escuta, empatia, vínculo e o cuidado em parceria foram atitudes para cuidar da família tendo por finalidade o projeto terapêutico singular e o cuidado continuado à criança no domicílio. **Conclusão:** conhecimentos, habilidades técnicas e atitudes particulares marcam a prática do enfermeiro, na qual o tempo e a qualidade da presença são desafios que sugerem ser preciso aliar aos procedimentos tecnológicos e burocráticos o cuidado com famílias. Serão necessárias competências para gerir e gerar inovação e renovação de atitudes e práticas do enfermeiro, sobretudo os valores atribuídos ao agir e não somente à disponibilidade de tempo.

Palavras-chave: Enfermagem. Cuidado intensivo. Enfermagem Familiar.

VALORACIÓN DE LA FAMILIA EN EL PROCESO DE CUIDADO: ACTITUDES DE ENFERMEROS EN UNIDAD NEONATAL

RESUMEN

Introducción: Estudio cualitativo, exploratorio y descriptivo, realizado en hospital público del nordeste brasileño. **Objetivo:** comprender las actitudes de los enfermeros en el cuidado a las familias en terapia intensiva neonatal y el modo como sus prácticas y actitudes influyen el proceso de cuidado. **Metodología:** los datos fueron obtenidos por entrevista abierta no estructurada con 11 enfermeros y basados en el Análisis de Contenido. **Resultados:** fueron construidos 4 temas en los cuales acogida, escucha, empatía, vínculo y el cuidado en conjunto fueron actitudes para cuidar a la familia teniendo por finalidad el proyecto terapéutico singular y el cuidado continuado a niños en el hogar. **Conclusión:** conocimientos, habilidades técnicas y actitudes particulares marcan la práctica del enfermero, en que el tiempo y la calidad de la presencia son retos que indican ser necesario aliar a los procesos tecnológicos y burocráticos el cuidado con familias. Serán necesarias competencias para gestionar y generar innovación y renovación de actitudes y prácticas del enfermero, sobre todo los valores atribuidos al actuar y no solo a la disponibilidad de tiempo.

Palabras clave: Enfermería. Cuidados intensivos. Enfermería Familiar.

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