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ORIGINAL RESEARCH

Home Health Care Nurses' Challenges in Implementing Person-Centered Care among Elderly Patients with Dementia

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Abstract

Background: As the global need to address the care of elderly patients with dementia continues to rise, various health care systems have adopted different approaches to uphold the highest form of dignity, respect, autonomy, and preferences of their patients. One such approach is Person-Centered Care (PCC), which has shown benefits in improving the quality of life for elderly patients with dementia and their caregivers. However, despite its recognized benefits, PCC faces implementation challenges and is not widely adopted in some health care settings, as its effectiveness in challenging scenarios remains unclear. Additionally, limited research exists focusing on the experiences and challenges encountered by home health care nurses in these cases.
Purpose: The primary aim of this study was to identify and describe the challenges faced by home health care nurses in implementing PCC, specifically for elderly patients with dementia.
Methods: The study utilized Husserl's transcendental phenomenology method. The participants included home health care nurses currently working with patients who had been medically diagnosed with dementia for at least six months. Sixteen participants were selected through purposive sampling. The nurses underwent thorough face-to-face interviews with the researchers. Inductive thematic analysis by Braun and Clarke was used to pragmatically organize the lived experiences.
Results: Upon data interpretation, the study revealed two major themes, namely: personal challenges with two sub-themes, (1) communication barriers and (2) limited training; and external challenges with two sub-themes; (1) powerlessness in decision making and (2) uncooperative patients.
Conclusion: The study highlights the various challenges faced by home health care nurses in implementing PCC for elderly patients with dementia. To improve nurses' capability to manage these challenges, support through education and training, policy development, and stakeholder involvement is essential to enhance the care delivery process.

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1. Introduction

The rising prevalence of dementia presents various challenges for different health systems all over the world, particularly in the care of elderly patients in a home health care setting. In Qatar, aligning its 2030 vision with the goal of the World Health Organization's global action plan, its government underwent significant steps toward dementia management and preparedness, including the development of a national dementia strategy, the pioneer of its kind in the Middle Eastern region (Al Hamad & Sathian, 2024; Alzheimer's Association, 2024).

As the preferred model in dementia care today, Person-Centered Care (PCC) emphasizes individualized care that respects the personhood, dignity, values, and preferences of elderly patients with dementia. It shifts the focus from disease-centered approaches to person-centered, which is holistic by nature (Molony et al., 2023). PCC focuses on adapting health care services to an individual's preferences, requirements, and values while encouraging dignity and autonomy (Coulter & Oldham, 2016; Hennelly et al., 2018). While this strategy has significant potential for

increasing dementia care quality, its implementation in home health care setting presents distinct problems (Kang & Hur, 2021; Richter et al., 2022).

Furthermore, PCC acknowledges that elderly patients with dementia may experience unmet needs, such as isolation, that can contribute to behavioral symptoms or non-pharmacological symptoms (Ahmed et al., 2022; Kim & Park, 2017). By incorporating PCC, health care providers are better equipped to understand and address the unique needs of individuals with dementia (Hoel et al., 2021; Kim & Park, 2017). In another study, PCC has been widely adopted and implemented, particularly in long-term care facilities, and involves incorporating personal knowledge of elderly patients with dementia, conducting meaningful activities, placing emphasis on well-being, and enhancing the quality of the relationship between the health care provider and the elderly patients with dementia (Güney et al., 2021; Richter et al., 2022).

However, translating PCC into a home health care setting remains complex and unexplored at the moment. Unlike hospital and other acute settings, home environments introduce unique challenges such as fluctuating routines, limited interdisciplinary collaboration and support, pressing family dynamics, and the unpredictability nature of dementia cases (Su et al., 2021). For home health care nurses, implementing this model involves maneuvering the complexity of these challenges while delivering the highest standards of clinical and emotional care. Subsequently, studies have indicated that nurses also face difficulty interpreting non-verbal cues from their patients, the complex behavior of patients with dementia, and involving many family members in the care decisions without compromising their professional boundaries (Guan et al., 2025).

PCC in dementia has shown effectiveness, as indicated in various studies. It is even integrated into various dementia guidelines on long-term facilities to enhance the quality of care completely implemented, which results in progressive improvement in the quality of life of the patients (Kim & Park, 2017; Surr et al., 2021). However, implementing PCC has been a constant challenge, especially in various set-ups, as it depends on the population, health care setting, and the capability of the health care workforce (Moore et al., 2017; Richter et al., 2022).

Now, despite the global literature indicating the effects of PCC on various settings, there is still a gap that can be explored by specifically describing the challenges experienced by home healthcare nurses, especially in the Middle Eastern regions. Qatar's evolving home health care landscape, shaped by cultural values and policy shifts, demands localized insights into these existing scenarios. Therefore, this study seeks to address the gap by identifying and describing the perceived challenges of the home health care nurses in implementing PCC for elderly patients with dementia in Qatar. Subsequently, this study seeks to add to the current literature by offering insights into the application of PCC, specifically in the Qatari setting.

2. Methods

2.1. Research design

This study used Husserl's transcendental phenomenology. It is a qualitative research method used to understand and interpret the subjective experiences of individuals without imposing pre-conceptions (Rodriguez & Smith, 2018). It focuses on describing and understanding the participants' experiences, especially on the aspect of the challenges in home health care setting.

2.2. Setting and samples

The study was conducted among registered home health care nurses presently working in Qatar for at least 6 months with patients diagnosed with dementia. The study employed purposive criterion-based sampling to ensure that participants possessed the needed experience relevant to the phenomena being studied. The total number of participants was 16 until saturation was met during the face-to-face in-depth interviews, wherein no new themes emerged, and the data were repetitive, indicating that the phenomena had been fully explored. Participants were initially selected with the inclusion criteria set forth: (1) Nurses who are working in the home health care setting for at least six (6) months, (2) Registered under the Ministry of Public Health-Qatar, (3) Currently handling medically diagnosed elderlies with dementia. The participant list was according to the official list released by a home health care institution.

2.3. Data collection

The study data collection was based on approval from the ethics committee and was conducted from February to August 2023. The research proposal, together with the participant

information, tool, and letter of invitation, was approved by the Qatar Care Ethics Committee for validation, following standards set by the ethics framework set by Qatar Care and the Qatar Government. Once approval was secured, a request for a list of nurses from the nursing service department was obtained. The list given was then counterchecked, selected according to the criteria set forth, and approved for this study.

Official respondent information and consent were sent out personally to the nurses for signing. Once a copy of the signed consent was received, researchers set a schedule with the nurses to ensure that they would be available since face-to-face interviews would be around 30-45 minutes. The researchers maintained open communication regarding the purpose of the study, how the data would be treated, and the processes involved. The researchers developed a semi-structured interview tool (see Table 1) that was validated and recognized by three (3) experts who are working in a college of nursing- university. To reduce reviewer prejudice, the identities of the reviewers and the research team are kept hidden in a double-blind review procedure. This allows the reviewers to ensure that the feedback is completely based on the content of the instrument and is not impacted by interpersonal or professional relationships.

The validation strengthens the validity of the semi-structured interview tool. Also, the tool was pilot tested to a group of five (5) nurses who were not included in the final participants to ensure question sequencing was easy to understand. During the interview, the right to self-determination to participate in the study, the right to fair treatment, the right to refuse to join the study, the right to withdraw from participation at any study stage, and the right to privacy and confidentiality were emphasized. Permission to use a voice recorder was secured to ensure the clarity and correctness of statements made during face-to-face interviews, particularly if any of them were confusing or difficult to capture in writing. Field notes were completed to ensure that all relevant data was captured. A single round of interviews was conducted in the participants' homes, in private areas, to minimize noise and ensure the participants' comfort.

Table 1. Semi-structured interview tool

Semi-Structured Interview Tool
1. Tell me about your work in your nursing home.
2. What do you think about person-centered care?
3. Tell me about your experiences in the implementation of person-centered care for elderly patients with dementia.
4. Tell me about other members of the house- implementation of person-centered care for elderly patients with dementia in your nursing home.
5. What are the barriers to the implementation of person-centered care for elderly patients with dementia?
6. What do you need for the implementation of person-centered care for elderly patients with dementia?
7. Is there anything else that you would like to add related to person-centered care for elderly patients with dementia?
8. What was it like to participate in this interview?

2.4. Data analysis

The study was analyzed utilizing Braun and Clarke's inductive thematic analysis method (Braun & Clarke, 2023). Once data collection and bracketing were completed, themes were identified within a data set. This method provides a highly flexible approach that can be modified for the needs of many studies, providing a rich and detailed yet complex account of data (Nowell et al., 2017). The actual notes written during the interview were compared with the data obtained via the audio recorder. Researchers thoroughly examined all the transcribed and compared data to gain a general understanding of the transcripts. Initial coding was conducted by systematically highlighting meaningful features across the available data. These codes were organized into potentially identified themes by grouping similar ideas into single groups and categorizing them according to emerging patterns and relevant issues within the data. These were grouped according to single units based on the transcripts, categorizing according to relevant issues, followed by identifying the main theme and subtheme, keywords, and highlights of the narrative. Next, a review of the transcript and identified themes was made. This is to ensure that there would be no

discrepancies between them. This was followed by comparing the identified themes and describing common practices, which will further refine and name the themes. For example, one central theme identified by the nurses was the "Personal Challenges" they experienced in handling these patients. This was further refined into a sub-theme, "Communication Barrier," with several of the respondents describing it as a difficulty in communicating with their patients since they have cognitive problems. Lastly, the draft report was generated and checked by all the researchers.

2.5. Trustworthiness/rigor

The study utilized multiple methods to ensure the trustworthiness and rigor of the obtained data from the participants. For credibility, researchers had a prolonged engagement with the participants. This is to fully understand the context of the study and build rapport with the home health care nurses. Transcripts were also counterchecked by each researcher by comparing them to the recording to ensure that there were no discrepancies among the data. To ensure transferability, complete participant background data was provided to define the study's context and provide a comprehensive description of the phenomenon being investigated. This approach enables meaningful comparisons and evaluations of the findings' application to various settings (Llyod et al., 2024). A code-recode strategy was also performed during data interpretation wherein one researcher coded the data independently and compared it with each other's results to ensure consistency and reliability. Debriefing was also present, wherein the researchers reviewed and critiqued the findings, providing a broader insight into the data.

2.6. Ethical consideration

This study was conducted in a home healthcare institution in Qatar in 2023, with the ethics approval of Qatar Care (Reference No. 2023/192/ET). All participants of the study received physical participant information and consent to obtain their signatures, ensuring that they understood the research process. During the interview, the right to self-determination to participate in the study, the right to fair treatment, the right to refuse to join the study, the right to withdraw from participation at any stage of the study, and the right to privacy and confidentiality were emphasized, and permission to audio record was obtained. The data obtained were maintained and stored with strict confidentiality, adhering to the standards set forth by the Qatar Government, and were disposed of upon the completion of the study. Codes were utilized, and no actual names were presented in the study.

3. Results

3.1. Characteristics of the participants

A total of 16 participants were interviewed until the researcher's saturation of data was reached. Thirteen (13) of them are female, and three (3) of them are male. All were Filipino nurses, with an average age of 30 years old. The average experience handling dementia patients is 1.5 years. Lastly, all home health care nurses graduate with a bachelor's degree in nursing that is duly accredited by the Ministry of Public Health, with a license to practice in Qatar as Registered General Nurses.

3.2. Thematic analysis findings

The study discovered two major themes, each with two sub-themes (Figure 1). The first major theme, "Personal Challenges Experienced by Nurses," is divided into two subthemes: "Communication Barrier," which reflects difficulties in effectively communicating and interacting with patients and their families, and "Limited Training Experience on Handling Elderly Patients with Dementia," which emphasizes the inadequacy of training for managing dementia care. The second major theme, which revealed critical gaps – "External Challenges Experienced by Nurses," has not been extensively addressed in existing literature. This includes "Powerlessness in Decision Making," which refers to a lack of authority when making critical care decisions, and "Uncooperative Patients and Decision Makers," which deals with patients and decision-makers who resist or refuse recommended care plans. These external challenges, particularly the lack of decision-making power and the role of uncooperative family members, represent a novel finding in the study, showing the significant gap in the current health care practices and highlighting the need for a stronger support and policy development in home health care settings.

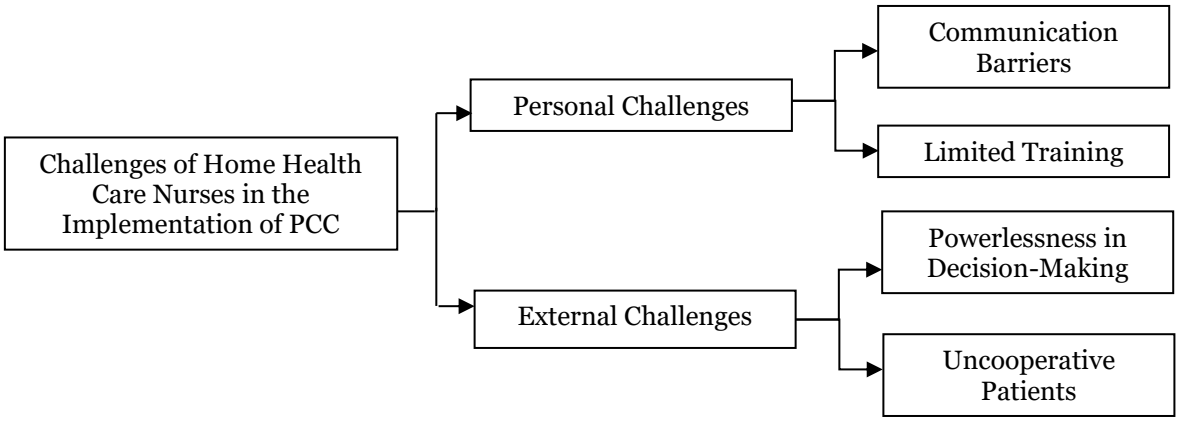

Figure 1. Themes and subthemes identified utilizing Braun and Clarke's thematic analysis

3.2.1. Theme 1 – Personal challenges

This theme pertains to the perceived challenges that home health care nurses experience about themselves. There were two (2) subthemes for this aspect.

3.2.1.1. Communication barriers

Most home health care nurses experience communication barriers with their patients and their families. Twelve of them emphasized that they have limited ability to converse in the Arabic language. Although training was conducted about the use of the Arabic language to communicate is being done, its actual application in the patient service area is challenging for them. In a study conducted in Iran, it was reported that effective communication between nurses and patients was perceived as being *"more significant than physical care"* (Kwame & Petrucka, 2021). Communicating with patients to understand their needs is a vital step in implementing PCC. Without clear communication, errors can be made. One nurse described the situation as follows:

> *"Sometimes I don't understand my Baba (patient). When he talks in Arabic, it's very fast confusing to me what he likes to do. I do call my care partner, but I also get confused at the time about how my care partner communicates with my Baba. His Arabic is broken; thus, I do not understand."* (P.12)

Furthermore, the phenomena were supported as one of the nurses mentioned, *"The classes done during orientation were not enough. No retention since Arabic is very hard. Words have gender to use, and it confuses me. That's why I am reviewing words using the word bank provided."* (P.5). Similarly, another participant stated:

> *"Arabic words are* different. *If I use this with one of my patients, it will not be the same with the other patient. Sometimes, they tend to be aggressive because we don't understand each other. They now shout if they get frustrated. We always advocate the use of PCC, but it's hard to implement PCC if we don't understand each other!"* (P.9)

3.2.1.2.Limited training

As perceived by the participants, limited training on how to care for patients with dementia and how to implement PCC in these types of patients is a challenge for them. Participants verbalized that they have limited knowledge of these aspects. It was discovered that the nurses had limited opportunity to attend available training since there is difficulty in scheduling and relievers available for their patients. One nurse shared:

> "*I have received minimal training about dementia. I have received an online module to learn more about dementia, but to apply PCC in these cases, I did not. Even training about aggressive behavior, still I am waiting to be enrolled."* (P.7)

Furthermore, it was noted that despite the educational activities offered, a sense of frustration was noted due to the scheduling. A nurse mentioned, "*There are trainings that are offered by Training and Education and HAMAD, but I can't attend because there are no relievers available. Sometimes, my day off is not in line with the schedule of the training offered.*" (P.2) Additionally, a participant stated:

> "*PCC is great; it teaches us to learn more about the patient's condition holistically. But it's hard to learn more about PCC, about dementia, about home care when every day you are tired coming home after a long day with an aggressive patient.*" (P.4)

Sundowning is also a concern for the nurses. One nurse said, "*I have attended HAMAD's Compassionate Interaction Training to develop my skills on PCC, but it's hard to do it for patients with dementia, especially since my baba is always confused. Sundowning is also frequent.*" (P.16)

3.2.2. Theme 2 – External challenges

This theme pertains to the perceived challenges experienced by the nurses from external factors such as the family and environment. There were two (2) identified subthemes as well.

3.2.2.1.*Powerless in decision-making*

Most participants reported feeling powerless in determining the ideal care plans that would benefit their patients. One aspect of PCC is to consider the preferences of their patients, but this overshadows the nurse's ability to decide for the welfare of their patients (Montori et al., 2023). Several of them mentioned that some of the family members of their patients refuse to implement the correct management and do not support the nurse's care plan. A nurse mentioned:

> *"I feel powerless sometimes with the situation with my patients, especially when the daughter of Baba visits him. She will instruct us not to do anything when she is around despite explaining that turning and exercise are good for Baba."* (P.10)

Instead of implementing co-designing strategies, the care now becomes passive. Nurses verbalize becoming followers of the preferences, which should not be.

> *"There is* confusion *about who should be followed. When the authorized decision maker is at home, she asks us to do this and that. When the sibling of Madam is also around, they want the opposite. PCC offers us to have shared care planning and decision making, and yet we experience this."* (P.7)

> *"I appreciate how PCC works, and I think it will really be beneficial in the hospital setting. But in Home Care? I don't know. Most of what Madam likes is not in line with what PCC asks us to do. She always decides even how we prepare medication; she is monitoring us."* (P.11)

3.2.2.2. *Uncooperative Patients*

Almost all the nurses indicated that their patients were uncooperative. This is due to the progression of dementia, which makes care management challenging. Some of them verbalized that the frequent sundowning phenomena of their patients make it difficult for them to handle. Patients tend to become confused, aggressive, and delirious. One nurse described the situation:

> *"You know, when we try to transfer Baba as his routine, especially in the evening after Maghrib (4th prayer for Muslims), he tends to become delirious and will start shouting at us. Sometimes this tires us, especially when family is not appreciated with what you do."* (P.1)

Another nurse supported the claim:

> *"I really try to implement PCC to our patients because it is our core as nurses, but uncooperativeness from our patients serves as a barrier for us. They will always contradict the things that should be done, although they have the right to refuse, but it saddens me that this happens."* (P.3)

Several nurses expressed that the challenge of uncooperativeness extends beyond the patients themselves and involves other parties, such as care partners and decision-makers. A nurse mentioned, *"I think uncooperativeness not only with the patient but with the care partners and decision-makers is the greatest challenge we experience"* (P.15). Another nurse exclaimed the overwhelming nature of non-compliance stating, *"Yes, I do experience this. Theres too much noncompliance!"* (P.8)

4. Discussion

The study aimed to identify and describe home health care nurses' challenges in the implementation of PCC, specifically for elderly patients with dementia. In connection with these, the research discovered two emerging themes as a challenge experienced by home health care nurses, namely, (1) Personal challenges and (2) External challenges.

4.1. Personal challenges

The study showed that most of the participants experienced personal challenges, which are further categorized as communication barriers and limited training. It also revealed that these perceived challenges may be intertwined since the inability to speak Arabic of the home health care nurses is derived from the lack of training. Communicating with patients in their own language was essential to convey their messages effectively, and this also helped them to calm down, especially during aggressive episodes. Effective communication in a patient's preferred language increases satisfaction and perceptions of care quality. Building trust and developing a strong relationship between health care practitioners and patients requires effective communication (Al-Yateem et al., 2023). This finding is consistent with the previous study, which emphasized the critical role of language competence in enhancing care experiences and patient satisfaction, particularly in the Middle Eastern context. Similarly, a study conducted in a home health care setting in Canada found that the language gap between health care providers and patients is associated with poor health outcomes, which reinforces the critical role of effective communication in the health care delivery system (Reaume et al., 2024).

While these studies were conducted in a larger scope of health care settings, this study uniquely highlights the diverse challenges faced in home health care settings, where nurses often work alone with minimal or no support from other health care disciplines. This calls for the need for structured communication training tailored to this type of challenge.

This study also revealed a lack of access to or offering available dementia training, which results in difficulties in care management. Besides communication being a main personal challenge, nurses who cannot obtain proper training in handling these cases can have difficulty implementing PCC in the patient service area. Providing training may improve coping mechanisms and minimize job stress by ensuring that staff has the skills needed to maintain consistent resident care (Barbosa et al., 2015; Spector et al., 2016). This finding is consistent with previous research that emphasizes the role of dementia training in enhancing the quality of care and staff confidence necessary (Mulyani et al., 2021). It showed that comprehensive PCC training on these cases improves nurses' attitudes toward dementia patients and increases the nurses' knowledge and attitude. However, while a previous study was conducted in a long-term care setting in the hospital, this study highlights the diverse challenges experienced by home health care nurses where access to training opportunities is even limited due to scheduling and workforce shortage. By focusing on these areas, health care workers can dramatically increase their ability to understand and respond to the requirements and preferences of dementia patients, resulting in a more compassionate and tailored treatment approach. Improved communication skills enable caregivers to better read dementia patients' sometimes subtle and nonverbal indications, while focused training programs offer staff the information and strategies required to provide high-quality, tailored care. Prioritizing these difficulties improves patient outcomes and fosters a

more supportive and sympathetic care environment, preparing them more for such challenging cases (Kim & Park, 2017).

Furthermore, future studies may focus on developing and testing tailor-fit communication training programs that address both language proficiency and dementia-related strategies for home health care settings. Effective training methods such as simulated activities, mobile applications, and modules are recommended to overcome constraints on training (Su et al., 2021).

4.2. External challenges

External challenges frequently present home health care nurses, creating significant barriers to the adoption of PCC in dementia patients. One prominent challenge experienced by nurses is the sense of powerlessness in decision-making. The respondents frequently find themselves caught between the family's preferences of care and evidence-based care management as established by the medical team. The lack of professional autonomy over their patients may be disadvantageous for the nurses, where timely, individualized, and consistent interventions are needed for holistic management.

The study also revealed that powerlessness in decision-making on care management is a significant concern for them. Participants reported that they are not given the authority to make sound clinical judgments, as they often experience micromanaging by some family members. While PCC offers a co-designing approach and collaboration with the family members to make collective decisions, still several nurses during the interview exclaimed that some care partners and decision makers are unreasonable with their decision-making choices, which leads to frustration, feelings that they are unheard and emotional exhaustion from the nurses. In a study conducted with nurses, moral distress among nurses increases further when they are not involved in the decision-making process and are confronted with treatments they are not in favor of (Arends et al., 2022). The findings of this study align with the previous literature emphasizing the powerlessness from the capacity of the nurses (Arends et al., 2022). However, unlike studies conducted in acute care settings, this study highlights the unique context of home health care, where nurses often work in patient's homes with minimal support from the other health care disciplines, increasing the feelings of isolation and powerlessness. This finding highlights the need for strategies and education that enhance nurse empowerment as advocates of the patient in the context of home health care.

Additionally, the study revealed that uncooperativeness from the patient or family member is another external challenge perceived by the nurses. Family members play a pivotal role in home health care, frequently functioning as primary caretakers and decision-makers (De Lima et al., 2024). However, when family members exhibit unwillingness to collaborate with nurses or follow planned care goals, it creates a significant challenge to deliver coordinated and consistent care- which is a fundamental principle of PCC. This uncooperativeness can be attributed to a variety of circumstances, including denial regarding the severity of the patient's condition, conflict, and inability to cope with care expectations, or a lack of understanding of dementia (Hazzan et al., 2022).

The study further revealed that nurses struggle to establish the effective implementation of PCC, resulting in fragmented and less effective care planning. This can result in increased patient distress, behavioral issues, and a decline in overall health and well-being. Family preferences and resistance to care plans can increase caregiver load and exacerbate dementia symptoms in patients (Kim et al., 2021). This aligns with the literature mentioned emphasizing the impact of family resistance on care delivery and caregiver stress (Kim et al., 2021). However, the previous studies were conducted in acute settings, which is in contrast with what the current study highlights. With the presence of family members is constant, and nurses have limited institutional authority to resolve conflicts.

Future studies could examine interventions that empower home health care nurses in shared decision-making processes, such as nurse-family advocacy programs. Research exploring strategies to improve collaboration between nurses and families, family education initiatives, conflict resolution, and culturally sensitive activities would be valuable (Mohr et al., 2021). Addressing these external challenges through better communication strategies, family education, and advocacy for nurse empowerment is essential to enhance PCC implementation and improve the quality of life for patients with dementia (Fazio et al., 2018).

5. Implication and limitation

The findings of this study highlight the need for critical improvements in the implementation of PCC for elderly patients with dementia in home health care settings. Development and implementation of language training programs and dementia-related care planning to enhance their communication skills and clinical care, respectively, can be accomplished. As a result, this shall empower nurses to deliver more emphatic, responsive, and effective care.

Furthermore, improving organizational policies that empower nurses' autonomy in decision-making processes and support their ability to advocate for patients' needs, even when they conflict with family preferences, will be beneficial. Collaborative care planning shall engage the family more, reducing conflicts and creating a more consistent PCC approach to care. These findings also underscore the need for leaders, nurses, and educators to include strategies to further promote more culturally sensitive care to ensure effective implementation of PCC in the unique setting of home health care.

This study has a few limitations. It was completed with a specific cohort of home health care nurses, which may restrict the findings' generalizability when compared to those acquired from a larger home health care institution. Furthermore, the study's findings may have differed if the participant pool had been more varied, as the sample consisted primarily of Filipino nurses at the time of the study.

6. Conclusion

The study identified the pressing challenges in adopting PCC for individuals with dementia in home health settings. Addressing personal and external challenges identified in the study through tailor-fitted training, strengthening collaboration with other disciplines in having the correct care management, and encouraging better family interaction are critical to boosting PCC efficacy in the area. Although the study's findings are influenced by the sample size and context, they provide useful insights into areas for future research and practice improvements to improve dementia care quality.

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Author contribution

AA and VCM were responsible for the conceptualization and presentation of the proposed study to the management. AA and VCM were responsible for the finalization of the ethics requirements, consent from the participants, and data gathering process. NS was involved in data interpretation together with the other authors. AA, NS, and VCM were responsible for the selection of the journal, drafting and revision of the study, and approval of the study for publication. All authors agreed to be accountable for the published work.

Conflict of interest

Nothing to declare.

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