Original Article

Terms of the ICNP® used by the team of nurses assisting people in palliative care

Termos da CIPE® empregados pela equipe de enfermagem na assistência à pessoa em cuidados paliativos

Rudval Souza da Silva[1], Maria Miriam Lima da Nóbrega[2],
Ana Claudia Torres Medeiros[3], Núbia Virgínia Almeida de Jesus[4], Álvaro Pereira[5]

[1] Nurse, Ph.D. in Nursing. Assistant Professor at the State University of Bahia, Campus VII. Salvador, Bahia, Brazil. E-mail: rudvalsouza@yahoo.com.br.
[2] Nurse, Ph.D. in Nursing. Full Professor at the Federal University of Paraíba. João Pessoa, Paraíba, Brazil. E-mail: miriam@ccs.ufpb.br.
[3] Nurse, Ph.D. in Nursing. João Pessoa, Paraíba, Brazil. E-mail: anaclaudia.tm@hotmail.com.
[4] Nurse. Salvador, Bahia, Brazil. E-mail: nubia.gms@hotmail.com.
[5] Nurse, Ph.D. in Nursing. Associate Professor at the Federal University of Bahia. Salvador, Bahia, Brazil. E-mail: alvaro_pereira_ba@yahoo.com.br.

RESUMO

Este estudo objetivou identificar os termos empregados pela equipe de enfermagem da UTI de um hospital especializado em oncologia, na assistência à pessoa em cuidados paliativos, que caracterizam a linguagem específica da Enfermagem, e mapeá-los com o Modelo de Sete Eixos da CIPE® 2011. Foi desenvolvido no período de janeiro a abril de 2013, por meio de entrevista com profissionais da equipe de enfermagem. Das entrevistas foram extraídos e agrupados termos que configuram a assistência à pessoa em cuidados paliativos. Feito o mapeamento, foram obtidos 432 termos. Finalizada a padronização dos termos, foi realizado o mapeamento cruzado e identificados os termos constantes e não constantes na CIPE® 2011. Foram encontrados 167 termos constantes e 95 não constantes. Com a realização deste estudo, conhecemos termos utilizados pela equipe enfermagem na assistência à pessoa em cuidados paliativos, o que possibilitará apresentar contribuições para a terminologia na área.

Descritores: Enfermagem; Classificação; Terminologia; Cuidados Paliativos.

ABSTRACT

The aim of this study was to identify the terms that characterize specific nursing jargon, used by the nursing team at the intensive care unit of an oncology hospital when assisting people in palliative care, as well as mapping them alongside with the 7-Axis Model of the ICNP® 2011. This study was conducted between January and April 2013 through interviews with the nursing team professionals. The terms that characterize assistance to people in palliative care were identified in the interviews and later grouped together. Once the mapping was finished, 432 terms were identified. After the terms had been standardized, we applied cross-mapping and identified the terms that were either listed or not listed in the ICNP® 2011. We found 167 listed terms and 95 that were not listed. The development of this study allowed to learn the terms used by the nursing team when assisting people in palliative care, which will enable further contributions to the terminology of this area.

Descriptors: Nursing; Classification; Terminology; Palliative Care.

INTRODUCTION

In modern society, there is an isolation from death that works almost as a denial of its existence. This behavior leaves people who are dying, their family members and friends completely unprepared for something that is inevitable. Following this reasoning, we observe that, in the daily life of healthcare teams, speaking spontaneously with people undergoing the dying process—which consists of a pre-eminent need on their part—is increasingly difficult. This refers us back to a concept of death embedded in a negative sentiment, as something that is contagious and threatening, and a reason why the living people involuntarily withdraw from those who are dying. This results in what can be called social death[1].

Certainly, the attitudes of modernity still exist in our current reality, also because it is difficult to verify, at the beginning of the 21st Century, that something has changed dramatically. Thus, due to the changes in human behavior, the symbolism of a good death, derived from a social interaction process where humans establish behavioral relations with one another, emerges with a new symbolism in post-modernity: the control over the dying process and death[2].

The idea of controlling the dying process emerges in the transition to post-modernity, in the scope of the advent of palliative care in the field of healthcare sciences. The key difference in the symbolism of a good death between the pre-modern and the post-modern eras has to do with the control element, which emerges in the healthcare field. People who go through the dying process are expected to have an active participation in their decision making at the end of their life[2].

In this context, we will find the emergence of the palliative care philosophy, which, according to the World Health Organization[3], is an approach that seeks to improve the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other physical, psychosocial and spiritual problems.

Palliative care has come about, primarily, to assist oncology patients in advanced disease stage, and it has been currently extended to all people carrying any kind of illness that causes intense pain, with no possible cure, as well as other physical, emotional and/or spiritual symptoms that make life intolerable. In addition, it is directed at patients whose illness has no possible cure but can be cared for, aiming at improving the quality of the dying process and death[4].

Thus, considering that it is possible to provide high quality nursing care and dignity for these patients, the need to systematize and organize these practices is increasingly pressing. This movement gives nurses the subsidies for clinical and therapeutic judgment, based on individualized and ethical human care, laying its foundations in the nursing process.

To contribute to this model of care, nurses have been studying means to describe the phenomena they are responsible for. In this context, we highlight nursing records as instruments to clarify the concepts underlying the nursing practice. In healthcare services, nursing records facilitate the communication and the continuity of care. However, these records are still incipient (nursing diagnoses, outcomes, and interventions) and this contributes to the invisibility of nursing professionals in health care[5].

Amongst the elements that characterize the caregiving process, we highlight nursing diagnosis, i.e., the clinical judgment conducted by a nurse regarding a professional practice phenomenon, which will guide the choice of nursing interventions. This phenomenon may represent one's health status or illness, as well as and the potential for complications that require nursing interventions[6].

In the realm of palliative care, studies focusing on nursing diagnoses are still incipient, especially when it comes to palliative care at intensive care units (ICU). This can hardly promote clarification of the phenomena of

interest for the nursing practice. In Brazil, a classification system that represents the realm of nursing has not been widely spread yet[7].

In the daily life of nursing professionals, it is possible to pinpoint terms to make up all the elements that underlie the caregiving process; however, it is still difficult to frame them so that all professionals may use them with the same meaning in face of various clinical, regional or cultural realities in order to create combined nomenclatures and form a classification system that standardizes the language[8].

The International Classification for Nursing Practice (ICNP®) emerged as the unifying framework whose purpose is to meet the need for developing a terminology to describe the nursing practice worldwide and grant visibility to the contribution of nursing professionals to create information systems. The statements of nursing diagnoses, outcomes and interventions, composed of ICNP® listed and unlisted terms, can be organized in groups that are meaningful for the nursing practice, targeted at various specialty areas, with the perspective of meeting a practical need to build both manual or electronic patient record systems[9].

The ICNP® version used in the present study – ICNP® 2011 – is based on the 7-Axis Model, in accordance with ISO Standard 18.104: an integrative model of nursing terminology[10] described in these axes: Action, Client, Focus, Judgment, Location, Means, and Time.

We proposed this study to follow the advances in research that have been fostered worldwide through the use of ICNP®, as well as to offer our contribution to enhance palliative care services by supporting them with studies on nursing diagnoses/outcomes and interventions and to increase the visibility of nursing professionals. Our objectives were to identify the terms used by the ICU nursing team of an oncology hospital when providing care to patients in the dying process and which characterize the specific language of nursing, as well as to map the terms listed by the ICNP® 2011 7-Axis Model.

METHOD

Regarding our method, this research was exploratory and descriptive, conducted in the period between January and April, 2013. We used secondary data found in the master's thesis presented at the Graduate Program in Nursing at the Federal University of Bahia, entitled "*O cuidar para uma boa morte: significado para a equipe de enfermagem de uma UTI*" **[**Comfort for a good death: meaning to the nursing staff of an intensive care unit][11], whose locus was an oncology hospital in the city of Salvador, state of Bahia. The research project was analyzed and approved by the Research Ethics Committee of the institution where the study was conducted, complied with the ethical aspects described in Resolution 466/12 of the Brazilian National Health Council, and it was approved under protocol no. 264/10.

To identify terms, we used the data from the aforementioned thesis, which originated the project for a dissertation. The first phase of this research consisted of identifying the terms—which characterizes this research as methodological—developed from the interviews found in the thesis with the nursing team (nurses and nursing technician) professionals of an ICU at an oncology hospital. The object of this study was the care toward a good death[11].

The terms—nouns, verbs, phrases, and acronyms—were identified by recording and transcribing the interviews, as well as performing a critical and analytical reading, aiming at filling in the gaps in new terms referring to new concepts that characterize the nursing practice focused on palliative care.

The terms were identified by two of the authors; after that, the list was revised by three additional professionals familiar with classification systems studies. We identified a total of 915 terms that underwent a standardization process[12] regarding their gender (masculine) and number (singular). We disregarded term duplications, corrected spelling errors, and neutralized verb tenses, which resulted in a total of 432 terms that were entered into Microsoft Office Excel® 2010 software via the cross-

mapping technique. This enabled a cross-mapping with the ICNP® 2011 terms using Microsoft Office Access® 2010 software to identify the terms that were listed and not listed in that terminology.

After having completed the mapping, we exported the table to Microsoft Word® 2010 software, and analyzed and classified the terms according to the following criteria[13]: a) the term listed in the ICNP® 2011 is equal to that used in the nursing team professionals' speeches when talking about the care provided to people undergoing a terminal process, i.e., the term and definition match; b) the ICNP® term is similar to the one used by the nursing team, i.e., the terms do not match but their meanings are identical; c) the ICNP® term is broader than the one used by the nursing team, i.e., the term in the nomenclature is narrower and more specific; d) the ICNP® term is narrower, i.e., it is more specific; and e) the ICNP® term and the term used do not match. It is important to highlight that, before classifying the terms, it was necessary to use a dictionary [14] to check their meaning and the respective synonyms, and then select those that did not belong to the ICNP® and could be included in a coming edition, making up the study's terms database.

The terms were distributed among the axes Action, Client, Focus, Judgment, Location, Means, and Time, according to the ICNP® 7-Axis Model, taking into account the agreement between each term's meaning and the definition of each axis[15].

RESULTS

Of the 432 terms selected in this study, 167 were listed in the ICNP® 2011; of these, 39 were classified as similar, and 95 as unlisted: 4 terms considered as broader, 9 as narrower, and 82 did not match the ICNP® 2011 terms. A remainder of 170 terms were considered as terminological waste, resulting from the elicitation of terms and that either belonged to other areas or indicated pseudo-terminological expressions that casually appeared in the interviewees' speeches. These terms do not characterize the nursing practice focused on palliative care[12].

Table 1 presents the terms identified in the interviews with the nursing team professionals and that are listed in the ICNP® 2011.

The terms that were not listed in the ICNP® were distributed among its seven axes, taking into account the terms that did not match (Table 4), and broader (Table 2) and narrower terms (Table 3). Their classification according to each axis is as follows: 8 terms in the axis Action; 5 terms in the axis Client; 33 terms in the axis Focus; 17 terms in the axis Judgment; 1 term in the axis Location; 27 terms in the axis Means; and four terms in the axis Time.

Table 1: Presentation of terms identified in the interviews and listed in ICNP® 2011. Salvador, Bahia, Brazil, 2013.

Axes	ICNP - 2011 Terms
Action	Administering; Alleviating; Supporting: Assisting: Attending; Increasing; Evaluating; Warning; Lowering; Controlling; Talking; Caring for; Caring for Hygiene; Giving; Bathing; Empowering; Facilitating; Intubating; Measuring; Minimizing: Offering; Guiding; Prescribing; Preparing; Reporting; Requiring; Reassuring; Treating
Client	Sick Person; Family; Individual; Patient
Focus	Drug Abuse; Acceptance; Adaptation; Distress; Support from the family; Attention; Attitude; Characteristic; Condition; Control; Fatigue; Ability to feel; Foul odor; Coma; Communication; Comfort; Conscience; Awareness; Coping; Cure; Discomfort; Despair; Dignity; Dyspnea; Pain; Edema with exudation; Hope; Expectation; Wound; Heart rate; Hypertension; Injury; Dying; Death; Need; Guidance; Hygiene standard; Breathing pattern; Role; Role of family support; Thought; Pressure; Procedure; Process; Pathological process; Dietary regime; Sign; Symptom; Suffering; Sadness; Pressure ulcer; Ventilation; Sight
Judgment	Absence; Status; Degree; Severe; Severity; Improved.
Location	Clinic; Body; Housing; Hospital ward; Hospital; Healthcare facility; Hand; Skin; Position; Intensive care unit
Means	Discharge; Social worker; Dressing; Device; Nurse; Glove; Material; Medication; Drug; Physician; Nutritionist service; Technique; Television; Pillow
Time	Contact; Continuous; Day; Time interval; Morning; Present; Situation; Always; Afternoon; Time; Visit

Table 2: Presentation of terms considered broader than the ICNP® 2011 terms. Salvador, Bahia, Brazil, 2013.

Axis	Broader terms	ICNP® 2011 terms
Focus	Disease	Incidence of disease
Judgment	Expected	Expected level
Means	Health area	Health service
	Invasive	Invasive device

Table 3: Presentation of terms considered narrower than the ICNP® 2011 terms. Salvador, Bahia, Brazil, 2013.

Axis	More specific terms	ICNP® 2011 terms
Focus	Problematic action	Problematic
	Pleasure	Joy
	Ventilation	Interacting in ventilation
	Psychological process	Psychological
	Secretory process	Secretion
Means	Mattress	Egg crate mattress
	Heating device	Heating
	Music therapy	Background music
	Oxygen therapy	Oxygen

Table 4: Presentation of terms that were not listed in the ICNP® 2011. Salvador, Bahia, Brazil, 2013.

Axes	Unlisted terms
Action	Working with the family; Dedicating; Unwinding; Staying; Investing; Fighting; Providing; Knowing
Client	Companion; Loved one; Terminally Ill patient; Being
Focus	Love; Moral support; Psychological support; Aesthetic aspect; Psychological and spiritual aspect; Nursing assistance; Good death; Need; Embarrassment; Nursing care; Palliative care; Ethics; Professional; Experience; Lack of oxygen; Humanization; Idea; Brain death; Oncology; Anasarca; Role of the nurse; Complaint; Respect; Responsibility; Routine; Singularity; Survival
Judgment	Reached; Good; Right; Full; Correct; Difference; Difficulty; Specific; Essential; Favorable; Humble; Equal; Important; Lucid; Possible; Little
Location	Hospital environment
Means	Comprehensive care; Discussion; Vasoactive drug; Nursing; Team; Hess scale; Evolution; Shortage of staff; Employee; Hemodynamics; Practice; Profession; Professional; Healthcare Professional; Psychologist; Prognosis; Human resources; Sedation; Basic support; Therapeutic; Therapeutic ceiling.
Time	Stage; Terminal phase; Schedule; Incident.

DISCUSSION

The International Council of Nurses (ICN) has undertaken efforts to develop the International Classification for Nursing Practice (ICNP®) and make it more consistent in order to meet the cultural diversity of the nursing practice worldwide. For that purpose, the Council has asked nurses to develop research in their work environments to ensure the dynamic nature of this terminology and enable the inclusion of new terms, as well as concepts pertaining to diagnoses/outcomes and nursing interventions, which enhances the classification dynamism.

According to guidelines in the ICN website(16), the Council welcomes recommendations from nurses and other ICNP® users worldwide, based on research results, in order to have a clinically relevant, valid, and useful classification for the professional nursing practice, with data that are sensible to the cultural differences and local circumstances. In this perspective, the ICN adopted the following criteria to evaluate and accept terms as belonging to each axis and definition for diagnoses/outcomes and nursing interventions: the concept must belong to the realm of nursing; it must be useful to the clinical practice; the concept and its definition must not be redundant, taking into account the concepts that are already included in the ICNP®; it must be supported by scientific evidence found in studies and reviews of literature – content validation or clinical validation – and, finally, each concept must follow the ICNP® structure, which adopts as a standardization parameter the ISO 18.104 Standard – Integration of a reference terminology model for nursing(16-17).

Considering that the axis Focus is of particular attention and relevance for nursing(6,10), we have decided to concentrate our discussion on the terms of this axis that relate to palliative care. Amongst the terms that pertain to the axis Focus, it was possible to classify each unlisted term in the 21 subsets of this axis, following the classification rules and using the ICNP® 2.0 Version(10) taxonomy tree as a foundation.

In the **Social Support** subset, we identified the following terms: *aesthetic aspect, anasarca, and embarrassment*, which refer to one's physical appearance. This factor is important when it comes to palliative care patients, considering that with the clinical and/or psychological decline of the person receiving palliative care, hygiene and physical comfort care tend to reach a greater dimension due to one's loss of autonomy and difficulty to care for oneself(18).

These changes reflect on the family dynamics; therefore, it is even more important for the team to pay attention to family support in face of the changes that take place in the terminally ill person's body, as well as the embarrassment resulting from these changes. This takes us back to what is already recommended by the WHO when it comes to the definition of palliative care and family care, which are largely considered as hidden care, taken for granted and critically important for a good death(19).

Only two terms were classified under **Characteristics**: *professional* and *role of the nurse*. They are relevant to team work in the context of palliative care because of the professional profile of nurses, who are considered the link between patients/families and the other team members when we take into account the particular fact that they are 24 hours a day with patients(20).

To develop trans- and interdisciplinary team work, it is mandatory that each member of the team pays attention to the need to develop skills and abilities to manage his or her own emotions and the feelings in an adaptive, intelligent way, inasmuch emotional control is essential for palliative care professionals' interpersonal relationships and professional activity(21).

Status as a subset is defined as one's condition in relation to other people's conditions. Consequently, the following terms were identified: *love and moral support* as qualities that are required by the people receiving palliative care, whether they are patients or their families. An ill person's first reference is their family and friends. Thus, a terminally ill person needs to be supported,

listened to and seen[22] as in need of moral support and love, and the nursing professionals who belong to the palliative care team must allow for the potentials of the natural network composed of that person, his or her family, friends and professionals in the palliative care team to flourish.

The subset **Service** addresses a subdivision of the **Set of actions,** which stands for the subsidies to support one's needs. Amongst the identified terms, we included *routine* in this taxonomy level, standing for the daily lives of those who experience the care for someone undergoing the dying process, in the context of palliative care. The intensive routine of care for a patient who is beyond the possibility of cure fosters a constant contact with pain and suffering, which may lead the professional caregiver into deep physical, psychological, and emotional burnout, and that may lead into a high level of stress[2,11].

Complication is a subset that corresponds to phenomena and is subdivided into **Diagnoses phenomena and outcomes**. In this level, the following terms were identified: *lack of oxygen* and *need*, which can actually represent nursing outcomes/diagnoses phenomena together with the possibility of implementing nursing interventions to produce outcomes such as comfortable ventilation and a comfortable, affective status of well-being.

The term *need* can be understood under various angles. One of the possible interpretations in palliative care is the need for information on the part of the palliative care team in order to help patients and their families exercise their rights when making decisions with awareness and responsibility. Often times, the lack of information and clarity leads to a conspiracy of silence that compromises the relationship between patients and their families, and between them and the team[21,23].

The conspiracy of silence that results from the lack of information and dialogue is considered as a potential problem in the daily lives of terminally ill people and their families. It can vary according to various cultural differences and family dynamics. It is noteworthy that this conspiracy can be partial or complete and that the situation can become even more complex when it comes to care provided at the end of one's life[24].

Problematic action is a subset that accounts for situations that require more attention from the nursing team. The following unlisted terms have been classified under this taxonomy level: *brain death* and *oncology.* These terms refer to a trigger to the conspiracy of silence in face of the transition process from the paradigm of illness changing therapies to palliative care, aiming at preventing and alleviating suffering and improving quality of life. Speaking of brain death and cancer is thought of as a complex situation, which helps the conspiracy of silence and interferes with communication channels[24].

Entity is a subset that relates to the **Emotional support** subset. In this taxonomy level, only one term was identified: *psychological support*. Psychological support can produce relevant nursing interventions for the caregiving practice in the scope of palliative care, considering that the psychological dimension is one amongst various human dimensions affected by a terminal condition[2-3].

Family support is a subset that is subdivided into **Phenomenon** and **Process**, referring to a series of functions or actions whose purpose is to reach an outcome. In this taxonomy level, we could observe a larger number of terms that relate to guiding the caregiving practices by nurses and their team when in contact with a terminally ill person. The identified terms were: *nursing assistance, good death, humanization, respect, responsibility, singularity, survival,* and *ethics*. These terms denote subjectivity in the professional practice, involving a level of sensitivity that is singular to palliative care[20].

Families play a significant role in each stage of the health promotion process, from tracing to diagnosis, treatment and follow up. In this context, it is understandable that family members wish to protect their loved ones and the communication process must be as effective as possible and advocate active listening in

order to decrease or cancel out the conspiracy of silence, as well as to protect people from potential harms, minimizing concerns about the patient's future [24].

In the subset **Thought**, we classified the terms *experience* and *idea.* In the subset **Prophylactic**, which is subdivided into **Side effect**, **Signs** and **Symptoms**, only one term was found: *complaint.* This may be a sign that most of the terms that could be included in this taxonomy level could be terms that are already listed in the ICNP®, as one can verify in the case of terms listed in Table 1, in the axis Focus.

The subset **Spiritual support** is related to a human dimension that seems to be still far from being emphasized by healthcare teams[11,20]. However, in speeches that originated this study's term database, we could identify the term *psychological and spiritual aspect*, showing an extremely relevant concern for people undergoing the dying process and facing death.

As far as the other subsets are concerned, **Absent complication** and **Environmental entity**, we observed that, in this study, it was not possible to identify any terms that can be added to this ICNP® taxonomy level , in view of the lack of terms that could evidence this subset's concepts.

CONCLUSION

The development of this study paved the way so that we could learn the terms used by the nursing team providing care for people undergoing the dying process and facing death at the ICU of an oncology hospital. This will allow for contributions to develop terminologies in the palliative care area.

The data presented consist of a first stage of the process for building terms referring to nursing diagnoses/outcomes and interventions whose purpose is to present subsidies for the ICNP® Catalog for people in palliative care, carrying on the elaboration of a terminology that represents nursing internationally.

With these results, we hope that it will be possible to develop a light technology tool, composed of elements that represent nursing teams' practices in the context of palliative care, with nursing diagnoses/outcomes and interventions validated and focused on the demands for care that can be resolved, with the perspective of maintaining dignity for people undergoing the dying process and facing death, taking into account the singularities pertaining to finiteness.

This study presents gaps so that new terms and concepts will be included in the taxonomy that composes the ICNP®, focusing on palliative care for a dignified death. This consists of great help to standardize a language that facilitates communication amongst nursing professionals and between them and other palliative care team members.

The great value of including these terms is seen in the perspective of supporting nursing professionals' daily lives, especially those in palliative care, when it comes to providing care for people whose illnesses cannot be cured, facilitating the documentation of the nursing process, which is the main clinical reasoning within our area of knowledge, facilitating and giving dynamism to the recording of thoughts, information, doubts and feelings by the nursing teams.

REFERENCES

1. Elia N. A solidão dos moribundos. Rio de Janeiro: Jorge Zahar Editora; 2001.
2. Walters G. Is there such a thing as a good death? Palliative Medicine. 2004; 18(5):404-8.
3. World Health Organization. Definition of Palliative Care [Internet]. 2013 [cited 2013 abr 14]. Available from: http://www.who.int/cancer/palliative/definition/en.
4. Silva EP, Sadigursky D. Concepções sobre cuidados paliativos: revisão bibliográfica. Acta Paul Enferm. 2009; 21(3): 504-8.
5. Silva RS, Medeiros ACT, Nóbrega MML. Processo de Enfermagem na perspectiva dos cuidados paliativos. In: Silva RS, Amaral JB, Malagutti W, organizadores. Enfermagem em cuidados paliativos: cuidando para uma boa morte. São Paulo: Martinari; 2013. p.119-37.
6. Conselho Internacional de Enfermagem. Classificação Internacional para a Prática de Enfermagem CIPE® - Versão 1.0. São Paulo: Algol; 2007.

7. Bittencourt GKGD, Nóbrega MML. Meaning for the professional practice of terms attributed to actions of nursing - a descriptive study. Online Braz J Nurs [Internet]. 2006 [cited 2013 abr 14]; 5(3). Available from: http://www.objnursing.uff.br/index.php/nursing/article/view/308.
8. Andrade LL, Costa KNFM, Nóbrega MML, Oliveira JS, Accioly CMC. Termos identificados em uma clínica médica e classificados como não constantes na CIPE®. Rev. Eletr. Enf. [Internet]. 2012 [cited 2013 abr 14];14 (2): 330-6. Available from: http://www.fen.ufg.br/fen_revista/v14/n2/pdf/v14n2a13.pdf.
9. Nóbrega MML, Telma RG, Furtado LG, Albuquerque CC, Lima CLH. Nursing terminologies: the NANDA taxonomy to the International Classification for Nursing Practice. Rev enferm UFPE on line. [Internet]. 2008 [cited 2013 abr 14];2(4):454-61. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/viewFile/333/pdf_408.
10. Conselho Internacional de Enfermeiros. Classificação Internacional para a Prática de Enfermagem CIPE® - Versão 2.0. São Paulo: Algol; 2011.
11. Silva RS. O cuidar/cuidado para uma boa morte: significados para uma equipe de enfermagem intensivista. [dissertation]. Salvador: Escola de Enfermagem/UFBA; 2010. 114 p.
12. Pavel S, Nolet D. Manual de terminologia. Public works and government services: Canadá, 2002.
13. Leal MT. A CIPE® e a visibilidade da Enfermagem: mitos e realidades. Lisboa (PT): Lusociência; 2006.
14. Houaiss A. Dicionário Houaiss: sinônimos e antônimos. São Paulo: Publifolha; 2008.
15. International Council of Nurses. Guidelines for ICNP® Catalogue development. [Internet]. 2008 [cited 2013 abr 14]. Available from: http://www.icn.ch/icnp_Catalogue_Devlp.pdf
16. International Council of Nurses. ICNP® Concept Submission and Review Guideline [Internet]. Geneva: ICN; 2011 [cited 2013 abr 14]. Available from: http://www.icn.ch/pillarsprograms/icnpr-conceptsubmission-and-review-guideline/.
17. Cubas MR, Denipote AGM, Malucelli A, Nóbrega MML. A norma ISO 18.104:2003 como modelo integrador de terminologias de enfermagem. Rev. Latino-Am. Enfermagem [Internet]. 2010 [cited 2013 abr 14];18(4). Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692010000400002&lng=en&nrm=iso&tlng=en.
18. Pereira I, Sera CTN, Caromano FA. Higiene e conforto. In: Oliveira RA Coordenador. Cuidado Paliativo. Caderno CREMESP. São Paulo: 2008. p. 195-219.
19. Hermes HR, Lamarca ICA. Cuidados paliativos: uma abordagem a partir das categorias profissionais de saúde. Ciênc. saúde coletiva [Internet]. 2013 [cited 2015 mar 22];18(9): 2577-2588. Available from: http://www.scielo.br/pdf/csc/v18n9/v18n9a12.pdf
20. Silva RS, Pereira A, Campos AER. Caring for the patient in the process of dying at the Intensive Care Unit. Rev Esc Enferm USP [Internet]. 2011 [cited 2013 abr 14];45(3):738-744. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232013000900012.
21. Araújo MMT, Silva MJP, De Simone GG, Torales GMG. Inteligência emocional no trabalho em equipe em cuidados paliativos. Revista Bioethikos [Internet]. 2012 [cited 2015 mar 22];6(1):58-65. Available from: http://www.saocamilo-sp.br/pdf/bioethikos/91/a06.pdf
22. Sociedade Francesa de Acompanhamento e Cuidados Paliativos. Desafios da Enfermagem em Cuidados Paliativos: cuidar, ética e práticas. Loures (PT): Lusociência; 2000.
23. Martíns AMJ, Zarazaga RE. Dolor y sufrimiento en enfermos oncológicos al final de la vida: el papel del conocimiento de la enfermedad. Med. Paliat. 2009;16(4):229-234.
24. Chaturvedi SK, Loiselle CG, Chandra PS. Communication with Relatives and Collusion in Palliative Care: a cross-cultural perspective. Indian Journal of Palliative Care. 2009; 15 (1):2-9.

Received: 11/06/2013.
Accepted: 03/18/2015.
Published: 06/30/2015.