Rights of hospitalized children and adolescents in light of clinic management

Direitos da criança e adolescente hospitalizados à luz da gestão da clínica

Derechos de los niños y adolescentes hospitalizados a la luz de la gestión de la clínica

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Abstract

Objective: To analyze the (non)compliance with the rights of hospitalized children and adolescents in light of clinic management.

Methods: This is a mixed methods research, sequential explanatory, carried out between September and December 2019, in a university hospital in center-western Brazil. Sixty companions, eight professionals and four health care students participated in hospitalization sectors for children and adolescents. A Likert-type scale was applied with the twenty rights in the quantitative stage, and semi-structured interviews in the qualitative stage, with descriptive and content analysis, respectively. Data were integrated by connection and analyzed in light of clinic management principles.

Results: In the quantitative stage, rights were identified with the lowest percentages of compliance: staying by the mother's side at birth, being breastfed, psychological support, recreation, monitoring the school curriculum and dignified death. In the qualitative results, it was identified that participants did not know about the resolution, considering that the rights were partially complied with: not being hospitalized unnecessarily, having a companion, not being separated from the mother at birth, being breastfed, not feeling pain, knowing the disease, enjoying recreation and educational programs, receiving information, all resources for healing, protection against abuse, preservation of image, not being used by the media and having a dignified death. Limited principles of clinic management were identified, requiring development strategies in the hospital.

Conclusion: Principles of clinic management were weakened, especially those related to health needs and comprehensiveness, transparency and social accountability.

Resumo

Objetivo: Analisar o (des)cumprimento dos Direitos da Criança e Adolescente hospitalizados à luz da gestão da clínica.

Métodos: Pesquisa de métodos mistos, explanatória sequencial, realizada entre setembro e dezembro de 2019, em hospital universitário do Centro-Oeste do Brasil. Participaram 60 acompanhantes, oito profissionais e quatro estudantes da área da saúde, em setores de internação de crianças e adolescentes. Aplicou-se escala *Likert* com os vinte direitos na etapa quantitativa, e entrevista semiestruturada na qualitativa, com análise descritiva e de conteúdo, respectivamente. Os dados foram integrados por conexão e analisados à luz de princípios da gestão da clínica.

Resultados: Na etapa quantitativa, identificaram-se direitos com menores percentuais de cumprimento: permanecer ao lado da mãe ao nascer, receber aleitamento materno, apoio psicológico, recreação, acompanhamento do currículo escolar e morte digna. Nos resultados qualitativos identificou-se

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desconhecimento da resolução pelos participantes, considerando parcialmente cumpridos os direitos: não permanecer internado desnecessariamente, ter acompanhante, não ser separado da mãe ao nascer, receber aleitamento materno, não sentir dor, conhecimento da enfermidade, desfrutar de recreação e programas educacionais, receber informação, todos os recursos para cura, proteção contra maus tratos, preservação de imagem, não ser utilizado pela mídia e ter morte digna. Identificaram-se princípios da gestão da clínica limitados, exigindo estratégias de fomento no hospital.

Conclusão: Princípios da gestão da clínica mostraram-se fragilizados, especialmente os de orientação às necessidades de saúde e integralidade, transparência e responsabilização social.

Resumen

Objetivo: Analizar el (in)cumplimiento de los Derechos del Niño y del Adolescente hospitalizados a la luz de la gestión de la clínica.

Métodos: Investigación con métodos mixtos, explanatoria secuencial, realizada entre septiembre y diciembre de 2019, en un hospital universitario del medio oeste de Brasil. Participaron 60 acompañantes, ocho profesionales y cuatro estudiantes del área de la salud, en sectores de internación de niños y de adolescentes. Se aplicó una escala *Likert* con los veinte derechos en la etapa cuantitativa, y entrevista semiestructurada en la cualitativa, con análisis descriptivo y de contenido, respectivamente. Los datos se integraron por conexión y fueron analizados a la luz de principios de la gestión de la clínica.

Resultados: En la etapa cuantitativa, se identificaron derechos con menores porcentajes de cumplimiento: permanecer al lado de la madre al nascer, lactancia materna, apoyo psicológico, recreación, acompañamiento del currículum escolar y muerte digna. En los resultados cualitativos se identificó un desconocimiento de la resolución de parte de los participantes, considerando parcialmente cumplidos los derechos: no permanecer internado sin necesidad, tener un acompañante, no separarse de la madre en el nacimiento, lactancia materna, no sentir dolor, conocimiento de la enfermedad, disfrutar de la recreación y programas educativos, recibir información, todos los recorridos para la curación, protección contra malos tratos, preservación de la imagen, no ser utilizado por los medios y tener una muerte digna. Se identificaron principios de la gestión de la clínica limitados, exigiendo estrategias de fomento en el hospital.

Conclusión: Principios de la gestión de la clínica se mostraron fragilizados, especialmente los de orientación a las necesidades de salud e integralidad, transparencia y responsabilización social.

Introduction

Childhood and adolescence correspond to periods of life that require special care, due to the vulnerability of suffering interference from the environment, which can impact the future development of emotions, intellect, social relationships, among others.[1] The recognition of these peculiarities led to the need to create and implement protective measures for children and adolescents that, in the Brazilian context, are included in the Federal Constitution of 1988, in the Child and Adolescent Statute (ECA - *Estatuto da Criança e do Adolescente*) and in Resolution 41/95 of the Brazilian National Council for Children and Adolescents (CONANDA - *Conselho Nacional da Criança e do Adolescente*).[2]

The 1988 Constitution represented a milestone, by defining the State's and citizens' responsibility to fully guarantee the compliance with children's and adolescents' rights.[3] Later, in 1990, the ECA was promulgated, which constitutes a fundamental regulation for providing service parameters and ensuring that compliance is safeguarded.[4]

In 1995, with the objective of providing greater compliance with the ECA in the hospital environment and ensuring better care circumstances during hospitalization, CONANDA approved Resolution 41, entitled Rights of hospitalized children and adolescents.[5] In this scenario, the nurse is an important professional in the Resolution implementation, exercising the defense of rights, mainly through guidance on children's participation in their care and promoting the development of autonomy for parents and guardians to make decisions regarding the care of their children.[6]

Children's and adolescents' rights, to participate in the decision-making process during their hospitalization and confidentiality, have been discussed internationally.[7] It is essential to provide information to patients and caregivers, to ensure quality, holistic and people-centered care.[7]

Considering the above, it is understood that the responsibility for complying with the rights of hospitalized children and adolescents should be part of the organizational model adopted at the hospital, as this represents the way to organize and conduct institutional processes. This understanding is important, as it reflects the mission and responsibility for the institutional actions undertaken, so that the final product shown is fundamentally associated with the model used.[8]

Clinic management is a management model that articulates elements of health care, manage-

ment and education, aiming at the qualification of processes and raising the standards of clinical performance, through qualified and safe care.[9] It values knowledge, experiences and participation of the social actors involved, aims to share power and recognizes education as a strategic potential for organizational promotion and development.[9]

From this perspective, it is assumed that the guidance of professionals by principles that guide their clinical decisions is essential to comply with the rights of hospitalized children and adolescents, and, consequently, to implement the clinic management model. In this regard, it is essential that managers, health professionals and users share knowledge and are guided by common goals, as the low recognition and tensions produced by (non)compliance with such rights can interfere with comprehensive, safe and quality care.[9]

Thus, this study arises from the following questions: Which rights provided for in Resolution 41/95 are complied with from the perspective of companions of hospitalized children and adolescents? How is this effective, in the conception of professionals and academics who care for hospitalized children and adolescents in light of clinic management?

As stated, CONANDA Resolution 41/95,[5] in theory, can guarantee compliance with these rights. However, in previous studies, there is non-compliance with them[10] and weaknesses to ensure their implementation,[2] which may be related to the lack of knowledge of professionals and society,[10] making it difficult to implement principles for clinic management. An important knowledge gap is identified here, which justifies this study.

Compliance with established rights makes it possible to minimize the negative consequences of hospitalization, ensure the development of these patients[11] and promote shared responsibility in the production of health,[9] which can be aided by the implementation of actions guided by clinic management principles. Thus, the objective of this study was to analyze the (non)compliance with the rights of hospitalized children and adolescents, in light of clinic management.

Methods

This is a mixed methods research, with a sequential explanatory approach, whose quantitative data are collected first and the results obtained guide the collection of qualitative data.[12] Although scholars advocate greater attribution of weight to quantitative research, in this study an inversion of weight was carried out, as the qualitative approach assumed greater robustness and favored integration with the quantitative results.[13] Although infrequent, this alternative can be applied to the extent that one intends to investigate a phenomenon qualitatively, although it still needs preliminary quantitative results to correctly recognize and elect the correct participants.[14] The quantitative study (quan) was cross-sectional and the qualitative research (QUAL) was descriptive and exploratory (quan → QUAL).

Clinic management was assumed as a guiding theoretical perspective, according to Padilha et al.,[9] guided by the principles: 1) Orientation to health needs and comprehensive care; 2) Quality and safety; 3) Articulation and enhancement of knowledge and practices to face problems; 4) Sharing power and co-responsibility among actors in the production of care; 5) People and organization education; 6) Orientation to results that add value to health and life; 7) Transparency and accountability with collective interests.[9] In addition to these, the theoretical lens of the rights of hospitalized children and adolescents is associated.[5]

The study was carried out at a university hospital in center-western Brazil. Data production took place between September and December 2019 in sectors that have the presence and permanence of children and/or adolescents, namely: Pediatric Clinic, Neonatal Intensive Care Unit (NICU), Conventional Intermediate Care Unit (CoINCU) and Kangaroo Intermediate Care Unit (KaINCU).

In the quan stage, 60 usual companions of children and adolescents hospitalized for more than three days participated, excluding those with communication difficulties or disorders that affect their cognitive and/or psychological capacity. This quantity was established through a convenience sample, considering the average occupancy rate of the previ-

ous semester in these sectors (96.32%), of the total number of beds in the pediatric and neonatal units (29), being the minimum final sample of the stage when double this result (56 companions).

Participants in the quan stage responded to a form developed exclusively for the research that used the 20 rights of Resolution 41/95, described in Chart 1. Some rights had minor changes in their description to allow the companion to answer about the (non)compliance based on their experience in the hospital. For the answers, participants marked one of the Likert-type scale alternatives, which were: "totally agree", "partially agree", "neither agree nor disagree", "partially disagree", "totally disagree" and "not applicable". Rights one, four, eight, nine and ten were divided to facilitate the assessment of compliance by the accompanying persons. Since the Resolution was used in its entirety, and the instrument was applied to identify compliance of rights, it was not necessary to submit a pilot test or validation.

For quant data analysis. the rights marked "partially agree" or "totally agree" were attributed, and those marked "totally disagree", "partially disagree", and "do not agree or disagree" were not complied with. We chose to consider neutral answers, as belonging to the group of non-patients, due to the possibility of intimidation, since the researchers were responsible for marking the answers in the instrument.

For data descriptive analysis, the five points of the scale were reinterpreted: "totally disagree" (0%); "partially disagree" (25%); "neither agree nor disagree" (50%); "partially agree" (75%); and "totally agree" (100%). Thus, only valid percentages were considered, excluding "Not applied" responses.

Data from the quan stage were analyzed using the software STATA 14.0, presenting descriptive analysis with frequency, mean, standard deviation, minimum and maximum. From the results of this stage and considering the percentages obtained, we chose not to highlight some rights in the interviews, before presenting the complete list for professionals and students to explain about their compliance, configuring the data connection.[12]

The QUAL stage had 12 participants, among health professionals (three nurses, a psychologist, a social worker, a doctor, an assistant and a nursing technician), and academics as an intern or intern (two nursing, one psychology and one medicine). It is emphasized that the QUAL stage population was different from the quan stage, because it is understood that the inclusion of professionals would increase the results, since they act directly in the

Chart 1. Rights of hospitalized children and adolescents provided for in CONANDA Resolution 41/95

nº	Right
1	Right to protection, life and health with absolute priority and without any form of discrimination.
2	Right to be hospitalized when necessary for their treatment, regardless of social class, economic condition, race or religious belief.
3	Right not to be or remain hospitalized unnecessarily for any reason unrelated to the best treatment of illness.
4	Right to be accompanied by mother, father or guardian, throughout the period of hospitalization as well as receive visits.
5	Right not to be separated from the mother at birth.
6	Right to receive breastfeeding without restrictions.
7	Right not to feel pain when there are ways to avoid it.
8	Right to have adequate knowledge of illness, therapeutic care and diagnoses, respecting the cognitive phase, in addition to receiving psychological support when necessary.
9	Right to enjoy some form of recreation, health education programs, school curriculum monitoring during hospital stay.
10	Right to have parents or guardians actively participate in diagnosis, treatment and prognosis, receiving information about the procedures to which they will be submitted.
11	Right to receive spiritual/religious support, according to family practice.
12	Right not to be the subject of clinical trial, diagnostic and therapeutic evidence, without the informed consent of their parents or guardians and their own, when they have discernment to do so.
13	Right to receive all available therapeutic resources for their cure, rehabilitation and/or secondary and tertiary prevention.
14	Right to protection against any form of discrimination, negligence or ill-treatment.
15	Right to respect their physical, psychic and moral integrity.
16	Right to the preservation of their image, identity, autonomy of values, spaces and personal objects.
17	Right not to be used by the mass media, without the express will of their parents or guardians or their own will, guarding ethics.
18	Right to confidence of clinical data, as well as the right to become aware of them, filed with the institution for the period stipulated by law
19	Right to have their constitutional rights and those contained in the Child and Adolescent Statue respected by hospitals in full.
20	Right to have a dignified death, together with their families, when all available therapeutic resources are exhausted.

Source: Brazil. Resolutions, June 1993 to September 2004/organized by the Executive Secretariat of CONANDA. Brasília: Special Secretariat for Human Rights, 2004.[5]

defense and respect for the rights of children/adolescents. Furthermore, authors state that the findings of data collection of a stage/method can help in the definition of participants to be researched, or the questions to be asked in the second stage/method.[12]

The second stage consisted of a semi-structured interview, held in the hospital itself, in a reserved place, with the presence of the researcher and participant. It was recorded audio and, written by the Resolution items, and triggering question: Tell me about your knowledge regarding Resolution 41/95 and strategies used in your clinical practice to ensure compliance. The interviews lasted 20 minutes on average. From the results of the first stage and considering the percentages obtained, we chose not to highlight some rights, but rather to present the complete list for participants to explain about their compliance, configuring data connection.[12] It was not necessary to perform a pilot test, since it was based on the list of rights established in Resolution.

We sought to adopt sample criteria that provided data in sufficient quantity and quality to meet the objective of the study, as defined as: participation of professionals and students active in the sectors of the study; use of an open instrument to capture convergences and divergences in discourses; detailing the theme to identify aspects related to compliance or not with rights, associated with the presence or absence of important practices to clinic management; and consideration of unique reports, equally explanatory of the phenomenon.[17,18] In this perspective, it gains relevance, more than the volume of data, wealth and interconnections provided in the analysis of these.[19]

The interviews' content was submitted to thematic analysis, comprising the following stages: a) organization and familiarization with the data, performed by (re)readings, considering the objectivity and subjectivity implicit to the statements, observing the relevance in relation to the object; b) identification of codes and construction of a frame of reference, obtaining the set of meanings, allowing to categorize them; c) groupings of ideas into categories, associating them with the principles of clinic management.[15] Data analysis QUAL was performed in light of quan results, i.e., we sought with the interviews greater understanding of the findings of the first stage.

Since the nature of the research is essential to the choice of method, as well as to mixing and integration, consistent with authors,[12] in the connection of the findings, qualitative data allowed to assess and corroborate quantitative results guided by principles of clinic management.[9] Thus, quantitative data related to (non)compliance of rights are ratified by illustrative statements, which, in integration, characterize a problematizing approach about complying with these rights, and reveal elements of health systems and services, which sometimes (in) feasible their full effectiveness.

The ethical and legal precepts established in Resolution 466/2012 of the Brazilian National Health Council (*Conselho Nacional de Saúde*) were complied with. This study was approved by the Institutional Review Board, under CAAE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 09495919.9.0000.5541. Participants signed the Informed Consent Form, and their statements were coded with the letter "I" and number assigned according to the order of the interview: I1, I2.... I12.

Results

(Lack of) knowledge and (non)compliance with rights

The rights with lower percentages of compliance, according to the quan stage were: to stay at the mother's side at birth, to receive breastfeeding, psychological support, recreation, school curriculum monitoring and to have a dignified death. Table 1 describes the assessment of compliance with rights, according to the participants of this stage.

It is noteworthy that in the QUAL stage, professionals and students considered as complied with all the Resolution rights, although not in its full effectiveness, in the case of the third to the right tenth, and the 13th, 14th, 16th, 17th and 20th. Although participants stated that they did not know Resolution 41/95, and others, they knew superficially, they did

Table 1. Assessment of compliance with the rights of hospitalized children and adolescents according to their companions (n=60)

n	Right	Compliance n(%)	Non-compliance n(%)	Number of respondents	Mean	Standard deviation	Minimum	Maximum
1.1	Protection to life	60(100)	-(-)	60	99.6	3.2	75	100
1.2	Priority care according to health status	60(100)	-(-)	60	99.6	3.2	75	100
1.3	Care without any form of discrimination	59(98)	1(2)	60	97.1	14.6	0	100
2	Be hospitalized whenever needed	49(94.2)	3(5.8)	52	94.7	20.6	0	100
3	Do not remain hospitalized unnecessarily	59(98)	1(2)	60	98.7	9.7	25	100
4.1	Have a companion throughout hospitalization	60(100)	-(-)	60	100	0	100	100
4.2	Receive visits during hospitalization	58(97)	2(3)	60	96.2	16.5	0	100
5	Stay by the mother's side after birth	16(64)	9(36)	25	69	42.9	0	100
6	Receive uncomplicated breast milk in the hospital, when there is no medical contraindication to do so	17(68)	8(32)	25	82.7	34.5	0	100
7	Do not feel pain while hospitalized, when there are means to avoid it	57(95)	3(5)	60	95.8	16.1	0	100
8.1	Have knowledge about their illness and the care needed for a better quality of life, according to age	55(91.7)	5(8.3)	60	94.2	20.8	0	100
8.2	Receive psychological support whenever needed	46(78)	13(22)	59	80.9	37.2	0	100
9.1	Receive some form of recreation in the hospital	47(78.4)	13(21.6)	60	81.2	35.2	0	100
9.2	Have access to health education programs or school curriculum monitoring in the hospital	5(71.5)	2(28.5)	7	71.4	48.8	0	100
10.1	The hospital allows the participation of parents or guardians in diagnosis, treatment and monitoring of children's and adolescents' health	55(92)	5(8)	60	92.1	24.1	0	100
10.2	Parents or guardians are informed about the procedures that will be carried out	57(95)	3(5)	60	94.6	22.1	0	100
11	Receive spiritual and religious support according to family practice	49(84.5)	9(15.5)	58	88.6	28.0	0	100
12	Not be subject of clinical, diagnostic and therapeutic tests without the permission of parents or guardians and their own, when they have the capacity to do so	59(98.3)	1(1.7)	60	99.2	6.4	50	100
13	Receive everything possible for their cure, health recovery and/or prevention	59(98.3)	1(1.7)	60	99.2	6.4	50	100
14	The hospital provides protection against any form of prejudice, lack of care or ill-treatment	55(91.7)	5(8.3)	60	93.7	18.2	0	100
15	The hospital respects children and adolescents' physical, mental well-being and habits	57(95)	3(5)	60	96.2	15.8	0	100
16	The hospital protects the image, identity, decision-making power over their values and personal effects of children and adolescents	59(98.3)	1(1.7)	60	98.7	7.2	50	100
17	Do not have their image or state of health spread on the internet and other media, without their own permission or the guardian's	60(100)	-(-)	60	100	0	100	100
18	The hospital keeps children and adolescents' medical data confidential and enables their knowledge about it, in addition to keeping it for a period determined by law	56(93.4)	4(6.6)	60	94.6	18.5	0	100
19	The constitutional rights and those contained in the Child and Adolescent Statute are respected in this hospital	60(100)	-(-)	60	99.6	3.2	75	100
20	Have a dignified death, together with their families, when all therapeutic possibilities are exhausted	1(50)	1(50)	2	50	70.7	0	100

*For descriptive data analysis in mean and standard deviation, maximum and minimum, the five points of the instrument were reinterpreted, and the answer totally disagree was considered 0%; partially disagree, 25%; neither agree nor disagree, 50%; partially agree, 75%; totally agree, 100%

not know which items they included, but pointed out meanings and attitudes that guided their professional practice, and that even indirectly cooperated in compliance with the rights mentioned. The results of this stage allowed exploring and understanding elements raised in the quan stage and helped identify complementarities and divergences related to (non) compliance with rights, and how these potentiate or weaken principles of clinic management. Respecting the sequencing of the sequential explanatory mixed study, in Chart 2, the main rights evaluated in the quan stage are qualitatively described as potentiating and weakening of principles of clinic management.

Discussion

Respect for Resolution 41/95 depends on efforts from various spheres of society, since meeting children's and adolescents' needs requires the provision of qualified and articulated care at all levels of the Health Care Network (RAS - *Rede de Atenção à Saúde*), which denotes the complexity to achieve

Chart 2. Main rights evaluated as potentiators and weakeners of principles of clinic management in the perception of professionals and students (n=72)

n°	Right	QUAL stage Participants' speeches	Principle of weakened clinic management	Principle of enhanced clinic management
7	Do not feel pain while hospitalized, when there are means to avoid it	*"[...] I take him on the lap, I try to calm him down, there are methods of non-nutritive sucking, hot tub bath, prescribed analgesics" (I1).*		Quality and safety in health care.
14	Protection against any form of discrimination, negligence or ill-treatment	*"[...] cases are referred to the guardianship council" (I7).* *"There is a group called EMAC, composed of several professionals [...] that assesses and discusses case. Can see if this child is being abused" (I8).*		Articulation and valorization of different knowledge and practices in health to cope with health problems.
9a	Receive some form of recreation in the hospital	*"[...] this toy library is only closed, so that it has a toy library if it is not even open" (I4).* *"[...] do not know what could enter for premature newborns" (I1)*	Orientation to health needs and comprehensiveness of care.	
8B	Receive psychological support whenever needed	*"[...] the reduced number of psychologists impairs care, I am involved in specific cases, which need follow-up" (I1).* *"[...] has a psychologist alone and some interns" (I8).*	Articulation and valorization of different knowledge and practices in health to cope with health problems.	
9B	Access to education programs or school curriculum monitoring, if hospitalized for more than 15 days	*"[...] I have seen some interventions by the pedagogues [...] but I do not know how this is done, whether it is based on what they believe, the age group, or if it is something talked about with the school" (I3).*	Education of people and the organization.	
6	Receive breastfeeding without restrictions	*"[...] breastfeeding is free when the baby's clinic can, only when there is a disease, some complication that we suspend" (I11).*	Guidance on results that add value to health and life	
5	Stay by the mother's side after birth	*"[...] there are mothers who take time to see and pick up the child [...] sometimes the mother can pick it up, but the professional does not let her" (I1).*	Orientation to health needs and comprehensiveness of care.	
20	Have a dignified death, together with their families, when available therapeutic resources are exhausted	*"[...] they wait too long without giving opportunity [...] knowing that here they are unable to, research where they have a better support, to trigger justice, SUS to be forwarded" (I4).* *"[...] working with palliative care is something that still needs to improve as well. I see here individualized movements [...] punctual actions of some professionals" (I12).*	Quality and safety in health care.	

this goal.[19] Although rights three and 13 have been assessed as complied with, professionals emphasized that difficulties in accessing specialists, delay in performing exams and social hospitalization, prolonging hospital stay, and resulting in problems in the RAS implementation.

From this perspective, the results obtained denote the disfavor of clinic management implementation, since the model provides, among its principles, quality and safety in care, articulation between the various points of the RAS, professionals, managers and patients, in health care production.[9]

Although challenging, comprehensive health care for these individuals is the State's and society's duty[19] and foretells the need to join forces in favor of respect for the rights of hospitalized children and adolescents, to achieve the principle that it treats guidance to individuals' needs. Although this compliance depends on resolution in other organizations of the RAS, attitudes in lower-spectrum jurisdictions need to be taken. Moreover, the sharing of power and co-responsibility among the social actors involved in the care process for children and adolescents is valued – professionals, academics, family members, patients, managers; in order to ensure full care to this population, advocating for complying with their rights.[6]

In this scope, providing comprehensive care requires offering more than procedures, requires considering the uniqueness and interfering in the community environment of these patients.[20,21] Demand to offer fundamental means for the development of children/adolescents, such as the consummation of their rights,[19] favoring the biological, psychosocial and cultural dimensions. It becomes relevant and necessary to guarantee rights based on the sharing of knowledge among those involved, considering its importance and responsibility[22] in coping with health problems.

It is emphasized that non-compliance of some rights of Resolution 41/95 from companions' perspective, and the partial compliance with an even greater quantity according to professionals and academics, shows greater criticality on the part of the latter. A study that interviewed professionals from a Brazilian public pediatric hospital indicated that 80% of them considered children's and adolescents' rights to be complied with, and those who denied

compliance did so due to the lack of communication to companions, little reasoning of workers related to the humanization policy, absence of a playroom, obstacles related to visits and impediment of companions in the ICU.[10] There is convergence between the results of this study regarding insufficient recreation and communication difficulties, from QUAL participants' perspective, demonstrating inaccuracies with transparency and accountability of collective interests, compromising the implementation of this principle.

Authors also reveal failures in communication between staff, patients and companions, which directly affect care and influence the occurrence of adverse events,[23-26] factors that can cause an increase in hospitalization time, inadequate use of resources, and expose patients to risks, demonstrating weaknesses in the operationalization of clinic management principles, especially those related to quality and safety in care and guidance to results that add value to life.

A research conducted in hospitals in southern Brazil presents actions of nurses in defense of hospitalized children's rights, through information, guidance and nursing care.[6] To guarantee them, means contributing to the maintenance of community health, evidencing the need to break with the perception that playing in the hospital deserves devaluation in the face of other health needs.[23]

The toy library configures mandatory and propitious space to play, providing opportunities for interaction between patients, companions and staff, encouraging learning.[24] The continuity of play is fundamental in hospitalization, as it enables the development and minimizes negative repercussions of school and social leave, often provided in the so-called hospital classes and tied to the needs and learning stage of each child.[25] However, school curriculum monitoring and access to play require advances for total care,[11] including in the scenario of this study, which, even with the playroom and hospital class, proved to be a partially complied with right.

On the other hand, there are institutional practices and projects that serve as strategies to enhance compliance with the rights present in the Resolution. At the institutional level, when there is a lack of vacancies in the hospital, or when there is a lack of conditions to offer the support required by patients' clinical condition, regulation is made for other hospitals in the city. There are also cases of out-of-home treatments, through which transfers are made to large centers of the country, in cases of surgical interventions or specialized treatments. There are projects such as *Rede Cegonha*, *Ápice On* and *Parto Humanizado*, which encourage the preparation and more humanized care of pregnant women and newborns, with stimulation of the Golden Hour, which refers to early skin-to-skin contact between mother and child and the *Projeto Ipê*, aimed at serving children and adolescents who are victims of sexual violence.

At the operational level, the NICU and UCINCO rely on humanizing strategies by the team in the face of death, such as delivering letters to parents with newborns' foot stamp, the stump and bracelets, avoid pain and organize care to allow greater contact between the family and children. In pediatrics, there is the Multidisciplinary Child Care Team (EMAC - *Equipe Multidisciplinar de Atenção à Criança*), which meets weekly to discuss cases, with the participation of parents. There are also several projects that involve the toy library, such as therapeutic tours, visits by volunteers, and celebration of commemorative dates.

Interventions in scenarios that weaken compliance with rights become even more essential in hospitals that have clinic management as an organizational model, a condition that values educational processes, because it aims to transform health care practices, management and education through the production of comprehensive, safe and quality care, guided by people's needs and better standards of effectiveness.[9] In this sense, systematized methods of problem solving should be planned, considering that point interventions do not result in quality improvement.[27] Thus, in addition to respecting fundamental rights, shared responsibility among the actors involved in care is enhanced.[9]

Promoting the dissemination of knowledge related to the rights of hospitalized children and

adolescents is fundamental to mobilize and enable society to work in favor of complying with them.[28] Research showed that the rights of pediatric patients are little known by professionals, emphasizing the absence of training actions related to the theme.[10] This scenario denotes the need for institutional investments in favor of clinic management implementation, since in its principles education is a strategic device in the transformation of realities.

Expanding the understanding of children's and adolescents' rights allows the rupture of previously established concepts, and allows the perception of the need to comply with them.[28] This discussion is indispensable, especially if considered that clinic management has among its principles, the logic of organization that is transformed,[9] i.e., challenges related to non-compliance with children's and adolescents' rights should be triggers of learning among actors, environments and levels of care.

It is observed that orientation to the comprehensive children's and adolescents' needs, continuous improvement of quality of care, recognition of various knowledge and practices, sharing of power and responsibility among the actors of the process, valuing education, directing results that contribute to health and co-responsibility with collective demands are principles used in health, that situate clinic management in its approaches, and explain the sum of efforts to ensure comprehensiveness of care and collective well-being.[9] Thus, professional and institutional responsibility in defense of children and adolescents tends to be consolidated as an indispensable clinic management initiative in the scenarios of university hospitals.

As a limitation of the research, we highlight the instrument applied to verify compliance with the quan stage rights, which, even using CONANDA Resolution 41/95 as reference, some rights had minor changes in their description to allow the responding companion to have a greater understanding of the items. It should be emphasized that future research on the subject is necessary, given the scarcity of scientific productions related to the rights of hospitalized children and adolescents in the country, enabling broader discussions.

Conclusion

The study showed that in the hospital investigated there is compliance with most of the rights provided for in Resolution 41/95; however, it showed partial compliance with important rights such as remaining next to the mother at birth, receiving breastfeeding, psychological support, recreation, school curriculum monitoring and having a dignified death with their families. It was found that factors that weaken compliance with rights are related to failures in the operationalization of health actions in the RAS and conducting the work processes, and those that enhance are linked to humanized professional attitude, government policies and existing projects. With this, in order to promote compliance with rights, it is necessary to consider educational interventions and alignment of the work process with the principles of clinic management. The potential of the study is emphasized by providing analysis of (non)compliance with these rights, which can be a driving force to articulate strategies in favor of its implementation, as a promotion of the discussion of the rights of hospitalized children and adolescents with parents/family members, patients and professionals, obtaining support and infrastructure that collaborates with the enforcement of rights; group discussion to facilitate comprehensive care and communication, including parents in case discussions. It can also enhance safer decisions, qualified and aiming at comprehensive care and improvement of health outcomes, vectors essential to the implementation of clinic management. However, strategies such as these require the engagement of both managers and health professionals and the population involved. The results of the study also pointed to the importance of complying with these rights in care actions, aiming to meet the health needs of hospitalized children and adolescents, compatible with their reality. In addition to these benefits, the approach with mixed methods, involving different populations, is consistent with the premises of the clinic management framework, which value the construction of perspective that brings together the opinion of different actors involved in health care, aiming at the construction of common objectives, accountability and knowledge sharing. Moreover, the results allow designing feasible means and instruments

to reality, from a scenario of (non)compliance with essential health rights, and thus propose interventions such as those mentioned above, based on such findings, extrapolating a single dimension of child and adolescent health care, something still challenging in hospital care.

Collaborations

Peixoto CS, Moraes LG, Marques MAR, Alves MDS, Gaíva MAM, Ferreira GE and Ribeiro MRR contributed to the conception of the study, data analysis and interpretation, writing of the article, relevant critical review of the intellectual content and approval of the final version to be published.

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