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EDITORIAL

Humanization in Neonatal Intensive Care Units

Humanização em Unidades de Cuidados Intensivos Neonatais

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The emergence of neonatology, as an area of medicine, took place in France, in 1892, through the obstetrician Pierre Budin.[1] The french physician was the one who instituted principles and methods that formed the basis of neonatal medicine. For Budin, the participation of the mother in caring for their child was essential to develop the affective bond between both. Unfortunately, the arrival of technology in nurseries resulted in the exclusion of mothers, and the impact of this separation was reflected in the rupture of the mother-baby bond. Maternal-neonate separation for human neonates became the standard of care for more than a century.[2]

With the emergence of the modern neonatal intensive care units (NICUs), the care provided to sick neonates became more and more specialized and technological, through new techniques and sophisticated equipment. In this scenario, the family was not included as part of the neonate care and recovery for many years. It is only in recent years that it has been recognized that it is important to provide assistance beyond the clinical needs of the premature infant, to begin to promote family-centred care, and to include psychosocial aspects of parents.[3]

Including the parents in the process of hospitalization of their neonate, whether it's a very low birth weight premature or a sick term infant, and guaranteeing quality of care to both the patient and the family, are the primary objectives of humanization in NICUs. The parents are fundamental elements in the process of growth and development of the child, and the parent-child bond should always be maintained and encouraged, even in the complex intensive care scenario.[4]

In the NICU, the team caring for the neonate not infrequently shows difficulties in understanding reactions as consequence of the stress experienced by the parents. While some parents understand the conditions of infants and adjust to the practice of unity, others express opposite reactions such as denial. When the expectations of the healthcare team are not met by the parents, the team becomes emotionally distant and reluctant to perceive the parents who are suffering with their baby.[5]

For parents, humanization means to consider the family of the patient also as an object of work, with the need to be informed and treated with a careful and respectful attitude.[4] With regard to the care given to the neonate, to the parents, the sense of humanization presupposes that the care given to their child is based on human contact, in a welcoming manner, and it should also take into account the completeness and specificity of each child, as well as the scientific work of professionals.[4] Regarding the behaviour of health care professionals, for parents, humanization is related to the professional's behaviour, their attitudes, dedication and vocation to the activity.[4]

Thus, humanization involves the process of building and improving human interaction for a more friendly relationship with others. Communication and dialogue are fundamental.[5]

Humanized care is all that care aimed at the patient as a whole, and not having the patient seen as a sum of diverse and partial care. Humanizing is looking the other way, it's not just the clinic, it's not just the disease, but the well-being of the sick individual, even to improve his clinical conditions.[6]

Devaluation of singularities is an obstacle in understanding the other from his experiences and feelings. Understanding the meaning attributed by another person to suffering is only possible when we listen to them, verbally in addition to what is spoken by his body language and life. Words and all the means of expression are essential in practice. They allow for the suffering that the 'subject' experiences to be expressed. Dealing with the existing contradictions between over-valuing machines, diseases and human experiences in the search for integrating strategies where relations are valued represents the movement of humanization, and this is the great

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challenge.[5]

The environment inside the NICU is a very particular one, and efforts should be done to overcome the related difficulties. The physical environment of a NICU is stressful, not only for the babies, but also for their families: all the equipment, the alarms sound, the flashing lights usually generate a lot of anxiety in the family. NICU´s environment is intensely busy, especially in the morning, when routine care is performed and the visit of several professionals occur.[6]

Some modifications should be made in the ambience, such as decreasing the noise and sound level, reducing the amount of light, paying more attention to the baby's positioning, using less stressful treatments, reducing the number of times the baby is handled, using the perspective of minimal touches, preserving the temperature in a thermo-neutral environment, avoiding prolonged openings of incubators and repeated exposure of the baby to the cold.[6]

For health care providers in the NICU, pleasure and exhaustion can coexist in a paradoxical way in the same work activity. The main source of pleasure in hospital work, from the point of view of interviewed professionals, is the patient's hospital discharge, as it portrays in a more complete way the investment in the production of health care. However, despite the efforts of the team and the technological resources, some of the babies do not resist. If, on the one hand, hospital discharge is a source of pleasure and gratification for work, on the other hand, witnessing deaths represents a source of exhaustion.[7]

Death can generate the feeling of unfinished or unsuccessful work. A work interrupted by death, which in turn affects the ethos and mission of the professional group - saving lives. Considered a negative "product" within the work process, deaths are sources of suffering and exhaustion for both families and professionals.[7]

Other sources of tension at work that cause suffering on health care providers include elements related to the organization of work, such as division of tasks, adverse situations in terms of working conditions and relationships, lack of human or material resources, scarcity of physical space, and professional impotence. Wear and suffering can be generated not only by the activity that the worker performs, but also in the impediment of the activity, that is, the activity that is not carried out.[8]

Due to work overload and overcrowding at the unit, many professionals do not even leave the site for a break or lunch. The neonatal NICUs not infrequently work with a deficit of professionals, especially in nursing, which directly interferes with the quality of care production, causing an overload of work. The unit overcrowding is also mentioned as an impediment to humanized care. Another exhausting factor is the professional's performance time. Burnout is most prevalent in NICUs with high patient volume and electronic health records and may affect professionals disproportionately. It is considered that, in addition to emotional exhaustion, there is an important "physical exhaustion". Although the years "bring" the experience of practice, they "take" the vitality of the body. Physical and mental fatigue, exhaustion and burnout have detrimental effects on patient´s care and their families. Preventing this phenomenon in NICUs will lead to better results, and will facilitate a more humanized care.[9,10]

Another important point in relation to the production of wear and tear is the issue of limited physical space for accommodation of workers, who can stay for a period of up to 24 hours in the work environment. The construction of new subspecialties and new practices end up demanding concrete working spaces within the institution. In the NICU, it is no different. The lack of spaces for promoting leisure and rest for professionals is a cause of discomfort at work. Space should serve as a facilitating tool for the functional work process, favouring the optimization of resources and humanized, welcoming and resolute care. Material resources have also been cited as obstacles and a source of wear and tear in the production of humanized assistance.[11]

Measures that can be implemented in NICUs to further humanize the treatment of neonates and family care are as follows:

1. health policies that keep hospitals open 24 hours a day, where the presence of the family can be uninterrupted promoting their integration into the health care team, must be encouraged;
2. raise awareness and train health professionals in order for them to carry out a more humanized care;
3. healthcare management should promote the inclusion of healthcare professionals with specific training in this type of unit and even promote learning courses for new professionals that become part of the multi-professional team; such a situation would contribute, within the NICU, to the joint participation of the multidisciplinary team and the family;
4. support the emotional and psychological needs of the families;
5. promote communication between professionals, and between them and the patient´s families;
6. promote the physical and psychological well-being of the patient as well as promote a pleasant and reassuring environment for the patient and the family;
7. sensitize professionals about burnout syndrome and prevent it by promoting well-being;
8. create treatment and follow-up protocols for the patient and family in end-of-life situations and redirection of care, involving multidisciplinarity in these situations;
9. provide rest spaces and spaces suitable for the different tasks of health professionals;
10. avoid overcrowding and always have a number of professionals appropriate to the number of patients;
11. avoid over-administrative work of health professionals;
12. humanization within NICUs should be addressed from the outset by the professionals themselves, encouraging the involvement of parents and giving meaning to the experiences of families; this can happen in the management area, respecting the shifts changes of nurses in those units;
13. overcome barriers to the practice of skin-to-skin contact

between parents and infants;
14. provide positive touch when an infant cannot be held;
15. promote the provision of human milk and the means of access to human milk;
16. promote follow-up after hospital discharge with continuing family care and support;
17. health institutions must understand the need to humanize the NICU and allow the creation of the means to make it happen.

These and other practices are desirable and essential for humanized care at the NICU. The recognition of a humanized approach on the part of families is reflected in a greater commitment on their part in collaboration in the treatment of the infant and in a better relationship with health professionals, which ultimately is reflected in a better care for the patient himself. On the other hand, a better and more humanized relationship with the family turns the work of health professionals more pleasant, constituting a stress reduction factor in the NICU. Lately, it is important to understand that humanizing is not just giving, it is also receiving.

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