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Original Article

Organization of Nursing work regarding the integration of family care for hospitalized children

Organização do trabalho de Enfermagem diante da inserção dos cuidados familiares com a criança hospitalizada

Organización del trabajo de Enfermería delante de la inclusión de la atención familiar al niño hospitalizado

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Objective: to discuss the organization of Nursing technician's work in the interface of the care of family members of hospitalized children and to identify their perception of the insertion of family in caring for this child. **Methods:** this is an exploratory descriptive study with a qualitative approach, undertaken in the pediatric inpatient unit of a university hospital with six Nursing technicians, through semi-structured interviews. **Results:** professionals realized the importance of the family's presence for the child's recovery; however, in basic care which was previously developed by Nursing, they were eventually delegated to be companions, with care for the child-family binomial forgotten by the professional. **Conclusion:** nursing technicians recognize the benefits and difficulties of the presence of a companion. However, it is perceived that there was a lack of professional preparation when considering the binomial of child-family during hospitalization.
Descriptors: Work; Nursing Care; Child, Hospitalized.

Objetivo: discutir a organização do trabalho do técnico de Enfermagem na interface com os cuidados dos familiares com a criança hospitalizada e identificar sua percepção acerca da inserção deste familiar no cuidado com essa criança. **Métodos**: estudo descritivo-exploratório com abordagem do tipo qualitativa, realizado em unidade de internação pediátrica de um Hospital Universitário com seis técnicos de Enfermagem, por meio de entrevista semiestruturada. **Resultados**: os profissionais perceberam a importância da presença do familiar para recuperação da criança. No entanto, cuidados básicos, que antes eram desenvolvidos pela Enfermagem, acabaram delegados ao acompanhante, sendo o cuidado ao binômio criança-família esquecido pelo profissional. **Conclusão**: os técnicos de Enfermagem reconhecem os benefícios e as dificuldades da presença do acompanhante no entanto, percebe-se que houve falta de preparo dos profissionais, quando se considerou o binômio criança-família durante a internação hospitalar.
Descritores: Trabalho; Cuidados de Enfermagem; Criança Hospitalizada.

Objetivo: discutir la organización del trabajo técnico de Enfermería en la interfaz con la atención de familiares al niño hospitalizado e identificar su percepción acerca de la inclusión de esto familiar en la atención a ese niño. **Métodos**: estudio exploratorio, descriptivo, con enfoque cualitativo, realizado en unidad de hospitalización pediátrica de un hospital universitario, con seis técnicos de Enfermería, a través de entrevista semiestructurada. **Resultados:** los profesionales percibieron la importancia de la presencia familiar para recuperación del niño. Sin embargo, la atención básica, que antes fuera desarrollada por la Enfermería fue delegada al acompañante, siendo la atención al binomio niño-familia olvidada por el profesional. **Conclusión**: los técnicos de Enfermería reconocieron los beneficios y las dificultades de la presencia del acompañante, pero, se percibió falta de capacitación del personal, al considerar el binomio niño-familia durante la hospitalización.
Descriptores: Trabajo; Atención de Enfermería; Niño Hospitalizado.

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Introduction

In the course of history, the care of hospitalized children, especially since the late nineteenth century, has undergone significant changes due to individualized clinical medical practice with merely a microbiological approach to the proposal of pediatric rooming, focusing on the binomial assistance of child-family[1].

These changes were determined mainly by social organization; the value and significance that society has assigned to the child in each historical moment, the mode of production, the development of medicine and the incorporation of human and social sciences in the training of health professionals[1].

The permanence of a family member or guardian for the child full-time in the hospital and their participation in care has triggered new forms of work organization in the care of hospitalized children. From this perspective, it is necessary to turn our gaze to the family as an object of care, and in the production process of relations and interventions, in addition to clinical care[1-2].

Given this concern with the effectiveness of the inclusion of parents in the care of hospitalized children, on July 13, 1990, Brazil enacted Law 8069, which regulates the Statute of Children and Adolescents, ensuring the full-time permanence of one parent or guardian in cases of a child or adolescent being an inpatient in a hospital setting[3].

The full-time stay of parents, especially mothers, brought benefits to the health recovery process of the hospitalized child. It is believed that the child, by having someone they trust beside them, absorbs all the feelings brought forth, like love, security, confidence and tranquility, which directly influences satisfactory responses to their illness, shortening the length of hospital stay[3-5].

However, despite the benefits for the pediatric population, this insertion in the hospital also created many difficulties for the family, namely: fear of the disease and the unknown; guilt, insecurity and lack of control over the hospital, people, practices, procedures and equipment; fear of losing the affection of their child; change in their life routine and meeting the child's needs; financial, social and emotional problems linked to the illness; and behavioral standards required from the parents, different from the norm[3,6].

The full-time permanence of a family member is guaranteed by the Child and Adolescent statute, which also determines changes in the organization of the healthcare team work. That is because the family begins to act as agents in the care process. However, when the law was implemented, the conditions of coexistence between parents and professionals was not considered[1].

In addition to the aforementioned difficulties and changes, problems such as the inadequacy of the area for accommodation and food, insufficient number of professionals, lack of preparation to assist the family, and the family`s anxiety and stress hinder the interaction of child/staff/family[2].

Nursing, more specifically, has not included the family in the care perspective, including them just when health problems are present, and often delegate specific family care actions in the hospital without guidance or monitoring, which contributes to reducing the quality of care[3].

Despite the focus of Nursing work being centered on the child and their illness, pediatrics has been trying to change that focus to a more family-centered approach. From this perspective, the family is now considered as the primary care unit. This view does not ignore the whole systematization built up to this point, but broadens the focus of work[1,2,5].

In this context, this study aimed to discuss the organization of nursing technician work regarding the care of families with hospitalized children, and to identify their perception about the family's insertion in child care.

Method

A descriptive and exploratory study, with a qualitative approach that aimed to understand dimensions considered deep and meaningful that could not be confined to variables of the quantitative approach[7].

For empirical data collection, we used the technique of semi-structured interviews, combining open and closed questions where the interviewee could discuss the issue at hand without being attached to formulated questions[7].

The survey was conducted in a pediatric unit of a university hospital in the city of Santa Cruz-RN, in October 2013.

The study selection subject criteria were: Professional Nursing staff who worked for more than one year in the studied unit in accordance with the work scale. The exclusion criterion was the desire to withdraw from the study or not being available for the interview. Nine mid-level professionals worked in the pediatric unit, and six nursing technical professionals participated in the study.

In order to characterize the survey respondents, we collected data on gender, age, marital status, training time, graduation, training courses, work experience in child health, work experience time at the site under study and professional links outside the field of study. We performed descriptive statistical analysis to define the absolute and percentage frequencies for the information collected.

The interview was recorded with the help of an MP3 device and had the following open-ended questions: "Tell me about how you organize your work in the care of hospitalized children?"; " Could you talk about the care actions aimed at hospitalized children?"; " What is your perception about the inclusion of the caregiver (family) in the care process of hospitalized children on the daily dynamics?" These interviews were conducted individually in the workplace, so as to provide greater contact with the reality of care practice of the study subjects.

For determining the number of participants, we used the data saturation criterion, that is, when data became repetitive, we ended data collection.

Data analysis had Content Analysis as its theoretical basis, which corresponds to a set of communication analysis techniques that aims at indicators which allow the inference of knowledge concerning the conditions of message production and reception[8].

Thematic analysis occurred in three major stages: pre-analysis; material exploration and treatment of results; and interpretation. The first step was composed by organizing data through brief reading, corpus constitution, hypotheses formulation and reformulation, and it contributed to determine the units of records and concepts, categorization and theoretical concepts that guide the analysis. In the second stage, exploration of the material was included in order to identify the core understanding of the text, represented by categories and subcategories. In the last phase, there was the interpretation of the data.

All participants signed a consent form. In order to maintain the anonymity of the participants, we used the letter R, which meant "Respondent," numbered according to the sequence of interviews conducted (R1-R6).

The project was submitted to the Ethics Committee of the Trairí Faculty of Health Sciences/ Federal University of Rio Grande do Norte and approved under number 352.844.

Results

All six nursing technicians professionals interviewed working in pediatrics were female. The youngest was 24 years of age, and the oldest was 58.

Regarding marital status, 50% were married and 50% were single. It was found that 50% had over 30 years of training time, 67% had training courses, but did not intend to take a graduation course.

Their experience in children's healthcare ranged from 1 year to 35 years and 5 months, and 67%

had over 20 years of experience in this area. When asked about the extent of professional experience at the study site, 50% reported having more than 30 years of service in the institution. Most respondents (84%) had only worked in this studied institution as professional experience.

The current reality of family interactions in the care of the hospitalized child could be observed when subjects were questioned on the insertion of the family. Respondents demonstrated that the presence of a companion in the hospitalization process held a positive meaning for the recovery of the child *... when the family is present, the child feels more secure because it is a person who is there helping, speaking words of affection, support ...* (R3). *.... With the presence of the family, the child recovers faster as they have the support of their mother, her affection. It's a different business, it's very good ...* (R4). *The presence of the family greatly improves the working environment because it reduces our work in caring for the child ...* (R5). *.... I think it is very, very important, really, because the child feels safe at their side* (R6).

We noticed that the presence of a family member directly influenced the organization of the nursing team work, and it became even more evident when some of the interviewed professionals reported how the work was prior to the companion`s full time presence. *... before at night there was only one nursing technician to do everything, change the baby, bathe them, feeding a bottle, administering medications. It was a great suffering, because the mothers would come to us all anxious and worried wondering if we were mistreating their child ...* (R4). *... Before it was all very difficult, because in pediatrics when companions were not present, we did everything, we fed the baby, bathed them, changed diapers, all the care actions were performed by the nurse or the nursing technician* (R1). *... When the family arrived, everything had to be neat. We took care of everything, it was our responsibility ...* (R5).

In the absence of full-time companions, nurses had to perform all the care actions of a proper routine, with moments of being overworked and without demonstrating good communication/relationship with companions during hospitalization of children. When companions became mandatory, this new work dynamic was reorganized, and the new interface has enabled the creation of moments of difficulties and conflicts in the relationships. *... I think there should be several rules in pediatrics, they need to be clearly displayed to all the caregivers/companions so they become aware, they take it as a course, since they disrespect many professionals, they should be well aware of that ... all the time you just do good and you are not recognized, that makes the relationships difficult...* (R2). *The companions make problems for Nursing ... there is not a good reciprocity, they get in the way* (R5). *... We have many problems with companions; sometimes they do not understand our actions. When we perform a procedure on the child, they think we are hurting or mistreating them ... often there are verbal and physical attacks ...* (R1).

The understanding that, in addition to caring for the child, it was also imperative to care for the family, so that their needs were also met. *...the family bathes them, it's rare that we help, it is very rare; compresses are done by the family... we conduct the nebulization, but we don't hold it, we ask them to hold it....* (R2). *... the nebulizer is with them, the compress we place it on them but they hold it in place, and the bath is with them. (R4). The mother gives the bath, holds the compress, holds the thermometer, holds the nebulizer in place* (R5).

There was also conflict between what are the companion`s duties and what are the nursing staff responsibilities. For many professionals, the presence of a partner in the care of hospitalized children was correlated with the performance of activities that were private in Nursing, such as the supervision of the completion of intravenous infusions, serum drip closing, indicating medication schedules and often, administration of the same. *The mother is the one who put the thermometer on the child ... she is the one who gives oral medication ...* (R3). *... When drips are empty they come and warn us ... a compress for example, we are not we going to put it on them ... then sometimes we only deliver the medication and they give it to them, but they are the ones who give it ...* (R2). *Mothers ... watch when the medication is finished and call us, let us know ...* (R1).

During the interviews, lack of communication between the technician and the family became apparent, which consequently brought conflicts between these elements. Most of the time, part of the necessary communication for a successful relationship

has been delegated to other professionals, such as nurses, psychologists and/or social workers. *Many family members make it more complicated, others help. Unfortunately, this is it, when it is complicated it is hard for the whole team, everyone feels the difficulty: the nutrition team feels the difficulty, the psychologists feel it, everyone feels it, but when there is such a difficulty in the relationship, we call the nurses or psychologists or social workers* (R2).

Discussion

In 1990 in Brazil, there was the creation of programs for children and the emergence of the Statute of Children and Adolescents, beginning the fulfillment of the legal rights of this group. With the creation of the Statute of Children and Adolescents, enacted by Law 8069 of July 13, 1990, the child was guaranteed fundamental rights such as health, nutrition, protection, education, sport, leisure and culture, as well as family and presence of a full-time companion throughout infant hospitalization[9].

In this context, the family came to be considered a very important factor for mitigation of negative effects caused by pain, fear and insecurity from the experience of hospitalization[1].

To the respondents, the presence of this family became important for the child's recovery. However, it was noted that in addition to the emotional aspect and safety, there was the process of delegating some actions to these companions, where many of the actions of basic care that were usually carried out by Nursing turned out to be exercised by companions.

Starting with a comprehensive view of the work in the Nursing process, it is understood that the family is an inseparable member in the healthcare process. The presence of the family during hospitalization is of paramount importance, and the insertion of a companion into the pediatric inpatient unit is an indisputable question[10].

This inclusion of the family full time in the hospital environment, and their share in caring for the child have triggered new forms of organizing the care of hospitalized children, making it essential to expand the focus of the assistance, which was previously restricted to children alone, thereby extending the attention of Nursing towards family and other caregivers.

The graduation period of most of the technical professionals in our interviewed Nursing sample was centralized at the height of the privatized medical care model standing out in the educational projects of health courses.

In this study, the conflict between the experienced technicians and nursing attendants was solid, plus there was insecurity in the care focused on the patient-family binomial. These conflicts have undermined the quality of care provided by Nursing, as generated by the insecurity and disputed "power" on the part of caregivers about the care of the child by Nursing. The relationship established between the Nursing team and the family accompanying the child create conflict in relationships, manifesting relations of power throughout the hospitalization process[11].

It is observed that the professionals understand the importance of the relationship of the child with the family and how it helps in the therapeutic process of hospitalized children, and they feel freer in labor demand. However, in the realization of care developed by professional/family, there is delegation of tasks without monitoring and/or proper guidance, thereby showing a possible lack of accountability of professionals with regard to certain nursing care.

Thus, the nursing staff has to insert the family into caring for the child, to share the same responsibilities, providing spaces for qualified listening so that dialogue can be established among the peers involved, minimizing conflicts and negotiating care.

When couples involved in caring for hospitalized children do not have the understanding of division and negotiation of care, patient care and their recovery suffer. It can be seen that the inclusion of an accompanying family member in the care process is limited solely to perform tasks delegated to them, i.e.

the professional fails to perform the care and requires the companion to implement it, without looking at the needs of caregivers[12].

In research on relationships established by nurses with family during children's hospitalization, it is reported that the presence of negotiation between mothers and nurses regarding the care to be provided to children was not apparent during their hospital stay[13].

Often there is no clarification, for example, on the procedures that are to be performed on children by professionals, and this fact creates more anxiety in the family added to the modification of their routine due to hospitalization. This, among other causes of suffering and conflict in the companions, creates a feeling of helplessness and sense of dependence on the decisions to be made about the children[14].

The reports show that the accompanying procedures that are to be solely carried out by the nursing team, but by a professional, in delegating nursing care to the companion, without any supervision by the professional, ignoring the infraction, contravenes the Nursing Code of Ethics, and the team is likely to suffer penalties because any change in delegating performance of care will be at their own risk.

The Nursing team often assumes to be the holder of a position of knowledge, not organizing to integrate the companion care of hospitalized children. This imposition of duties for the family generates relationship conflicts between them and the professionals, because the family does not always respect this discipline.

Most of the time conflicts are established with the Nursing professionals, considering that they are the ones who have more contact with family and hospitalized children. Such conflicts are mainly generated from the lack of dialogue and the lack of preparation to deal with the pain and suffering of the children and their family.

Communication is an exercise to be effected in the daily tasks of health professionals, as well as in daily life of human beings, which therefore becomes a daily exercise to find the right words and the appropriate gestures[15].

It is in this context of inadequate communication, power relations, doubt and the different perceptions held by Nursing technicians that developed the care of hospitalized children, where on the one hand, there was acceptance of the family in the health work space when they were referred to contribute to the improvement of the child; moreover, their permanence in this environment has triggered conflicts and division of labor, which often occur without negotiation.

Final Considerations

In this study, the organization of the work of nursing technicians in child care with regards to the family being inserted in the care provided, was not included as an active subject of this process of care, and was often perceived as an obstacle that hinders the work of the professional.

The findings showed a lack of preparation of the professionals when it comes to dealing with the child-family binomial during the hospitalization. They lacked notions of how to work with the binomial needs, beyond the difficulty in establishing an effective dialogue process, which results in resistance and confrontational behavior, eliciting expressions of power by nursing team professionals.

Collaborations

Silva JL and Bay Júnior OG contributed to the design, field data collection, analysis and interpretation of data, and the final revision of the article. Santos EGO, Rocha CCT and Valença CN contributed to the design and wording of the article. Bay Júnior OG, Rocha CCT and Valença CN participated in the approval of the final version of the article to be published.

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