
Child feeding after palatoplasty: role of nursing staff in the training and evaluation of caregivers

Alimentação da criança após palatoplastia: o papel da equipe de enfermagem na formação e avaliação dos cuidadores

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Abstract

Objective – To promote and evaluate the ability of caregivers in child feeding during the postoperative period after palatoplasty. **Methods** – The sample comprised 44 caregivers of children with cleft lip and palate, trained during hospitalization and evaluated on hospital discharge concerning the care related to child feeding after palatoplasty. The study was conducted in 2010, using a constructed and validated instrument. The ability of caregivers was evaluated using a quantitative instrument and associated with socioeconomic factors. The Fisher exact test was used to analyze the significance of differences between paired samples. **Results** – Among the caregivers, 86% were able for feeding after palatoplasty, and the socioeconomic factors and type of cleft did not influence the acquisition of abilities. **Conclusions** – Most caregivers were able for the care; the socioeconomic factors analyzed did not influence the ability for self-care; and 24 hours of hospitalization were sufficient for achievement of abilities related to care.

Descriptors: Cleft palate; Feeding; Nursing

Resumo

Objetivo – Promover e avaliar a capacidade dos cuidadores na alimentação da criança durante o período pós-operatório após palatoplastia. **Métodos** – A amostra foi composta por 44 cuidadores de crianças com fissura labiopalatina, treinados e avaliados durante a internação na alta hospitalar sobre os cuidados relacionados com a alimentação da criança após palatoplastia. O estudo foi realizado em 2010, utilizando um instrumento construído e validado. A capacidade dos cuidadores foi avaliada utilizando um instrumento quantitativo e associado aos fatores socioeconômicos. O teste exato de Fisher foi utilizado para analisar a significância das diferenças entre amostras pareadas. **Resultados** – Entre os cuidadores, 86% foram capazes de alimentação após a palatoplastia, e os fatores socioeconômicos e tipo de fissura não influenciou na aquisição de habilidades. **Conclusões** – A maioria dos cuidadores eram capazes para o atendimento; os fatores socioeconômicos analisados não influenciaram a capacidade de auto-atendimento; e 24 horas de internação foram suficientes para a realização de habilidades relacionadas ao cuidado.

Descritores: Fissura palatina; Alimentação; Enfermagem

Introduction

Reconstructive surgeries are challenging for children with cleft lip and palate (CLP), from both esthetic and mainly functional standpoints¹. Palatoplasty is among the first reconstructive plastic surgeries performed during the long and complex treatment.

The diagnosis of CLP, either pre- or postnatal, raises insecurity in the parents and family, especially concerning feeding, due to anatomical disturbance of the oral cavity². Good results have been achieved by offering counseling to parents and caregivers of children with CLP as early as possible, even before birth, including those related with feeding³.

This concern continues after the accomplishment of reconstructive surgeries (palatoplasty), representing one of the main aspects of nursing care in the postoperative period. The diet should be liquid and cool for a period of 30 days, and even though there are controversies between different studies⁴, bottles and nipples are prohibited during this period at our institution. Therefore, spoons or cups are used to feed the child, with indication of adequate foods for the age, which are blended and sifted⁵⁻⁶.

Even though bottle feeding after cheiloplasty is widely accepted, its use after palatoplasty is controversial. Since this is the most invasive surgical procedure among the primary surgeries, it is associated with difficulties in satisfactory food acceptance by the child, leading to greater weight loss^{4,7}. Besides the bottle, other sucking devices should also be avoided, including nipples, pacifiers and drinking straws, to avoid damage to the surgical wound⁸. Within this context, the cup and spoon are viable options, due to their low cost, easy handling and hygiene⁵.

The child accustomed to using the cup or spoon before surgery presents better food acceptance postoperatively, therefore interrupting bottle feeding before surgery is advised^{6,8-9}. Conversely, a study on the nutritional status of children submitted to palatoplasty and fed with bottle and spoon concluded that children fed with the bottle early presented greater weight gain, yet that study included only children submitted to posterior palatoplasty¹⁰.

Another study analyzed the feeding practices among children with cleft lip and palate in different age ranges and concluded that spoon feeding was the most frequent method¹¹.

Children submitted to palatoplasty may receive hospital discharge when they present good food acceptance and their parents are able for the care inherent to the surgical procedure¹².

The nursing care should promote and/or reestablish the individual's health, by the establishment of assistance and educational practices to encourage the self-care¹³. Nursing care is also fundamental after palatoplasty, which promotes anatomical, physiological, emotional and psychological modifications, thus requiring changes in care.

The rehabilitation of individuals with CLP should comprise interdisciplinary care, aiming at biopsychosocial and functional outcomes. Within this context, nursing plays a fundamental and essential role in all stages of rehabilitation, mainly acting as educator and promoting the care¹⁴.

The achievement of competence in care related to child feeding after palatoplasty is fundamental, because it is directly related to maintenance of care after hospital discharge, significantly influencing the treatment success⁶.

The postoperative period involves great stress, since the child cannot make use of routine foods and devices, and the adequate food intake influences the healing process, risk of dehiscence and fistulas, infection, dehydration, re-hospitalization, stress, and others¹⁵.

The development of instruments and strategies to guide and enhance the achievement of abilities related to care, as well as evaluation methods, are paramount for the treatment success, since they are challenging for the professionals.

In addition to implications inherent to the surgical procedure, during the postoperative period the nurses may inform the caregivers on the related interventions, check their learning, and mainly supervise the procedures to achieve that goal¹⁵. It should be highlighted that this learning process should be systematic, because children are usually discharged 24 hours after surgery, considering the hospital costs, socioeconomic factors of the families, geographic distance between their homes and the craniofacial center, as well as the prevention of infections related to health care.

This study aimed to promote and evaluate the ability of caregivers related to child feeding in the postoperative period of palatoplasty; evaluate the influence of socioeconomic factors on the abilities for care related to child feeding after palatoplasty; and analyze if the 24-hour hospitalization period was sufficient for the achievement of abilities of care related to child feeding after palatoplasty.

Methods

This quantitative, prospective, cross-sectional study was conducted in a Specialized Center in the treatment of patients with cleft lip and palate and related anomalies.

The sample included caregivers of children in immediate postoperative period after palatoplasty, not previously operated (palatoplasty), free of surgical compli-

cations (such as excessive bleeding and need for surgical revision), comprising age between 11 and 18 full months. Data collection occurred in the period August to November 2010. The sample included 44 caregivers, being one for each child.

This study excluded caregivers of children with cleft palate associated with neurological or cardiac problems, or clinical and genetic syndromes, i.e. the children did not present feeding difficulties and dysphagia, thus they did not require the intervention of other health professionals, as well as the utilization of feeding facilitating techniques.

Based on the self-care theory¹⁶ a quantitative instrument was constructed and validated. This instrument comprised evaluation of the physical capacity (Cfi), including feel, vision, manual dexterity and movements and general energy (subitems 1 to 4), addressing the diet temperature, food loss through the lip commissure, and positioning of the caregiver; evaluation of mental capacity (Cme, subitems 5 to 8), addressing the mental abilities related to maintenance of the therapy, such as the ability to count, memorize, pay attention and learn; and finally, analysis of the motivational and emotional capacity (Cmo, subitems 9 to 13), including the variables self-value, self-image and self-concern, disposition for the care, self-discipline and ability to work with the parties.

The physical capacities included identification of food temperature (cold), ability to identify food outflow through the lip commissure, dexterity in using the cup or spoon for, adequate child positioning (half-seated) and caregivers' organization during feeding.

The mental capacities comprised the ability to correctly identify the quantity of food offered and ingested, knowledge on food texture in time interval for feeding, the recognition of cough, choke, vomiting and bluish mucosa or skin as a limiting factor to feeding, the ability to relate the food volume ingested to the child's needs, offering water after feeding aiming at hydration and cleaning of the oral cavity or surgical wound, the ability to identify symptoms related to lack of liquid, and acknowledgment of situations that might justify the search for medical care.

The motivational capacity considered the affective bond between caregiver and child, the interest in learning about care, safety, concern, child acceptance and the role as a caregiver.

Scores were assigned to each subitem for quantitative analysis. For physical capacity, the scores ranged from zero to 1.5; mental capacity from 1 to 3; motivational and emotional capacity from 1 to 3; however, the mean of scores was considered for the last item. All scores correspond to never, seldom and always, respectively. Caregivers who never performed care in any moment were classified as "never"; those who cared between one and three times were classified as "seldom"; and those who provided care in all moments of evaluation were classified as "always".

For scoring of competences for therapeutic care, three different levels were identified, scoring the ca-

regiver as: unable (level I, up to 9 points, no knowledge and unable to perform the role of caregiver), partially able (level II, from 9.5 to 22 points, deficient knowledge and ability, requiring further training), and able (level III, from 22.5 to 33 points, with knowledge and ability) for care activities related to child feeding after palatoplasty.

A structured interview was also used to collect the socioeconomic I, considering the following variables: age, educational level, number of children, marital status and socioeconomic level.

The present instrument was developed by the investigators based on an instrument designed, validated and used to evaluate the competence of caretakers in the care of children with Robin Sequence¹⁷. Content validation methods were used.

The content validation aims at verifying whether the instrument meets the related investigation needs¹⁸. Therefore, validation was performed to analyze whether the variables described by the investigator corroborate the standpoint of specialists experienced in this field.

Validation occurred in two different moments. Initially one letter was sent to each specialist asking for collaboration in the validation process, with theoretical base, together with a copy of the instrument and a guide for validation containing fields for comments and suggestion. After analysis and return of the guide for instrument validation by the specialists, the suggested changes were tabulated. The recommendations were accepted and enhanced the instrument. Thereafter, the instrument was re-sent to the specialists to check their approval. The instrument was sent to six specialists experienced in this subject, with mean of 23 years of experience.

The original instrument aimed to evaluate the ability of caretakers in feeding of children with Robin sequence, including care with nasopharyngeal intubation, feeding through a nasogastric tube and feeding facilitating techniques, including evaluation of physical, mental, motivational and emotional abilities. In the instrument used for this study, the content was adapted to the care related to child feeding in the postoperative period after palatoplasty, yet maintaining the evaluation of physical, mental, motivational and emotional abilities.

The study was approved by the Institutional Review Board of the institution (protocol n. 177/2010-SVAPEPE-CEP) and was carried out in accordance with The Code of Ethics of the Declaration of Helsinki. All caregivers participating in the study signed an informed consent form.

According to the protocol of our institution, food is offered to the children at every 3 hours during the immediate postoperative period. At all meals, the caregivers received information and help exclusively from the nursing team concerning the techniques and care related to child feeding.

The information provided to caregivers is based on the institution protocols, which includes cool liquid or

pureed food, using cup and/or spoon, not allowing the utilization of nipples, bottles and other suction appliances, feeding in half-seated position to prevent choking and excessive food outflow through the lip commissure, offering water after meals, using arm restraints in the upper limbs, contraindication of toys and acute objects that might damage the surgical wound, careful oral hygiene and others.

In our institution the nursing staff is exclusively in charge of promoting training of caregivers, including information, supervision and evaluation of child feeding after palatoplasty, since the nursing team is directly involved with the care of patients and their families throughout the hospitalization period.

As teaching method, in addition to direct supervision by the nursing team, demonstration and explanation on child feeding were provided in all feeding times. Additionally, the caregivers received a handout concerning the postoperative care, including those related with feeding.

In four consecutive meals, the caregivers were exclusively assisted by the investigator for the evaluation. Evaluation was performed at four different moments to avoid possible interferences, such as pain, agitation and initial anxiety of the caregiver. All evaluations were performed by a single investigator, aiming to avoid biases.

The instrument for evaluation of competence for the care was applied after completion of evaluations at the four different moments. The caregivers were interviewed in a private room.

Fields addressing the physical and mental capacities were filled based on direct observation by the investigator during the four moments of evaluation of feeding techniques, except for items 6, 8.2 and 8.3, in which the structured interview was used. Concerning the evaluation of motivational and emotional capacities, the form was filled by the caregiver himself.

When the caregiver was scored between levels I and II (unable and partially able), the nurses were informed to intensify the observation and training. The nurses were informed on the caretakers scored as I and II (unable and partially able), in order to intensify the training and supervision related to feeding, including care related to food texture and temperature, child positioning during feeding, monitoring of accepted food volume and utensils used for feeding.

The competence of caregivers for the care related to child feeding after palatoplasty was assessed by a quantitative instrument that yields three different levels, scoring as: unable (level I, up to 9 points), partially able (level II, from 9.5 to 22 points, requiring further training), and able (level III, from 22.5 to 33 points).

Thereafter, the competence of caregivers was associated with socioeconomic factors: age, educational level, socioeconomic level, number of children, marital status and kinship, aiming to identify the possible associations.

The significance of differences between paired samples was analyzed by the Fisher exact test, at a significance level of $p \leq 0.05$ (5%).

Results

Concerning the characterization of children, there was similarity between genders (50%), with predominant age range between 12 and 13 months (57%) and cleft lip and palate (59%), as presented in Table 1.

Table 1. Distribution of individuals according to gender, age range and type of cleft. Bauru-SP, 2010

Variables		n	%
Gender	Felame	22	50
	Male	22	50
Age range	12 – 13 months	25	57
	15 – 15 months	12	27
	16 – 18 months	7	16
Type of cleft	CLP	26	59
	CP	18	41

Concerning the characterization of caregivers, there was predominance of age range above 21 years (82%); 43% had completed the high school; there was predominance of low socioeconomic level (61%); 57% were first children. There was predominance of cohabitation (68%), and the kinship of the caregiver was habitual, being primarily composed of mothers (91%).

Table 2. Distribution of caretakers according to the scores (level I: unable, II: partially able, III: able) related to child feeding after palatoplasty, and factors related to the care: age, educational level, socioeconomic level, marital status, number of children and kinship. Bauru-SP, 2010

Variable	Scoring			Total	P
	Level I	Level II	Level III		
Age					1.000
Up to 21 years	–	1	7	8	
More than 21 years	–	5	31	36	
Educational level					0.611
Fundamental school	–	2	7	9	
High school	–	4	27	31	
College	–	–	4	4	
Socioeconomic level					0.739
Low	–	6	36	42	
Middle	–	–	2	2	
Number of children					1.000
1	–	3	22	25	
2	–	2	10	12	
3 or more	–	1	6	7	
Marital Status					1.000
Cohabitation	–	5	25	30	
Single	–	2	10	12	
Widow	–	–	1	1	
Divorced	–	–	1	1	
Kinship					0.177
Mother	–	5	35	40	
Father	–	1	–	1	
Grandmother	–	–	3	3	

*Fisher exact test, at a significance level of $p \leq 0.05$ (5%)

Concerning the identification of competence of caregivers for the care related to child feeding after palatoplasty, no caregiver was scored as level I, i.e. unable for the care; 14% of caregivers were scored as level II, i.e. partially able or requiring further training; and 86% were considered able (Table 2). However, it should be highlighted that the cleft extent did not influence the acquisition of abilities by the caretakers ($p=1.00$), as described in Table 3.

Table 3. Correlation between type of cleft and ability of care (level I: unable, II: partially able, III: able) related to child feeding after palatoplasty. Bauru-SP, 2010

Variable	Scoring			Total	P
	Level I	Level II	Level III		
Type of cleft					1.000
CPI	–	2	11	13	
CP	–	–	5	5	
CLPU	–	3	17	20	
CLBP	–	1	5	6	

*Fisher exact, at a significance level of $p \leq 0.05$ (5%)

Analysis of the association between the competence of caregivers and the socioeconomic factors age, educational level, socioeconomic level, number of children, marital status and kinship to identify their significance related to the performance of feeding after palatoplasty revealed that none of the variables presented statistical significance.

Discussion

Most caregivers were scored as able for the care related to child feeding after palatoplasty. This result may be related to the presence of caregivers with the children during the entire hospitalization period, allowing the nurse to offer support and education. This allows training and evaluation of learning, in which the nurse divides the care procedures with the caregivers^{12,19}.

This study evidenced the importance of interaction between nurse and caregivers, as well as the permanence of caregivers during the hospitalization period for evaluation of the learning process, which explains the acquisition of competence for the care in a relatively short period (24 hours).

A previous study reported that palatoplasty represents a new condition of care to the family, especially concerning feeding. The main challenge of professionals is related to effective training related to feeding. Within this aspect, the need of caregiver training is emphasized to assure the continuity of care at home⁶. Oren¹⁶ states that the caregivers search for training to perform actions, recognize and develop the therapeutic demand of care, becoming able to develop abilities related to the needs.

One study concluded that most caregivers follow the instructed postoperative care, including dietary restrictions; however, they highlight the need to make use of simple and routine methods that do not interfere with the healing process²⁰. The utilization of unconventional feeding methods, including tubes, leads to stress and irritation of both child and caretaker⁷. The benefits of utilization of cup and spoon, for example, are suggested in relation to child feeding in the postoperative period after palatoplasty⁶.

A prospective randomized study to evaluate the effect of feeding using bottle and spoon, cup or syringe in the immediate postoperative period after palatoplasty, related to the occurrence of surgical complications (oronasal fistula and surgical dehiscence), utilization of sedatives, oral ingestion in the first six days and weight gain in the first and second months, concluded that bottle feeding did not have adverse effects. However, the authors highlighted that during the first three days the group fed with spoon, cup and syringe presented greater ingestion and required less sedatives. The authors associated the presence of pain as a limiting factor precluding strong bottle sucking, relating this variable to the lack of occurrence of oronasal fistulas and surgical dehiscence. Even though the food volume accepted was significantly greater on the sixth day, the study evidenced the benefits of utilization of cup, spoon and syringe in the immediate postoperative period⁷.

Another study compared the food acceptance among children in immediate postoperative period after palatoplasty using cup and spoon, and evidenced that children fed with the spoon presented greater volume acceptance, in shorter time, with fewer cases of associated cough and choking, and less food leakage through the lip commissure⁶.

Counseling on the postoperative care should be initiated before surgery, favoring the learning on the necessary care¹⁵.

The socioeconomic factors addressed in this study (age, educational level, socioeconomic level, marital status and number of children) did not interfere with the training of caregivers. The predominant age range of caregivers was above 21 years, thus young individuals, who usually present greater disposition and easier learning¹⁷.

Concerning the educational level, there was predominance of completed high school; this is an important finding, since the caregivers are aware of the need to acquire knowledge related to the new situation after accomplishment of palatoplasty. The ability of learning is related to the educational level. The need of learning by caregivers is emphasized to assure the continuity of care at home¹⁶.

There was predominance of low socioeconomic level; this is a significant result, considering the possible influence of poverty on the care activities, as well as the influence related to the preparation and quality of foods that should be offered to the child at home. The nurse should aid the family in planning the care at home, identifying the need of community support to assure the continuity of care after hospital discharge⁶.

Most caregivers had a single child. The greater the number of children, the greater the difficulty of caregivers in care providing, especially for children submitted to palatoplasty, who require greater attention and more frequent care.

With regard to the marital status, there was predominance of cohabitation. It is frequently observed that caregivers with structured families presented fewer difficulties in caring procedures. Inclusion of the family in the rehabilitation process is related to the therapeutic success of rehabilitation²¹.

Most caregivers were represented by mothers. Pongpagatip and employees²¹ observed similar result in their study on caregivers of children with cleft lip and palate.

The presence of the mother strengthens the mother-child bond and contributes to improve the response to treatment response, minimizes the stress imposed to the child by the hospitalization process and prevents possible complications. Besides contributing to child recovery, the presence of mothers makes them more cooperative, combining efforts for a holistic and humanized care¹⁹. The hospitalization represents a very difficult experience for children, accompanied by feelings as anxiety and fear, and their support is the presence of parents¹⁹.

The surgical intervention is an event imposed by life, requiring a coping process in response to the stress experienced. This feeling is constantly evidenced in cli-

nical practice, demanding knowledge and strategies to minimize this problem by the team, especially the nurse, mainly using the training process.

The accomplishment of recreational and expression activities during hospitalization has been presented as an effective method to minimize the stress both of patients and caregivers, strengthening the bond between child and caregiver and favoring the feeling of self-assurance²³.

Within this context, it is restated that the focus of nursing care is not only on the child and its particularities, yet it also includes the caregivers and the family in the same context⁶.

The instrument constructed and validated for this study was based on the Self-Care Theory¹⁶ and presented to be effective in the care approach, guiding the nurse and the team to improve the care process, with a holistic and humanized view in preparing and evaluating the caregiver concerning the competence for the care related to child feeding after palatoplasty. However, it should be highlighted that the validity and reliability of measurement of outcomes could not be determined, since only one examiner assessed the competence of caregivers, which is a limiting factor of the present study.

Unfortunately, one limitation of this study is that patients in our service come from distinct regions of the country, receive discharge usually after 24 hours and we are unable to see them again in this short period, invalidating the assessment at different times.

Conclusion

Most caregivers were able for the care related to child feeding after palatoplasty; the socioeconomic factors analyzed did not influence the training of caregivers for child feeding after palatoplasty; and a hospitalization period of 24 hours was sufficient for achievement of self-care abilities related to related to child feeding after palatoplasty.

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