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Nursing welcoming of individuals who were victims of a motorcycle accident and of an accompanying family member[a]

Acolhimento de enfermagem à pessoa vítima de acidente de motocicleta e ao familiar acompanhante

Acogida de enfermaría a la persona víctima de accidente de motocicleta y al familiar acompañante

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ABSTRACT

Objective: To know how nursing welcoming occurs for the individual who is victim of a motorcycle accident and their family member, and the perception of both and of the nursing professionals about the weaknesses in the reception. **Method:** This is a descriptive, qualitative study carried out in a public hospital in northern Brazil. 10 nurses, 22 nursing technicians, 13 motorcyclists who were victims of accidents, and 13 family members. For data collection, an interview and non-participating observation were used. In the analysis, the Discourse of the Collective Subject was used. **Results:** In the discourses of professionals, the welcoming of individuals who are victims of motorcycle accidents and of the family members occurs by listening, meeting their comfort needs, and allowing the family member to stay by them in the hospital. However, in the observation, we could perceive that the actions of the professionals were focused on the physical aspects, disregarding the individuality of this population. Regarding weaknesses, the professionals perceive the need for better working conditions, while the individuals who are victims of accidents and their family members, for more investment in structure and materials for the hospital. Professionals, victims of accidents, and family members consider that improving welcoming requires more qualification and agility in care. **Conclusion and implications for the practice:** Deficiencies in nursing welcoming imply the commitment of hospital managers and professionals to overcome them.

Keywords: Nursing; Traffic Accidents; Motorcycles; Welcoming; Humanization of care.

RESUMO

Objetivo: Conhecer como ocorre o acolhimento de enfermagem à pessoa vítima de acidente de motocicleta e ao seu familiar e a percepção dos mesmos e dos profissionais sobre as fragilidades no acolhimento. **Método:** Estudo descritivo, qualitativo, realizado em um hospital público do Norte do Brasil. Participaram 10 enfermeiros, 22 técnicos de enfermagem, 13 motociclistas vítimas de acidente e 13 familiares. Para a coleta de dados, utilizaram-se entrevista e observação não participante. Na análise, empregou-se Discurso do Sujeito Coletivo. **Resultados:** Nos discursos dos profissionais, o acolhimento às pessoas vítimas de acidentes motociclísticos e familiares ocorre por meio da escuta, atendendo suas necessidades de conforto, permitindo ao familiar ficar junto no hospital. Entretanto, na observação constataram-se ações dos profissionais focadas nos aspectos físicos, desconsiderando a individualidade desta população. Quanto às fragilidades, os profissionais percebem a necessidade de melhores condições de trabalho; enquanto as pessoas vítimas de acidentes e familiares percebem mais investimento na estrutura do hospital e materiais. Profissionais, motociclistas vítimas de acidentes e familiares consideram que melhorar o acolhimento requer qualificação da equipe e agilidade no atendimento. **Conclusão e implicações para a prática**: As deficiências no acolhimento de enfermagem implicam no comprometimento de gestores e profissionais do hospital para sua superação.

Palavras-chave: Enfermagem; Acidentes de Trânsito; Motocicletas; Acolhimento; Humanização da Assistência.

RESUMEN

Objetivo: Conocer cómo se produce la recepción de enfermería para la persona víctima de accidente de moto y su familia, y la percepción de estos y de los profesionales sobre las debilidades en la recepción. **Método:** Estudio descriptivo, cualitativo, realizado en un hospital público del norte de Brasil. Los participantes fueron 10 enfermeras, 22 técnicos de enfermería, 13 motociclistas víctimas de accidentes, 13 familiares. Para la recopilación de datos, se utilizó una entrevista y observación de no participantes. En el análisis, se utilizó el Discurso Colectivo de Temas. **Resultados:** En los discursos de los profesionales, la acogida de las personas víctimas de accidentes de moto y sus familiares se produce a través de la escucha, de satisfacer sus necesidades de confort y permitir que el familiar permanezca junto a la víctima. Sin embargo, en la observación, notaron que las acciones de los profesionales están centradas en los aspectos físicos, sin tener en cuenta la individualidad de esta población. En cuanto a las debilidades, los profesionales perciben la necesidad de mejorar las condiciones de trabajo; mientras que las personas víctimas de accidentes y familiares, divisan más inversión en la estructura del hospital y materiales que superan sus demandas. Profesionales, motociclistas víctimas de accidentes y familiares consideran que mejorar la recepción requiere una mayor cualificación del equipo y agilidad en la atención. **Conclusión e implicaciones para la práctica:** las deficiencias en la recepción de enfermería implican un compromiso entre los administradores y profesionales del hospital para superarlas.

Palabras clave: Enfermería; Accidentes de Tránsito; Motocicletas; Acogida; Humanización de la Atención.

INTRODUCTION

In health care, welcoming arises as the guideline of the greatest political, ethical, and aesthetic relevance of the National Policy of Humanization (*Política Nacional de Humanização*, PNH).[1] It is an essential instrument for humanized care, which runs up against the inter-subjectivity of the subjects involved in the care process and the responsibility of the team, which encompasses a committed posture from the organization from the service to the clinical actions.[2] As a practice that collaborates for integral and quality care, welcoming begins upon the reception of the patient with care provisions, aims at listening, and provides security, comfort, respect for differences, and health education.[3,4]

The implementation of humanization practices in urgency and emergency requires the development of humanistic competence at the same level as the technical-scientific competence of the professionals is encouraged.[5] With regard to the welcoming conducted by the nurse, there are institutional deficiencies such as overcrowding of emergency rooms in hospitals, lack of working conditions, beds, materials, and especially of professionals, challenging its quality.[6,7]

Faced with this scenario, the professionals can create defense mechanisms that manifest as impatience, indifference, and irony and which impact on the patient in the form of psychological suffering, abandonment, helplessness, carelessness, and concern.[8] However, the care setting of hospital emergencies requires a qualified welcoming, which ensures humanization in care. Motorcyclists and their families become the focus of this welcoming given that, in urban traffic disputes over space have conflicts, violence, and a large number of accidents as consequences, especially with motorcycles, the main cause of overcrowding in emergency rooms.[9] The abrupt change in the health and routine of accident victims and their families can cause emotional stress to all of them, with pain and suffering, as well as expenses and loss of working time that impact on the family budget.[10] Traffic accidents are considered worldwide as a serious problem and difficult to solve, and it is responsible for deaths and disabilities, physical and psychosocial harms to the victims and their families,[11,12] combined with reduced worker productivity.[13] Therefore, the consequences of traffic accidents are not limited to high mortality but have an impact on the lives of those involved due to their high social and economic cost.[14]

In Brazil, in 2015 and 2016, there were more than 24,000 deaths of motorcyclists involved in traffic accidents. In the state of Amazonas, there were 363 deaths of motorcyclists, of which 210 occurred in the capital, Manaus.[15] Among the factors that result in motorcycle accidents we can mention the following: lack of attention, high speed, going through the corridors between cars, undue overtaking, acting on impulse, drinking alcohol, and exhibitionism,[16] which are responsible for overcrowding mainly the trauma reference hospitals.

Faced with the high incidence of motorcyclists who are accident victims, the accident implications for the patient, the family, and society, and with the relevance of a qualified welcoming in the emergencies, the present study was proposed, in which we considered welcoming and humane care as synonyms, which involves nursing procedures in meeting the needs of the patients and their families. Thus, the objective of this study was to find out how nursing welcoming to the victim of a motorcycle accident and their family members occurs, and the perception of those individuals and of the nursing professionals about the frailties in the welcoming.

METHOD

This is a descriptive study with a qualitative approach, under the Consolidated criteria for reporting qualitative research (COREQ) instrument, which was conducted in a reference hospital in Neurosurgery, Orthopedics, and Traumatology for adults located in a municipality in the North of Brazil. The study was approved by the Research Ethics Committee of the University of the State of Amazonas (*Universidade do Estado do Amazonas*, UEA), under Opinion No. 2,387,230, CAAE 79397717.1.0000.5016. All the participants signed the Free and Informed Consent Form and were identified with the letters E (Nurses, "*Enfermeiros*" in Portuguese), T (Nursing Technicians), M (Motorcyclists) and F (Family Members), followed by the number corresponding to the sequence of the interviews (E1, E2..., T1, T2..., M1, M2..., F1, F2...).

The inclusion criteria of the professionals were the following: being a nurse or nursing technician; working in the Polytrauma Room, Observation One, Two, Three or Orthopedic Ward, in the morning and afternoon shifts, having experience in the care of victims of motorcycle accidents, and having worked for at least six months in the study sectors, a time considered adequate to know the workplace, team, materials, procedures, and main characteristics of the patients. The exclusion criteria are as follows: being away from care for any reason during the data collection period.

Of the 20 nurses invited, 10 participated in the investigation, eight did not accept the invitation, and two had worked for less than six months in the sectors. Among the 31 nursing technicians who received the invitation for the study, 22 participated, six rejected the proposal, and three had worked for less than six months in the sector.

As for the individuals who were victims of motorcycle accidents, 28 were admitted to the hospital during the data collection period, 13 of whom participated in the investigation. The criteria for inclusion of the patients were the following: being at least 18 years old; being the motorcycle driver; living in the study city; being hospitalized in the Polytrauma Room, or Observation One, Two, Three; or in the Orthopedic Ward; being conscious at the time of the interview, and having a family member as a companion in the hospital. 15 patients were excluded: 13 were mildly wounded and were discharged from the hospital on the same day of admission, and two refused the invitation.

The following was considered as a criterion for the inclusion of the family member: being the companion of the person who was the victim of a motorcycle accident, for at least 80% of the days of hospitalization. Any person with inbred or affective

bonds, living or not in the patient's home, was adopted as a family member in this study.

Data collection took place in the period of December 2017 and January 2018, during all the days of the week, in the morning and afternoon shifts, on daytime duty, from 7:00 a. m. to 7:00 p. m. For the collection, a semi-structured individual interview and non-participating observation were used and conducted by one of the researchers. The interviews were transcribed in full and stored in a file on the computer, and the observations were recorded in a field journal.

The interviews with the professionals took place in the nursing posts of the emergency room (Polytrauma) – place for receiving the patients –, of Observation rooms One, Two, and Three, and of the Orthopedic Ward. The interviews with motorcycle accident victims and their families were conducted by the bedside, in Observation Room Three and in the Orthopedic Ward. As for non-participating observation, it took place in five settings (emergency rooms, observation rooms One, Two, and Three, and orthopedic ward), with a mean duration of two to eight hours a day, and was recorded in a field diary.

The interview with the professionals addressed the welcoming actions for victims of motorcycle accidents and relatives in the rooms and ward, in addition to the need for improvements in this reception. In the interview with the motorcycle accident victims and their family members, they were asked how they perceived the nursing care they received and what should change in the hospital setting and in the care provided by the nursing staff in order to improve it. The end of the interviews occurred when all the professionals who agreed to participate in the study were interviewed.

For the observation of the professionals a script was used with the following details: how the welcoming of a motorcycle accident victim and their family member in the sectors was carried out; identification of the permission for the family member to enter the Polytrauma room granted by the professionals; and how the professionals carried out the reception.

In the Polytrauma and Observations rooms, the nursing team, with a 12-hour work shift, consisted of one nurse and four to six nursing technicians in each room while, in the Orthopedic Ward, two nurses and 10 technicians made up the team.

The data were organized and analyzed using the Discourse of the Collective Subject (DCS) technique, which employs individual statements to build a unique and collective statement prepared in the first person singular.[17] At the end of the transcripts, the testimonials were entered into the *QualiquantiSoft* Software, version 1.3c.

The DCS technique consists of four methodological figures: Key Expressions (*Expressões Chaves*, ECHs) - literal excerpts from the testimony, selected by the researcher and representing the content essence; Central Ideas (*Ideias Centrais*, ICs) - summarized and objective descriptions of the meanings from each of the statements; Anchorage (AC) - contains linguistic traits of manifestations of the subject's belief; and the DCS itself - the union of the ECHs present in the statements that bring CIs or ACs with the same or complementary meaning.[17]

RESULTS

10 nurses participated in the study, eight being female. The working time of the professionals ranged from seven to 28 years, while the experience in urgency and emergency services ranged from four to 28 years. 21 out of the 22 nursing technicians in the study were female. Their professional practice ranged from two to 30 years and their experience in urgency and emergency services, from one and a half to 20 years. Regarding the individuals who were victims of motorcycle accidents, 12 were male, aged between 19 and 50 years old, 9 had completed high school and 10 had lower limb fractures. All of them underwent surgery. As for the outcome of these individuals, one died after 48 days of hospitalization and 12 were discharged. Among the latter group, four needed to be hospitalized again due to infection in the surgical wound and needed surgery to clean the region and for antibiotic therapy. All the 13 family members of motorcycle accident victims that participated in the research were female, represented by mothers, wives, sisters, and aunt, aged between 19 and 65. Four ICs with their respective DCSs emerged from the interviews:

IC1: The nursing welcoming to motorcycle accident victims at the time of hospital admission is aimed at the physical aspects.

> **DCS1**: *After the consultation with the doctors, the nursing team takes over the care. I listen to what the SAMU nurse has to say about the patient's condition. They come already punctured, the level of consciousness and vital signs are checked; analgesia, hydration and monitoring are conducted according to the medical prescription. If they have a bleeding wound, we bandage it. Depending on the case, I take the medical chart to the orthopedic surgeon to evaluate the accident victim that will undergo an X-ray. If a neurologic evaluation is needed, they are referred for a CT scan. I advise the relatives to bring clothes, pillow, sheets, blanket, towel, and hygiene materials; in addition, I explain that they cannot be at the Polytrauma Room, but when the patient goes to the observation room or ward, they will be allowed stay there. Some cases I refer to the Social Worker to contact the family members. Sometimes the accident victims get here alone, only a while later do the relatives arrive.* (E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, T1, T2, T3,T4, T5, T6, T7, T8, T9, T10, T11, T12,T13, T14, T15, T16, T17, T18, T19, T20, T21, T22)

IC2: The nursing professionals welcome the motorcycle accident victims by listening, meeting their needs for comfort, and allowing the family member to stay by them in the hospital.

> CSD2: *I welcome the accident victims by treating them well, respecting them, putting myself in their situation, having compassion for the condition they are in. I listen to what they have to ask. I calm them down, guide them, make them physically and psychologically comfortable,*

put them on a stretcher with a sheet, administer pain medication and, as much as possible, listen to their complaints. I contact the family, talk about the condition of the victim and the procedures they have already gone through or will. I let the companion stay with the patient. (E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12, T13, T14, T15, T16, T17, T18, T19, T20, T21, T22).

IC3: Improving nursing care requires investment in the working conditions, qualification of the team through continuing education, and agility in care.

DCS3: *For better care there must be improved hospital management, thus providing better working conditions for the professionals in general, by increasing human resources: Here at the hospital, we lack people to work and the companies should pay correctly those who are working. There is lack of materials: medications, diaper, adhesive tape, egg-crate mattress; there's no sheet, the beds are broken, sometimes we don't have even a stretcher so that the rigid SAMU board can return to the ambulance. There is lack of equipment: hemodynamic monitor for everyone who needs it and enough secretion aspirator... we give priority to the more serious ones. Lack of team qualification: we have no continuing education. Lack of humanization with the patients, empathy, care for the nursing team so that they take good care of others. The professionals in general need to be more committed to the patients. A lot of them come stressed out to work. In addition, it lacks agility in care, the patient arrives, stays on the stretcher, waits a long time for the evaluation and care procedures* (E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12, T13,T14,T15, T16, T17, T18, T19, T20,T21,T22).

IC4: Improving care requires investing in the structure of the hospital, in materials that meet our needs as patients, in addition to greater agility in the care procedures and more politeness from the professionals.

DSC4: *There's no agility in the service and in the scheduling of the surgery, meanwhile, we're waiting, there is no material for the surgery. Besides, the hospital structure is very precarious, the bathroom floor is completely broken, there's no shower, there's a pipe with cold water and a hose, the serum support is rusty, broken and patched with adhesive tape, the air conditioning is broken, the room gets very hot, the security guards do not allow entering with a fan. There are no water fountains, they're broken or without water, we have to bring water from home. Many lamps are broken. There's no sanitary water to clean the rooms, the odor in the rooms doesn't go away; there's no sheet, we have to bring it from home; we have to buy and bring the adhesive tape, there's no chair for the companions, many sleep on the floor next to the stretcher. It also lacks privacy, here men and women stay together in the same room, sometimes there's a lot of noise, a lot of talking, we can't rest. Besides, the professionals are impolite with us, some people are rude; we talk, nobody listens to us* (M1, M2, M3, M4, M5, M6, M7, M8, M9, M10, M11, M12, M13, F1, F2, F3, F4, F5, F6, F7, F8, F9, F10, F11, F12, F13).

Non-participating observation of the care provided by the nursing professionals allowed us to identify in the welcoming of individuals who were motorcycle accident victims that the welcoming occurs mainly through actions focusing on physical aspects such as patient monitoring, verification of vital signs, administration of drugs for analgesia and bandage, and care given by nursing technicians. The nurses treated other more severe patients requiring cardiorespiratory resuscitation or transfer to the ICU. Most of the time these professionals were dedicated to the care records, to the nursing process by filling out a printed form and scheduling prescribed medications.

At no time the search or contact were observed of the nurses or nursing technicians with the relatives of the victims of motorcycle accidents who were in the polytrauma room. The family members entered the room alongside the Reception guard to see the patient. In observation rooms One, Two, and Three, and in the orthopedic ward, companions were allowed.

Below are some notes that were recorded in the field journal about the observations of the care provided by the nursing staff to motorcycle accident victims and their family members:

- Polytrauma room – December 4th, 12th, and 19th, and January 9th, 16th, and 20th: "the nurses (E1, E3, E4, E5, E7, E10) fill out the Nursing Care Systemization (*Sistematização da Assistência de Enfermagem*, SAE) form before the accident victim arrives in the room"; "there is no action of the nurses towards the search for the motorcyclists' relatives";
- Polytrauma room – every day of data collection: "the nurses (E1, E4, E5, E6, E7, E10) spend most of the time on duty looking for vacancies for patients in other rooms so that the SAMU stretcher can be released"; "the nurses talk to the patients who are victims of motorcycle accidents only to confirm their full names for the medical records";
- Polytrauma room – December 12th, 15th, and 20th, and Orthopedic Ward – December 1st, 26th, 27th and January 3rd and 4th: "the nurses (E1, E2, E3, E4, E5, E6, E8, E9) did not carry out the physical examination on the motorcyclists at any time on duty". All study sites - every day of data collection: "the nursing technicians (T1...T22) talk to motorcycle accident victims and their families members, clarify doubts, and create bonds."

DISCUSSION

The characteristics of the individuals who were motorcycle accident victims are similar to the ones identified in national[18-20] and international[21,22] research studies, and the majority are young adult males with injuries on the lower limbs. Because the driver absorbs the energy generated, the vulnerability of the rider at the time of the accident can produce traumatic injuries, such as fractures of the limbs, which can prolong the period of hospital stay and cause complications. Although they are frequent in motorcycle accidents, there is a gap in measures or resources capable of preventing or reducing this type of injury.[23]

Regarding the characteristics of the participating professionals in the research, those with many years of experience in urgency and emergency stood out; these findings are also revealed in a study developed in Portugal,[24] which can produce a feeling of more security in the care provided in the victims of accidents and in their relatives.

The discourse of the professionals regarding the welcoming of the nursing team to the victims of motorcycle accidents in the Polytrauma room of the hospital evidenced a reception with actions focused on objectivity and subjectivity of care; while the non-participating observation revealed the predominance of a welcoming with objective actions that were focused on technical and recording procedures: assessment of vital signs, administration of medications, referral to exams, hydration, monitoring, bandages, interventions of the cardiorespiratory resuscitation protocol, and conduction of the nursing process.

By the observations, it was perceived that the actions were carried out in the same way for all the individuals, their individualities being disregarded. In the nurses' practice, no subjective care actions were observed such as listening to the complaints and calming the patient, contacting the family, and allowing the presence of a companion in the emergency room. By ignoring the uniqueness and individuality of the patients to submit them to protocols, the professionals contribute little to humane care.[25] A qualitative study on spirituality and humanization also highlighted in the discourse of nursing graduate students on care/assistance the procedural technical valorization to the detriment of welcoming.[26]

Under the aspect of humanized care, the nurse-patient interaction includes different stages: showing willingness and interest in overcoming the simple task; caring with an ethical approach; showing empathy, cordiality, and understanding; and finally, by means of communicative ability and a family approach, establishing relationships with the patient that consider their conditions and reflect an interest in the other and in the solution of their problems.[25] It is understandable that this type of interaction, proper of humanized care, but not observed in the welcoming of the nurses to the victims of accidents and their family, signals the need for improvements in the qualification of health care.

In this sense, the National Humanization Policy presents in its devices the unpreparedness of the health professional in dealing with the patients' subjective issues. Furthermore, the professional may get more stimulated to offer a welcoming reception, if they are welcomed and valued in their work.[27]

In the emergency services, many professionals work exclusively in the search for results and not for quality. The individual who is a victim of a traffic accident requires integral health care;[12] however, the exclusivity of the biomedical model can dehumanize the care, as well as the lack of accountability and bond production.[28]

Similarly to the findings of the present study's observation, in Colombia a study on the rights of the patients in relation to the services offered, revealed insufficient quality in the care provided, the patients being seen as sick and isolated organisms, bodies devoid of their singularity and restricted to technical-scientific knowledge that involves clinical experience, which increasingly distances them from their fundamental rights.[29]

This research also reported the need for the professional to respect the patients, be cordial, and try to solve their physical or emotional problems, especially when they are most vulnerable, such as being victims of motorcycle accidents. The fact that the health institutions do not offer humanized care is justified by the lack of resources. Furthermore, the workload of nurses distances them from the patients and prevents them from providing care.[30]

Thus, offering welcoming in precarious conditions of physical structure, human resources, and materials is a great challenge. However, the nursing professionals can be mediating agents for the understanding of patients and family members about the structural deficiencies experienced by the hospital. Explaining to the motorcycle accident victim that the nursing team does not rule over certain setting problems related to lack of materials and of human resources for them being responsibility of the hospital management, as well as the State's, can contribute to a more favorable care relation among nursing-patient-family.

The perceptions of nursing as regards motorcycle accident victims and their relatives, in relation to the necessary improvements to the nursing care, show that managements are not involved in solving problems ranging from the physical structure to the qualification of the professionals by means of continuing education. In line with the present study, a research study in a number of hospitals of a Brazilian municipality on nursing welcoming in trauma wards revealed institutional and professional aspects necessary for greater humanization: continuing education; increase in the number of workers; increase in the material resources; longer direct care time; flexibilization of rigid routines; incentive for interpersonal relationships; permission for companions in critical areas; and a permanent room where patients and companions can stay.[31]

Although in the present research, the family was not included in the emergency room, this is a possibility that must be considered in the search for more humanized care. However, it is worth mentioning that the family needs to be accompanied by a professional, whose role would be to decode the procedures, which implies staff resizing. Still, the presence of the family in the emergency room requires human resources prepared for this experience in stressful situations. Therefore, the need for beginning a process of preparation to receive the families in this scenario is unveiled.[32]

Also, the results analyzed in the light of the Urgency Care Network guidelines[33] point to the need for advancing in the welcoming to motorcycle accident victims and their family members

in order to guarantee care integrality when answering emergencies related to external causes, which include motorcycle accidents.

The place and the moment of the interview for data collection are considered to be the limitation of this study since they happened in the nursing wards as the professionals could not leave their workplace.

CONCLUSION AND IMPLICATIONS FOR THE PRACTICE

The study revealed in the professionals' discourse that, in the hospital, nursing welcoming to individuals who were motorcycle accident victims and their family members occur by listening, meeting their comfort needs, and allowing the family member to stay by them. Furthermore, the observation of the professionals' practice allowed us to identify that the welcoming is rather aimed at physical aspects and disregards the individualities of this population.

As for the weaknesses in the welcoming, the nursing professionals see the need for investment in the working conditions; and the accident victim and their relatives, for more investment in the hospital structure and materials to supply their needs. All the participants (professionals, motorcycle accident victims, and their family members) consider that, for the welcoming to improve, more team qualification and greater agility in the care are required.

The study has the following implication for the care practice: the commitment from the managers and professionals of the hospitals with overcoming the deficiencies evidenced in the nursing welcoming, in order to assure that it occurs effectively.

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AUTHOR'S CONTRIBUTIONS

Study design and review. Data acquisition and analysis, and interpretation of the results. Content writing and/or critical review. Approval of the final version of the article. Responsibility for all aspects of the content and integrity of the published article. Lilian de Oliveira Corrêa. Eliane Regina Pereira do Nascimento.

Data analysis and interpretation of the results. Content writing and/or critical review. Approval of the final version of the article. Responsibility for all aspects of the content and integrity of the published article. Patrícia Madalena Vieira Hermida. Daniele Delacanal Lazzari. Luciana Bihain Hagemann de Malfussi.

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