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Original Article

Managing nursing care to puerperae and newborns in primary healthcare*

Gestão do cuidado de enfermagem a puérperas e recém-nascidos na Atenção Primária à Saúde

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ABSTRACT

Objective: understanding the meaning of managing nursing care for puerperae and newborns in primary healthcare. **Methods:** qualitative study, based on the theoretical framework of Data-based Theory. Participant observation and semi-structured individual interviews were conducted with eleven primary healthcare nurses. The analytical process involved open, axial, and selective coding/integration. **Results:** the central phenomenon, Promoting the management of nursing care in primary healthcare, indicates the leadership of nurses when dealing with challenges in the context of care. That suggests actions and interactions to guarantee autonomy and the quality of care, in addition to empowering the parents. **Conclusion:** the management of care from nurses who participated in the research aims to embrace the mother-child and family particularities since the prenatal, and to promote a singular, multidimensional, continuous, vigilant, and systematized care, which values the subjectivity and the main role of the woman-mother and the care they should have with themselves and the newborn. **Descriptors:** Primary Health Care; Patient Care Management; Nursing Care; Postpartum Period; Infant, Newborn.

RESUMO

Objetivo: compreender o significado da gestão do cuidado de enfermagem a puérperas e recém-nascidos na Atenção Primária à Saúde. **Métodos:** estudo qualitativo, baseado no referencial teórico-metodológico da Teoria Fundamentada nos Dados. Realizaram-se observações participantes e entrevistas semiestruturadas e individuais com onze enfermeiras da Atenção Primária. O processo analítico envolveu a codificação aberta, axial e seletiva/integração. **Resultados:** o fenômeno central: Promovendo a gestão do cuidado de enfermagem na Atenção Primária à Saúde, aponta a liderança de enfermeiros frente aos desafios no cenário de cuidados, induzindo ações e interações para garantir a autonomia e a qualidade dos cuidados, além do empoderamento materno/paterno. **Conclusão:** a gestão do cuidado realizada pelas enfermeiras participantes buscava acolher as singularidades do binômio mãe-filho e família, desde o pré-natal, e promover cuidado singular, multidimensional, contínuo, vigilante e sistematizado, que valoriza a subjetividade e o protagonismo do ser mulher-mãe e os cuidados consigo e o recém-nascido.

Descritores: Atenção Primária à Saúde; Administração dos Cuidados ao Paciente; Cuidados de Enfermagem; Período Pós-Parto; Recém-Nascido.

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Introduction

It is widely known that primary healthcare for pregnant women, puerperae, newborns, and families is more significantly present in primary healthcare, where it is more commonly offered by nursing workers.

In this clinical setting of assistance, nurses have an essential role, which they perform through nursing consultations and educational actions in groups of pregnant women. They act in the preparation of the woman/couple for the arrival of the newborn and through the coordination of the Family Health Strategy team and the nursing team. As a result, primary healthcare stands out in the coordination of care, and nurses stand out as those who manage the nursing care that is offered to the women, the newborns, and to their families, especially as the nurse occupies the role of leader of the Family Health Strategy team[1-3].

The management of care is a human and social process that involves leadership, motivation, participation, interpersonal influence, communication, and collaboration. It is focused on the care for the person, within an organizational culture in which the nurse has a relevant role. This role has challenges with regards to establishing adequate regulations that define their professional identity, actions, field of work, and autonomy[4].

The management of nursing care is a tool that brings together administration and care in nursing. It revolves around the managing of nursing care as carried out by nurses and offered to human beings as well as possible, based on scientific evidences and on the systematization of assistance. Nurses, through clinical evaluations and their own judgment, manage the care, planning, organizing, motivating, and controlling the provision of care in a timely, safe, and integral manner, articulated with the care offered by other professionals. To do so, they consider the conditions, resources, and technologies available, offering a favorable environment for the individual to experience the health-disease process, reestablishing their own health and caring for themselves, or being cared with the help of other people.

Few researches have been carried out on the management of care by nurses, be it in hospitals or in primary care. However, there are many studies which address, separately, the actions of care and management, reflecting a dichotomy between these two dimensions. The small number of publications can be explained by the fact that the managing of care is a recent concept, one that is still being developed in the field of Nursing.

The management of nursing care in obstetric and neonatal care contributes for the qualification of nursing assistance in all levels of healthcare, as it promotes the protagonism of women and the participation of the men-father in the care for the newborn. In addition, it stands out, as it considers the application of care, considering the empowerment of the woman/couple with relevant and useful information, based on the best evidence available to make it possible to offer a humane, longitudinal, safe, and timely care, which includes the use of appropriate technologies, such as good practices, educational and integrative actions, pharmacological and non-pharmacological technologies, surgeries, and others, according to the needs[5].

Nursing clinical protocols, based on the best evidence available, are examples of innovations for the management of nursing care. Many of these instruments were elaborated through the mobilization of nurses in positions of responsibility, confronted with the challenges of professional overload and the need to care, in a resolutive and accountable manner, to the needs of users[1,3,6].

The protocols have been built to develop the clinical practice of nurses in primary healthcare and to improve the quality of the assistance offered to the users. These instruments contribute to increase the autonomy of nurses and their clinical capability of dealing with issues, offering a technical-scientific base for them to make decisions and manage nursing

care. As a result, they positively impact the quality of nursing care and help improving the access of users to health services[1,3,6].

As a result, it is useful to understand the meanings involved in the management of nursing care to puerperae, newborns, and their families, as carried by nurses from the primary health care in a city with 100.0% coverage from Family Health Strategies. Therefore, this study hopes to contribute with nursing/health and disseminate positive strategies that can contemplate the real needs of users, in addition to valuing the actions of nurses in maternal and neonate health.

To answer the question: "How is healthcare managed for puerperae and newborns in the primary healthcare of the city Florianópolis/SC, Brazil?", this article aimed to understand the meaning of managing nursing care for puerperae and newborns in the primary healthcare.

Methods

This study used the theoretical methodological framework of the Evidence-Based Theory, in its Straussian variant[7], which aims to develop theories inductively and deductively. Its primary objective is reaching a theory, inventing, discovering valid explanations for natural phenomena. It carries out a qualitative analysis of data in order to build a theory based on it.

Data collection was carried out using a theoretical sampling from September 2016 and September 2017. Participant observation techniques and an interview were applied. The participant observation took place in nursing consultations, groups of pregnant women, and meetings with nurses, using a printed, standardized, and specific script, in which the main researcher recorded information from each observation period. The interview followed a semi-structured script, guided by the following initial question: What does it mean to you to manage nursing care to offer quality obstetric and neonate primary healthcare?

Informants were intentionally selected according to the following criteria: being nurses from the Municipal Health Secretariat of Florianópolis/SC/Brazil; working in one of the seven health centers selected for the study, which belonged to the many Sanitary Districts of the city; having more than six months experience; having expertise in managing care in the fields of obstetrics and/or women's health (which was assessed through a series of closed questions). Nurses on vacation, on leave, or who were working as residents, were excluded.

Participants were contacted via institutional e-mails, which were sent, at first, to their sanitary districts, and, later, to the coordinators of the health centers. The interviews were scheduled (at a time selected by the worker) in a private room in the workplace of the participant.

The interviews were recorded in audio using a voice recording app and with the consent of the participant. Recordings were later transcribed in their entirety by the main researchers, in a Word® document, including the intonation, emotions, pauses, and non-verbal expressions of the interviewees. Generally, the interviews lasted for a mean of 45 minutes.

During data collection and analysis, memos and charts were elaborated. They were recommended by the authors to be used as visual and analytical schemes, to aid in the coding of data and in the elaboration of the theory[6]. During the process of data collection and analysis, there were losses, namely: one of the seven health centers did not participate in the research, because there was no response to the three invitations the main researcher sent in the period of data collection. Two other nurses, after some attempts to schedule the interview, said they did not have time.

After the participant observations and 11 interviews were carried out, theoretical exhaustion was reached, i.e., the researcher finished data collection because the question that was the objective of the research had been answered, and further development of the investigation no longer added new elements to it[7].

The analytical process consisted in the techniques of data collection and analysis, carried out alternately, through open coding, axial coding, and selective coding/integration, in addition to the use of the paradigmatic model to delimit the theory. Data was organized and compared systematically using the NVIVO10® software, until a substantive theory was constructed. It was named: Promoting the management of nursing care in primary healthcare.

The Research Ethics Committee gave their approval to the research under No. 1,148,080/15, with the Certificate of Presentation for Ethical Appraisal No. 43112415.5.0000.0121. The names of the subjects were replaced by the letter "E" (for "Enfermeira" – "Nurse" in Brazilian Portuguese), followed by a number that indicated the order of the interviews (from E1 to E11).

Results

The study included 11 nurses. Five were from the Family Health Strategy; three were coordinators of health centers; two were managers from the Municipal Health Secretariat; and one was an assistance nurse and the coordinator of the unit.

A substantive theory, i.e., the central phenomenon, based on the paradigmatic model, was created from the analysis of research data. It was called Promoting the management of nursing care in primary healthcare. It included three categories: 1 - Understanding the meanings of managing nursing care in primary healthcare, and was related to the component "conditions"; 2 - Dealing with the antagonistic and regulating movement that influences quality, relating to the component "actions/interactions"; and 3 - Improving the quality to increase the capability of dealing with issues in primary care, relating to the component "consequences". They can be positive or negative and result from these movements/interactions, all from the perspective of the nurses.

To integrate the research question and the objective of this article, category 1 was emphasized: Understanding the meanings of nursing care management in primary healthcare, related to the "conditions" component of the data-based theory.

The compression of the component "conditions", which involves work and the management of the care offered by the nurses, highlights that the healthcare they offer aims to promote the particularities of each puerpera in the context of their own lives, as to allow them to have the main role in their own care and in the care for their newborn. The conditions/contradictions there are in the setting induced the central phenomenon of the study, which was the promotion of managing nursing care in primary healthcare. The base of this entire process was the main role of nurses in the discussion, elaboration, and implementation of clinical nursing protocols to give support to the management of nursing care, as to ensure its quality, its consistency, and the continuity of the healthcare of puerperae, newborns, and their families.

In the initial paths in favor of improvements/innovations, the puerperium was seen as a challenging moment, in which the woman is vulnerable, due to the social and bio-psychological changes experienced by them and by their families. The interviewees suggested that the care offered during the puerperium must focus in valuing the subjectivity of the woman-being, and not only in the care with the newborn. *I think that during the prenatal it's necessary to talk a bit more about how it's going to be after she gets the baby. They suffer a lot in the postpartum. I see puerperae crying in front of me. Who are full of doubts, who are having trouble, who don't know what to do* (E10).

As a result, this understanding, that should start during prenatal care, that should improve (and build) the self-esteem of the mother, the self-care, and the personal empowerment, aims to bring women as close as possible to the knowledge they need to deal well with the changes that come from labor and childbirth. From the perspective of the interviewees, the puerperae might experiment feelings of sadness, and professionals must be aware of that, so they can offer support and adequate assistance.

The participants mentioned that it is essential

to embrace these women considering the particularities of each one. During consultations in the puerperal period (or even in the prenatal), in addition to reiterating the advice offered in prenatal consultations, the nurses offered support to the mothers in the new routines that the arrival of the newborn required them to follow, without criticism and/or judgment of any kind. *I emphasize it a lot when the woman comes to the consultation and the father is there too, that now that the baby is born... The mother still exists! She didn't die. She didn't go anywhere. The mother also needs care* (E9). *I think that the empowering comes from the moment the woman understands what will happen to her... And, she doesn't need to be that which society says she needs to be inside my office. She doesn't need to be a perfect mother, she doesn't need to be that mother that wants to breastfeed at all costs, she doesn't need to be a women who must do everything right and can handle everything, she has to be herself. So, this is the bond that will help care to be effective* (E2).

The bond of the woman with the health services is part of a broader look into the management of care. An example is the Capital Children Program, from Florianópolis/SC (the Municipal Program for the Attention to the Health of Women and of Children up to Ten Incomplete Years of Age), which works as a link between maternity and the Primary Healthcare. From the perspective of the interviewees, this program contributes for the quality of the attention to the puerpera and to the newborn, since it organizes, among other activities, the bonds between the family and the health center, through actions in the first week of birth. These include the first consultation of the newborn, scheduled with a pediatrician; a scheduled consultation of the puerpera, with the nurse; consultations with the dentistry services; immunizations; and the neonatal heel prick. *We have the Capital Children, which organizes the demands for the newborn, the entire puerperium and all the care with the child* (E8).

However, the attention is not always of quality. As a result, assistance is not always integral, since, when these women miss the consultations scheduled, not only they miss this approach, but they also miss the opportunity of discussing their reproductive planning. *Some women don't come (to the consultation). Sometimes they forget, and we only see them in the consultation there is when the child is two months old* (E3). In these cases, nurses could search for puerperae for the puerperal consultation through the person of the team who can be the connection between them: the community health agent.

From this perspective, according to some interviewees, offering nursing care means not only to complete the minimal amount of correct consultations, but also to be present and available for that family. In many statements, the feeling of safety generated by the guidance offered by the nurse could be noticed, as well as the bond established with the woman/family. *To see that pregnant woman in a family context that she needs to address. In addition to a detailed physical examination, which is important, but pregnant women as a whole, her insertion in the family. How does the family behave during the pregnancy? How does the father behave? So, it means to understand that this pregnancy is a family event* (E4).

As a result of the actions and interactions that take place in this context and were revealed in the interviews and observations, it was found that nurses had to prioritize certain actions and types of care. An example is the development of house visits to the newborn/puerpera in the first week after birth. The nurses interviewed were asked (in accordance to questions prescribed in the questionnaire of the research) about house visits, and said they were not doing these visits. Not because they did not see them as important for the quality of neonate care, since they recognized that the family environment shows the dynamics of care for the newborn, in addition to social vulnerabilities. However, interviewees mentioned work overload as an impediment, due to the demands of care from the users, which made it difficult for them to be absent from the health center. In addition to their little time availability, they mentioned that they often have to deal with a lack of human resources and a lack of transportation (car) that could be offered by the mayor's office and used for house care.

Therefore, actions for other moments were discussed, such as the neonatal heel prick, vaccines, medical and nursing consultations, and the training of

the assistance team, including qualified listening and embracing as strategies to deal with the absence of the visits. The aim, however, is not to replace the consultations. *We are overloaded with many other demands, and so we leave this one to the side. Which is the original idea. The concept of having a Family Health Strategy, which is the ability of involving this family, to have a bond and a longitudinal care. This was kind of lost. It would be really interesting if we could go to their house and see this baby. Sometimes, the house has no structure at all, it's dangerous, it's in a risky area. And, sometimes, we can't see the baby* (E9).

Longitudinal nursing care and the bond between women-nurse/newborn/family are a privilege of nursing. There are many opportunities to plant the seeds of practices that can be effective, and positively impact the lives of the users. The interviewees talked about how gratifying and rewarding it is to offer clinical care that is safe and manages to deal with the issues that need solving, from the prenatal to actions to monitor the growth and development of the child. *You monitor the child since they are newborns and then you see them grown, it's very good. Some children come running to you, they come with their mothers and run to the office. It's really good, because we saw them since they were little* (E11). *Pregnant women like doing their prenatal here and we see that we can make a difference in their lives* (E10).

Discussion

A limitation of this study is the fact that the results found cannot be generalized for all health centers included, since each center functions in different ways. However, this study brings contributions, as it deals with the construction of a theory based on the meanings generated by routine assistance. This theory has a social use that is processed with direct results for puerperae, newborns, and their families, as indicated above. It is also useful for nursing and health workers, since it contributes to understand better the meaning of managing the nursing care to be offered to puerperae and newborns in the primary healthcare.

This study shows how necessary it was to carry out changes in the working process and in the offer of services, including actions of planning, education in health, and nursing care organization. Small changes in the offer of care and in nursing actions can value maternal competence and autonomy. They also show that these actions are equally important for the quality of the assistance, as well as for clinical practice itself[8-10].

A study carried out in primary care, involving pregnant women who were in the third trimester of pregnancy, found that the prenatal care still has shortcomings, although, generally, the women who participated were satisfied. In general, they associated the quality of assistance with the embracing and the way they were treated, though not so much with the clinical assistance received. As a result, the pregnant women suggested, as improvements: increasing the length of prenatal consultations; promoting groups of pregnant women/couples in primary care; offering more guidance/information about all aspects related to pregnancy, especially with regards to labor, childbirth, and breastfeeding; and offering humane embracing and qualified listening[11].

In the same study, the pregnant women stated that they prefer prenatal consultations carried out by nurses. They perceived nurses to be more humane, allowing them to express their feelings, and found that these workers were more empathetic, listening and explaining better and producing feelings of safety in the pregnant women[11].

The weaknesses in the monitoring of puerperae/newborns/families, generally, were related to the fact that care in the puerperium generally revolves around the newborn, meaning that women and families are seen as distant participants in this period. The fact that parents also have complex needs of care/self-care is also dismissed in this period[11-12]. An analysis of these observations and interviews seem to show that, with the innovations brought forth by nurses, women/families started to recognize, in the family nurse, a reference for clinical care and guidance/in-

formation, capable of dealing with their problems and needs for self-care and family care[8-10].

The puerperium is a physiological and transitory process, with a strong emotional load and changes in the personal, familial, and social routine. In this period, many feelings and emotions are brought forth, triggered by different physiological, psychological, and social mechanisms, not only in women, but also in their relatives[11-13]. In this context, the actions of the nurse are decisive to improve the quality of life of puerperae, newborns, and families, as it promotes a unique type of care, considering the holistic health of those involved, as well as their social/familial history. Teams of assistance must be vigilant, so they can identify and act with regards to any risks and needs of the users. They should also include actions and interactions that make it possible to express feelings, beliefs, and experiences, in addition to having potential to introduce new knowledge through educational, individual, and collective action. Also, they should encourage the active and complicit participation of fathers and other relatives in this process[8-10].

Regarding the house visits that are recommended in the first week after birth, the nurses interviewed recognized that these are necessary, but not viable in the setting were the study was carried out. A broader look to the conditions/contradictions in the settings shows, on one hand, a perception that this strategy is unique to the primary healthcare and brings many benefits when carried out, since parents have doubts, difficulties, fears, and insecurity in the first care they offer the newborn. As a result, the presence of an encouraging figure is beneficial for the wellbeing and safety of those involved[14-15].

On the other hand, nurses deal with situations that extrapolate their clinical competence, such as incomplete healthcare teams and work overload, as shown by another study that highlighted the absence of professionals a reason for not carrying out domiciliary visits[14]. Therefore, to deal with these hindrances, nurses used their creativity to develop new working processes that can mitigate these problems[1,15]. These measures, however, cannot eliminate them. The interviewees also reported that these strategies do not mean that municipal management can avoid giving conditions for the professionals to offer care in the setting of assistance.

This result is the same found in other nursing teams in three cities in the Northwest of the Rio Grande do Sul state, in Brazil. These researches found, as challenges for the management in nursing: the slowness of public management, related to administrative hindrances and bureaucracy that compromises the quality of assistance; the fragmentation and discontinuity of assistance, which compromise the possibility of offering integral healthcare, since the teams do not have 100.0% coverage; and the shortcomings in the process of referrals and counter-referrals[16]. These challenges revolve around the organization of the systems that involve the sectors that structure and generate actions that are not in accordance to the prescriptions of the Single Health System. They, however, can be overcome through strategies and planned actions of management, involving all actors, and considering the reality of territories.

Conclusion

The management of care means to embrace the particularities of the pair mother-child and of their family since the start of the prenatal, as well as to promote a singular, multidimensional, continuous, vigilant, and systematized care, which values the subjectivity and the main role of the woman-mother and the care with the newborn. It is based on well-defined and implemented protocols that consider the social and bio-psychological changes experienced by the woman and the context of the life of each family, according to which the puerpera is the protagonist of the care with herself and with the newborn. It also involves the participation and the support of the family in healthcare.

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Collaborations

Amorim TS and Backes MTS contributed for the conception and for the project, data analysis and interpretation, article writing, in the relevant critical review of the intellectual content and the final approval of the version to be published.

References

1. Costa MFS, Gomes Jr SC, Magluta C. Analysis of the distribution of births with severity markers in maternity with neonatal intensive care unit in the Unified Health System. Cad Saúde Coletiva. 2018; 26(2):125-30. doi: http://dx.doi.org/10.1590/1414-462x201800020419
2. Pessoa TA, Martins CBG, Lima FCA, Gaíva MAM. The growth and development against the prematurity and low birth weight. Av Enferm [Internet]. 2015 [cited may 28, 2019]; 33(3):401-11. Available from: http://www.scielo.org.co/pdf/aven/v33n3/v33n3a08.pdf
3. Ministério da Saúde (BR). Atenção humanizada ao recém-nascido de baixo peso. Método Canguru: manual técnico [Internet]. 2017 [citado 2019 out 22]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/atencao_humanizada_metodo_canguru_manual_3ed.pdf
4. Phillips RM. Seven core measures of neuroprotective family-centered developmental care: creating an infrastructure for implementation. Newborn Infant Nurs Rev 2015; 15:87-90. doi: https://doi.org/10.1053/j.nainr.2015.06.004
5. Marques LF, Ribeiro RV, Rocha CR, Carreiro MA, Santiago LC. Care to the extreme premature: minimum handling and humanization. Rev Pesqui Cuid Fundam Online. 2017; 9(4):927-31. doi: http://dx.doi.org/10.9789/2175-5361.2017.v9i4.927-931
6. Freitas P, Munhoz MMB, Costa P, Kimura AF. Effect of two immersion bathing techniques on the axillary temperature of preterm newborns: a pilot study. Texto Contexto Enferm. 2018; 27(1):e0580016. doi: http://dx.doi.org/10.1590/0104-070720180000580016
7. Fernández D, Antolín-Rodriguéz R. Bathing a premature infant in the intensive care unit: a systematic review. J Pediatr Nurs. 2018; 42:e52–e57. doi: https://doi.org/10.1016/j.pedn.2018.05.002
8. Freitas P, Bueno M, Holditch-Davis D, Santos Jr HP, Kimura AF. Biobehavioral responses of preterm infants to conventional and swaddled tub baths. J Perinat Neonat Nurs. 2018; 32(4):358-65. doi: http://dx.doi.org/10.1097/JPN.0000000000000336
9. Çaka SY, Gözen D. Effects of swaddled and traditional tub bathing methods on crying and physiological responses of newborns. J Spec Pediatr Nurs. 2018; 23(1):e12202. doi: https://doi-org.ez39.periodicos.capes.gov.br/10.1111/jspn.12202
10. Vinuto J. A amostragem em bola de neve na pesquisa qualitativa: um debate em aberto. Temáticas [Internet]. 2014 [citado 2019 mar. 14];22(4):203-20. Disponível em: https://pdfs.semanticscholar.org/cd8e/3ecb215bf9ea6468624149a343f8a1fa8456.pdf
11. Oliveira, DC. Análise de conteúdo temático-categorial: uma proposta de sistematização. Rev Enferm UERJ [Internet]. 2008 [citado 2018 mar. 2]; 16(4):569-76. Disponível em: http://www.facenf.uerj.br/v16n4/v16n4a19.pdf
12. Edraki M, Paran M, Montaseri S, Nejadi MR, Montaseri Z. Comparing the effects of swaddled and conventional bathing methods on body temperature and crying duration in premature infants: a randomized clinical trial. J Caring Sci. 2014; 3(2):83-91. doi: http://dx.doi.org/10.5681/jcs.2014.009

13. Ministério da Saúde (BR). Método canguru: diretrizes do cuidado [Internet]. 2018 [citado 2019 out 22]. Disponível em: http://portaldeboaspraticas.iff.fiocruz.br/wp-content/uploads/2018/09/metodo_canguru_diretrizes_cuidado2018.pdf

14. Lund C. Bathing and beyond: current bathing controversies for newborn infants. Adv Neonatal Care. 2016; 16(5):13-20. doi: http://dx.doi.org/10.1097/ANC.0000000000000336

15. Freitas P, Marques SR, Alves TB, Takahashi J, Kimura AF. Changes in physiological and behavioral parameters of preterm infants undergoing body hygiene: a systematic review Rev Esc Enferm USP. 2014; 48(spe):178-83. doi: http://dx.doi.org/10.1590/S0080-623420140000600025

16. Trettene A, Luiz A, Razera A, Maximiano T, Cintra F, Monteiro L. Nursing workload in specialized semi-intensive therapy unit: workforce size criteria. Rev Esc Enferm USP. 2015; 49(6):958-63. doi: http://dx.doi.org/10.1590/S0080-623420150000600012

17. Lima LSC, Souza NVDO, Gonçalves FGA, Pires AS, Ribeiro LV, Santos DM. Subjectivity of the nursing workforce and the practice of adapting and improvising material. Cienc Cuid Saúde. 2016; 15(4):685-92. doi: https://doi.org/10.4025/cienccuidsaude.v15i3.31555

18. Brandon D, Hill CM, Heimall L, Lund CH, Kuller J, McEwan T, et al. Neonatal skin care: evidence-based clinical practice guideline. [Internet]. 201 [cited Dec 13, 2019]. Available from: https://research-portal.uws.ac.uk/en/publications/neonatal-skin-care-evidence-based-clinical-pratice-guideline

19. Amaral GF, Sales ASD, Mota PMT, Monteiro SBLL, Cordeiro SPSR, Cavalcante MM. Development of a nursing protocol for childcare consultations. Rev Rene. 2015; 16(1):81-9. doi: http://dx.doi.org/10.15253/2175-6783.2015000100011

20. Silva LJ, Leite JL, Silva TP, Silva IR, Mourão PP, Gomes TM. Management challenges for best practices of the Kangaroo Method in the Neonatal ICU. Rev Bras Enferm. 2018; 71(Suppl 6):2783-91. doi: http://dx.doi.org/10.1590/0034-7167-2018-0428