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PERSPETIVA DOS ENFERMEIROS ESPECIALISTAS SOBRE OS CUIDADOS ATRAUMÁTICOS EM PEDIATRIA
PERSPECTIVE OF SPECIALIST NURSES ON ATRAUMATIC CARE IN PEDIATRICS
PERSPECTIVA DE LOS ENFERMEROS ESPECIALIZADOS EN CUIDADO ATRAUMÁTICO EN PEDIATRÍA

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RESUMO

Introdução: A hospitalização consiste numa transição saúde-doença potenciadora de efeitos negativos na criança e família, como alterações na dinâmica familiar, retrocessos no desenvolvimento, ansiedade e medo. A prestação de cuidados atraumáticos deve ser uma premissa base em Pediatria, para minimizar estes efeitos.
Objetivo: Identificar os conhecimentos dos Enfermeiros Especialistas acerca dos cuidados atraumáticos em contexto hospitalar pediátrico; identificar as intervenções e estratégias promotoras de cuidados atraumáticos implementadas pelos Enfermeiros Especialistas; identificar os obstáculos à implementação de cuidados atraumáticos na prática referidas pelos Enfermeiros Especialistas.
Métodos: Estudo descritivo, exploratório de natureza qualitativa, recorrendo a *focus group*, com amostra por conveniência de oito Enfermeiros Especialistas em Saúde Infantil e Pediátrica, e analisando os dados segundo a técnica de análise de conteúdo de Bardin.
Resultados: Da análise dos dados relativos às quatro dimensões pré-estabelecidas para o estudo, emergiram 12 categorias.
Conclusão: Os Enfermeiros Especialistas reconhecem a importância dos cuidados atraumáticos em Pediatria, implementando-os intrinsecamente na prática. Identificam como principais obstáculos à sua implementação a falta de tempo e de recursos. Reconhecem a necessidade da gestão de recursos humanos e materiais, a importância da formação profissional na temática, e a necessidade da criação de intervenções protocoladas relacionadas com cuidados atraumáticos, de forma a promover a humanização da assistência.

Palavras-chave: cuidados atraumáticos; enfermagem pediátrica; cuidados de enfermagem; enfermeiras pediátricas

ABSTRACT

Introduction: Hospitalization consists of a health-disease transition which enhances negative effects on child and family, such as changes in family dynamics, setbacks in development, anxiety and fear. The provision of atraumatic care should be a basic premise in Pediatrics to minimize these effects.
Objective: Identifying the knowledge of Specialist Nurses about atraumatic care in pediatric hospital context; identifying interventions and strategies promoting atraumatic care implemented by Specialist Nurses; identifying the obstacles to the implementation of atraumatic care in practice mentioned by Specialist Nurses.
Method: Descriptive, exploratory study of qualitative nature, using focus group, with a convenience sample of eight Specialist Nurses in Child and Pediatric Health, and analyzing the data according to Bardin method.
Results: From the analysis of data related to the four pre-established dimensions for the study, 12 categories emerged.
Conclusion: Specialist Nurses recognize the importance of atraumatic care in Pediatrics, implementing them intrinsically in practice. The main obstacles to its implementation are the lack of time and resources. They recognize the need for the management of human and material resources, the importance of professional qualification in this subject, and the need to create protocoled interventions related to atraumatic care, in order to promote the humanization of care.

Keywords: atraumatic care; pediatric nursing; nursing care; pediatric nurses

RESUMEN

Introducción: La hospitalización consiste en una transición salud-enfermedad que tiene efectos negativos en el niño y la familia, como cambios en la dinámica de la familia, retrocesos en el desarrollo, ansiedade y miedo. La prestación de cuidados atraumáticos debe ser una premissa básica en Pediatría, para minimizar estos efectos.
Objetivo: Identificar el conocimiento de Enfermeros Especializados sobre cuidado atraumático en el contexto hospitalário pediátrico; identificar intervenciones y estrategias que promuevan lo cuidado atraumático implementadas por Enfermeros Especializados; identificar los obstáculos para la implementación de lo cuidado atraumático en la práctica mencionados por Enfermeros Especializados.
Métodos: Estudio descriptivo, exploratorio de carácter cualitativo, utilizando un grupo focal, con una muestra de conveniencia de ocho Enfermeros Especializados en Salud Infantil y Pediátrica, y analizando los datos según el método de Bardin.
Resultados: Del análisis de datos relacionados con las cuatro dimensiones preestabelecidas para el estudio, surgieron 12 categorías.
Conclusión: Los Enfermeros Especializados reconocen la importancia de lo cuidado atraumático en Pediatría, implementándolos intrinsecamente en la práctica. Los principales obstáculos para su implementación son la falta de tiempo y recursos. Reconocen la necesidad de la gestión de los recursos humanos y materiales, la importancia de la formación profesional en el tema y la necesidad de crear intervenciones protocoladas relacionadas com el cuidado atraumático, com el fin de promover la humanización del cuidado.

Palabras clave: cuidado atraumático; enfermería pediátrica; cuidado de enfermagem; enfermeras pediátricas

INTRODUCTION

Based on Meleis' Theory of Transitions, hospitalization in paediatrics is a health-disease transition that can have negative effects on the child and family (Meleis et al., 2000). The unknown environment, painful procedures, and changes in the daily routine are some of the factors that cause anxiety and fear in children and their families, making hospitalization in paediatrics in a negative experience with effects that may reflect on the child's development, namely developmental regressions, decreased sleep, changes in diet and lack of energy (Pereira et al., 2018). Providing atraumatic care plays an important role in minimizing these effects with the aim of reducing the negative impact of hospitalization on the child and family.

In order to understand the perspective of Specialist Nurses in Child and Paediatric Health (SNCPH) regarding atraumatic care in paediatrics, the aims of this study were to identify knowledge about atraumatic care, to identify interventions and strategies that promote atraumatic care implemented in a hospital context, and to identify obstacles in implementing atraumatic care.

1. ATRAUMATIC CARE IN PAEDIATRICS

The concept of atraumatic care in paediatrics was first approached by Wong in 1999. It consisted of a set of interventions to eliminate or reduce the physical or psychological suffering experienced by children and their families in health care. Its main presupposition is to cause no harm based on three principles: avoiding the removal of the child from the family, stimulating a sense of control, avoiding or minimizing bodily distress or pain (Hockenberry & Wilson, 2014).

Two of the specific competencies of the SNCPH consist of providing quality care to children and young people and their families in situations of special complexity in order to maximize their health, with care being adequate to the needs of their lifecycles and development (Ordem dos Enfermeiros [OE], 2018). Thus, specialized nursing care must include interventions that promote atraumatic care.

Nursing care for hospitalized children sees them as developing beings with the needs and vulnerabilities intrinsic to hospitalization. Children need to maintain a continuous affective bond with people and the environment around them. The nurse must enable these bonds to be maintained through the provision of atraumatic care (Barroso, 2016) with differentiated management skills for their pain as well as their physical, psychosocial and spiritual well-being (OE, 2018).

From the literature review performed, it is consensual that during hospitalization, the performance of invasive procedures is what causes the most anxiety and fear in children expressed through crying, anger and aggressive behaviour (Pereira et al., 2018). In view of these procedures, there are interventions that promote atraumatic care, such as: allowing the person accompanying them to remain and ensuring their participation as partners in the child's care (Perry et al., 2017), promoting the child's coping during the procedure, giving him/her control enabling their collaboration (Ellis et al., 2004), and using EMLA® anaesthetic cream associated with the topical application of heat (Huff et al., 2009). Employing distraction techniques, guided imagery and positive reinforcement, providing information to the child and family about the procedure, adapting the environment by decorating the walls with attractive images and colours and wearing colourful uniforms with cartoon characters (Mediani et al., 2019), and therapeutic play are other examples of interventions that can be implemented (Barroso, 2016; Costa et al., 2016; Freitas & Voltani, 2016; Marques et al., 2016). From the literature review, the perspective of nurses regarding therapeutic toys was found to be addressed occasionally; however, there are very few studies which encompass various types of atraumatic care.

term neonates (Yin et al., 2015).

In paediatrics, the current paradigm of care is the dyad/triad child/significant person/family, and the provision of atraumatic care should promote the involvement of all stakeholders. Atraumatic care is also beneficial to the family, which feels empowered and included given the changes intrinsic to hospitalization (Marques et al., 2016).

Although atraumatic care is implicit in paediatric nursing, nurses do not always recognize its importance, and even if they do, they do not always implement interventions that promote this type of care (Costa et al., 2016; Marques et al., 2016; Pereira et al., 2018). The importance of atraumatic care in paediatrics is widely referred to in terms of interventions in the literature; however, only the benefits or difficulties experienced by nurses in relation to this care are addressed, and strategies for its implementation are not addressed. The literature shows barriers to the implementation of atraumatic care, such as the deficit in training and lack of knowledge of nurses on the subject. Milk et al. (2016) found that nurses identified manifestations of tension on the part of the child; however, due to lack of time or ability to deal with this situation with humanistic strategies, they focused their care on the recovery of biological health.

Given the relevance of the topic and because there are no studies on specialized nursing intervention in Portugal in this area, this study was conducted to answer the research question: "What is the SNCPH's perspective on atraumatic care in paediatrics?"

2. METHODS

Taking into account the concerns that led us to carry out this study, the methodology followed was the qualitative, exploratory and descriptive research method. Data collection was performed using a focus group. Based on current literature and in response to the aims set out, an a priori script was created, with four guiding questions: 1) What is the SNCPH's knowledge on atraumatic

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care in the context of paediatrics in hospital? 2) What are the interventions that promote atraumatic care that SNCPH implement in paediatrics? 3) What are the obstacles to implementing atraumatic care referred to by the SNCPH? 4) What are the strategies mentioned by the SNCPH that they can adopt to implement atraumatic care?

2.1 Sample

The sample is non-probabilistic and for convenience, since the participants were selected by invitation. The inclusion criteria were established at the outset: to be a SNCPH practicing in paediatrics for at least the last five years. SNCPHs were chosen due to their specialized intervention, and the minimum experience was a methodological option as five years is understood to be the minimum experience that allows SNCPHs to have a more competent view of their specialized practice. The sample consisted of eight nurses from a paediatric hospital in northern Portugal working in two inpatient services, who met the inclusion criteria and agreed to participate in the study after being informed of its aims and framework and formalizing consent to participate.

2.2 Data collection instruments

The focus group took place online on the Microsoft Teams platform in September 2020. It lasted approximately 60 minutes and was recorded in audio format. One of the researchers moderated the focus group based on a pre-established script. Data collection and processing took place in the months of October and November 2020 with the recorded data being transcribed in full, and later categorized and analysed by the researchers independently.
Data categorization, carried out by consensus, was based on the content analysis technique developed by Bardin (2010), based on the stages that constitute this technique: analysis organization, coding, categorization, treatment and interpretation of results (Urquiza & Marques, 2016).

2.3 Procedures

Throughout the study, there was a commitment to respecting the ethical aspects and fundamental rights of authors and participants. The study was approved by the Ethics Committee of the Northern Health School of the Portuguese Red Cross. The focus group was transcribed without directly identifying the participants (coded from P1 to P8), and all the documents resulting from the data collection were subsequently destroyed.

3. RESULTS

Prior to the focus group, based on the guiding questions defined in the guide, four dimensions were defined: “Knowledge about atraumatic care in paediatrics”, “Interventions which promote atraumatic care in paediatrics”, “Obstacles to implementing atraumatic care in paediatrics” and “Strategies to be adopted for the implementation of atraumatic care in paediatrics”.
From the analysis of the data obtained, twelve categories emerged, relating to the perspective of the SNCPH on atraumatic care in paediatrics. The categories originate from the semantic aggregation and agreement relationship of the registration units and subcategories identified. Table 1 presents the registration units that best characterize the categories and subcategories for a better understanding of them.

Table 1 - Categories and subcategories identified

Dimension	Category	Subcategory	Recording units	Percentage of recording units
Knowledge about atraumatic care in paediatrics	From theoretical foundations	Evolution of care	“Over the years of our practice this has evolved and we are increasingly sensitive to this type of care” P1	12.5%
			“This is already very much a part of our day-to-day, it is already intrinsic” P3/P2	25%
		Partnership in care	“Care should be centred on a partnership in care between the family, the child and the nurse" P5	12.5%
			"Allow the presence of parents" P1/P7	25%
			"The presence of family members" P3	12.5%
			"We negotiate with the child and the parents" P7	12.5%
			"We focus the family on care" P6	12.5%
		Health-disease transition	“When children come to the hospital, whether in an acute or a chronic phase, they are in a transition process, we want to have strategies in order for them to have as healthy a transition as possible” P1	12.5%
	From clinical practice	Minimizing the impact of pain	“All those strategies used to minimize the impact on the child: pain, crying, fear, separation anxiety” P2	12.5%
			“Measures or strategies to alleviate pain” P1	12.5%
			“By decreasing the pain, they will provide well-being to the child" P6	12.5%
			"Decrease the negative impact of hospitalization" P1/P6	25%

Dimension	Category	Subcategory	Recording units	Percentage of recording units
		Minimizing the impact of hospitalization	"Minimize the repercussions of hospitalization" P5	12.5%
			"Minimize the feeling of loneliness and the anguish of separation" P5	12.5%
Interventions which promote atraumatic care in paediatrics	Cognitive-behavioural interventions	Recourse to playing with therapeutic intent	"Telling stories" P6/P5/P3	37.5%
			"Using to puppets, dolls" P5	12.5%
			"Playing around, games" P8/P1	25%
			"Writing, drawing" P3/P1	25%
			"The activity of playing" P5	12.5%
			"Mobile phones, tablets, computers" P4	12.5%
			"Provide the opportunity to have access to audiovisual means to become distracted" P6	12.5%
			"Using a distraction tactic" P 3	12.5%
			"Distraction" P1	12.5%
			"Handling the instruments we use, allowing them to pretend to draw blood from us" P3	12.5%
			"Let them pick up the needle, see the needle, if you let them choose the vein that they want" P6	12.5%
			"A book with a story about a boy who was going to undergo surgery and his fears that was offered to the child before the surgery" P8	12.5%
		Reference object	"We allow the presence of an object that the child likes to sleep with, the dummy and their security blanket or nappy, objects that are a reference and that give them some comfort" P3	12.5%
			"Pet object" P1	12.5%
			"We had a boy who brought a small fish, a pet" P1	12.5%
		Music therapy	"The use of music" P3/P2	25%
			"Music therapy" P5	12.5%
			"Singing, dancing" P4/P3	25%
		Relaxation	"Breathing deeply" P5	12.5%
			"Favouring relaxation" P5	12.5%
	Specific interventions in newborns/infants	Sucrose	"The use of sucrose" P1/P6/P7/P2	50%
		Breastfeeding	"Staying at the breast while some procedures are performed" P5	12.5%
			"Breastfeed" P7	12.5%
		Retention	"Swaddle the baby, position it comfortably" P5	12.5%
		Skin-to-skin contact	"Skin-to-skin contact" P5	12.5%
		Non-nutritive suction	"Using a dummy" P5	12.5%
	Using local anesthetic	EMLA®	"Use of EMLA®" P1/P6/P8/P5	50%
	Communication	Communication techniques	"Creative communication techniques" P5	12.5%
	Support interventions	Parental stay	"Allowing parents' presence" P1/P7	25%
			"Parents mediate trust" P5	12.5%
			"We use playing around with the parents" P5	12.5%
		Nurse-child relationship	"This approximation we have with them, entering their world" P3	12.5%
			"The pampering" P2	12.5%
			"All implemented non-invasive interventions that generate empathy" P8	12.5%
			"Empathy" P5	12.5%
			"Getting close to the child in order to create empathy" P1	12.5%
			"Giving the child the opportunity to get involved in the provision of care" P6	12.5%
			"Positive reinforcement" P5	12.5%
Obstacles to implementing atraumatic care in paediatrics	Related to strategic management	Lack of resources	"Lack of human and material resources" P8	12.5%
			"We don't have enough staff" P3	12.5%
			"Lack of staff or lack of some materials" P4	12.5%
			"We often have a lot of patients and we can't do it" P7	12.5%
			"The uniforms often intimidate the children" P7	12.5%
		Service management	"The pressure of work and the disorganization of the service as well" P6	12.5%
			"For administrative reasons, because you couldn't make yourself up, because of service heads, there was always a series of impediments" P6	12.5%
		Lack of time	"Lack of time" P4/P7/P8	37.5%

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Dimension	Category	Subcategory	Recording units	Percentage of recording units
	Related to nursing professionals		"We are always very rushed in executing treatments, which does not help at all" P7	12.5%
			"If there were more time to do it" P5	12.5%
			"You had to have time" P6	12.5%
		Deficit in training	"For a person to provide atraumatic care, they must have knowledge about this way of providing care to children" P6	12.5%
		Lack of protocols	"Lack of protocols that standardize procedures in the atraumatic approach" P8	12.5%
	Relating to external factors	Pandemic	"Covid is a big obstacle at this time, apart from affection and expression of affection, they are not allowed to take anything at all tor the block" P2	12.5%
			"Now with Covid this has made it very difficult" P1	12.5%
Strategies to adopt to implement atraumatic care in paediatrics	Relating to the physical environment and resources	Treatment room	"Our treatment room to be a more pleasant space " P1	12.5%
			"Our treatment room could also have suitable music for the child's age" P5	12.5%
			"I wished to make a blood collection room, a dressing room, which would be different from the normal rooms" P6	12.5%
			"The paintings " P3	12.5%
		Uniform	"The colour of our uniform, make our uniforms more cheerful" P4	12.5%
			"The colour of the uniform, the cartoon characters on the uniform, having a uniform with patterns" P5	12.5%
			"The existence of colourful uniforms" P3	12.5%
			"The uniforms we wear" P6	12.5%
		Privacy	"Privacy, each child has an individual room" P5	12.5%
	Relating to nursing professionals	Increase in training	"In-service training can be a way; training in this area would be very good" P6	12.5%
			"This implies constant reflection" P5	12.5%
			"And also the knowledge of health professionals regarding pain, the appropriate scales and the focus of pharmacological and non-pharmacological activities" P5	12.5%
		Implementation of protocols	"Implementation of protocols related to atraumatic care" P8	12.5%

4. DISCUSSION

From the perspective of the SNCPH regarding the first dimension Knowledge about atraumatic care in paediatrics, two categories emerged: From theoretical foundations and From clinical practice. Regarding this dimension, 75% of the participating SNCPH (n=6) reported knowledge arising from theoretical foundations, and 50% (n=4) reported knowledge arising from clinical practice. We found that the participants have knowledge regarding atraumatic care in accordance with the literature, namely with regard to the definition of the concept, as evidenced in the expression of P6 "Care provided to the child that provides for their well-being and reduces the negative impact of hospitalization". Some definitions mentioned focused specifically on minimizing the impact of hospitalization and minimizing the impact of pain, in line with the definition by Hockenberry and Wilson (2014). We found that the knowledge referred to by the SNCPH is in accordance with Hockenberry and Wilson's three principles (2014): avoiding the separation of the child from the family ("Care should be centred on a partnership in care between the family, the child and the nurse" P5); stimulating a sense of control ("We negotiate with the child and the parents" P7); and avoiding or minimizing bodily suffering or pain ("All those strategies used to minimize its impact on the child: pain, crying, fear, separation anxiety" P2).

In the first dimension, 62.5% of the participants (n=5) mentioned the subcategory partnership in care, in keeping with the current paradigm of care in paediatrics, which states that allowing the person accompanying them to stay with the child and their participation promotes comfort and prepares the child before the procedure, allowing them to express their fear (Perry et al., 2017). Partnership in care is promoted through Negotiating care with the child and the parents (P7) and the involvement of the family in the decisions to be taken in relation to the child (Çalişir & Karataş, 2019). Another aim of providing atraumatic care in partnership with the family is to empower the family, providing positive reinforcement, regularly assessing the family situation, providing options for decision-making and encouraging the family to share emotions and seek support when necessary (Çalişir & Karataş, 2019), issues that are particularly important and were not mentioned in the study.

In the first dimension, 37.5% of the participants (n=3) also mentioned the intrinsic and evolutionary nature of atraumatic care in paediatrics. In fact, the literature presents a reduced number of studies on atraumatic care, which has been replaced by other terms.

Analysis of the data from the second dimension, Interventions which promote atraumatic care in paediatrics, 5 categories emerged: Cognitive-behavioural interventions, Specific interventions in newborns/infants, Use of local anaesthetic, Communication, and Support interventions.

Of the interventions in the subcategory Recourse to playing with therapeutic intent, cognitive-behavioural interventions was most often reported by the participants (75%), which is in accordance with the literature. Therapeutic play in the context of hospitalization is an intervention that promotes the understanding of the disease and acceptance of the treatment with a therapeutic perspective when implemented through hospital clowns, bibliotherapy or the use of therapeutic toys (Pereira et al., 2018). In this subcategory, 25% of the participants mentioned simulation or modelling interventions, namely the handling by the child of blood collection material such as tourniquets and peripheral venous catheter without a mandrel, promoting their collaboration during technical procedures. These interventions are in line with current literature, allowing medical staff to inform children about the procedure and provide them with an environment closer to reality, reducing feelings such as fear, pain and anxiety (Ordem dos Enfermeiros [OE], 2013). 25% of the participants also mentioned distraction techniques, also present in the literature (Mediani et al., 2019).

There is a relevant prominence in the dimension Specific interventions in newborns/infants, being mentioned by 62.5% of the participants, respecting the principle of minimizing bodily suffering or pain referenced by Hockenberry and Wilson (2014) and in line with interventions involving non-pharmacological measures of pain relief in invasive procedures in children (Direção-Geral da Saúde, 2012). As in the literature, participants addressed sucrose (50%), breastfeeding (25%), Retention (12.5%), skin-to-skin contact (12.5%) and non-nutritive sucking (12.5%), which are nothing more than interventions that promote comfort in newborns/infants during painful procedures, such as interventions that promote atraumatic care. These interventions significantly attenuate pain signals and decrease hypoxia events during procedures (Yin et al., 2015). However, it is worth noting that they are more widely explored in the literature and can be associated with other types of facilitating interventions not mentioned by the participants.

Also in the subcategory Using local anaesthetic, reported by 50% of the participants, we found that the isolated use of anaesthetic EMLA® cream is mentioned. The literature indicates that its effect is enhanced by the association with the topical application of heat, allowing for a better visualization of the vein and a reduction in puncture attempts (Huff et al., 2009). According to the Directorate-General for Health (2012), EMLA® ointment is the most commonly used drug for topical anaesthesia and should be associated with the non-pharmacological interventions previously described to enhance its action effect.

In the second dimension, the categories Communication (12.5%) and Support interventions (87.5%) also emerged. Two subcategories emerged from the Support interventions category: Nurse-child relationship (75%) and Parental permanence (37.5%). These data are in line with the literature, as the nurse must ensure that the child maintains a continuous affective bond with the people and the environment surrounding them (Barroso, 2016).

37.5% of the participants mentioned empathy in the subcategory Nurse-child relationship, and the literature mentions that the paediatric nurse must establish an empathetic relationship with the child and family, and their interventions must be appropriate to their needs and characteristics (Çalişir & Karataş, 2019). In this subcategory, 12.5% of the participants also mentioned the intervention of involving the child mentioned in the literature so as to promote the child's coping during the procedure, giving them control over the situation, allowing them to collaborate whenever possible (Ellis et al., 2004).

The categories that constitute the second dimension have a common purpose of reducing pain, fear and anxiety in children during invasive procedures (OE, 2013).

From analysing the data from the third dimension, Obstacles to the implementing atraumatic care in paediatrics, three categories emerged. 62.5% of the participants mentioned obstacles related to strategic management, and from the data analysis the following subcategories were identified: Lack of resources (50%) and Service management (12.5%). 62.5% of the participants mentioned obstacles related to nursing professionals, and from the data analysis the following subcategories were identified: Lack of time (62.5%), Deficit in training (12.5%) and Lack of protocols (12.5%). The External factors category includes only the Pandemic subcategory, mentioned by 25% of the participants as a current obstacle to the implementation of atraumatic care.

Although the literature mentions that atraumatic care may be implicit in paediatric nursing, nurses do not always recognize its importance, nor do they always implement interventions which promote it (Costa et al., 2016; Marques et al., 2016; Pereira et al., 2018) From this study, these factors were shown not to be directly referred to as obstacles to implementing atraumatic care, but could be understood indirectly by identifying the subcategories Training Deficit and Lack of Protocols albeit very insubstantially.

Data analysis highlights that the participants recognize the definition and importance of atraumatic care; however, they list other obstacles to its applicability other than lack of knowledge or lack of will. Analysing the third dimension, the most emphasized obstacles were lack of time (62.5%) and lack of health resources, namely human resources (50%). These obstacles, associated with the priority of medical procedures, constrain provision of atraumatic care. It is understood that because they are not prescribed interventions, atraumatic care should be autonomous nursing interventions. Nevertheless, during care management and due to lack of time and resources, technical and bureaucratic procedures are sometimes prioritized to the detriment of humanistic interventions. Another possibility is that interventions that promote atraumatic care are in fact implemented, but because they

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are not registered in the child's records, it is impossible to validate their implementation. The importance of a specialized intervention by the SNCPH in this issue is highlighted.

Another important fact that emerges from the study is the fact that the current literature addresses nurses' knowledge about atraumatic care, the interventions that promote it and the obstacles to its implementation, with no evidence of strategies to implement this type of care. The results of the study also allowed us to identify a fourth dimension, Strategies to be adopted to implement atraumatic care in paediatrics. The researchers believe that this dimension is an added value, since there are no previous studies regarding the perspective of the SNCPH on this subject.

Two categories emerged from the fourth dimension: Related to the physical environment and resources (62.5%), and Related to nursing professionals (37.5%). Regarding the strategies related to the physical environment and resources, 50% of the participants reported that the use of colourful uniforms should be adopted because the white uniform causes fear and anxiety in the child; and 50% of the participants report that aspects relating to the treatment room of the inpatient services should be improved, as an uncharacterized treatment room conditions the use of therapeutic play and distraction techniques, reducing the child's collaboration and causing fear and anxiety. With regard to strategies related to nursing professionals, 25% of the participants reported that there should be an increase in training, and 12.5% (n=1) referred to the implementation of protocols. It is important to mention that, despite being identified, the implementation of protocols must be considered and, if they exist, they must be adapted to the different age groups present in paediatric inpatient services.

CONCLUSION

The study allowed us to ascertain that SNCPHs have knowledge about the definition of atraumatic care and interventions that promote it, consciously implementing several of these interventions. Moreover, they recognize the importance of atraumatic care in the practice of specialized care in paediatrics. SNCPHs validate the benefits of atraumatic care in paediatrics including reducing the child's fear and anxiety, minimizing the negative impact of hospitalization and promoting a more adjusted health-disease transition for the child and family.

We may conclude that, from the perspective of the SNCPH, the provision of atraumatic care should be seen as a basic premise in paediatrics to minimize the negative repercussions caused by hospitalization with the SNCPH holding specific skills for the implementation of this care.

From the data analysis, we found that the obstacles the SNCPH most emphasized related to providing atraumatic care in paediatrics were lack of time and lack of health resources, particularly human resources.

The researchers understand that the fact that the participants work at the same institution, albeit in different services, may have constituted a limitation of this study, and it would be interesting to investigate the opinion of SNCPH in other paediatric hospitals regarding atraumatic care. To this end, we suggest carrying out future studies with diversified samples and expositors of different institutional realities.

Regarding the strategies to be adopted for the implementation of atraumatic care in paediatrics, the SNCPHs mentioned strategies related to the physical environment and resources, and related to nursing professionals. It is evident that to implement these strategies, SNCPHs need to invest in training in atraumatic care in paediatrics and in its adoption as structured procedures. We would also add that it is important to record the implementation of interventions properly that promote atraumatic care and their outcomes. Atraumatic care is already recognized in paediatrics; however, there are few studies that address the different types of atraumatic care in its entirety. There are guidelines from the General Directorate of Health regarding pain assessment and non-pharmacological measures for pain relief in children. Nevertheless, it is considered important to develop procedures or work instructions within the scope of accreditation and quality certification programs, covering all types of atraumatic care in hospitals, recording and assessing its implementation, showcasing the work developed by SNCPHs in paediatric services and to the health gains obtained through a practice with humanization of care as a core principle.

The aim of this study was to highlight the importance of atraumatic care in paediatrics from the perspective of the specialized practice of the SNCPH, as well as to raise the SNCPH's awareness to adopt strategies that promote the provision of this care, and for the importance of future research that will make its implementation visible.

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