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REVISTA DE ENFERMAGEM DA UFSM

ISSN 2179-7692
OPEN ACCESS

Rev. Enferm. UFSM, v.14, e23, p.1-18, 2024 •
Submission: 04/13/2024 • Acceptance: 09/05/2024 • Publication: 09/27/2024

Original Article

Therapeutic itinerary of premature newborns and communication in the Health Care Network*

Itinerário terapêutico do prematuro e a comunicação na Rede de Atenção à Saúde

Itinerario terapéutico de la prematuridad y la comunicación en la Red de Atención a la Salud

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* Extracted from the dissertation "Discharge summary for continuity of care for premature babies in Primary Health Care", Postgraduate Program, Professional Master's Degree in Nursing in Primary Health Care, University of the State of Santa Catarina, 2024.

Abstract

Objective: to describe the therapeutic itinerary of the premature newborn and the communication between professionals in the Health Care Network. **Method:** qualitative research with 11 nurses, recruited by snowball technique. Data collection was carried out through semi-structured face-to-face and virtual interviews in August 2022. Thematic content analysis was conducted. **Results:** two categories stood out: "Therapeutic itinerary of premature newborns and referrals" and "Communication between the services of the Health Care Network in the therapeutic itinerary of premature newborns". **Conclusion:** the therapeutic itinerary of premature newborns is defined from birth, according to health conditions. After discharge from hospital, care is taken by the professionals of Primary Health Care, who will determine referrals to specialized care. Knowing the therapeutic itinerary of premature babies and communication between points of the Health Care Network contributes both to the continuity of care and to the reduction of infant morbidity and mortality.

Descriptors: Nursing; Infant, Premature; Therapeutic Itinerary; Health Services; Health Communication

Resumo

Objetivo: descrever o itinerário terapêutico do recém-nascido prematuro e a comunicação entre os profissionais na Rede de Atenção à Saúde. **Método**: pesquisa qualitativa, com 11 enfermeiras, captadas pela técnica *snowball*. Coleta de dados ocorreu por meio de entrevistas semiestruturadas presenciais e virtuais em agosto de 2022. Realizou-se análise de conteúdo temática. **Resultados**: evidenciaram-se duas categorias: "Itinerário terapêutico do prematuro e encaminhamentos realizados" e "Comunicação entre os serviços da Rede de Atenção à Saúde no itinerário terapêutico do prematuro". **Conclusão**: o itinerário terapêutico do recém-nascido

prematuro é definido a partir do seu nascimento, conforme condições de saúde. Após a alta hospitalar, cuidados são assumidos pelos profissionais da Atenção Primária à Saúde, os quais determinarão encaminhamentos para cuidados especializados. Conhecer o itinerário terapêutico do prematuro e a comunicação entre pontos da Rede de Atenção à Saúde contribui tanto para a continuidade do cuidado quanto para a redução da morbimortalidade infantil.
Descritores: Enfermagem; Recém-Nascido Prematuro; Itinerário Terapêutico; Serviços de Saúde; Comunicação em Saúde

Resumen

Objetivo: describir el itinerario terapéutico del recién nacido prematuro y la comunicación entre los profesionales de la Red de Atención a la Salud. **Método:** investigación cualitativa, con 11 enfermeras, captadas por la técnica snowball. La recogida de datos se realizó mediante entrevistas semiestructuradas presenciales y virtuales en agosto de 2022. Se llevó a cabo análisis de contenido temático. **Resultados:** se evidenciaron dos categorías: "Itinerario terapéutico del prematuro y derivaciones realizadas" y "Comunicación entre los servicios de la Red de Atención a la Salud en el itinerario terapéutico del prematuro". **Conclusión:** el itinerario terapéutico del recién nacido prematuro se define desde su nacimiento, según condiciones de salud. Después del alta hospitalaria, los cuidados son asumidos por los profesionales de la Atención Primaria a la Salud, quienes determinarán derivaciones para cuidados especializados. Conocer el itinerario terapéutico del prematuro y la comunicación entre los puntos de la Red de Atención a la Salud contribuye tanto a la continuidad del cuidado como a la reducción de la morbimortalidad infantil.
Descriptores: Enfermería; Recien Nacido Prematuro; Ruta Terapéutica; Servicios de Salud; Comunicación en Salud

Introduction

Premature birth is the one that occurs before completing 37 weeks of gestation, categorized according to gestational age (GA). The World Health Organization (WHO) classifies these births in three spheres, namely: late premature (between 34 and 36 weeks and 6 days), moderate (between 28 and 33 weeks and 6 days) and extreme (less than 28 weeks of gestation).[1]

Prematurity is characterized as a public health problem, since its etiology is multifactorial and interrelated. A studie[2] presents a theoretical model of the determinants of premature birth through determination hierarchy, distributed in three levels: economic conditions – distal level; psychosocial factors, stress, depression, anxiety, health services utilization and risk behavior – intermediate level; and factors related to mother and fetus - proximal level.

The rates of premature births did not change globally, and between 2010 and 2020, about 152 million premature babies were born. At the national level, from 2011 to 2019, around 3 million premature births were registered, corresponding to a prevalence

of 11%, placing Brazil among the ten countries with the highest occurrence of these births. In 2011, the South region of the country had a prevalence of 9.3% of premature infants; and in 2021, 11.3%.[1,3-4]

There is a growth in premature births throughout Brazil. These high rates generate high costs for the Unified Health System (UHS) and are one of the main causes of infant mortality, that is, that which occurs before 5 years, especially in the neonatal period, up to 28 days of life. Those who survive face health consequences, such as disabilities and developmental delays.[1,3,5]

When born prematurely, the newborn (NB) must quickly adapt to an environment to which he/she is not yet fully prepared to be and inhabit due to his/her organic, physiological and sometimes anatomical immaturity. When this process does not occur effectively, the premature baby needs specialized care, with human and technological support, resulting in a hospitalization resource in the Neonatal Intensive Care Unit (NICU).[6-7]

The neonatal hospitalization has increasingly counted on scientific progress, which allows technological advances, causing changes in the care process to premature babies that presents greater risks of mortality, infections, nutritional problems and delays in development, leading to an increase in the quality of their survival. This process of hospitalization can last for a long period, in order to enable the NB to be adapted and prepared to face the extra-uterine life independently.[6,8]

Therefore, even after discharge from hospital, the premature baby will still face an evident risk of morbimortality, because he/she has health-disease process conditions that are still unpredictable and influenced by socioeconomic and adaptive factors. The involvement of health professionals working in different points of the Health Care Network (HCN) in the extension of the care employed in hospitalization is one of the determining factors for the follow-up of premature babies after hospital discharge to be guaranteed. For this, it is essential to ensure a minimum environment that facilitates life and with conditions worthy of full development, assigning continuity of care.[6,9]

The complexity and plurality of the continuity of care for premature infants and the interface with the National Policy on Comprehensive Child Health Care (NPCCHC) refer to the implementation of communication between the following Thematic

Networks: *Rede Cegonha*, Urgency Care Network, Psychosocial Network, Disability Care Network and Chronic Disease and Conditions Care Network.[10-11]

In this scenario, the path taken from the hospital exit to seek care to maintain the child's health is called therapeutic itinerary. This path is related to the services and care actions accessed, including ease or difficulty of access and agility in referrals, which may interfere with the results achieved. The itinerary taken by premature infants in HCN varies according to their health needs, where continuity of care is directly impacted in this process.[12-13]

In this context, the communication between professionals who work at different points of HCN, traversed by premature babies, in their therapeutic itinerary, is an essential element, because, when analyzing information from previous events lived by them, the professional can perform a clinical analysis and develop an interpretation for planning interventions. Recognizing the need and addressing the gaps in health communication enables the improvement of care delivery, enabling comprehensive care and, consequently, avoiding its fragmentation.[14-16]

Considering the above, it was asked: what is the therapeutic itinerary followed by premature babies after birth in the HCN and how does communication occur between professionals who work at different points of the network?

This study aims to describe the therapeutic itinerary of the premature newborn and communication between professionals in the Health Care Network.

Method

This is a descriptive research with qualitative approach, carried out in the HCN of the Western and Far-Western health regions of the state of Santa Catarina (SC), composed by 57 municipalities, located in the interior of the state, distant approximately 600km from the capital Florianópolis. Data from the last demographic census estimate that these regions have a population of 649,406 thousand inhabitants, assisted by a single hospital of reference for high complexity, located in a strategic city, commercial and industrial pole of the region, with about 250,000 inhabitants, where the hospitalizations of serious and potentially severe NB occur, including premature newborns (PTNB).[17]

The municipalities of the study regions have as a model of Primary Health Care (PHC) the Family Health Strategy (FHS), through which prenatal consultations occur. In

the occurrence of risk or premature labor, there is a referral to the reference municipality for high-risk prenatal care and, if it is the case, premature birth. In 2022, the study regions had 8,484 births, with a prematurity prevalence of 10.08%, similar to data from the southern region of Brazil and the country, which varied around 11% in 2021.[4] The method followed the criteria of the checklist Consolidated Criteria for Reporting Qualitative Research (COREQ).[18]

The participants were nurses working in PHC and hospital units of seven municipalities from the Western and Far-Western health regions of SC. The inclusion criteria were: to be a nurse, to act in the care of premature babies in hospital and in the Basic Health Unit (BHU), in the assistance modality, for at least 6 months. Those who were on leave for any reason or those who were temporarily replacing another professional in that unit were excluded.

The participants were recruited by snowball technique. The first was indicated by convenience by one of the researchers, who, at the end of the interview, indicated another and so on. The initial contact was by messaging application for interview scheduling.[19-20]

The information was collected through semi-structured interviews[21], conducted in the professionals' work environment, virtually by the Microsoft Teams tool, guided by a script created by the researchers. Two scripts were used to guide the collection of information.

The interview with PHC nurses was composed of eight guiding questions, which addressed the dynamics of care from the diagnosis of pregnancy, identification of a possible premature labor, to the return of the preterm baby after the hospital stay. The script for hospital care nurses was composed of seven guiding questions, about the dynamics of the pregnant woman's embracement in premature labor, the process of neonatal hospitalization and referral to the hospital.

The interviews were recorded and transcribed in full for further analysis. The technique of data collection occurred by the flexibility of investigation, allowing questioning, obtaining data in depth, capturing body expression and emphasis on responses, ensuring the understanding of the phenomenon researched from the perspective of the interviewee. To limit the quantification of interviews, theoretical saturation was used, that is, the inclusion of new participants was interrupted when the information obtained became repetitive or redundant.[19-20]

Nurses were chosen for interview because they are reference professionals in the teams in the detention of information and ease of access. They are at the forefront of workflows, defining and/or implementing operational processes, directly influencing the efficiency and quality of services provided to patients. The interviews were conducted during the month of August 2022, with an average duration of 1 hour.

The information was analyzed by the thematic content analysis[22] method, which consists of three essential steps: pre-analysis, material exploration, interpretation and treatment of the results obtained.

In pre-analysis, the interviews were transcribed manually, in full, using the Microsoft Word tool. Then, a brief reading was performed, making possible the pre-analysis and constituting an overview of the therapeutic itinerary of premature infants by HCN. During the exploration of the material, all possible scenarios and aspects involved in the process of therapeutic itinerary and communication between professionals were designated, coding the data and separating them by green (for the scenarios of the itinerary) and orange colors (for the communication aspects). The information was peer-reviewed, with extensive discussion and reflection, giving credibility and confirmability to the data.[23] After interpretation of the data, two categories were established: "Therapeutic itinerary of premature newborns and referrals performed" and "Communication between the services of the Health Care Network in the therapeutic itinerary of premature newborns".

This study was approved by the local Research Ethics Committee under Opinion no 5,047,628. All ethical aspects of research involving human beings, as stated in the resolutions n. 466/2012 and n. 510/2016 of the National Health Council, were respected. The participants were identified with the letter N (nurse), followed by numbers according to the order of participation: N1, N2, N3 [...], N11. By agreeing to participate in the study, they signed the Informed Consent Form and the Consent Form for Photographs, Videos and Recordings.

Results

This research depicts the reality of a hospital service, reference for neonatal hospitalizations and seven municipalities that are part of the Western and Far-Western health regions of the state of SC.

The participants were 11 nurses, all female, three working in hospital institutions and eight in BHU. The professionals have been working for at least 6 months in health services, in FHS teams; and in hospital environment for at least 3 years in the NICU, Clinical Neonatology and Pediatric Hospitalization sectors.

The analysis of the interviews allowed the construction of two categories.

Therapeutic itinerary of premature newborns and referrals

The beginning of the premature newborn's therapeutic itinerary occurs at the time of birth, which happens, most often, in hospital, where, depending on the severity of the conditions and aggravating factors, there is admission to NICU or Clinical Neonatology. As the days pass, considering the clinical stability and conditions of the NB, such as weight greater than 1800g and corrected gestational age (CGA) of 34 weeks, the NB can be transferred to pediatric hospitalization and, if there are conditions, hospital discharge occurs. From that moment, the care of premature babies is taken over by professionals who work in the PHC of the territory to which his/her family belongs.

According to the conditions and needs of the premature baby's discharge, he/she may need specialized care, prescribed at the time of discharge. Some of the specialties are not available in PHC, being referred through the National System of Regulation (SisReg) for specialized attention and assistance.

From the information collected from the nurses participating in the research, a flow chart of the therapeutic itinerary of premature babies in the HCN was created, as well as all the possible paths that it can have.

The starting point, represented by the reference hospital, and the destination, represented by PHC, stand out. There are several places where premature babies can pass through and, therefore, communication is a *sine qua non* condition for the child to reach an integral and continuous care at the end of the therapeutic itinerary.

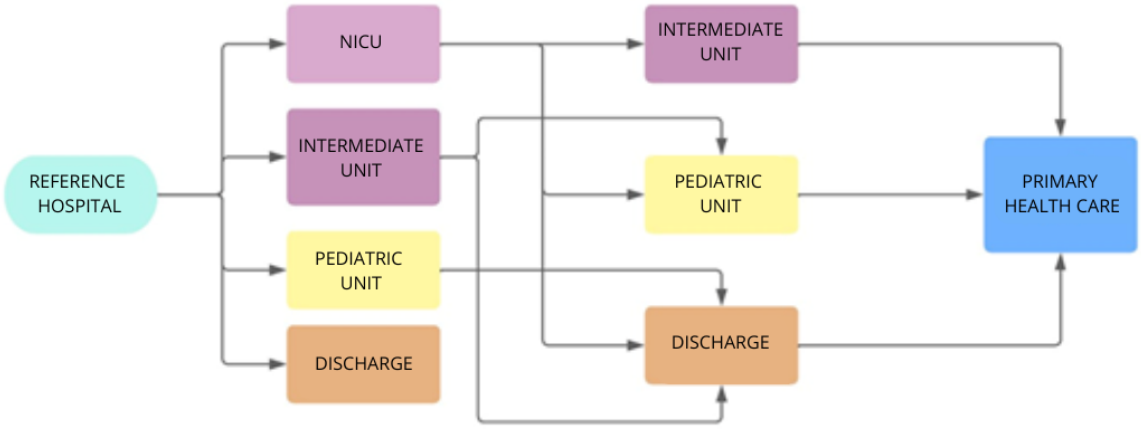

Figure 1 - Flowchart of the therapeutic itinerary for premature infants in the Health Care Network, Chapecó, Santa Catarina, Brazil, 2023

When starting the itinerary, at the time of intra-hospital transfer, the documents sent are copies of the last prescriptions, both from the doctor and the nurse, the examinations performed, the vital signs, in addition to the card of the child accompanying the premature baby in the HCN, in the services that receive him/her.

> *[...] we copy the last exams, the prescription, the peripherally inserted central catheter (PICC) sheet, send the card, but it is "some" copies of what is relevant for them to see, follow up, and follow treatment. (N1)*
> *We receive the copy of the last prescription, the last record evolution and the last copy of vital signs. They come to us. (N7)*

The hospital discharge is a delicate moment for each premature baby. The fact that the hospital environment is no longer needed does not mean that care should be interrupted there, that is, the hospital is only the first point of the assistance network in the therapeutic itinerary. After discharge from the service and return to home, the premature baby needs continued care, being PHC responsible for the completeness of the assistance.

For care to be effective, it is essential that these services refer to PHC with relevant information on the continuity of care. It was observed that there is only one sector of the hospital that has a discharge checklist, being the parents responsible for taking it to the BHU to receive the appropriate referrals.

> *We put on the card what the mother has to look for, it is oriented to her [...] parents are kind of responsible for doing it. We do not have that referral and counter-referral with the municipalities [...] when the mother goes, she is guided*

> *that she has to go with the card every time [...] The card even includes the discharge evolution. (N1)*
> *We have a form that is filled out on discharge, the nursing technician who makes the discharge of this patient fills it. The doctor makes the discharge report, in their discharge reports, they will write everything that happened with this baby, which will be stapled on the card, and the mother will take it to this doctor, who will follow up in Primary Care [...]. (N2)*
> *[...] the doctor makes a report [...] a discharge report and refers. (N7)*

The premature newborn's therapeutic itinerary is a complex system that begins in the hospital, extending to PHC, which assumes the continuity of care. This process should be facilitated so that there is no fragmentation of care, and can be ensured when communication between the different levels of assistance occurs effectively. However, the responsibility often falls on the parents, highlighting the need to improve the mechanisms involved.

Communication between the services of the Health Care Network in the therapeutic itinerary of premature newborns

At the time of premature birth, in most cases, there is a need for admission to an NICU or Clinical Neonatology. When hospitalization occurs, the hospital issues a daily birth sheet and sends by e-mail to the BHU of the same municipality a document with information about the mother's name, GA, neighborhood of residence and, occasionally, whether there was a need for hospitalization.

Nevertheless, this referral is not carried out to other municipalities in the region. Moreover, it was noticed that these data are not always considered in their entirety. The information is rarely passed on to all BHUs, there is no standardization.

> *We receive every week, almost daily, the information of live births [...] name of mother, date of birth, neighborhood that lives and if it is in Neo ICU. (N3)*
> *We receive the announcement via a birth doc of the child, I will be able to identify that was premature or not, or if I remember her name, or if I look in the record [...] there is the communication of the birth itself, but not the specifics, if it is premature, if she is in the ICU. Sometimes, the users find out about the information of the community agent or make contact. (N5)*
> *Usually, there is a return for a doc [...] all the NBs that are born, we receive who was in the ICU or hospitalized in the Neo ICU. (N6)*

There is no communication with the neighboring municipalities for which the hospital is a reference for neonatal hospitalization. Professionals will only be aware of

the birth through the residents, or when a premature newborn needs transportation to return to his/her city, in hospital discharge.

> *The contact occurs when we need to go pick up. So that, as it is a small municipality, the Department is responsible for the transport. [...] then, we know that the baby was born and that the baby was born premature, and that they needed to stay in the ICU. (N10)*
> *Actually, not, unfortunately, from the hospital: what happens is that as our municipality is small, our drivers usually take, they end up bringing us the information. (N11)*

Communication between the hospital sectors occurs by telephone call, in a concise and non-standardized manner, without detailed information about the clinical history of premature babies and judged by the evaluation of each professional. It was observed that the data focus on the clinical condition at the time of transfer, ignoring complications and interventions performed during hospitalization.

When it comes to hospital transfers, they should be regulated by the Internal Regulatory Center (IRC) of hospitals. However, before the request to the center, there is a telephone communication between medical professionals to report the current condition of the NB and the possibility of bed, according to information:

> *We call [...] the baby was born on that day, the shift is handed over by phone [...] bed request; the doctor often has to talk from doctor to doctor. (N1)*
> *The doctor usually calls and says that they need a bed. We organize our bed, our nurse co-worker hands over the shift to the sector with the clinical conditions of this child and the materials that need to be ready, organizes all transfer from here. We call the hospital to talk with our nurse co-worker there, pass the clinical picture of the nursing part of this patient, and request the patient's transport [...] the Internal Regulation Center (IRC). Then, talking to the IRC of the other hospital to see the availability of beds and will pass on that there is bed for the transfer. (N2)*
> *No, there is no written document?! It is by telephone [...] The internal regulation center of the hospital, this would be the flow and, of course, the doctor there calls the doctor here: "There is a child like this, do you have bed? (N7)*

When the premature babies are discharged from hospital and arrive at their homes, the PHC is responsible for the continuity of care, which must provide care following the schedule of child care consultations, performed by doctors and nurses. The research revealed that (at the time of data collection) only one municipality had a defined calendar of childcare consultations, carried out interspersed among health professionals, but with the prevalence of follow-up with a pediatrician.

> *That first consultation in the first week began to be done; at least on paper, it should be done by the pediatrician. We don't have a pediatrician [...] the nurse will end up seeing the child at 2 months and then [...] with 5, 6 months. I think it is a period like this if there was a loss of this follow-up in nursing [...] all because it is a flow that they are "popping". (N4)*
> *[...] we have this insecurity about the childcare of the NB, because we assist the NB with 2 months and then with 15 months. So, we spend a long time without seeing this child [...]. (N6)*
> *Today, they come straight to the appointment with the pediatrician from 7 to 10 days and then a re-evaluation in 10 days, not seeing the nurse. (N5)*

Regarding the follow-up prescribed by the pediatrician, the PHC professionals of a municipality do not have access to this information through the system, and there is no communication of this information by the professionals. Thus, care is fragmented, often placing the responsibility of the process in the role of the caregiver.

It was observed that most municipalities do not have a defined and/or standardized calendar of childcare consultations. There are frequent modifications and adaptations, according to the demands of BHU professionals and according to the demand of the family itself, with the prevalence of follow-up by the doctor.

> *Because the nurse, unfortunately, doesn't do childcare. Even by the demand, we do not have an organization in this sense, to do childcare, and we end up passing to the doctor; and, according to the child's demand, the doctor determines when that child will return. (N11)*
> *It fits the childcare and newborn consultation [...] this first assessment with the nurse in the health unit, then, the child care sequence is done by the pediatrician, we have a pediatrician who works there in the city. (N10)*

There was a certain insecurity of nurses in relation to the care provided to premature babies during childcare consultations. This feeling is the result of inexperience and low frequency of consultations, triggered by the routine of childcare consultations, when the child will be seen by the nurse in a few moments of all this journey.

> *[...] the greatest difficulty is the physical examination of a normal child. Let alone of a premature newborn. (N3)*
> *[...] there is still a resistance from professionals, both nursing and medical, to make newborn care [...] Even a term newborn already generates enough difficulty in the care. The professional does not refuse to see, any change in the physical examination, he is already [...] he already feels unprepared to follow up. (N4)*
> *[...] but, regarding the nurse's appointment, I tell you this: "that sometimes I feel a little insecure about it [...] I don't have enough security as I have to do a prenatal, as I have to do other more habitual things. (N6)*

The analysis of the interviews revealed that, although the therapeutic itinerary of premature babies within the HCN is well defined, the course is complex and sometimes fragmented. From birth, usually in hospital, with admission to NICU or Intermediate Care Unit, until discharge and transfer of care to PHC, there are a series of steps that require effective communication between the different levels of care. Communication between services is often flawed and not standardized, with information transfer that depends on the initiative of caregivers. Thus, the lack of a defined schedule for childcare consultations and the insecurity of PHC professionals regarding the care of preterm infants contribute to the fragmentation of care.

Discussion

Concomitant with prematurity, hospitalization in neonatal care units is a challenging experience, since it changes the family dynamics, and the perspective of hospitalization is accompanied by many painful feelings. The NICU environment, although focused on intensive care with the objective of improving the conditions of premature babies, increases the level of neonatal stress, since it is a place that has intense sensory stimulation. Therefore, some short- and long-term complications may result from the stay in the NICU, thus compromising growth and development due to the fact that preterm infants have extremely sensitive sensory receptors.[7,24]

The premature babies that leave hospital have a load of perceptions associated with fragility and immaturity, which can generate fear and insecurity in the professional who will provide care. It is known that this public demands specialized care, however, it will have, at some point, the same basic needs of care as any other child. Therefore, it is important that the premature baby follows specialized care, but also receives routine care and attention from PHC.[25]

The conditions associated with premature birth make it difficult for professionals to provide care in PHC, since care and follow-up of this premature birth are often almost predominantly carried out at hospital level.[25]

After discharge from hospital, there is still an acute risk of morbidity and mortality, because preterm infants have an unpredictable clinical picture and will be accompanied by parents, who, most often, do not have preparation to deal with the

situation. The survival rate of a premature baby depends on several factors, based on his/her vulnerability, which makes it necessary to have more accurate long-term assessment and monitoring. In this sense, it should be noted that the nurse has competence and scientific technical basis to act and shape intervention plans in order to contribute to the survival and quality of life of these children.[6,26]

The results reveal that the therapeutic itinerary of premature babies in the HCN is delineated and determined by their conditions and clinical needs, which are managed, mostly, by the doctor. In the implementation of the consultation by the nurse in childcare, there is a delay in contact with the child and family due to the calendar of childcare consultations of the municipalities, as well as due to the insecurity portrayed by the low frequency of its execution.

In the context of PHC, the consultation performed by the nurse in childcare facilitates the early identification of health problems that may interfere with the health-disease process, as well as the monitoring of growth and development within the family, cultural and community context surrounding the baby.[9]

Furthermore, there is a fragmentation of information and communication among professionals due to the weaknesses of the information system, which sometimes ends up placing the responsibility of the process on the role of family members, caregivers and home caregivers. Nurses still play an incipient role, where existing weaknesses in relation to the integral care of the child can leave them in a position of greater distance than the recommendation for the effectiveness of the continuity of harm-reducing care for healthy growth and development.[6]

Another result of this study reveals the deficit in the articulation between the points of the HCN and the lack of standardized communication among health professionals, especially nurses. The articulation of the HCN points still has a fragility between the primary and tertiary levels in relation to prematurity, which is predominantly associated with the hospital level.[6,27] Communication with healthcare professionals is a skill that enables the collective construction of care and, in turn, prevents its fragmentation. When not standardized, information promotes solitary and isolated care, making it difficult to enhance and continue care.[26-27]

When analyzing the effectiveness of communication between services, it is highlighted its relationship with excessive and unnecessary pilgrimage through the HCN, in which relatives pass through different services seeking resolution. Sometimes, the path traveled bumps into various obstacles, including the redirection, usually, to places where these services take place, in search of assistance and resources to meet the demands.[14]

The results of this study describe the therapeutic itinerary of premature babies in the HCN, as well as the particularities involved in this process, and highlight contributions to strengthen the role of nurses in the healthy growth and development of preterm infants. The active and decisive participation of the nurse during the dehospitalization process is highlighted, with effective communication with professionals from other points of the HCN. This collaboration enables an integrated approach to the biopsychosocial needs of premature infants, allowing early detection and prompt resolution of complications, which not only promotes health but also effectively prevents future complications.

The results of this research reveal particularities of the studied place, not being possible to compare with other realities and other regions of the state, constituting a limitation. Furthermore, the results are similar to those of several studies carried out, confirming the findings and corroborating the importance of more comprehensive studies.

Conclusion

The therapeutic itinerary of premature babies in the HCN of the region investigated is delineated according to the needs and health conditions of each one, starting at birth, which, in most cases, occurs in the hospital. According to the evolution and complexity of care, the premature baby may need the care of the NICU, the Intermediate Care Unit and the Pediatric Unit. At hospital discharge, the care is continued by the PHC of the family's territory of residence, with the possibility of referral to specialized care. It is noted that the therapeutic itinerary of premature babies is a multifaceted process, which demands from professionals an integrated and collaborative approach between the different levels of the HCN, having as a facilitator effective and continuous communication.

It was found that the communication between the different levels of the HCN is fragile, keeping some information held under the knowledge of only a few professionals, associated with solitary and fragmented work, supported by the information system adopted.

The lack of formal and standardized communication between professionals and the disarticulation between the registration system of the services provided by the various points and services of the HCN are emphasized. As a result of this panorama, the pilgrimage of the premature baby and his family in front of the referrals and the mismatch of information is a reality.

In this context, the nurse has an important role in managing and directing nursing care, contributing to a suitable therapeutic itinerary, improvement of the assistance provided and effective communication between professionals, In addition to providing security to the premature NB, strengthening ties, promoting the autonomy of family members and, above all, ensuring continuity of care for the premature child, resulting in the reduction of infant morbidity and mortality.

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Editor in Chief: Cristiane Cardoso de Paula
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How to cite this article

Parisotto D, Adolfo KS, Getelina EC, Zanatta EA, Zanotelli SS. Therapeutic itinerary of premature newborns and communication in the Health Care Network. Rev. Enferm. UFSM. 2024 [Access at: Year Month Day]; vol.14, e23:1-18. DOI: https://doi.org/10.5902/2179769287476