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HOSPITAL CARE OF WOMEN THAT EXPERIENCED A HIGH RISK PREGNANCY: CONTRIBUTIONS TO NURSING

CUIDADO HOSPITALAR DE MULHERES QUE VIVENCIARAM A GESTAÇÃO DE ALTO RISCO: CONTRIBUIÇÕES PARA A ENFERMAGEM

ATENCIÓN HOSPITALARIA A LAS MUJERES QUE HAN EXPERIMENTADO EL EMBARAZO DE ALTO RIESGO: CONTRIBUCIONES A LA ENFERMERÍA

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ABSTRACT

Objective: to understand the hospital care of women who experienced a high-risk pregnancy. **Method:** descriptive, exploratory study with a qualitative approach, based on the theoretical framework of the Phenomenology. The setting was a hospital in the Mineira Forest Zone. The open interviews with 10 deponents was guided by the research question << How was the hospital care during pregnancy, childbirth and postpartum? >>. **Results:** deponents meant: different understandings about hospital care: the wonderful to the unpleasant; that the hospital care extends to caring for the baby during and after pregnancy. **Conclusion:** it was possible to identify the importance of the nursing care in so far as it provided care, safety and protection, providing assistance to qualifying. **Descriptors:** Pregnancy, High-Risk; Nursing Care; Qualitative Research; Obstetric Nursing. **Descriptors:** Pregnancy, High-Risk; Nursing Care; Qualitative Research; Obstetric Nursing.

RESUMO

Objetivo: compreender o cuidado hospitalar de mulheres que vivenciaram a gestação de alto risco. **Método:** estudo descritivo-exploratório, com abordagem qualitativa, fundamentado no referencial teórico-metodológico da Fenomenologia. O cenário foi uma Instituição Hospitalar da Zona da Mata Mineira. A entrevista aberta, com 10 depoentes, foi norteada pela questão de pesquisa << Como foi o cuidado hospitalar durante a gestação, parto e pós-parto? >>. **Resultados:** as depoentes significaram: As diferentes compreensões acerca do cuidado hospitalar: do maravilhoso ao desagradável; que o cuidado hospitalar se estende ao cuidado com o bebê durante e após a gestação. **Conclusão:** foi possível identificar a importância do cuidado de enfermagem na medida em que este proporcionou acolhimento, segurança e amparo, conferindo à assistência a qualificação. **Descritores:** Gravidez de Alto Risco; Cuidados de Enfermagem; Pesquisa Qualitativa; Enfermagem Obstétrica.

RESUMEN

Objetivo: entender la atención hospitalaria a las mujeres que han experimentado el embarazo de alto riesgo. **Método:** estudio descriptivo exploratorio con un enfoque cualitativo, en base teórico-metodológica de la Fenomenología. El escenario fue un Hospital de la Zona da Mata de Minas Gerais. La entrevista abierta con 10 deponentes fue guiada por la pregunta de investigación << como ha sido la atención hospitalaria a lo largo del embarazo, parto y post parto?>>. **Resultados:** los deponentes significaron: los diferentes entendimientos sobre la atención hospitalaria: del maravilloso hasta el desagradable; el cuidado hospitalario se extiende al cuidado del bebé durante y después del embarazo. **Conclusión:** fue posible identificar la importancia de la atención de enfermería en la medida en que esta ha proporcionado refugio, seguridad y protección, dando el soporte a la calificación. **Descriptor:** Embarazo de Alto Riesgo; Atención de Enfermería; Investigación Cualitativa; Enfermería Obstétrica.

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INTRODUCTION

Improving maternal health is one of the objectives for the development of the millennium proposed in 2000 by the World Health Organization. To this end, in fifteen years it was expected to have a decline by three quarters the maternal mortality ratio (MMR), however, in Brazil despite the policies of government efforts and classes of entities involved with this situation, the projection of MMR between 2008-2015 is 77 deaths per 100,000 live births.¹⁻²

Faced with this panorama, the policies formulated around the attention to high risk pregnancies, childbirth and the postpartum stage, indicates how the health care system must be organized in different levels of care in the face of comprehensive care to women, the baby and their families. With this prerogative, we highlight the Program for Humanization of Prenatal and Childbirth; and the National Comprehensive Health Care Women's Policy, which are committed to the implementation of actions to be effected through a partnership with managers and health professionals.³⁻⁴

With regard to delivery, and especially the delivery arising from a pregnancy classified as high risk, it follows that this must be done in hospitals and maternity wards properly structured in the face of the woman and the baby's needs. It is expected that this area of care, nurses, doctors and other professionals, move around the humanized, safe, dignified and quality obstetric and neonatal care. However, they relate commonly to hospital obstetric practice, the technocratic model, biocentered, medicalization and permeated by the use of multiple interventions, sometimes arbitrary and abusive. In this sense, the pregnant-woman is separated from the role that should belong to him by constitutional law and the proposed active policies.⁵

Postpartum, professional concerns are focused predominantly on clinical aspects of prevention of complications to the detriment of pregnancy risks and guidelines for care of themselves and the child. However, if the physiological nature of actions are essential for the maintenance of life, the subjective aspects should not be less considered, since they influence the well-being and affect the organic homeostasis.⁶

In this perspective, feelings of anxiety, fear, anxiety and uncertainty about the future are often related to women who experience pregnancy-puerperal cycle risk. The emotional dimension can go further, considering that

they permeate guilt, since they assume for themselves the chance of death itself, as well as the concept.⁶⁻⁷ Therefore, attention to the multifaceted dimensions of the patient as well as the solidarity and support to all who surround them meets the ethical, aesthetic, philosophical and humanistic concepts that should guide the formation and practice of midwifery. When you have the specifics of being who takes care through sensitive listening, it becomes possible to enlist more interactive practices that enhance and improve the quality of care in childbirth and the puerperal stage.⁸⁻⁹

In a way that it directs the eye to the knowledge of the subjective realities that constitute the women, the nurse is able to objectively plan the nursing care that they need.¹⁰ From then, they can take care in an ontic-ontological way, in a expanded perspective able to give answers to policies aimed to the women's comprehensive health.⁸

This (re) consideration implies the appreciation of the meanings that the mother-parturient-puerperal gives the experienced care in hospital, residing at this point the uniqueness of this article. By giving voice to patients, guiding questions about how the woman who received this care, meant and still the nursing care for this woman appeared before the health care role in the hospital, they could be answered. Given this, it is presented as the objective: to understand the hospital care of women who experienced a high-risk pregnancy.

METHOD

A descriptive qualitative study, based on the theoretical framework of phenomenology.¹¹ In this particular study, we allowed the meeting to be that poses to the objective reality - the woman who experienced hospital care in pregnancy conditions classified as high risk. Therefore only able to mean it and give it meaning.

The scenario that composed the study consisted of a Hospital Institution located in the Mineira Forest Zone, classified as a philanthropic hospital, reference in the care of high-risk pregnant woman who has an agreement with the National Health System and other private plans in addition to their own agreement also being a professional training institution in the medical and nursing technical level.

Initially, the survey of electronic medical records using the International Classification of Diseases (ICD), in which were covered the main pathologies present in a high-risk pregnancy, was carried out in order to raise

the personal and telephone contacts, and inclusion criteria have over 18 years when the invitation to participate in the research; having the last pregnancy classified as high risk and; has been hospitalized during pregnancy / childbirth / puerperium in the study setting. The exclusion criteria included the woman who had mental disorders.

To support the characterization of the participants, we looked up the records of the medical and nursing anamnesis, capturing the reason for admission, diagnosis, care plans, adopted therapeutics and evolution of women seen in the years 2012 and 2013.

Later, there was telephone contact with potential witnesses by telephone inviting them to participate, 10 women agreed to participate in the study. The statements occurred in the time and place designated by the participants in their homes and workplaces. To ensure anonymity, we used an alpha-numerical code designated by the letter G accompanied the number corresponding to the chronological order of the meetings (G1 to G10).

For Martins and Bicudo, the phenomenon of the intentionality of consciousness, understood as manifested from themselves and by themselves, but should encompass its entirety and essence.¹¹ The open interview mediated by empathy and inter-subjectivity, which began with questions about the characterization of the participants and their previous pregnancy history and finally was guided by the question: How was the hospital care during their pregnancy, childbirth and postpartum? and made it possible for the opening of deponents that signify the phenomenon.

The MP3 recordings were transcribed, as well as records of perceptions of noted researchers in each encounter in the field diary. It was permitted as a criterion of reliability that each deponent heard and confirmed his testimony.

In the analytical moment, we sought to unveil the meanings of descriptions. To this end, it started with prior readings of the transcripts and field diary, which allowed greater familiarity between the said and the unsaid of the deponents and consequent approach to the phenomenon. The ideographic and nomothetic steps followed.

The ideographic analysis made the ideology contained in the naive speech of each witness visible, as well as the capture of Meanings units after repeated and attentive readings the descriptions containing essential structures responsive to the purpose of the study, using thus the phenomenological

reduction. For this we looked to the empathic immersion in the descriptions; in expanding the look on them; suspension assumptions; transposition sentences for meanings.

The nomothetic transposed the individual to the general, making it possible to formulate and describe the general phenomenon in the form of naked categories or propositions of a priori considerations. At this stage, we analyzed the content in general, have been identified and grouped themselves, convergences with the purpose of revealing common phenomenon ideas; description and reflection of contents.¹¹

The field stage covered the months of January and February 2014 and only began after the approval of the Ethics and Research Committee of the Federal University of Juiz de Fora under CAAE No. 23383113.9.0000.5147 and Opinion No 454778, with compliance to ethical principles according to Resolution No. 466 / 2012.¹²

RESULTS AND DISCUSSION

In the characterization of the ten interviewees, we have that the average age was 33 years, three pregnancies, two deliveries and 0.4 abortions. Among the delivery mode of the last pregnancy, balanced the number of vaginal and cesarean deliveries. Regarding the gestational risk classification three women for gestational hypertension, two by prior diabetes, two for pre-eclampsia, one for abortion, one for carrying an intrauterine device and one for Anti-phospholipid antibody Syndrome. The delivery was on average 36 weeks and participants were admitted to the Hospital Institution during the last pregnancy 1.7 times beyond the hospital for delivery.

About hospital care, women who experienced a high-risk pregnancy, meant: Different understandings about hospital care: the wonderful to the unpleasant; The hospital care extends to caring for the baby during and after pregnancy.

◆ Unit of Meaning I: Different understandings about hospital care: wonderful to unpleasant

Women meant the hospital care in previous hospitalizations and during the most recent pregnancy and childbirth. They understood the wonderful when the nursing staff and the medical team treated them well and in a thoughtful way. They stressed the closeness of nursing care from a technical point of view and inter-subjectivity in the measurement of blood pressure, administration of insulin, in the bath, breastfeeding and childbirth:

It was perfect, if not for them I would not have won it, it was great. I was so satisfied, very fast, nursing girls have measured the pressure and have spoken, I have been quickly for them, they were very nice. Wow! In all, including the time of delivery. (G01)

The service was very good, many nurses caring, even when I got to win the super attentive doctor, the nurses helped in the bath, breastfeeding everything right. (G02)

Oh it was great, I got all our hospital support, all the same, support was very good you know? I felt very blessed, the nurses were very good to me too. (G03)

I was treated well, I know the people there, I was already working there. (G04)

Ah, the nurses treated me well. (G05)

My stay was good, so even though it was suddenly, suddenly, I have nothing to complain about. (G06)

Oh I do not have anything to complain, you know?! Both in the first and in the second, I have nothing to complain about, the treatment was good, is no sycophant, at least I know, this problem of having to take insulin every time someone comes and injects you, every time someone sticking your finger, you know, then the nurses were very affectionate, talking to me a lot know? So it was good. (G09)

Oh, it was very well right, well maintained, it was very quiet, medical I went too, they gave me a lot of attention and thank God everything was quiet. (G10)

On the other hand, meant pain, waiting, doubt and worry by understanding carelessness in the hospital for a few members of the multidisciplinary team. They stated that these professionals were impersonal, distant and at times aggressive, which caused grief and annoyances. They also related suffering the experience of a high-risk pregnancy, lack of attention of health professionals to this suffering and the lack of guidance about the pregnancy risk factors. Show passivity against the imposition and power professionals. Understand that health care in this sense, must be rethought:

We get kind of upset, sad, because I was there so I got the doctor, said it is normal delivery, will not have that. Then I waited, they were doing a C-section and left me there waiting. When they arrived the doctor went, I blow her purse that has to be born now, then he broke the bag and the water did not come out. They were forcing delivery when they pulled it, I felt a lot of pain, but even then I did not know what had happened [...]. I think they should have time, pay more attention to those women who are having babies, are suffering a lot, I do not want anybody to go through what I went through, I do not want people to go

through a lot that's going on, so this has to be rethought. (G05)

I was hospitalized with my blood pressure eighteen by twelve, did the delivery with fifteen by eight, did not normalize, but had to do it anyway, that the medical was clear, she told me and the baby were already at risk, then had to do a C-section. (G06)

Then came the dr. bronco, who said that three, if you have two normal deliveries, why not do the third, the lack of liquid did not matter because it took a long time even to come out ... geez! (G07)

Oh, I will not speak very well, they took care of me very badly, I was there, my water broke, the doctor or went, there was almost nothing there, my husband had to complain to the hospital supervisor, had to complain for them to check on me. (G08)

I went through it and it was terrible you know?! Because I had an abortion and to this day I do not know why, so I asked a doctor and she said it could be because of diabetes you know?! And she said so in this case I would have to have taken the exam before but when I got pregnant I went out I was already three months along and my doctor was not bothered to take to know if I had diabetes. (G09)

◆ Unit of Meaning II: hospital care extends to caring for the baby during and after pregnancy.

Women meant that after the baby's birth, the care dispensed to this affects them directly, adding positively or negatively to their understanding of hospital care. Understand how good care during breastfeeding and the beneficial effects of assistance provided to the child's life after being discharged. On the other hand, appears to be affected by complications during childbirth and the child's health condition at birth.

Wow! Everything's good. It was very good, the lady taught me to breastfeed, my baby breastfed from the first minute she came to me. (G01)

On the day she was born, it was quiet, I say it was God Himself, because I did not feel anything, it was wonderful. No problem, she hardly gets sick, she was born great, was born with a lot of weight, was born healthy. (G02)

My little girl was well, she was born with two kilograms and six hundred, went home with two and four hundred and already came with me, went straight to my room. (G04)

Her arm because it broke her collarbone, she was very big at the time of birth. (G05)

I only had a rough time with respect to the admission of my son, you know, he was fifty-nine days old, he had a cold there in

the hospital, he was born with just a kilo, low birth weight, premature. (G06)

Even with diet, six months in he already weighed three kilograms, there the doctor chose to take him out because if not he would have heart trouble, then he chose to take him. I took a white to breastfeed, could not, the milk does not go out, there the girl was there taught me how to take it out, you know? (G09)

Among the objectives of the Program for Humanization of Prenatal and Birth (PHPN), there is the sum of efforts to reduce maternal, perinatal and neonatal morbidity and mortality. To this end, priority of humanization of Obstetric Care and Neonatal childbirth and postpartum period from the perspective of ethics and concern for health professionals who assist pregnant women to receive them and the implementation of health care strategies beneficial in monitoring delivery and birth, to the detriment of interventionist practices commonly used, which generate more risks than benefits.³

It takes into account that the quality and the humanization of this hospital level care are linked to those professionals who have their work process based on the host with active, empathic and prejudice-free listening. Regarding the risk of pregnant women, in addition to the clinical signs and symptoms, they present feelings of vulnerability, since pregnancy is permeated in transformations of social, family organization, self-esteem and identity.¹³

Inherent to this process psychic and emotional changes, results in changes in mood and behavior, fear and distress, which most often are configured as separated feelings of hospital care for fear or lack of staff or lack of preparation for dealing with such feelings. However, the attention given by the professional provides greater bond and security, contributing to the physical and consequently welfare minimizing possible pregnancy risk complications.¹⁴

Evading from the current programs aimed at maternal health and women, are in the hospital professional level with wrong postures that monitor the humanization of care provided to high-risk pregnant women. Thus, the carelessness inhibits the concreteness of comprehensive care with serious damage to the role of women at delivery and the role of health-promoting actions throughout their reproductive lives, at risk due to the pathology base.¹⁴⁻¹⁵

From the 70s, midwifery gained force and expression through ministerial devices, ensuring their exercise. Under the legislation,

the nurses hitched their practices to government intentions at national and international levels. To this end, sought to perform training, events for dissemination of knowledge and specialization courses. It was possible to inaugurate a new era of expression and autonomy of nursing care in obstetrics.¹⁶

In other poles of action, contrary to biomedicalization and childbirth technocracy, obstetric nurses guided nursing care to pregnant/parturient/puerperal women respecting the decision of the woman in the zeal to her body and the partner presence of her desire, by setting humanized practice movements in response to PHPN.⁵

The nursing staff are sensitive listeners and solicitous towards the mother, value in equal proportion the achievement of technical procedures - necessary for the health of mother and baby - and subjectivities that permeate the puerperal pregnancy cycle as a whole.¹⁷ This double valuation gives the aperture for the resulting guidelines woman doubts over the view of the professional about who needs to hear this. This allows the establishment of more human relationships informed by the bond and trust, and reveals nursing as an art of mediated scientific knowledge.¹⁸

In parallel, this way of nursing care meets the woman-mother's expectations with regard to the guidance required to care for the babies, overcoming insecurities arising from ignorance about the baby care and breastfeeding process, especially in gilts. It highlights the concern that the nursing staff should have in relation to different cultures and ways of understanding of postpartum women. The prevalence of the nursing diagnosis of Effective Breastfeeding in a rooming unit confirms the importance of the nursing orientation, similar to the protection, promotion and support of maternal breastfeeding.¹⁸⁻²⁰

In this context of practices, there is the education initiative for the development of maternal identity in primiparous and multiparous situations, before and after birth, with the continuity of care actions to support the mutual process of perception of mothers and their babies in favor of maternal self-confidence.²¹ On the other hand, it is presently configured as factors hindering the exercise of humanization, the lack of structuring the physical environment, the right conditions for the planning and execution of the work process, patient admissions beyond the institutional capacity, the shortage of nurses and other nursing.²² Allied professionals that also date back to lack

of nursing staff knowledge about the prevention of complications related to lactation, the management for the promotion of good catches with higher early as possible to the beginning of breastfeeding. In this sense, the constant updates and training should be part of the institutional program and the nurse's self in search of a better quality care, able to promote overcoming the limitations imposed by everyday care.²³

FINAL CONSIDERATIONS

By understanding the hospital care of women who experienced a high-risk pregnancy, it was possible to identify the importance given to nursing care in so far as it provided care, safety and protection, providing assistance to qualification and humanization that dispenses, and helps to minimize complications of professional inattention.

In the scenario discussed, the approached the interviewees pointed out how nursing care was important in the hospital. This is because the care in question has supplanted a purely objective point of view, to suit the specificities of women and indicating possibilities to meet the challenge of transcending merely medical practices toward comprehensiveness for health policies for women.

In this sense, the construction of professional visibility assumed a multitude of technical-scientific activities allied to the development of interactive skills strengthened in sociopolitical bases.

Despite the limitations of this research, because of the number of single participants and locus, their results suggest meanings and possibilities of reflection about the autonomy of Obstetric Nursing institutions where the delivery is carried out by the medical staff, suggesting the expansion of the phenomenon of vision located from new investigations.

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