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DOCUMENTAÇÃO EM CUIDADOS PALIATIVOS: EXIGÊNCIAS NORMATIVAS E REALIDADE DOS REGISTOS DE ENFERMAGEM

DOCUMENTATION IN PALLIATIVE CARE: REGULATORY REQUIREMENTS AND THE REALITY OF NURSING RECORDS

SUPERVISIÓN CLÍNICA EN LA INTEGRACIÓN DE ESTUDIANTES DE ENFERMERÍA EN PRÁCTICAS PEDIÁTRICAS: EXIGENCIAS NORMATIVAS Y REALIDAD DE LOS REGISTROS DE ENFERMERÍA

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RESUMO

Introdução: A documentação em enfermagem representa um desafio complexo para a enfermagem, especialmente na articulação entre classificações padronizadas e a abordagem da complexidade humana. Porém, reveste-se de extrema importância, pois, através destes, é possível garantir a continuidade e a qualidade dos cuidados, especialmente em cuidados paliativos.
Objetivo: Analisar a documentação em enfermagem no contexto dos cuidados paliativos, identificando correspondências nas diversas classificações. Identificar os dados mais frequentes na prática e as principais limitações da documentação dos cuidados de enfermagem.
Método: Estudo qualitativo com recurso à técnica de *focus group* para a recolha de dados junto de uma amostra de enfermeiros considerados peritos em contexto de cuidados paliativos.
Resultados: Os dados indicaram que fenómenos clínicos e funcionais, como dor, fadiga, náusea e risco de queda, têm representação consistente nas classificações utilizadas. Mas, as dimensões psicoemocionais, sociais, espirituais e existenciais apresentaram representações fragilizadas ou ausentes. Destacou-se a necessidade de articular terminologias padronizadas com narrativas livres para assegurar a cientificidade, comparabilidade, humanização e integralidade do cuidado.
Conclusão: A documentação em enfermagem para cuidados paliativos deve ser entendida como um instrumento clínico, ético e comunicacional fundamental. O estudo reforça a necessidade de metodologias mistas em investigações futuras, ampliando contextos e amostras, e destaca a importância da integração entre registos classificados e narrativos para melhorar a comunicação interprofissional, a segurança clínica e a experiência do paciente e dos familiares.

Palavras-chave: cuidados paliativos; registros de enfermagem; cuidados de enfermagem; terminologia padronizada em enfermagem

ABSTRACT

Introduction: Nursing documentation represents a complex challenge for nursing, especially in the articulation between standardized classifications and the approach to human complexity. However, it is extremely important because through these, it is possible to ensure the continuity and quality of care, especially in palliative care.
Objective: To analyze nursing documentation within the context of palliative care, identifying correspondences across the various classification systems. To identify the most frequently recorded data in clinical practice and the main limitations observed in the documentation of nursing care.
Method: Qualitative study using the focus group technique for data collection with a sample of nurses considered experts in the palliative care context.
Results: The data indicated that clinical and functional phenomena, such as pain, fatigue, nausea, and risk of falls, have consistent representation in the classifications used. However, psychoemotional, social, spiritual, and existential dimensions showed fragile or absent representations. The need to articulate standardized terminologies with free narratives was highlighted to ensure scientific rigor, comparability, humanization, and comprehensiveness of care.
Conclusion: Nursing documentation for palliative care must be understood as a fundamental clinical, ethical, and communicational instrument. The study reinforces the need for mixed methods in future research, broadening contexts and samples, and highlights the importance of integrating classified and narrative records to improve interprofessional communication, clinical safety, and the experience of patients and families.

Keywords: palliative care; nursing records; nursing care; standardized nursing terminology

RESUMEN

Introducción: La documentación en enfermería representa un desafío complejo para la enfermería, especialmente en la articulación entre clasificaciones estandarizadas y el abordaje de la complejidad humana. Sin embargo, es de suma importancia, ya que a través de estas es posible garantizar la continuidad y calidad de los cuidados, especialmente en cuidados paliativos.
Objetivo: Analizar la documentación de enfermería en el contexto de los cuidados paliativos, identificando correspondencias entre las distintas clasificaciones. Identificar los datos más frecuentes en la práctica clínica y las principales limitaciones presentes en la documentación de los cuidados de enfermería.
Método: Estudio cualitativo con recurso a la técnica de grupo focal para la recolección de datos en una muestra de enfermeros considerados expertos en el contexto de cuidados paliativos.
Resultados: Los datos indicaron que los fenómenos clínicos y funcionales, como el dolor, la fatiga, las náuseas y el riesgo de caídas, tienen representación consistente en las clasificaciones utilizadas. Por otro lado, las dimensiones psicoemocionales, sociales, espirituales y existenciales presentaron representaciones frágiles o ausentes. Se destacó la necesidad de articular terminologías estandarizadas con narrativas libres para asegurar la cientificidad, comparabilidad, humanización e integralidad del cuidado.
Conclusión: La documentación en enfermería para los cuidados paliativos debe ser entendida como un instrumento clínico, ético y comunicacional fundamental. El estudio refuerza la necesidad de metodologías mixtas en investigaciones futuras, ampliando contextos y muestras, y destaca la importancia de la integración entre registros clasificados y narrativos para mejorar la comunicación interprofesional, la seguridad clínica y la experiencia del paciente y familiares.

Palabras clave: cuidados paliativos; registros de enfermería; atención de enfermería; terminología normalizada de enfermería

INTRODUCTION

Nursing documentation constitutes a central process in clinical practice, ensuring the continuity, quality, and safety of care. Beyond its clinical and legal value, nursing records are fundamental instruments of interprofessional communication, reflecting not only the actions undertaken but also clinical decision-making and the reasoning underpinning interventions (Kuusisto et al., 2022).

In the context of palliative care, documentation assumes heightened relevance, as this field is dedicated to complex human phenomena that transcend the biomedical dimension, encompassing physical, emotional, social, spiritual, and existential aspects (Kuusisto et al., 2022). The use of terminologies such as the International Classification for Nursing Practice (ICNP), NANDA-I, and the nursing ontology enables the categorisation of clinical findings, fostering comparability and research in nursing (Gün & Aktaş, 2025). Nevertheless, limitations persist when these are applied to phenomena that are difficult to objectify, such as suffering, dignity, spirituality, or the meaning of life (Kuusisto et al., 2022; Cardoso et al., 2019).

The primary objective of this study is to analyse nursing documentation in palliative care, identifying correspondences among different classified languages and the limitations of structured recording for complex human phenomena. The specific objectives are to: (i) identify the data most frequently recorded by nurses in palliative care; (ii) establish correspondences between the documented data and classified languages (ICNP, NANDA-I, nursing ontology); (iii) demonstrate the limitations of these languages in documenting phenomena such as spirituality, suffering, dignity, meaning in life, and the caregiver role; and (iv) reflect on the adequacy of clinical content and practice, and on domains that remain under-represented in records.

The relevance of this study rests on several premises: inconsistencies persist, such as spiritual and psychosocial phenomena being under-represented in information systems (Doody et al., 2018; Kuusisto et al., 2022); the absence of specific fields may compromise continuity of care and responsiveness to the needs of the patient and family (Cardoso et al., 2019); and the growing digitisation of clinical systems demands critical reflection on their suitability for the challenges of palliative care, lest human complexity be reduced to simplified categories (Kuusisto et al., 2022).

1. LITERATURE REVIEW

Nursing documentation in palliative care lies at the confluence of scientific terminology and the imperative to capture the singularity of human experience. In this field, two concepts are particularly salient: terminology, which corresponds to formal systems for categorising data, diagnoses, goals, and interventions with a view to standardisation and interoperability (Toker et al., 2025), and narrative documentation, understood as free-text recording that makes it possible to describe the subjective and contextual dimensions of care, which are fundamental to a holistic understanding of the person at the end of life (Sousa & Figueiredo, 2021). The coexistence of both formats is indispensable, as terminology ensures rigour and comparability, whereas narrative preserves the humanisation and contextualisation of care (Rosa et al., 2025).

The articulation between these two modes of recording has received growing attention in the literature, chiefly because the quality of information transferred between palliative care teams depends on its completeness and relevance; limitations in continuity of care and difficulties in interprofessional coordination tend to emerge, particularly in psychosocial, spiritual, and existential dimensions that are frequently under-represented in formal systems (Kuusisto et al., 2022).

This pattern reveals a tendency to privilege physical phenomena—such as pain, fatigue, or nausea—while more complex human phenomena—suffering, spirituality, hope, caregiver role, and family processes—are described insufficiently or only residually (Silva et al., 2023). This reduces the analytical capacity of information systems and weakens the visibility of nursing clinical reasoning. Accordingly, authors argue that deliberate integration of clinical narrative and terminology is essential to capture both the uniqueness of experience and scientific comparability (Gün & Aktaş, 2025).

In the Portuguese context, this issue has likewise been highlighted in research on clinical records (Sousa & Figueiredo, 2021; Belchior et al., 2022). Documentation of prevalent symptoms in the patient in a palliative situation, such as dyspnoea, shows gaps in systematisation and re-evaluation: although the symptom is identified, records do not always include structured scales, plans differentiated by intensity, or the monitoring of intervention effectiveness. This deficit compromises continuity of care and communication with the multidisciplinary team, reinforcing the need for standardised instruments, clinical audit, and continuous training (Sousa & Figueiredo, 2021; Belchior et al., 2022).

Complementarily, the National Coalition for Hospice and Palliative Care Guidelines (4th edition) emphasise that documentation in palliative care should encompass, in an accessible and shareable manner, a multidimensional assessment (physical, psychological, social, spiritual, and cultural), integrating the goals and preferences of the patient and family, as well as advance care planning. This ensures congruence and continuity of the integrated individual plan of care across different levels of provision (NCHPC, 2018).

There is a coexistence of two distinct realities: on the one hand, structured documentation, which guarantees rigour, consistency, and research potential; on the other, narrative and subjective documentation, which is indispensable for recording complex human phenomena that may elude formal classifications. Thus, reconciling these two formats is a necessary condition to

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guarantee not only scientific uniformity but also the humanisation and ethical sensitivity of care for the patient in a palliative situation (Gunhardsson et al., 2008; Kuusisto et al., 2022).

Within this framework, nursing documentation may be interpreted as the tangible record of the interactions and transactions that occur within these systems. In the personal system, records translate individual phenomena such as pain, fatigue, or suffering; in the interpersonal system, data emerge relating to the caregiver role, communication, or family support; and in the social system, broader dimensions become evident, such as dignifying death, spirituality, and the integration of care within institutional networks (Silva & Dias, 2018).

King's theory further emphasises the importance of perception, communication, and transaction as central concepts for defining and achieving goals (Silva et al., 2024). In documentation, this translates into the need for records that not only code objective data but also integrate narratives capable of capturing the singularity of human experience. The conceptual model thus permits a critical analysis of how documentation reconciles technical precision with subjective expression, identifying gaps and potentialities.

The relevance of this model lies in its capacity to articulate the technical and human dimensions of care. By framing documentation as the product of nurse–patient interaction, the theory provides a robust framework for analysing whether documentary records adequately reflect shared goals and the complex phenomena specific to the patient in a palliative situation (Moura & Pagliuca, 2004).

2. METHODS

This study adopted a qualitative, exploratory, and descriptive approach, as it is suited to an in-depth understanding of complex human phenomena and to identifying the meanings attributed by participants. Qualitative inquiry enables the exploration of perceptions, experiences, and practices in natural settings, fostering an interpretative analysis of the phenomenon under study (Silva, Veloso, & Keating, 2014; Miguel & Caldeira, 2017). The choice of this methodology is grounded in the objective of analysing nursing documentation in palliative care, capturing not only objective data but also the subjective dimensions present in nurses' discourse.

2.1 Sample

The sample comprised 12 nurses with training in palliative care, including Specialists in Medical–Surgical Nursing (EEMC) and/or EEMC in the area of nursing care for the person in a palliative situation, as well as master's graduates in palliative care. All had more than three years of professional experience in the field and worked in different palliative care contexts, namely inpatient units, community teams, and hospital teams.

Participants were selected through non-probabilistic convenience sampling, a strategy frequently used in qualitative studies for its ability to assemble individuals with experiences relevant to the study's aim (Gondim, 2003). The number of participants was set at 12, deemed appropriate for a focus group (FG) as it ensures a balance between diversity of perspectives and depth of analysis (Krueger & Casey, 2015).

2.2 Data collection instruments

Data were collected in May 2024 through an FG held via videoconference, a modality that enabled the participation of nurses from different regions, ensuring accessibility and logistical efficiency. The FG was conducted by two researchers: a moderator, responsible for guiding the discussion, and a rapporteur, who recorded field notes and provided technical support.

A semi-structured guide, devised from the literature review, was used and comprised open-ended questions that encouraged the sharing of experiences, critical discussion, and the collective construction of meaning. This technique is widely recognized as suitable for exploring shared and divergent perceptions, promoting the emergence of dimensions not readily captured in individual interviews (Silva et al., 2014; Gondim, 2003). The session lasted approximately 90 minutes, was audio- and video-recorded with informed consent from participants, and was subsequently fully transcribed. Transcriptions were produced verbatim by the lead researcher and validated by the second author, ensuring the integrity of original expressions. Anonymization was ensured by replacing proper names with alphanumeric codes. Participants did not review the transcripts (member checking), a recognized limitation. Thematic saturation was assessed throughout the focus group session.

2.3 Qualitative analysis

Transcripts were subjected to thematic analysis conducted systematically in three stages: exhaustive reading and familiarisation with the data; initial coding of units of meaning; and construction of emergent categories and subcategories. The analysis followed an inductive approach with initial open coding, category development, and subsequent aggregation into core themes, in accordance with the steps proposed by Braun and Clarke (2006). The process was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ), which ensures transparency and methodological rigor in qualitative studies (Tong, Sainsbury, & Craig, 2007).

To enhance the credibility and validity of the analysis, investigator triangulation was employed, ensuring discussion and consensus on the categories defined. To strengthen reliability, double coding was performed on 25% of the material, with inter-rater comparison until consensus was reached. In addition, an auditable record of all stages of the analytical process was maintained, ensuring traceability and reliability of the results (Nowell et al., 2017).

The study received approval from the Ethics Committee of the Research Unit of the Escola Superior do Norte da Cruz Vermelha Portuguesa (approval no. 2024-031), in accordance with the ethical principles of scientific research and guaranteeing the confidentiality and anonymity of participants.

3. RESULTS

The sample comprised 12 nurses with consolidated experience in palliative care, reflecting a differentiated professional group in terms of age as well as academic and clinical background. In terms of age, most were between 31 and 50 years (66.6%), corresponding to a mid-career stage marked by professional maturity. The remaining participants were aged 51–60 years (25.0%) and over 61 years (8.3%), suggesting the presence of nurses with extensive accumulated experience, albeit in a later phase of professional life.

Geographically, professionals from the North predominated (58.3%), followed by the Center (25.0%) and the South (16.7%), ensuring territorial diversity, albeit with greater weight from the North.

Academically, the sample revealed a highly qualified profile: three-quarters of the nurses (75.0%) held a master's degree, 16.7% held a bachelor's degree with specialty certification, and only one participant (8.3%) had a doctorate. This advanced qualification is consistent with the fact that 83.3% of the nurses were specialists, underscoring the importance attributed to differentiated competencies in this field.

Another distinctive feature of the sample was experience in palliative care: all nurses had been working in this area for more than 10 years (100.0%), evidencing not only stability but also deep practical and theoretical knowledge of the complexity of this field.

The results are organized in Table 1, according to standardized nursing terminologies: the International Classification for Nursing Practice (ICNP), NANDA-I, and the Nursing Ontology.

The results obtained are presented in Table 1, according to the classified nursing languages: International Classification for Nursing Practice (ICNP), North American Nursing Diagnosis Association (NANDA) and Nursing Ontology (NO).

Table 1 - Correspondence between palliative care recording units and standardised nursing terminologies.

Recording Unit	*ICNP*	*Nursing Ontology*	*NANDA-I*
[P3] "Include management of the therapeutic regimen (…)"	Impaired capacity to manage regimen (10000885); Impaired capacity to manage exercise regimen (10022603); Impaired capacity to manage dietary regimen (10022592); Impaired capacity to manage medication regimen (10022635)	Impaired self-management of medication regimen (ICN: 10046837; 10011884; 10012938; SNOMED: 422979000; 260379002); Self-management of dietary regimen (ICN: 10005951; 10046837; SNOMED CT: 182922004; 406211006); Self-management of exercise regimen (ICN: 10023667; 10046837; SNOMED: 229065009; 406211006)	Ineffective health self-management (00276)
[P3] "(…) pain control (…)." [P7] "We frequently document diagnoses such as pain (…)" [P5] "Beyond pain control (…)" [P6] "In our service, we see a lot of pain (…)." [P1] "Pain (…) are diagnoses we always identify (…)."	Pain (10023130)	Pain (ICN: 10013950; 10023130; SNOMED: 22253000)	Ineffective pain self-management (00418); Chronic pain (00133); Acute pain (00132)
[P7] "We frequently document diagnoses such as (…) fatigue (…)." [P11] "Fatigue (…) are very common diagnoses (…)." [P4] "Asthenia (…) are diagnoses that almost always appear (…)."	Fatigue (10000695); Activity intolerance (10000431)	Activity intolerance (ICN: 10000408; 10000431; SNOMED: 77427003; NANDA-I: 00298)	Excessive fatigue burden (00477); Decreased activity tolerance (00298)
[P7] "We frequently document diagnoses such as (…) nausea (…)."	Nausea (10000859)	Nausea (ICN: 10012453; 10000859; SNOMED: 422587007; NANDA: 00134)	Ineffective nausea self-management (00384)
[P7] "We frequently document diagnoses such as (…) constipation (…)."	Constipation (10000567)	Constipation (ICN: 10004999; 10000567; SNOMED: 14760008; NANDA: 00011)	Chronic functional constipation (00235)
[P7] "We frequently document diagnoses such as agitation (…)." [P2] "In our practice, we include data on (…) agitation (…)."	Agitation (10002035)	—	Acute confusion (00128)
[P7] "We frequently document diagnoses such as agitation and restlessness (…)."	Restlessness (10025722)	—	Acute confusion (00128)
[P5] "In addition to pain control, it is common to record alterations of the mucous membrane (…)."	Impaired mucous membrane (10012760)	Impaired mucous membrane (ICN: 10012938; 10012288; SNOMED: 414781009; 95351003; 260379002)	Impaired oral mucous membrane integrity (00045)

Recording Unit	*ICNP*	*Nursing Ontology*	*NANDA-I*
[P11] "(…) suffering (…) are very common diagnoses (…)." [P2] "In our practice, we include data on emotional suffering (…)." [P1] "One of the main foci in our records is the assessment of emotional suffering (…)."	Suffering (10019055)	—	Impaired psychological comfort (00379); Impaired physical comfort (00380)
[P11] "(…) mood changes are very common diagnoses (…)."	Mood (10036241)	Depressed mood (ICN: 10005784; 10022402; SNOMED: 366979004)	Impaired mood regulation (00241)
[P6] "In our service, we see (…) issues of dignifying death (…)." [P11] "A diagnosis we regularly document is dignifying death (…)."	Tradition regarding death (10038005); Death (10005560)	—	Impaired end-of-life comfort syndrome (00342)
[P6] "In our service, we see (…) caregiver stress (…)."	Caregiver stress (10027773)	—	Excessive caregiving burden (00366)
[P12] "Diagnoses related to spirituality (…) are relevant (…)." [P7] "Documentation on spirituality and religious beliefs is complicated. We do not have tools that allow us to record this well (…)."	Impaired spiritual status (10023336)	—	Impaired spiritual well-being (00454)
[P12] "Diagnoses related to (…) meaning in life are relevant (…)." [P11] "We also record concerns about the transcendent and the meaning of the end of life (…)."	Hope (10025780); Lack of meaning (10023423)	—	Readiness for enhanced hope (00185); Readiness for enhanced resilience (00212)
[P4] "The diagnosis of sadness (…) appears often in our records (…)."	Sadness (10040662)	—	Ineffective emotion regulation (00372)
[P4] "The diagnosis of (…) anxiety appears often in our records (…)." [P4] "(…) anxiety (…) are diagnoses that appear almost always (…)."	Anxiety (10000477)	Anxiety (ICN: 10002429; 10000477; SNOMED: 48694002; NANDA: 00146)	Excessive anxiety (00400); Excessive death anxiety (00399); Excessive fear (00398)
[P1] "One of the main foci in our records is the assessment of (…) acceptance of health status (…)."	Acceptance of health status (10023499)	—	Readiness for enhanced health self-management (00293)
[P4] "(…) risk for falls are diagnoses that appear almost always (…)."	Risk for falls (10015122)	Event: Fall (10007512; 10029405; SNOMED: 1912002)	Risk for adult falls (00303)
[P1] "(…) risk for pressure ulcers (…) are diagnoses we always identify (…)." [P11] "We also often see risk for pressure ulcers, especially in more debilitated people (…)."	Pressure ulcer (10025798)	Pressure ulcer (ICN: 10015612; 10025798; SNOMED: 1163215007)	Risk for adult pressure injury (00304)
[P1] "(…) problems with appetite are diagnoses we always identify (…)."	Lack of appetite (10033399)	Impaired appetite (ICN: 10002455; 10012938; SNOMED: 249473004; 33911006; 260379002)	Inadequate nutritional intake (00343)
[P7] "Documentation on (…) and religious beliefs is complicated. We do not have tools that allow us to record this well (…)."	Hindering religious belief (10021757)	—	Impaired religiosity (00169)
[P6] "In home care, we often assess the impact of the social environment, such as housing quality and caregiver support (…)." [P9] "We often assess caregivers and their capacity to care (…)." [P11] "Documentation on the family is another complicated area. We do not have specific fields to record the caregiver role or the support we provide to the family (…)."	Caregiver role (10003962); Impaired caregiver's ability to provide care (10035414)	—	Excessive caregiving burden (00366)
[P6] "In home care, we often assess the impact of the social environment, such as (…) caregiver support (…)."	Lack of family support (10022473); Lack of social support (10022753)	—	Impaired family processes (00388)
[P6] "In home care (…) we often assess the impact of the social environment, such as housing quality (…)."	Housing problem (10029904)	—	Ineffective home maintenance behavior (00300)

Note: ICNP = *International Classification for Nursing Practice*; NANDA-I = *North American Nursing Diagnosis Association International*; ICN = *International Council of Nurses*; SNOMED CT = Systematized Nomenclature of Medicine – Clinical Terms.

The analysis shows that several phenomena frequently recorded by nurses in palliative care find correspondences across ICNP, NANDA-I, and the nursing ontology. These are chiefly clinical and functional phenomena that are readily amenable to objective assessment—such as pain, fatigue, nausea, constipation, risk of falls, and risk of pressure ulcers. In these cases, the terminology exhibits consistency, enabling uniformity and clear communication among professionals.

There is thus strong congruence in the representation of the most common physical and clinical phenomena. Pain, for example, appears transversally across the three terminologies used, confirming its centrality in documentation. Likewise, diagnoses such as fatigue or activity intolerance are represented relatively consistently, ensuring continuity and standardization in documentary practice.

By contrast, phenomena of a psycho-emotional, spiritual, social, or existential nature display greater weaknesses of representation. Aspects such as suffering, dignifying death, spirituality, hope, religious beliefs, caregiver role, or family support often emerge in nurses' narratives but do not find full correspondence, being absent or represented only partially and reductively. By way of example, "suffering" is included in ICNP but lacks an equivalent translation in the nursing ontology, while "spirituality" or "meaning in life" appear vague and with limited operational value.

These results, therefore, reveal two distinct realities:

1. Structured documentation, via terminology, which secures rigor and consistency, particularly for objective clinical phenomena; and
2. Narrative documentation, essential for recording complex human phenomena, which remain insufficiently represented in classified terminologies.

Analysis of Table 1 thus confirms the need to reconcile structured documentation with free narrative. While the former ensures standardization and comparability, the latter captures subjectivity, the singularity of experience, and the ethical, humanized dimension of care for the patient in a palliative situation.

The descriptive analysis of correspondences showed that phenomena frequently recorded in free narratives—such as pain, fatigue, nausea, constipation, and risk of falls—have direct counterparts in classified terminologies (ICNP, NANDA-I, and the Ontology), being predominantly biological or physical-functional in nature. This is exemplified by the systematic presence of "pain" across all systems, evidencing its centrality and clarity in nursing practice.

There is robust congruence in common clinical areas—pain, fatigue, constipation, nausea, and risk of pressure ulcer or falls—where classified language affords uniformity, comparability, and effective communication among professionals. "Fatigue," for instance, is consistently mapped across ICNP, NANDA-I, and the Ontology, providing adequate coverage.

Some phenomena arising from clinical practice—chiefly complex human dimensions such as emotional suffering, dignifying death, spirituality, hope, religious beliefs, and the caregiver role—display fragmented or absent correspondences in classified terminologies, with classifications reducing complex concepts to generic terms or lacking clear representation across all languages, as seen in the inconsistent representation of agitation and restlessness. The analysis shows that while standardized terminology adequately addresses objective clinical phenomena, it struggles to capture the subjective and multidimensional richness of palliative care—particularly psycho-emotional, spiritual, existential, and social dimensions—thereby compelling nurses to resort to free narrative to document aspects not formally covered.

The coexistence of structured, classified documentation—well-suited to common clinical phenomena—and narrative, subjective documentation—indispensable for complex human phenomena—underscores the need to reconcile classified language and free narrative to guarantee scientific uniformity, humanization, and ethical sensitivity in palliative-care documentation.

4. DISCUSSION

A The analysis evidences a clear duality between objective clinical phenomena—well represented by terminologies—and complex human phenomena, whose documentary expression remains fragile. The findings of this study corroborate that diagnoses such as pain, fatigue, constipation, nausea, risk of falls, or risk of pressure ulcer show transversal correspondences across ICNP, NANDA-I, and the nursing ontology, thereby ensuring terminological uniformity and communication among professionals. These phenomena, amenable to objective clinical assessment, have been described as central elements in nursing records in palliative care, enabling consistency and comparability (Gün & Aktaş, 2025).

However, psycho-emotional, spiritual, and social phenomena—such as suffering, spirituality, dignifying death, hope, or the caregiver role—show greater fragility in their documentary translation. These results echo the literature, which demonstrates that subjective aspects are frequently absent or under-represented in formal records, often being relegated to free narratives (Alves & Pina, 2018; Silva & Dias, 2018). For example, in Alves and Pina (2018), dyspnoea, although correctly identified by nurses, exhibited shortcomings in the documentation of its subjective dimensions, illustrating the limitations of documentary practice when quantitative assessment alone is privileged.

The congruence observed in clinical phenomena and the incongruence in existential phenomena confirm the need to reconcile terminology with free narrative. Previous studies reinforce that the use of structured classifications enhances the scientificity and interoperability of records but does not replace the richness of subjective narrative, which is indispensable to capture the singularity of end-of-life experience (Gunhardsson et al., 2008). Moreover, the systematic review by Feliciano and Reis-Pina (2024) shows that integrated palliative interventions—by prioritizing the centrality of the patient and family—improve quality of life and reduce unnecessary admissions, outcomes that are only possible when complex human phenomena are also considered in the planning and documentation of care.

Accordingly, documentation in palliative care should integrate two complementary dimensions: terminology, which guarantees technical rigor and communicability, and free narrative, which ensures humanization and the expression of complexity. Silva and Dias (2018) stress that only this combination can address the challenge of representing, simultaneously, objective and subjective, physical and existential, technical and ethical phenomena. Thus, integrating distinct spaces for classified and narrative records, coupled with nurse training, may be an effective strategy to guarantee the quality and ethical sensitivity of records in palliative care.

The results of this study indicate that while objective clinical phenomena have consistent representation in terminologies, complex human dimensions are less represented. The combination of terminology and free narrative is presented as a relevant strategy to ensure both scientific precision and the completeness of documentation in palliative care.

CONCLUSION

This study met its objective of analyzing nursing documentation in palliative care, identifying correspondences among different terminologies and evidencing limitations in recording complex human phenomena. It was found that clinical and functional phenomena—such as pain, fatigue, nausea, and risk of falls—are consistently represented in classifications (ICNP, NANDA-I, Nursing Ontology), whereas psycho-emotional, spiritual, social, and existential dimensions remain weakly represented or absent. The main contributions of this study lie in demonstrating the need to articulate the terminology in use with free narrative, recognizing both as complementary and indispensable dimensions to guarantee scientificity and comparability, and, simultaneously, the humanization and completeness of care. This study reinforces the importance of conceiving documentation as a clinical, ethical, and communicational instrument with a direct impact on the continuity and quality of palliative care. These results align with Imogene King's Goal Attainment theory, which emphasizes perception, communication, and nurse–patient interaction as central to defining shared goals (Moura & Pagliuca, 2004; Sousa et al., 2024).

As limitations, the use of a single focus group conducted in a specific national context with a small, convenience sample should be noted—an approach that enhances interpretive richness but may limit the generalization of results. Nevertheless, the experience and qualifications of participants confer relevance to the reflections produced. Although the sample comprised highly qualified nurses, the possibility of bias is acknowledged, given that professionals with different training levels may hold distinct perceptions of documentation in palliative care.

Future research should explore different institutional and cultural contexts, increase the number of participants, and employ mixed methodologies that allow for data triangulation. Additionally, we recommend evaluating innovative strategies for integrating classified and narrative records, as well as studying the impact of these practices on interprofessional communication, clinical safety, and the experiences of the patient and family in palliative care.

AUTHORS' CONTRIBUTION

Conceptualization, D.C., R.S., A.O. and F.P.; data curation, D.C., R.S. and A.O.; formal analysis, D.C., R.S. and A.O.; investigation, D.C., R.S., A.O. and F.P.; methodology, D.C., R.S., A.O. and F.P.; project administration, D.C.; resources, D.C., R.S., A.O., F.P.; supervision, D.C. and F.P.; validation, D.C., R.S., A.O. and F.P.; visualization, D.C. and R.S.; writing-original draft, D.C., R.S. and A.O.; writing- review & editing, D.C., R.S., A.O. and F.P.

CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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