ORIGINAL ARTICLE *DOI: 10.4025/cienccuidsaude.v18i3.45090*

THE PERCEPTION OF CRITICAL CARE NURSING PROFESSIONALS ON HARD TECHNOLOGY CARE

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ABSTRACT

Objective: To identify the perception of the nursing team about the hard technology in intensive care unit settings. **Methods:** This is a descriptive-exploratory study with a qualitative approach and developed in adult intensive care units of private hospitals in the city of Resende - Rio de Janeiro. The data, obtained through a semi-structured interview script with 36 participants, were analyzed from the perspective of the thematic analysis and with the help of Iramuteq software. **Results:** A total of 12,751 distributed occurrences and 1772 different forms were recorded. The occurrences with higher Chi^2 were: change, team and tachycardia. **Conclusion:** Despite advances in technology, especially in nursing, care has become more bureaucratic and nurses are making the machine the core of care. It is necessary to redefine this way of thinking through the training of professionals.

Keywords: Technology. Critical care. Critical care nursing.

INTRODUCTION

Contemporaneity brought knowledge and technique through technologies that have been carried out in several fields, including Health. This fact confirmed repercussions on nursing practice, changing the values, knowledge and human relations that, since then, are mediated by technology[1].

Technology is categorized from the perspective of the existence of three valises: in the first valise are the instruments (hard technologies); in the second valise, the structured technical know-how (light-hard technologies) and in the third, the relations occurred in encounters of subjects that materialize in an act (light technologies)[2].

On hard technology, the negative characteristic of omission of elements of human subjectivity, alienating them to therapeutic diagnoses and therapeutic conduits, favors the objectivity that is shown totalitarian through numbers and graphs[3].

In fact, technology cannot be condemned, but it must be used in a creative and humane way to improve the quality of life of the assisted clientele and for the nurses to become aware that their goal is care and that the machine will never replace the human essence [4].

The care given in the Intensive Care Unit (ICU), due to its technological apparatus, can overestimate the hard technology that will make the nurse's model of care the technological action[3].

The nurse is important throughout the hospital setting, highlighting the ICU, where he/she is provoked to show his/her role due to the complexity of care, and instigated to promote comfort and well-being in a non-responsive client with invasive devices in an environment of noise produced by alarms and people[5].

The nurse in the ICU has forgotten to perceive the human being as a whole, as a being who thinks, feels and externalizes what he/she feels, once he/she becomes involved in a technological routine that is intuitively more reliable[6].

It is important to note that caring for the other is not only about assisting him or her technically, but also about receiving suffering, hearing

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doubts and anxieties, and understanding their demands, considering their uniqueness[7].

Technology in nursing care should be perceived as an agent and not as the whole of care, being harmonious with the praxis of the professional, since the symbolism that surrounds it is a socially built reality[8].

It is possible to see that nursing practice is influenced primarily by hard technologies, followed by light-hard ones, and light ones are still undervalued during care[9].

Often, the nurse does not have a holistic view due to the great work demand and multifunction exercised along the shift, devaluing the patient's bedside moment. The practice of care ends up being developed in a fragmented, routinely and mechanistic way, alienating the real needs and promoting adverse events, increasing hospitalization time and hospital costs, dehumanizing what is naturally human[10].

The relevance of this study, mainly as a critical-reflexive contribution on ICU nursing, resided in the importance of discovering how nurses view care in a highly technological environment.

What also justified the accomplishment of this study was the fact that comfort and communication, in nursing care actions to the critical patient, are still practices distant from the reality of users and health workers, especially regarding ICU care[11].

Although the premise of nursing care is the client's satisfaction and well-being, not always the care implemented, given the usual knowledge, can be enough to minimize the patient's feeling of discomfort[7]. In this sense, not losing the focus of nursing care is central, because it is through this that comfort is promoted.

Therefore, this study aimed to: identify the perception of the nursing team about the hard technology in care in an ICU environment.

METHODOLOGY

This is a descriptive-exploratory study with a qualitative approach and that involved the participation of 36 nursing professionals working in intensive care units of two private hospitals in the city of Resende - Rio de Janeiro. The choice of the study scenario was based on the identification of the two hospitals with the greatest technological resource in the ICU in this city and the signing of the consent term in agreement with the study.

The sample was by convenience, since the individuals were invited to participate in the study according to their schedule and the presence of the researcher who performed the data collection.

The inclusion criterion was: to be a nurse or a nursing technician or with a professional experience of more than three months in intensive care units. For the professionals considered eligible, and who accepted to participate in the study, the signing of the Informed Consent Term (TCLE) was requested.

Hospitals, whose identities were preserved, had fictitious names, A and B. The ICU of hospital A had 19 nursing technicians and 06 nurses, while hospital B had 20 nursing technicians and 7 nurses. A total of 13 nursing technicians and 4 nurses from hospital A and 16 nursing technicians and 03 nurses from hospital B participated in the study. The study sample consisted of 36 nursing professionals, of whom 07 were nurses and 29 were nursing technicians. It should be noted that, of the 52 professionals, 16 refused to participate in the study.

Data collection took place from January to May 2018, by the study's main author, in the hallway for access to ICUs. It was used a semi-structured interview script that had questions that aimed to obtain the characterization of care in the technological environment of ICU, namely: technology in care, comfort and humanization.

The interviews were recorded in a cellphone device (Iphone 6.0 from the Apple manufacturer) and transcribed, being inserted into Iramuteq lexical analysis software[12].

From the textual corpus, the possible analyzes with the Iramuteq were generated, being: classic textual statistics, descending hierarchical classification (CHD)[12].

The analysis of the data occurred in the light of the content analysis that is "a set of communication analysis techniques aiming to obtain, by systematic and objective procedures of message content description, indicators (quantitative or not) that allow the inference of knowledge on the conditions of

production/reception (inferred variables) of these messages"[13].

The interviews were transcribed in their entirety, originating a textual corpus that was prepared according to the guidelines described in the Iramuteq software tutorial[13]. After the preparation, the corpus was analyzed in order to seek answers to the study objectives. The exploitation of the corpus promoted a framework of characteristics/slogans associated with the theme: comfort. These characteristics were grouped into subjects represented by the contexts in which comfort can be experienced, according to Kolcaba.

This study was approved by the Ethics and Research Committee (CEP) of the Federal University of the State of Rio de Janeiro under protocol n CAAE 73565617.7.0000.5285 and complied with the precepts of Resolution 466/12 of the National Health Council[14].

RESULTS AND DISCUSSION

The beginning of the presentation and discussion of the results will be given by the variables, which will help to characterize the profile of the subjects of the study in relation to: gender, professional training and time of professional experience.

Such variables were defined by considering that sociodemographic characteristics may imply the way individuals perceive the world around them and, in addition to, the being and the doing in nursing. In this way, these are variables that help in the understanding of their knowledge and practices, as well as in their perceptions and values about comfort, technology and intensive nursing care.

Regarding the sociodemographic profile, the results showed a supremacy of female respondents - eighty-nine percent of the participants of the study. Regarding the professional category, the most representative group was nursing technicians, 27 of the total, and nine other nurses. Regarding the time of experience, it can be verified that 18 individuals fit the population group with experience of 02 to 06 years of ICU; 08 had 07 to 14 years of experience; 06 were less than 1 year and 04 had between 15 to 29 years of experience.

Data obtained through the interview made it possible to evaluate the perception of nursing professionals regarding hard technology in care. After the preparation of the corpus of analysis with all the answers, totaling 361 text segments, when processed by Iramuteq 0.7 alpha 2, it was possible to obtain the return of 12,751 occurrences (words), distributed in 1772 different forms (prepositions, verbs, adjectives, etc).

The number of words with a single frequency was 926, representing little more than 7.26% of the occurrences and little more than 52,26% of the forms. It was emphasized that it was possible to use lexical analyzes without loss in the context in which the occurrences appeared in the answers of the studied group, contributing to greater objectivity and advancement in the interpretations of the text sections.

The analysis of the corpus promoted Factorial Correspondence Analysis (AFC). In this analysis the frequencies and Qui^2 correlation values of each word contained in the corpus are returned from the pre-defined frequency, which, in this case, obeyed the minimum of 10. All variables were analyzed and the index used was Qui^2 (chi square).

The Descending Hierarchical Rating (CHD) by Iramuteq after analysis of the corpus in its totality of 36 texts, distributed in 361 text segments, 1760 forms, 12751 occurrences, 1188 slogans, 1073 active forms, 104 active and supplementary forms, production of 6 classes from segments composed the corpus. As for the frequency of total occurrence in the corpus, the word "change" occurred 23 times, it was present in the discourse of 63.8% of the study participants and absent in 12 discourses (sub_1, sub_2, sub_3, sub_11, sub_13, sub_15, sub_17 , sub_26, sub_28, sub_29, sub_33, sub_34).

The word "team" occurred 14 times, it was present in the speech of 38.8% of the study participants and absent in the discourse of 22 subjects (sub_3, sub_5, sub_9, sub_10, sub_11, sub_12, sub_14, sub_15, sub_16, sub_18, sub_19, sub_20, sub_22, sub_24, sub_26, sub_27, sub_28, sub_30, sub_31, sub_32, sub_33, sub_34, sub_35 and sub_36).

The word "tachycardia" also had an important frequency in the discourse of the study participants, being present in the discourse of 22 subjects, which corresponded to 61.1% of the total participants.

Figure 1 highlights the frequency of the highest correspondence classes after the Descending Hierarchical Classification (CHD) from Iramuteq:

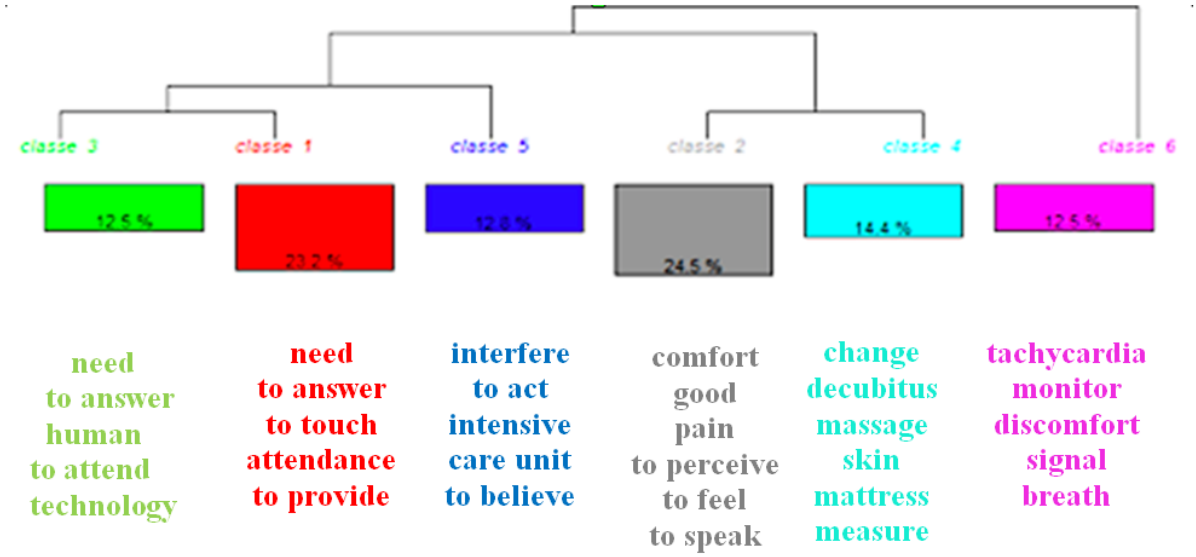

Figure 01. CHD words of the analyzed corpus

Figure 01 allows to identify, by the diversity of colors, the words and their respective correspondences. Even though the words "years", "need" and "then" were the most occurring words, what, according to Zipf's Law, they are those located in the first zone, corresponding to the group of trivial words, since it is expected that they are of high frequency, its semantic power is small and does not allow any relation with the studied subject. They are occurrences with higher Chi^2 values ranging from subject to subject. On the other hand, the words with greater semantic power for the studied subject were "change", "team" and "tachycardia".

Observing the above dendogram (Figure 01), it is noticed that the class of higher elementary context unit percentage (UCE) is class 2 (24.5%). In this class, the variable that can be considered is *te_3, which relates to the subjects' experience time between 23-29 years. Professional experience is a contributory factor for perceptions of comfort and well-being, as well as analysis of pain/discomfort relief in its broader coverage in various critical client contexts.

In hospital practice, especially in the technological scenario of Intensive Care, the humanization of care has been the subject of research about its materialization in the relationship between professional and client, since it is identified the verticalization of care[8].

The humanist sphere of assistance is being deconstructed by fragmentation — the technique as the principal and the organization of the work team only by specialties —, which limits humanization and maximizes technicality[8].

Since taking care of the other goes beyond medical care, welcoming the suffering, doubts and anguishes, Critical Care Nurse needs to have the client's whole look, especially in the environment in which the hard technology is preponderant and the biomedical model at the core of care.

The balance between humanization in care and technology becomes urgent in densely technological environments, such as those of Intensive Care. The ICU, because it contains several stressors, such as alarms, lighting and the constant movement of professionals, which interferes with the recovery of the patient, making care mechanical and denying the patient's biopsychosocial needs to low priority, needs a re-signification of the role of the nursing. In view of the above, the nursing

professional should be prepared to deal with technology as an instrument in care and not as care itself[9].

There are nursing professionals who view hard technology as a primary target in care because they believe in the ability of the equipment to meet the demands of patients in their entirety with more security in the care process, as can be seen in the following statements:

> (n_27) [...] I believe that the use of technology only adds to the provision of care. Technology coupled with empowered people improves care. The technology offers everything that the patient needs because it is advancing more and more and this enables us to take care of the patient more and more [...]
>
> (n_28) [...] I affirm that the technology meets the needs of the patient because if something happens, everything is already in the system [...]
>
> (n_03) I have been five years in the ICU and believe that the use of technology can interfere with the provision of care in intensive care units in order to improve care. A modern respirator and a monitor make care more reliable. Technology is everything, especially in an ICU.

Speeches such as these reveal the perception of some professionals in the face of hard technology: they value equipment more than care itself, perhaps because they consider the manual care simplistic and, therefore, devoid of the demand for attention and knowledge of the same amplitude as a machinery, focusing more on machine complexity and less on human complexity.

This overvaluation of technology makes assistance mechanical, alienating the values, feelings, and beliefs of care. The nurse, with his technical-scientific knowledge, must base his/her practices on ethics and bioethics, considering the values, beliefs, moral principles and autonomy of the person's care. Physical and emotional suffering, perhaps spiritual, must be minimized by all the therapeutic resources that extrapolate hard technology[8].

To have the sensitivity that the existing equipment in the ICU is an arsenal, a way among others to reach the goal of care, whether to promote comfort, corroborates for the link between the objectivity of the monitors, and other machines, and the intrinsic subjectivity in each client who, regardless of his or her condition of responsiveness to the external environment, should be considered in therapeutic actions that seek healing or pain relief, a signal that is not always measurable due to the magnitude of their understanding and meaning of who feels it .

Thus, professionals who have this understanding recognize that hard technology can negatively interfere with care because it represents one more element that requires attention from the team, causing a reduction in the time of contact with the patient and influencing the humanization of care:

> (n_06) I have been in this hospital for seven years in the ICU and I think that the use of technology can interfere with the provision of ICU care because we are very involved with the devices, with the whole question of monitoring and care. That attention the patient needs sometimes gets a bit sideways in my opinion. Since technology does not meet all of the client's critical health needs because the client needs technology, as much as he or she is not critical, but sometimes he needs more attention, talk, to be heard, and often monitoring does not solves this emotional, psychological need of the patient [...]
>
> (n_15) [...] I think that technology can interfere with the provision of care because today it is very advanced and I think that the ICU is not humanized, especially the nursing that works on it.
>
> (n_05) I have been an ICU professional for two years and believe that the use of technology can interfere with the provision of care in this environment, because despite helping, it ends up interfering in the environmental issue: a lot in a bed, which physically hinders care because there is a lot of equipment there around the patient[...]
>
> (n_06) I have been in this hospital for seven years in the ICU and I think that the use of technology can interfere with the provision of ICU care because we are very involved with the devices, with the whole question of monitoring and care. That attention the patient needs, sometimes gets a bit sideways in my opinion.

Simple actions that are also part of care, such as touching, listening, and talking, are not performed because of the intense routine nurses are subjected to, with the prevailing of technological arsenal[8].

This way, in addition to attention to

circulatory, respiratory and nervous system parameters, equipment manipulation and medication administration, the nursing team should be able to encourage, promote autonomy, when possible, and respect the patient through an assistance that individualizes their needs, so that it can be, in fact, humanized. Such preparation, immediate and mediated in undergraduate school, should be made for professional training, aware that, regardless of technology, care should be performed in a humanized way.

FINAL CONSIDERATIONS

The present study sought to identify the perception of the nursing team about the hard technology in care in an Intensive Care Unit environment in order to promote a critical-reflexive approach on nursing, as a promoter of care in the ICU, with a view to promoting the comfort.

The results from the testimonies allow us to infer that the technology, despite having provided speed and quality in day-to-day care, provided, contradictorily, a distancing of the nursing staff from the client's bed, since it is no longer needed to touch him/her to check its vital signs or some other hemodynamic parameters, considering the existence of sophisticated equipment that aim to save time, promote agility of the diagnosis, and facilitate the routine of the team.

It was possible to identify in the speeches of the study participants the understanding that caring by the machine is also to take care of the client, but that the behaviors to be adopted by the professionals should be beyond just attending to the equipment, that is, the focus of nursing care in ICU should be the needs of the client.

Many were the advances that hard technology brought, especially in Intensive Care, which undoubtedly collaborated for life support. However, on the other hand, it has overwhelmed an environment that, by itself, already has excesses regarding the routine and the clinical state of its target public.

The easiness with which the machine is used in the daily life of the ICU, such as the electronic measurement of parameters, which was previously manual, feeds the belief that this is a quality assistance, which helps to build the idea of many nurses to be offering humanized care.

The challenge presented in this study, and which may reflect on nursing care practices in ICUs, is to rethink the process of association between hard technologies and interdisciplinary work with the humanist vision that is necessary to the environment of technological density and intensity of routines.

In order to do so, it is essential a request for a debate that involves professionals in the care and education field in order to work on the development of strategies to be implemented both in the ICUs' performance scenarios and in the training of technical professionals and nurses. Thus, in fact, a holistic care that permeates the conduct of each professional and objective can be seen not only the maintenance of life, but also the promotion of comfort in the ICU.

It should be noted that one of the main limitations of the present study is related to the scarcity of recent literature on the subject. Therefore, it is urgent to carry out other studies that depict the triggers of vertically oriented, technical nursing care, centered on the biomedical model, to the detriment of the promotion of the humanization of care, not only through quality, technological and human resources, but also by care actions that aim at the integrality of human needs.

PERCEPÇÃO DOS PROFISSIONAIS DE ENFERMAGEM INTENSIVISTAS SOBRE A TECNOLOGIA DURA NO CUIDADO

RESUMO

Objetivo: Identificar a percepção da equipe de enfermagem sobre a tecnologia dura no cuidado em ambiente de unidade de terapia intensiva. **Métodos:** Trata-se de um estudo descritivo-exploratório com abordagem qualitativa cujos cenários foram unidades de terapia intensiva adulto de hospitais privados situados no município de Resende - Rio de Janeiro. Os dados foram obtidos por meio de roteiro de entrevista semiestruturada e analisados sob a perspectiva da análise temática com o auxílio do software Iramuteq, para 36 entrevistados. **Resultados:** Foram registrados 12751 ocorrências distribuídas e 1772 formas diferentes. As ocorrências que obtiveram maior Chi^2 foram: mudança, equipe e

taquicardia. **Conclusão:** Apesar dos avanços da tecnologia principalmente na enfermagem, o cuidado está se tornando mais burocratizado e os enfermeiros fazendo da máquina o cerne do cuidado. É preciso uma ressignificação desta forma de pensar a partir da formação dos profissionais.

Palavras-chave: Tecnologia. Cuidados críticos. Enfermagem de cuidados críticos.

PERCEPCIÓN DE LOS PROFESIONALES DE ENFERMERÍA INTENSIVISTAS SOBRE LA TECNOLOGÍA DURA EN EL CUIDADO

RESUMEN

Objetivo: identificar la percepción del equipo de enfermería sobre la tecnología dura en el cuidado en ambiente de unidad de cuidados intensivos. **Métodos:** se trata de un estudio descriptivo-exploratorio con abordaje cualitativo hecho en unidades de cuidados intensivos a adultos de hospitales privados ubicados en el municipio de Resende, Rio de Janeiro-Brasil. Los datos fueron obtenidos por medio de un guión de entrevista semiestructurada y analizados bajo la perspectiva del análisis temático con la ayuda del *software Iramuteq*, para 36 entrevistados. **Resultados:** fueron registradas 12751 ocurrencias distribuidas y 1772 formas diferentes. Las ocurrencias que obtuvieron mayor ji-cuadrado fueron: cambio, equipo y taquicardia. **Conclusión:** pese los avances de la tecnología principalmente en la enfermería, el cuidado se está volviendo más burocratizado y los enfermeros haciendo de la máquina el núcleo del cuidado. Es necesaria una resignificación de esta forma de pensar a partir de la formación de los profesionales.

Palabras clave: Tecnología. Cuidados críticos. Enfermería de cuidados críticos.

REFERENCES

1. Bidô EL, Lima TCF, Coelho NMD, Soares GS, Gonçalves RQ. Reflexões sobre a assistência de enfermagem humanizada e a tecnologia usada na unidade de terapia intensiva. Rev Conexão Eletrônica [on-line]. 2016 [citado em 2018 Set]; 13(01):01-11. Disponível em: http://revistaconexao.aems.edu.br/wp-content/plugins/download-attachments/includes/download.php?id=923.

2. Ponte KMA, Silva LF. Teoria do conforto no cuidado clínico de enfermagem: análise de conceitos e definições. Essentia [on-line]. 2016 [citado em 2018 Set]; 17(1):207-227. Disponível em: http://www.uvanet.br/essentia/index.php/revistaessentia/article/view/17.

3. Matsuda LM, Higarashi IH, Évora YDM, Bernardes A. Percepção de enfermeiros sobre o uso do computador no trabalho. Rev Bras Enferm [on-line]. 2014 [citado em 2018 Set]; 67(6):949-956. doi: http://dx.doi.org/10.1590/0034-7167.2014670613.

4. Cruz APC, Cunha MS. Formação em psicologia da saúde: tensões e potências no campo interdisciplinar. Rev NUFEN [on-line]. 2015 [citado em 2018 Out]; 07(02):137-151. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S2175-25912015000200007&lng=pt&tlng=pt.

5. Medeiros AC, Siqueira HCH , Zamberlan C, Cecagno D, Nunes SS, Thurow MRB. Comprehensiveness and humanization of nursing care management in the Intensive Care Unit. Rev esc enferm USP [on-line]. 2016 [citado em 2018 Out]; 50(5):817-823. doi: http://dx.doi.org/10.1590/s0080-623420160000600015.

6. Evangelista VC, Domingos TS, Siqueira FPC, Braga EM. Multidisciplinary team of intensive therapy: humanization and fragmentation of the work process. Rev Bras Enferm [on-line]. 2016 [citado em 2018 Out]; 69(06):1099-1107. doi: http://dx.doi.org/10.1590/0034-7167-2016-0221.

7. Louro LFM, Santiago LC, Louro TQ, Ribeiro YC, Silva RCL, Silva CRL. Comfort from the perspective of cancer client sunder going out patient chemotherapy treatment. Cienc Cuid Saude [on-line]. 2018 [citado em 2019 Jan]; 17(4):e45001. doi: http://dx.doi.org/10.4025/cienccuidsaude.v17i4.45001.

8. Ouchi JD, Lupo APR, Alves BO, Andrade RV, Fogaça MB. O papel do enfermeiro na unidade de terapia intensiva diante de novas tecnologias em saúde. Saúde em Foco [on-line]. 2018 [citado em 2018 Dez]; 412-428. Disponível em: http://unifia.edu.br/revista_eletronica/revistas/saude_foco/artigos/ano2018/054_O_PAPEL_DO_ENFERMEIRO_NA_UNIDADE_DE_TERAPIA_INTENSIVA.pdf.

9. Reis CCA, Sena ELS, Fernandes, MH. Humanization care in intensive care units: integrative review. Rev pesqui cuid fundam [on-line]. 2016 [citado em 2018 Dez]; 08(02):4212-4222. doi: http://dx.doi.org/10.9789/2175-5361.2016.v8i2.4212-4222.

10. Vila VOSC, Rossi LA. O significado cultural do cuidado humanizado em unidade de terapia intensiva: "muito falado e pouco vivido". Rev Latino-am Enfermagem [online]. 2002 [citado em 2018 Dez]; 10(2):137-44. doi: http://dx.doi.org/10.1590/S0104-11692002000200003.

11. Cavalcante AKCB, Cardoso Rocha R, Tolstenko Nogueira L, Dantas Avelino F, Santiago da Rocha S. Cuidado seguro ao paciente: contribuições da enfermagem. Rev Cubana Enferm [on-line]. 2015 [citado em 2018 Dez]; 31(4). Disponível em: http://www.revenfermeria.sld.cu/index.php/enf/article/view/907/141.

12. Camargo BV, Justo AM. Tutorial para uso do software de análise textual IraMuTeq. Laboratório de Psicologia Social da Comunicação e Cognição – LACCOS [online]. Universidade Federal de Santa Catarina, Brasil. 2013 [citado em 2018 Dez]. Disponível em: http://www.iramuteq.org/documentation/fichiers/tutoriel-en-portugais.

13. Bardin L. Análise de conteúdo. 70ª ed. São Paulo: 2011.

14. Brasil. Conselho Nacional de Saúde (Brasil). Resolução 510. Distrito Federal; 2016 [citado em 2018 Dez]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/cns/2016/res0510_07_04_2016.html.

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Submitted: 24/10/2018
Accepted: 31/05/2019