

Experience of nursing staff facing the hospitalization of burned children

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Objective. To present the experiences of nursing staff working with hospitalized burned children. **Methodology.** Qualitative study. Data were obtained from semi-structured interviews applied to 16 people of the nursing team (12 professional technicians and 4) working at a burn treatment center. For the analysis, the Method information Interpretation of the Senses was used. The theoretical basis used to support the discussion of the study was proposed by Geertz's interpretive anthropology. **Results.** The narratives showed that the process of care to burned children is stressful for the participants because they are psychologically involved with the tragic story of a patient who suffered burns, and therefore with the clinical situation. This allows for the development of empathy. On the other hand there cultural involvement facing and accepting the consequences of what happened to the patient, due to the change of body image stigma that the child will suffer hamper the re-socialization of the child after discharge. **Conclusion.** The nursing team is affected in various ways during the care of hospitalized burned children. There is need for educational programs for their preparation in the care of these patients.

Key words: child; burn units; burns; nursing team.

Vivencia del equipo de enfermería frente a la hospitalización del niño quemado

Objetivo. Presentar la vivencia del equipo de enfermería que trabaja con niños quemados hospitalizados. **Metodología.** Estudio cualitativo. Los datos se obtuvieron a partir de entrevista semiestructurada aplicada a 16 personas del equipo de enfermería (12 técnicos y cuatro profesionales) quienes trabajan en un centro de tratamiento de quemados. Se utilizó para el análisis de información el Método de Interpretación de los Sentidos. La base teórica utilizada para apoyar la discusión del estudio fue la Antropología interpretativa propuesta por Geertz. **Resultados.** Los relatos mostraron que el proceso de atención a niños quemados es estresante para los participantes porque se

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encuentran inmersos dentro de la trágica historia del paciente y, por consiguiente, con su situación clínica, lo que los afecta psicológicamente. Esta circunstancia permite el desarrollo de la empatía. Por otra parte, se involucra culturalmente puesto que afronta y acepta las consecuencias de lo ocurrido al paciente. Debido al cambio de la imagen corporal, el niño sufrirá estigmas que dificultarán su resocialización después del alta. **Conclusión.** El equipo de enfermería se ve afectado de diversas formas durante el cuidado del niño quemado hospitalizado. Por esto, es necesario realizar programas educativos para la preparación en su atención.

Palabras clave: niño; unidades de quemados; quemaduras; grupo de enfermería.

Vivência da equipe de enfermagem frente à hospitalização da criança queimada

Objetivo. Apresentar a vivência da equipe de enfermagem que trabalham com meninos queimados hospitalizados. **Metodologia.** Estudo qualitativo. Os dados se obtiveram a partir de entrevista semiestruturada aplicada a 16 pessoas da equipe de enfermagem (12 técnicos e 4 de profissionais) que trabalham num centro de tratamento de queimado. Utilizou-se para a análise de informação o Método de Interpretação dos Sentidos. A base teórica utilizada para apoiar a discussão do estudo foi a Antropologia interpretativa proposta por Geertz. **Resultados.** Os relatos mostraram que o processo de atendimento a crianças queimadas é estressante para os participantes porque se veem envolvidos psicologicamente com a trágica história de um paciente que sofreu queimaduras, e portanto com a situação clínica. Esta circunstância permite o desenvolvimento da empatia. Por outra parte, há envolvimento cultural ao enfrentar e aceitar as consequências do ocorrido ao paciente, devido à mudança da imagem corporal o menino sofrerá estigmas que dificultarão a ressocialização do menino depois do alta. **Conclusão.** A equipe de enfermagem se vê afetado de diversas formas durante o cuidado do menino queimado hospitalizado. Há necessidade de realizar programas educativos para sua preparação no atendimento destes pacientes.

Palavras chave: criança; unidades de quemados; queimaduras; equipe de enfermagem

Introduction

The occurrence of accidents in childhood maintains a strong correlation with the style of life, the habits of the family, the social network to which the child belongs, the phases of child growth and development, in addition to other factors, such as financial, cultural and educational aspects.¹ In Brazil according to data from the Ministry of Health (MOH),² the burns, in their various forms, are one of the leading causes of hospitalization in children. They are in 2nd place among childhood accidents and occupying the 5th and 6th places in cases of mortality in children up to 4 and from 5 to 9 years of age, respectively.

Burns are considered a serious public health problem in Brazil,³ they constitute an attack on the physical and psychological integrity of the

victim, because they submit them to a potentially painful and traumatic experience, with severe involvement of tissues, organs and limbs and, consequently, with the impairment of body image and self-esteem.^{4,5} In addition, the relatives, and even the professionals themselves directly involved in the care of burn victim children, suffer when faced with such a touching situation of pain and suffering. The fear and insecurity of the unknown are disorders that accompany the whole trajectory of child hospitalization,⁶ mainly, in the beginning. The presence and participation of the parents⁷ and the humanization of care are essential elements for ameliorating the frightening and distressing condition in the hospital environment.

The total recovery is slow and demand a series of clinical and surgical procedures, especially in

cases of 2nd and 3rd degree burns, more extensive, involving body regions considered most critical or those called noble regions, which are the ones that reflect poor prognosis. They embody high risk of disability and are unsuitable for donor grafting in cases such as the face and neck (especially eyes upper respiratory tract), flexure sites, hands, feet, scalp, breasts and genitalia.^{8,9} In addition, the most serious burns may compromise vital systems such as the cardiovascular, immunological, nutritional status, among others, which reflects the clinical evolution, in response to the treatment and survival of the child.⁸ It is in this context that this study sought to unveil the experiences of nursing staff working with the hospitalized child burn victim.

Methodology

This study, which is characterized as descriptive and exploratory qualitative approach, was carried out in a Treatment Center for Burns (CTQ - *Centro de Tratamento de Queimados*) reference in northern Parana (Brazil). There were 16 participants in the study, divided as follows: in the mornings, afternoon and evening (even and odd), 12 nursing technicians (three per shift) and 4 nurses (one per shift). It is worth noting that nursing assistants are not allowed in this sector.

The selection of subjects was random, with no distinction of sex or age, but it was essential that they were working in the nursing area and act as staff at the place of study. There was no refusal to join the study. For data collection, in June 2011, the semi-structured interviews were conducted and recorded, which occurred in the CTQ, in a meeting room or in the nursing room, as determined by the shift leader. The interview was based on a form with six questions about personal identification data and information regarding professional experience. In addition to, six open questions that questioned the following: the meaning of caring for a burned child, the participant's understanding of pain in childhood, their attitudes in relation to pain management

in pediatric patients and suggestions to help the team deal with the child pain sensation within the burn sector.

The participants were identified numerically in the order in which data were collected, regardless of their gender or professional category, in order to preserve their personal identity, since there are few nurses and professionals of the male gender. A spell checking was performed as well as the removal of language defects in order to facilitate the reading and understanding of the data. The data analysis was conducted on the Method of Interpretation of the Senses, which are characterized by the interpretation of words, actions, set of inter-relationships, among other metrics, described from the interpretative analysis that involves the cultural systematization. It had the objective of advancing beyond the texts and increasingly approaching the comprehensive and critical phase that permeates the subjective dimension of a given context.¹⁰

The Interpretative Anthropology, linked to the current ethnographic formulated by Geertz, was used as the theoretical framework for the discussion of this study. This framework makes it possible to step inside and understand the world these professionals through their own statements, because the structure of human existence, the uniqueness of each individual and the details of life and culture experienced.¹¹ Therefore, the results and discussion of the research were presented, after deep analysis and correlation of the data collected, based on the categories found: The feelings that arise in the experience of care for the burned child and coping strategies in care to the burned child. All procedures were approved by the Ethics Committee in Research Involving Human Beings at the State University of Londrina, Protocol No. 010/2011, and CAAE No 0267.0.268.000 10.

Results

Of the 16 participants, two were male and 14 female, were between 27 and 51 years of age and

two to four years working in the researched sector, being that 8 already had previous experience with children. Two of them have worked for 12 years in pediatric units.

The feelings that arise in the experience of caring for the burned child

The cultural question is directly involved with the care process. There are professionals who are more emotional and caring; others are more rational, and speak little. Thus, each one has specific characteristics, experiences and beliefs that influence their coping actions. The reactions of each child may also influence the way that they employ the care. The more calm and cooperatives tend to be cared for with greater patience and attention, on the contrary, the more aggressive and little collaborative in general cause complaints from the staff.

While caring for small patients, many of those interviewed reported that imagining their children in that situation, which, on the one hand, caused them suffering. On the other hand they became more dedicated and their care, more humanized: *You imagine as if it was your child, you have to imagine as if it was your child, how to take care of your child. [...] for example, I have two children, [...], everything that happens that day you worry about your child* (Participant 1).

The professional said put yourself in the place of the mother and/or the family for a few moments. Those who experience the delicate health situation, marked by suffering and anxiety and constant by the dependence of the support of unknown, for which delivery care of the child, as in the following report. *[...] I put myself in place of the mother, I imagine my daughter, then I think that suffering for me with the child is greater[...] I imagine my daughter instead, empathy, in the in place of that mother, by putting our child in the place of that child, it is difficult, it is difficult* (Participant 3).

According to some professionals, not only the members of the family, but, in some cases, the

child itself demonstrates guilt, because he believes that everything occurred by disobedience to parents or by foolishness with friends. This fact makes the situation even more distressing because, in addition to live with the pain of the injuries, the child needs to deal with the guilt of being hospitalized and see the grieving parents. *[...] there are children who become extremely anxious, because it reminds them very much of the time that the burn happened, and many times it is interesting, because when the child is burnt from their foolishness, when they remembers they feel guilty, they think, "why didn't I obey my mother". Therefore, they suffers a lot with this* (Participant 4).

There are still those who blame those responsible for their care, which interferes negatively in procedures and in the relationship with the team. *[...] there are families that instead of helping you, sometimes they even interfere in your work, sometimes you want to position, something, "ah, but if you move she will feel more, don't move them, I don't want you to move them,"[...] I think that the greatest difficulty, it is up to the family accept the treatment, because they see that you causes more pain in the child, they see you as an enemy, [...] sometimes the child is crying and the mother will not let you get close [...]* (Participant 5).

While immersing yourself in the cultural world of the patient and their family, the professional, as well as establishing a system of communication and socialization, which is crucial to the efficiency of the treatment, creates an emotional involvement able to influence their way of acting and thinking. *[...] We greatly sympathize [...] every child is very special, because [...] we have children who come here and leave that mark [...] just the other day [...] I got a child, [...] he was in pain, you could see he was moaning, he said this "thank you auntie ok" [...] you're so grateful, because you say geez, poor boy, is dying of pain, everything is burned and auntie thank you very much [...] I'm very emotional (participant cries)* (participant 6).

However, the interaction with the suffering of others, especially when it involves children,

makes the care become more of a challenge than a motivation for some members of the team, as you can see in the following statement. [...] *I thought to myself, who have had experience caring for children before, it was a matter of having a training session to remember and I would not have much trouble, but the issue is not a technical problem, but for me, taking care of a burned child often brings me great suffering [...]* (Participant 4).

Coping strategies in the care of a burned child

One of the interviewees reported that, due to the emotional shock generated by hospitalization, especially in CTQ, the child patient becomes vulnerable and fragile, changing, including, their behavior, in a curious and regressive manner: [...] *we even perceive a change in behavior among mothers, fathers and children [...]* Sometimes they even regress. Once came a child 4-5 years came speaking like a little baby, you know that she wants to wear diapers and use a pacifier again. [...] *a child who didn't have the custom of having the mother time whole, and suddenly has [...]* because the mother is forced to stand by her, we realize that is where she regresses to draw attention as well (Participant 2).

Another limitation is the difficulty in establishing communication with the child, the young age and, consequently, the lack of mastery of speech, or suspicion and fear of the unknown. *It is more difficult [...]* because the child feels pain and sometimes [...] *does not speak, they cry depending on their age, then it is more complicated for you thus have access to the child even so, at the beginning they are very distant from you, then it is difficult you communicate with them* (Participant 7).

This difficulty is reflected in the child's team, mainly because the hospitalization of burn victims involves suffering and constant anxiety because they are subjected to painful care during a phase of life in which leave their routine and it is scary and stressful. The following report highlights this

condition: *And children have to be hospitalized, bedridden, burn patients have to stay at rest, grafting, debridement, then imagine for a child who is very active, running, playing all day, having to stay most of the time without being able to move around sometimes play or because of the bandage or sedation* (Participant 5).

Look and worry about the child, a being who has a future ahead, but whose image, marked by sequels, probably will influence their path, decisions and friendships, it is not always easy for those professionals who are key elements in the care for pediatric patient burn victims. This question can also influence the shape of the child to be and be seen as a person in a world full of prejudices and judgments. [...] *we need that give the utmost of care [...]* how are you going to treat because we have to think that this child will grow and how they will be later, as we will return the child to society, to their family [...] *I think sometimes we tend to take better care of a child, also by the fact that they are young, thinking about how they will be in the future, so for me it means you have to give double and triple care* (Participant 8).

According to the interviewees often, the child knows that they will be the target of teasing among peers, thus seeking to isolate and avoid contact with other people: [...] *the trauma that they will have their life is very great, because they'll be with marks; they'll have scars, so you put yourself in their place. It's happened to have child left here saying he was not going back to school because their friends were talking about he turned gay because he was pink [...]* (Participant 3).

It is in this context that enters humanized care, because this, in addition to alleviating the suffering reveals itself as an opportunity to approach and gaining the trust of the little patient, as pointed out by one respondent. [...] *you take care of the child; you have affection for that child [...]* in terms of humanization I think that child care it even better than adult care. (Why?) *Because children, from the moment you earn them, have*

affection for them, surely they will like you, they will always want you to take care of them (Participant 1).

Attitudes of compassion, however, do not only benefit the children, but also the professionals themselves. For Participant 1: the simple fact of professional knowing that the small and anxious patient trust in them and in their work is already reason to feel honored by the effort and dedication for the recovery of their well-being. Now Participant 4 went beyond. Considering their work is a mix of suffering and gratification. While it is distressing to live with a small patient in an unfortunate situation, it is also gratifying to witness the admirable way as the child recovers. As can be seen in the following reports, it is important to recognize that the professional also contributed to a happy outcome, even after a difficult path: *[...] you have affection for a child, [...] they will have confidence in you, then it is rewarding, I like children* (Participant 1); *[...] while it is one thing that really stirs with me, which causes me even suffering, it is also a job that gratifies me very much. Because the child they actually mark us a lot [...] you see them calling you and saying, "Auntie, the doctor said I'm leaving," those who have already been able to write and leave a note and this is very rewarding. When we finish our shift, tired and say, "Oh my I can't wait to see my bed," but you get there in the outpatient clinic and they say, "Hi auntie you came to see me!"* (Participant 4)

Discussion

Childhood is a period of life in which the dependency generates moments of insecurity when the Infant is faced with the situation that they are taken away from their usual routine. The hospitalization is a scenario that exemplifies well this condition by distancing them from friends, family, their home and coziness of what was convenient and safe. The majority of health care professionals are not prepared to care for the child client in a hospital environment, because they are

not always able to relate the manifestations of aggressiveness with feelings of fear and insecurity of the unknown.¹² In general, patients who have constant complaints, cry or mourn more intensely are regarded as exaggerated and scandalous by the team.¹³ This interpretation may have relationship with cultural aspects of the professionals involved, which influence their evaluation facing the manifestations if the individual's care.¹³

On the other hand, to witness moments of suffering and the child's family, the professional immediately remembers their children and other relatives.^{14,15} The image of a loved one in a similar situation, instinctively, cause anguish and concern, because, in any event, you don't want to see them experiencing this kind of suffering. The feeling of empathy, which emerges, when experiencing hypothetical misfortune, leads to decisions, sometimes even more careful. For the family members who experienced the situation, however, the coping is still much more difficult, resulting from the coexistence with the feeling of guilt that emerges to observe every tear of pain and despair of the child, due to the fact that most accidents occur in a domestic environment, under the supervision of an adult.^{3,16} Whereas by an oversight, is faced with the child in serious condition, with several injuries and constant pain, being subjected to daily highly traumatic procedures.

As these accidents, most of the times, could be prevented, it is common for the feeling of guilt, even if not always this is clearly expressed by the parties involved.¹⁷ However, for most families, small falls and light abrasions are part of everyday life and the child's learning and do not require major concerns. In cases that involve impairment of physical integrity or strong feeling of loss, however, the feelings of guilt and shame experienced by the parents increase their suffering not only because they believe that they have contributed, unconsciously, for the occurrence of the accident, but also because they feel that, culturally, outside of standards established by the society in general.¹⁸ The parents should be, for the population in general, the greatest protectors

of their children, so that, when the burns occur in the presence of one of them, just the same they feel they are not fulfilling their role properly or incapable of such a role.

The period of hospitalization in burned child is long and intense, depending on location and area of the body affected, which involves deep knowledge of the history of life, emotional involvement and attachment to patients by professionals. They usually engage with the family, the situation of children hospitalized because they want to offer support and comfort, however, are often blamed for causing pain, and suffering to the child during the basic care provided,¹⁴ the fact is that causes discomfort, since their intention is to help and assist in patient recovery. In addition the pleas suffered by the team, prolonged hospitalization, anxiety and stress caused by the condition and the physical fatigue also tend to instigate disagreements between families and professionals, which results in wear and ultimately affect the quality of care provided.^{6,19}

For parents, while more protective of their children, to see them in such a vulnerable situation as in a hospital bed tends to encourage them to take the process of observation and perception and keener critical because the protective instinct is most active. They start to notice every attitude and behavior of professionals caring for the child; how they act and why they do, their gestures, care towards family, and especially the patient.²⁰ To develop a critical view of acceptability and positive face of hostile attitudes of caregivers, professionals must know the cultural context in which the family is inserted. Understanding their customs not only provides the development of a communication link and knowledge between the individuals involved, as it facilitates the understanding and socializing with the differences.^{13,18}

As the burn victim child tends to stay more time hospitalized in comparison to other pathologies in childhood, this study proposes that the healthcare staff use this time in their favor to strengthen the capacity of caring and if inter-relate with the patient and their family members.²¹ Moreover,

it is necessary that the professional seek to understand the concepts of the other, not in a global nor individual manner. It is necessary to learn about the individual in their world, in their simplicity, character, way of being, act and interact based on physical aspects, psychological, social, and cultural that composes the individual and their genuine evolution.¹¹

Knowledge of The cultural aspects of the groups with which he works assists the team in the preparation of educational strategies and guidelines, as well as, in the assimilation of the family as to what needs to be exposed, which facilitates the process of cure and prevention and prevents this act as judge of the situation.^{4,18} Study¹³ revealed that, for the nursing team who works daily with burned patients, taking care of the child is much more difficult and stressful, especially at the time of the procedures which are indispensable, as the diaper changing and the dressing, due to the high degree of pain involved in such cases. For the authors, such a situation can result in feeling of limitation, because the circumstances are difficult to alter with the passing of time. However, the team can take ownership and adopt alternatives that mitigate the suffering of patients and, consequently, theirs.¹³

In this regard, a strategy to be deployed would be the multidisciplinary team, which includes the occupational therapist and psychologist, to meet and accompany the professionals with the aim of relieving the tension that burdens them on the daily basis. However, the insertion of both sector professionals studied is limited only to the children and their families, while reserving little or no attention to the professionals involved in daily care of these patients. However, even with the accompaniment of a psychologist, the process of hospitalization, many times, remains incomprehensible to the child, because it creates fear, inability and induces a series of behaviors and emotional instability, due to the alteration of their habits and routines, which are exacerbated in the absence of any family member.²²

The child development depends not only on biological aspects also suffering influences of the

environment, so that in order to adapt can react in various ways. While in a disease situation, the hospitalized child is subjected to invasive care, such as venous access and dressing, which limit their movements to play, walking or running.²³ The adaptation becomes more difficult, when the assistance is carried out in an impersonal way, little considering the development phase in which they are situated.²³ These situations require reflections on the gaps in existing in affective care offered to the child, who needs complete care, directed also towards emotional issues and not only to the technical and biological standards, in addition to nursing professionals being prepared to meet such requirements.¹⁹

The humanized care is a topic much discussed in the area of health, but has a unique significance in assistance the hospitalized child, because childhood has peculiar circumstances, and involvement is not only the patient, but also their family. The first contact requires caution and the conquest of confidence requires commitment and patience. For these patients and caretakers simple gestures of partnership and attitudes of interest in direct care to form more individualized and personal acts are justified as being respectable, which makes the hospital more tolerable and less traumatic care.²⁰

One of the most difficult barriers to be overcome in the care of pediatric patients is, therefore, the first contact and it depends on the establishment of a relationship of permanent trust. Many times, to talk with the child, it is necessary to penetrate their imaginary world of "make-believe",²⁴ mainly, by means of a toy, an effective method of communication and mutual cooperation⁴ that facilitates the approximation. Unfortunately, the unit under study this practice is not adopted, nor is there a qualified professional to use the toy with the child. By being a mixed sector, with adult and pediatric patients, there are few specialized staff or with some experience in the children's area, which prevents an assist closer, which is a service that is based on mutual professional / patient understanding in practicing better and more integrated care.

Among the factors identified by parents during the hospitalization of the child are the knowledge and practice of professional towards the needs of the pediatric patient. This is justified, in addition to the overprotection of the parents, by countless peculiarities of childhood, such as physiological and emotional immaturity, and vulnerability to various pathologies and accidents, such as the burns.²⁰ In its more aggressive forms, burns affecting the child, most of the times, to spend a long period hospitalized, away from social conviviality and family, in addition to exposure to a high physical suffering, characterized by intense pain and stressful procedures, carried out by unknown persons in an atypical environment.⁶ In addition, even if the child recuperates and their skin is re-adapted, scars and contractures important may change your body image, sometimes, in a permanent way, which results in possible and frequent "social death", with involvement of emotional aspects, social and financial damages, both for the family and for society.¹⁶ The community is not always prepared to receive an individual culturally judged by their appearance, since it differs from the conventional standards of external beauty.¹⁸

People; usually tend to establish criteria considered normal in order to create a conducive link in proposing a relationship with each other. Thus, when an individual is seen as different from what they should be, this becomes less desirable and passes to be classified as a creature defective and inferior, what is called a stigma.²⁵ This term that came in Greek culture, has a pejorative sense and with respect to the physical scars caused by cuts or fire; in ancient Greece, it defined the moral status of an individual, according to the social class in which they exist.²⁵ Thus, the person becomes stigmatized configuring them as a discredited individual, when the Deviant factor is apparent and expected, or unbelievable, when pathological features are not perceptible or known. In addition, the individual can strive and try to improve, use the problem as an excuse for their failures, or hide, making them, in this case, in a depressed, anxious and hostile person.²⁵

There are three types of stigmas in accordance with the same author: the abomination of the body, the guilt of character and the stigmas of race, nation or religion.²⁴ In the case of burned children, the permanent marks on your body represent the attribute does not expected by others, who may develop stigmatizing reactions, i.e. isolate, ignore or defame them. Thus, the presence of so-called normal, the child may feel insecure and exposed in a disrespectful manner. In the case of the child, there is another aspect to be considered, that is the fact that the family is always present and ending up, thus, being victim of judgments imposed by society, which is called as stigma of courtesy.²⁵ For still being in early life, the way the child and their family face the looks and malicious attitudes of other will define the consequences for their future. Dealing with the judgment of others is difficult and painful for the child and their family members, for that which is visible to the eyes of others is subject to evaluation and selection for full socializing, requiring often the penalized to stay permanently inside their homes, as well as to change their lifestyle habits. In this context, families come to hide the child due to the shame and fear.¹⁸

Caring is part of life. The healthcare team, as a source of care, searches to alleviate the suffering of the patient by means of a more humanized care. Philosophically, there are two types of care: what you do for the other to grow; and what organizes and gives meaning to life. The latter is what organizes the other values and becomes central, already that assists people to lie in the world.²⁶ For the professional who cares, witnessing the effect of aggression the physical integrity of the child, caused by burns, generates suffering and discomfort, as well as concern and anxiety before the responsibility to relieve this pain and rebuild their body and mental image, even considering the peculiarities of the treatment. However, the suffering experienced by the team is replaced by a sense of satisfaction when, subsequently, the professional is faced with the result of their commitment and dedication, to see the child recovered and smiling, returning home.¹⁴

Often trying to alleviate this suffering, professionals can have passive attitudes or even dispose complaints of their patients as a way not to witness situations that cause emotional stress, especially in an environment where the relationship with the patient and their family becomes unavoidable by the time of hospitalization and the feeling of empathy created.²⁷ The outcome, however, is not always positive, because the death rates of burn victim children are high. In this context, it is worth highlighting that preventative campaigns have a fundamental role in reducing the incidence of this type of accident.³

Final considerations. It was possible to realize how scary the admission process for the burn victim patient is. This situation is made worse when communication with the health care team is a failure, as in the case of the child, because few are able to understand their crying, their ways or behavior. The nursing staff needs to hear constantly the parents and caretakers, because they know the child well, and their needs, characteristics, and how they manifest their desires. This will contribute significantly to better quality care and efficiency given that the admission of the burned child tends to be prolonged and particularly painful.

Perceiving themselves as “responsible” for the pain of the children during the care produces distressing feelings in the team. On the other hand, there is the perception of the role fulfilled and the satisfaction in seeing the recovery as expected, in a process where everyone is dedicated. Still, it is important to create spaces for professionals to expose their own feelings as a way to relieve the tension generated during their work. For burned children, the process is extremely stressful, due to painful procedures and the physical and emotional consequences that accompany after the discharge and hinder their re-socialization. The professionals involved in the care, especially nursing, are responsible for comprehensive care and for the way these patients return to their social life.

There is no doubt that the best way to avoid these sorrows and anguish is prevention. The health

teams should be involved in the dissemination of preventive information, by means of guidance and campaigns, strategies that are still with low visibility and little explored in Brazil, even with the high indices of burn victims, especially in childhood.

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