PRÁTICAS EDUCATIVAS, MEMÓRIAS E ORALIDADES

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Implementation of interdisciplinary visits in pediatrics: development and validation of an operational guideline

PEDAGOGIC PRODUCT

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Abstract

Introduction: Hospital bedside visits allow access to relevant information, clarification of immediate doubts and inclusion of patients and family members in care, favoring a more humanized care. This methodological study has three stages: literature review, development of the educational product and validation by experts, using the content validation coefficient (CVC) and the percentage of agreement. The literature review highlighted Patient and Family Centered Care, safety, teamwork and communication. The product was validated by 19 experts, reaching the necessary CVC and being adjusted according to suggestions. The guideline systematizes interdisciplinary practices, strengthening continuing education and improving the quality of pediatric care, aligning with the principles of the Unified Health System.

Keywords: Interdisciplinary Visit. Pediatrics. Validation Study. Health Teaching.

Implementação de visitas interdisciplinares em pediatria: desenvolvimento e validação de diretriz operacional

Resumo

As visitas à beira do leito hospitalar permitem o acesso a informações relevantes, esclarecimento de dúvidas imediatas e inclusão de pacientes e familiares no cuidado, favorecendo um atendimento mais humanizado. Este estudo metodológico tem três etapas: revisão de literatura, elaboração do produto educacional e validação por especialistas, utilizando o coeficiente de validação de conteúdo (CVC) e a porcentagem de concordância. A revisão de literatura destacou o Cuidado Centrado no Paciente e Familiar, segurança, trabalho em equipe e comunicação. O produto foi validado por 19 especialistas, atingindo o CVC necessário e sendo ajustado conforme sugestões. A diretriz sistematiza práticas interdisciplinares, fortalecendo a educação permanente e melhorando a qualidade do cuidado pediátrico, alinhando-se aos princípios do Sistema Único de Saúde.

Palavras-chave: Visita Interdisciplinar. Pediatria. Estudo de Validação. Ensino em Saúde.

1 Introduction

Most medical visits still predominantly follow the biomedical—or mechanistic—model, which emerged during the Renaissance and is grounded in a Cartesian view of medicine. This model establishes a clear division between physician and patient, generating a certain distance between them (Barros, 2002).

In the traditional model, the physician assumes a central and active role, collecting information and conducting clinical reasoning to determine diagnosis and treatment. However, this approach tends to disregard the patient's perspective, perceptions, and expectations, as well as the social consequences and daily routines of the individual. The absence of active patient participation in the decision-making process suggests a relationship of authority and superiority on the part of the physician (Barbosa; Ribeiro, 2016).

This model of medical visits is considered insufficient for excluding essential aspects of the illness process (Wanderley *et al.*, 2020). The critique of the biomedical model, as pointed out by Cutolo (2006), highlights the need for a more holistic approach that integrates not only physical aspects but also the social and emotional context of the patient. Although medical specialization has brought significant advances, it often results in a fragmented view of care.

In a study by Shivananda *et al.* (2022), family members and health professionals expressed concerns about traditional medical visits, considering them inconsistent and inefficient due to variations in start times, duration, sequence of reports and visits, as well as lack of preparation and limited engagement of families and teams. Interprofessionality has become increasingly relevant in the health sector, being incorporated by professional organizations, accreditation agencies, and credentialing institutions. Interprofessional clinical and operational practice arises as a response to the recognition that the traditional model of care—in which professionals from different fields work in parallel rather than in an integrated manner—limits the capacity of health

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professionals to address persistent challenges and achieve optimal outcomes for patients and their families (Baird; Ashland; Rosenbluth, 2019).

In contrast to fragmented knowledge, interdisciplinarity emerged as a way to unite different disciplines to solve everyday problems, while interprofessionality is linked to professional practice, focusing on collaboration among various fields to meet patients' needs and organize health services (Spagnol *et al.*, 2022).

In this context, the implementation of an interprofessional and interdisciplinary teamwork model is essential to ensure comprehensive care. This collaborative synergy extends beyond the team itself, encompassing a network-based practice with professionals, patients, families, and the community, aiming to improve the quality of care provided (Peduzzi *et al.*, 2020). This approach is directly aligned with the concept of Family- and Patient-Centered Care (FPCC), which, according to the American Academy of Pediatrics (AAP), recognizes the family as the primary source of support and values the perspectives of patients and families as integral partners of the healthcare team. Such partnerships can lead to better patient outcomes, increased professional satisfaction, cost reduction, and more efficient resource use (Ernst, 2020).

According to Castaneda (2019), the biopsychosocial model arises from the need to complement biomedical knowledge with a broader view of health, considering not only physical aspects but also experiences related to body functions and structures, activities, participation, and environmental and personal factors. This model seeks to meet patients' needs in a comprehensive and personalized way, with the healthcare team focusing on prevention as well as clinical and psychological treatment, using technology when necessary.

In 1892, physician Sir William Osler stated that real learning in medicine occurs at the patient's bedside, not only in classrooms. He emphasized that doctors should learn directly from patients by observing their conditions, listening to their stories, and understanding their needs. This teaching method is particularly valuable because it allows healthcare professionals to develop a more human and effective connection with patients (Ngo; Blankenburg; Yu, 2019). Osler also emphasized that the joint presence of patients,

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families, and members of the healthcare team, combined with accumulated knowledge and experience, creates an extremely rich learning environment (Destino; Shah; Good, 2019).

Bedside visiting practices provide professionals with access to important visual information, allow for the immediate clarification of doubts, and enable patients and caregivers to actively participate in the care process. This approach promotes more humanized and patient-centered care (Minagorre *et al.*, 2023). Among the benefits of these visits are increased patient satisfaction, more effective communication, reduced hospital stays, better understanding of information, greater family trust in the medical team, and less anxiety among family members (Pegorin; Santos; Angelo, 2021).

The *Educação Permanente em Saúde – EPS* (Permanent Education in Health – PEH), established by the Ministry of Health, aims to qualify professionals within the *Sistema Único de Saúde – SUS* (Unified Health System) and to transform work practices according to system demands (Brasil, 2009). In light of technological advances, PEH has been consolidated as a strategy to train reflective professionals, promoting interprofessional integration and innovation in work processes (Santos *et al.*, 2021).

Using professional daily life as a learning foundation, PEH values the integration of knowledge and the use of technologies to solve problems and adapt educational practices to local realities. In this context, the *Produto Educacional* – PE (Educational Product – EP) emerges as a strategic tool developed through research to improve practices and foster critical and reflective learning (Biasibetti *et al.*, 2019; Locatelli; Rosa, 2015).

The adoption of active teaching methodologies is seen as a way to strengthen students' autonomy and engagement (Faria; Martins; Cristo, 2015). These approaches, which prioritize the combination of knowledge and critical-reflective thinking, are enhanced through the use of digital technologies. In this way, active methodologies encourage proactivity, interaction between students and teachers, and connect learning to real-world contexts, aiming to increase participants' commitment to transforming their surrounding environment (Lima, 2017).

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Motivated by the absence of interdisciplinary visits in a pediatric ward, the researcher proposed a project to create and validate a guideline aimed at implementing this practice.

The expectation is to improve the quality of care for patients and families, enhance teamwork, and consequently reduce costs and improve hospital bed turnover. The central hypothesis is that an educational product focused on family-centered care can be an effective strategy for achieving comprehensive care. The objective of this study is to describe the creation and validation of this educational technology, which will serve as an operational guideline.

2 Methodology

This is a methodological study that adopts a quantitative approach to develop and validate an educational product. This instrument aims to implement structured interdisciplinary and interprofessional visits in pediatric wards in a systematic way and was developed in three stages.

The *Produto Educacional – PE* (Educational Product – EP), entitled *Operational Guideline for the Implementation of Interdisciplinary and Interprofessional Visits Centered on the Patient and Family in Pediatric Wards*, originates from a master's dissertation in the Professional Master's Program in Innovation in Higher Education in Health at the Universidade Municipal de São Caetano do Sul (2024), entitled *Construction and Validation of an Educational Product for the Implementation of Interdisciplinary and Interprofessional Visits Centered on the Patient and Family in Pediatric Wards*.

As specific objectives, the EP aims to consolidate a collaborative and systematized practice of interdisciplinary and interprofessional visits in pediatric wards, ensuring comprehensive and patient- and family-centered care. Initially, the study presents an operational guideline and the conceptual foundations supporting the implementation of these visits, providing a theoretical and practical basis for the professionals involved.

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In addition, a multidimensional admission form and a post-visit documentation form were developed to allow detailed monitoring and historical tracking of the interventions performed. Complementarily, an implementation protocol is proposed to structure the visiting process, clearly defining the steps and responsibilities of each team member.

To bring patients and families closer to this process, a best practices manual was also developed to guide professionals on recommended principles and conduct, along with an explanatory brochure containing accessible information about the visits, aiming to promote understanding and adherence to the proposed care model. The study also seeks to encourage discussion of clinical cases among professionals, fostering continuous learning and the improvement of hospital care practices.

Another objective is to improve the teaching–learning process among team members, promoting collaboration across different professional fields and encouraging the joint development of competencies. Finally, the study outlines a strategy for Family- and Patient-Centered Care (FPCC), ensuring that care is humanized and aligned with the needs and expectations of all those involved. The target audience of the EP consists of healthcare professionals from various specialties working in pediatric wards.

Regarding the material's complexity, it is considered low, since it was developed based on professional practical observation and is linked to the research and dissertation. The type of impact is potential, as the benefits foreseen by the researcher have not yet been fully achieved but are expected with the material's use. The impact area mainly covers the healthcare sector. The overall impact is also considered low, as the material was conceived from practical observation and is directly related to the research and dissertation. The material's replicability is feasible, and its scope is national. Its innovative content is rated as low, given that it is adapted from pre-existing knowledge. The technology stage is considered pilot, indicating that the material is still in a testing and initial implementation phase.

It was developed in three stages: a narrative literature review, product design, and validation.

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2.1 First Stage: Narrative Review

In the first stage, a narrative literature review was conducted. This is a non-systematic literature review approach that provides rapid updates on a specific topic. Such methodology offers relevant theoretical support, helping to describe the current state of knowledge on a subject, whether from a theoretical or contextual perspective (Soares *et al.*, 2013).

The review for the development of the EP focused on best practices in pediatric visits and interprofessional practices in hospital settings. Searches were carried out between October 2023 and June 2024 in scientific databases such as PubMed, SciELO, and the Biblioteca Virtual em Saúde – BVS (Virtual Health Library – VHL) to locate relevant articles, systematic reviews, and high-quality studies essential to theoretically ground the research with recent and reliable data. The descriptors used were: “Family- and Patient-Centered Care,” “Interdisciplinary Visit,” “Comprehensiveness,” “Health Education,” “Validation,” “Protocols,” “Pediatrics,” “Communication,” “Patient Safety,” “Collaborative Interprofessional Practice,” “Disciplinary,” “Pediatric Protocols,” and “Hospital Pediatrics.” The most recent guidelines from SUS (Unified Health System), HumanizaSUS, and the World Health Organization were also considered.

At this stage, the research was broad and well-founded. The proposed methodology included the use of diverse information sources, such as searches in both white and gray literature. White literature comprises formal materials widely accessible to the public, such as books, dictionaries, journal articles, and book chapters. In contrast, gray literature refers to nonconventional or hard-to-access publications that require more in-depth searches. This type of literature includes dissertations, academic papers, educational products, government publications, technical reports, and theses (Botelho; Oliveira, 2015; Sipriano; Souza; Pereira, 2024).

The search for theses and dissertations was carried out in the *Catálogo de Teses e Dissertações da Coordenação de Aperfeiçoamento de Pessoal de Nível Superior – CAPES* (Catalog of Theses and Dissertations of the Coordination for the Improvement of

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Higher Education Personnel – CAPES) between October 2023 and June 2024. The descriptors used were: “Family- and Patient-Centered Care,” “Interdisciplinary Visit,” “Comprehensiveness,” “Health Education,” “Validation,” “Protocols,” “Pediatrics,” “Communication,” “Patient Safety,” “Collaborative Interprofessional Practice,” “Disciplinary,” “Pediatric Protocols,” and “Hospital Pediatrics.”

2.2 Second Stage: Development of the Educational Product

The second stage was carried out through the compilation of gray and white literature, as cited in the first stage, using the Canva and Word applications to create the product. In this phase, an operational guideline and a protocol for implementing interdisciplinary and interprofessional visits in pediatric wards were developed as an educational instrument aligned with the principles of SUS.

During the development of the PE, the need arose to implement an operational guideline composed of: a Best Practices Manual, which guides professionals regarding recommended principles and conduct; an implementation protocol, detailing the process and steps to be followed during interdisciplinary visits; an explanatory brochure aimed at patients and family members, providing clear information about the process; and two support instruments for the visits: an admission form, which gathers the patient’s initial and essential information, and a documentation form for recording observations and interventions carried out during the visits.

The EP consists of: Best Practices Manual for Interprofessional and Interdisciplinary Visits Centered on the Patient and Family in Pediatric Wards; Protocol for the Implementation of Interdisciplinary and Interprofessional Visits Centered on the Patient and Family in Wards; Explanatory Brochure for Patients and Families; and Support Instruments for the Visits.

The Best Practices Manual comprises conceptual aspects; interdisciplinary and interprofessional collaborative team centered on the patient and their family; justification; benefits of interdisciplinary and interprofessional visits; necessary elements; general and

specific objectives; eligibility criteria; frequency; location; assignment of responsibilities among team members; preliminary clinical discussion; dynamics of the interprofessional visit; completion of medical records; and hospital discharge.

The protocol developed for the implementation of interdisciplinary and interprofessional visits centered on the patient consists of eligibility criteria, frequency, location, fixed team, preliminary clinical discussion, administrative steps to be checked, and a step-by-step guide for conducting the visit. It was designed based on the works of Farias (2021), Santos *et al.* (2020), Conselho Regional de Enfermagem de Sergipe (2017), and Gardner *et al.* (2022).

The explanatory brochure for patients and families illustrates the interdisciplinary visit, explaining how to participate in order to provide high-quality and safer care for the patient, as well as presenting its frequency, location, and participating team members.

In addition, two other instruments were created by the researcher: the Multidimensional Admission Form and the Post-Visit Documentation Form for Interdisciplinary Visits Centered on the Patient and Family. These instruments are intended for use by professionals during the visit.

The admission form contains patient information and personal history such as allergies, comorbidities, previous surgeries, recent antibiotic use, and prior hospitalizations. It also includes information on direct family history, usual diet, screen use, physical exercise habits, continuous medication use, patient's risk classification upon admission, fall risk information, cultural/religious aspects, communication with the patient and family, and other relevant details.

The documentation form contains the patient's personal data, test results, therapeutic plan, hospitalization information, expected discharge date, and other relevant information related to the hospital stay.

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2.3 Third Stage: Validation of the Educational Product

The validation of the EP began with the definition of inclusion criteria for selecting the expert judges who participated in the study. Professionals with at least two years of experience in interdisciplinary teams or in clinical care practices in the field of pediatrics were selected. Specialists were also considered eligible if they had publications in scientific journals or participation in events on the development and validation of Educational Technologies (ET), as well as those with specific experience in ET, a master's or doctoral degree in this area, or membership in scientific societies related to ET.

Regarding the exclusion criteria, professionals who did not accept the invitation to participate in the study were excluded, either due to lack of response to the email within the established 15-day period for data collection or for not meeting the inclusion criteria.

After defining the inclusion and exclusion criteria, 79 specialists from different regions of the country were invited, selected through searches on the *Plataforma Lattes* and by convenience sampling, based on their areas of expertise and research. To broaden participation and include professionals from interdisciplinary teams with pediatric practice experience who might not be registered on the *Plataforma Lattes*, specialists accessible to the researcher were also invited. Thus, the validation process involved judges chosen through intentional and convenience sampling.

The expert judges individually received an invitation letter via email in May 2024, explaining the research objectives, the *Termo de Consentimento Livre e Esclarecido – TCLE* (Free and Informed Consent Form – FICF), and a questionnaire divided into two sections: (a) sample characterization and (b) validation instrument for the guidelines. Participation included the possibility of a second round, should it be necessary to review the reformulated version of the guidelines after the first evaluation.

The study followed the guidelines of Resolution No. 466/2012 of the CEP/CONEP System, ensuring the protection of participants involved in health research, under approval number 6.340.223. Participation was voluntary and informed, with consent obtained

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https://revistas.uece.br/index.php/revpemo
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through the online signing of the FICF, and all participants had their identities protected with confidentiality and anonymity.

Participants were informed about the minimal risk involved in the study, which included possible discomfort when responding to the validation instrument for the guidelines—such as disagreeing with items or identifying issues in the protocol—as well as the time required to complete the questionnaire. To mitigate these risks, the researcher remained available for clarification and support. Participants had full access to the material and could request the removal of any information without prejudice.

The benefits of participation included the promotion of comprehensive, patient- and family-centered care, improvements in the quality of care provided, strengthening of professional relationships, encouragement of clinical discussions through an interdisciplinary approach, shorter hospital stays, reduction of errors and adverse events, enhanced patient safety, and decreased institutional costs.

Out of the 79 specialists invited, 20 responded to the invitation. After analyzing the participants' profiles, one was excluded for not meeting the inclusion criteria—specifically, the minimum requirement of two years' experience in interdisciplinary teams or pediatric clinical practice. This participant, who worked in the pharmaceutical industry and was unfamiliar with the topic, was not included, resulting in a total of 19 participants in the study.

The number of expert judges was determined based on the criteria proposed by Pasquali *et al.* (2013), who suggest the participation of approximately 20 specialists, with at least three from each field (Medicine, Nursing, Nutrition, and Pharmacy), which together constitute the fixed interdisciplinary team working in the pediatric ward. According to Pasquali *et al.* (2013), the minimum recommended number of judges is six, while Alvarez *et al.* (2018) emphasize that the maximum should be 20, since an excessive number of judges may reduce subjective biases in the evaluations. Data collection was conducted virtually in June 2024 through a questionnaire sent by email using the Google Forms platform.

The questionnaire aimed to assess the Content Validity Coefficient (CVC) and the percentage of agreement among judges, based on the 12 evaluation criteria proposed by

Pasquali and collaborators (Pasquali *et al.*, 2013), following the research conducted by Faria (2021). The instrument measures expert agreement using a Likert scale with three options: 3 – “adequate,” 2 – “partially adequate,” and 1 – “inadequate.” The evaluation criteria are: behavior, objectivity, simplicity, clarity, relevance, precision, variety, modality, typicality, credibility, breadth, and balance.

The data obtained from the Likert scale were organized in Excel, and the CVC was calculated, considering valid those items that showed agreement equal to or greater than 0.80 or 80% among experts (Perdigão *et al.*, 2019). After each validation criterion, open-ended questions were included so that the specialists could provide suggestions, which were then analyzed by the researcher to identify potential adjustments to the product.

The validation followed a sequential seven-phase process. Initially, the process began with the selection of expert judges (Stage 1), followed by data collection (Stage 2) based on their evaluations. In Stage 3, calculation methods such as the CVC were selected to assess inter-rater agreement. Subsequently, data were analyzed quantitatively (Stage 4) using Excel, and the qualitative feedback from judges was analyzed in Stage 5. Based on these analyses, final adjustments to the product were made (Stage 6). The process concluded with Stage 7, which presented the final CVCt result of 0.99570, indicating a high level of validation.

3 Results and Discussion

The validation of the educational product included the participation of 19 specialists, of whom 84.21% were women and 15.79% men, with an average age of 38.9 years. All professionals worked in the state of São Paulo, with 36.85% holding degrees in Nursing and 21.05% in Medicine, Nutrition, and Pharmacy. Each participant had at least two years of experience in an interdisciplinary team or in pediatric clinical care practice, ensuring a solid and specialized foundation for the validation process.

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Figure 1 presents the results of the product validation according to the responses of the expert judges. The evaluation of the EP was based on questions that applied the 12 criteria proposed by Pasquali *et al.* (2013) and Farias (2021).

Figure 1 – Percentage of agreement among judges by item

QUESTÕES	ADEQUADO (3)	PARCIALMENTE ADEQUADO (2)	INADEQUADO (1)
1) O (a) senhor (a) considera a diretriz aplicável, com informações claras e precisas?	100%	0	0
2) O (a) senhor (a) considera que o objetivo proposto é passível de ser alcançado com as instruções fornecidas?	89,50%	10,50%	0
3) O (a) senhor (a) considera que a diretriz apresenta uma ideia única e contínua?	89,50%	10,50%	0
4) O (a) senhor (a) considera o conteúdo compreensível, simples, claro e inequívoco?	89,50%	10,50%	0
5) O (a) senhor (a) considera que a diretriz é pertinente e atende à finalidade proposta?	100%	0	0
6) O (a) senhor (a) considera que os itens presentes são distintos e não propiciam confundimento?	94,70%	5,30%	0
7) O (a) senhor (a) considera que a linguagem é adequada?	89,50%	10,50%	0
8) O (a) senhor (a) considera que o vocabulário é adequado e não gera ambiguidade?	94,70%	5,30%	0
9) O (a) senhor (a) considera que o conteúdo apresenta expressões condizentes com a temática?	94,70%	5,30%	0
10) O (a) senhor (a) considera que a diretriz apresenta uma atitude favorável de utilização e compreensão de conteúdo?	94,70%	5,30%	0
11) O (a) senhor (a) considera que a diretriz é prospectiva suficientemente para a compreensão da temática?	94,70%	5,30%	0
12) O (a) senhor (a) considera que o conteúdo proposto se apresenta de forma equilibrada e coerente?	94,70%	5,30%	0

Source: Research data (2024).

During the validation process, the specialists evaluated the educational product using a questionnaire. Since the Content Validity Coefficient (CVC) was higher than 80%, there was no need for an additional round of evaluations, with a final result of 0.99570. Nevertheless, the researcher reviewed and incorporated the experts' comments and suggestions to improve the material.

The accepted suggestions included changes in technical terminology, redefining the nurse's role to include assessing the family's perception, incorporating discharge

guidance from the moment of admission, and considering cultural aspects. The rejected suggestions included making the brochure more visual (after a pilot test showed lower comprehension), allowing more than one family member to attend meetings (due to hospital policy), and increasing the spacing on the admission form.

The development and validation of the educational product highlight the importance of promoting educational and organizational strategies that strengthen collaboration among healthcare professionals (Pegorin; Santos; Angelo, 2021). The EP is entitled Operational Guideline for the Implementation of Interdisciplinary and Interprofessional Visits Centered on the Patient and Family in Pediatric Wards.

According to Corrêa (2011), guidelines are recommendations developed by experts based on scientific evidence, designed to support both healthcare professionals and patients in making decisions in specific clinical situations. Their central purpose is to improve the quality of care, avoid inadequate decisions, and facilitate the rapid integration of technological advances and updated knowledge into clinical practice. These guidelines cover critical and highly relevant aspects, serving as references for the creation of protocols adapted to the context in which they will be applied.

Operational guidelines, in turn, guide the planning, execution, implementation, and monitoring of health units. They consist of a structured set of standards, procedures, and instructions that direct all stages of development and operation of these units. Such guidelines ensure that operations are carried out in accordance with best practices, promoting efficiency, quality, and safety throughout all phases of healthcare delivery (Prefeitura Municipal de São Paulo, 2016).

In the present study, the following will be presented: the Protocol for the Implementation of Interdisciplinary and Interprofessional Visits Centered on the Patient and Family in Pediatric Wards, the Multidimensional Admission Form, and the Post-Visit Documentation Form for Interdisciplinary Visits Centered on the Patient and Family.

The implementation of guidelines and protocols as systematized technological tools contributes to reducing adverse events and improving the quality of comprehensive

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care. This approach aligns with the best clinical care practices promoted by the UHS (Sousa; Mendes, 2019; Medeiros *et al.*, 2019).

The use of protocols standardizes care delivery, significantly enhancing patient safety. This practice also improves documentation, optimizes the efficiency of visits, and ensures greater integrity in records (Joshi *et al.*, 2022).

Figure 2 presents the protocol for implementing interdisciplinary and interprofessional visits centered on the patient, which can be accessed in both physical and online versions. This protocol was developed based on the literature by Farias (2021), Santos *et al.* (2020), Conselho Regional de Enfermagem de Sergipe (2017), and Gardner *et al.* (2022), and it includes eligibility criteria, frequency, location, composition of a fixed team, preliminary clinical discussion, administrative steps to be verified, and a step-by-step guide for conducting the visit.

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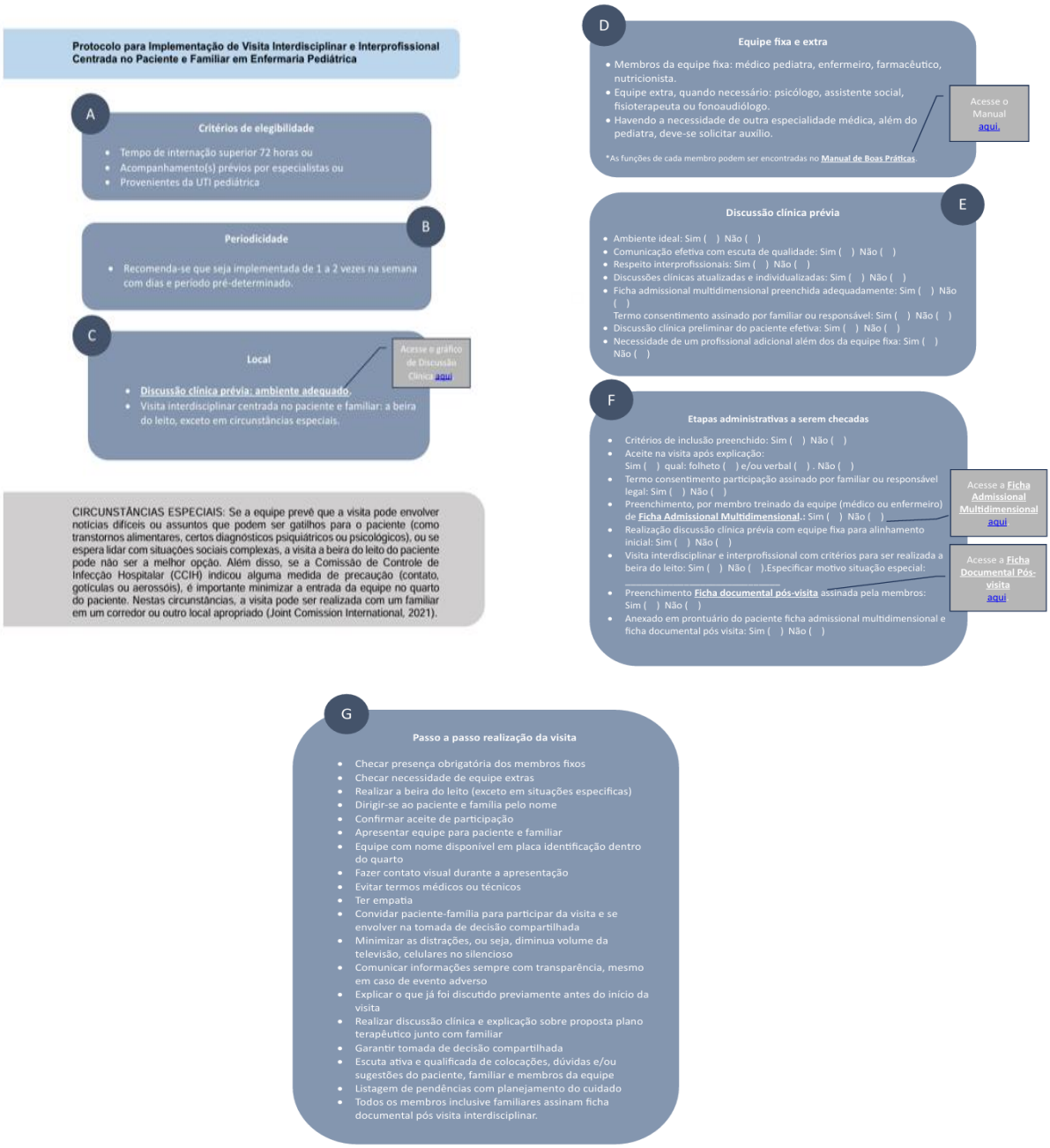
Figure 2 – Protocol for the Implementation of Interdisciplinary and Interprofessional Visits Centered on the Patient



Source: Prepared by the author (2024)

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The use of checklists and information centralization are considered essential tools for ensuring patient safety and quality of care. According to the World Health Organization (WHO) and several authors, standardizing procedures through checklists helps ensure the correct execution of protocols, minimizes errors, and contributes to patient safety during hospitalization (Aranha; Cruz; Pedreira, 2023; Desmedt *et al.*, 2021; Melo; De Noronha; Nascimento, 2022).

These tools also assist in organizing medical records, planning therapeutic interventions, and managing information, in addition to strengthening teamwork and performance among healthcare professionals. In the pediatric context, scientific evidence reinforces that checklists can improve the quality of care, suggesting the need for further research to develop tools specifically designed for this field (Melo; De Noronha; Nascimento, 2022).

The Multidimensional Admission Form (Figure 3) compiles essential patient information, including personal history such as allergies, comorbidities, previous surgeries, recent antibiotic use, and hospitalization history. It also includes direct family history, eating habits, use of electronic devices, physical activity, continuous medication use, risk classification at the time of admission, fall risk assessment, cultural and religious aspects, communication with the patient and family, and other relevant data.

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Figure 3 – Multidimensional Admission Form

Identificação:.....
Prontuário: .....
Atendimento: .....
Data: .....
Idade: .....
Data da internação: .....
Nome do responsável: .....
Religião: .....
Proveniente de qual setor (psi, uti, outro local): .....
Peso: .....
Altura: .....
Motivo internação (História Pregressa da Moléstia Atual): .....
.....
.....

Antecedentes pessoais:
Alergias alimentar: Sim ( ) Qual? ..... | Não ( )
Alergia medicamentosa: Sim ( ) Qual? ..... | Não ( )
Comorbidades: Sim ( ) Qual? ..... | Não ( )
Cirurgias prévias: Sim ( ) Qual? ..... | Não ( )
Uso recente de antibiótico: Sim ( ) Qual? ..... | Não ( )
Internação prévia: Sim ( ) Quando e diagnóstico? .....
..... | Não ( )

Antecedentes Familiares diretos (pais e irmãos):.....
Realiza acompanhamento pediátrico regular: Sim ( ) | Não ( )
Realiza acompanhamento com outra especialidade (exemplo: fisioterapia, fonoaudiologia, psicóloga, médico especialista entre outros):
Sim ( ) Qual? ..... |Não ( )
Carteira de vacinação atualizada: Sim ( ) | Não ( ) | Não sabe informar ( )
Trouxe carteira de vacinação? Sim ( ) | Não ( )

Alimentação habitual:.....
Hábito intestinal regular: Sim ( ) | Não ( ) Frequência:.....
Tempo de tela (horas/dia) : .....
Prática de atividade física: Sim ( ) Qual /Frequência? .....Não ( )
Relação familiar – dinâmica: .....
Uso de medicações habituais: Sim ( ) Qual? ..... | Não ( )
Comunicação com paciente / familiar harmoniosa: Sim ( ) | Não ( )
Observações:.....
Classificação do risco do paciente na internação: Alto ( ) Médio ( ) Baixo ( )
Informado sobre riscos (quedas): Sim ( ) | Não ( )
Explicações funcionamento da unidade, visitas, direitos: Sim ( ) | Não ( )
Explicado sobre visita interdisciplinar: Sim ( ) (panfleto e/ou verbal) | Não ( )
Expectativas da criança e família na internação:.....
Aspectos culturais e/ou religiosos que possam causar conflitos no plano de cuidados? Sim ( ) Qual?.....Não ( )
Assinatura de termo concordância: Sim ( ) | Não ( )

Source: Prepared by the author (2024)

The Post-Visit Documentation Form for Interdisciplinary Visits Centered on the Patient and Family (Figure 4) includes the patient's personal information, test results, therapeutic plan, hospitalization details, expected discharge date, and other important information relevant to the hospitalization period.

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Figure 4 – Post-Visit Documentation Form for Interdisciplinary Visits Centered on the Patient and Family

Identificação: .....

Data: .....

Dia de internação: .....

HD: .....

Intercorrências: .....

Medicações em uso: .....

Uso de Antibióticos: se sim, dia, dose utilizada .....

Reconciliação medicamentosa: .....

Orientação nutricional: .....

Solicitada avaliação outro especialista, além equipe fixa:

Sim ( ) Qual? ..... | Não ( )

Resultado de exames: .....

Acesso: Sim, venoso ( ) Sim, central ( ) | Não ( )

Dreno: Sim ( ), Local: ..... | Não ( )

Sonda: Sim ( ), Tipo: ..... | Não ( )

Pendências: .....

Paciente e familiar sem dúvidas ou questionamentos: Sim ( ) | Não ( )

Relação equipe com paciente / familiar harmoniosa: Sim ( ) | Não ( )

Plano terapêutico proposto: .....

Ocorreu mudança plano terapêutico prévio:

Sim ( ) Qual? ..... | Não ( )

Previsão de alta em dias: .....

Assinatura dos participantes: .....

Source: Prepared by the author (2024)

In the researcher's professional practice, it was observed that pediatric hospital care often lacks interdisciplinary visits and effective inclusion of patients and families as part of the care process. This gap reflects a tendency to prioritize the biomedical model, in which each professional works in isolation and interactions are minimal. According to Spagnol *et al.* (2022), interprofessional practice, on the other hand, values collaboration

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and integration, promoting more comprehensive care and reducing the risks of fragmentation in healthcare delivery.

The physician–patient relationship plays a key role in improving the quality of healthcare services and is supported by components such as the humanization of care, the right to information, and the personalization of assistance (Oliveira; Albertin, 2014). In the researcher's professional experience, it was found that providing excellent pediatric care requires structuring the healthcare team according to the patient's specific needs. This team should be coordinated by the attending pediatrician and may also include medical trainees (when applicable), nurses, nutritionists, pharmacists, and, when necessary, professionals such as physiotherapists, social workers, psychologists, and speech therapists. Support from other medical specialties can be requested individually according to the patient's needs.

A collaborative approach to healthcare requires a shift in power dynamics and a recognition of each professional's contribution, acknowledging that teamwork results in safer, more patient-centered care. To overcome the model of isolated practices, the team must maintain continuous communication, in which transparency with patients and their families allows them to participate in the care process while ensuring that their needs and perspectives are respected. Studies confirm that family engagement improves patient safety and the effectiveness of care (Amboni *et al.*, 2012; Destino; Shah; Good, 2019).

Interdisciplinary visits are an effective strategy for standardizing care and increasing team accountability, fostering collaboration and enhancing the quality of care. The use of tools such as checklists and standardized medical records contributes to safety and continuity of care while involving family members in the process.

This practice also promotes continuing education among professionals, allowing them to share knowledge and refine their skills to provide more comprehensive care focused on the specific needs of each patient (Baird; Ashland; Rosenbluth, 2019).

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4 Final Considerations

The methodological study aimed at developing and validating an educational product for a Pediatric Inpatient Unit allowed the identification of essential steps for creating an operational guideline for interdisciplinary and interprofessional visits. The process included building content based on best practices, developing clear and applicable educational material, and validating it with experts, demonstrating an effective and replicable path for other areas that could also benefit from an interdisciplinary approach.

The developed guideline is grounded in patient- and family-centered care, aligning with the principles of the SUS—comprehensiveness, equity, and universality—while creating opportunities for holistic care. Furthermore, the interdisciplinary visit proved to be an important space for continuing education, promoting learning and integration among team members.

During the research, it was challenging to contact specialists through the Lattes Platform, with few responses from approximately 60 invitations sent, and the literature on interdisciplinary visits in pediatrics was found to be scarce. Future studies could broaden contact with specialists from other regions and explore alternative recruitment platforms.

It is expected that the educational product will improve care for patients and families, enhance the work environment and professional relationships, increase patient safety, reduce adverse events and hospital stay duration, and foster more up-to-date clinical discussions from an interdisciplinary perspective.

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