QUALITY OF NURSING RECORDS IN INTENSIVE CARE: EVALUATION THROUGH A RETROSPECTIVE AUDIT*

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ABSTRACT: This study aimed to evaluate, through a retrospective audit, the quality of the nursing records made in an Intensive Care Unit in a public teaching hospital. This study analyzed 50 hospital records of clients who had been hospitalized for more than three days in the Department, in the period May – July 2009. Records were considered to be quality if their Percentage of Completion (PoC) ≥ 80%; Incomplete up to 15%; Not Completed with less than 5% and; Incorrect 0%. It was ascertained that no records met all the quality criteria proposed, given that the mean PoC was 46% Complete; 43% Incomplete; 10% Not Completed and 1% Incorrect. It is concluded that the nursing records do not satisfy the quality items, and that investments are therefore necessary in raising awareness, training and constant monitoring of the team, such that adequate records may be made.
DESCRIPTORS: Nursing audit; Quality of health care; Evaluation in nursing; Intensive care; Intensive care units.

QUALIDADE DOS REGISTROS DE ENFERMAGEM EM TERAPIA INTENSIVA: AVALIAÇÃO POR MEIO DA AUDITORIA RETROSPECTIVA

RESUMO: Estudo que objetivou avaliar, por meio da auditoria retrospectiva, a qualidade dos registros de enfermagem realizados em uma Unidade de Terapia Intensiva de um Hospital Universitário Público. Nesta pesquisa foram analisados 50 prontuários de clientes que permaneceram internados por mais de três dias no setor referido acima, no período de maio a julho de 2009. Consideraram-se de qualidade os registros com percentual de preenchimento completo ≥ 80%, incompleto até 15%, não preenchido com menos de 5% e incorreto 0%. Verificou-se que nenhum registro correspondeu a todos os critérios de qualidade propostos, visto que o percentual de preenchimento médio foi de 46% completo, 43% incompleto, 10% não preenchido e 1% incorreto. Concluiu-se que os registros de enfermagem não correspondem aos quesitos da qualidade sendo necessário, portanto, investimentos na sensibilização, capacitação e monitoramento constante da equipe, para que se realizem registros adequados.
DESCRITORES: Auditoria de enfermagem; Qualidade da assistência à saúde; Avaliação em enfermagem; Cuidados intensivos; Unidades de terapia intensiva.

CUALIDAD DE LOS REGISTROS DE ENFERMERÍA EN TERAPIA INTENSIVA: EVALUACIÓN POR MEDIO DE LA AUDITORÍA RETROSPECTIVA

RESUMEN: Estudio que buscó evaluar, por medio de la auditoría retrospectiva, la cualidad de los registros de enfermería realizados en una Unidad de Terapia Intensiva de un Hospital Universitario Público. Fueron analizados, en esta investigación, 50 prontuarios de clientes que se quedaron internados en ese sector por más de tres días, en el periodo de mayo a julio de 2009. Fueron considerados registros de cualidad aquellos con porcentual de relleno completo ≥ 80%, incompleto até 15%, no rellenado con menos de 5% e incorrecto 0%. Se verificó que ningún registro correspondió a todos los criterios de cualidad propuestos, ya que el porcentual de relleno medio fue de 46% completo, 43% incompleto, 10% no rellenado y 1% incorrecto. Se concluyó que los registros de enfermería no corresponden a los criterios de cualidad, siendo necesario, por lo tanto, inversiones en la sensibilización, capacitación y acompañamiento constante del equipo, para que se realizen registros adecuados.
DESCRIPTORES: Auditoría de enfermería; Cualidade de la asistencia a la salud; Evaluación en enfermería; Cuidados intensivos; Unidades de terapia intensiva.

*Article resulting from a Master's dissertation, titled: 'Auditing as a Tool for the Quality of Nursing Care in an Intensive Care Unit in a Teaching Hospital', presented to the Postgraduate Program in Nursing at the State University of Maringá, State of Paraná-PR-Brazil.

Received: 02/10/2012
Finished: 26/02/2013

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INTRODUCTION

The advent of globalization, the transformation of the economy and the growing incorporation of new technology has driven society increasingly to seek quality, whether in products manufactured or in services provided.

In the ambit of health, the conception and practice of ensuring quality have found a legitimate space since the 1990s. Prior to this, the formal concern regarding this attribute, in the medical-hospital services, was very small, as health care was poorly distributed and, in general, of low quality, which caused dissatisfaction in the service users[1].

In the area of nursing, the first formal initiatives in the interests of quality arose in the United States of America (USA) in the 1940s, with the proposal for evaluating the quality of the institutions training nurses, and with programs for continuous improvement for professionals, following their academic training[2].

In Brazil too, following the example of the USA, one can observe actions directed towards care quality in nursing, although on a lesser scale. Among other measures which promote continuous improvement in nursing, the creation of the Nursing Process (NP) stands out; along with the mandatory nature of its implantation in all Brazil's health establishments[3], and the growing use of processes for evaluating the quality of the care given, among others.

Regarding the processes for evaluating care, emphasis is placed on Quality Auditing, which can be undertaken in two ways: Operational Auditing and Retrospective Auditing. The first is based on the conditions of the patient/client/service user, in the environment where he/she receives the care. The second, on the other hand, encompasses the evaluation of the nursing records, undertaken in the hospital records of the patient following his or her discharge[4].

The nursing records or notes are an important form of written communication of the actions undertaken/observed and of the information obtained from the patient/family, with the essential purpose of providing data on the care given, ensuring communication between the health team members, and guaranteeing the continuity of the care[4-5].

In the light of the importance of nursing records, both for the profession and for the patient, Retrospective Auditing, which encompasses the evaluation of the records, is the most traditional in the field of nursing. Furthermore, this type of audit also stands out because of the fact that there is no need for the auditor to be present while the care is being carried out, which facilitates its undertaking[6].

The evaluation of the nursing records is an important action because it allows the verification not only of the quality of the content, but also of the team's professional practice. Despite the importance which evaluating the nursing records has the system of care and for the patient's health, studies on this issue using retrospective auditing are not very frequent in Brazil[4,6-7]. Moreover, regarding the evaluation of the nursing records in Intensive Care Units (ICU), the rate of publications is even lower[8].

In considering the gap which exists in the ambit of retrospective auditing of nursing records in intensive care, and the importance of frequent and complete notes, given that this may reflect the quality of the care provided, it is asked: What is the nature of the record-taking in an Intensive Care Unit? In order to respond to this question, it was proposed to undertake the present study, which aims to evaluate the quality of the nursing records made in an Adult ICU (A-ICU) in a public teaching hospital, through retrospective auditing.

METHOD

This descriptive, retrospective, quantitative study was undertaken in the period May – June 2009 and used the nursing records of patients hospitalized in an A-ICU in a public teaching hospital located in the Brazilian state of Paraná. The sample was made up of 50 hospital records of patients/clients/service users aged 18 years old or over and who had spent a minimum of three days in the Unit studied.

The data collection instrument used was a two-part questionnaire: the first contained items relating to the patient's personal data, and the second was a script elaborated by the Quality Control Advisory Body of Nursing Assistance (ACQAE) team of the Londrina Teaching Hospital in Paraná, made up of seven items and 52 sub-items, distributed as follows: Item I – Identification Data; Item II – Nursing Prescription; Item III – Nursing Procedures; Item IV – Nursing Records; Item V – Undertaking of the Medical Prescription; Item VI – Discharge Conditions and Item VII - Intensive Care Unit.

Only one response was marked for each sub-item on the script, out of the following possibilities: 1 – Not applicable; 2 - Complete; 3 - Incomplete; 4 – Not filled out and 5 - Incorrect. The audit encompassed the records/notes made by the A-ICU nursing team, made in the first 24 hours of hospitalization, on the third day, and on the last day, following the same criteria adopted by the ACQAE of the Londrina Teaching Hospital (PR).

In the process of treating the data, these were categorized and compiled in a computerized database in the Microsoft Office Excel 2007 program, after which statistical analysis was undertaken, using the calculation of the relative frequency of the responses obtained for each item of the Script in order to obtain the Percentage of Completion (PoC).

Items on the script were considered to be quality if they presented a joint PoC superior to 80%; Incomplete of up to 15%; Not Filled Out inferior to 15% and Incorrect of 0%[1]. The data will be presented in tables, containing the seven items of the Script and the respective PoCs for each response possibility, apart from response 1 – Not applicable.

The patient's authorization was sought for using their hospital records – where this was not possible, it was sought from the responsible family member – through signing the Terms of Free and Informed Consent, in two copies. Of these, one was handed to the subject/family member, and the other remained in the possession of the researcher. The research project for this investigation was approved by the Standing Committee for Research Involving Human Beings, of the State University of Maringá, under Decision N. 132/2009.

RESULTS

The results obtained for PoC Complete, Incomplete, Not Filled Out and Incorrect, for each of the items on the script, are shown in Table 1.

As may be observed in Table 1, item I, Identification Data presented the study's second highest Incomplete PoC, (60%), a value four times higher than the maximum value established for quality (up to 15%). Another item which evaluated the records made by the nursing team was number II – Nursing Prescription, which obtained Complete PoC of 67%, this being the item which presented the study's highest Complete PoC, although the value obtained was below that established (> 80%).

In III – Nursing Procedures, the Not Filled Out PoC of 18% stands out, as a value more than three times higher than that stipulated (below 05%). Item IV – Nursing Records – obtained Incomplete PoC of 45%, which characterizes a percentage above that stipulated for this study (up to 15%). Item V, Undertaking of the Medical Prescription, had the highest Incorrect PoC (03%) compared to the specified value (0%) as well as a Complete PoC (53%) far below that stipulated (>80%). Regarding item VI – Discharge Conditions, the Incomplete PoC was 78%, with the PoC obtained in this item being the largest observed, far above that proposed (up to 15%).

The last item, number VII, which evaluated the records made by the nursing team, stood out with the highest Not Filled Out PoC (20%). The records referent to this item had values superior to that considered to be quality (below 05%).

Table 1 - Distribution of the Percentages of Completion of the nursing records made in the A-ICU of the teaching hospital. Cascavel (PR), 2013

Items Evaluated		Percentage of Completion			
		Complete	Incomplete	Not filled out	Incorrect
I	Identification Data	38	60	01	01
II	Nursing Prescription	67	25	08	00
III	Nursing Procedures	65	15	18	02
IV	Nursing Records	48	45	07	00
V	Undertaking of the Medical Prescription	53	43	01	03
VI	Discharge Conditions	03	78	19	00
VII	Intensive Care Unit	45	35	20	00
General mean		46	43	10	01

DISCUSSION

The incomplete filling out of Patient Identification data, especially regarding family name, is concerning as the incomplete registration of these data can cause harm to the patient, mainly related to the administration of medications, blood products and the collecting of material for tests[9].

In order to minimize the risks arising from lack of identification, the literature referring to patient safety proposes strategies such as: confirmation of the full name with the patient; the use of at least two identifiers (for example: full name and date of birth) and standardization of the filling out of identification bracelets[10].

The incomplete filling out of data observed in the Nursing Prescription occurred mainly in the sub-items related to the prescription of special care in accordance with the pathology's signs and symptoms and the progression of the patient; the presence of the signature and; the checking of the nursing care prescribed by the nurse.

In relation to the incomplete filling out of the prescription for special care, it was observed that the care prescribed was similar for all the patients, with the care listed in the unit's routine predominating, such as: washing of the patient's body; oral hygiene and ocular hygiene, among others which do not require accurate knowledge of the signs and the symptoms and the patient's progression.

The characteristic of the Nursing Prescriptions observed in this study is similar to those analyzed in a study undertaken in a hospital in Porto Alegre (in the Brazilian state of Rio Grande do Sul), in which the Nursing Technicians stated that the Prescriptions undertaken by the nurses were very similar and that they were only undertaken when the patient's clinical situation was serious[11].

Conduct such as that mentioned above tends to hinder the nursing team's work process because the Prescription's lack of specificity can cause the patient not to receive the care necessary for her clinical condition or, further, causes the technical team to undertake care which is different from that prescribed by the nurse[12].

For the issue of the Nursing Prescription's lack of specificity to be minimized, it is necessary to invest in raising nurses' awareness regarding the need to undertake this, associated with professional training regarding improving their clinical reasoning[13]. In addition to this, it is necessary for the technical team to recognize its importance in the patient's recovery and in the organization of the actions to be undertaken in the unit[11-12].

In relation to the lack of the signature and the checking of the care prescribed by the nurse, it is believed that this results from the low value which the team attributes to the Prescription, which according to the workers, does not correspond to the patient's specific needs.

Even if the nursing care prescribed does not deal with specific/individual actions, as would be appropriate, this being a legal document[5], the checking and the signature must be present to provide evidence that the care has been undertaken. Moreover, the lack of these items inevitably creates doubts which can result in harm to the continuity of the care and to the checking of judicial/ethical processes[5].

The failure to fill out the Nursing Procedures was most frequent in the records related to the undertaking of oral hygiene and daily washing of the patient's body. The absence of records of these procedures is also concerning, because, even being considered "routine" care, they are very important for the patient's well-being and recovery. Moreover, the lack of information indicates that the hygiene care is not valued by the team.

From the ethical and legal point of view, only the recording of the undertaking of an activity can actually guarantee that this was undertaken by the nursing professional[5]. This being so, the recording of the activities undertaken is always necessary because it promotes greater visibility of the professional category and contributes to the comprehensiveness of the care given to the patient[12].

The incomplete Nursing Records occurred, above all, in the time and in the signature in each record made; in the description of the admission, of the discharge, or the death of the patient, and; in the recording of the appearance and the progression of the skin wounds.

Regarding the time and signature, it was ascertained that the nursing records are not written in accordance with the recommendations of the Federal Nursing Council (Cofen)[14], which

emphasizes, among other aspects, the need to record the time before/at the beginning of the record and the professional identification, after/at the end of the same. The inclusion of these data, according to the above-mentioned body, is necessary as the complete recording of the nursing records is an ethical responsibility, specified in the category's Code of Ethics[14].

Failure to comply with Cofen's recommendations, regarding the presence of the time and signature in each record, is a datum found not only in this study, but also in a study undertaken in another public teaching hospital, which indicated that the records evaluated did not reach the appropriate percentage regarding the time and signature[7], suggesting that in the Service investigated, the nurses were failing to value the regulatory norms for exercising the profession.

In relation to the Incomplete filling out observed in the records for admission, discharge or death, it is believed that in the case of admission, this occurs due to the excessive care burden when it is undertaken, due to the need to prioritize direct care to the patient at the time of their arrival, which, theoretically, is one of the patient's most serious periods. In spite of this, the team cannot dispense with making records referent to the activities undertaken, because the information recorded is necessary for the continuity of the care and the quality of the same.

Regarding the incomplete filling out of the discharge records, the literature indicates that due to involvement with the unit's duties, the nursing staff do not record the information immediately after the patient leaves the Department/unit, and that because of this, the patient's hospital records, often, are collected for archiving without such information[1,7].

Regarding the appearance and the progression of the skin wounds, it was observed that there were no complete nursing records with all the necessary data. This data corroborates the results of other studies which indicate the occurrence of incomplete records regarding the appearance and the progression of skin wounds in hospitalized patients[4,7].

The making of incomplete records regarding care for skin wounds, in addition to being characterized as a lack of commitment and an omission of care on the part of the nursing team, interferes in their treatment, given that for the continuity of the same, sufficient and exact information is necessary regarding the actions undertaken and the daily progression of their characteristics[7].

Incorrect filling out regarding the Undertaking of the Medical Prescription in this study was observed particularly in sub-item Transcription of Medical Guidance for the Nursing Prescription. This data is also reason for great concern because the guidance contained in the Medical Prescription generally refers to issues which are not routine and which require greater attention from the nursing team.

The fact that incorrect transcription occurs indicates lack of attention on the part of the professional nurse regarding the special care which the patient requires, and this conduct can compromise the patient's safety, especially if the medical advice refers to restriction of movement, and the checking of vital signs with greater frequency, among others.

In order that the medical guidance should not be transcribed incorrectly, it is suggested that the nurse should read all of the Medical Prescriptions at the start of her care activities so as to identify the special care required for particular patients, and that only after this should she transfer this care, correctly and safely, to the Nursing Prescription.

Furthermore, in relation to the low Complete PoC of this study, it was also observed in the Undertaking of the Medical Prescription, in the items regarding checking of medications prescribed, in particular in the items: insulin; plasma volume substitutes and normal saline 0.9%.

The incomplete checking of the medication prescribed by the doctor creates doubts relating to whether it has been undertaken or not[7] and this uncertainty can lead to the patient receiving duplicate drug therapy or not receiving it at all. The checking of medications is, therefore, a fact which causes great concern because it involves risks and harm to the patient's progression and prognosis. In the economic ambit, the incomplete checking of medications prescribed promotes failure to bill, causing economic harm to the institutions[15].

In the Discharge Records, incomplete filling out was present mainly in the records made regarding the patient's physical condition at the time of her discharge, and in the guidance for the

continuity of the care and treatment.

Studies indicate that incomplete filling out of data regarding the patients' discharge conditions also occurs with patients who are not seriously ill, and that this lack of records may be associated with the fact of professionals delaying making the report until after the patient has left the hospital, which may cause the professional to forget things and, through this, not to record important data[1,4].

In the specific case of intensive care, where the patient is not normally discharged directly home, but, rather, moves to another inpatient care unit (semi-intensive care unit or inpatient unit), complete records regarding the patient's discharge conditions contribute to the avoiding of the loss of important information, such as that referent to care undertaken, which allows the continuity of the treatment in the inpatient unit to which the patient was referred[4].

In the records referent to the Intensive Care Unit item, a high percentage of non-filling out in the sub-item Recording of the Undertaking of Physical Examinations once per shift was observed.

The above-mentioned datum is worrying because the physical examination is the main procedure supporting the planning of the nursing care, and the low percentage of its undertaking observed in this study may be a strong indication that the Systematization of Nursing Care (SAE in Portuguese) is undertaken incorrectly or inadequately.

The fragmented application of SAE hinders its use as a scientific instrument for the exercising of nursing, given that its stages are interdependent and that the physical examination is one of the initial stages of the systematization, in which the nurse establishes contact with the patient in searching for the identification of the signs and symptoms of physical and emotional maladjustment[16]. In the light of this, the failure to undertake the physical examination can compromise the care given to the patient, given that it stops this from being evaluated in its totality.

In intensive care, the planning of the nursing care, based on the specific characteristics of each individual, is indispensable because in these units, normally, the patients have important hemodynamic alterations and specific characteristics which, in the majority of cases, are identified through undertaking the physical examination.

In the light of the above, it is necessary to identify, alongside the nurses from the Unit studied, whether there are shortcomings in the propaedeutic bases for the undertaking of this procedure, so as to propose strategies which instrumentalize them to undertake this activity.

CONCLUSIONS

In this study, it was ascertained that the nursing records presented Complete PoC below that considered to be quality (PoC>80%); those which were Incomplete reached a percentage nearly three times higher than that specified for the study (PoC≤15%); those which were Not Filled Out obtained a percentage twice that considered (PoC≤05%), and; only the category of Incorrect presented a percentage close to that considered to be quality (PoC=00%).

Taking into account that in the general average, the Complete PoC obtained 46%; the Incomplete, 43%; the Not Filled Out, 10%, and the Incorrect 01%, it is recognized that the nursing records analyzed are not quality. As a result, it is suggested that the nursing team investigated should undertake actions training them to undertake regular, complete, specific and exact records.

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