Humanization of obstetric nursing during the COVID-19 pandemic in a reference hospital

Humanização da enfermagem obstétrica durante a pandemia de COVID-19 em um hospital de referência

Humanización de la enfermería obstétrica durante la pandemia de COVID-19 en un hospital de referencia

RESUMO

Objetivo: Relatar aspectos da assistência e humanização da enfermagem obstétrica durante a pandemia de coronavírus em diversos setores de um hospital materno-infantil de referência. Métodos: Relato de experiência realizado em uma maternidade no período de maio a julho de 2020 a partir da coleta de dados utilizando a técnica da observação participante com transcrição de notas em diário de campo. Para a análise, realizou-se a modalidade de conteúdo. Resultados: Observaram-se modificações positivas e negativas na rotina de atendimento do enfermeiro obstetra com relação a humanização, levando-se em consideração os princípios da Política Nacional de Humanização. Desta forma, os quesitos mais prejudicados foram: ambiência e acolhimento. Conclusão: Os enfermeiros não estavam treinados, tampouco preparados para receber alta demanda de pacientes em uma pandemia, por isso também houve uma necessidade de adaptação física e mental. Entretanto, algumas adequações possíveis foram realizadas pautadas nos princípios da humanização.

DESCRITORES: Humanização da Assistência; Enfermagem Obstétrica; Unidade Hospitalar de Ginecologia e Obstetrícia; Pandemias; Infecções por Coronavírus.

ABSTRACT

Objective: Report aspects of the assistance and humanization of obstetric nursing during the coronavirus pandemic in various sectors of a reference maternal and child hospital. Methods: Experience report performed in a maternity hospital from May to July 2020 based on data collection using the technique of participant observation with transcription of notes in a field diary. For the analysis, the content modality was used. Results: Positive and negative changes were observed in the obstetric nurse's care routine in relation to humanization, taking into account the principles of the National Humanization Policy. Thus, the most affected items were: ambience and reception. Final considerations: Nurses were not trained, nor prepared to receive high demand from patients in a pandemic, so there was also a need for physical and mental adaptation. However, some possible adjustments were made based on the principles of humanization.

DESCRIPTORS: Humanization of Assistance; Obstetric Nursing; Obstetrics and Gynecology Department, Hospital; Pandemics; Coronavirus Infections.

RESUMEN

Objetivo: Informar aspectos de la asistencia y humanización de la enfermería obstétrica durante la pandemia del coronavirus en diversos sectores de un hospital materno infantil de referencia. Métodos: Informe de experiencia realizado en una maternidad de mayo a julio de 2020 a partir de la recolección de datos mediante la técnica de observación participante con transcripción de notas en diario de campo. Para el análisis se realizó la modalidad de contenido. Resultados: Se observaron cambios positivos y negativos en la rutina de atención de la enfermera obstétrica en relación a la humanización, teniendo en cuenta los principios de la Política Nacional de Humanización. Así, los ítems más afectados fueron: ambiente y recepción. Consideraciones finales: Las enfermeras no estaban capacitadas, ni preparadas para recibir una alta demanda de pacientes en una pandemia, por lo que también había necesidad de adaptación física y mental. Sin embargo, se hicieron algunos ajustes posibles basados en los principios de humanización.

DESCRIPTORES: Humanización de la Atención; Enfermería Obstétrica; Servicio de Ginecología y Obstetricia en Hospital; Pandemias; Infecciones por Coronavirus.

RECEBIDO EM: 01/02/22 **APROVADO EM:** 28/03/22

Thais Cristina Flexa Souza
Professor, Nurse, Master in Nursing from the Federal University of Pará
ORCID: 0000-0002-7296-0380

Antonio Jorge Silva Correa Júnior
Professor, Nurse, Master in Nursing from the Federal University of Pará
ORCID: 0000-0003-1665-1521

Dirce Nascimento Pinheiro
Professor, Nurse, PhD in Tropical Diseases at the Federal University of Pará
ORCID: 0000-0002-4232-9272

Mary Elizabeth de Santana
Professor, Nurse, Doctor in Nursing at the University of São Paulo at Ribeirão Preto College of Nursing
ORCID: 0000-0002-3629-8932

INTRODUCTION

Humanized care for the parturient is the result of the relationship between health professionals and pregnant women and stems from the understanding of the phenomenon experienced by the other, as labor and delivery are remarkable, refers to care organized and provided to all women in a way that maintains their dignity, privacy and confidentiality, ensure physical integrity and appropriate treatment, and allow a decision to be made, informed and receive ongoing support during labor and delivery. [1]

With a view to the benefits of humanization, the National Humanization Policy (PNH) HumanizaSUS was created in 2003. The central objectives of the PNH refer to quality and dignity in health care. In this retrospect, in 2000 the Prenatal and Birth Humanization Program (PHPN - Programa de Humanização do Pré-Natal e Nascimento) was created, which defined improvements in obstetric care, with guaranteed access, coverage and quality of prenatal care. In addition, it reinforced the need to establish links between prenatal care and childbirth, changes in the structure of hospitals and in the training of professionals 1 and with the aim of consolidating PHPN, Rede Cegonha was created in 2011. [2]

Subsequently, on December 12, 2019, a cluster of pneumonia cases caused by a coronavirus was announced in Wuhan, China. Initially named as 2019 Novel Coronavirus (2019-nCoV). A pandemic of acute respiratory tract infection quickly set in, with the World Health Organization (WHO) naming the disease as Covid-19, and the new Coronavirus (severe acute respiratory syndrome coronavirus 2–Sars-CoV-2). It is transmitted by droplets, secretions and direct contact, showing signs and symptoms of fever, malaise and dry cough, leading to severe pneumonia and even death. [3]

Specifically, the obstetric nurse needs to maintain closer contact with the pregnant woman due to antenatal care, assistance in labor, neonatal and postpartum care.

In view of the experienced scenario in which nurses are one of the professionals most susceptible to infection because they are on the front line of care, the ways in which the effectiveness of humanized care is being fulfilled are considered. Specifically, the obstetric nurse needs to maintain closer contact with the pregnant woman due to antenatal care, assistance in labor, neonatal and postpartum care. [4] Thus, the objective was to report aspects of the assistance and humanization of obstetric nursing during the coronavirus pandemic in various sectors of a reference maternal-infant hospital.

METHOD

Descriptive experience report type research based on a qualitative approach focusing on the HumanizaSUS framework, whose setting was the Santa Casa de Misericórdia do Pará. The sectors described were: Obstetric Triage, Prepartum, Delivery, Postpartum, in addition to three obstetric/puerperal pathology wards.

Data collection and structuring took place simultaneously from May to July 2020, based on participant observation during the assistance, using the technique of participant observation with transcription of notes in a field diary as an instrument for data collection. Field notes alluding to the assistance of three obstetric nurses per shift, in each chosen scenario, were included, excluding notes and descriptions that touched on nursing care and humanization, such as those that perhaps dealt with other professional categories. The observation period was three months, four times a week with an average stay of twelve hours each time (morning and afternoon). The six assumptions of HumanizaSUS used as a theoretical framework were observed and detailed in sections in the diary, including the day and time of the recorded facts, namely: Reception; Management; Ambience; Expanded and shared clinic; Employee appreciation; and the defense of users' rights. [5]

An exhaustive reading of the records was carried out by the research team and the subsequent typing into Microsoft Word files to then carry out the content analysis in a matrix file resulting from the union of all individual notes, being modality, the thematic analysis in three stages: pre-analysis, material exploration and treatment. 6 Resolution No. 510/2016 on research ethics followed, with approval by the ethics committee of the larger project with CAAE number 29652420200000018 to which this report is linked.

RESULTS

During the COVID-19 pandemic, Fundação Santa Casa de Misericórdia do Pará was the largest public institution for the care of pregnant/puerperal women in the State of Pará, according to the State Department of Public Health (SESPA - Secretaria de Estado de Saúde Pública).

Obstetric screening for asymptomatic respiratory patients

Although with the division between screening for non-COVID patients and another exclusively for patients with suspected/ confirmation of COVID-19 the fear of the disease by the multiprofessional team was still present because some patients did not report their true symptoms, this attitude resulted in great work stress, harming the reception and ambience of these women. There was a fear of contamination on the part of health professionals who avoided maintaining closer contact, for example, handshakes.

In addition, during the consultations, the requirement for agility and efficiency of the obstetrician nurse in the service, even with the excess of patients in the service, was a constant, therefore, empathic attitudes were sometimes relegated due to work overload, such as: asking how the woman is tolerating the pain and her individual expectations regarding the birth of the baby.

The behavior of pregnant women changed, as stress and insecurity due to the possibility of absence of companions in the screening was another intricate factor. They stay in front of the hospital waiting for them until the end of the service. If the patient is hospitalized, the companion is verbally informed by the concierge to accompany her during the procedure. However, this whole process was stressful for both, increasing dissatisfaction with the service and causing complaints to fall on the professionals present at the screening. In this regard, some users use their rights and go to the hospital ombudsman to present their statements about care, often praising and valuing the worker.

Prepartum, delivery, postpartum (PDP)

Some pregnant women are hospitalized before the right time because they are not in active labor, increasing their length of stay in the hospital to an average of around three to four days. This impairs the ambience, expanded and shared clinic and reception, as cesarean sections are performed without indication for such.

After undergoing obstetric screening, non-suspected COVID-19 patients are referred to the PDP. When these women were admitted, most of them already wore a cloth mask brought from their homes, as well as their companions. The surgical mask was only offered to the woman and/or companion in the absence of cloth masks, due to the containment of hospital material for professional use. It should be noted that all pregnant women and companions were guided by the nurse regarding the use of the mask during pre-delivery and delivery.

It was noticed in the women the difficulty of oxygenation, especially during the expulsive period of labor and in many visits the pulse oximetry was not performed. Likewise, service was hampered in this scenario in terms of ambience, as overcrowding in delivery rooms, often due to high demand, meant that up to two women were served in a single room. As positive points in this scenario, there was a higher frequency of Personal Protective Equipment (PPE) during labor and a higher frequency of hand washing. These positive points resulted from permanent education, prioritizing the health of women and workers.

An element about humanization in obstetrics and the right of pregnant women is the companion at the time of delivery and birth, but due to COVID-19, if the companion of her choice had respiratory symptoms, he/she could not enter the hospital environment and the pregnant woman would have to choose another person for the moment, emphasizing the principles of participatory management and co-management and defense of users' rights. Empirically, there was no difference in time regarding umbilical clamping and skin-to-skin contact.

During the research period, the transport of newborns in closed cribs to the wards was not carried out, because due to not having enough cribs available

for such transport, this type of modality was prioritized in cases of premature newborns. Usually after two hours of postpartum, the mothers are transported by the stretcher-bearer and the babies are delivered to the nursing technician, and the binomial is destined for rooming-in.

The wards

There was a ban on visits for puerperal women and newborns and only the exchange of companions at a certain time stipulated by the institution in agreement with the nurses of the rooming-in, highlighting the participatory management and co-management and the defense of the puerperal woman's right to always keep a companion in the postpartum health service. Upon arrival at the PDP, the guidelines for safe breastfeeding, hand washing and mask use are sometimes under-emphasized due to work overload.

During the admission and visits of the nurse, fear was perceived to approach the puerperal woman/companion and newborn due to the pandemic, in addition to a decrease in listening support and negligence of the physical examination, falling into the failure of the principle of reception and ambience. However, both the puerperal woman and the companion understand the need for the nurse to leave due to the world scenario, some even asked the professional to keep distance to avoid possible contagion.

However, before hospital discharge, the guidelines on general care in the puerperium and with the newborn are given by the nurse and were added to these, the guidelines regarding the prevention of transmission of COVID-19 such as: use of alcohol gel to handle the breast during breastfeeding, use of a mask during breastfeeding and reduction of visits in the puerperal period, reinforcing the unique care recommended by the expanded and shared clinic.

DISCUSSION

The behavior of pregnant women changed, as stress and insecurity due to the possibility of absence of companions in the screening was another intricate factor.

First, the organization of care flows in the pandemic included the adoption of an ideal flow for specific care for suspected/confirmed pregnant women. [7-8] Some measures are mentioned, such as: the specific place of care for pregnant women with suspected/confirmed COVID-19 must be identified and independent of routine care with separate entrances, use of signs with guidance on symptoms of infection and respiratory etiquette and use of surgical masks by symptomatic patients. The differentiated flow is monitored in all facilities, including diagnostic support, and exclusive teams are adopted during the pandemic, providing the necessary PPE for protection, with a marked area for professional attire and undressing. [7]

It is imperative to perform diagnostic tests on symptomatic employees quickly.4 The importance of valuing the worker is reinforced here, a fundamental guideline of the National Humanization Policy. The ambience favors humanized health actions, improving the practice with the parturient and the family, the implementation of which gives centrality to the person and integrality. 9 In the scenario, the companion was recognized by the same as a facilitator of the labor and birth process, thus reducing tensions 10 at the institution, the companion was essential to maintain the emotional health of pregnant women, helping with non-pharmacological methods for pain relief.

Regarding the situation of women in the face of the pandemic, most are afraid of becoming infected and later being unable to choose the type of delivery. It is pointed out that pregnant women with SARS-Cov-2 infection who progress to a severe condition associated with a comorbidity are more likely to undergo an emergency cesarean delivery or premature delivery, increasing the risk of maternal and neonatal death. 11 During the observations, most of the women were taken to normal delivery, by the professionals who believed it was the

most clinically recommended.

It is known, however, that the prolonged hospitalization time of cesarean sections is one of the factors that contributes to the higher hospital costs. [12] However, even in the face of an adverse situation, rights must be respected, such as the right of the companion in the prepartum and postpartum period, but some maternities and hospitals as a form of prevention have adopted isolation at the time of delivery and this measure violates the Companion Law. [13]

Regarding access to PPE for health professionals, as for surgical masks, these should be reserved exclusively for health professionals. This is explained by the fact that the use of surgical masks in the community creates a false sense of security and neglects other protective measures, in addition to resulting in unnecessary costs. [14] For this reason, during labor and delivery, the COVID-19 asymptomatic woman and her companion used a fabric mask and health professionals must be wearing a surgical mask/N95, disposable coat, glasses, beanie and face shield, if any, as anyone in times of a pandemic can be a transmitting agent.

The maintenance of PPE must be a State policy and hands must be washed between visits to different patients, after the completion of each visit and before removing N95 masks and glasses. Faced with the impossibility of washing them, 70% alcoholic preparations can be used with the same movements, as it is friction that guarantees cleaning, but applying a large amount of the product without friction does not produce the expected effect. [15] It is noteworthy that the prevention and control of COVID-19 includes goggles or face shield, surgical mask, apron, procedure gloves and cap. [16] In the scenarios, continuing education actions contributed to a greater frequency of PPE use, as similar experiences in field hospitals during the pandemic clarifying theoretical and practical issues such as surface and hand hygiene. [17]

In addition to the quality of care for women, another point was the satisfaction of users, as recommended by the environment and the relationship with health professionals, listening and welcoming influence these perceptions. [12] However, a high degree of dissatisfaction with the waiting time was also experienced.

With regard to childbirth practices, it is recommended for asymptomatic parturients who do not have home contact with a person with a flu-like syndrome or proven respiratory infection, timely clamping. The newborn is dried with the cord intact, and bathing is not necessary immediately after birth. For the prevention of contamination, skin-to-skin contact and breastfeeding took place after the parturient's hygiene care, including bed bath, change of mask, cap, nightgown and sheets. [18] It was observed that timely clamping was performed, but skin-to-skin contact was not provided because they believed that it increased the risk of probable contamination.

On the other hand, in cases of suspected or confirmed mothers, private accommodation with the newborn with a minimum distance of 1 meter and preferably 2 meters between the mother's bed and the newborn's crib is suggested. Some alternative methods for newborn protection use incubators instead of cribs. [16-18] It was observed in the rooming-in that the crib was kept 1 meter away, but incubators were not used for transport and masks were not used in newborns.

During the pandemic, it was established that companions cannot be from a risk group, be between 18 and 59 years old, cannot have flu symptoms and must undergo clinical screening. For asymptomatic pregnant and postpartum women who did not test positive, the presence of a companion should be accepted without restrictions, avoiding transiting in other areas of the hospital. For the safety of the newborn, the puerperal woman and her companion were wearing a mask in the rooming-in and constantly sanitizing their hands. Visits were suspended regardless of confirmation and in case of positivity, contacting family members [7], for the clinically stable mother and asymptomatic newborn, the housing regimen was maintained. [16]

The use of a mask covering the nose and mouth was advised during breastfeeding, the mask should be changed in case of sneezing or coughing or with each new feeding, hand hygiene must be done for at least 20 seconds before handling the newborn or bottles, if milk extraction is used, the equipment must be cleaned with soap and water before and after use. When possible, avoid talking during feedings and not allow the baby to touch the mother's face. [7,19-20]

However, for puerperal women with flu-like symptoms or with household contact with a person with flu-like syndrome or proven respiratory infection (last 10 days), the nurse guides the minimum distance of one meter between the mother's bed and the NB's crib, sanitize hands and breasts, disinfect shared surfaces, maintain private rooming with isolation characteristics. [16]

CONCLUSION

Changes were observed in the obstetric nurse's care routine in relation to humanization according to the principles of the PNH, the most affected items were: ambience and reception. As a limitation of the report, it is suggested that interpretation of the observed facts was required, which may reflect the subjectivity of the researcher. It is noteworthy the observance of the subjective aspects of the professionals involved, the nurses were not trained nor prepared to receive high demand for care and volume of patients in a pandemic, therefore, there was also a need for physical and mental adaptation of these professionals to deal with adverse situations such as pandemics, catastrophes and other unpredictable and stressful events. However, a better flow of care by the obstetrician nurse for pregnant/puerperal women based on the principles of humanization was essential.

REFERENCES

1.Silva LNM, Silveira APKF, Morais FRR. Humanization of labor and birth program: institutional aspects in the quality of assistance. Rev enferm UFPE [Internet]. 2017[cited 2021 Mar 05]; 11(Supl. 8):3290-4. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/download/110195/22086

2.Assis TR, Chagas VO, Goes RM, Schafauser NS, Caitano KG, Marquez RA. Implementação da Rede Cegonha em uma Regional de Saúde do estado de Goiás: o que os indicadores de saúde mostram sobre atenção materno-infantil? Reciis (Online)[Internet]. 2019 [cited 2021 Mar 05]; 13(4):843-53. Avaliable from: https://www.reciis.icict.fiocruz.br/index.php/reciis/article/download/1595/2326

3.Thuler LCS, Melo AC. SARS-CoV-2/COVID-19 in Patients with Cancer.

Rev bras cancerol (Online). 2020; 66(2): e-00970. DOI: 10.32635/2176-9745.RBC.2020v66n2.970.

4.Medeiros EAS. Health professionals fight against COVID-19. Acta paul enferm (Online). 2020; 33:e-EDT20200003. DOI: 10.37689/acta-ape/2020edt0003.

5.Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Política Nacional de Humanização. 1 ed., 2 reimp. Brasília (DF): Ministério da Saúde, 2014.

6.Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2011.

7.Ministério da Saúde (BR). Secretaria de Atenção Primária à Saúde. Departamento de Ações Programáticas e Estratégicas. Manual de Recomendações para a Assistência à Gestante e Puérpera frente à Pandemia de Covid-19. Brasília (DF): Ministério da Saúde, 2020.

8.Mei Y, Luo D, Wei S, Liao X, Pan Y, Yang X et al. Obstetric management of COVID-19 in pregnant women. Microbiol frontal [Internet]. 26 de maio de 2020 [cited 2020 Set 15]; 11:1186. Avaliable from: 10.3389/fmicb.2020.01186.

9.Dias PF, Miranda TPS, Santos RP, Paula EM, Bem MMS, Mendes MA. Concept formation of ambience for labor and normal institutionalized delivery. Rev bras enferm. 2019; 72(Suppl 3):348-359. DOI: 10.1590/0034-7167-2018-0698.

10.Neves L, Gondim AA, Soares SCMR, Coelho DP, Pinheiro JAM. The impact of the hospitalization process on the caregiver of a chronic critical patient hospitalized in a Semi-Intensive Care Unit. Esc Anna Nery Rev enferm. 2018; 22(2): 1-8. DOI: 10.1590/2177-9465-EAN-2017-0304.

11.Li N, Han L, Peng M, Lv Y, Ouyang Y, Liu K et al. Maternal and neonatal outcomes of pregnant women with COVID-19 pneumonia: a case-control study. Clin infect dis. 2020. DOI: 10.1101/2020.03.10.20033605.

12.Silva ALA, Mendes ACG, Miranda GMD, Souza WV. A qualidade do atendimento ao parto na rede pública hospitalar em uma capital brasileira: a satisfação das gestantes. Cad. saúde pública (Online). 2017; 33(12):e00175116. DOI: 10.1590/0102-311x00175116.

13.Brasil. Lei nº 11.108 de 7 de abril de 2005. Altera a Lei nº 8.080 de 19 de setembro de 1990, para garantir as parturientes o direito à presença de acompanhante durante o trabalho de parto, parto e pós-parto imediato, no âmbito do Sistema Único de Saúde - SUS. Diário Oficial da União, 2005; 8 abr.

14.Organização Pan-Americana de Saúde (OPAS). Orientação sobre o uso de máscaras no contexto da COVID-19. 2020. Avaliable from: https://iris.paho.org/bitstream/handle/10665.2/51994/OPASBRACOVID1920041_por.pdf?sequence=1&isAllowed=y

15.Marques LC, Lucca DC, Alves EO, Fernandes GCM, Nascimento KC. COVID-19: nursing care for safety in the mobile pre-hospital service. Texto contexto enferm. 2020; 29: e20200119. DOI: 10.1590/1980-265x-tce-2020-0119.

16.Ministério da Saúde (BR). Secretaria de Atenção Primária à Saúde. Nota Técnica nº 14/2020-COCAM/CGCIVI/DAPES/SAPS/MS. Atenção à Saúde do Recém-nascido no contexto da Infecção pelo novo Coronavírus (SARS-CoV-2).2020. Avaliable from: https://portaldeboaspraticas.iff.fiocruz.br/wp-content/uploads/2020/08/20200805_N_NotaTecnicaCovidCocam14_3588521282864535759.pdf

17.Dzivielevski AMO, Costa ADMB, Paraizo-Horvath CMS, Silva SA, Sanches RS, Resck ZMR. Estruturação de um hospital de campanha na pandemia COVID-19: relato de experiência. Saúde Coletiva (Barueri). 2021;11(COVID):6983-6992. DOI: 10.36489/saudecoletiva.2021v11iCOVIDp6983-6992

18.Sociedade Brasileira de Pediatria (SBP). COVID-19: SBP apresenta recomendações sobre uso de máscaras por crianças e adolescentes. 2020. Avaliable from: https://www.sbp.com.br/imprensa/detalhe/nid/covid-19-sbp-apresenta-recomendacoes-sobre-uso-de-mascaras-por-criancas-e-adolescentes/

19.Sociedade Brasileira de Pediatria (SBP). Recomendações para assistência ao recém-nascido na sala de parto de mãe com Covid -19 suspeita ou confirmada- atualização. Avaliable from: https://www.sbp.com.br/fileadmin/user_upload/22499c-NA-Assist_RN_SalaParto_de_mae_com_COVID-19.pdf

20.Poon LC, Yang H, Dumont S, Lee JCS, Copel JA, Danneels L et al. ISUOG Interim Guidance on coronavirus disease 2019 (COVID-19) during pregnancy and puerperium: information for healthcare professionals - an update. Ultrasound obstet gynecol. 2020;55(6):848-862. DOI: /10.1002/uog.22061.