DOI: http://dx.doi.org/10.18569/tempus.v11i1.2061

Quando a vida começa diferente: cuidado postural no cotidiano da equipe multiprofissional em terapia intensiva pediátrica

Cuando la vida empieza distinta: el cuidado postural en la rutina del equipo multiprofesional de cuidados intensivos pediátricos

When life begins different: postural care on daily life of the multiprofessional team in pediatric intensive care

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RESUMO: Objetivo: Compreender as práticas da equipe multiprofissional no cuidado postural da criança cardiopata na unidade de terapia intensiva. **Métodos**: Trata-se de estudo descritivo de cunho qualitativo, realizado na Unidade de Terapia Intensiva cardiopediátrica de um hospital de referência de Fortaleza, Ceará, Brasil, no tratamento de doenças cardíacas e pulmonares em abril de 2016, com profissionais de saúde lotados há pelo menos seis meses na unidade atuando no manejo da criança no leito. A coleta de dados foi através da observação participante e da entrevista semiestruturada. Utilizou-se a Análise de Conteúdo para a análise das informações. A pesquisa cumpriu a Resolução 466/12 e foi iniciada após a aprovação do Comitê de Ética do referido hospital com parecer de nº 53399616.4.0000. **Resultados**: Emergiram as seguintes categorias de análise: "Só mais uma vez... amanhã talvez": a distância dos sujeitos nos processos de cuidado em saúde e "Oh me vira aqui... me mexe aqui": outros modos de ser profissional de saúde. **Conclusão**: Há que se refletir criticamente acerca das ações e interações no contexto dos serviços de saúde sobre o que, como e quando falar; o que, como e quando olhar; como se posicionar e tocar a criança. Importa compreender o que a criança transmite e tentar atender às suas necessidades como pessoa e não só como paciente.

Descritores: Unidade de Terapia Intensiva. Pediatria. Posicionamento do Paciente.

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RESUMEN: Objetivo: Comprenderlasprácticasdel equipo multiprofesional para el cuidado postural delniñoconcardiopatíaenlaunidad de cuidados intensivos. **Métodos**: Se trata de unestudiodescriptivo y cualitativo realizado enlaUnidad de Cuidados Intensivos cardiopediátrico de un hospital de referencia de Fortaleza, Ceará, Brasil, para eltratamiento de enfermedades cardíacas y pulmonares en abril de 2016 conprofesionalessanitarios que trabajaban desde hace por lo menos seis meses enlaunidadenel manejo delniñoenla cama. La recogida de datos se dio a través de laobservación participante y de la entrevista semiestructurada. Para elanálisis de lasinformaciones se utilizóelAnálisis de Contenido. La investigación ha cumplidolaResolución 466/12 y se ha iniciado traslaaprobacióndel Comité de Ética del referido hospital conel informe de nº 53399616.4.0000.**Resultados:** Emergieronlassiguientescategorías de análisis: "Solo una vez más….mañana tal vez": la distancia de lossujetosenlosprocesosdel cuidado ensalud y "Oye, voltéameaquí…me mueveaquí": otros modos de ser profesionalsanitario. **Conclusión:** Hay que reflexionar críticamente sobre lasacciones y interaccionesenel contexto de losservicios de salud sobre el que, cómo y cuándohablar; el que, cómo y cuándo mirar; como posicionarse y tocar elniño. Es importante comprenderlo que elniñotrasmite y intentar atender sus necesidades como persona y no solo como paciente.
Descriptores: Unidades de Cuidados Intensivos. Pediatría. Posicionamiento del Paciente.

ABSTRACT: Objective: To understand the practices of the multiprofessional team in the postural care of the cardiopath child in the intensive care unit. **Methods**: This is a qualitative descriptive study, carried out in the Cardiopediatric Intensive Care Unit of a reference hospital in Fortaleza, Ceará, Brasil, in the treatment of heart and lung diseases in April of 2016, with health professionals who had been working for at least six months at the unit dealing with child in bed. A semi-structured interview and participants observation was used to collect data. Content Analysis was used to analyze the information. The research complied with Resolution 466/12 and it started after the approval of the Ethics Committee of said hospital with the opinion of nº 53399616.4.0000. **Results**: The following categories of analysis emerged: "Only once more ... maybetomorrow ": the distance of the subjects in the processes health care and "Oh turn me here ... move me here": other ways of being a health professional. **Conclusion**: It is necessary to reflect critically on the actions and interactions in the context of the health services on what, how and when to speak; what, how and when to look; how to stand and touch the child. It is important to understand what the child transmits and try to meet their needs as a person and not only as a patient.
Descriptors: Intensive Care Unit. Pediatrics. PatientPositioning.

INTRODUCTION

When parents receive their child diagnosis of congenital heart disease of their child before or after the birth, they begin with the unique experience of the process of deconstruction and reconstruction of the child's representation, which is developed by the resilience of the child facing a

new situation. It begins for the child a different life, with congenital heart disease, which is defined as a malformation in the structure of the heart or of the great vessels, vital organs, present at birth, and may represent an individual cardiac defect or a combination of defects [1].

Congenital heart defects can often be corrected through surgery, ensuring parents the expectation of a normal life. However, the later the surgical procedure is performed, the greater the physical and psychological sequelae for the child, since it involves the use of invasive diagnostic and treatment techniques. The experience of frequent early hospitalization in the Pediatric Intensive Care Unit (UTIP/PICU), the care environment of rigorous, painful and robotic routines and protocols, causes feelings of distress, guilt, fear and insecurity, being considered a crisis process for the family system[2].

It is a reality that deprives the child of his function: being a child. This environment, usually of prolonged negative stimulation, due to the difficulty of harmonizing the accomplishment of a large number of invasive procedures and the recovery and promotion of patient safety, may lead to deleterious effects, generating a growing concern about its prognosis[3].

Working in a Pediatric ICU is a challenge and a constant quest to associate cutting-edge technology with human sensitivity, on which the baby's survival depends. It requires skill, attention, flexibility, talent, vocation and love, so the ICU is no longer just a place, in spatial terms, it transform itself into a context that generates meanings[4].

The reduction of noise, the reduction of luminosity and the adoption of measures of control the pain are strategies that contribute to the development of the newborn. In addition, initiatives such as touch, speech and containment facilitated during routine procedures allow the reduction of stress of the newborn, favoring a more harmonious neuromotor development[5].

Therapeutic / adequate / functional positioning or postural care is a form of intervention that allows the development of adaptive responses similar to those presented by healthy full-term newborns (RNT). Functional positioning within the neonatal ICU, as a simple care intervention, exerts a significant influence on ventilation and pulmonary perfusion parameters, ensuring, depending on the position of the baby, an improvement or worsening of ventilatory mechanics[6].

The postural care of the newborn is directly related to the improvement in the care of this clientele by contributing to the regulation of their physiological functions, providing stability and reduction of energy expenditures, and is even recommended by the Ministry of Health as a strategy in the humanized attention to the low weight newborn[7].

The important thing in the positioning is to verify how each baby behaves before the new posture. It is suggested to use materials such as fabric diapers, swaddles or swaddle blankets to pro-

mote containment and facilitate posture. It is an effective comfort method that favors the organization of the child on the bed[8].

The adoption of measures aimed at strengthening humanistic health practices directed at children is essential, such as the execution of a timely and effective intervention planning aimed at promoting the well-being of the hospitalized child. It should be emphasized that the awareness of the multiprofessional team for patient care requires hospitals to practice an action policy that encompasses their interprofessional work, understanding that humanization is not only the result of the application of material resources, but essentially the change in attitudes of human resources involved in the process[9].

The health professional that practices a humanized practice values the various forms of communication and expression of suffering and carefully examines the person who seeks it. The humanized approach is based especially on the understanding of the singularity of the subjects, based on the principles of the extended clinical practice, potentializing the addition of non-pharmacological agents as a significant change in hospitalization processes[10].

Having said that, it is worth mentioning that the programs of Multiprofessional Residency enter the hospital scope by virtue of the Proposal of Humanization in Health, intensifying that humanizing care and management in the Unified Health System (SUS) is presented as a means for the qualification of health practices, in line with a project of co-responsibility and intensification of inter-professional links and between these and users in health production[11].

The Multiprofessional Residence emerges in this new scenario to offer and experience this new health, with the challenge of imposing significant changes in the processes of formation. It is also seen as a strategy for the organization of services, since it infiltrates in the hospital context interdisciplinary teams, impelling the realization of reflections in life, in the spirit and power of care. When entering a complex and hierarchical universe, it provides a professional maturity[12].

In this context, this study is justified because it is motivated by the personal sensitivity of trying to understand the complexity surrounding congenital heart diseases and the need to understand the practices of the multiprofessional team regarding the postural care of the cardiopathchild in a pediatric intensive care unit in the reason for the incipience of scientific studies on the subject, aiming at strengthening a more comprehensive and longitudinal care of the cardiopath child.

It is important to emphasize the importance of functional positioning for children's health and the need to promote a theoretical reflection that provides support for the actions and interventions of the multiprofessional team in the postural care of the cardiopath child in the PICU, factors that confirm the relevance of this study to the professional by opening space for discussion and understanding of the experiences lived by the team, with the purpose of producing new ways of under-

standing and acting in health care, promoting a special service both in the care line of the service and in theaspects related to the particularities of the children involved.

The objective of this study is to understand the practices of the multiprofessional team in the postural care of the cardiopath child in the intensive care unit.

METHODS

In order to reach the proposed objective, it was decided to develop a descriptive study with a qualitative approach. Qualitative work privileges the universe of meanings, motives, aspirations, beliefs, values and attitudes, corresponding to a deeper space of relationships, processes and phenomena that cannot be reduced to the operationalization of variables[13].

The research was carried out at the Pediatric Cardiology Intensive Care Unit (PCICU/UTIP) of a Reference Hospital in the Treatment of Cardiopulmonary Diseases in the city of Fortaleza, CE, in the month of April 2016. This unit is composed, on average, by 60 professionals of different categories and currently has eight hospital beds, arranged bilaterally.

Participants in the study were health professionals, regardless of age and gender, who provided services at the pediatric cardiology ICU for at least six months, acting directly in the management of the child in the hospital bed and who agreed to participate in the research. Those who were on vacation during the data collection period, were not present at the ICU at the time of collection or refused to participate in the study were excluded. The number of participants was determined by the saturation of the information.

The possible participants were explained the objectives, the methodology, the risks and the benefits of the study with the presentation of the Term of Free and Informed Consent (TCLE). The participation of the professional was effected with the signing of mentioned term.

To characterize the participants of the study, a socio-demographic form was applied, which included information such as identification, sex, time and weekly workday in pediatric ICU, number of jobs, as well as participation in further training courses on postural care in bed or related topics.

The participant observation technique was used to describe the experience / living of the health professionals about the positioning in the bed of children with heart disease, consisting in the insertion of the researcher in the territory, in the case, in the pediatric ICU, for a period, so that he could observe the productions of that daily life. The researcher observed the team, recording information they considered relevant in a field diary, such as the characteristics of the intervention in the observed work process, to support their analysis and enable a confrontation with the interviewees' discourses.

To identify and apprehend the reasons for the positioning of the children with heart disease as a daily practice adopted by professionals in thePICUa semi-structured interview was conducted based on four guiding questions - "Describe how the child was positioned in the bed: in which decubitus? Did you use any artifact?" "Why is the child in this posture?" "What is your opinion regarding the positioning of children in the ICU bed?" "For you, is there is a difference between positioning the child in the bed and changing the child decubitus?", - shortly after the professional's intervention with the child. These questions served as a basis for analyzing the professional's perception of the positions adopted in theICU, taking into account their knowledge acquired during the practical experience of patient care. The interviews were recorded with the consent of the professional and transcribed in full.

We analyzed the information obtained through the Content Analysis method, which proposes to find answers to the questions formulated, besides referring to the discovery of the elements inherent to the manifest content[14].

In order to safeguard the anonymity of the children involved in the research, the types of positioning were used as pseudonyms in the records made in the field diary.

This research obeyed the ethical principles set forth in the Resolution of the National Health Council (CNS) nº 466, of December 12, 2012 [15], beginning only after the approval of the Committee of Ethics in Research (CEP) of said Hospital with opinion of Nº 53399616.4.0000.

RESULTS AND DISCUSSION

Characterization of participants

The study included 18 professionals from the health team, including 2 physiotherapists, 3 nurses, 10 nursing technicians and 3 doctors, with emphasis on the female gender. Of all the professionals surveyed, most of them perform their activities only in the hospital environment, for a period varying between 10 months and 28 years. Their reports showed physical and mental exhaustion when referring to an exhaustive work day, around more than 40 hours per week.

Then emerged two categories: "Just one more time? ... maybe tomorrow": the distance of the subjects in the processes of health care and" Oh, turn me here ... move me here ": other ways of being a health professional.

"Just one more time? ... tomorrow maybe":the distance of subjects in health care processes

The conception of health training originated from a pedagogical practice based on a vision of body, health, illness and reduced and apart, above all, statictherapeutic. This assertion corroborates the fact that learning at that time was accomplished by reading, observing and touching the dead

body, offering as only sources the contact with the teacher in the classroom, the textbook and the reduced supervised training. However, real professional intervention happens in the living body and in interaction with the environment, under processes of subjectivation, generating challenges in practice [16].

Experiences, combined with the observations, from the beginning of fieldwork have made it possible to identify students as passive, coadjuvant interlocutors who "collapse" into services to be protagonists of care, ending up as captured professionals involved in care and reproductions of the axis instrumental-trimmed-corporate-centered.

> *[...]The child was in decubitus ... ventral is? Upwards ventral right?*(Nurse 1).

> *[...]because in the case it is a postoperative ICU, right? So when the child comes from surgery we cannot handle, change the decubitus or position!* (Nurse 3).

The training institutions have perpetuated the use of essentially conservative models, centered on apparatus and organ systems and highly specialized technologies. It occurs that the training cannot take as reference only an efficient search for evidence in the diagnosis, treatment, prognosis, etiology and prophylaxis of diseases and injuries [17, 18], since we deal with singular subjects and not with pathologies. Thus, the negative reflection of training in health work in general, as shown in the following reports, is shown in the programmed procedures and not in the real needs of the people, resulting in impoverishment of the caregiver dimension.

> *[...]I put in DLD due primarily to atelectasis, because it has to be side-to-side and also by performing plication and withdrawal of the thoracic drain today [...]* (Physiotherapist 1).

> *[...]We strictly obey the change of position every three hours, when the child can, right? be positioned, handled, right?* (Nurse 2).

The organization of health work was intensely affected by the constant technological advances and by the increasing specialization, fact that is proven in the hospital scope. The institutionalization of health practices, the loss of control over the means of work and the massive incorporation of cutting - edge technologies in the work environment contributed to the impoverishment of the intersubjective aspects of the professionals - users relationship[19].

Thus, a diversified, specialized and fragmented set of caregivers' acts in practice, in its biologicist dimension, guided by pathology persists. In this context, it should be noted that the practice of health care should be shaped taking into account respect for human nature and not only based on techniques or procedures structured in the provision of assistance purely as described in the

interviews below.

> *Postural care course? No, actually this is not even part of my medical training.* (Doctor 1).

> *[...]so the last one I attended, as it was a big child, it does not need much ... so, an artifact to help in positioning ... and, at most, covers, right??* (Nurse 1).

It is considered, in the hospital practice, the inclination of the subjects to reiterate the social practices of their historical time, and the alienation of the agent in the sense of positioning itself before the situations. All share the common value attributed to the hegemonic clinical model, leaving behind the knowledge and actions coming from different fields, such as educational, preventive, psychosocial, and communicational, that appear as peripheral to nuclear work -individual medical care [20, 21].

The hospital can be seen as a functional system, but it is also bureaucracy, order, place of reproduction and hierarchy. In this environment of urgency and immediacy, the complex web of acts, procedures, flows, routines, knowledge, in a process of complementation and dispute, generates overload and weakens the production of care [22]. This narrative highlights the more technical work culture, the tendency towards the fragmentation of practices, giving greater or lesser completeness to the attention produced, showing the need to review postures.

> *When entering the pediatric environment, in the morning, I visualize the hospital dynamics. Several professionals already positioned at the edge of the beds ... all committed and focused on their tasks: baths, dressings, exams, aspirations, evaluations ... tic, tac, tic, tac ... time does not seem to stop ..., therefore, the difficulty of being able to leave the child in a comfortable and quiet position. You cannot position the child. This is the daily routine of the child's ICU".* (Field diary – third day in April).

> *[...]now there is a child, more serious children than usually we only put the head, turns just a little the head to the side, does not touch the body.* (Nursing technician 1).

Immobility is a frequent problem in patients admitted to childhood postoperative units and may contribute to generalized functional impairment. Regarding this issue, it can be noted, in the scenario observed, that several factors may contribute to the establishment of this condition, among them, the time of stay in mechanical restraint and the high levels of sedation. Thus, it is opportune to rethink the production of health care in the hospital, caring about patient safety.

> *[...]We use a roll made of cloth, also to immobilize the child a little in the*

bed, so she does not keep moving [...] (Nurse 3).

DLE (child) is inert in bed, after all, is always sedated. Nursing arrives to fulfill its protocol and quickly signals to a physiotherapist that the child needs care. "Só mais uma vez? ... Amanhã, talvez!" ... Hospital physiotherapy is seen as an integral part of the treatment of patients in ICU, however, due to the severity of the condition of the babies, it becomes a rapid care, mainly understood as simple withdrawal of secretions. It is difficult for a physiotherapist to perform respiratory and motor physiotherapy for total functional recovery. The time of care is not relevant given the children's prolonged sedation time. (Field diary – eight day in April).

The patient, being restrained, especially the child, loses his freedom of movement and, thus, deals with many feelings, among them inferiority, fear of not being able to protect himself and also the humiliation of being exposed to the handling of a stranger; therefore, the health professional must always consider the patient's restraint as part of his work process and evaluate that its application is of the utmost importance so that care does not simply become routine[23].

The post-operative team enters the unit bringing another post-surgical baby. The multiprofessional team is ready and everyone is positioned to welcome him. The static baby, in DD, sedated, is quickly immobilized / contained in the bed, through the use of artifacts that facilitate containment. Nobody questions this initiative. Yes, it is observed the daily practice of the sector. (Field diary– fifth day in April).

The therapeutic positioning is related to the dermatological prevention of the areas of pressure and ischemia, the improvement of the oxygenation, besides promoting the generalized functional facilitation [24]. The change in decubitus itself consists of the ability to change, maintain or sustain certain body positions in the bedridden patient, especially at times interspersed [25]. It is important to note the difference between the two.

The constant practice of alterations in the positioning is essentially relevant in immobilized patients, hospitalized, in intensive care units, however, in front of the material collected, it is possible to perceive that health professionals perform the change of decubitus in their work routine, but do not perform the so-called therapeutic positioning, portraying, above all, the automation of hospital care.

[...]because if she stays like this ... in a position too long, right? surely it will create ulcers, then changing the decubitus you avoid, right ?, and a lot !, and still think the child is more comfortable. (Nursing technician 2).

> *I believe it exists, because you change position ... you have to, how is it ?, position it all, raise it a little, right? While only positioning alone, just going, like, raise a limb a little, will not be total, positioning would be total, than change of decubitus.* (Nursing technician 1).

The posture assumed by the body exerts a direct influence on the health of the worker. During the working day, it is fundamental, according to the peculiar characteristics of each function, that the workers perform their tasks with a correct posture, with the objective of not compromising the physical integrity and the health. The physical and emotional exhaustion, often caused by the factors that involve the individual's postural problems in the work environment, decreases the worker's income, which can range from stress, migraine, low back pain, hyperkinesis and tendinitis, to chronic diseases, such as : scoliosis and herniated disc.

Inadequate postures assumed in the performance of a given activity may cause a greater wear on functional body functioning [26]. The systematic observations, recorded in the field diary, show that the work overload, in the hospital setting, reverberates in the positional relation of the child in the bed.

> *DD (Health professional) arrives at work early in the day. DV (child) is in bed and begins to shake. The professional's posture reflects that something is not right. Anteriorisation of shoulders, reactions of pain, distraction, eyes of hangover. The journey begins ... and it becomes visible the postural maladjustment in the imminence of compensating the rigid and contracted muscular structures. It is not easy to deal with ... the child remains hours in the same position.* (Field diary– third day in April).

It is therefore extremely important to point out the need for reflection on care in the technology perspective, provoking the rethinking of the inherent capacity of the human being to seek innovations capable of transforming their daily life, estimating to open new horizons and new perspectives for the improvement the quality of work / care and life of caregivers and those cared for, in the dimension of living work in health [27].

"Oh, turn me here ... move me here": Other ways of being a health professional

In the field of health, in general, one only thinks that one acts when one is attending somebody. It is as if one thinks exclusively in the care in situations of the individual watch, according to patho-physiological patterns[28]. In the field observation, the difficulty of explaining and recognizing all the other educational acts, promoters, questioners, investigators and producers of other orders that are demanded by the diverse situations brought to the world of doing in health.

> *After a few shifts of unsystematic observation, I enter the unit again in*

> *the morning and, as usual, introduce myself to the on-call staff as a resident health professional. I explain that I am conducting a course completion survey and that I would need the support of everyone to start collecting data. Therefore, the posture of the physiotherapist, with the arrival of the resident, expresses the possibility of assistance work, when referring to the collection of data, as double-handed.* (Field diary – 6th Day in April).

Being a health professional requires scientific and technological knowledge, but also a humanistic and social knowledge related to the care process. The diploma in any area of health is not enough to guarantee the necessary qualification, since knowledge and information are constantly changing and require updating by the professional [29]. Thus, it should be noted that training institutions must provide adequate means to train professionals to face the new realities of care.

> *I work here from 12 to 14 years ... course, course I did not do, but I have read enough about the positioning of any patient in the bed, but the specific course no.* (Physiotherapist 1).

> *I have been working here for 28 years ... I have worked in both adult and children's ICUs, course specifically about postural care, I did not do.* (Physiotherapist 2).

> *I have been working here for 17 years ... I did not do it, I already saw it as a topic of some course, but about positioning, not with this theme..* (Nurse 2).

Hospitalization involves a deep adaptation of the child to the various changes that occur in his daily life, requiring caregivers to turn to the senses, values and meanings of their practice and to whom they are directed. This initiative involves the search for humanization, quality and safety of the patient and it is in this context that the hospital begins to be demystified within health care, in the perspective of "know-how", with the production of restorative care alternatives, enabling a resurgence of knowing how to be" [30].

> *[...]There are a lot of people who work harder for money, like everyone else knows, right? But there are people who are pure love! Sometimes I spend three days away from home, working ... do you have a son? I have! I have 8 here, 10 there ... okay! Yeah, they're my ICU babies!*(Nurse technician1).

> *I left her in DLE ... we use a cushion here on the shoulder, right? And the little roll, more for her not to come down, put gauze near her mouth, because sometimes the tube, it causes the child to leave a secretion, not to go down to the neck we put, put on a flannel that we have here as it were a*

> *sheet for babies, to cover her, her arm to the foot, but we're looking for, I always try to leave her chest so we can watch.* (Nursing technician 2).

> *I could not speak, my back ached, my head hurt because of that position I had and I intubated ... I could not speak, I was very swollen, I could not open my eyes ... I wanted to tell people ... "oh, turn me here, move me here"[...]* (Nurse 2 – Experience when hospitalized).

The ICU child is subject to greater loss of muscle mass, which predisposes to generalized weakness, contributing to worsening of the clinical picture. Thus, adequate bed positioning, described as an integrative therapy and complementary to other treatments, may signal a unique opportunity for sensory-motor stimulation as a means of preventing complications secondary to hospitalization, above all, meaning a different beginning of life for the Child, as mentioned in the interviews that follow [31].

> *[...]A child that she is not ... is made change of decubitus or positioning, she will acquire other problems outside of what she is already there, the reason she is already there, she can create a scar and this escara is ... Come to get an infection through it. If this change is not made it may happen ... it is important, yes, too much.!* (Nursing technician1).

> *[...]I believe that a good posture, a good positioning of it in the bed is fundamental in every way, for breathing, to avoid aspiration, care with decubitus ulcers, even careful with the accesses, and for you to examine, for you to medicate .. I think the correct way of positioning is fundamental.!* (Doctor 2).

> *Positioning a patient in an ICU is everything, it should be seen as a very important thing, a very important aspect! ... aiming at the comfort of the child and especially avoiding vicious positions.* (Phisiotherapist2).

In Brazil, in recent years, many strategies have been developed to improve child health, so that the Ministry of Health has reinforced actions that promote multidisciplinary professional training at all levels of care, always prioritizing the humanization of care[32].

The Multiprofessional Health Residency program is a strategic training modality for workers, considering their potential to transform hegemonic practices in health services. This training provides for the effective insertion in daily life of the professional exercise in the health of the different professional categories involved, together with the constitution of spaces of discussions about the work developed[33].

The training of professionals in the perspective of health education, integrating teaching and

work as a strategic action for health sector reform, is of paramount importance for patient safety. In this context, "whoever forms, forms and reforms while forming and who is formed forms and forms when formed" [34]. It was noticed that immersion of the resident professional, already egressed from the line of care in particular, reverberated in the daily routine of the team, by reminiscing and reliving moments of potentializing care practices with the "small" patients in the scenario studied.

> *Resident professional enters the line of care in the evening period. The body of the professionals seems to emit signs of mistrust and strangeness. His presence seems to attract attention. Wide-eyed, "egg-stomped" ears, tuberculous ears, attached antennas are just a few of the expressions visualized. The resident presents himself, contextualizes his presence, focusing on his participation and experience in the sector. It highlights significant acquired learning and the desire for continuity of attention. It is observed production of senses in the scenario, such as cautious procedures, voice pondering, stimulus in risk prevention.* (field diary – 4th Day in April).

The integration between technology and humanization can ensure focus on the patient and their needs within hospital care [35]. At this juncture, it is estimated the reorganization of the work process from the concepts of expanded clinical and democratic management, giving hospital attention based on the production of health care [36].

It is known that it is fundamentally important for the health professional to incorporate the learning and the improvement of the interpersonal aspects in the daily life of their practices, thus, the lived experiences reveal that the insertion of the resident professional the health team, in the teaching hospitals, The deconstruction and reconstruction of the assistance model, at the singular subjective interface, through a meaningful collective learning, making the humanization of assistance resurfaced in the studied context.

> *[...]Because I think it's the best position for her, because she's uncomfortable, and when she gets prone she greatly improves saturation, heart rate and even she gets calmer. [...] some rolls, we make some rolls, it's like a uterus, right? To keep her well wrapped so she does not look like this ... loose, because they're little babies, right? And they usually keep moving [...]* (Nurse 2).

> *[...]Positioning you will leave her both in the most comfortable and most effective way for her treatment, open via air, leave her well positioned, without posture, that kind of thing [...]* (Doctor 1).

> *[...]she had been extubated the same day, it was dangerous to go to CPAP, so we left in this posture to facilitate this breathing [...]* (Nurse 1).

At the same time, the coexistence of multiple categories that perform their own therapeutic acts in a team should imply the intersection between the disciplines of knowledge. Interdisciplinarity does not necessarily disassemble vigilance in health care itself, but rather it reconfigures itself as a new form of training that provides different positions to look at, proposing a recognition of fissures as a possibility of creation, trying to bring to light the significance of the experience the other in the relationship with you and with the [37].

> *[...]And I usually leave it in the same position that it was, because of the multidisciplinary team ... the nursing, in the ICU that I work here, has this task of them to change of decubitus, so I try to leave in the same way that I found, that the child needs, there is a previous vicious position before surgery, has some blockage, something.* (Phisiotherapist 1).

Thus, a privileged space of interdisciplinary practices allows, ideally, a differentiated training of workers for the SUS, by adding humanistic aspects to the formation strictly technicist. Humanization aims to incorporate the art of care, based on the subjective dimension of the process, into a technological world, facilitating the joint construction of new access practices, integral care and longitudinality of care, consolidating another professional way of being, as well as a new health care[38].

FINAL CONSIDERATIONS

The development of the technology used by health professionals in services to assist in the maintenance of life is a reality that both charms and scares. The humanization of care has become a challenge, as technology is increasingly being overcome and, often, there is the involvement of the professional with the machines, which facilitates the forgetfulness that is taking care of people.

Mechanical restraint is widely used to ensure success in performing therapeutic procedures. It may represent a public health problem because its indiscriminate use in the hospital environment sometimes results in causing physical or emotional damage to the child involved, as well as their respective family.

The scientific evidence indicates that this issue is not discussed in hospital and academic institutions because it is not a priority among professionals, on the grounds that any procedure they may undertake, including mechanical containment, aims to improve the condition of the patient.

Although the different therapeutic positions found in the literature are extremely beneficial and indicated for hospitalized patients, especially in pediatric intensive care units, experience shows that, in practice, there is still conflicting data about its concept, as well as fragility in its concrete and correct operation.

Therapeutic positioning depends on the involvement of the multiprofessional team, family

members and / or caregivers, and, whenever possible, the patient himself. It is important to schedule theoretical and practical training and periodic retraining involving all staff and persons responsible for patient care.

It seems that postural care, in order to be considered adequate, requires not only its technical management, but also a sensitivity on the part of the professional who is competent to deal with the patient. It is believed that it would be important for professionals to allow themselves this intervention: to prepare and comfort, so this fact must be experienced and constructed, and depends on the singular maturation.

It remains only to emphasize the importance, for health professionals, of being open and sensitive to the signs of patients, in the production of live work in the act, reforming the way of working in health care.

It is then necessary to carry out a serious constructive critical reflection about the actions and interactions in the context of the health services on what, how and when to speak; what, how and when to look; how to position oneself and touch, an act that transcends the mere manipulation of the other. In this context, it is crucial to seek to understand closely the message, verbalized or not, that the other tries to convey, so that one can attend to their needs as a person, not just as a patient.

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Article submitted on 01/30/2017

Article approved on 03/10/2017

Article posted to the system on 06/22/2017