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RESEARCH | PESQUISA

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Divergences regarding the care of newborns in the obstetric center

Divergências em relação aos cuidados com o recém-nascido no centro obstétrico

Divergencias relacionadas a los cuidados con el recién nacido en el centro obstétrico

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Abstract

Objective: To know the divergences related to the care actions provided to newborns in the Obstetric Center of a public hospital, under the viewpoint of nurses. **Methods:** This is a qualitative research conducted with the nurses in the Obstetric Center of a public hospital. The data collection took place between September/2011 and April/2012 and encompassed statements resulting from interviews and workshops. The analysis followed the steps of absorption, synthesis, theorization and transfer. **Results:** Four categories were created: Comprehension of the care of newborns; Care focused on the human being or on technique; Lack of unique routine for caring and Strategies to tailor the care to the newborn. The main divergences refer to the prioritization of care actions, sometimes focused on the person, sometimes focused on the technique; disagreements in relation to schedules, materials and techniques adopted in practice and in the literature, situations that might interfere in the care and in the parents/newborns bond. In order to overcome these divergences, we have suggested training/integration of professionals and collective construction of a proposal of care based on the good practices. **Conclusion:** The study has expanded knowledge and generated changes in daily care.

Keywords: Newborn; Nursing Care. Nurses; Neonatal Nursing.

Resumo

O objetivo deste estudo foi conhecer as divergências relacionadas aos cuidados prestados ao recém-nascido no Centro Obstétrico de um hospital público, na ótica de enfermeiras. **Métodos:** Pesquisa qualitativa desenvolvida com enfermeiras no Centro Obstétrico de um hospital público. A coleta de dados ocorreu entre setembro/2011 e abril/2012, englobou depoimentos de entrevistas e oficinas. A análise seguiu as etapas de apreensão, síntese, teorização e transferência. **Resultados:** Originaram-se quatro categorias: compreensão dos cuidados com o recém-nascido; cuidado centrado no ser humano ou na técnica; ausência de rotina única para cuidar; estratégias para adequar o cuidado ao recém-nascido. As principais divergências referem-se à priorização dos cuidados, ora centrando-se na pessoa ora na técnica, e discordâncias relativas aos horários, materiais e técnicas adotadas na prática e na literatura, situações que podem interferir no cuidado e vínculo pais/recém-nascido. Para superar essas divergências sugeriu-se: capacitação/integração dos profissionais e construção coletiva de proposta de cuidados fundamentada nas boas práticas. **Conclusão:** O estudo ampliou conhecimento e gerou mudanças no cotidiano do cuidado.

Palavras-chave: Recém-nascido; Cuidados de enfermagem; Enfermeiras; Enfermagem neonatal.

Resumen

Objetivo: Conocer las divergencias relacionadas con el cuidado del recién nacido en el Centro Obstétrico de un hospital público, bajo la óptica de las enfermeras. **Métodos:** Estudio cualitativo. Los datos fueron recorridos entre septiembre/2011 y abril/2012. El análisis siguió las etapas de aprehensión, síntesis, teorización y transferencia. **Resultados:** Emergieron cuatro categorías: Comprensión del cuidado con el neonato; Cuidado centrado en el ser humano o en la técnica; Ausencia de rutina para cuidar; Estrategias para adecuar el cuidado con el recién nacido. Las principales divergencias se refieren a la priorización de la atención, centrándose en la persona o en la técnica, y desacuerdos relativos a los horarios, materiales y técnicas, que pueden interferir en el vínculo padres-neonato. Se sugirió la capacitación de los profesionales y la construcción colectiva de una propuesta de cuidados fundamentada en buenas prácticas. **Conclusión:** Ampliación de conocimientos y cambios en el cotidiano del cuidado.

Palabras-clave: Recién nacido; Atención de Enfermería; Enfermeras; Enfermería neonatal.

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INTRODUCTION

The care of newborns (NB), immediately after birth and during the first hours of life, has crucial importance for their survival and for their healthy and harmonious development.

Approximately three million children are born in Brazil annually; most of them are born with good vitality. Nonetheless, many die before reaching one year of age. Neonatal mortality accounts for almost 70% of deaths in the first year of life[1], and, of these deaths, more than 45% take place during the first 24 hours after birth[2]. The suitable care of newborns has been emphasized as one of the challenges to be overcome in order to reduce infant mortality rates in our country[1].

Over the years, there has been improvement in the neonatal care. This benefit was generated by scientific and technical progresses, by adequateness and by enhancement of care actions, which have contributed to the decreased morbidity and mortality rates in Brazil. Nevertheless, one should observe a distancing between the mother and her son, thereby hindering early interaction and breastfeeding.

In the neonatal period, bearing in mind the vulnerability in the lives of newborns, there are biological, environmental, psychological, socioeconomic and cultural risks. Accordingly, it becomes necessary to establish special care, timely, comprehensive and qualified action and social and health protection to this segment of the population[1]. Afterbirth, the newborn takes its first steps towards independent living and will need to definitely adapt to the extrauterine environment[3]. This transitional process is usually physiological[4], however, at birth, because of the fragility of the newborn, in addition to the concern about the risk reduction, it is essential to worthily welcome it, by recognizing it as a dependent being, which requires protection, care and safety to promote its health.

The attitudes of professionals who provide care procedures to newborns in Obstetric Centers (OC) are extremely important, since they might interfere, easing or hindering the early approximation and the mother-infant bond. It is essential to provide individual and personalized care to NB for that it can smoothly transit from the intrauterine life to the new life, early interact with its parents, develop physically and mentally, and also to contribute to the reduction of the neonatal mortality[3].

The newborn that is born in good vitality conditions and in a timely manner, i.e., with gestational age over 37 weeks, rosy and active, with no signs of respiratory suffering or serious clinical changes[5], must be encouraged, in the first minutes of life, to interact with its mother. The health care staff must promote skin-to-skin contact between mother and child, as well as the early and practice breastfeeding, which must overcome any routine activity[2,3,6]. Under this perspective, it is imperative that the professional is able to serve the NB on the basis of scientific evidence and that reviews its working practice. Harmful and unhealthy practices for mothers and newborns must be abolished[2].

Thus, in this study, based on scientific literature[1-4], We have considered as good practices to the care of newborns, held in OC, those that favored the safe, comprehensive and qualified ways of caring, focused and targeted to NB, their necessities and their parents, and grounded on scientific knowledge, with a view to adapting this new being to the world, to the prevention and promotion of their health and their full physical, mental and social development. These actions aim at welcoming the newborn in a dignified manner, by recognizing it as a being with potentialities, thereby avoiding the accomplishment of unnecessary interventions and ensuring interaction and early bond between newborns and their parents.

The care of the newborn that is born at term and in good vitality conditions is reduced to dry it, warm it, assess its vitality and welfare and deliver it to the mother for the conduction of a close and early contact[1,2]. All the usual procedures must be performed after the contact between mother and baby[2]. The care of NB in OC is understood as the one provided immediately after delivery[6], or during the first hour following the delivery, or in the first two hours[7]. The main objectives of these care actions is to provide to all NB the conditions that favor their adaptation to the extrauterine life and ensure their welfare[7].

The care of newborns might be conducted from different ways, according to the model adopted by the health care institution[3]. When observing the practices performed in a public hospital, which is field of activity of one of the researchers of the study, and, when investigating the theme in the literature, one can see that the determination of the immediate period after delivery, of the care procedures to be performed and the way in which they must be conducted vary among authors belonging to the field and in relation to practices carried out in OC. The differences are related to the appreciation of the human being or of the technical used in the act of caring; to procedures (what, how and when to perform them) and their interference or not in the relationship between NB and their parents; to techniques and instruments to be used; to the person who must conduct the procedures and if the care actions must or not be held in OC.

These differences are not highlighted, reflected and discussed in the working environment and continue to be routinely performed, with no scientific basis, which has generated concern. Such concern, the relevance of this issue, the differences in the literature and in the practice in relation to care provided to NB in OC, the expressive number of births in Brazil, as well as the gap existing in the knowledge production that support and that define the best practices from a scientific and humanistic viewpoint, constitute themselves as the factors that led to the accomplishment of this study, which has the following research question: what are the differences relating to the care provided to newborns under the viewpoint of nurses of the Obstetric Center of a public hospital?

In order to respond to this question, we have drawn up the following objective: to know the differences relating to the care provided to newborns under the viewpoint of nurses of the Obstetric Center of a public hospital.

METHODOLOGY

This is a descriptive and exploratory research, developed in the OC of the maternity of a hospital in the Brazilian South, which is the workplace of one of the nursing researchers. The subjects involved were eight nurses who are members of the health care staff of the sector at stake, providing comprehensive care to newborns, attendance to parents and coordinate the actions of the nursing team. All of them work in the institution for more than nine years and have specialization courses, with five masters and two PHDs. Nurses in period of sick leave were excluded.

The data collection took place in two moments. The sampling period started in September 2011 and was finished in April 2012. Firstly, individual interviews, with open and closed questions, were conducted. In the second stage, the information from the interviews, after a preliminary analysis, and studies on the best care practices for newborns subsidized the reflections in the six developed workshops. Therefore, the data collection encompassed the testimonies, reflections and consensus resulting from the interviews and workshops. These were collected until their saturation, i.e., when information started to be repeated and the objectives were achieved.

The workshops were organized into seven steps: 1. To welcome: preparation of the environment and welcoming of participant; 2. To interact and sensitize: accomplishment of a group dynamic; 3. To plan, validate and define ways: time in which the working proposal was exposed, the synthesis of the previous workshop was done and the consensus were validated; 4. To discuss the theme: time in which they worked the central thematic in subgroups; 5. To integrate: integrative snack; 6. To share and define consensus: presentation of subgroups and accomplishment of group discussions, thereby seeking consensus in relation to the discussed issues; and 7. To review and redirect behaviors: time in which the meeting was assessed, suggestions were presented and strategies were defined.

The Paulo Freire's ideas were used as theoretical benchmarks to guide the study, because of its collective, humanistic, reflective and dialogic approach and of the good practices targeted to the NB. The statements derived from the interviews and discussion meetings were recorded and subsequently transcribed and organized.

The analysis and interpretation of data involved four analytical processes proposed in the convergent/care-related research[8], which are: absorption, synthesis, theorization and transfer. In absorption, after in-depth reading, the information arising from the interviews were systematically arranged, incremented with testimonials from the workshops, and coded. Next, the vertical and cross-referenced readings were performed, by seeking expressions with similar characteristics, thereby giving rise to the categories. Through the synthesis, we sought to interpret, synthesize and remind what was emerged from the interviews and workshops, thereby describing such information. In theorization, we sought to analyze, interpret and associate the collected information to the theoretical benchmark. The obtained results might be contextualized in similar situations, provide that they are adapted to the new realities, thereby characterizing the transfer.

This survey has followed the ethical guidelines and the standards recommended in the Resolution 196/96, and was authorized by the Research Ethics Committee of the institution to which the hospital is linked, with approval under the Protocol number 2194 FR: 454946/2011. The participants signed a Free and Informed Consent Form, and, with a view to preserving their anonymity, they were identified by the letter "E", which refers to the word "*enfermeiro*" (nursing professional in Portuguese language), followed by a corresponding number.

RESULTS AND DISCUSSION

A thorough analysis of the performed interviews and workshops gave rise to four categories: 1. Comprehension of the care of newborns; 2. Care focused on the human being or on technique; 3. Lack of unique routine for caring; and 4. Strategies to tailor the care to the newborn.

Category 1: Comprehension of the care of newborns

The participants have described the care of newborns with no clinical complications, with good vitality and at term as being the reception, the attendance and the accomplishment of routine care procedures to NB in OC. According to them, these are indispensable care that must be performed immediately after delivery, by the health care staff, in a sensitive, harmonious and loving manner, in a calmness and welcoming environment, thereby respecting the newborn's conditions and the uniqueness involving the moment of birth.

Furthermore, they highlight the importance of the care actions being preferably conducted together with the mother and of encouraging the fathers or caregivers to engage themselves since the time of birth, by guiding and involving them in the accomplishment of care procedures. Nonetheless, they indicate that this understanding is not always presented and implemented in practice, which raises a discrepancy between the idealized and the performed in the routine of caring.

> *[...] Those care procedures are indispensable, there's no way of not conduct them immediately. [...] The warm of the NB is very important; skin-to-skin contact is an essential care. [...] The involvement and participation of families in such care [...] That the newborn stays longer with its mother in the first hour and that care can be conducted next to the mother, the Crede's method, the Kanakion®, one can make anthropometry too; not taking off the baby from the mother's vision. This gives tranquility to her [...] (E-2).*

It is a consensus for the participants that the care of newborns at term and with no clinical complications in OC include: to dry, warm, assess the vitality and identify the NB; to promote

skin-to-skin contact between mother and baby; to clamp the umbilical cord; to encourage breastfeeding; to administer the Crede's procedures and the Kanakion®; to check vital signs and anthropometric data and perform stump care. For some nurses, the first bath of the newborn is also considered an immediate care, which is a divergent point between participants, as well as in the literature itself. They also consider that, in NB at term and with no clinical complications, the airways aspiration and gastric washing must not be routinely used.

Regarding the procedures of drying and warming and care against the heat loss from the NB, the majority reinforces that these actions must be primarily performed towards the mother, there by registering the concern of keeping the baby warmed up, by wearing blanket and cap and removing the moistened cloths.

> *[...] If the baby is okay, one should put it directly on the mother for providing a good contact. [...] the baby must be dried on the mother [...]. To dry, to have the concern to care to dry the baby in a correct way, to check if the baby is breathing well, [...] to allow the father to cut the umbilical cord, I think it's pretty important, because it's already common to involve the father during delivery (E-5).*

Participants reinforce the concepts expressed in the literature, i.e., if the NB is born in good conditions of vitality and in a timely manner, nothing more should be done in addition to drying it, heat it, assessing its vitality, its welfare and putting it next to the mother, with the aim at providing an early and close contact[2]. Thus, such actions are recommended to minimize heat loss, prevent respiratory distress and ease the adaptation of the newborn to the external environment, when welcoming it, drying, immediately, all its skin and scalp with pre-warmed towel, protecting its head with a cap and putting a heated blanket or sheet over it and its mother[1,2,4,9].

The first closer ties between mother and child are crucial to foster the formation of the bond and the mutual recognition[10] and to provide a good adaptation of the newborn. Therefore, these stages must be experienced in pleasant environment, which favors the exchange of gazes and the touch between parents and their babies, the breastfeeding, and the involvement on the part of the father[6]. All the usual procedures must be delayed in order not to interfere in the early interaction and in the breast feeding in the first hour of life[1-4,6].

In this sense, the acts of avoiding unnecessary separations between the binomial mother and child and adopting behaviors fostering the bond of newborns with their parents are considered good practices. Moreover, unnecessary interventions must be avoided. Thus, according to studies, the airways aspiration after birth, as well as the gastric aspiration must not be conducted in the every day care, because they might be harmful and do not bring benefits to NB[4].

Category 2: Care focused on the human being or on technique

Although there is a consensus in the speeches of participants that the care must be and remain primarily focused on newborns, their health and affective necessities, their welfare and on their parents, in practice, not rarely, some professionals prioritize diseases, procedures and interventions, thereby devaluing human beings and health care.

The participants were unanimous in their placements, when indicating that the skin-to-skin contact and the respect towards the formation of bonds between parents and newborns must prevail in relation to other care actions, by considering them priorities.

> *[...] The care of NB should be prioritized and not made all at once. The priority should be the skin-to-skin contact with the mother, the permanence in mother's lap, so that, later, we can conduct others care actions. That is to say, avoiding all unnecessary care procedures for this moment [...] (E-6).*

Furthermore, they highlight the importance of this first contact for the maintenance of the newborn's warming, for promoting breastfeeding and for consolidating the affection between mother and baby, and must be provided even before the clamp process of the umbilical cord, during the period in which the newborn is still dry and warmed up on the mother. As for the father, this first contact and interaction takes place when he has the chance of knowing the baby, cutting the umbilical cord, helping to dry the NB and of staying next to his partner, by assisting her and giving emotional support.

According to the nurses' perceptions, the NB stays calmer and seems to feel pleasure when it is together with its mother, and parents, in turn, become more involved and happy. A quiet environment, with low light, and delicate handling of the baby contribute to the formation of this bond and the welfare of NB. As a way of facilitating this contact, the interviewees suggest that, as far as possible, other care procedures (identification, Crede's method, Kanakion®, etc.) are carried out with the mother and father, which reinforces the idea that it is essential to involve them in the process.

> *[...] A care action that is important is, if the baby is well, one must put it immediately on the mother, in order to provide a contact between mother and baby, and the father cut the umbilical cord, [...] he's participating there at the moment of birth. The father will also feel important at that time [...] (E-5).*
>
> *[...] The necessity is very clear, one needs only observing the behavior of NB, when they are in contact with their mothers. [...] They seem to feel a great pleasure, get calmer, stop crying and seek protection [...] (E-4).*

[...] A care action for which we have always fought for and have always endeavored for that it was respected [...] all NB stay, at least, 20 minutes with the mother, people have internalized this care. Everyone respects it [...] (E-3).

The above mentioned data converge with the literature. The World Health Organization (WHO) recommends that the skin-to-skin contact must be initiated immediately after birth, being continuous, prolonged and established between any mother and child at term, in good conditions of vitality, and establishes one hour as time minimum for such contact[1,4]. Skin-to-skin contact is a safe method, with no costs and brings benefits in short or long term, both for mothers and for newborns, such as the increased success and duration of breastfeeding, the temperature control of NB and the consolidation of the mother-son bond. Therefore, health care professionals must be facilitators of the approximation among mother-NB-father[2,4]. Regarding the contact time recommended by the institution, one can realize divergence, since some interviewees indicated 20 minutes as the ideal time, but other ones mentioned 30 minutes. Differently, several literatures that follow the WHO rules recommend that the skin-to-skin contact time must be extended for at least one hour[1,4].

Professionals must encourage the father of the NB to participate in the care actions performed towards the baby. The father-baby bond in the first months of life is important and must be increasingly appreciated in today's society[1].

Even aware of the importance of the necessity for valuing the early skin-to-skin the and formation of bond between the NB and its parents, the participants high light that, in practice, some members of the health care staff give higher priority to the technical aspect, i.e., the procedures, in detriment of the primary necessity of NB for interacting with their parents. According to the statements, managerial aspects such as lack of human resources, physical structure, permanent health education and stance of professionals have contributed to such a situation. In this sense, they refer to the overload of work of some professionals as one of the factors that can interfere, thereby taking away newborns from their mothers prematurely for the accomplishment of physical examinations and everyday procedures, since they need to assume other activities.

The existence of bureaucracy regarding the registration contributes to worsen the problem, since, according to the participants, the same information are recorded several times in different documents, which causes a large loss of time and demonstrates that it becomes necessary to assess and review this question.

[...] I think there is a lot of sheets to be filled, one should review it, one would have to optimize it, because a lot of data are repeated, [...] it is written in our history of nursing, in books, in sheets for further observations, in physical examinations of pediatricians, in vaccination cards, but this is not too much necessary. [...] (E-1).

Accordingly, the literature indicates that, in the nursing work process, there are rooted standards and routines, in addition to bureaucracy. In many situations, the excess of formalism of documentation might make the work dozy and lead to low efficiency, thereby causing damages to customers requiring assistance. The filling of a large amount of sheets might require greater time of nurses than direct nursing care actions and assistential necessities of their customers[11]. Thus, they should analyze benefits of their behaviors and adopt strategies for organizing the services, by considering the wishes of those who are served[2].

The physical structure does not allow the completion of the care for mothers and newborns in the same place, at the moments of birth and immediate postpartum, thereby hampering the bond and moving away the newborns from their mothers.

Implicitly, one should observe the power of health care professionals, especially of the physician. Occasionally, some professionals even intervene in a natural process by limiting the mother-child contact time to carry out procedures that could be done later, which demonstrates appreciation of diseases and techniques, in the detriment of the human necessities, as well as revealing a hospital-centered and technicist stance. There are also professionals who put their interests and comforts in first place. There are also professionals who put their interests and amenities in first place. Similarly, the different behaviors of professionals were exposed: some of them encourage inadequately the early contact between mother and child and others not; some of them involve the paternal figure and easing interaction, but others not.

Through the statements, one can realize the lack of commitment, training and information on the part of some professionals and trainees in the health field in relation to the best practices in the care of newborns, which might generate, as a consequence, the "routinization" (banalization) and inflexibility in some situations.

[...] It hinders the bond, because it takes away the baby from mother in a fast way[...] we change the state of neonatal reactivity of NB, it will lose the reference of the maternal smell, of the maternal voice [...] Nowadays, all care shares that we perform can interfere in this process. [...] It breaks the bond of the first hour of life, because of absolutely unnecessary things [...] people are very technical in relation to care procedures; they have no sensitivity. [...] (E-6).

[...] There are personal interests, arrogance due to the fact of deeming themselves more important than the birth itself [...] Unfortunately, a professional ends up conveying its disbelief among its colleagues and the thing becomes a snowball. [...] (E-4).

[...] Sometimes, the baby is submitted to aspiration without necessity, stays beneath a heated crib, with a light with strong bright, in a place that is not the mother's lap, thus hearing voices that are not known of him. The father even stays abreast of it, but he is so cornered that becomes

unable to talk to the baby. We are very technicists, since we want conduct routines and care actions immediately, whether nursing and medicine, [...] in the sense of speed up the process, so that the woman readily goes to the Rooming-in [...] (E-6).

Authors consider that unnecessary interventions after birth, such as clamping the cord early, aspiring airways, performing care actions without drying the wet body and/or in a "routinized" manner, manipulating excessively the NB, administering medications, performing bath and anthropometry prematurely might be harmful and negatively affect mothers and newborns, and these procedures might be configured as institutional violence[2]. Such abuse is due to omission and lack of training on the part of professionals. These are situations that might and should be avoided or mitigated. The feasibility of this topic depends on the position change of health care professionals involved in the care. The practice of health care professionals that, when assisting the woman during delivery, separate the mother from the NB at low risk, by using interventionist measures, must be rethought and this conduct must be modified[3]. These inappropriate practices must be replaced by good practices for the suitable physiological, psychological and sociocultural development of mothers and newborns[12].

The transformation of the current technocratic care model, focused only on the technique, interventionist and hegemonic in a humanistic perspective, is not quickly consolidated; by considering that it presupposes change of paradigms, beliefs, attitudes and practices of women and health care professionals[3].

Appropriate, comprehensive and scientifically based care practices must be adopted as a model in dealing with delivery and in the care of newborns. Practices that have proved harmful or those that do not benefit in any way the health of mothers or newborns must be suppressed[2]. A review of the evidence regarding the care practices of newborns reveals that, in most cases, the fewer interventions we conduct, the better will be for the NB. Accordingly, we recommend a family-centered care[4].

Although knowledge of scientific evidence-based practices is necessary, not always it is enough to ensure its application in the form of appropriate interventions, and is fundamental to understand the reasons and the barriers of this resistance to change and propose strategies to overcome them[2]. There is an evident discrepancy between the spoken and the exercised by some professionals, as well as the divergences in relation to the scientific foundations through which one advocates that interventions with no indications are relevant barriers hindering early interaction and formation of bonds.

Interventionism is present in many situations of everyday services, but, for the interviewees, one should appreciate more the interaction and the welfare of newborns and of their parents.

[...] we are very interventionists towards the mother-infant relationship. We go there and interfere too much as a result of routines. We should avoid anything that is unnecessary care for this moment [...] The priority of care should be the skin-to-skin contact with the mother, the permanence in the mother's lap [...] firstly, we could wait the mother and the baby have this contact by means of the gaze, the act of sucking, [...] (E-6).

Convergent with the information, some authors strengthen the importance of avoiding unnecessary interventions in the birth process. They state that the separation of the newborn from its parents must be avoided in the first hour after birth. The care of NB must take into account all the physical, psychological and social dimensions. The other routine care actions must be postponed in order not to interfere in the early interaction and in breastfeeding in the first hour of life, however, one should often keep the observation, with the aim at detecting any complication[1,4].

Category 3: Lack of unique routine for caring

The placements of the participants indicate that there is no unified behavior to conduct care actions, when observing divergences in several points: in relation to the way of developing the care and the materials to be used, the definition of priority care actions, moment and place more appropriate to perform them, often, depending on the professional and the working shift, as can be seen the following statement:

[...] we work a lot with this question on who is the doctor that is on-duty and what the team is acting, on how one should operate. [...] I realize there are differences among caregivers. Depending on the shift that you work, you realize you do not have a routine that is basic to all of them. People follow routines, but the procedure is not a consensus for everyone [...] it seems that the practice gets lost over time [...] (E-3).

Because of the extent of the issue, we highlight the differences considered priorities by the participants and those that were more repeated throughout the study. One of them concerns the clamping process of the umbilical cord. Among nurses, there was consensus that the priority would be the act of waiting for the cord to stop pulsing before clamping it, but, in the daily care, such conduct is not respected, mainly by the medical staff. Most often, the cord clamping is early performed.

[...] something that has to be urgently changed is the issue of cutting the umbilical cord, which is being extremely early. It's absurd, anti-scientific, cutting the cord and not to wait stopping to beat. When it is cut ahead of schedule, it is like cutting the flow of energy and blood, and can cause trauma or future anemia. If one needs a blood reserve, it won't have, and will sometimes have to take supplement. We have to think about the consequences of interfering so much in nature. [...] (E-6).

Various recent evidence arising from randomized and controlled trials suggest that a timely clamping of the umbilical cord is beneficial in comparison with immediate clamping and protects children against anemia. The ideal moment for clamping the umbilical cord of the newborn is when the circulation of the cord has ceased and it is flattened and pulseless, around three minutes or more after birth, and the NB must be placed on the maternal abdomen or kept below the level of perineum until complete placental transfusion[1,2,4]. Nonetheless, the information suggests that immediate cord clamping is more frequent, even if there are protocols that recommend late clamping. There is no available information regarding compliance with this recommendation[2]. Thus, it is necessary to qualify and sensitize professionals for that the recommendation is performed in practice.

In addition to these differences, we have observed those ones related to the application location of Kanakion®, the administration of the Crede's method and the place and time of the first bath of the NB.

Regarding the administration of Kanakion®, the intramuscular region (IR), defined for its application, has divided two opinions. Some nurses consider that the ventrogluteal region (VG), which is also known as Hochstetter (H), would be the most suitable location to apply the above mentioned medication. Others demonstrate doubts in relation to the application on H, which suggests a review. Some positioned themselves favorable to the application on the vastus lateralis muscle (VL), but reported following the routine of applying on H for being a procedure established in the OC of the institution, even without having the updated scientific information on how to perform this action. Similarly to what is done in some countries, the possibility of orally administering Kanakion® (Per os) has also been raised, however, as it requires the application of multiple doses, the consensus, after workshop, was to rule out this possibility, in order not to run the risk of making an incomplete scheme.

> *[...] I think it should be done in a less traumatic way, might be done while the baby is on the mother's lap, during breastfeeding. [...] Because of the administered volume of Kanakion®, I imagine the situation of this procedure when being performed on H. In relation to H, one shouldn't administer this medication in children, since H is not a well-developed muscle. Even so, it holds up this quantity and I think it is much less likely to reach the sciatic nerve [...] this region is much less painful; we would be attacking the baby in lesser degree, that's why I'm for the conduction of this action on H (E-6).*

> *[...] I do on H since it was stipulated as a routine within the sector. I remember that, when I was a student, the H was contra-indicated until the second month of life due to difficulty in delimiting the right location. It is one of the best locations, but, up to the second month, it is contraindicated in function of the above mentioned. I think we rightly delimit it [...] (E-4).*

In the literature world, these divergences are also found. Many authors recommend the vastus lateralis muscle[5,9]. Conversely, others report that the Hochstetter's region might be used[13-15]. The VL muscle is the recommended location, but the area of H is an alternative location for PO medications in children, including for children under the age of 12 months, however, who will administer must have ability and be acquainted with the reference points used to identify the location[15]. Through these references, one can conclude that both sites might be used in newborns, provide that the health care staff has technical knowledge and mastery of the application technique.

The issue of implementing the Crede's method also generated some divergent points with regard to the technique and product to be used in such a procedure. Currently, in the institution, the product used in performing the Crede's method is the 2.5% povidone-iodine solution (2.5% PVPI), used for some years and with no complications. PVPI was considered as the suitable product by the majority of the interviewed. Nonetheless, some of them have questions in relation to the product that would be the most suitable, such as, for example, silver nitrate, PVPI and erythromycin, which were cited by one of the participants as an efficient product, but she was not sure of that.

> *[...] We arrive at the PVPI, as the best product. It is a product that has the same effectiveness and works very well in preventing ophthalmic gonococcal. [...] (E-2).*

> *[...] I have doubts about the effectiveness of PVPI [...]. What I do know is that the erythromycin eye drops would be more efficient [...] (E-4).*

The practice of eye prophylaxis is heterogeneous, because it seems there is no a common practice adopted by the international community for the prophylaxis of neonatal conjunctivitis[16], since the used product varies according to the countries and the maternities. The most commonly used products are: 1% silver nitrate solution, 0.5% erythromycin ointment, 1% tetracycline and 2.5% PVPI[9,16]. The National Health Surveillance Agency describes the convenience of the use of PVP for the prophylaxis of neonatal conjunctivitis and highlights that the 1% silver nitrate does not act on chlamydia[16].

Studies conducted on the use of PVPI have described it as the one of the broader spectrum, which is active against all possible agents of neonatal conjunctivitis, and has advantages over other products used until now. Furthermore, it does not induce microbial resistance, has low toxicity, self-sterility and low cost[16]. Scientific evidence indicate the benefit of prophylaxis with silver nitrate, tetracycline or erythromycin ointment, and this practice is established in a large part of the developed countries. Despite the shortage of data, in developing countries, it is pointed out that the 2.5% PVPI is effective, and this item is even recognized and indicated by the American Academy of Pediatrics as a first-line prophylactic agent[9]. These authors complement by stating that

the choice of agent might be less important than the concern in implementing this care.

As for the application technique of PVPI, some participants express the necessity for reviewing this technique, thereby highlighting doubts or different ways of performing the procedure. They differ in relation to the following questions: if the eye hygiene must be performed before applying the product or not, if the product should be applied in the corner of the eye or in the conjunctivitis sac, if it is necessary to wait the product acts, if the procedure must be performed in case of cesarean delivery, since the NB does not pass through the birth canal, which hinders its contamination. These doubts reinforce the necessity for training and reviewing behaviors.

> *[...] The application method is not within the standards that are established. [...] The correct use of PVPI in the time of dripping the eye drops. Some people do not perform hygiene or wait for the required time; these are things that have to be reviewed. [...] Why put it? Why do it, if there had no vaginal infection? [...] (E-3).*

The Crede's administration is indicated to all NB, including those born by means cesarean delivery, because we must consider the risks of contamination through ascending way, which might go unnoticed[1,16].

One should not irrigate the eyes of newborns with water or saline solution, but just scrub soft gauze or a piece of cotton wool on their faces to dry and avoid sliding of hands[5]. This author also describes the importance of performing the procedure with delicacy and of maintaining the sterility of the tip of the bottle.

The lack of professional training to employ the new practices or already existing techniques is a reality[2]. The awareness of professionals towards the importance of the proper care, as well as the experience, practice and permanent education of health care professionals participating in the care of NB are paramount in this critical period of transition to the extrauterine environment[1].

Another question that has generated divergences among the participants is related to the bath, especially with regard to the schedule. Some of them express concern about the contamination due to the possibility of having contact with maternal blood and secretions, by being favorable to early bath, during the first hour of life, as is currently performed in the institution in which the research was conducted. Nevertheless, others have proved to be favorable to the option of delaying the bath, by recommending that it has to be accomplished, preferably in the Rooming-in or, at least, after the first hour of life the NB, in order to enable the bond between parents and neonates, greater absorption of vernix and avoiding loss heat.

> *[...] there are studies recommending that one should wait any longer to bath the baby. Here, we perform it soon after birth. [...] Due to the issue of not keeping the baby long with secretions. Because the father and the mother touch, we touch the baby; of course, we touch it with gloves, but there is a risk. But, for the baby, I know it would be good to wait, it would be less aggressive (E-5).*
>
> *I think the babies' bath could be delayed in order to perform it in the Rooming-in. In early bath, NB does not have the benefit of absorption of vernix soon after birth. This goes against the physiology itself [...] (E-2).*
>
> *There is a break of the bond of the first hour of life [...] bath should be conducted after the contact with the mother, [...] should be done, at least, after the first hour of life (E-6).*

The divergence regarding the most appropriate time for the first bath is also found in the literature. Currently, bath has been conducted earlier, in order to reduce the possibility of transmitting blood-borne pathogens and maternal body fluids and, consequently, contamination of newborns, health care professionals and families[5]. However, the WHO recommends that the first bath is conducted six hours after birth, because of the risk of hypothermia and stress during this period of great physiological transition of NB[9].

Category 4: Strategies to tailor the care to the newborn

The participants suggest the following strategies: appropriateness of care actions, changes in the physical structure, redefinition of human resources and collective elaboration of a proposal to conduct care.

The appropriateness of care actions based on scientific foundations requires, in the opinion of the participants, updating, better staff training, communication and integration on the part of the health care team. Furthermore, they report that the lack of permanent training with regard to good practices in obstetrics and neonatology are important barriers to reach a convergence of scientifically grounded actions. The students from the health area, common in training institutions, depending on turnover, sometimes, are not informed about how they should develop care and, due to uncertainty, fear and anxiety, end up inappropriately intervening in various situations.

> *[...] It seems that the practice is weakened over time. I realize that there are differences and there is a necessity for provision of this, so that everyone worked in the same way. [...] We never had here an updating on the care of NB. [...] (E-3).*

The qualification and the sensitive and technical-scientific competence of health care staff are necessary for the maintenance of all vital activities of NB and conservation of their organic, personal, family and social integrity, i.e., for a health care assistance with quality[6]. For the safety and welfare of newborns, we need to produce a body of knowledge grounded on the best practices, thereby preventing unnecessary interventions[4].

In relation to changes in the physical structure, some participants suggest that care actions towards NB are conducted in the same environment in which the mother is inserted. The ideal would be that the woman stay during labor, delivery and birth in a single environment, through the establishment of the PPP system (*Pré-parto, Parto e Pós-parto imediato*, and these three Portuguese words mean pre-birth or pre-delivery, delivery or birth and immediate after-birth or immediate postpartum, respectively), where the mother-baby binomial could be safely treated.

The redefinition of staff, through contracting more members for the health care staff, was emphasized as one of the factors that favor the bond, since professionals could have more time to serve the binomial at stake.

> *[...] If there was a PPP room, we would be promoting a large proportion of the contacts between mothers and newborns in a much easier way. It could solve the entire issue of routine. Thus, all care actions would be provided there, with the mother seeing what was happening to the NB, all happening in the same environment. [...] (E-6).*
>
> *[...] not having a full-time neonatologist within the OC makes it very difficult, because they have to be in two places at the same time. Accordingly, one takes away the baby from the mother, so that it might be evaluated, with the aim at allowing it to go quiet and do the other work of it. [...] There would be no this necessity for performing such intervention towards the NB (E-6).*

In order for conducting a safe assistance, it is necessary to have material infrastructure and adequate human resources, besides the development of integrated work, through an interdisciplinary team, with professionals trained to meet the routine and emergency situations[17].

In addition to these issues, the majority of participants highlight the lack of an updated written routine that establishes the scientifically-based care, as well as the necessity for raising awareness, reflecting together with the group, discussing the situation with the involved professionals, reviewing routines and elaborating, collectively, an updated proposal for the care of newborns within the OC. Furthermore, we should provide a space for dialogue in which one can discuss the care actions from updated and scientific information.

> *[...] The nurses should promote meetings, one should verify the priority precautions and try to work and bring it in the form of meetings with on-duty employees, or bring in the form of updating courses. Let's standardize it, in order to enable everybody to do in the same way. [...] (E-3).*
>
> *[...] One should prepare a handbook. We need to have something standardized, then one does it in a way, others do in a different way, we do it because we hear about the matter, there is no a standardized routine with NB. [...] (E-1).*

The reflection, the discussion and the changing of reality might be implemented in the collective scope. The knowledge is the product of the relationships of human beings with each other and with the world. In these relationships, men and women are challenged to find solutions to situations in their everyday lives[18]. To that end, they need to recognize the situation, understand it, reflect on it and imagine alternative ways of responding and selecting the most suitable response, thereby constructing something and transforming this reality.

The direction indicated to the appropriateness of care actions is to provide training, awareness and improvement of communication among the members of the health care staff, as well as the collective organization of a proposal to conduct the care of NB based on the best practices and with a view to achieving a humanized care. Under this perspective, the most important is not to follow rigid routines, but consider the experience and practice of the health care team participating in the care actions, make them aware of the importance of providing a suitable care and provide spaces for health education[1].

It is necessary to overcome the barriers preventing the adoption of practices of perinatal care based on scientific grounds. Through the review of handbooks and standards, the assessment of current practices and the training of the health care team, we can achieve the desired care[2].

FINAL CONSIDERATIONS

The study confirmed the existence of divergences in the care provided to NB by nurses and health care teams in their practices and also in the literature, which might affect the development of appropriate actions focused on newborns and their parents. It was evidenced that there is divergences between the spoken and the exercised by some professionals, even with the existing scientific foundations that recommend the appropriate and less interventionist way of developing care. The results have indicated as divergences: the different ways of conducting care actions, sometimes focused on NB and stimulating interaction, sometimes focused on procedures; disagreements in the development of the technique itself by professionals with regard to the steps, locations, medications and materials to be used; and practice of unnecessary or inappropriate interventions, thereby contrasting with the scientific foundations and the necessities of the mother-child-father trinomial.

The research points to the necessity for seeking ways to overcome the difficulties, by going beyond the differences, and these changes might begin by means of nursing. To that end, we propose the training of professionals and the development of a collective proposal, prepared by the nursing staff, defining the care actions based on the best practices and the integration and communication among the members of the health care team. It is understood that this integration include: to foster spaces for discussion, questioning, search for solutions and of the collective construction of knowledge about this theme with the entire interdisciplinary team; to establish pacts among professionals with a view to transforming reality and implementing them in

the daily care of NB, based on the scientific foundations found in national and international literature. Thus, one suggests the provision of moments of dialogues with other professionals and with other admission units that are articulated to the service and deal with this phenomenon for discussing these questions and implementing the consensual topics.

It is worth highlighting that, although participants have the appreciation of the skin-to-skin contact as consensus, the formation of the bond between the newborn and its parents without the intervention in this process, as well as the completion of the care actions to NB, preferably, close to its mother, involving parents, by guiding them throughout the accomplishment of care, there is also, on the part of some members of the health care team, the prioritization of techniques and procedures, thereby following the technocratic logic and care model. The overload of work in function of the reduced number of professionals, the influence of certain professionals, the power relationships and the lack of information, updates and discussions about the daily care contribute to the determination and maintenance of this situation.

The proposal to raise the divergences related to the care of newborns, under the viewpoint of nurses working in OC, was configured as something relevant to the care planning.

The knowledge of care procedures by the staff, the reflection and the discussion about the daily practice of professionals are essential to deepen this theme, support and transform deep-rooted and culturally constructed behaviors still in force within a technocratic model, which are focused on procedures and on the physiological and biological dimension and do not appreciate the human aspect, i.e., the newborns and their parents, their necessities and their multidimensionality.

We conclude that this research has contributed to the reflection, discussion and assessment of care actions provided to newborns and to the production of knowledge, which might generate changes and innovations in the health care of newborns and of their parents within the institution, study setting, and, perhaps, in situations similar to this. We recommend the development of this study in other institutions, with the remaining professionals of the health staff and also with fathers and mothers, thereby expanding state of the art of this theme and improving the care provided to NB and their parents.

REFERENCES

1. Ministério da Saúde (Brasil). Atenção à saúde do recém-nascido: guia para os profissionais de saúde, cuidados gerais. Brasília (DF): Ministério da Saúde; 2011. [citado 2011 jul 28]. Disponível em: http://portal.saude.gov.br/portal/saude/area.cfm?id_area=1461.
2. Ministério da Saúde (Brasil). Além da sobrevivência: práticas integradas de atenção ao parto, benéficas para a nutrição e a saúde de mães e crianças. Brasília, DF: Ministério da Saúde; 2011 [citado 2011 mar 4]. Disponível em: http://bvsms.saude.gov.br/bvs/publica coes/alem_sobrevivencia_atencao_parto.pdf.
3. Cruz DCS, Suman NS, Spíndola T. Os cuidados imediatos prestados ao recém-nascido e a promoção do vínculo mãe-bebê. Rev. Esc. Enferm. USP [online]. 2007;[citado 2012 ago 10];41(4):1-8. Disponível em: http://www.scielo.br/pdf/reeusp/v41n4/20.pdf.
4. Mercer JS, Erickson-Owens DA, Graves B, Haley MM. Práticas baseadas em evidências para a transição de feto a recém-nascido. Revista Eletrônica Tempus Actas Saúde Coletiva [online]. 2010 nov;[citado 2012 jan 10];4(4):173-89. Disponível em: http://www.tempusactas.unb.br/index.php/tempus/article/viewFile/845/808.
5. Zaichkin J. Recém-nascido saudável. In: Orshan SA. Enfermagem na saúde das mulheres, das mães e dos recém-nascidos: o cuidado ao longo da vida. São Paulo: Artmed; 2010. p. 805-90.
6. Monticelli MO, Oliveira ME de. Cuidados de enfermagem ao recém-nascido no Centro Obstétrico. In: Brüggemann OM, Oliveira ME de, Santos EKA dos, organizadores. Enfermagem na atenção obstétrica e neonatal. Curitiba(PR): Progressiva; 2011. p. 143-62.
7. Souza ASG. Enfermagem neonatal: cuidado integral ao recém-nascido. São Paulo: Martinari; 2011.
8. Trentini M, Paim L. Pesquisa convergente-assistencial: desenho que une o fazer e o pensar na prática assistencial em saúde-enfermagem. 2ª ed. Florianópolis (SC): Insular; 2004.
9. Bhutta ZA, Darmstadt GL, Hasan BS, Haws RA. Community-based interventions for improving perinatal and neonatal health outcomes in developing countries: a review of the evidence. Pediatrics [Internet]. 2005 feb [cited 2012 Out 12];115(2):519-617. Available from: http://pediatrics.aappublications.org/content/115/Supplement_2/519.full.
10. Rosa R, Martins FE, Gasperi BL, Monticelli M, Siebert ERC, Martins NM. Mãe e filho: os primeiros laços de aproximação. Esc Anna Nery. 2010 jan/mar;14(1):105-12.
11. Leal A, Pinno C, Sarturi F, Maron L, Garcia SS. Teoria da burocracia: uma reflexão para a enfermagem. Revista Contexto e Saúde [online].2011 Jan./Jun [citado 2013 jan 18];10(20):1381-84. Disponível em: https://www.revistas.unijui.edu.br/index.php/contextoesaude/article/view/1813/1519.
12. Ministério da Saúde (BR). Alguns documentos introdutórios sobre a rede cegonha. Distribuição na oficina sobre rede cegonha no seminário do CONASEMS. Brasília (DF): MS; 201. [citado 2011 jul 28]. Disponível em: ehttp://www.saude.pi.gov.br/ckeditor_assets/attachments/138/DOCUMENTOS_REDE_CEGONHA.pdf.
13. Collet N, Oliveira BRG de, Vieira CS. Manual de enfermagem em pediatria. 2ª ed. Rev. atual. ampl. Goiânia (GO): Editora AB; 2010.
14. Wheeler BJ. Promoção da saúde do recém-nascido e da família. In: Marilyn J, Hockeuberry DW. Wongon fundamentos de enfermagem pediátrica: adaptação à realidade brasileira. 8ª ed. Rio de Janeiro: Elsevier; 2011.
15. Department of Health and Ageing. National Health and Medical Research Council. Administration of vaccines. In: ______. The Australian immunisation handbook. 7th ed. Canberra: Australian Government Publishing Services; 2009 [cited 2012 Feb 15]. Available from: http://www.health.gov.au/internet/immunise/publishing.nsf/Content/handbook-vaccine-admin.
16. Passos AF, Agostini FS. Conjuntivite neonatal com ênfase na sua prevenção. Rev Bras Oftalmol [periódico na Internet]. 2011 jan/feb; [citado 2012 fev 12]; 70(1):57-67. Disponível em: http://www.scielo.br/pdf/rbof/v70n1/12.pdf.
17. Lara SHO, Goulart MJP, Carmo TMD. Assistência ao recém-nascido pelos profissionais de enfermagem na sala de parto no momento da recepção. Ciênc Prax Passos [periódico na Internet]. 2010 [citado 2012 mar 10]; 3(5). Disponível em: http://www.fip.fespmg.edu.br/ojs/index.php/scientae/article/viewFile/99/81.
18. Freire P. Educação e mudança. Rio de Janeiro: Paz e Terra; 2003.