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Original Article

FAMILY'S PRESENCE DURING PEDIATRIC EMERGENCY CARE: PERCEPTIONS OF HEALTHCARE TEAM MEMBERS

PERMANÊNCIA DE FAMILIARES NO ATENDIMENTO DE EMERGÊNCIA PEDIÁTRICA: PERCEPÇÕES DA EQUIPE DE SAÚDE

PERMANENCIA DE FAMILIARES EN LA ATENCIÓN DE EMERGENCIA PEDIÁTRICA: PERCEPCIONES DEL EQUIPO DE SALUD

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Objective: to determine perceptions of health professionals about family's presence during child care in emergency room. Method: this was a qualitative study including 16 health professionals from a pediatric emergency care unit. Data was collected using semi-structured interviews, and then were submitted to content analysis. Results: categories that emerged from the study were "benefits of family's presence in pediatric emergencies", "limitations of family presence during emergency care", and "suggestions for family inclusion in pediatric emergency care". Conclusion: the reduced physical structure and human resources in this pediatric emergency room was one of the facts that limited the support for families during emergency care, although health care professionals recognized the importance of family inclusion.

Descriptors: Pediatric nursing. Family. Emergency medical services.

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Objetivo: conhecer a percepção da equipe de saúde sobre a permanência de familiares durante o atendimento à criança em situação de emergência. Método: pesquisa qualitativa que utilizou, para a coleta de dados, a entrevista semiestruturada com 16 integrantes da equipe de saúde de um pronto-socorro pediátrico. Os dados foram submetidos à análise de conteúdo temática. Resultados: emergiram as categorias benefícios da presença do familiar em situações de emergência pediátrica, limitações da presença do familiar durante o atendimento de emergência e sugestões para a inserção do familiar no atendimento de emergência pediátrica. Conclusão: a reduzida estrutura física e de recursos humanos do pronto socorro pediátrico foi um fator que dificultou o acolhimento dos familiares durante o atendimento de emergência, mas os profissionais da equipe de saúde reconheceram a importância da inclusão da família.

Descritores: Enfermagem pediátrica. Família. Serviços médicos de emergência.

Objetivo: conocer la percepción del equipo de salud sobre la permanencia de familiares durante la atención al niño en situación de emergencia. Método: investigación cualitativa que ha utilizado, para la recolección de datos, la entrevista semiestructurada con 16 integrantes del equipo de salud de un servicio de urgencias pediátrico. Los datos han sido sometidos al análisis de contenido temático. Resultados: han emergido las categorías beneficios de la presencia de los familiares en situaciones de emergencia pediátrica, limitaciones de la presencia de los familiares durante la atención de emergencia y sugerencias para la inserción de los familiares en la atención de emergencia pediátrica. Conclusión: la reducida estructura física y de recursos humanos del servicio de urgencias pediátrico ha sido un factor de dificultad para la acogida de los familiares durante la atención de emergencia, pero los profesionales del equipo de salud han reconocido la importancia de la inclusión de la familia.

Descriptores: Enfermería pediátrica. Familia. Servicios médicos de urgencia.

Introduction

Humanization in health care, which is regulated since 2003 by the National Humanization Policy (NHP), constitutes a need for care delivery considering that it places participants as protagonists and responsible for their care. This policy shows the current and growing need of family-centered health care that is the major premise of humanization in health care[1].

In pediatric context, the concept of humanization in health care is closely correlated with family care, and it compromises all members of health team for considering the binomial child/family. The family inclusion in care settings, and its actions as protagonists and co-responsible in this process, comprises a way for soften hostility of the hospital, and help child to adapt in such environment[2-3].

For this reason, family's presence in the hospitalization period of a child is paramount for offering support during healthcare, which is a right since 1991, after implementation of Statute of the Child and Adolescent (Estatuto da Criança e Adolescente – ECA) in Brazil[4]. The positive effect of this condition is seen in pediatric inpatient units when parents remain with the child helping with care, nutrition, and hygiene. However, the family's presence entails great challenges for health professionals because Brazil's legislation does not have precise definitions on this regard.

Health professional's opinion is still controversial regarding this issue. Some professionals believe that family's presence should not be allowed during emergency care because they can influence negatively the performance of the health care team members, whereas other professionals highlight the importance of family's presence during emergency because of the emotional support they provide, which is fundamental to the child recovery[5-8].

To health care teams to understand humanization in a complex care environment means to embrace the dynamic of the organization that promotes human and professional relationships/interactions. In addition, such understanding is correlated with recognize humans as complex and singular beings who can reorganize themselves depending on the

conditions and environment in which relations are formed[9].

Based on this reality, healthcare teams experience daily in pediatric emergency units situations that involve decision about family's presence or not during emergency care and these professionals also face difficult to include family members in care of a child who is clinical instable. In order to find a way to enable the permanence of family members in the pediatric emergency room, focusing on humanization, without causing any disservice to the healthcare staff; in addition to generating subsidies to support legal regulations on the subject, it is necessary to promote discussions about this problem.

For this reason, the question is: What is the perception of health care team members from a pediatric emergency unit regarding family's presence during assistance given to children in emergency room?

This study aims to understand the perception of health care teams about the presence of family members during the care given to a child in an emergency situation.

Method

This study was designed with a qualitative, descriptive, and exploratory approach; carried out in a pediatric emergency unit at a teaching hospital in a municipality from South Brazil. The emergency unit is reference in the city for pediatric emergency and urgent care.

The studied population included healthcare team members of a pediatric emergency unit; composed of seven nurses, six nursing technicians, and six pediatricians. One nursing technician and two nurses were excluded of the study because they were on vacation and/or sick leave during data collection. Thus, the final sample included 16 professionals: 6 pediatricians, 5 nurses, and 5 nurse technicians.

Interviews were conducted by researchers (a master degree student and an undergraduate student – enrolled in scientific initiation program), done in the first semester of 2014, in a private room of the hospital. The interviews had an average duration of 40 minutes and were recorded and transcribed. The first question of the interview was "Based on your experience, what is your perception about family's presence, or not, in pediatric emergency care units?".

Subsequently, the *corpus* of the study was analyzed using a thematic content approach[10] in three fundamental phases: pre-analysis, exploration of the material and treatment of results.

Pre-analysis entailed the exploration of material to be analyzed in order to turn it operational, and systematize initial ideas to identify related themes to the object and objectives of the study. This phase was subdivided into fluctuating reading, chosen of documents, and preparation of the material.

The second stage of the content analysis consisted in the exploitation of the material, moment that the raw data were organized and aggregated into units, which allowed a description of the relevant characteristics of the content[10]. In this phase, occurred both codification (identification of themes) and categorization (approximation of themes to constitute thematic categories).

The third and last phase entailed the analysis of results – regarding interpretation. Were created analytical charts including relevant information for data analysis based on what was obtained in the categorization of the previous phase. Contents of the charts comprised in participants, identified by alphanumeric codification, comment of the professional, and subsequently, the analytic commentary.

It should be highlighted that this study is part of a larger study entitled "Family/Accompanying person's presence in Pediatric Emergency Care: Perception of Medical and Nursing Team, and Family/Accompanying person". The study was approved by the Ethical and Research Committee, CAAE number 18519513.0.0000.5346 according to Resolution nº 466/12 of the Brazil's National Health Council[11]. To guarantee confidentiality of interviews identification, we used the initials "N" for nurses, and "T" for nursing technicians,

and "P" for physicians, followed by an ordinal number order randomly.

Results and Discussion

Participants' age ranged between 27 and 60 years, and 36 hours in a weekly workload in the institution. Data analysis enabled to create three categories: benefits of family's presence in pediatric emergencies, limitations of family's presence during the emergency care, and suggestions to include family members during pediatric emergencies care.

Benefits of family's presence in pediatric emergencies

The healthcare team reported the main positive aspects regarding family's presence during pediatric emergency care, which showed that these professionals are sensitive to humanized care of children.

> *If the child is conscious or active, family's presence can bring safety, calmness, and in such extent, reduce trauma* [...] (N3).
>
> *When the child is conscious, for example, the mother and the father can calm he/she down*. (N4).
>
> *In some situations, family can help a lot mainly because the child might be insecure and have parents close can calm he/she down* […] (T1).
>
> *If parents are calm, they would be able to calm down the child, and I believe it is important in those emergencies in which the child life is not at risk. For example, a child who suffered a needle stick injury…a child who is clinically stable*. (P2).

Participants highlighted that the child who is conscious would feel more calm and safe with family's presence. The healthcare team showed a behavior based on principles of humanization concerning the importance of family's presence during an emergency care of a child.

For this reason, there is a broadening of the care focus that implicates in recognize the child and their family as multidimensional beings and, therefore, give them value for their singularity and diversity during care. Such circumstances are an invitation to the nurse to perform a variety of interactions, given that an unidirectional approach centered in the disease is not enough to address demands required by the child and his/her family[7]. Therefore, there is need to give value to human beings, respect their dignity and singularity by providing health assistance that goes beyond technical emergency care. Humanization in health care in emergency service entails the consideration of physical, emotional, and social aspects of patients[12].

Participants reported that during emergencies, family is the main source of information about clinical history of the child, and to know patient's clinical history is required to define the clinical approach, particularly because, in most of cases, the child is not able to talk or is admitted unconscious to the emergency service:

> *The family knows the child better than anyone, they might not know what to do during the traumatic situation, but they can provide important information*. (N3).
>
> *The child does not know how to report what he/she is felling. If the family is not accompanying the child, you probably do not know what the child needs*. (N5).

In this perspective, family is also seen as a facilitator for child care in emergency context, and they might provide information to contribute with anamnesis and assessment for an efficient and safety care. In addition, participants recognize that, most of times, although experience of traumatic situation with a child might cause intense suffering, if family controls their anxiety, they may feel safer and remain in the emergency room without causing any disservice.

> *Sometimes we underestimate the ability of parents to face a traumatic experience with their child, and most of them can face the situation. They may cry, bit their nails, go crazy, but they can survive the experience. The caregiver should be very sensitive to the situation and not expected to find a relaxed family in the emergency room* [...] (N3).
>
> *The father was calm. To him, it was best to stay there where the child was. But, he did not interfere at all*. (N2).
>
> [...] *some parents can be nervous, but they do not put their anxiety on us*. (T2).

Family's presence can bring benefits for quality of life of both patient and relatives because observe how treatment is managed brings relieve to them[13].

In another study, which also sought to know the opinions of health professionals regarding

the presence of the family during pediatric emergency care, the professionals pointed out as main reasons for the inclusion of the family in the emergency room: the observation of the family in relation to the health team's efforts in the care, the importance of the information to the health team about the patient, and the safety that the family can provide to the child[14]. In addition, results showed that family's presence is considered a benefit because they can observe their child care in the emergency and, therefore, feel safer regarding the health team performance. Were observed the same perceptions in this study, which can be noticed in the following fragments:

> *Some people think that family's presence can be something bad, a limiting factor for a health team, but family's presence may avoid false ideas from the family about what and how things have been done. For this reason, if family follows the procedures, they will be better informed.* (N3).

> *It is obvious that for the family, even to accept an unfavorable result, perhaps, for them to be there would be useful. To follow closely the care can help them to understand what factors led to the result* [...] (P4).

> *Depend on the degree of understanding of the family, if they can understand that they can be there but not interfere in the care, I believe their presence is a good thing. When family is present they can understand better what is going on, and they probably do not create a situation in their minds* [...] (P5).

Family's presence during emergency procedures offers benefits because family can observe the effort of the health care team to deliver the best care possible to the child. In addition, their presence may provide greater security for the health team itself, when there are doubts about the performance of professionals involved in the recovery of the child. Therefore, the family presence during the emergency care can support the understanding about all care process to patient who need emergency care. In addition, this can reduce doubts about efforts and performance of health team, and family members can receive guidance about health situation[5].

According to both, participants of the study and the international literature, family's presence helps in the acceptance and construction of grief in case of death or how to deal with other negative outcomes, and also in health professionals misconducts during the emergency care. To allow family's presence during emergency care may facilitate grief elaboration as much as the construction of more positive experiences for both, patient and his/her family[5].

Thus, the healthcare team pointed out the relevant aspects of the family members' presence during pediatric emergencies and the need to understand the benefits of this inclusion in child care.

Limitations of family's presence during the emergency care

The difficulties mentioned by the professionals were related to operational aspects regarding lack of professionals that provide support for families during emergency situations. Such difficulties are also related to institutional aspects such as lack of physical space and permanent education of the health care team.

In addition, participants of the study pointed out that physical and emotional conditions of families can difficult the health care team members' performance because of some people's reaction in stressful situations. For this reason, were included as relevant conditions the lack of physical space, and someone who can guide and/or provide care for families.

Thus, issues related to emotional aspects may include syncopes linked to nervousness and panic situations, due to the severity of the child's health condition, which is one of the most cited cases. Therefore, professionals have reported disagreement to family's presence in the emergency room when a complex care is needed and the situation could be traumatic to the family of the child.

> *One of the family members had a syncope in the room and part of the family helped and forwarded him to health assistance* [...] *The situation in some extent affected and delayed the care [to the child]* (N3).

> [...] *because some family members end up not feeling well. We have had cases which we had to stop caring for the child and attending to the family member* [...] *So, we had to stop the assistance to the child who was priority at that time* [...] (T3).

> *When parents are nervous, anxious, they end up passing these feeling to the child... and this affect negatively the*

care [...] *in cases that a child health status is critical, we need to take aggressive measures [such as orotracheal intubation], something invasive. Watch this might be very disturbing to parents, so I prefer that family stay out of the unit*. (P2).

It is quite disturbing to parents who their child is having a cardiac arrest; the child will be intubated, you know, it is an invasive and aggressive procedure, they are not used to such situation. They might think that we're not treating the child accordingly. (N1).

[...] *an intraosseous puncture* [...] *parents observe that [the procedure]* [...] *it is torture for them!* (T2).

Many people have difficulty experiencing stressful situations, mainly related to the disease. When it comes to the experience of a member of the own family, the difficulty of facing critical situations, such as those that lead to the need for emergency care to become even greater and, several times, people end up responding to stress presenting physical malaise, being due to emotional overload[15].

Some studies[5,15-18] have pointed out that the most common reason for the healthcare team not to consent the presence of the family during emergency care is related to the severe traumatic effects that family members could feel during and aftercare, while the family was watching more complex procedures. In addition, reports based on professionals' experience point out other situations that can difficult the care for the child in emergencies:

The child was having a seizure and the father was in shock…he started to curse the team [saying] that team was not doing anything. (T1).

Some of them just grab the child and do not let us to come close. So, we need to ask the security staff to take the mother out of the room [...] *The child was in respiratory arrest, and the mother was holding the child and we could not get close to assist [the child]*. (N1).

She was interfering and causing problems! I said: "Or you stay quiet and stop hitting the walls and knocking and kicking the stretchers or you're going to leave" She was so desperate that she did not hear what I said. When someone is desperate, they do not listen and they may transform themselves. (N2).

I'm against it. I'm against it because parents are bounded with the child, and they become nervous and it end up affecting the medical procedure [...] *Because, in general, they do not understand the severity of the case and the procedures required for the child benefit, and they interfere sometimes trying to give an opinion or sometimes they are rude with the healthcare team member because some of them do not agree with some procedures needed*. (P6).

[...] *I already experienced a situation: family tries to interfere in procedures because they believe that it is aggressive or because they believe the procedure is inadequate, and this affects negatively the focus of the healthcare team members*. (P4).

According to the participants of this study, family members could face difficulty to experience the situation of having a child in severe health state, and they may have a behavior or attitude that affect negatively the emergency care. Moreover, when family members interfere in the procedure they sometimes are aggressive or rude with healthcare team members. For this reason, is difficult to include family in care because they are unfamiliar with the diagnosis and procedures of pediatric emergency care, and their interference might cause delays in the treatment.

Studies on the subject show that healthcare professionals reported to be concerned about their practice because of the possibility of medical lawsuit, distraction and anxiety of healthcare team members that affect the quality of performance, maintenance of problems regarding material sterility, and questions related to professional ethics[5,15-18].

In this scenario, family members end up pondering that they can protect the child from a suffering situation with a distorted perspective, when they do not perceive the importance of the procedures and the need for agility in the care, also acting in manners that hinder the performance of the healthcare team.

This result corroborates with other study including participants who had unfavorable arguments to family's presence because of the fear of people to loss their emotional control and stop the care of the patient, which can harm the child because of the delays in emergency interventions. The guarantee that family will not interrupt the procedure is fundamental for success of family's presence during emergency care[15].

However, a recent study[19] highlighted that problems regarding family´s presence is uncommon. In addition, the study also mentioned that family members who have watched the emergency care of their relative were less likely

to present post-traumatic stress disorder and other psychological problems than those who did not watch[19].

Another study including a multidisciplinary team evidenced that, although healthcare professionals show positive attitudes regarding family involvement during the routine care, these professionals perceived as negative the presence of family during cardiorespiratory reanimation or other complex procedures. Also, physicians were more against family's presence than nurses[16], the same result was observed in our study based on the participants reports.

Suggestions to include family members during pediatric emergencies care

Nurses, nursing technicians, and pediatricians suggested strategies to avoid interference of family members during child care in emergency situations, which can benefit all involved individuals. Among these strategies, emphasis is given to the presence of a person acting as facilitator, aiming to provide emotional support to families and give information about the child's clinical condition:

> *Someone not involved in the care of the child who is in an acute crisis or emergency. This person should stay next to the parents. But the question is: Who? Our team has only one nurse and one nursing technician! But, there are* [...] *plenty of medical students...perhaps someone from the medicine could do it.* (N2).

> *To be outside waiting [out of the emergency room] is also anguishing* […] *someone should go there and say that things are going well, or if the situation is being reverted, of even if the clinical situation is getting worse* [...]*"* (N2).

> [...] *social workers could do the job of talking with the family and to support them* [...] *There is a need for a professional to assist them* […] *a psychologist* […]. (T4).

> *Ideally would be someone to support them* [...] *someone who would guide the family, so they could understand the procedures that have to be done.* (P6).

Healthcare team members recognize that family members are not included in care by professionals once the focus is in the child who is in crisis and, in some cases, who is at risk of life, and needs intensive and emergency care.

Presence of a trained professionals to deliver assistance to family members and who could establish a more effective communication is seen as a strategy to reduce traumas related to experiences of pediatric emergencies. Participants of the study reported that there is no one in the staff to support the family during child care in emergency, but they also recognize that a multidisciplinary team could offer care with higher quality.

For this reason, when family members understands the procedures to be done and why they are needed, and when they are also constantly informed about the health status of their child, they would feel less uncomfortable to cope with emergencies. In addition, such attention to family can reduce suffering for both family members and for the child.

Health professionals recognize the importance of communication that cannot be linear, but through an articulated network of information presented in communication. The communication occurs during all context of care delivered to the child, including language, behavior, and professional attitude which are conductors in the meeting among health professionals, child, and his/her family[20].

Based on positive and negative aspects of the family's presence during child care in emergency units, the health care professionals of this study, suggested strategies to include family members in the care process, therefore, showing that humanized care to the child is possible and can be extended to the family.

Other studies corroborate the results of this study, emphasizing that even with some professionals not believing in the possibility of family inclusion in emergency care units, the existence of concern with improvements that can be applied to facilitate the presence of family members in the emergency care. As mentioned, among others: extension of visiting hours in emergency room, improvement of physical structure, training of professionals to act and intervene to support the family, need of sharing information, or psychological support[8].

In the following reports participants suggested the existence of a place to provide comfort to family members:

> *Something that lacks here is a waiting room, so parents would not stay standing in the hallway.* (N1).
>
> *The ideal would be a place for people to stay seated, to wait the procedure, but I believe that our current structure does not allow it, but such place would be interesting.* (N3).
>
> [...] *an adequate place to seat, a waiting room* [...] *and someone who can bring news from time to time.* (T4).
>
> *First, it would be a place for them to stay together, and chairs for them be seated* [...] (P5).

A space for family members is suggested, and it could be inside or outside of the emergency room; given that, when people stay within the emergency care area there is no adequate space for them to observe the procedures. However, when they stay out of the emergency room, they wait standing in the hallway because there is no adequate space for waiting in the institution where this study was carried out.

A study that addressed the perception of physicians and nurses about family-centered care in emergency care units has shown that the perception and understanding of professionals, although limited in the philosophical and practical aspects of family-centered care it opens space for possibilities implementation of this approach in different health institutions and types of care. Healthcare professionals themselves pointed out possibilities, although some of them are against family's presence[8]. Therefore, is important highlight that, by definition, family-centered care refers to a partnership that mutually benefits patients, family, and healthcare professionals regarding planning and delivery of care[21].

To facilitate family integration in the model of humanized health care in emergency services, it is necessary to understand that the family member is very important for the child; as well as clinical and caring barriers, hospital resources, policies and guidelines, staff, and continuing education[16].

However, is important stress out that emergency services are related to characteristics of its own environment. Therefore, there is a need to develop a broad viewing of the healthcare given encompassing not only the care delivered for patients, but also to the healthcare team, and family members, in an attempt to articulate the actions of these professionals and seek a care with higher quality, considering yet the dynamic of emergencies services[22].

In this scenario, there are factors that difficult the humanization in such services, such as professionals leading scarcity of human resources, inadequate working conditions, excessive demand of patients, and lack of adequate physical structure[12].

Family's presence during emergency care, when not appropriately planned, can cause negative consequences for healthcare professionals, patients, and family members. For this reason, to guarantee that healthcare professionals are trained to provide a consistent approach to all family members, it is essential to implement a policy regarding family's presence and also define guidelines to be given for healthcare teams involved in such situations[19]. Investments are needed for the continuous education of healthcare professionals, in order to reinforce attitudes, behaviors, and values that promotes the presence and partnership of family members in the care of a child[23].

Studies developed with the same clientele recommend the development of strategies that facilitate the decision-making process regarding family member's presence during a pediatric emergency; thus, the family's inclusion in the child's care in any situation is promoted, respecting the uniqueness of each human being. In addition, such studies suggest deeper investigations about the subject to support the development of policies and guidelines to implement safe practices in healthcare institutions[24].

To sum up, in this study, healthcare professionals believed that family's presence could calm down the child during a procedure. In addition, they also think that it can contribute to family's elaboration of grief, as much as also provide them a better understand of the activities developed by healthcare team members. However, these professionals also highlighted that both family's agitation and anxiety are obstacles as much as the difficulties related to the inclusion of the family members in the

face of a reduced physical space, and lack of human resources, as a multiprofessional team available to be with the family, helping these individuals in the understanding of the diagnosis and explaining the procedures.

As a final point, the development of this study in only one pediatric emergency service is a limitation, and it is suggested to carry out new researchs in the area, in different realities and services, in order to improve knowledge.

Conclusion

The perception of healthcare professionals about the family's presence in emergency room is important when they can contribute for the care and benefit all subjects involved in the process. Although many healthcare team members included in our study present unfavorable positions in relation to family members' presence during emergency care, the common sense is that family should be included in the care process. Such positive approach is due to the importance that a family have in child care, and also for the effort of professionals to promote humanization in health care.

The reduced physical structure and limited human resources in the pediatric emergency unit were factors that made difficult to include families during emergency care, but health care professionals recognize the importance regarding the inclusion of these family members in the process.

Therefore, as an implication for the healthcare practice, it is recommended the creation of a physical space in the service that allows family to stay, as well as a multiprofessional team organized to care for the child, in addition to someone from the healthcare team to support the family. However, it is well known that this reality is not practiced, due to the problems that involve the country's health services in the current context, especially human resources, which are insufficient in most Brazilian healthcare organizations.

Collaborations

1. conception, design, analysis, and interpretation of data: Júlia Heinz da Silva, Fernanda Luisa Buboltz, and Eliane Tatsch Neves;

2. writing of the article and relevant critical review of the intellectual content: Júlia Heinz da Silva, Fernanda Luisa Buboltz, Eliane Tatsch Neves, Andressa da Silveira, Janete de Lourdes Portella, and Leonardo Bigolin Jantsch;

3. final approval of the version to be published: Eliane Tatsch Neves.

References

1. Brasil. Ministério da Saúde. Política Nacional da Humanização. Brasília; 2013 [cited 2016 June 25]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_humanizacao_pnh_folheto.pdf

2. Ferreira CA, Balbino FS, Balieiro MM, Mandetta MA. Presença da família durante reanimação cardiopulmonar e procedimentos invasivos em crianças. Rev Paul Pediatr [Internet]. 2014 [cited 2016 June 25];32(1):107-13. Available from: http://www.scielo.br/pdf/rpp/v32n1/pt_0103-0582-rpp-32-01-00107.pdf

3. Rodrigues PF, Amador DD, Silva KL, Reicherte AP, Collet N. Interação entre equipe de enfermagem e família na percepção dos familiares de crianças com doenças crônicas. Esc Anna Nery [Internet]. 2013 [cited 2016 June 25];17(4):781-7. Available from: http://www.scielo.br/pdf/ean/v17n4/1414-8145-ean-17-04-0781.pdf

4. Brasil. Câmara dos Deputados. Estatuto da criança e do adolescente [recurso eletrônico]: Lei n. 8.069, de 13 de julho de 1990, e legislação correlata. 13a ed. Brasília; 2015. (Série legislação; n. 175). [Cited 2016 June 25]. Available from: http://www.camara.leg.br/editora

5. Dougal RL, Anderson JH, Reavy K, Shirazi CC. Family presence during resuscitation and/or invasive procedures in the emergency department: one size does not fit all. J Emerg Nurs. 2011;37(2):152-7.

6. Barros LM, Araújo TM, Neri MFS, Soares E, Caetano JA. Internação em uma unidade de emergência hospitalar: vivência. Cogitare Enferm [Internet]. 2013 [cited 2017 June 20];18(2):336-43. Available from: http://revistas.ufpr.br/cogitare/article/view/32583/20699

7. Silva TP, Silva MM, Alcantara LM, Silva IR, Leite JL. Estabelecendo estratégias de ação/interação para o cuidado à criança. Esc Anna Nery [Internet]. 2015 [cited 2017 June 20];19(2):279-85. Available from: http://www.redalyc.org/html/1277/127739655012/

8. Barreto MS, Arruda GO, Garcia-Vivar C, Marcon SS. Cuidado centrado na família em unidades emergenciais: percepção de enfermeiros e médicos brasileiros. Esc Anna Nery [Internet]. 2017 [cited 2017 June 26];21(2):e20170042. Available from: http://www.redalyc.org/pdf/1277/127750429014.pdf

9. Sanches RCN, Gerhardt PC, Rêgo AS, Carreira L, Pupulim JSL, Radovanovic CAT. Percepções de profissionais de saúde sobre a humanização em unidade de terapia intensiva adulto. Esc Anna Nery [Internet]. 2016 [cited 2016 June 25];20(1):48-54. Available from: http://www.redalyc.org/articulo.oa?id=127744318007

10. Bardin L. Análise de conteúdo. 8a ed. Lisboa, PT: Geográfica; 2011.

11. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução n. 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Brasília; 2012.

12. Cavalcante AKCB, Damasceno CAF, Miranda MDS. Humanização da assistência em atendimento de urgência hospitalar: percepção dos enfermeiros. Rev baiana enferm [Internet]. 2013 [cited 2016 June 25];27(3):221-33. Available from: http://www.portalseer.ufba.br/index.php/enfermagem/article/view/8318/8421

13. Dwyer TA. Predictors of public support for family presence during cardiopulmonary resuscitation: A population based study. Int J Nurs Stud [Internet]. 2015 [cited 2017 June 20];52(1):1064-70. Available from: http://www.journalofnursingstudies.com/article/S0020-7489(15)00066-8/pdf

14. Mekitarian FFP, Angelo M. Presença da família em sala de emergência pediátrica: opiniões dos profissionais de saúde. Rev Paul Pediatr [Internet]. 2015 [cited 2017 June 20];33(4):460-6. Available from: http://www.scielo.br/pdf/rpp/v33n4/pt_0103-0582-rpp-33-04-0460.pdf

15. Porter JE, Cooper SJ, Sellick K. Family presence during resuscitation (FPDR): perceived benefits, barriers and enablers to implementation and practice. Int Emerg Nurs. 2014;22(2):69-74.

16. Al Mutair A, Plummer V, O'Brien AP, Clerehan R. Attitudes of healthcare providers towards family involvement and presence in adult critical care units in Saudi Arabia: a quantitative study. J Clin Nurs. 2014;23(5-6):744-55.

17. Balogh-Mitchell C. Is it time for family presence during resuscitation in the OR? AORN J. 2012;96(1):14-25.

18. Tripon C, Defossez G, Ragot S, Ghazali A, Boureau-Voultoury A, Scépi M, et al. Parental presence during cardiopulmonary resuscitation of children: the experience, opinions and moral positions of emergency teams in France. Arch Dis Child. 2014;99(4):310-5.

19. Jabre P, Belpomme V, Azoulay E, Jacob L, Bertrand L, Lapostolle F, et al. Family presence during cardiopulmonary resuscitation. N Engl J Med. 2013;368:1008-18.

20. Martinez EA, Tocantins FR, Souza SR. As especificidades da comunicação na assistência de enfermagem à criança. Rev Gaúcha Enferm [Internet]. 2013 [cited 2016 June 15];34(1):37-44. Available from: http://www.scielo.br/pdf/rgenf/v34n1/05.pdf

21. Committee on Hospital Care and Institute for Patient-and Family Centered Care. Patient-and Family-Centered Care and the pediatrician's role. Pediatrics [Internet]. 2012 [cited 2017 Jan 26]; 129(2):394-404. Available from: http://pediatrics.aappublications.org/ content/pediatrics/129/2/394.full.pdf. doi: 10.1542/peds.2011-3084

22. Santos JLG, Lima MADS, Pestana AL, Colomé ICS, Erdmann AL. Estratégias utilizadas pelos enfermeiros para promover o trabalho em equipe em um serviço de emergência. Rev Gaúcha Enferm [Internet]. 2016 [cited 2017 June 26];37(1):76-82. Available from: http://www.lume.ufrgs.br/bitstream/handle/10183/141481/000991423.pdf?sequence=1

23. Ferreira CAG, Balbino FS, Balieiro MMFG, Mandetta MA. Presença da família durante reanimação cardiopulmonar e procedimentos

invasivos em crianças. Rev Paul Pediatr [Internet]. 2014 [cited 2017 jun 26];32(1):107-13. Disponível em: http://www.scielo.br/pdf/rpp/v32n1/pt_0103-0582-rpp-32-01-00107.pdf

24. Buboltz FL, Silveira A, Neves ET, Silva JH, Carvalho JS, Zamberlan KC. Percepção de familiares sobre sua presença ou não em situação de emergência pediátrica. Texto Contexto Enferm [Internet]. 2016 [cited 2017 June 26];25(3):e0230015. Available from: http://www.scielo.br/pdf/tce/v25n3/pt_0104-0707-tce-25-03-0230015.pdf

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