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PRACTICE STANDARDS FOR NURSES PROVIDING PEDIATRIC CANCER CARE IN ATLANTIC CANADA: TRANSLATION AND VALIDATION IN PORTUGUESE

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PRACTICE STANDARDS FOR NURSES PROVIDING PEDIATRIC CANCER CARE IN ATLANTIC CANADA: TRADUCCIÓN Y VALIDACIÓN EN PORTUGUÉS

Fernanda Ribeiro de Araujo Oliveira[1]
Alexandre Pazetto Balsanelli[2]
Aida Maris Peres[3]
Edvane Lopes Birelo de Domenico[4]
Patrícia Luciana Moreira Dias[5]

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Objective: to perform translation, cultural adaptation and validation of content and appearance of the instrument "Practice Standards for Nurses Providing Pediatric Cancer Care in Atlantic Canada" into Brazilian Portuguese. Method: this is a study of translation, cultural adaptation and validation of content and appearance of instrument. Eight professionals participated in the committee of judges. Results: there was a need to adapt the semantics and grammatical corrections with the version approved by the Canadian Association of Nurses in Oncology. The Content Validity Index was adopted. Three rounds were performed to achieve the Content Validity Index ≥0.8 in 100% of items: first 233 items (96%), second 9 items (90%), third round 1 item. In the pre-test, 100% comprehension was obtained. Conclusion: the translated version of the original instrument is suitable for use in Brazil.

Descriptors: Nursing. Professional Competence. Medical Oncology. Pediatric Nursing. Validation Study.

Objetivo: realizar tradução, adaptação cultural e validação de conteúdo e aparência do instrumento Practice Standards for Nurses Providing Pediatric Cancer Care in Atlantic Canada para o português do Brasil. Método: trata-se de um estudo de tradução, adaptação cultural e validação de conteúdo e aparência de instrumento. Participaram 8 profissionais no comitê de juízes. Resultados: houve a necessidade de adequar a semântica e correções gramaticais com a versão aprovada pela Associação Canadense de Enfermeiros em Oncologia. Adotou-se o Índice de Validade

Corresponding Author: Fernanda Ribeiro de Araujo Oliveira, fernanda.ribeiro.ara@hotmail.com

[1] Universidade de São Paulo. São Paulo, SP, Brazil. https://orcid.org/0000-0003-3757-1061.
[2] Universidade Federal do Paraná. Curitiba, PR, Brazil. https://orcid.org/0000-0003-2913-2851.
[3] Universidade de São Paulo. São Paulo. São Paulo, SP, Brazil. https://orcid.org/0000-0001-7455-1727.
[4] Universidade de São Paulo. São Paulo. São Paulo, SP, Brazil. https://orcid.org/0000-0001-7455-1727.
[5] Universidade Federal de São Carlos. São Carlos, SP, Brazil. https://orcid.org/0000-0002-3153-5302.

de Conteúdo. Foram realizadas três rodadas para atingir o Índice de Validade de Conteúdo ≥0,8 em 100% dos itens: primeira 233 itens (96%), segunda 9 itens (90%), terceira rodada 1 item. No pré-teste obteve-se 100% de compreensão. Conclusão: a versão traduzida do instrumento original está adequada para utilização no Brasil.

Descritores: Enfermagem. Competência Profissional. Oncologia. Enfermagem Pediátrica. Estudo de Validação.

Objetivo: realizar traducción, adaptación cultural y validación de contenido y apariencia del instrumento "Practice Standards for Nurses Providing Pediatric Cancer Care in Atlantic Canada" para el portugués de Brasil. Método: se trata de un estudio de traducción, adaptación cultural y validación de contenido y apariencia de instrumento. Participaron 8 profesionales en el comité de jueces. Resultados: hubo la necesidad de adecuar la semántica y correcciones gramaticales con la versión aprobada por la Asociación Canadiense de Enfermeros en Oncología. Se adoptó el Índice de Validez de Contenido. Se realizaron tres rondas para alcanzar el Índice de Validez de Contenido ≥0,8 en el 100% de los ítems: primera 233 ítems (96%), segunda 9 ítems (90%), tercera ronda 1 ítem. En el pre-test se obtuvo 100% de comprensión. Conclusión: la versión traducida del instrumento original está adecuada para su uso en Brasil.

Descriptores: Enfermería. Competencia Profesional. Oncología Médica. Enfermería Pediátrica. Estudio de Validación.

Introduction

Based on the World Cancer Report of the International Agency for Research on Cancer of the World Health Organization (WHO), it is unquestionable that cancer is a public health problem, especially among developing countries. In the coming decades, the impact of cancer on the population is expected to correspond to 80% of the more than 625 thousand new cases estimated for 2020 – 2022[1]. Childhood and adolescence cancer, from 0 to 19 years old, is considered rare when compared to adult tumors and corresponds between 2% and 3% of all malignant tumors. An estimate by the National Cancer Institute (INCA) for the year 2020 revealed that there were about 8,460 cases per year in children and adolescents with 8% of deaths in the Brazilian population[1].

Childhood and adolescence cancer cannot be considered a simple disease, but a group of different malignancies that vary according to the histological type, primary tumor location, ethnicity, sex and age. The incidence rates of childhood-specific tumors are much more variable among populations[1].

In recent years, several advances have emerged in the diagnosis and treatment of cancer that have provoked a number of physical, emotional and social consequences. These advances require more and more qualified professionals to deal with the new demands of the professional practice, directed to the epidemiological reality of our country. It is necessary to join efforts for a more effective participation of health professionals in early diagnosis, disease control and improvement of the quality of care provided[2,3].

Therefore, nurses must have the skills to provide assistance to cancer patients in the diagnostic evaluation, treatment, rehabilitation and care to family members. In addition to the ability to apply knowledge, oncology nurses need to increase competence to direct and influence the care plan[2-4].

Currently, there is a lack of studies published in the literature that define in a structured way the standardization of a competence matrix for the organization of institutions and development of nurses in pediatric oncology[5,6]. In Brazil, through the National Curriculum Guidelines (NCGs) for Nursing Graduate Courses in force, the general skills to be achieved by the future nurse are: health care, decision making, communication, leadership, management and permanent education[7].

The standardization of a set of competencies is fundamental for the management systems of health institutions, both for the qualification of care, as for the conformation of human resources capable of reaching high levels of excellence.

In this perspective, there is an instrument developed by the Canadian Association of Nurses in Oncology (CANO) in conjunction with the Atlantic Provinces Pediatric Hematology Oncology Network (APPHON)[8] that gathers attributes capable of supporting the set of competencies of pediatric oncologist nurses.

There are similarities between the Canadian and Brazilian health services system, which occur through receiving federal contribution in full money under the Health Transfer of Canada, ensuring that all eligible residents of the country have access to health services insured on a prepaid basis, without direct charges at the point of care for these services[9]. Considering the similarities between the Canadian and Brazilian health systems, it was decided to perform the translation and cultural adaptation of the instrument and submit it to a process of evaluation of its suitability for use in the national scenario of pediatric oncology. The objective is to perform the translation, cultural adaptation and validation of content and appearance of the instrument "Practice Standards for Nurses Providing Pediatric Cancer Care in Atlantic Canada" into Brazilian Portuguese.

Method

This is a methodological research of translation, cultural adaptation and validation of content and appearance of the instrument[10] "Practice Standards for Nurses Providing Pediatric Cancer Care in Atlantic Canada" for Brazilian Portuguese.

To begin the process of translation and cultural adaptation, it was necessary to obtain the permission of the authors[10]. CANO and APPHON allowed the study to be carried out. According to recommendations, failure to perform this step implies legal disorders and involves copyright issues.

The methodological framework of this study is based on Beaton, which consists of six stages: guaranteed permission, translation, synthesis of initial translations, back translation, review by the expert committee and pre-test[11-12].

Stage 1 – Permission assured by the authors for use and translation of the instrument: to perform the translation of the instrument from English to Brazilian Portuguese, the authorization was requested, by e-mail to the associations (APHON and CANO).

Stage 2 – Translation Portuguese Version: the instrument was translated by two independent bilingual translators of the original language, English, into the language, Brazilian Portuguese. Each produced an independent version, called T1 and T2. After the return of the translations, two online meetings were held by video call lasting 2 hours each, originating the 1st round, version in Portuguese.

Stage 3 – Back Translation: the document was translated from the Portuguese language again to English, by two other translators, T3 and T4, bilingual, Brazilian and unaware of the original instrument. T3 had experience with translations for health professionals and in specific terminologies. Each translator produced a new English version. Two online meetings were held by video call, lasting 2 hours each for consensus. The final version in English was sent by e-mail to the evaluation by the CANO association, being fully approved, thus advancing to the validation stage of the judge committee.

Stage 4 – Judge Committee: after approval by CANO, the form for validation of the judge committee was prepared. The judge committee was composed of 8 experts who met the following inclusion criteria: be a nurse, work in pediatric oncology and have Master's as the minimum degree and professional experience in the area.

Judges received an email invitation to participate in this stage. After acceptance, the Google Forms link and the Informed Consent Form (ICF) were sent. The following variables were included in the form: current position, sex, professional training, time of graduation, workplace, time working in nursing, time working in pediatric oncology, level of mastery in English. Regarding the level of English, this was an initial decision, because the document is in the English language and we found it interesting for the

evaluator to have this competence, in case there was need for a different perception of what was presented in the translation.

The questionnaire was developed to assess the understanding of aspects of semantic equivalence (grammars and vocabularies), idiomatic equivalence (substitution of expressions or culture), cultural equivalence (experiences lived within the cultural context of society) and conceptual equivalence (validity of concepts explored)[11] There was evaluation of 243 items, related to the seven domains: 1. Health evaluation; 2. Supportive and therapeutic relationships; 3. Management of treatment side effects and cancer symptoms; 4. Teaching and coaching, facilitating continuity of care/navigating the system; 5. Decision-making; 6. Advocacy and professional practice; 7. Leadership, according to response variation of a Likert scale (1 to 5), composed of the following categories: 1 – strongly disagree, 2 – disagree, 3 – neutral, 4 – agree and 5 – strongly agree. To describe the critics and suggestions of the experts, a long field was made available after the item, to detail the information. The content validity index (CVI) is one of the most used methods in the health area and measures the percentage of agreement of judges on semantic, idiomatic, cultural and conceptual equivalence, and can be analyzed individually and then as a whole. This procedure is essential to ensure that the process will be reliable and appropriate for the population studied[12]. The content validity index was used to evaluate agreement, with the expectation of CVI ≥0.8[11-13].

Stage 5 – Final Version: after applying all stages of the processes of Translation and cultural adaptation of the instrument "Practice standards for Nurses providing Pediatric cancer care in Atlantic Canada" to the Brazilian Portuguese, the final version will be produced. The contributions and agreement indexes among the judges were analyzed and adjusted to compose the final version.

Stage 6 – Evaluation of the instrument (Pre-test): this stage aimed to evaluate the comprehensibility of the instrument by the final public.

The participants were five nurses who met the inclusion criteria: to perform their professional activities in the field of pediatric oncology for at least six months and who worked with distinct specialties in oncology, namely, experience in bone marrow transplantation, intensive care unit, permanent education, coordination or leadership of unit and outpatient antineoplastic chemotherapy. Participants received the final version and a questionnaire with the following questions: 1. The instrument is easy to understand; 2. Describe the suggestions or doubts found in the evaluation of the instrument. In question 1, the Likert scale (1 to 5) was used, composed of the following categories: 1 – strongly disagree, 2 – disagree, 3 – neutral, 4 – agree and 5 – strongly agree. Open field was used in question 3, to describe the suggestions and doubts.

This study was approved by the Ethics and Research Committee of the *Universidade Federal de São Paulo* (UNIFESP), Certificate of Presentation of Ethical Assessment (CAAE) n. 29696420.0.0000.5505, following the recommendations of Resolution n. 466/12 of the National Health Council.

Results

The translation of T1 was more relevant to the study, because it brought more details and terms with the reality of health than T2. Regardless of this information, there was a need to adapt the semantics and make grammatical corrections, generating agreement by all professionals (T1, T2, researcher and advisor). There were no difficulties to achieve a single version or disparities between the translations.

In the back translation process, the alignment meeting was fundamental to adjust the difference between the translators' versions and also efficient because there was no suggestion of modification by the institution that idealized the instrument.

Eight professionals were invited to join the committee of judges, but 6 participated effectively in the three rounds, all female, aged between 30 and 61 years and average time of professional

activity of 26 years. The majority had more than eleven years of work dedicated to pediatric oncology 4 (67.1%); with stricto sensu degree, 5 (83.3%) with master's degree and 1 (16.7%) with doctorate and 83.3% with basic to intermediate mastery of the English language. The work of these nurses was: 1 (16.7%) permanent education nurse, 1 (16.7%) clinical specialist nurse, 1 (16.7%) assistant nurse, 1 (16.7%) nursing supervisor and 2 (33.3%) nursing managers.

In the first round, 233 (96%) items of the instrument obtained CVI ≥0.8. These items include the complete instrument, from the introduction to the final evaluation, as presented in Chart 1, requiring a 2nd round with the committee of judges to validate the 10 (4%) items that did not have the CVI ≥0.8.

Chart 1 – Content validation index – 1st Round. São Paulo, SP, Brazil, 2021 (N=6)

Items assessed with CVI ≤ 0,8	Semantics	Idiomatic	Cultural	Conceptual
Initial guidelines				
Beginner	0.66	..	..	0.66
Advanced beginner	0.66	..	..	..
Competent	0.66	..	..	..
Not applicable	0.66	..	..	..
1. Health assessment				
I. Recognizes comorbidities and variations in the normal growth and development of the child/adolescent.	0.66	..	..	..
I. Demonstrates knowledge about the specific medications in the child/ adolescent's protocol, favoring an accurate assessment of the appropriate medication.	0.66	..	..	..
S. Evaluates, without critical judgment, past, present, and/or future use of complementary or alternative health practices.	0.66	..	..	0.66
2. Support and therapeutic relationships				
3. Management of side effects of cancer treatment and symptoms				
A. Integrates the care treatment plan with the other specialties of health professionals.	0.66	0.66	0.66	..
Other alternative or complementary therapies:	0.66	..	..	..
4. Teaching and coaching				
S. Facilitates the understanding of the child and the family about the acute and chronic forms of cancer.	..	0.66	..	..
5. Facilitating the care continuity/navigating the system				
6. Decision-making and defense of rights				
7. Professional practice and leadership				

Source: Created by the authors.

Notes:

I. Intermediate Care; S. Subspecialized Care; A. Advanced Care.

Conventional signal used:

..Numerical data does not apply.

Six (75%) judges returned from the experts invited to participate in the second round survey. Of the 10 (4%) items evaluated, only 1 item of the instrument obtained the CVI ≥0.8 (Table 2), being necessary to perform the 3rd round.

Chart 2 – Content Validation Index – 2nd Round. São Paulo, São Paulo, Brazil, 2021. (N=6)

Items evaluated with Content Validation Index	Semantics	Idiomatic	Cultural	Conceptual
Initial guidelines				
Not applicable	0.63	0.63	0.63	0.63

Source: Created by the authors.

In the third round, only 1 (10%) item of the instrument presented CVI ≥0.8, completing the validation step since the nature of the item does not imply a change in content.

The changes suggested by the experts who composed the committee of judges were related to semantics, grammar corrections, and cultural, represented by the inclusion of the word adolescent in all items that refer to the word child, adhering to the binomial child/adolescent, as well as "palliative therapies" for "palliative care".

After completion of the guaranteed permission of associations, translation, back translation, evaluation of the committee of judges for cultural adaptation of the instrument "Practice standards for Nurses providing Pediatric cancer care in Atlantic Canada" for the Portuguese language of Brazil, the final version was obtained.

Of the five nurses participating in the pre-test, 4 (80%) were female and most were aged between 30 and 39 years (60%). All with experience in pediatric oncology and average time of work of 10 years. Respondents attested 100% clarity of the instrument. However, 40% expressed doubts about the interpretation of the final proportion related to the classification of the level of competence attributed to the professional.

Discussion

Adapting an instrument to another language is a complex process. Performing a simple translation does not meet the requirements of excellence for validation. This process takes into account language, cultural context, lifestyle, technical and semantic aspects[10-13]. For this reason, it is important to carry out all the stages recommended in the literature to ensure and maintain the study potential, as well as to have the results comparable to the original language, one of the main qualities of validation[14].

Given the scarcity of literature on pediatric oncological nursing and, more specifically, on the skills of nurses dedicated to this area, it is considered that the execution of this research provided relevant innovation for the processes of care management and continuing education in nursing. The stages of assertive approval and evaluation conferred by CANO and APPHON were fundamental to reaffirm the contemporaneity of the technological, training and human resources contexts contained in the instrument, since this was developed in 2007[1,15-16].

Given the above, the instrument "Practice standards for Nurses providing Pediatric cancer care in Atlantic Canada" was chosen, identifying it as a potential for the Brazilian reality. APPHON showed interest in having the final result of the research, because it is an instrument published by them in 2007. They also reported that the review

would be interesting to identify possible changes in technological, training and human resources contexts. The completion of the rounds and back-translation sought to be as assertive as possible for the evaluation of the judges, minimizing the number of corrections, demonstrating at the end of the study that the instrument can be applied in Brazil. A better understanding of these differences can help and indicate that the culture of oncology in the Brazilian context is consistent with practices of the health system in developed countries[12]. No suggestion was made by CANO[1,15-16]. The literature indicates for the content evaluation the composition of the committee by five to ten judges and, therefore, the participation obtained in this investigation was adequate numerically, as well as qualitatively, another very important factor in this research methodology, since judges must present close compatibility between intellectuality and experience with the phenomenon that is in the process of evaluation[12].

The participation of judges in this stage of the research was effective, since the document had 23 pages, with 243 items for evaluation, keeping the same judges from the beginning until the end of the validation process[17].

Among the suggestions of the judges, the most common was the request for inclusion of adolescents in the instrument to assess the applicability, not only in children. The suggestion is understandable because there is no consensus regarding age to consider tumors. Following the morphological characteristics similar to those classified by the International Classification of Childhood Cancer (ICCC), each institution should establish the age group that will be used to select cases of tumors in pediatric age. With this practice, specialists in pediatric oncology started to include in their studies and analyses the age limit of 19 years, considering that the tumors that affect individuals of this age group still have pediatric morphologies[18].

Another suggestion was to change the terms: “palliative therapies” for “palliative care” and “other therapies” for “other alternative and complementary therapies”. The term Palliative Care was defined by the World Health Organization (WHO) in 2017 as an approach that improves the quality of life of patients and families facing problems associated with diseases, through prevention and relief of suffering, early identification, assessment and treatment of pain, among other physical, psychosocial and spiritual problems[6,19-21]. As there is an inequality in the supply of specific knowledge in pediatric oncology[2,19] and in the development of competencies, the Practice standards for Nurses providing Pediatric cancer care in Atlantic Canada implemented by health institutions will contribute to the standardization of the evaluation process of professionals, in order to favor a more appropriate development plan directed to the care of pediatric and adolescent patients with cancer.

The professional legislation that regulates the work of nurses in oncology is not unique, and, for this reason, the levels of educational developments are different. The professional in this area is responsible to seek self-development with reduced courses, training in services or even self-learning[16].

Another challenging point is specialized training in pediatric oncology. Currently, there are specializations in the area, but some of these are made available to the multidisciplinary team and not specifically for nurses. In specialized hospitals, there are professionals with training and specialization in the area, but the admissions processes are not always able to attract nurses with these experiences. It is a constant challenge to ensure development according to the level of performance from the freshman/beginner to the advanced. The “Practice standards for Nurses providing Pediatric cancer care in Atlantic Canada” will facilitate the identification of these differences, so that structured processes occur in institutions that favor the provision of knowledge, skills and attitudes for these professionals, ensuring a safe care of patients and families.

Some nurses perform functions in pediatric oncology, such as clinical integration, research, education and management, professional autonomy and independent practice, case

management, advanced assessment skills, decision making and diagnostic reasoning, recognized advanced clinical competencies, consulting to health providers, planning, implementation and evaluation of programs and recognition by customers as a first point of contact. Despite these functions, in Brazil, there is no specific legislation, norm or regulation that supports them, justifying the need to have a matrix of competences that contributes to the identification of the characteristics of the practice, or is even used in the specialty test in conjunction with specific associations in the field of pediatric oncology[22-24].

Another important factor is the concept of competencies in the document Practice standards for Nurses providing Pediatric cancer care in Atlantic Canada, which, within the evaluation tool, are denominated as the items of each domain. For this reason, we suggest this change within the instrument so that, during evaluation, it is clear that competence is something greater to be evaluated and that items are deliveries, according to the Dutra reference[23].

In this context, competence is the result of knowledge that includes graduation, training, experience and self-development, which meets the proposal of the evaluation of the instrument. All these items are covered in the description of each domain. This study provides the possibility of using a specific tool, which can be applied to nurses assisting pediatric cancer patients in any institution. However, there is a need to apply the tool in various scenarios and in professionals with varied experiences, such as acting in an outpatient antineoplastic chemotherapy, hospitalization unit, surgical unit, surgical center, bone marrow transplantation, intensive care unit, research, continuing education, management and others, so that opportunities for improvement in the instrument are identified, not evaluated in this study.

The instrument "Practice standards for nurses providing pediatric cancer care in Atlantic Canada" translated into Brazilian Portuguese will contribute as an instrument for the evaluation of nurses working in pediatric oncology, combining the quantitative and qualitative results necessary to identify strengths and opportunities for improvement and, consequently, support professional development in the area.

The study limitation concerns the amount of items for the evaluation, as it will require more time from the nurse to complete the instrument. The lack of other studies with the intention of translating and validating the instrument to other languages and cultures was one of the main limiting factors in the discussion of the results obtained in this investigation, not allowing comparisons or transpositions.

Therefore, this instrument has the potential to be used in the practice of competency management of pediatric oncologist nurses, subsidizing performance evaluation processes or professional development, as it brings a structured model of competencies, with a wide variety of skills and attitudes that must be defended for a professional practice of excellence.

Conclusion

The instrument "Practice standards for Nurses providing Pediatric cancer care in Atlantic Canada" was translated and culturally adapted according to the methodology recommended in the literature. The instrument presented good content validity indexes and the Brazilian version adequately represents the original instrument, demonstrating equivalence between the 243 items and their meanings.

Collaborations:

1 – conception and planning of the project: Fernanda Ribeiro de Araujo Oliveira and Alexandre Pazetto Balsanelli;

2 – analysis and interpretation of data: Fernanda Ribeiro de Araujo Oliveira and Alexandre Pazetto Balsanelli;

3 – writing and/or critical review: Fernanda Ribeiro de Araujo Oliveira, Alexandre Pazetto Balsanelli, Aida Maris Peres, Edvane Lopes Birelo de Domenico and Patrícia Luciana Moreira Dias;

4 – approval of the final version: Alexandre Pazetto Balsanelli.

Competing interests

There are no competing interests.

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