Work process in the neonatal intensive care unit: building a holistic-oriented care*

PROCESSO DE TRABALHO NA UNIDADE DE TERAPIA INTENSIVA NEONATAL: CONSTRUÇÃO DE UMA ATENÇÃO ORIENTADA PELA INTEGRALIDADE

PROCESO DE TRABAJO EN LA UNIDAD DE TERAPIA INTENSIVA NEONATAL: CONSTRUCCIÓN DE UNA ATENCIÓN INTEGRAL

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ABSTRACT

This is a qualitative study aimed at analyzing the performance of healthcare professionals, as well as their contribution to a holistic-oriented care towards newborn babies in a Neonatal Intensive Care Unit (NICU). The study was carried out in the Sofia Feldman Hospital, in Belo Horizonte, State of Minas Gerais, Brazil. The study's subjects were ten healthcare professionals who cared for newborns in the NICU, and seven parents of admitted newborns. Data was collected by means of workshops and participant observation processes. Data were treated and analyzed by means of discourse analysis concepts. The resulting data highlighted the following aspects: the potential and holistic-oriented practices of healthcare professionals; the presence or absence of healthcare actions that materialized the holistic care; the different perceptions of the participants about the work carried out by the team; and in what sense the rationale of the work organization encompassed the workers' collective performance.

KEY WORDS

Infant, newborn.
Intensive Care Units, Neonatal.
Comprehensive health care.
Patient care team.

RESUMO

Trata-se de um estudo qualitativo, que teve como objetivo analisar a ação dos profissionais e sua contribuição na construção da integralidade do cuidado ao recém-nascido internado na Unidade de Terapia Intensiva Neonatal (UTIN). O estudo foi realizado no Hospital Sofia Feldman, em Belo Horizonte (Minas Gerais), e teve como sujeitos 10 profissionais que assistem o recém-nascido na UTIN, e 7 pais de recém-nascidos ali internados. Para coleta de dados utilizaram-se a Oficina de Trabalho e a Observação Participante. O tratamento e a análise dos dados coletados foram feitos por meio de Análise de Discurso. A partir dos dados, evidenciaram-se as potencialidades da prática dos profissionais orientada pelo sentido da integralidade, os atos de saúde que materializam ou não a integralidade, as diferentes percepções dos participantes acerca do trabalho realizado pela equipe, e de que forma a lógica da organização do processo de trabalho inscreve o fazer do coletivo de trabalhadores.

DESCRITORES

Recém-nascido.
Unidades de Terapia Intensiva Neonatal.
Assistência integral à saúde.
Equipe de assistência ao paciente.

RESUMEN

Se trata de un estudio cualitativo que tuvo como objetivo analizar la acción de los profesionales y su contribución en la construcción del cuidado integral al recién nacido internado en la Unidad de Terapia Intensiva Neonatal (UTIN). El estudio fue realizado en el Hospital Sofía Feldman, en Belo Horizonte (Minas Gerais) y tuvo como sujetos 10 profesionales que asisten al recién nacido en la UTIN y 7 padres de recién nacidos, allí internados. Para recolectar los datos se utilizó el Taller de Trabajo y la Observación Participante. El tratamiento y el análisis de los datos recolectados fueron hechos por medio del Análisis del Discurso. A partir de los datos se evidenció el potencial de la práctica de los profesionales orientada por el sentido del cuidado integral, por los actos de salud que materializan el cuidado integral, las diferentes percepciones de los participantes acerca del trabajo realizado por el equipo y de que forma la lógica de la organización del proceso de trabajo inscribe el quehacer del colectivo de los trabajadores.

DESCRIPTORES

Recién nacido.
Unidades de Terapia Intensiva Neonatal.
Atención integral de salud.
Grupo de atención al paciente.

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INTRODUCTION

The increase in the life expectancy of infants born prematurely or with a disease is a result from the technologies used in their specific care, and requires the incorporation of professionals with better technical, scientific, and ethical qualifications. Specific knowledge and developing techniques and equipment for neonates have a direct effect on the survival of infants born prematurely.

First, technological development is effective in reducing mortality. However, it changes the work organization of newborn health care and affects the relationship between healthcare professionals and children[1].

The Neonatal Intensive Care Unit (NICU) is one of the sectors in the hospital with the highest specialization for newborn care. This limited space groups different professionals, technologies, and knowledge. Newborn care is oriented towards diagnosis and the therapy aims at the newborns' recuperation[1].

In my professional practice, I note that professionals often work synergically so as to provide care that is more comprehensive and in terms of meeting newborns' needs. In other occasions, the professionals' practice is fragmented to the point that they certainly do not cover the child's dimensions, considering their insertion in the family and in the society. This kind of care is away from the perspective of integral care.

Hence, we understand that if the care provided by the multiprofessional team lacks the sense of integrality, there can be unsatisfactory results for the individual in development, as well as for the family and the society.

NICUs usually value therapy and diagnosis procedures, which often overlap other possibilities of care[2]. This makes it challenging to think about a practice referenced by the sense of integrality, knowing that it requires considering that in addition to the need to extend life, the newborn must grow strong attachments and acquire autonomy to live.

Taking into consideration the principles of the Brazilian Unified Health System (SUS) in the everyday of health care services, integrality should cover an integral care practice that produces relationships of welcoming, dignity, attachment and respect among the people involved (professionals, users, and institutions)[3].

Considering that integrated care is made effective through the practice of these professionals, in their contact with the users, there is a need to observe the professionals' practice to learn about the meaning of integrated care.

OBJETIVE

The objective of the present study is to analyze the practice of professionals and its contribution in developing integrated care to newborns hospitalized in NICU.

METHODS

The health field demands different, though integrated, types of knowledge, which confront theory and practice dialectically in an everyday practice filled with social relationships, with the aim to develop the practice of healthcare.

In this view and considering the applicability of the qualitative method

> to study history, relationships, representations, beliefs, perceptions, and opinions, all of which are products of the interpretations that human make about how they live, build their artifacts and themselves, feel and think[4]

we decided to use it to research a certain health care reality.

The present study considers the dynamic social interaction of the people involved, where they transform themselves and also become producers of new realities. It was based on the recognition of this dynamism, temporariness, transformation and authorship of professionals and users that we chose dialectics to approach the reality.

This study was performed at Hospital Sofia Feldman (HSF), which belongs to Fundação de Assistência Integral à Saúde - FAIS (*Integral Health Service Foundation*). FAIS is a philanthropic institution located in the city of Belo Horizonte, Minas Gerais State. About 98% of its revenue comes from SUS.

The NICU was created in 2000 and has 32 beds organized in three units, with an average 58 hospitalizations/month in 2007[5]. Professionals working at these units include nursing technicians, nurses, physiotherapists, psychologists, social workers, and occupational therapists.

The infants' mothers stay at the units, whenever they wish, for 24 hours a day. The fathers have visiting hours between 9am and 9pm, with exceptions made according to the infant's clinical conditions or any other specific situation.

HSF was chosen for this study because of the integral care they provide to women and their infants and the practices developed by the study researcher at that institution, where she works as a nurse.

The study subjects are professionals working in the NICU health team, providing direct care to newborns and their families. Regarding the infants' family members, they were included as study subjects provided they met the criteria of the hospitalization period being of at least seven days and the family member should have direct participation in caring for the newborn, regardless of the level or type of kinship.

Data collection was performed using participant observation and workshop strategies. The latter refers to a structured activity focused on a central issue that the group discusses with an objective analysis, and also involves the subjects as a whole, including their thoughts, feelings, and actions[6]. The workshops were performed in October 2006,

and lasted one hour and forty minutes. The activities and reflections in the workshops were carried out using the following guiding themes: the feelings of integrated care at the NICU at HSF, the contribution for creating integrated care, and the factors that facilitate or hinder the implementation of integrated care.

Two workshops were conducted; one with parents (Group 1), and the other with professionals (Group 2). For Group 1, two fathers and eight mothers who met the inclusion criteria were invited, of which one father and seven mothers attended. To compose Group 2, the names of professionals working in the NICU were first distributed in envelopes identified with the professional category they belonged in, and then a raffle was conducted to keep the same proportion of the health team. Professionals of all categories working in the NICU were invited, forming a group with 12 participants, including one occupational therapist, one social worker, one psychologist, one nurse, four nursing technicians, three pediatricians, and one physiotherapist.

Each group was informed about the objectives of the research and permission was requested to record statements; all participants signed the informed consent form.

The workshops were recorded and transcribed by the researcher, identifying the informants and pertinent information for further analysis, such as expressions that were used, moments of silence, exclamations and questions. The workshop participants' names were then replaced to assure anonymity. In this manner, participants were named with flower names (Sunflower, Lily, Azalea, Poppy, Gardenia, Pansy, Bougainvilla, Jasmine, Orchid), and the professionals were named with precious stone names (Agate, Crystal, Amethyst, Ruby, Topaz, Aquamarine, Turquoise, Diamond, Tourmaline, Emerald, Pearl). As the meaning units were recorded, they were coded with the name of the person who made the statement, and identified if it was a user (U) or professional (P), and the order in which the meaning unit appeared in the text (Ex.: sunflower, U-9; Aquamarine, P-22).

Observations occurred in the three NICU units, from August 18 to October 17, 2006, on different days and times, and lasted from 10 minutes to two hours. The participant observations were performed using a script with situations to be observed, searching for what did or did not represent integrated care.

Records were made immediately after or even during the observations on a *Field Journal*, in which the researcher also took note of impressions.

Ethical aspects

The project was approved by the Research Ethics Committee at Hospital Sofia Feldman (record number 04/2006) and at Universidade Federal de Minas Gerais on June 14, 2006 (record number 0080/06).

DATA ANALYSIS

The data was analyzed from the Discourse Analysis perspective considering the possibilities of reflecting about the conditions in which the

> meaning of texts produced in the most different fields [...] are constructed and apprehended. The aim is to understand the functioning, principals of organization, and the forms of social production of meaning[4].

From this discursive point of view, language

> does not simply represent something, since it is part of a social construction that breaks with the illusion of a natural relationship between linguistic and extra linguistic limits. Language cannot be dissociated from social interaction[7].

The discourses produced in each workshop provided a large amount of meaning units, which were selected and grouped under their respective codification. The results were grouped by meaning units according to their similarities.

The results were presented and discussed using the discourse statements and, in some cases, excerpts were used, always identifying the informants.

The observations stated in the Field Journal were used for better contextualization and understanding of the users' and professionals' discourses. To do this, the observations were also grouped according to their similarities and to the meaning units extracted from the workshops.

RESULTS AND DISCUSSION

In the study setting, when parents were together with their children, they did not limit themselves to observing and interacting with the infant. The parents helped taking care of their babies, observed the nurses' work as well as everything happening around them.

A study[8] described the experience of mothers whose children were taken care of in a NICU and found that some of the mothers' behaviors, during the period their child was hospitalized, reflected the form the mothers adapted to that new environment and to their children's condition. Such behaviors include the difficulty mothers have focusing attention on their babies instead of on the equipment being used, the work and language of the health team, or cases when the mothers' attention switched between their babies and what was happening around them. Another behavior described in this study is that, after they became familiar with the everyday routine at the unit, parents assume a more active role in taking care of their children by performing activities such as feeding, bathing, changing positions, or by keeping their eyes on the professionals as a way of guaranteeing their child's safety.

There was no rule about the time that parents would stay in the unit, the activities that would be accomplished, what to observe, or any commitment with the health team members. But certainly parents were alert to what, to their knowledge, could harm or help their child so that the infant received integrated care. Several aspects contributed to making parents *privileged observers*, who, with their meticulous and sensitive eye, were deeply involved with the unit's everyday activities. This permitted a clear depiction of the NICU work environment.

Sunflower (U-49) stated that one of the aspects that made it difficult for users to understand the organization of work at the unit was the identification of what could actually be done by the health professionals. In his example, Sunflower made suppositions such as the orientations given by the head of the unit, how work was divided between the nursing technicians, in regards to which children each of them would look after and how they could collaborate in taking care of other children. Apparently, for Sunflower, this was what defined what each professional can do.

Parents and the health team were oriented about some care actions to prevent the transmission of infections and Sunflower (U-43) uses this knowledge, acquired during his experience staying at the unit, to differentiate which conditions justify breaking the rules. As an example, (U-47) reported a moment in which a health professional, without washing her hands, held a baby that was about to fall off the crib.

Aspects contributed to making parents privileged observers, who, with their meticulous and sensitive eye, were deeply involved with the unit's everyday activities. This permitted a clear depiction of the NICU work environment.

Sunflower (U-47), however, did not agree with situations in which the nursing technician who was holding a newborn, for any *simple reason*, touched another newborn without washing her hands or refused to give a mask to a mother because she was not the person responsible for taking care of that baby, or, yet, another technician who refused to feed a newborn because her shift was over, so she waited for the professional who would take on the shift to arrive.

These situations, described by Sunflower (U-43, 47 and 49) show that, despite not being informed about how the work at the unit was organized, he had an idea about some of the basic aspects that should be used for orientation, such as permanent evaluation of risks and cooperation.

Even though the professionals mentioned by Sunflower were from one same professional category, submitted to the same work process organization, a close look at the professionals' everyday routine shows the singularity of the relationships and the different rules that existed in that environment.

Sunflower, a privileged observer, mentioned a specific work policy, which is practically invisible to a less careful observer. He pointed out issues that should be considered in the study setting, which are important resources to be used by the professionals since they reveal the unpredictability of health work and how to plan that work. This requires giving health professionals continuous reorientation about their activities.

In terms of the unpredictability of health work, Sunflower reaffirmed that normalization is often impossible. It is a *production process always operating at a high level of uncertainty*, which occurs between the health professional and the user at the moment that work is being delivered and in a setting when both act according to their own beliefs, values, and conceptions[9]. The relationships between people as structuring elements of health work and the presence of the user in this relationship increase the aspects of variability and unpredictability. This increases the demands over the health professional and the need for making decisions within the process of developing *health care actions*[10].

The data demonstrated how health professionals deal with unexpected events, adapting techniques and standardizations, based on their values and needs. It is also permitted to recognize the way that health professionals work among the team, expressing agreements they make, which surpass the norms and formal work shifts, creating micro-spaces for negotiations and decisions. In terms of the everyday negotiations, they *take into consideration two levels of reality*: *the organizations' side and the needs of health professionals regarding comfort, safety, and health*[11].

Health services are the arena of *actors* who work according to their beliefs and compete in terms of the meaning of work. In their activities, there is a mixture, which is often unclear, between their private action territories and the public process of work. In this sense, the work routine would have the dimensions of the institution's norms and roles and of each health professional's private practices[9, 12].

Data show that health professionals have searched for ways to exert self-management in terms of the work organization as defined by the administration, aiming at better harmony between themselves and the circumstances of work. It is also shown there is a gap between the activities that are planned and the ones that are actually performed. There is a need to look into these aspects more carefully, with the aim to create a different work environment, considering that the present one has clearly shown the limitations in meeting the health professionals' needs as well as the needs of the newborns and their families. If this concept is to be maintained, integrated? care can be compromised and health professionals can become unsatisfied. One possible solution is to have a group analysis about the work routine, so that negotiating about situations that can lead to problems can help change the current situation.

We understand that this is the path to making shared decisions between health professionals, administrators, and users. Together a problematic situation can be identified and efforts made to solve it, anticipating possible trouble. In addition, other possibilities can be identified when considering the points of view of other *actors*, by explaining and recognizing the different interests involved. It is worth mentioning that consensus is temporary, since they cause new conflicts, which, in turn, assign dynamics to other movements.

In this important approximation between planning and executing work, the professionals that provide direct care to newborns (herein referred to as executors) are important interlocutors to facilitate the process of work planning/re-planning. These professionals can strengthen and boost the changes that are made in their organization, with a view to meet their own needs, as well as that of the newborns and their families.

The professionals' decisions are made in private practice, and their logic is often not understood or followed by the user. This can be noted in a statement made by Gardenia (U-26 and 27) regarding the death of a newborn in the unit. Gardenia reported that the same nursing technician who took care of her daughter also took care of the newborn who eventually died. When that newborn died, the professional was feeding milk to Gardenia's daughter and chose to finish that before helping her colleague to prepare and remove they newborn's body from the bed.

If we look at this situation from a perspective of health care priorities, which should prioritize activities that represent higher risk to the newborn or that comprise the care routine, the professional's decision appears to be obvious. However, it is not that simple if we consider the subjectivity evidenced in the perspective of Gardenia's point of view, who did not consider that as work to be done, but the body of a child, who just like hers, still needed care. It does not mean we should disregard the subjectivity of the professional, even though she had not been expressed in any way in this statement, but it is evident that, in this specific case, the work routine prevailed, despite the occurrence of a death. Perhaps what favored the decision of maintaining the routine was the cooperation from other professionals, which, according to Gardenia, came and cared for the newborn who had died.

Although healthcare demands other forms of organization, there is a prevalence of rules centered on procedures, routines, and norms among other manuals, and the health team's performance is evaluated by its ability to perform all the procedures. In other words, the number of procedures performed is what counts[13]. This can lead to a fractioning in the work, thus fragmenting health care, which opposes the construction of integrated care.

It was possible to identify situations in which it appeared that activities could be developed by any professional present at the moment, but, as Gardenia (U-52) pointed out, it seemed that certain *rules* determined *what one person could or could not do*. The specific activities of each professional were also explained by Jasmine (U-57), when speaking about the activities that each of them performed on her baby.

The statements by Sunflower, Jasmine and Gardenia demonstrate the intervention potential of professionals, marked by the relationship between what is referred to as *specific problem group, specific professional group,* and the *caring dimension* that any health professional holds. The *specific problem group* concerns very specific knowledge regarding what one will have to deal with, within their professional action territory. This limited territory characterizes the *specific professional nucleus;* which, in turn, is covered by a territory that marks the *caring dimension* about any kind of professional action[12].

Based on these definitions, the statements reveal that the caring dimension is subsumed in the *specific professional nucleuses*, weakened by this form of care production. These findings reinforce the perception about what currently occurs in health services where the healthcare model is organized based on specific problems, and considering the caring dimension as being irrelevant or complementary[12]. The consequences of this form of organization also result from the discourses which show the work done by health team professionals within the dominating logic of the biomedical model, which is centered by *specific problem* and *professional nucleuses*.

Another aspect evident in the study is that when there is no specificity, work is forwarded to nursing technicians. This statement is in agreement with findings regarding how work is divided in the health area. Those findings have shown that the work performed by nursing technicians derives from medical practice, and that the work is considered technically different and does not have the same social value[14].

Therefore, when work that does not belong to the *specific professional nucleus* (i.e., belonging to the *caring dimension*), is delegated to nursing technicians, the differences and inequality between health professionals become more evident. This reinforces the existing relationships of subordination.

Considering that professional development and responsibility are necessary and complementary in meeting the newborns' health needs, the specificity of activity of each professional on the health team is important, as long as the *caring dimension* is strengthened. This dimension of *soft* skills[12], where relationships take place, offers more possibilities of interaction, reducing the relationships of subordination.

To adopt other forms of administration that are more democratic and participative requires 'changing power schemes' of several health professionals, in addition to negotiations with several sectors to implement change[15].

There is a need for professionals and administrators to reflect on the work process. From a perspective of change, professionals should think about their activities, revealing circumstances that imply any sort of problem.

Poppy (U-55) states a situation she experienced, in which a nursing technician, who also took care of her daughter, had to take care of one child more than the usual number of children and on that day the health professional had to go without lunch. In Poppy's opinion, there were other health professionals at the unit who could have helped, but no one did.

These discourses reveal fragile aspects in teamwork, which, somehow, translate to limitations in the organization. This can compromise the outcome and affect the quality of heath care. The construction of health care with a sense of integrity requires change in administration and work organizations. It in incongruent with health professionals who accept the determinism of the structures, and it requires *actors* reaffirm themselves as capable of thinking of strategies and of assigning a meaning to their work in the attempt to follow the dynamics and intensity of what happens in the healthcare environment.

Discussions about the organization of work have focused more on the productivity and efficiency of the organization, leaving health professionals on a secondary plane. Models that are more participative could combine productivity and health professionals' participation[16].

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While the participants' discourses revealed their views about the limitations in the activity performed by the health team, no evidence about this was found in the health professionals' statements, since they mentioned that teamwork occurs in an *inter and cross-disciplinary* manner, always focused on the newborn (Aquamarine; P-1).

A group of health professionals performing their activities in a *cross-disciplinary* fashion would imply dissolving boundaries between their specific knowledge nucleuses[17]. Furthermore, the *interdisciplinary* focus and *multi-professional* organization breaks with outdated dichotomies such as think-do and health-disease[18].

Considering the inefficiency of the logic of the work organization based on physiopathology towards integrated care, the teamwork, performed in an *inter-* and *cross-disciplinary* fashion, as observed by Aquamarine (P-1) would be the best to perform healthcare *focused on the newborn*. There is no doubt about the considerable success of a physiopathology-oriented organization. However, if we consider other dimensions of the suffering process, it is implied that there is a need for dialogue between subjects, thus breaking down the barriers between disciplines toward an equitable construction of care.

For Amethyst (P-22), teamwork is what strengthens individual actions, overcoming each health professional's limitations. This is demonstrated when she states that sometimes the health condition of the newborn is getting worse and she has the impression that nothing is being done, *but another team could manage doing it*.

Considering the teamwork strategy, there is team-grouping and team-integration. The former model is characterized by fragmentation, with grouped health professionals and overlapping activities, whereas in the latter model, there is a coherent articulation among health professionals, with the purpose of integrating activities[14].

In order to practice integrated care, professionals should make an effort to work together, taking into consideration their specific types of knowledge and practices. It is by understanding the importance of diversity in addition to working in a way that is not limited to the activity of each team member that it becomes possible for the health professionals to act together.

Although Amethyst (P-19, 21) recognizes that the team works together, the users' statements actually demonstrated the dissociation of the health professionals' activities, in addition to the lack of a common healthcare plan and the fact that the health professionals' differences were reinforced with markedly different values among them.

Emerald (P-85) clearly states how the environment where the health professionals work eventually affects the way she sees the healthcare service on the unit. In her opinion, people who are *in the ICU for too long have one view, and those outside […], who aren't involved in that work, [...] have a different view... it's an inner world and an outer world*.

Professionals of the *outer world* include occupational therapists, psychologists and social workers who, maybe because they are not in the unit and due to their profession, are able to see other realities. They do not have their *specific nucleuses* of knowledge circumscribed by the disease of the newborn, but by social and psychological implications. They are able to assign a different view for the *inner world*. Recognizing the possibilities of these professionals' work has strengthened the institutional decision of incorporating them in health care services.

Professionals and users stated that the team is prepared to provide healthcare in the NICU. As stated by Turquoise (P-58), the professionals receive continuous training. This is also evidenced in the statement by Sunflower (U-48), who states that sometimes something is frightening for the parents, but for the health professional, it only takes a quick look at the newborn to understand what is going on.

Sunflower (U-48) shows, in his statement, that the health professionals' preparation is more focused on the biological aspects of health care. Their preparation concerns emergency services and competency in identifying problems with the

newborns, and solving them quickly. Competencies, in this sense, refer to a group of resources mobilized to act in view of the situation, the profile, as presented by the participants. It is limited in the sense that the participants did not express any competencies related to other dimensions of care.

Through their discourses, the participants state actions they observed and they evaluate the health care provided in the institution as a psychological support offered to parents, as pointed out by Turquoise (P-56). For example, an incentive for breastfeeding was providing women with orientation and prioritizing breast milk as opposed to formulas, stated by Turquoise (P-57) and reinforced by Amethyst (P-25).

Even when facing various aspects, which health professionals consider positive and which also qualify healthcare delivery, the discourses revealed some flaws. Sunflower (U-30) states that just as any place has flaws, so does the healthcare unit, pointing out the difficulty of pleasing people, in general.

Gardenia (U-20) is more emphatic in this respect and states *there are no excuses for our mistakes* to say that it is unacceptable that users or professionals fail to comply with what they must do. Gardenia states the example of visitors who, in spite of their knowing it is not allowed, try to touch the baby when the health professionals are not aware of it, or cases when health professionals *arrive tired [...] and fail to do some things* because of their job at other institutions. The health professionals' fatigue and other problems they may have at home worry Gardenia because she understood this can lead to errors.

The users who participated in the workshops expressed their understanding that their children could be offered better care, either from their noticing that their child's discomfort, or from their experience in that environment, which gave them the chance of learning from the knowledge in the NICU. This way, parents state what is best or worse for their children, using their perception and knowledge.

The discourse by Orchid (U-69) shows that to become informed about the best form of care her child could receive, the mother relied on the knowledge she acquired during her stay in the unit and from what she observed in her child. The team, on the other hand, is guided by the healthcare routine. By using her perception, the mother is able to come closer to the need of comfort she sees in her child, which is not possible for health professionals, because they focus care on handling routines that must be followed.

It is possible for different technologies to coexist in healthcare, but the technologies of the established relationships are what assign a new meaning to how health care is delivered.

In her discourse, Poppy (U-61-62) exhibited disapproval regarding conversations the health professionals had about topics unrelated to the newborns, as if the fact that they talked about other subjects among themselves was enough to compromise their work. The workers' life somehow reflected in their work environment, making us believe that the workers cannot be imprisoned in the user's therapeutic plan. It is a place where work takes place and where relationships between individuals are built.

FINAL CONSIDERATIONS

The participants, through their views, allowed a closer understanding of the reality of healthcare delivered to newborns in the NICU, and the existing challenges. This illustrates the efforts the health team will have to make to overcome those challenges and build integrated care. Those challenges include the need to invest in strategies that support the health team, to articulate work between the different health professionals, and between the different centers of attention. The presence of the family in the unit and their privileged observations help to develop more integrated health practices.

The data permitted to evidence that health care is delivered based on the newborn's needs. In fact, those needs work as a trigger of what kind of practice the health professionals must perform.

The participants of the workshops expressed different perceptions about the work performed by the team, demonstrating how the logic of the work process organization in the unit determines the collective work, and revealed the close relationship the work organization has with the team work. In this view, the users stated their perception of teamwork that is often weakened by the lack of group actions by the health professionals. This was standardized care, and not well integrated, thus challenging the implementation of integrated care practices.

As opposed to recognizing the specificity and responsibility of each health care professional and the strength of their *group* action towards the production of integral care, what was demonstrated was the fragmentation of the newborn care, including the biological dimension, among the many types of practice.

Healthcare for newborns and their families is the common point for health professionals working with highly diverse practices, logics, and organizations. The health professionals' awareness about the different practices and types of knowledge, and the importance of these differences, can be used to build consensual healthcare proposals, reinforce the idea that what guarantees teamwork is not knowledge, per se, but how that knowledge is used to serve work. It should express the relation between thinking, doing, and being in the *actual work in action*.

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