ORIGINAL ARTICLE

COMFORT ORAL ROUTE IN HOSPITALIZED OLDER PEOPLE: THE MULTIDISCIPLINARY TEAM PERCEPTION

Magali Scheuer[1]; Rosangela Marion da Silva[2]
Gabriele Rodrigues Bastilha[3]

Highlights: (1) The multidisciplinary team has limited knowledge regarding the oral comfort route. (2) There is little practical application of the oral comfort route in hospitalized elderly patients. (3) Health education strategies should be adapted to the routine of the healthcare service.

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[1] Federal University of Santa Maria – UFSM. Santa Maria/RS, Brazil. https://orcid.org/0000-0001-7093-7139

[2] Federal University of Santa Maria – UFSM. Santa Maria/RS, Brazil. https://orcid.org/0000-0003-3978-9654

[3] Federal University of Santa Maria – UFSM. Santa Maria/RS, Brazil. https://orcid.org/0000-0003-4207-8001

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ABSTRACT

Objective: To analyze the perception of the multidisciplinary team regarding the use of comfort oral feeding in elderly individuals before and after training. Methods: A cross-sectional and descriptive quantitative study was conducted with professionals from the multidisciplinary team of a University Hospital. A questionnaire was administered before and after training on the use of comfort oral feeding. The sample consisted of 21 professionals from different professions. Statistical analysis was performed using Pearson's Chi-Square test (5% significance level). Results: The average age of the sample was 31.86 years, with most participants having one to five years of professional experience and being from the Nursing field. In the association between pre- and post-training responses, only the question related to the authorization of oral feeding for a patient despite aspiration risk showed statistical significance (p=0.003), indicating that the training was an effective tool, as professionals who had previously marked "do not know" in response to the first questionnaire took a clear favorable or unfavorable position. Conclusion: The perception of the multidisciplinary team regarding comfort oral feeding for hospitalized elderly individuals reveals that this topic is still not widely disseminated and lacks consensus among healthcare professionals. There are doubts regarding its applicability in hospital routines. These uncertainties can be resolved through health education strategies tailored to daily workflow realities, such as training sessions utilizing banners.

Keywords: Palliative Care; Swallowing Disorders; Elderly; Patient Care Team.

INTRODUCTION

Change in the Brazilian populations' epidemiological profile evidence a growing increase in population aging, with chronic communicable and non-communicable diseases being the main agents of morbidity, mortality, and functional disability[1]. As a result of chronic diseases, older people are at greater risk of developing dysphagia, which is characterized as any change in swallowing biomechanics that compromises the swallowing effectiveness and safety, resulting from an acute or progressive process[2,3].

Dysphagia, by impacting older people's diet, can increase the risk of nutritional and clinical complications, reduce the pleasure of eating, and favor a poor perception of quality of life, influencing general health[3].

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It is known that food has a biological, symbolic-cultural, and affective character, besides being a resource of comfort and quality of life for patients with dysphagia and who have therapeutic limitations or who fall within the perspective of palliative care. For these patients, who present changes in swallowing biomechanics at any stage between the mouth and the stomach, oral rout (OR) feeding aims to prioritize comfort and food intake in a pleasurable and safe manner, thus going beyond nutritional aspects and respecting the patient's and their family's autonomy, and thus it is considered a comfort OR[4-6].

Therefore, speech therapy work with older people is necessary in order to guarantee the maintenance of coexistence and social interaction through communication and oral feeding in a safe and pleasurable manner. It is up to the speech therapist to evaluate, together with the multidisciplinary team, the possibility of maintaining oral feeding and indicate the safest consistency for efficient swallowing and the use of postural maneuvers, consistency adjustments and adaptations, suggesting the fractionation of the volume to be offered in order to provide comfort, pleasure, and prioritize quality of life and the maintenance of family and emotional relationships[7,8].

It is known that multidisciplinary action and decisions made by the team impact directly the care provided to the patient,[9,10] and cooperation between the team, family members, and caregivers is essential for optimizing care and shared goals[11].

However, one believes that the multidisciplinary team's knowledge of the use of comfort OR in its hospital routine is still incipient, as there are studies[8,11-13] that present only the speech therapy point of view on this topic, and training on this subject is a possible tool to improve the quality of multidisciplinary and interdisciplinary care.

Training can be aimed at improving the multidisciplinary team's knowledge of certain topics of interest, because even if training actions are not constant, professionals, in order to meet their needs, have the possibility of deepening their knowledge[14]. Training enables the development of teamwork and effective communication, which can impact patient care[15].

Therefore, the objective of this study was to analyze the multidisciplinary team's perception of the use of comfort OR in older people before and after training.

METHOD

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This is a cross-sectional descriptive study, which was carried out in a University Hospital, from October 2022 to January 2023. The study was approved by the Research Ethics Committee of the institution of origin (opinion no. 60869822.9.0000.5346). All participants agreed with the research by reading and signing the Informed Consent Form (ICF).

Health professionals working in the surgical clinic unit of the aforementioned hospital participated, which is the unit with the largest number of beds in the institution (52 beds occupied, mostly by hospitalized older people) and has approximately 47 professionals in the multidisciplinary team, working on the day shift.

After institutional authorization and ethical procedures, the research was disclosed and professionals were invited through posters fixed in the nursing and medical prescription rooms, in addition instant messages via application to a private group. It should be noted that the messages were disseminated to professionals by the sector leadership, thus complying with the Brazilian General Data Protection Law.

Health professionals who worked in the surgical clinic inpatient unit during the day shift were included, from the following professional groups: medicine, nursing, speech therapy, pharmacy, nutrition, dentistry, psychology, social work, nursing technicians, physiotherapy and occupational therapy, who agreed to participate in the research. Professionals who were not present during the shift in which the training was conducted, as well as those who did not complete the questionnaire in the online format, were excluded.

Data collection took place in two stages. The first stagetook place in person, in a reserved room, on previously informed date and time, conducted by a professional speech therapist with experience in managing older people with dysphagia. On the meeting date, firstly the research objectives and data anonymity were informed, and then the ICF was handed over.
Participants were requested to read and sign it in case of agreement, and one copy was given to the participant and the other was retained by the researcher.

Next, participants received a questionnaire prepared by the authors was composed of five objective multiple-choice questions that dealt with the professional perception of the comfort oral route (question 1, with five alternatives where the professional should mark the ones they considered correct) and frequency of use, power of decision about comfort OR,

importance of preserving the patient's desire and the indication to use comfort OR (2 to 5, where only one answer should be given for each question). The researcher in charge provided instructions for answering the questionnaire, which was applied in person, printed, and answered by the participants themselves. It should be noted that questionnaires were answered according to the participant's own perception, with no correct or incorrect answers for each question. It is important to note that the response option "sometimes" was considered to represent a frequency of use once a month within a 30-day period, while "frequently" referred to use more than once a month.

Data related to profession, years of professional experience, and age were also collected. A 20-minute period was ensured to complete the instrument. Thirty professionals participated in this first stage, which included filling in the initial questionnaire and training.

Subsequently, an expository training session was conducted, featuring the presentation of a banner developed by the authors. The banner contained scientific information regarding the use of comfort oral feeding (COF) in hospitalized older adults with chronic illnesses[2–5, 13], and was validated by two speech-language pathologists specialized in the field. The training was delivered by a speech-language pathologist with extensive clinical experience in the care of hospitalized elderly patients. It lasted 30 minutes, a duration determined so as not to disrupt the routine of the multidisciplinary team. The banner presented concepts related to swallowing, dysphagia, the prevalence of chronic diseases in older adults, and comfort oral feeding[2–5, 13].

The objective of the training was to clarify the doubts raised in the questionnaire and to emphasize the importance of the triad "multidisciplinary team, family, and patient" in the decision-making process regarding the use or non-use of comfort oral feeding. At the end of the session, participants were informed that they would receive the online questionnaire after 20 days[16] and were invited to complete it again.

In the second stage, 20 days after the training session, the questionnaire was resented to the participants of the first stage via institutional email. Two invitations were sent to the 30 participants from the initial stage, and 21 completed questionnaires were returned. The purpose of carrying out this second stage of questionnaire reapplication 20 days after the date

of training was to determine whether there were changes in the multidisciplinary team's perspective and comfort OR application after training on the theme.

Data were statistically analyzed in a descriptive and inferential manner with the Pearson Chi-Square test, using the SPSS 25.0 software, with a 5% significance level.

RESULTS

A total of 21 healthcare professionals participated in the study (Figure 1), with a mean age of 31 years and eight months (median = 30.00; minimum = 22.00; maximum = 47.00). Of these, 52.38% had between one and five years of professional experience, 23.81% had six to ten years of experience, and 23.81% had more than ten years of professional experience.

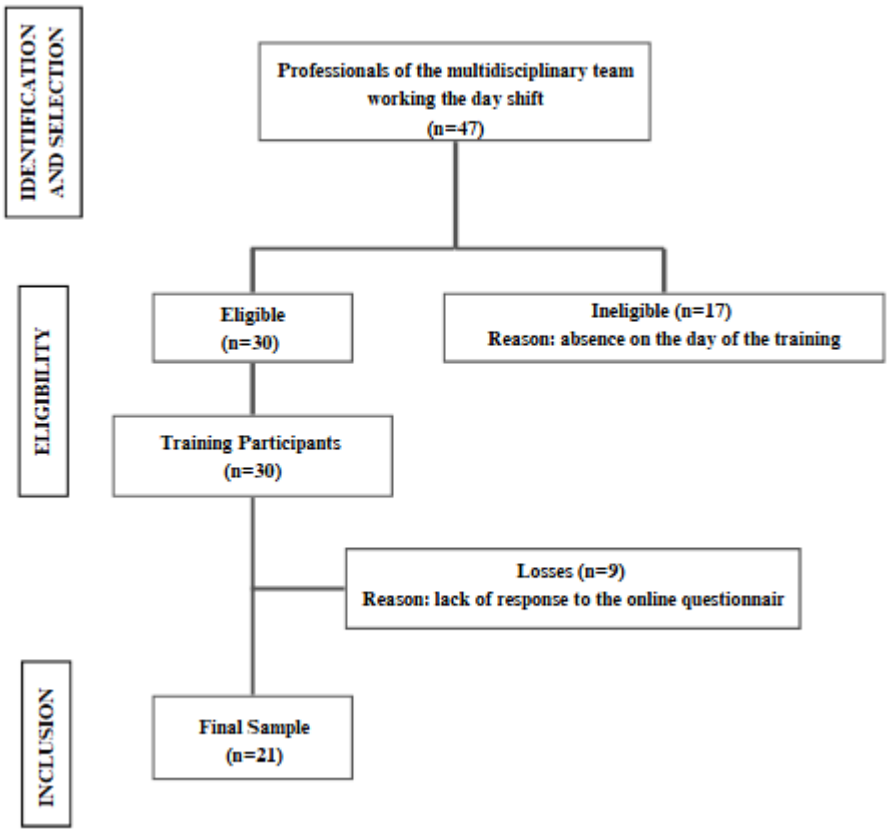

Figure 1 – Study Flowchart

Caption: n = number of participants

The following professional categories comprised the sample: nursing (23.81%, n=5), speech therapy (14.29%, n=3), pharmacy (9.52%, n=2), nutrition (9.52%, n=2), dentistry (9.52%, n=2), psychology (9.52%, n=2), social work (9.52%, n=2), nursing technicians (9.52%, n=2), and physiotherapy (4.76%, n=1).

Tables 1 and 2 present the inferential analysis of the association between the responses to the pre- and post-training questionnaires. A statistically significant difference was observed (p = 0.003) in the question: "Would you recommend the authorization of oral feeding for a patient even in the presence of aspiration risk?" Prior to the training, 38.1% (n = 8) of participants indicated they were in favor of authorizing oral feeding, while 23.8% (n = 5) were against it, and 38.1% (n = 8) reported not knowing how to respond. After the training, there was a decrease in the number of participants who were unsure (23.8%, n = 5), and an increase in those who took a position either in favor (42.9%) or against (33.3%). The other inferential analyses did not show statistical significance ($p > 0.05$).

Table 1 – Association between responses to the first question of the questionnaire administered to the multidisciplinary team before and after the training on comfort oral feeding (n = 21)

	RESPONSES		PRE-TRAINING	POST-TRAINING	p-value
Comfort oral route is only for patients with life-threatening diseases and in the terminal phase of life	**YES**	**n(%)**	5 (23,8)	4(19,0)	0,171
	NO	**n(%)**	16(76,2)	17(81,0)	
Cancer patients are more likely to use the comfort oral route	**YES**	**n(%)**	13(61,9)	12(57,1)	0,154
	NO	**n(%)**	8(38,1)	9(42,9)	
Comfort oral route is exclusive for patients using alternative feeding routes (GTT or NGT)	**YES**	**n(%)**	-	1(4,85)	a
	NO	**n(%)**	21(100)	20(92,2)	
In the comfort oral route, the patient is allowed to eat freely of all consistencies, without any restriction	**YES**	**n(%)**	12(57,1)	12(57,1)	0,056
	NO	**n(%)**	9(42,9)	9(42,9)	
In the comfort oral route, the use of one consistency prevails, but foods of other consistencies can be offered	**YES**	**n(%)**	9(42,9)	9(42,9)	0,899
	NO	**n(%)**	12(57,1)	12(57,1)	

Caption: *n* = absolute frequency; *%* = relative frequency; GTT = gastrostomy; NGT = nasoenteral tube; *a* = no statistics were calculated because the responses are constant. Pearson's Chi-square test.

Table 2 – Association between responses to the remaining questions of the questionnaire administered to the multidisciplinary team before and after the training on comfort oral feeding (n = 21)

	RESPONSES		PRE-TRAINING	POST-TRAINING	p-value
The frequency with which you see the use of the comfort oral route in your clinical practice	**NEVER**	**n(%)**	-	1(4,8)	0,849
	SOMETIMES	**n(%)**	17(81,0)	16(76,2)	
	FREQUENTLY	**n(%)**	4(19)	4(19)	
You consider that the decision to use the comfort oral route is mainly up to	**SLP**	**n(%)**	4(19)	1(4,8)	0,216
	MDT	**n(%)**	4(19)	-	
	MDT AND FAMILY	**n(%)**	12(57,1)	20(95,2)	
	DOCTOR	**n(%)**	1(4,8)	-	
You consider it important to preserve the patient's desire to feed orally	**YES**	**n(%)**	20(95,2)	21(100)	a
	NO	**n(%)**	-	-	
	DON'T KNOW HOW TO ANSWER	**n(%)**	1(4,8)	-	
In your opinion, would you recommend the authorization of oral feeding for a patient even with the presence of aspiration risk	**YES**	**n(%)**	8(38,1)	9(42,9)	0,003 *
	NO	**n(%)**	5(23,8)	7(33,3)	
	DON'T KNOW HOW TO ANSWER	**n(%)**	8(38,1)	5(23,8)	

Caption: *n* = absolute frequency; *%* = relative frequency; SLP = speech-language pathologist; MDT = multidisciplinary team; *a* = no statistics were calculated because the responses are constant; * = *p* value ≤ 0.05. Pearson's Chi-square test.

DISCUSSION

Comfort OR is a topic primarily addressed in scientific literature from a speech-language pathology perspective[8,11-13], however, it is still not widely disseminated or implemented by the multidisciplinary team. It is believed that spreading knowledge about its use and applicability may bring benefits, with a positive impact on the quality of life of hospitalized older adults.

Most of the health professionals who participated in the research had between one year and 10 years of professional experience, which shows that they are demonstrating that the

sample possesses a considerably up-to-date level of knowledge. Regarding profession, the majority of participants are nurses, followed by speech therapists. It is known that nursing plays an important role in the care of hospitalized older people, as this professional has next contact with patients. Speech-language pathology, in turn, plays a key role in adapting food consistencies for hospitalized patients, particularly those with a limited prognosis who wish to continue oral feeding[8,12-14].

When asked whether comfort OR is exclusive to patients using an alternative feeding route (gastrostomy or nasoenteral tube), 100% (n=21) of professionals answered in the pre-training questionnaire that comfort OR is exclusive to this group of patients, and after training, 95.24% of professionals answered that comfort OR is not exclusive to patients with an alternative feeding route. Although not statistically significant, this percentage difference in pre- and post-answers demonstrates that training can be a tool used to disseminate knowledge, and health education is an effective method for building knowledge, expanding critical knowledge and developing collective health[17].

Furthermore, studies indicate that comfort OR can be indicated when there is a prevalence of comfort care, aiming to alleviate terminally ill patients' suffering, symptoms, besides promoting their quality of life and satisfying their desires, with limitations in therapeutic effort and guarded prognosis[7,8,11]. However, the use of an alternative feeding route does not prove to be a determining factor in increasing these patients' survival and ensuring their comfort, since the alternative feeding route does not promote quality of life. In these cases, the multidisciplinary team has the important role of identifying the benefit of using this technology for each case[8].

Regarding the frequency of use of comfort OR, 80.95% (n=17) of professionals reported using it "sometimes" in their clinical practice, and this answer remained even after training was completed. This raises the question of whether the consistency in responses is due to the multidisciplinary team's low adherence to the use of comfort oral feeding, the limited number of patients for whom it is indicated in daily practice, or the absence of an established routine for prescribing comfort oral feeding in the hospital where the study was conducted.

In a study[8] with hospitalized patients and those undergoing palliative care, it was found that 26% of the studied sample used comfort OR and the rest used OR in order to meet their caloric needs. The authors also state that terminally ill patients commonly present compromised food efficacy and safety, thus requiring special care aimed at comfort.

Regarding the power of decision to maintain oral feeding aiming at patient comfort, prior to training, 57.14% (n=12) of participants answered that it was a joint decision between the multidisciplinary team and the family, 19.05 % (n=4) answered that it was a decision made by the speech therapist, 19.05% (n=4) answered that the decision was only made by the multidisciplinary team, and 4.76% (n=1) answered that it was a decision made by the medical team. After training completion, 95.24% (n=20) of the participants answered that it was a decision between the multidisciplinary team and the family, and 4.76% (n=1) answered that it was a decision made by the speech therapist. Although there is no statistically significant association, such results may suggest a closer relationship between the multidisciplinary team and the patients' families regarding decision-making about the indication of comfort OR.

Furthermore, it is believed that if the training session could last for more than 30 minutes, it could be offered on a permanent and continuous basis to health professionals with a view to qualifying comprehensive and interdisciplinary care, seeking to strengthen relationships between the multidisciplinary team, family, and patient. The changes may not have been as noticeable in this study considering that, in order not to harm the hospital routine, only 30 minutes were available to carry out professional training. In this case, the banner was the most viable option.

Multidisciplinary action in palliative care requires humanized and empathetic assistance towards other team professionals, the patient's family and the patients themselves[7,9]. The relationship between professionals in the multidisciplinary team impacts the assistance provided to the patient and their family, and it is extremely important that decisions are made democratically together by the patient (when they have full decision-making capacity), the family, and the multidisciplinary team, which reaffirms the importance of defining therapeutic conduct between the team and the family.

When asked about the importance of preserving the patient's desire to have oral feeding, 95.24% (n=20) of the participants answered that they considered it important to preserve the patient's desire, and 4.76% (n=1) answered that they did not know how to answer

the question. After training, 100% (n=21) of the participants answered affirmatively to the question, demonstrating that they consider it important to prioritize the patient's desires. Thus, despite there being no statistically significant association, it is possible to observe that training had some impact on the multidisciplinary team's awareness of comfort OR and the maintenance of the patient's desire to receive OR feeding.

Previous research[4,12] highlights the importance of preserving the patient's preferences and desires, aiming at comfort, quality of life and maintaining the patient's autonomy in their decisions, in addition to respecting the family's desires. It also emphasizes the need to control symptoms in order to minimize possible discomfort during feeding times and make the terminal process less painful.

In relation to the participants' opinion, as professionals who are part of the multidisciplinary team, regarding the indication of comfort OR even when there is aspiration risk, there was an increase in the number of positive answers after training regarding OR indication, and reduction in the number of participants who were unable to answer the question, which was statistically significant (p=0.003). This suggests that training was a useful tool for positioning professionals regarding the use of comfort OR in their professional practice, since some of the professionals who had stated in the first questionnaire that they did not know how to answer the question, positioned themselves in favor or against the indication of comfort OR when there is risk of aspiration. Training sessions can serve as effective tools for health education, enabling the development and deepening of knowledge, as well as positively impacting the quality of care provided by healthcare professionals[14,17].

Furthermore, it is observed that the team did not have knowledge of the topic prior to training and that being trained may have had a positive effect on the search for multidisciplinary team's awareness and empowerment regarding the use of comfort OR. This impact may not have been greater due to the amount of time available for training.

Training, therefore, is a tool that should permeate the implementation of qualification actions of a permanent and continuous nature among healthcare professionals in the hospital setting. Its aim is to enhance comprehensive and interdisciplinary care, thereby promoting the quality of life and comfort of hospitalized elderly individuals.

This study sought to contribute to science, not only in the area of speech therapy, but also in other health professional areas, as it is the first Brazilian study to date that analyzed

multidisciplinary hospital team's perception of comfort OR for older people, a subject that is still little discussed in the literature.

Nevertheless, some limitations are due to the sample size, as it was limited to only one inpatient unit in a single hospital, and the reduced adherence of the multidisciplinary team, as not everyone on the team participated and not all participants in the first stage answered to the final questionnaire, in addition to the little training time. One also believes that the constancy shown in some participants' answers may have been influenced by the time interval between the first questionnaire application and the second one, which may be longer so that the effects of the training could be reflected, or, conversely, if it had been lower, it might have resulted in a higher number of respondents in the second stage.

Although there is no consensus in the literature, the 20 day interval between the first and second administration of the questionnaire was chosen to analyze whether participants would provide similar responses at two distinct moments, separated by a time interval that would not be influenced by memory recall of the answers[16]. Additionally, this interval aimed to determine whether, within this period, participants could already be applying the knowledge acquired during the training in their clinical practice.

It is expected that this topic will be the subject of ongoing education actions, with the introduction of training tools that can generate positive effects on care quality and service indicators. Furthermore, it is suggested that new research should be carried out in order to understand the realities experienced in other places and in different care settings, aiming to disseminate knowledge and provide support for health professionals regarding this topic, which can increase patients' quality of life.

CONCLUSION

The multidisciplinary team's perception of comfort oral feeding in hospitalized elderly individuals reveals that this topic is still not widely disseminated and lacks consensus among healthcare professionals. There are uncertainties regarding its applicability in hospital routines. Such doubts can be addressed through health education strategies tailored to the realities of daily workflows, such as training sessions utilizing banners.

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Magali Scheuer: Conceptualization; Investigation; Methodology; Visualization; Writing – original draft; Writing – review & editing.

Rosangela Marion da Silva: Investigation; Methodology; Supervision; Validation; Visualization; Writing – review & editing.

Gabriele Rodrigues Bastilha: Conceptualization; Methodology; Project administration; Resources; Supervision; Validation; Writing – review & editing.

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Corresponding Author:
Gabriele Rodrigues Bastilha
Federal University of Santa Maria – UFSM
Av. Roraima nº 1000, University City
Camobi District, Santa Maria – RS, Brazil. ZIP Code 97105-900
gabriele.bastilha@ufsm.br

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