Social representations of nursing professionals on pain assessment in pediatric oncology patients

Representações sociais dos profissionais de enfermagem sobre a avaliação da dor na criança oncológica

Martins Rodrigues de Sousa[1], Edna Maria Camelo Chaves[2], Ana Raquel Bezerra Saraiva Tavares[2]

DOI 10.5935/2595-0118.20220007

ABSTRACT

BACKGROUND AND OBJECTIVES: As pain is subjective, a personal and unique experience, professionals cannot ignore it or even underestimate it, especially thinking about the pediatric cancer patient. The objective was to apprehend the social representations of the nursing technicians on pain assessment in oncological children.
METHODS: Qualitative research, based on the Representation Theory. Collection was carried out in the pediatric oncology care sector in March 2017.
RESULTS: Six nursing technicians participated in the study, their speeches were grouped through a thematic categorization, namely: category 1. Pain perception in pediatric cancer patients, with two subcategories (pain assessment methods and institutional protocol for pain assessment) and category 2: Difficulties in applying the pain assessment method.
CONCLUSION: Pain assessment of pediatric oncology patients is limited by nursing professionals, who perform it empirically or even through touching and observing face changes. Without a standardized and validated measurement instrument, this assessment may not be reliable, even though it's understandable that this is partly due to the process of adapting to the social reality that was established in the care system.

Keywords: Cancer pain, Nursing care, Oncology nursing, Pain measurement.

RESUMO

JUSTIFICATIVA E OBJETIVOS: Por ser a dor algo subjetivo, uma experiência pessoal e única, os profissionais não podem ignorá-la ou mesmo subestimá-la, ainda mais pensando na criança oncológica. Objetivou-se apreender as representações sociais dos técnicos de enfermagem sobre a avaliação da dor na criança oncológica.
MÉTODOS: Pesquisa qualitativa, utilizou como fundamentação a Teoria das Representações, coleta realizada no setor de cuidados oncológicos pediátricos, no mês de março de 2017.
RESULTADOS: Participaram do estudo seis técnicas de enfermagem, suas falas foram agrupadas, ocorreu categorização temática, a saber: a categoria 1. Percepção da dor na criança oncológica, apresentando duas subcategorias (métodos de avaliação da dor e protocolo institucional para avaliar a dor) e a categoria 2. Dificuldades para aplicação do método de avaliação da dor.
CONCLUSÃO: A avaliação da dor da criança oncológica é limitada pelas profissionais de enfermagem, que a realizam de forma empírica ou mesmo tocando e observando a alteração da face. Sem um instrumento de medida padronizado e validado, essa avaliação pode não ser fidedigna, mesmo entendendo que em parte deve-se ao processo de adaptação à realidade social que foi estabelecida no sistema de assistência.

Descritores: Cuidados de enfermagem, Dor do câncer, Enfermagem oncológica, Oncologia.

INTRODUCTION

Cancer is seen as a major public health problem worldwide, compromising not only the health of the population, but the psychological stability of those who experience it[1]. Among the causes of death in children and adolescents in Brazil, cancer stands out because it has the highest number of deaths in children and adolescents between one and 19 years old[2].
Childhood cancer involves a set of diseases consisting of the uncontrolled multiplication of abnormal cells and undifferentiated cells. The most common types are leukemias, lymphomas, neuroblastoma, Wilms' tumor, retinoblastoma, sarcomas, osteosarcomas, and germ cell tumors[3].
Individuals who receive a cancer diagnosis go through a number of changes, and when that happens during childhood it's no different. From the diagnosis and treatment to the outcome or impossibility of a cure, there are several degrees of suffering for the family, professionals, and especially for the child. These stages,

Martins Rodrigues de Sousa – https://orcid.org/0000-0002-4125-8660;
Edna Maria Camelo Chaves – https://orcid.org/0000-0001-9658-0377;
Ana Raquel Bezerra Saraiva Tavares – https://orcid.org/0000-0003-4398-2633.

1. Dr. Leão Sampaio University Center, Nursing, Juazeiro do Norte, CE, Brazil.
2. Ceará State University, Graduate Program in Nursing and Health Clinical Care, Fortaleza, CE, Brazil.

Submitted on February 05, 2021.
Accepted for publication on November 19, 2021.
Conflict of interests: none – Sponsoring sources: none.

Correspondence to:
Ana Raquel Bezerra Saraiva Tavares
E-mail: raquel.tavares@aluno.uece.br

full of meanings, cause changes that require adjustment and monitoring by the multidisciplinary team, including psychological support for the family[2,3].

During hospitalization for cancer treatment, the children go through changes in their routine due to exams, painful and invasive procedures, such as chemotherapy, and several side effects, which can affect their physical, intellectual, and emotional development[4].

The child receives treatment according to the type of cancer they present, which can be chemotherapy, radiotherapy, and surgery. Among the side effects that can arise with treatment are changes in the digestive system, such as nausea, vomiting, diarrhea, decreased appetite, and apathy, with consequent loss of hair and weight[5,6].

Thus, the nurse's assignment consists in providing assistance to cancer patients, including diagnostic assessment, treatment, rehabilitation, and family care, besides the development of educational actions with the population for the prevention and treatment of childhood cancer[1].

Nursing is present in different stages of care, integrating the family to the treatment, minimizing children's suffering, seeking to promote pain control actions, as well as recognizing the signs and symptoms of the disease[3]. The professional's qualification is important for the development of pediatric care, observing and understanding all the phenomena that involve cancer treatment[1].

A very common and distressing event in the treatment of childhood cancer is pain, defined as ''an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage"[7]. This pain may be associated with a secondary effect, such as treatment, invasive diagnostic procedures, and drug treatment, or even a combination of stress factors due to prolonged hospitalization, loss of the child's autonomy, and fear[5,6].

Even with the understanding that pain is a personal and unique experience, associated with biological, psychological, and social factors, one must remember it encompasses different phenomena[7], and one must not ignore it or even underestimate it; especially when dealing with a child with cancer. For this, the professional must be sensitive and understand pain as a phenomenon that is present in all stages of treatment.

From this perspective, the management of pain in children with cancer is considered as a fundamental nursing care, which must contemplate the multidimensionality of chronic cancer pain, taking into account the child and family suffering, as well as the underlying aspects that permeate the process of child hospitalization[6]. Thus, the Theory of Social Representations (TSR) helps to understand the pain in children with cancer using several representations for the professionals, allowing expanded assistance based on the construction of reality. Since it's a theory about the production of social knowledge[8,9], to broaden the professionals' point of view about pain would enable the production of the child's daily life, making it belong to the world of experiences lived by the professionals.

Therefore, TSR is seen as a modality of knowledge elaborated in a social and shared manner, with the objective of contributing to the construction of a reality common to the social whole[8-10].

Thus, the phenomena that are part of TSR can be seen everywhere, in culture, workplaces, institutions, social practices, and even in individual thoughts. To have a Social Representation (SR), the object of study must initially present sufficient cultural relevance or social thickness[10].

Therefore, it's importance to understand the knowledge that nursing technicians have about pain assessment measures in children with cancer and the means of intervention they use to prevent pain. And so, the present study's objective was to apprehend the social representations of the nursing technicians on pain assessment in oncological children.

METHODS

This study was based on the Consolidated Criteria for Reporting Qualitative Research (COREQ)[11] guide. This research respected all the ethical precepts of Resolution 466/2012, which governs research involving human beings, under opinion number 2.085.927.

The final term nursing student author conducted all interviews after being trained for conducting interviews.

There were no previously established relationships between interviewees and interviewers. Initially, the sample participants did not know any information about the interviewer, nor what their personal objectives were, nor the reasons that motivated them to develop the research. Subsequently, the objective established in the present research was presented: to investigate the SRs of nursing technicians about pain assessment in pediatric oncology patients. Moreover, the participants were not told any information about the interviewer, what their expectations, assumptions, reasons, and interests would be in the research topic.

Qualitative research which used the SRT as a basis to investigate pain in the pediatric oncololy patients.

The sampling process was by convenience. The collection was carried out in the Pediatric Oncology Care Sector of a reference hospital in Ceará. The Pediatric Oncology Unit is attached to the pediatric ward of the referred hospital. During the collection period, one nurse and six nursing technicians worked at the unit. The authors chose to interview the technicians in order to reach the proposed objective, obeying the inclusion criteria: nursing technicians, working in the pediatric oncology sector and with more than 6 months of experience in the field. The exclusion criteria were nursing technicians with less than six months of service and those who were on vacation and/or on sick leave.

The participants were personally approached, with previously scheduled dates and times. Six nursing technicians were included in the study. None refused to be interviewed or withdrew from the study afterwards.

The data were collected at the professionals' workplace, at the nursing sector rest area, in a calm and private environment, with only the interviewer and the participant present, preserving their individuality. It is worth remembering that some data from the participants were collected, such as gender, age, length of professional experience in the unit, and professional training and qualification courses.

The interviewer provided initial instructions and questions for the study sample, using a semi-structured interview script with guiding questions that could meet the research objective, without having carried out a pilot test stage. The interviews were conducted only once with each participant. It must be said that the participants were questioned about the use of pain assessment scales in the pediatric oncology sector. However, due to the lack of use of validated and standardized instruments, the script was adapted to understand how the nursing technicians perform and comprehend the children's pain.

Each interview lasted approximately 30 minutes, and no tape recorders were used. No field notes were made during and/or after the interview. Data saturation was not discussed in this study. Transcripts were returned to the participants for comments and editing of the transcribed information, being returned afterwards to the researcher.

Four encoders were used, representing two categories, and one of the categories presented two subcategories. Through the reports of the interviewed professionals, themes were derived from the data, which generated the thematic categorization, as follows: 1. Pain perception in in pediatric cancer patients (which presented, in turn, two subcategories: 1.a. Pain assessment methods and 1.b. Institutional protocol for pain assessment) and 2. Difficulties in applying the pain assessment method.

The participants' quotes are presented to better exemplify and illustrate the findings obtained during the interviews. Each quote is identified to preserve the participants' anonymity and organize the data, using the NS codes, referring to each ''nursing technician", followed by numbers, determining the sequence of the interviews.

RESULTS

All the research participants were female nursing technicians. Regarding the time of experience in pediatric oncology, one of the participants had between six months and one year of experience, three had between two and five years and two had between 10 and 16 years of experience.

As for training courses and/or specific specialization in pediatric oncology, none presented training in the area, but they had professional experience in Pediatrics, Clinical Medicine, Surgery Center and Geriatrics.

In the first category, it was possible to observe the perception that the nursing technicians have in recognizing the pain that is felt by the pediatric cancer patient, as well as recognizing at which moments it presents a greater occurrence, outlining reactions to pain, and which methods they use to perform pain assessment.

"I perceive it by the manifestations, like in the case of restlessness, frequent crying, agitation, pale skin and sweating" (NS2).
"I do perceive it, yes, it's persistent crying, irritability, they get restless" (NS3).
"Yes. So, because it's noticeable, isn't it? The crying, it's the crying" (NS6).

Others stated that pain is only seen during procedures that are known to be painful, such as: venous access, dressings, and drug administration. However, one interviewee reported pain as a factor arising from the disease itself and another mentioned fear.

"Let's say, if the pain is from a surgery or something, when I touch them, the child immediately starts crying, gets irritated. And if it's from the access, when you're going to do a medication and it's not yet in the vein, just by touching them, sometimes just by seeing it they already start crying" (NS4).
"In a peripheral puncture, in the administration of medication, it's routine, right? Because normally a child feels pain when you are going to do a procedure or because of their illness, depending on the stage it's in" (NS1).
"When we are doing some kind of procedure, some children are crying, sometimes because they are in pain, but sometimes not. Because they are afraid, when we are puncturing an access, changing dressings, because we are touching them, sometimes it's not pain, we realize it's not pain, it's just fear" (NS5).

When questioned about knowledge of methods that can be used to evaluate and measure the child's pain, only one individual reported a numerical scale, describing how it's applied.
"I know the one with the number scale. The numerical scale that you ask the child to say how much is their pain, from 0 to 10?" (NS1).

The other participants were unable to list valid pain assessment instruments, and demonstrated in their statements that they perform assessments using empirical methods, such as palpation and child movement or even the subjective experience of several years working in the field.
"Yes. In that case, by touching the child, when you pick them up, in that case sometimes when you put them on the bed or on the chair, then you realize that they are in pain" (NS6).
"The best-known method in this case is palpation" (NS2).
"When touching, moving the child, we identify if they are feeling pain or not" (NS5).
"What we use most of the time is touch, we touch the affected place, where the mother thinks the child is feeling, if the crying persists, we tell the doctor" (NS4).
"From my experience, I observe a lot, you know! I observe how that child is, how they are behaving, that's basically it. It's more of a matter of experience" (NS3).

Institutional protocol for pain assessment

As the pediatric oncology unit does not have an institutional protocol to evaluate pain, the nursing technicians observe other alterations in the children. Therefore, the nonexistence of a validated and standardized protocol hinders the professionals' conducts, as well as the adequate assistance to the child and reiterates that if it exists, it was not passed on to all professionals.
"Not a protocol" (NS4).
"No, I don't use it here in pediatric oncology" (NS5).
"No. I don't know that. In that case, only the children's complaints" (NS6).
"No, we don't have this practice of that method. It's more through the symptoms" (NS2).
"Not to my knowledge. If there is, it was not passed on to the professionals" (NS1).

"No. I don't use this method, the evaluation is during contact with the child, when puncturing 'an access', it's the only way to assess pain, if you are going to move them, then you see it through the crying and restlessness" (NS3).

Difficulties in pain assessment

As the nursing technicians did not go through any type of training and qualification course on humanization of assistance to pediatric cancer patients which contemplated pain assessment, there was difficulty in responding how they recognize pain in a technical manner based on literature, showing that the empirical assessment stands out, in addition to the years of professional experience, which leads them to question and disqualify the real existence of this pain.

"You have to know how to deal with the child to know if it's a hunger cry, if it's really from pain. For example, a child that doesn't want to suck, a child that never soothes, that frequent crying, that child is not normal, something is happening, they are having some pain, I see it that way, because a child that cries is feeling something" (NS3).

"There is! I just can't say which one is it" (NS4).

"No, it's not easy. Many times the child is not in physical pain, sometimes it's psychological pain, because of the environment they are in, the state they are in" (NS5).

To create evaluation methods due to the nonexistence of standardization, in addition to observing the child's behavior allied to professional experience, makes it possible to correctly interpret their reactions regarding the child's pain.

"Yes, it's hard because you don't have a method to evaluate. An effective method that can be used and give an immediate answer, we don't have" (NS2).

"In reality, as I said, it doesn't exist, we create it, many times, as I gave the example of medications, because it's the only way we have, but in reality it doesn't exist" (NS1).

"No, I don't think it's easy, it will depend a lot on your experience, the day to day with that child" (NS6).

All participants considered it's not easy to evaluate pain, even more so when one does not know and does not consider pain to be something real. It's noteworthy that not only observation, but also sensitization and time of experience as a professional make it possible to assess pain and manage it adequately, minimizing suffering and trauma.

DISCUSSION

The interview fragments showed the existence of pain representation in pediatric oncology patients because the interviewees recognize pain during treatment and procedures, but don't know how to quantify it. The technicians question whether the pain is real or imaginary, ignoring the information reported by the child.

The representations are complex phenomena that act on social life. This complexity allows us to say that their manifestation can occur through several elements, whether they are information, beliefs, or opinions. With that, these phenomena are passed on and shared with the practical objective of building a reality that is common to a given social group[8]. The participants in this study recognize pain mainly through the child's behavior, through restlessness, frequent crying, agitation, paleness and sweating. However, validated instruments that measure pain has not yet been introduced in the unit's routine to achieve effective assessment.

The pain in children with cancer is sometimes only recognized when a painful procedure is performed, such as puncture or in the postoperative period. However, professionals question whether the pain is real or imaginary. This discredit in the child's speech can be evidenced when the participant mentions the appearance of pain due to the fear of puncture, and this leads to a reflection about the representation of the child's speech or the construction of childhood itself.

Childhood was constructed from several historical, cultural, social, and economic events that have interfered and may still interfere in this social construction. The conceptions seen as "universalizing" and "naturalizing" are based on other childhoods, although they may have been constituted from social constructions, entangled in several meanings according to the different layers of society[12].

The professional's view on children pain and their speech is important as to whether it's real or imaginary, but it's necessary to understand how the professional sees, evaluates, and believes in the children and their speech, since failure in this understanding can lead to neglection and/or underestimation of pain, causing more suffering.

When considering the social representations of cancer, its dimensions must be detected, especially the negative ones verbalized by the patients, always associated with fear of death, suffering, and pain, besides the often prolonged treatment, leading to difficulty in coping with the disease. However, even with the comprehension of the association between the severity of neoplasms and pain and suffering, it's necessary to rethink ways to give new meaning to the experience, broadening the view to allow "living, feeling, and speaking",[13] respecting the age of those involved, as well as their identity and belonging.

When the social construction of childhood based on social reality is analyzed, not justifying the view that excludes the child's speech, it's possible to understand how the professionals built their concept of childhood. Thus, these actions entail the production and reproduction of these realities, leading to the compromise of the care provided[12].

Observing and understanding each representational element is important in pediatric care, considering the complexity of the changes in daily life related to childhood illness, both in the individual and family contexts, and its new social configuration[13].

What has been frequent in clinical practice is the construction of power in decisions during hospitalization and childcare, which has always been subordinated to their legal guardians, whether biological parents or guardians, and health professionals. Evidently, due to the legal characteristics developed in Brazil, the child has no space to give their opinion or even participate in this decision making, nor in the procedures that will be performed[14].

These representations compose the collective consciousness, and explain objects and events surrounding the phenomenon, making them more accessible to anyone's understanding[10].

To use only empirical methods when evaluating pain, justified by professional experience, can result in an inadequate assessment due to a lack of reliability. The SR is a socially elaborated form of knowledge, built along social interactions with the world, which can be seen during the interaction among the care performers. By observing the grouping of these sets of meanings, it's possible to give meaning to both new and unknown facts, but present in daily life[8] such as the recognition of pain in pediatric oncology patients.

In the social representations of cancer patients, the treatment is seen ambiguously; on the one hand, it's an option for cure, and, at the same time, it's full of adverse effects resulting from the therapy[15]. Thus, this negative apprehension of the treatment experience, combined with the professional disbelief of the pediatric patients' pain symptoms, confirms this image of pain and suffering, resulting in a negative impact on the treatment.

The nursing team, through their daily and uninterrupted monitoring of the patients, can help by providing humanized conditions during treatment[15]. For this, it's necessary that the professional shows empathy to the pain condition of the children, allowing the reconstruction of their social representations.

In the institutional protocol subcategory, there is a lack of standardization for assessment, hindering the quality of care and patient safety, because the absence of a validated assessment tool makes it possible for professionals not to recognize the event, jeopardizing their conduct, in addition to minimizing or disqualifying suffering.

To reflect on patient safety in pediatric oncology, understanding the children's growth and development and perceiving the family as an ally in care, allows for a comprehension of all particularities and singularities, considering the caregiver's speech. Among the main causes that can compromise the children's safety are: identification, professionals' experience, performing technical procedures, drug dosage calculations, and interprofessional communication[16].

This patient safety is directly related to quality in care delivery and should be effective in all health care areas. The World Health Organization (WHO) states that safety should be seen as the absence of avoidable harm to the patient during care, as well as the reduction of risks of damage or injuries that are related to health care[17].

Therefore, the SR in the study participants' speeches about the absence of instruments reflect the reality that many health institutions experience. This lack of standardization expressed in a construction of several meanings that permeate an interpretation of reality, showing the lack of assessment standardization, results in an empirical assessment guided by professional knowledge and observation. Thus, this care presents a gap, represented by the construction of SR of the professionals.

These SRs contribute to the common identity of the individuals, promoting social identifications and differentiations, based on affiliation and belonging to the social group. Thus, this social categorization, constructed between "who we are and who we are not", leads to an understanding of reality that will determine their identity[18].

Providing a safe care to pediatric oncology patients based on international safety goals contributed to the quality of nursing care. Thus, the work process of nursing technicians should guarantee safe pediatric care, considering that children have anatomical and physiological differences, as well as different stages of development, with specific needs for each age group[17].

The role of nursing, in addition to performing care, involves the process of assistance, assessment, planning, intervention, guidance, performance of procedures, and administration of drugs, carried out with knowledge and professional commitment. The lack of quality in this process can lead to adverse events that could be avoided by management interventions, such as training the team through continuous education on all stages of care, aiming for greater patient safety in pediatric oncology[19].

Ensuring the child receives safe care is part of the planning that allows the continuity of care[17], especially when analyzing pain events that the child experiences during treatment for cancer. This relationship in which nursing is inserted allows patients to express their anxieties and demonstrate their needs[20], however, the analysis of the participants' speeches shows the little credibility of the child's pain report.

The use of instruments that assess the intensity of pain events by the nursing team minimizes anxiety when facing the unknown. For this, talking to the child, guiding and encouraging collaboration during treatment, besides clarifying doubts, will considerably reduce fear and pain.

The professional must observe the child's level of development, if it's preverbal, if the child is able or unable to communicate their pain, and also observe other manifestations such as crying, facial alterations, or gestures, allowing the measurement of pain by means of standardized instruments. Health services must select instruments that are in accordance with the child's specific condition in order to avoid difficulties in handling by the team, favoring the quality of care.

The limitation of this study is the small sample obtained by convenience in a hospital service.

CONCLUSION

Pain assessment in oncologic pediatric patients performed by nursing technicians is inadequate, since they perform it empirically through non-standardized observations of the children's behaviors or reports. The empirical evaluation, supported only by professional experience, may have been originated in the construction of the process of adaptation to the social reality that has been established in the care system.

AUTHORS' CONTRIBUTIONS

Martins Rodrigues de Sousa
Data Collection, Research, Writing - Preparation of the original
Edna Maria Camelo Chaves
Writing - Review and Editing
Ana Raquel Bezerra Saraiva Tavares
Methodology, Writing - Review and Editing, Supervision

REFERENCES

1. Rolim DS, Arboit EL, Kaefer CT, Marisco NS, Ely GZ, Arboit J. Produção científica de enfermeiros brasileiros sobre enfermagem e oncologia: revisão narrativa da literatura. Arq Cienc Saúde UNIPAR. 2019;23(1):41-7.
2. Santos MR, Wiegand DL, Sá NN, Misko MD, Szylit R. From hospitalization to grief: meanings parents assign to their relationships with pediatric oncology professional. Rev Esc Enferm USP. 2019;53:e03521.
3. Santos GFATF, Alves DR, Oliveira AMM, Dias KCCO, Costa BHS, Batista PSS. Cuidados paliativos em oncologia: vivência de enfermeiros ao cuidar de crianças em fase final da vida. Rev Fun Care Online. 2020;12:689-95.
4. Neves SJO, Prado PF. Contação de Histórias em Unidade Oncológica Pediátrica. Rev Bras Cancerol. 2018;64(3):383-7.
5. Díaz-Morales K, Reyes-Arvizu J, Morgado-Nájera K, Everardo-Domínguez D. Síntomas en niños con cáncer y estrategias de cuidado familiar. Rev Cuid. 2019;10(1):e597.
6. Silva TP, Silva LJ, Ferreira MJC, Silva ÍR, Rodrigues BMRD, Leite JL. Aspectos contextuais sobre o gerenciamento do cuidado de enfermagem à criança com dor oncológica crônica. Texto Contexto Enferm. 2018; 27(3):e3400017.
7. Santana JM, Perissinotti DMN, Oliveira Junior JO, Correia LMF, Oliveira CM, Fonseca PRB. Definição de dor revisada após quatro décadas. BrJP. 2020;3(3):197-8.
8. Sousa KN, Souza PC. Representação social: Uma revisão teórica da abordagem. Research, Society and Development. 2021;10(6):e38610615881.
9. Bertoni LM, Galinkin AL. Teoria e métodos em representações sociais. In: Mororó LP, Couto MES, Assis RAM. Notas teórico-metodológicas de pesquisas em educação: concepções e trajetórias [online]. Ilhéus, BA: EDITUS, 2017, pp. 101-122. DOI: 10.7476/9788574554938.005. Disponível em: http://books.scielo.org/id/yjxdq/epub/mororo-9788574554938.epub.
10. Araújo EM, Vieira VMO, Borges HV. A experiência de vida como um sistema dinâmico e aberto: um diálogo entre Merleau-Ponty e Moscovici. Braz J Develop. 2021;7(8):85367-94.
11. EQUATOR Network. Enhancing the QUAlity and Transparency of health Research (EQUATOR Network) [Internet]. EQUATOR Network. 2019. [cited 2020 Mai 20]. Available from: http://www.equator-network.org/
12. 12. Martins EC, Viana CVA. Representação da infância e representatividade infante: posições ético-políticas. Psicol Clin. 2020;32(1):151-72.
13. Wakiuchi J, Oliveira DC, Marcon SS, Oliveira MLF, Sales CA. Meanings and dimensions of cancer by sick people – a structural analysis of social representations. Rev Esc Enferm USP. 2020;54:e03504.
14. Bubadué RM, Cabral IE, Carnevale F, Asensi FD. Análise normativa sobre a voz da criança na legislação brasileira de proteção à infância. Rev Gaúcha Enferm. 2016;37(4):e58018.
15. Wakiuchi J, Marcon SS, Oliveira DC, Sales CA. A quimioterapia sob a ótica da pessoa com câncer: uma análise estrutural. Texto Contexto Enferm. 2019;28:e20180025.
16. Franco LF, Bonelli MA, Wernet M, Barbieri MC, Dupas G. Patient safety: perception of family members of hospitalized children. Rev Bras Enferm. 2020;73(5):e20190525.
17. Ferraz SCS, Rocha PK, Tomazoni A, Waterkemper R, Schoeller SD, Echevarría-Guanilo MEC. Uso das tecnologias de enfermagem para uma assistência segura no perioperatório pediátrico. Rev Gaúcha Enferm. 2020;41:e20190251.
18. Silva RC, Ferreira MA, Apostolidis T. Ser enfermeira intensivista: elementos identitários presentes no campo das representações sociais. Rev Enferm UERJ. 2018;26:e20787.
19. Manzo BF, Brasil CLGB, Reis FFT, Correa AR, Simão DAS, Costa ACL. Segurança na administração de medicamentos: investigação sobre a prática de enfermagem e circunstâncias de erros. Enferm Glob. 2019;18(56):19-31.
20. Frías EL, Ruiz MAV, García CC. Clima ético y cultura de seguridad del paciente pediátrico en un hospital de especialidad del sureste de México. Horizonte Sanitario. 2019;18(2):201-10.