Humanization of care from the perspective of nurses in a neonatal unit

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ABSTRACT
humanization can be understood as an initiative that values the excellence of care. In what tends to the care of newborns, the neonatal units have as main objective to provide continuous resources, prioritizing the best practices, proposing individualized strategies, respecting the particularities and needs of each one. Thus, combining the humanized personality with the actions of health professionals. Objectives: to describe the profile of nurses working in a neonatal unit; to analyze the humanized practices performed in a neonatal unit; and to discuss the nurses' view of neonatal humanization. Methodology: descriptive, exploratory research with a qualitative approach, carried out in a national health institute. Operationalized through a form and semi-structured interview. Results: the humanization strategies most cited by the interviewees were the issue of family inclusion in care, the baby's warmth and non-nutritive sucking. Conclusion: a team with varying degrees of understanding on the subject was perceived. In addition to a difficulty, some professionals have difficulty in establishing an interface between theory and practice, limiting the use of humanization tools. There was also a great reference to the insertion of the family in care as a strategy, in addition to the overvaluation of the mother-baby relationship to the detriment of the paternal one, evidencing the need for appropriation of the theme by the nurses, for a better application.

Keywords: Nursing, Humanization, Newborns, Neonatal Intensive Care Unit.

1 INTRODUCTION

The National Humanization Policy (PNH) was launched in Brazil by the Ministry of Health (MS) in 2003, seeking to put into practice the principles of the Unified Health System (SUS) in the daily routine of the services, with the objective of producing changes in the ways of managing and caring (BRASIL, 2010).

The PNH It permeates several spheres of health work and is the reference for this type of practice in the country. This points out the need for investments beyond the expansion of the network and access, but also for the quality of care practices (FERREIRA; ARTMANN, 2018).

Humanization, as a concept, can be understood as an initiative that values the excellence of care, considering the technical point of view, the subjective aspects of the user and the professional, the cultural references and the right to health. Not limited to being just an idea, but a practice based on human appreciation, implemented effectively and systematically in care (NODA; ALVES; GONÇALVES et al, 2018).

The hospital environment, in turn, already causes some anguish, anxiety, fear, discomfort, doubts and other diverse feelings for those involved, which influence the evolution of the health-disease process (JUNIOR; BATISTA, 2020). In this context, Carlo et al (2018), show that humanization should enable the expansion of well-being, both of patients and professionals, contributing to the minimization of hospitalization time and absenteeism.

In what tends to the care of newborns (NBs), the neonatal units have as main objective to provide continuous and specialized resources to ensure the survival of these neonates, prioritizing the best practices, proposing individualized strategies, respecting the particularities and needs of each one. Thus, combining the humanized personality with the actions of health professionals. (SMITH; MELO; Smith, 2022).

However, although it is essential, humanizing health care requires a lot from professionals, especially nurses, because to practice this practice is to situate oneself in other people's personal issues, where care is linked to compression, which is a challenge. Therefore, offering humanized care interferes in the moral, subjective, technical and institutional dimensions of nurses, which permeates the values, feelings and limits of both being a caregiver and being cared for (ANTUNES; GARCIA; OLIVEIRA et al, 2017).

In view of the above, the following objectives were established for the present study: to describe the profile of nurses working in a neonatal unit; to analyze the humanized practices performed in a neonatal unit; and to discuss the nurses' view of neonatal humanization.

2 METHODOLOGY

This is a descriptive, exploratory research with a qualitative approach (QUEIROZ; FEFERBAUM, 2022). Performed on the premises of the Neonatal Unit – which comprises the Neonatal Intensive Care Unit (NICU), Conventional Neonatal Intermediate Care Unit (UCINCo) and Kangaroo Neonatal Intermediate Care Unit (UCINCa) – of a national health institute, in the state of Rio de Janeiro, Brazil. Evaluated as a unit of care, teaching, research and technological development, specialized in high fetal risk, in addition to having the title of "Baby-Friendly Hospital".

Regarding the Neonatal Unit, the study scenario, it has 26 beds registered in the MH, being distributed in: 14 in the NICU, 8 in the NICU and 4 in the NICU. The interdisciplinary team of the unit is composed of physicians of varied specialties, nurses, nursing technicians, physiotherapist, psychologist, nutritionist, occupational therapist, speech therapist and social worker.

The nursing team is divided into 3 day shifts and 3 night shifts. Being on average, 3 nurses and 9 nursing technicians in each shift. There are also 2 nurse laborers and 12 resident nurses of the specialization course in neonatal nursing (6 residents of the 1st year and 6 of the 2nd year), with their own workload based on the program guidelines.

Nurses from the neonatal unit participated in this study, totaling 22 participants (N=22). All those who agreed to participate in the research read, signed and remained with a copy of the free and informed consent form (ICF).

The inclusion criteria were: those who acted directly in the care of the NBs. And as exclusion criteria: being on vacation or with any other type of leave or absence during the period of data collection. Data collection was operationalized between March and May 2022, after approval by the Research Ethics Committee, under CAEE 56972422.5.0000.5269.

Initially, in order to categorize the profile of the participating professionals, a form was applied, with the following variables: gender, age, time since graduation, time working in neonatology, if they have specialization – and what would be, work schedule in the institution and in how many places they work.

Next, a semi-structured interview was conducted, where the following was asked: What do you understand as "humanization of care"? What strategies for humanization of neonatal care do you know? Which ones are most used by you in your professional routine?

Data analysis took place between June and September 2022, using Bardin's (2011) Content Analysis method. And, to explore the material, in order to protect the identity of the interviewees, it was decided to identify them through an alphanumeric code with the letter A followed by an Arabic numeral (example: A1).

3 FINDINGS

From the analysis of the data, obtained through the forms applied to the 22 participants, it was possible to infer that 100% were female, with ages ranging from 26 to 56 years, with an average of 36.2 years, as described in table 1.

Table 1 – Ages of the interviewees in years.

AGE (YEARS)	Nº PARTICIPANTS	%
26 a 31	9	41,0
32 a 36	1	4,5
37 a 41	5	22,7
42 a 46	4	18,2
47 a 51	2	9,0
52 a 56	1	4,5
TOTAL	**22**	**100**

Source: own authorship.

The mean time since graduation was 10.8 years, with a minimum of 1 year and 4 months and a maximum of 36 years (Table 2). Among them, 18 (81.8%) had specialization and 4 (18.2%) did not. Among the specialists: 14 in neonatology, 3 in neonatology and another specialty and 1 in perinatal health – which has an interface with neonatology. And, among the non-specialists, all of them were attending the post-graduation in neonatology in the residency molds.

Table 2 – Time of formation of the interviewees in years.

TIME OF FORMATION (YEARS)	Nº PARTICIPANTS	%
< 2	3	13,6
2 a 5	7	31,9
6 a 10	2	9,0
11 a 20	7	31,9
> 21	3	13,6
TOTAL	**22**	**100**

Source: own authorship.

The mean time of work in neonatology was 9.8 years, with the shortest time of 1 year and 1 month and the longest time of 36 years (Table 3).

Table 3 – Time of work in neonatology, of the interviewees, in years.

TIME OF OPERATION (YEARS)	Nº PARTICIPANTS	%
< 2	7	31,9
2 a 5	4	18,2
6 a 10	1	4,5
11 a 20	8	36,3
> 21	2	9,0
TOTAL	**22**	**100**

Source: own authorship.

Regarding the work schedule, 16 (72.7%) interviewees were on the day shift and 6 (27.3%) on the night shift. And in relation to working in another unit, 18 (81.8%) worked exclusively in the institution where the research was conducted, while 4 (18.2%) had more than one employment relationship.

Moreover, from the analysis of the collected material, the first registration units (RU) were defined, based on the humanization strategies that emerged from the interviewees' statements (table 4).

Table 4 – Humanization strategies most cited by the interviewees.

REGISTRATION UNITS (UR)	FREQUENCY	%
Bath	3	1,16
Hot tub	1	0,38
Listen	1	0,38
Pain/pain relief	8	3,11
Suction	17	6,61
Containment/contain	6	2,33
Glucose	12	4,66
Positioning/positioning	10	3,89
Snuggle/snuggle	17	6,61
Roll/Nest/Cigar	10	3,89
Dust	1	0,38
Breastfeeding	5	3,11
Kangaroo	15	5,83
Family	46	17,89
Parents	22	8,56
Mother	65	25,29
Father	18	7,0
TOTAL	**257**	**100**

Source: own authorship.

The aforementioned table gave rise to the first category that will be discussed below, entitled "The nurse's view regarding neonatal humanization strategies".

It is observed that the RH related to the family and/or family members together constitute more than 50% of the total, while others appear in less than 1% of the speeches, which motivated the construction *of the corpus* of the second category: The role of the family in neonatal humanization.

4 DISCUSSION

4.1 THE NURSE'S VIEW OF NEONATAL HUMANIZATION STRATEGIES

Humanization strategies offer subsidies so that professionals can multiply them, improving their reality, because in addition to being a theoretical-practical process, it establishes a culture focused not on the disease, but on the being who falls ill and should be seen holistically in its biopsychosocial integrality (FERREIRA; DANTAS; DANTAS et al, 2021).

Among the humanization strategies most cited by the interviewees were the issue of family inclusion in care, the baby's warmth and non-nutritive sucking.

> "I think it's this family issue, putting it on your lap." (A7)
>
> "Humanization is a more child-centered care, a child-centered care." (A9)
>
> "It's snuggling him ... Give the non-nutritive suction, give the little finger right, or if he has a pacifier, give a pacifier." (A2)
>
> "It's the baby's warmth, positioning it properly, non-nutritive sucking, that you use in many procedures." (A14)

The insertion of the family in the care of the baby, emerges from a relationship of partnership and construction of bond of these with the health team, in which the responsibilities need to be stimulated and shared (BRASIL, 2019). To this end, initiatives aimed at setting up and promoting a healthy environment have been beneficial for safe and healthy biopsychoaffective development (SILVA; BRAGA, 2019).

In turn, the "baby's warmth" reflects the posture techniques of the NB, providing neurobehavioral organization and comfort for this (BRAZIL, 2019). The non-nutritive sucking technique can be performed with the introduction of a non-lactating nipple or gloved little finger into the oral cavity of the NB, stimulating – during rhythmic movements – the release of serotonin, which inhibits hyperactivity, modulating discomfort and reducing the pain of the newborn (VIRGINS; GRECO; OAK, 2018)

It was possible to observe that some strategies, although used in the unit, appeared little in the speech of the participants. The following statements illustrate this premise:

> "Strategies? Funny to say, is that, for me, it's not a strategy, because strategy is something that you take, study, but it doesn't work anywhere." (A16)
>
> "Humanization of care? I think it's you being... let me think... being human with the person." (A5)

> "I can't explain to you what I understand about the humanization of care, because for me it's very... like, humanization of care already speaks for itself" (A3)

You can see that there is a gap between recognizing humanization practices as genuine, which may be involved in the difficulty of some professionals in understanding humanization as a scientific, solid and palpable knowledge.

Scientific knowledge is critical and grounded, aiming to produce interpretations of reality and a certain consensus about something. It is intentional because it constitutes certain objects and intends to provide subsidies to understand them or to produce instruments of intervention on them. It is systematized and obeys the rules of a certain field and is also a knowledge that is intended to be true (DAGMAR, 2006).

From this understanding, we can infer that scientific knowledge is essential for the professional who works in the NICU, enabling an adequate preparation that sustains the complexities of the care practices developed for the newborn at risk (COSTA; PADILHA, 2011).

The lack of understanding, observed on the subject, causes it to be treated as something more trivial or fraternal. Causing the professional not to recognize the strategies that he uses and/or that he can use, allowing the application of these to his personal feelings, and not to a routine that is inseparable from the attributions of neonatal nursing. The PNH clarifies that humanization must be understood beyond a personal perception, but as a public policy that transversalizes the different actions and instances of the health system (BRASIL, 2010).

Thus, it is considered that clarifying the concept of humanization, as well as monitoring how professionals present it in their actions, could lead them to improve this approach in neonatal care (COSTA; SANFELICE; Carmona, 2019).

It is important to highlight that participants A4 and A11, in particular, were the only ones to mention the humanization of the professional in their speech, when asked about what they understood as humanization of care, they say:

> "(...) try to reduce the suffering of both the team and the patient. Because in reality it's all a two-way street, so there's no such thing as a good team and the patient doesn't." (A4)

> "Humanization is you look at a whole, right? In the case of the child, you not only watch the child, but watch the family, be attentive to the care of the team as well." (A11)

Among the principles of the PNH is the inseparability between management and care. And within this, it is proposed as one of the strategies, the promotion of actions that ensure the participation of workers in the processes of discussion and decision, strengthening and valuing the workers, their motivation, their development and their personal growth (BRAZIL, 2010).

Therefore, the fact that most professionals do not recognize this issue as a fundamental part of the humanization of care is worrisome in the sense of the management of the organizational environment by the nurse, since he performs a leadership function.

It is noteworthy that, as well as for the time of formation, it is observed with regard to the time of work in neonatology, a higher percentage of participants in the interval of 10 to 20 years. And, in view of this information and noting that the publication of the PNH is from the year 2003, it could be inferred that the lack of knowledge about humanization could be related, among other reasons, to the outdated professional.

However, participants A3, A5 and A16, who showed imprecision regarding the knowledge of humanization as scientific knowledge, have the respective times of training and performance in neonatology: 5 and 3 years, 9 and 8 years, 5 and 4 years. And, the participants A4 and A11, who were able to identify relevant points in relation to the theme, are 36 and 36 years old, 18 and 18 years old as their respective times of formation and performance with newborns.

It was demonstrated, therefore, that a longer time gap since graduation was not a limitation for the knowledge of humanization practices. Ruling out the hypothesis that a training prior to the publication of the PNH would be a negative determinant for their knowledge.

4.2 THE ROLE OF THE FAMILY IN NEONATAL HUMANIZATION.

The mention of the family was widely observed as a strategy of neonatal humanization.

> "We have to try to bring the family as much as possible to get involved in small cares, which they may be doing under our supervision." (A1)
>
> "I try as much as I can, to promote that contact whether it's the touch, whether it's the diaper change, those little things, to incorporate this family more." (A15)

It is known that, as a result of the hospitalization of the NB, there is an early separation of the mother-child binomial and the difficulty of approaching the other family members with the new family member. Thus, the family is partially or totally deprived of seeing, touching, talking and caring for the baby during this period, while these are fundamental actions for the formation and strengthening of affective bonds (SOUSA; AVERAGE; BENEVIDES et al, 2019).

Tamez (2002), brings the year 1987 as a milestone of the recognition of the importance of the presence of parents in the NICU. With this, ideas emerged on how to promote family-centered care, since this is the central component in the child's life and should be central to the care plan.

It was understood that the company and participation of parents with the hospitalized child are necessary not only for the establishment of the affective bond, but also for the reduction of stress caused by hospitalization and for the preparation of health care at home (DIAZ, 1992; BOWLBY 1995).

It is important to emphasize that in the case of the family as part of neonatal humanization, RH appeared in the text in the following proportions: family (17.89%), parents (8.56%), mother (25.29%) and father (7.0%). Revealing a tendency to prioritize the mother-baby relationship to the detriment of the paternal one, since the highest percentage recorded was the one referring to the word "mother" and the lowest to "father".

It is significant to consider that "mothering", recognized as a caregiving practice that starts from the bond and care developed for the child, appears altered in the context of neonatal hospitalization. That is, the actions conferred on mothers are allowed gradually and often even impossible, depending on the physical condition of the child (MARTINS; OLIVEIRA, 2010).

The accompanying mothers experience a challenge when trying to adapt to the hospital environment, considered as a new space, different from their home, which materializes the experience of illness and represents the cessation of living a habitual day to day (ALMEIDA; MILK; FERREIRA et al, 2016). This condition subjects the mother to the hospital routine and to both family and social distancing, which generates negative effects, which can interfere with the bond with the NB. (SOUZA; SAINTS; MENDONÇA et al, 2012).

With regard to the father, Matos et al (2017) report that the information that men have about the care of their children, most of the time is not valued by their partner, family and even by health professionals. Thus, the father begins to think that his performance with regard to the burdens with his son is insignificant, causing him not to be truly involved in the process.

Ordinance No. 930 of May 10, 2012, which defines the guidelines and objectives for the organization of comprehensive and humanized care for severe or potentially severe newborns, in its third article, brings as one of the guidelines the encouragement of the participation and protagonism of the mother – and the father – in the care of the newborn.

The Statute of the Child and Adolescent regulates in its article 12, that hospitals must provide conditions for the full-time stay of a parent or guardian, in cases of hospitalization of a child. However, in most hospitals, these conditions are offered to mothers, in the so-called "mothers' accommodation", "mother's house/hotel" and the like. This makes it even more difficult for other family members, especially the father, to be partners in care and not just as a visitor.

It is also emphasized, according to the Ministry of Health (2010), that the following points characterize humanization: valorization of the different subjects involved in the process of health production: users, workers and managers; fostering the autonomy and protagonism of subjects and collectives; increase in the degree of co-responsibility in the production of health and subjects; establishment of solidarity bonds and collective participation in the management process. Thus, evidencing the need for broad insertion of all those involved in the process.

5 CONCLUSION

It was possible to identify that the team of the studied unit is diverse and with varying degrees of understanding about the theme "humanization". It was observed that there is the difficulty, of some professionals, to establish an interface between theory and practice. And, the fact that they do not recognize humanization as a knowledge based on scientific evidence, is a limitation for its application. There is a need to appropriate the theme and its tools, to apply them well and minimize the impacts of hospitalization for NB and their families.

It was noticed, also, a great reference to the insertion of the family in care as a humanization strategy. And, it is notorious how the unlimited permanence of the parents, in addition to the extended visit to other family members, is important in the evolution of the health-disease process of the NB. However, there is a fine line between the real importance of the family, and the outsourcing of care from the NB by the team to the family.

Still on the family issue, there was an overvaluation of the mother's relationship with the child and there is no need to question the value of the maternal bond. However, this inclination can make the father not feel a necessary part of the care, in addition to overloading the woman.

In view of this, the importance of extending care beyond the NB is highlighted, establishing a welcoming and trusting relationship, perceiving the family members in their individualities, and not only as companions. Since they also need care, sensitive listening and being active subjects throughout hospitalization, so that they can understand and accept the reality in which they find themselves (ALMEIDA; MORAL; LIMA et al, 2018).

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