Original Article

Standardization of nursing care in a palliative care oncology setting: perceptions of nurses*

Sistematização da assistência de enfermagem em cuidados paliativos na oncologia: visão dos enfermeiros

Sistematización de la asistencia de enfermería en cuidados paliativos en oncología: visión de los enfermeros

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ABSTRACT

Objectives: This study sought to: describe the view of palliative care oncology nurses about the nursing care system (SAE); analyze the factors involved in the implementation of SAE; and, discuss possible strategies proposed by the nurses to encourage implementation. **Methods**: A descriptive, qualitative research design using focus group technique with content analysis was used. Participants were eight nurses working at the Cancer Hospital IV, a unit of the National Cancer Institute specializing in palliative care, located in the municipality of Rio de Janeiro, Brazil. **Results**: The participants indicated that the unit was in the planning phase of implementing SAE; challenges of this process due to its complexity and the clinical context in which it was to be implemented were identified. **Conclusions**: The need for training staff in relation to the theoretical foundation and preparation for decision making, taking into consideration the complexity of the clinical practice area, was the main strategy identified for successful implementation of SAE.
Keywords: Oncologic nursing; Hospice care; Nursing process; Management

RESUMO

Objetivos: Descrever a visão dos enfermeiros a respeito da sistematização da assistência de enfermagem (SAE) a clientes com câncer avançado em cuidados paliativos; analisar os fatores intervenientes na implantação da SAE na visão dos enfermeiros e discutir possíveis estratégias propostas pelos enfermeiros que favoreçam sua implantação nesse cenário. **Métodos:** Pesquisa qualitativa, descritiva. Participaram oito enfermeiras do Hospital do Câncer IV, unidade do Instituto Nacional do Câncer especializada na área, localizada no Município do Rio de Janeiro, Brasil. Foram usadas a técnica do grupo focal e a análise de conteúdo. **Resultados:** Os discursos dos sujeitos indicaram que a unidade encontrava-se na fase de planejamento de implantação da SAE, bem como o reconhecimento dos desafios do processo relacionados com sua complexidade e o contexto de atuação. **Conclusões:** Como principal estratégia para implantação da SAE evidenciou-se a necessidade de capacitação da equipe em relação à fundamentação teórica e preparo para a tomada de decisão frente à complexidade da área.
Descritores: Enfermagem oncológica; Cuidados paliativos; Processos de enfermagem; Gerência

RESUMEN

Objetivos: Describir la visión de los enfermeros respecto a la sistematización de la asistencia de enfermería (SAE) a clientes con cáncer avanzado en cuidados paliativos; analizar los factores intervinientes en la implantación de la SAE en la visión de los enfermeros y discutir posibles estrategias propuestas por los enfermeros que favorezcan su implantación en ese escenario. **Métodos:** Se trata de una investigación cualitativa, descriptiva. Participaron ocho enfermeras del Hospital del Cáncer IV, unidad del Instituto Nacional del Cáncer especializada en el área, localizada en el Municipio de Rio de Janeiro, Brasil. Se usó la técnica del grupo focal y el análisis de contenido. **Resultados:** Los discursos de los sujetos reflejan que la unidad se encontraba en la fase de planificación de la implantación de la SAE, así como el reconocimiento de los desafíos del proceso relacionados con su complejidad y el contexto de actuación. **Conclusiones:** Como principal estrategia para la implantación de la SAE se evidenció la necesidad de capacitación del equipo en relación a la fundamentación teórica y preparación para la toma de decisiones frente a la complejidad del área.
Descriptores: Enfermería oncológica; Cuidados paliativos; Procesos de enfermería; Gerencia

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** Study conducted in the "Instituto Nacional de Câncer – Hospital do Câncer IV" (HC-IV), specialized in palliative care in oncology and located in the city of Rio de Janeiro (RJ), Brazil.*

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INTRODUCTION

In recent decades, the growth in nursing research, with Brazilian nursing standing out in the Latin American context with the greatest amount of research production published in specific periods between 1959 and 2005[1], has shown the need for this profession to face the complexity of health care for the population in the 21st century and to follow the technical-scientific advances in the area of health, on behalf of the quality of care provided and construction of their scientific knowledge[2]. In this movement, the search for organized and systematized practice should be emphasized, including the fact that this is a legal question, as provided for by Resolution 358/2009 of the *Conselho Federal de Enfermagem* (Brazilian Nursing Council)[3].

Nursing Care Systematization (NCS) consists in the way as to how the nursing work is organized, according to the scientific method and theoretical framework, so that the needs for individual, family and community care can be fully met by applying the following stages, included in the nursing process: patient history, nursing diagnosis, planning, implementation and evaluation[3]. The application of these stages requires nurses to have, in addition to scientific knowledge, cognitive, psychomotor and affective abilities and capacities, which help to establish the phenomenon observed and its meaning[4].

Although not being a recent concern in the political, health care and academic context, NCS is an incipient practice, with many difficulties involved in its implementation process, among which the following stand out: nurses' lack of knowledge about the methodology of health care, theoretical models and application of nursing process stages[5]; great demand for bureaucratic and administrative services, lack of personnel and material resources for health care[6]; nursing team's undervaluing of NCS application, often resulting in practice based on common sense concepts and fragmented actions focused on tasks[7].

In view of these difficulties and recognition of the complex, multidimensional and multifaceted reality present in health service organizations of the 21st century, nursing experts seek to follow the paradigmatic changes, discussing the contributions of complex thinking as a possibility of avoiding the biomedical/Cartesian model and fragmentation of human care (for oneself, for others and for "ourselves"), corroborating the comprehensive care principle of the *Sistema Único de Saúde* (SUS – Unified Health System)[8-9].

According to this perspective, in health care for patients with advanced cancer, multiple and complex care demands that affect bio-psycho-socio-cultural aspects cause the area of nursing to have certain peculiarities, aiming to achieve comprehensiveness on behalf of interactive and complex care[10].

In the context of palliative care in oncology, it is necessary to consider the fact that health care objectives, in agreement with World Health Organization (WHO) recommendations, include the promotion of quality of life and comfort of clients and their family members, who deal with this life-threatening disease together by preventing and alleviating symptoms and by helping to meet their psychosocial, emotional and spiritual needs[11].

The approach to complexity in this area of nursing work recognizes the necessary effort of the health team, by means of multidisciplinary work, to meet the health care needs of clients and their families, within the bounds of possibility, and according to the uncertainties, diversities and unpredictability that set the limits of complex reality, in view of the clients' clinical picture instability and proximity of death.

In this way, systematized nursing practice is thought to promote the identification of health care needs that are manifested and/or reported by clients and family members in its entirety, in addition to the interaction and negotiation with the remaining health team members, aimed at the accomplishment and improvement of health care, thus representing an adequate strategy for patient-centered practice, instead of task-centered only. However, apart from the difficulties already associated with NCS, the use of strict and linear benchmarks has contributed to a practice developed in a mechanical and bureaucratic way, which can be essentially observed in health care plans and in the evolution of nursing[6]. Based on this problem and critical discussion, nursing needs to be guided by dynamical and flexible benchmarks, capable of predicting the nuances of complex health care.

During the professional experience in a federal public hospital specialized in palliative care in oncology, researchers empirically observed that the theoretical-philosophical approach was not clear in the clients' medical records and that nursing practice was fragmented. The nursing process stages identified in the context of hospitalizations – history and evolution of nursing – prioritized aspects guided by the biomedical/Cartesian model and, most times, they did not involve questions about psychosocial needs. However, in this context, there is a way of organizing, planning and coordinating actions, whose practice is expressed in the nursing team's cooperative work, showing a participative approach towards clients and their family members and concern for the non-physical aspects of health care.

Thus, the present study focused on the "nurses' perspective of NCS in palliative care for hospitalized clients with advanced cancer".

Recognizing the nurses' perspective of NCS may contribute to management strategies, in the sense that this perspective is supported by individual expectations,

imaginations and analyses made by a person, based on their inclusion in a certain context[12]. This can guarantee realism, adequacy and reasonability to strategic predictions by valuing the team's preferences for the most desired future and the results to be obtained through group work, comprising the first step of the NCS implementation process.

Based on these considerations, the present study aimed: to describe nurses' perspective of NCS; to analyze the factors involved with NCS implementation, according to the nurses' view; and to discuss possible strategies, proposed by nurses, that can promote this implementation.

METHODS

A descriptive study with a qualitative approach was conducted. This type of approach was selected because researchers aimed to understand the meanings, aspirations, attitudes, opinions, perceptions, beliefs and values based on the nature of the object of study[13].

Data were collected from the *Instituto Nacional de Câncer* (INCA – National Cancer Institute), more specifically the *Hospital do Câncer IV* (HC-IV), which is the unit specialized in palliative care in oncology, situated in the city of Rio de Janeiro, RJ, Brazil. This is one of the Institute's five health care units, responsible for health care for individuals with cancer, in the sphere of the SUS. The HC-IV provides the following four types of service: outpatient care, home care, emergency care and hospitalizations.

The hospitalization service includes 56 beds and 17 nurses, one of whom is the head of the sector, and they work 40 hours per week, with shifts of day-shift nurses and nurses on duty. This is a type of care recommended for highly refractory and discomforting symptoms and/or serious social problems. Such situations are usually associated with the exacerbation of symptoms that characterize the proximity of death or that indicate greater clinical impairment and a short remaining time of life[14].

The data collection technique used was the focus group, which is a technique that facilitates the identification of nurses' perspective of NCS. It is recommended that the group be comprised of eight to ten individuals. Information about the reality of the context was key to understand individual and group meanings and, as a result, to identify the adequate strategies for the implementation of systematized nursing practice. This technique characteristically evidences the human tendency to give opinions, to have certain attitudes and to interact with others. When exposed to group discussions, people usually listen to different opinions about the subject being discussed, formulate their own opinions or improve the ones that have been given, based on what has been exposed[13].

According to methodological rigor, prior to group composition, the profile of 17 nurses working in the hospitalization sector was characterized, seeking to achieve homogeneity, based on the nature of the phenomenon studied. Data were collected by participants completing a form that included questions such as age, sex, length of time of experience in oncology and in palliative care and academic titles.

Participants included eight nurses, who had agreed to research inclusion criteria, i.e. to have a minimum length of time of experience of two years in the hospitalization sector and to accept to participate in the study by signing the Informed Consent Form. Nurses chose the following code names: Flower, Perfume, Humming Bird, Fish, Beauty, Orchid, Tulip and Rose. The invitation to participate in the study was made after approval from the INCA Research Ethics Committee (protocol n.º101/07), respecting individuals' interest and availability, according to what the *Conselho Nacional de Saúde* Resolution n.º 196/96 recommends.

There were two focus group moments, which included the presence of a moderator with technical experience and the researcher. The first moment occurred in February 2008 and lasted approximately 1 ½ hours, when questions about NCS implementation in the context of nurses' performance and factors involved with this process were discussed. The second moment occurred in March 2008, lasted 1 ½ hours and aimed at group validation of the results obtained in the first moment and discussion with the nurses about the strategies that promote NCS implementation in this context. The material produced was organized according to the full transcription of the recorded reports and observations. The process of analytical treatment of data was performed from raw data, according to content analysis[15]. The organization of codification occurred through classification and grouping, i.e. selection of categories. The recording unit was the theme, which comprises the content analysis characteristics. The theme is used as recording unit to analyze the motivations to have certain opinions, attitudes, values, beliefs and tendencies, among other aspects, as exposed by participants while the focus group is conducted.

Data were grouped into three categories: recognition of the current situation: a shared view of the NCS implementation stage; challenges to NCS implementation; and team learning as an institutional strategy for NCS implementation.

RESULTS

The profile of the 17 nurses who participated in this

study is described as follows: they were all females, predominantly aged between 31 and 40 years (47%) and with a length of time since graduation of one to five years (35%). The majority reported a length of time working in oncology of one to five years (53%). Almost all nurses mentioned being ex-INCA residents (82%). A great number of them (94%) participated in an NCS qualification course, which was promoted by the Institute in 2007, lasted 30 hours, and was included in the strategic plan for NCS implementation.

Recognition of the current situation: a shared view of the NCS implementation stage

In the context of the present study and at the time of data collection, systematized nursing practice was fragmented, considering the necessary theoretical basis and scientific methodology, with evidence of the biomedical/Cartesian model that coincided with empirical observations made during the researchers' professional experience, as observed in the following reports:

"There's no way we can pick up the pieces. And this is what's happening in our unit. We have a poor patient history, we don't have diagnosis or prescription. There's progress here, which is poor though. But everything is important" (Fish – G1).

"We're not doing NCS. We perform a kind of broken nursing process here. This is not based on any nursing theory. We see the problem and prescribe. So, it's a broken nursing process. We want to do the NCS, Nursing Care Systematization. From the theory to the final result. But, like, what do we want from nursing care for the patient? What do we do about the patient who arrives? First, what's our goal? To control the symptoms? Doctors will deal with this aspect when it comes to medication, but we want to improve the patient's condition through nursing care. Well, a patient arrives with severe dyspnea. Of course, we'll have to follow the medical prescription, but what about nursing? What's the area of nursing going to do about that problem?" (Orchid – G1).

As shown in Orchid's report, nurses raised discussions about the role of nursing in solving client problems that surpass the physical aspect, although biomedical/Cartesian model concepts are still present.

The nurses' perspective of NCS was considered difficult and complex, dependent on multiple factors, from structural ones to those related to the commitment of all individuals involved with this process. However, they view NCS as something feasible and favorable to this profession, in terms of autonomy. The commitment factor was extensively discussed, once the group showed concern about the common sense concepts that influenced their view of NCS, which can be interpreted as yet another task for the nurse that does not function. The reports were as follows:

"[...] *I think that putting NCS into practice in the beginning... it's difficult, because this means everyone has to be involved. But when people have already understood this, I think things begin to flow more easily, this becomes like a cogwheel, you know? But I think that's why we're going to have difficulties* [...]*"* (Perfume – G1).

"[...] *because people don't believe that this works, or because they think this is another task for nurses. So, I think their awareness and commitment are important* [...]*"* (Rose – G1).

"[...] *We also have to think how beneficial this is going to be for nursing care* [...]*"* (Flower – G1).

"Awareness is important, not only of the group of nurses, I think, but also of managers. I think that if managers are aware of its importance and accept it, they will promote this and help, whether by hiring more nurses, or by facilitating this type of nursing work. And we have to be aware that NCS is key [...]*"* (Orchid – G1).

All nurses comprising the group showed interest and recognized the importance of systematized nursing practice. In addition, they emphasized the need for everyone's awareness, including the different levels of power, i.e. the general immediate management levels, which contribute to the view of NCS as a macro-dimensional process, with stages that require planning and strategies on an institutional level.

Recognition of the current situation has implications that will be discussed in the subsequent categories, whether they are associated with intervening factors, or with institutional investment, aiming to gather knowledge for the group, thus characterizing the strategic stage of NCS implementation.

Challenges to NCS implementation

Lack of knowledge about NCS and the processes involved were recognized by nurses as one of the main difficulties for its implementation, as observed in the following reports:

"What we saw in college wasn't enough, in my opinion. I realized that, during my undergraduate studies, I didn't learn enough about the teaching of nursing theories" (Flower – G1).

"I think one thing we got to remember is that we need knowledge to do this. We need to have knowledge not to make assumptions or be stuck in a rut and, then, say something that has nothing to do with it. And, suddenly, one makes a diagnosis that doesn't apply to the patient. So, I think knowledge is a determining factor for us to do this in an adequate way" (Perfume – G1).

Reports show indications of nurses' lack of preparation when dealing with the requirements needed to adopt critical thinking in the organization of health care processes. When encouraged to reflect on this issue, they emphasize the problems related to the thinking and

doing, in addition to the professional qualification process, where these actions are usually transmitted in a dichotomous, rather than dialectical, way.

In addition to lack of knowledge, the context of work is marked by unpredictability, the uncertainties of life, proximity of death, instability of the client's clinical picture and multiplicity of problems, apart from other factors that nurses consider to be hindering the NCS implementation process. This profile of clientele requires nurses to conduct constant reassessments of each situation, once they can vary quite quickly, demanding action and decision while facing urgency and uncertainty. In this way, the majority of these situations are not restricted by rules and patterns, requiring professionals' availability of time and, consequently, adequate human resources and a humanized practice regulated by dynamic and flexible benchmarks, because the complex reality needs to be managed by nurses. Flower stated the following:

"We're talking about patients in palliative care, we're not talking about general oncology patients. So, our unit will have to set up a different instrument to collect data, because it's different from the others, which treat patients' heads and necks, breasts, urinary system and so on. These patients arrive with breast cancer, with psychological problems, a social history of abandonment, the job that one has left behind and the fact they don't have an income now. These problems come together and this makes things more difficult […]*"* (Flower – G1).

With regard to human resources, the unit is affected by a deficit in the number of nurses, a problem which is aggravated in the weekend shifts, an important intervening factor in the NCS implementation process.

"[…] *a large number of professionals are required to perform such complex process. There is the problem with weekends too, when there are fewer nurses, which means everyone has to be committed. It doesn't work if the day-shift nurse does her part, but the nurse on duty doesn't, both on weekends and in the night-shifts* […]*"* (Tulip – G1).

Nurses also pointed to the difficulty in establishing health care priorities. Concern for the time available to perform NCS was extensively discussed and associated with the importance of setting up priorities, aimed at meeting health care requirements with quality and favoring the necessary adaptations to maintain and promote quality of life and comfort. In her report, one participant stated the following:

"It's necessary but difficult to establish priorities, because everything is a priority. So, it's also difficult for us to deal with priorities […]*"* (Perfume – G1).

Nursing care planning, based on the theoretical model or models that best suit the clientele's profile, is capable of helping nurses to establish the priorities and to meet the health care needs. In addition, assessment is a key step, permeating all nursing process stages and, as it is a continuous, guided and comprehensive action, it enables information to be gathered and used, thus promoting decision-making.

In this way, nurses should understand that assessment precedes decision-making. Even the valuing of subjective questions when conducting the health care process can facilitate the establishment of priorities, according to clients' actual needs in the dying process. Care effectiveness is directly associated with the client's and family's level of participation in decision-making. For this reason, the establishment of priorities in palliative care requires nurses to have an attentive, respectful and empathetic approach, so that health care proposals and client needs are as balanced as possible.

Team learning as an institutional strategy for NCS implementation

Considering the fact that team learning is the necessary basis for NCS implementation, in view of the complexity of the process and context of work, it should be the first point to be valued and the focus of institutional and personal investment. This prerequisite cannot be avoided or disregarded, so that the other stages do not become vulnerable or lose strength throughout time.

The unit is in the strategic planning stage of NCS implementation. The investment made in the NCS qualification course was part of the plan. This course was held in December 2007, lasted 30 hours and involved 94% of the hospitalization sector nurses. Thus, team learning was the main strategy discussed, it was associated with continuing education, necessary to eliminate the group's deficit in knowledge about NCS and theoretical framework, and it should thus be considered as a continuous process. The reports were as follows:

"The course was the first initiative. We did it and this proved that the best thing there is for nursing care is for us to do the systematization and keep it […]*"* (Flower – G2).

"I think the first step is this, to do training, lectures, courses, that which is most adequate for our needs, so that we raise our knowledge about theory and NCS. Because what we learn in college is superficial [...]*".* (Tulip – G2).

"[...] *unfortunately, we know that this process is going to take a long time, because we still don't have enough workers. So, as you put it in your presentation, there are professionals who are engaged and committed, but we know this doesn't depend on our engagement and commitment only, or our dedication and how things are applied, it also depends on other administrative and structural*

issues that are not within our power […]*"* (Flower – G2).

Education in the service must be a continuous and permanent process, although nurses recognize the need for group learning. The growing demand for NCS implementation, as a result of service assessment systems, must not contribute to the performance of incoherent and tiring actions.

DISCUSSION

The results indicate that lack of knowledge is a factor that hinders the NCS implementation process, associated with the fragmented practice of nursing process stages, lack of theoretical-philosophical framework and difficulty in breaking away from the biomedical/ Cartesian model.

Systematized nursing practice is made operational through the application of the stages that comprise the nursing process, each with their importance and objective, in an interrelated and interactive way. However, their fragmented practice represents fragility, creating immediate actions without previous planning, which could compromise the quality of health care provided[16].

In the perspective of complex thinking, the professional qualification process should surpass the fragmentation and linearity of knowledge that, conversely, has been promoted in modern societies in their search for a simplistic way to explain everything, without paying attention to contextualization[17]. However, the teaching of nursing, although showing flaws that do not escape the reality of simplification and fragmentation and thus resembling the dichotomy between theory and practice, has eclectic characteristics, from the valuing of traditional pedagogical foundations and the technically-oriented model to the incorporation of humanistic ideal aspects, adding values of complexity to its practice, values that need to be further promoted and agreed to[18].

The client's profile, given their multiple and complex health care needs, requires nurses to use dynamic and flexible frameworks, in addition to team work commitment, on behalf of an interactive and complex type of care, regulated by contextualization, interdependence and relationship of all aspects associated with human life[8].

Interdisciplinarity and the involvement of all levels of power and academic institutions themselves with the NCS implementation process were essential to achieve success, which refers to investments made to improve healthcare practices. The involvement of all individuals was associated with the nursing team itself, aiming to contribute to the collective movement which provides more strength, motivation and power to this team. In addition, it was associated with the recognition of the importance of systematized nursing practice by managers and directors, with the purpose of gathering resources and viewing NCS as an aspect that needs to be a part of institutional strategic planning, essential to qualify health care and certify hospital accreditation processes.

In view of the main problems related to the NCS implementation process, team learning strategy was emphasized. The group recognizes the need for permanent and continuing education and the necessary individual responsibility in the acquisition and application of knowledge to make NCS operational. However, this is a strategy that also requires dynamic, participative and interdisciplinary planning, so that it objectively meets the nursing professionals' and institution's needs[19].

FINAL CONSIDERATIONS

NCS is a current requirement in the context of organization of health institutions, as a result of service assessment systems, and the nurses who participated in the present study recognize its value to qualify health care and to provide more visibility to the nursing profession.

However, they have to face difficulties to systematize the health care managed by them. Some of the difficulties reported have been observed in studies previously conducted in different clinical contexts. Others, however, are related to a field of complex work, marked by the routine act of dealing with human fragilities on the threshold between life and death.

In general, nurses aim for NCS to be implemented in the service and to share opinions, which, at the moment, are mostly related to problems involved with the process. However, they consider this to be a feasible task, important for nursing care practice, which depends on the joint work of all individuals involved.

Lack of knowledge to subsidize the NCS implementation stage is considered to be one of the main factors causing anxiety in nurses. However, institutional initiatives aimed at team qualification have contributed to the continuity of the NCS implementation process.

In conclusion, considering the context of work of nurses in palliative care in oncology, it is understood that investments in the learning process should surpass technical knowledge. It is necessary to think of NCS in a flexible way, free from the rigidity of conventional patterns. Subjectivity, empathy and love are necessary aspects, so that clients' and family members' health care demands are met. Nurses must pay attention to complaints, in addition to what is directly reported to them, the physical aspect and considerations of the biomedical/Cartesian model.

It is worth reflecting on the fact that attributing

complex thinking to a social phenomenon is a positive attitude, in the sense that it will increase motivation and help to reveal its nature, so that practical solutions can be found in the end. Thus, recognition of the context of work and the need to learn can be considered a positive and stimulating factor for the NCS implementation process, characterizing this moment as one when nurses can reflect on the need to systematize nursing care. It is a moment that indicates the fact that new investigations on behalf of continuous nursing practice improvement, based on scientific principles, need to be conducted. This is because the nursing profession seeks to incorporate emerging paradigmatic changes, in view of the new perspective of social reality.

REFERENCES

1. Mendoza-Parra S, Paravic-Klijn T, Muñoz-Muñoz AM, Barriga OA, Jiménez- Contreras E. Visibility of Latin American nursing research (1959-2005). J Nurs Scholarsh. 2009;41(1):54-63.
2. Stacciarini JMR. Pesquisa na enfermagem brasileira: esse é o momento para mudanças? Rev Eletrônica Enferm. [Internet]. 2009;11(4):776. [cited 2010 Jun 12]. Disponível em: http://www.fen.ufg.br/revista/v11/n4/pdf/v11n4a01.pdf
3. Brasil. Conselho Federal de Enfermagem. Resolução COFEN nº 358/2009. *Dispõe sobre a Sistematização da Assistência de Enfermagem e a implementação do Processo de Enfermagem em ambientes, públicos ou privados, em que ocorre o cuidado profissional de enfermagem, e dá outras providências. [Internet]*. [citado 2008 Out. 12]. Disponível em: http://site.portalcofen.gov.br/node/4384
4. Garcia TR, Nóbrega MML. Processo de enfermagem: da teoria à prática assistencial e de pesquisa. Esc Anna Nery Rev Enferm. 2009;13(1):188-93.
5. Takahashi AA, Barros ALBL, Michel JLM, Souza MF. Difficulties and facilities pointed out by nurses of a university hospital when applying the nursing process. Acta Paul Enferm. 2008;2(1):32-8.
6. Castilho NC, Ribeiro PC, Chirelli MQ. A implementação da sistematização da assistência de enfermagem no serviço de saúde hospitalar no Brasil. Texto & Contexto Enferm. 2009;18(2):280-9.
7. Alves AR, Lopes CHAF, Jorge MSB. Significado do processo de enfermagem para enfermeiros de uma unidade de terapia intensiva: uma abordagem interacionista. Rev Esc Enferm USP. 2008;42(4):649-55.
8. Baggio MA, Monticelli M, Erdmann AL. Cuidando de si, do outro e do "nós" na perspectiva da complexidade. Rev Bras Enferm. 2009;62(4):627-31.
9. Nascimento KC, Backes DS, Koerich MS, Erdmann AL. Sistematização da assistência de enfermagem: vislumbrando um cuidado interativo, complementar e multiprofissional. Rev Esc Enferm USP. 2008;42(4):643-8.
10. Silva EP, Sudigursky D. Conceptions about palliative care: literature review. Acta Paul Enferm. 2008;21(3):504-8.
11. World Health Organizationn. WHO Expert Committee on Cancer Pain Relief and Active Supportive Care. Geneva: World Health Organization; 1990. (Technical report series WHO, 804).
12. Motta PR. Desempenho em equipes de saúde. Rio de Janeiro: Ed. FGV; 2001.
13. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 11a ed. São Paulo: Hucitec; 2008.
14. Teixeira M, Lavor M. Assistência no modelo *hospice*: a experiência do INCA. In: Pimenta CAM, Mota DDCF, Cruz DALM. Dor e cuidados paliativos: enfermagem, medicina e psicologia. São Paulo: Manole; 2006. p. 360-83.
15. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2008.
16. Koerich MS, Backes DS, Nascimento KC, Erdmann AL. Patient care system: bringing health care practice, knowledge and legislation together. Acta Paul Enferm. 2007;20(4):446-51.
17. Morin E, Almeida MC, Carvalho EA, organizadores. Educação e complexidade: os sete saberes e outros ensaios. 4a ed. São Paulo: Cortez; 2007.
18. Silva AL, Camillo SO. A educação em enfermagem à luz do paradigma da complexidade. Rev Esc Enferm USP. 2007;41(3):403-10.
19. Silva GM, Seiffert OMLB. Educação continuada em enfermagem: uma proposta metodológica. Rev Bras Enferm. 2009;62(3):362-6.