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PROTOCOL

Standardized nursing terminologies: scoping review protocol

Terminologías de enfermería estandarizadas: protocolo de revisión del alcance

Terminologias padronizadas de enfermagem: protocolo de revisão de escopo

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Abstract

The aim is to map the use of standardized terminologies in professional nursing practice in the literature. A scope review protocol will be prepared according to the steps of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews, with the methodology of the Joanna Briggs Institute. Studies that answer the research question, presented in any language, will be considered. Two independent reviewers will identify the documents in the databases: Latin American and Caribbean Literature in Health Sciences, Medical Literature Analysis and Retrieval System via PubMed, SCOPUS, EMBASE, OVID, Scientific Electronic Library Online, and gray literature. A narrative summary will accompany the results and the data will be represented through tables and graphs according to the review question. It is expected that the construction of this protocol will demonstrate a synthesis of evidence to support nursing terminologies in health records in computerized systems, assisting in forming diagnostic expressions and nursing actions.

Descriptors: Terminology; Taxonomy; Literature Reviews; Nursing; Standardized Nursing Terminologies.

Resumén

El objetivo es mapear el uso de terminologías estandarizadas en la práctica profesional de enfermería en la literatura. Se elaborará un protocolo de revisión de alcance según los pasos de los Elementos de Informe Preferidos para Revisiones Sistemáticas y Extensión de Metanálisis para Revisiones de Alcance, con la metodología del Instituto Joanna Briggs. Se considerarán estudios que respondan a la pregunta de investigación, presentados en cualquier idioma. Los documentos serán identificados por dos revisores independientes, en las bases de datos: Literatura Latinoamericana y del Caribe en Ciencias de la Salud, Sistema de Análisis y Recuperación de Literatura Médica vía PubMed, SCOPUS, EMBASE, OVID, Biblioteca Electrónica Científica en Línea y literatura gris. Un resumen narrativo acompañará los resultados y los datos se representarán mediante tablas y gráficos según la pregunta de revisión. Se espera que la construcción de este protocolo demuestre una síntesis de evidencia para sustentar las terminologías de enfermería en los registros de salud en sistemas computarizados, ayudando en la formación de expresiones diagnósticas y acciones de enfermería.

Descriptores: Terminología; Taxonomía; Revisiones Bibliográficas; Enfermería; Terminologías Estandarizadas de Enfermería.

Resumo

Objetiva-se mapear na literatura, o uso das terminologias padronizadas na prática profissional da enfermagem. Protocolo de revisão do escopo será elaborada conforme as etapas do *Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews*, com a metodologia do Joanna Briggs Institute. Serão considerados estudos que respondam à pergunta de pesquisa, apresentados em qualquer idioma. Os documentos serão identificados por dois revisores independentes, nas bases de dados: Literatura Latino-Americana e do Caribe em Ciências da Saúde, Medical Literature Analysis and Retrieval System via PubMed, SCOPUS, EMBASE, OVID, Scientific Electronic Library Online e literatura cinzenta. Um resumo narrativo acompanhará os resultados e os dados serão representados por meio de quadros e gráficos de acordo com a questão da revisão. Espera-se que a construção deste protocolo demonstre síntese de evidências para apoiar as terminologias de enfermagem nos registros de saúde em sistemas informatizados, auxiliando na formação de expressões diagnósticas e de ações de enfermagem.

Descritores: Terminologia; Taxonomia; Revisões de Literatura; Enfermagem; Terminologia Padronizada em Enfermagem.

Introduction

In the hospital environment, nurses are crucial as primary providers of frontline care. They have the responsibility to continually identify patients' health problems and, based on this assessment, plan and implement the care necessary to achieve the desired results. Care plan information represents nurses' clinical reasoning and includes patient problems, expected outcomes, and planned and implemented nursing interventions[1].

Therefore, the International Council of Nurses (CIE), based in Geneva, seeks to universalize professional language, aiming for agility and readiness in defining nursing diagnoses and interventions, as well as possibilities for dialogue at an international level, in different cultural, social, and contexts. of health[2].

In Brazil, the Systematization of Nursing Care (SAE) is regulated by Resolution No. 358/2009 of the Federal Nursing Council (COFEN), which recommends it as a nurse's exclusive activity and is adopted in health institutions that house nursing services, as a model of nursing care based on scientific principles. SAE is a structured approach that aims to guarantee the quality and safety of nursing care, using standardized language, protocols, and specific guidelines for each clinical situation[3].

Thus, the SAE represents a way of organizing and implementing the Nursing Process (NP) using a theoretical basis, in addition to clinical reasoning and judgment that guide the nurse's choices[4].

According to COFEN Resolution No. 358/2009, the Nursing Process (NP) is didactically subdivided into five stages, however, they are all interconnected and dependent on each other. These steps are nursing history, diagnosis, planning, implementation, and nursing assessment[3].

The nursing process (NP) is the nurse's work methodological tool, organized and used by professionals to provide individualized and quality health care to patients[5].

In general, the execution of the systematization of Nursing care, following the steps of the process, improves the service offered, since the care provided to the person becomes individualized, and the NP has, therefore, the function of directing the work of the nurse regarding the search for data relevant to the care plan.

The Systematization of Nursing Care is a comprehensive process that ranges from the definition and application of standards and procedures in health units to the standardization of documentation in patient records, such as medical records and nursing records. This is a fundamental part of the execution of the Nursing Process (NP), ensuring complete and organized care for patients[6].

When using the NP, it is essential to adopt a common language, as well as nursing taxonomies that represent and organize the elements involved in the NP. These practices help in the representation and organization of the elements involved, contributing to the reduction of ambiguities and inconsistencies[7].

Among the available categorizations, the International Classification of Nursing Practice (ICNP®), adopted by the International Council of Nurses, stands out as a unifying language reference. ICNP® integrates the documentation of nurses' clinical practice, giving greater visibility to their actions and making nursing data available to information systems. This produces a more consistent and effective nursing approach[8].

Integrating the nursing process into a standard classification is essential in all areas of nursing practice. This promotes easier communication, recording, and planning, enabling a unified language between professionals to ensure continuity of care[9].

Standardized nursing terminologies (NTs) are a set of terms used to describe nursing care and interventions carried out by professionals in the field. Thus, terminology is defined as the language used by a discipline to describe its specific knowledge[10].

Terminology is considered by nursing as differences in speech or expression of specialized language which are not part of or are a contemporary phenomenon, being present within the history of humanity and observations of examples such as those of Greek philosophers, which have in their language of merchants' business or specialized words. It is also understood that this relationship between terminological practice and the more eloquent and expressive development, as well as research that relates the lexical component of specialized relationships in a relative way with the present, thus placing this study in the context of the 20th century[2,11].

Furthermore, nursing is an encouragement in the development of terminology among the needs and determinations of identification and classification of concepts linked to the discipline, aiming to meet other purposes, of which are the implementation of technological systems in the clinical aspect that contribute to Nursing care for the client is ensured, based on development and holistic assistance[11].

Recognition of the role of nursing is something that has been understood and defended in almost all countries in the world, which makes this function invisible in information systems. Thus, in clinical care settings, there is increased pressure for nursing professionals to meet their responsibilities efficiently and effectively, meeting professional obligations and developing ways to schedule practice so that understanding is met accurately[12].

Regarding this, it is still stated that even with the daily execution of data collection, diagnosis, planning, implementation, and evaluation of nursing, each stage of the professionals' action is considered in terms of the results to be obtained systematically. Even with incentives for professionals, there is still no common language to clearly describe what is done, for which patients, and how the results were obtained, which leads to a failure in active communication with professionals[12-14].

Standardization allows not only communication and use of computer systems, but also the accurate and reliable presentation of clinical nursing information. By promoting semantic interoperability, that is, the accurate and reliable sharing of content between different computer systems, it is possible to offer excellent quality care and reduce healthcare costs in healthcare systems in different countries[15].

To achieve semantic interoperability, it is necessary to use NTs and domain-based ontologies. These terminologies and ontologies provide a set of common terms and concepts that facilitate the efficient exchange of information between different health information systems. In this way, the integration of information systems is improved, avoiding the loss of important data and promoting the effective exchange of information between different platforms and electronic health records[16].

Simply incorporating standardized language into electronic health records is not enough to improve the quality and continuity of care. However, by using data structuring and adopting standards for electronic health records, it contributes to improving the quality and continuity of care, as well as semantic interoperability between health systems[1].

Furthermore, NTs in nursing contribute to the advancement of research and development in the area. By using standardized language, collected and documented data can be aggregated and analyzed more effectively, allowing for the generation of knowledge and the identification of best care practices[17].

The International Council of Nurses developed the International Classification of Nursing to meet the need to formalize a single system to represent the elements of nursing worldwide with predefined statements about diagnosis (ND), outcomes (OT), and nursing interventions (NI)[18].

From this perspective, the clinical practice scenario based on the understanding of nurses' knowledge and attitudes concerning nursing documentation directs actions to improve the process. However, effective implementation of NTs requires a significant effort to train and educate nursing professionals about the importance of accurate and complete documentation, following established standards and protocols[19].

The adoption of standardized terminologies has the potential to improve the accuracy of nursing documentation, however, it remains unclear whether nursing staff truly feel supported in providing nursing care using electronic health records that include NTs[5].

To date, few reviews of secondary analyses of nursing data coded in NTs have been identified. It was identified that the use of NT has evolved over the years, mainly describing the focus of the study and the frequency of publications. More recently, the coverage of the CADDIE (Biomedical and HealthCare Data Discovery Index Ecosystem) bio metadata specification in representing nursing data from published studies was evaluated. Therefore, the development of this scoping review protocol fills an important knowledge gap[20,21].

Adopting standards for electronic records is essential to ensure effective retrieval and analysis of health information. This standardization of clinical terms must comply with criteria such as validity, specificity, ease of acquisition, and communication of data, in addition to being easily understood, codified, and intuitive for the professionals involved[22].

Information science contributes to the development of healthcare information systems such as electronic health records (EHR) and hospital management systems. Therefore, the protocol described when conducting a literature review of the Scoping Review type aims to assist researchers in health and information science, as it facilitates the standardization of terminology, data formats, and communication protocols, facilitating the exchange of information between different health systems and institutions. Added to the importance of systematizing knowledge as a powerful way to map evidence on broad themes, with diverse study designs, in a reliable and quality manner[23].

Based on evidence that highlights the relevance of nursing documentation to improve care, this study was conducted, given the notable importance of the topic of nursing terminologies. The main objective was to map the use of (NTs) in professional nursing practice in the literature.

Methodology

This is a scoping review that will be conducted according to the methodology proposed by the Joanna Briggs Institute (JBI). The findings of this review will be reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist, adapted for conducting scoping review studies. It is expected, therefore, to achieve the suitability of the study constitution and guarantee its quality. The review protocol was registered in Portuguese on May 29, 2023, on the Open Science Framework (OSF) platform and can be accessed via the electronic address https://osf.io/gcnd3.

Joanna Briggs Institute is an international organization, based in the Faculty of Health and Medical Sciences at the University of Adelaide, Australia. JBI's goal is to develop and provide information, software, education, and training on Evidence-Based Healthcare. To this end, they developed methodologies for conducting systematic reviews and various other types of reviews[24-26].

The research period began with the preparation of the protocol in April 2023.

The JBI in its Manual recommends the necessary steps to carry out the Scope Review and from the protocol, the five steps are established, which will be described below[27]:

Identification of the research question

To prepare the question for this review, a strategy was adopted that considers aspects of the population, concept, and context of the object to be researched, under the acronym PCC: Population (nurses); Concept (use of NTs), and Context (clinical practice)[27] as shown in Figure 1.

Identification of relevant studies

The second stage comprises the choice of databases, the elaboration of search strategies with Boolean descriptors and operators, and the definition of inclusion and exclusion criteria[26].

The mapping of concepts/terms was selected from descriptors present in four databases: Descriptors in Health Sciences (DeCS), Medical Subject Headings (MeSH), CINAHL Headings, and EMTREE (Chart 1) in Portuguese, English, and Spanish.

Figure 1. PCC strategy applied in the scoping review. Rio de Janeiro, RJ, Brazil, 2023

Question: What scientific evidence is available regarding the use of NTs in nurses' clinical practice?	
POPULATION	Participants in this review will be considered nurses.
CONCEPT	Studies that include the use of standardized terminologies (NTs) in clinical practice will be considered.
CONTEXT	Studies conducted in healthcare settings will be considered, including hospitals, community settings, home care, universities, schools, and long-term care settings with related inpatients in clinical practice.

Chart 1. Concept/term mapping. Rio de Janeiro, RJ, Brazil, 2023

Acronym	Terms
P	Enferm* OR Nurs*
C	"Terminologia Padronizada em Enfermagem" OR "StandardizedNursingTerminology" OR "Terminología Normalizada de Enfermería" OR "Registros Eletrônicos de Saúde" OR "Electronic Health Records" OR "Registros Electrónicos de Salud" OR "Registros Médicos" OR EHR OR "Medical Records" OR "Registros de Enfermagem" OR "Nursing Records" OR "Registros de Enfermería" OR "Terminologia Enfermagem" OR "TerminologyNursing" OR "TerminologíaEnfermería" OR "prontuário eletrônico" OR "electronichealthrecord" OR "historia clínica electrónica" OR "Enfermagem padronizada" OR "StandardizedNursing" OR "EnfermeríaEstandarizada" OR Terminologia OR Terminology OR Terminologie OR "linguagem de enfermagem" OR "nursinglanguage" OR "lenguaje de enfermeria" OR "Classificação Internacional para a Prática de Enfermagem" OR "InternationalClassification for NursingPractice" OR "Clasificación Internacional para laPráctica de Enfermería" OR OR "diário de saúde" OR "Health Diary" OR "diario de salud" OR "Registro Médico Computadorizado" OR "Computerized Medical Record" OR "Expediente Médico Computarizado"
C	"Enfermagem Primária" OR "Primary Nursing" OR "Enfermería Primaria" OR "Diagnóstico de Enfermagem" OR "Diagnóstico de Enfermería" OR "NursingDiagnosis" OR "Avaliação em Enfermagem" OR "Nursing Assessment" OR "EvaluaciónenEnfermería" OR "Cuidados de Enfermagem" OR "NursingCare" OR "Atención de Enfermería" OR "Prática clínica" OR "Clinical practice" OR "Prácticaclinica"

A three-step search strategy will be used for this review. An initial limited search in MEDLINE (PubMed) and SCOPUS was performed, followed by analysis of the text words contained in the title and abstract, and the indexing terms used to describe the article.

A thorough secondary search will be performed on all included databases using the keywords and index terms identified in the initial limited search. The need to adapt search strategies for each database will be considered, maintaining the similarity of the combination of descriptors using Boolean operators (OR and AND) and this stage will be constructed with the help of a librarian.

In the third search phase, the reference lists of all literature that meets the inclusion criteria of this review will be examined. The databases to be searched include MEDLINE (PubMed), Latin American and Caribbean Literature in Health Sciences (LILACS), Virtual Health Library (VHL), Scopus, Embase, and OVID. In addition, a search will be carried out in the Catalog of Theses and Dissertations of the Coordination for the Improvement of Higher Education Personnel (CAPES), and the search in the gray literature for non-indexed materials will be conducted through Google Scholar. The first stage of the search strategy is described in Chart 2.

The eligibility criteria for the studies that will be considered to compose the research are complete and available text, methodological approaches comprising qualitative, quantitative, mixed, published without time and language limitations that address the study theme (NTs) applied in a scenario clinical (including education) and assessed local or internationally recognized terminology. The exclusion criteria defined for this review are editorials, reviews, letters, opinion articles, case studies, undergraduate coursework, and studies not available free of charge and online in full.

Chart 2. Primeira etapa de estratégias de busca das Bases de Dados MEDLINE/PubMed e SCOPUS. Rio de Janeiro, RJ, Brasil, 2023

Data base	Search strategy	Result
PubMed	("Standardized Nursing Terminology"[MeSHTerms] OR "standardized nursing terminol*"[Title/Abstract] OR "Standardized Nursing"[Title/Abstract] OR "Terminology Nursing"[Title/Abstract] OR "terminol*"[Title] OR "clinical terminolog*"[Title/Abstract] OR "nursing language"[Title/Abstract] OR "International Classification for Nursing Practice"[Title/Abstract] OR "Clinical Care Classification"[Title/Abstract]) AND ("Electronic Health Records"[MeSHTerms] OR "electronic health record*"[Title/Abstract] OR "EHR"[Title] OR "health record electronic*"[Title/Abstract] OR "Electronic Health Record Data"[Title/Abstract] OR "computerized medical record*"[Title/Abstract] OR "Medical Records"[MeSHTerms] OR "medical record*"[Title/Abstract] OR "health diar*"[Title/Abstract] OR "Nursing Records"[MeSHTerms] OR "nursing record*"[Title/Abstract]) AND ("nursing"[MeSHTerms] OR "nurs*"[Title/Abstract] OR "nursing"[MeSHSubheading] OR "Primary Nursing"[MeSHTerms] OR "primary nurs*"[Title/Abstract] OR "nursing care*"[Title/Abstract] OR "Nursing Diagnosis"[MeSHTerms] OR "nursing assessment*"[MeSHTerms] OR "Clinical practice"[Title/Abstract])	345 06/14/2023
SCOPUS	(TITLE(Nurs* OR "Primary Nursing" OR "Primary Nurs*" OR "Nursing Care*" OR "Nursing Diagnosis" OR "Nursing Assessment*" OR "Clinical practice")) AND (TITLE-ABS-KEY("Electronic Health Record*" OR EHR OR "health record, electronic*" OR "Electronic Health Record Data" OR "Computerized Medical Record*" OR "Medical Record*" OR "Health Diar*" OR "Nursing Record*")) AND (TITLE-ABS-KEY("Standardized Nursing Terminol*" OR "Standardized Nursing" OR "Terminology Nursing" OR Terminol* OR "Clinical, terminolog*" OR "nursing language" OR "International Classification for Nursing Practice" OR "Clinical Care Classification"))	972 06/14/2023

Study selection and initial assessment

After searching, all identified citations will be collated and uploaded to Endnote (Clarivate Analytics, PA, USA), and duplicates removed. Titles and abstracts will then be selected by two independent reviewers for assessment against the inclusion criteria for the review. These steps were carried out using the Rayyan program by pairs of reviewers independently, with the participation of a third reviewer to resolve conflicts when necessary.

After searching the databases accessed via the CAPES Journals' Portal, the results found will be managed by the Rayyan tool, where analysis of remaining duplicates and their respective exclusions will also be carried out[28].

Rayyan is a 100% free web application to help systematic review authors get their work done quickly and easily. The evaluation of the references found will be conducted by two reviewers in a blind evaluation so that one reviewer will not have access to the decision to include or exclude a particular reference defined by the other reviewer. Discrepant cases will be evaluated by a third reviewer. Thus, the pre-selection of studies will be carried out by reading the title and abstract and verifying compliance with the inclusion and exclusion criteria[28].

Studies identified by Google Scholar and those collected by the reference list will also be evaluated for relevance, based on the title and abstract with the help of Rayyan software. The pre-selected studies will be read in full and evaluated considering the inclusion criteria already defined. This process will be recorded in detail, enabling the identification of all decisions made. This registration will be carried out in a narrative form and by completing the PRISMA-ScR flowchart.

Data analysis

When extracting data from articles, a JBI reference instrument will be used, considering the following aspects: identification (title, authors, language, country, location, periodical, year of publication); methodological aspects (objective, research design, framework, sampling, data processing); and critical analysis (themes covered, resources, positive and negative points, and main conclusions).

As scoping reviews do not seek to assess the quality of the selected studies, the risks of bias in the studies will not be assessed. The data will be entered into an Excel® table, from which the characteristics of the studies, grouping, synthesis, and description of the results of the research question will be made, subsequently, the participants, concept, context, study methods, and main findings pertinent to the review question will be inserted and adapted to the structure proposed by the MaxQda software for the decoding process.

The data extraction tool developed by the authors will also include specificities related to the use of standardized terminology in the electronic record (Chart 3).

The publication selection steps will follow the PRISMA–ScR scoping review flowchart.

Chart 3. Scope review data extraction form Standardized Nursing Terminologies. Rio de Janeiro, RJ, Brazil, 2023

Year	Title	Author	Journal	Method used	Participants	Concept	Context	Main results	Conclusions/ Gaps

Source: Adapted from Aromataris and Munn[30].

Synthesis and presentation of results

A narrative summary will be displayed alongside the tabulated and mapped results, detailing how the results correlate with the objective and scoping review question. The research results will be reported in full in the final scoping review and presented in a PRISMA – ScR flowchart[29-31].

The synthetic table will contain a summary of the studies reviewed according to the information contained/retrieved in the data extraction form, characterizing them and presenting the overview of nursing NTs in clinical practice, according to each study. A quantitative synthesis of the main ones will also be prepared in the context of evidence-based practice.

The information will be listed in a table, thus forming a summary compiled with the main results. In addition, a narrative synthesis of the findings related to the recommendations and limitations of the studies will be produced, to produce useful information for future research on the topic. The final data will be presented descriptively and through tables and graphs that facilitate the visualization of the results.

The description of the results will be grouped by categories: standard terminologies, and continuing education. According to the analysis of the collected data, a structure will be developed with a configuration based on the characteristics of the studies and the components found.

It is worth noting that as the data will be obtained from databases of already published material, it is not necessary to be assessed by a Research Ethics Committee, but all rigors will be followed in the preparation of the research protocol. The results of this investigation will be published in open-access journals or presented at relevant scientific events.

Expected Results

It is expected that the construction of this protocol will demonstrate a synthesis of evidence to support nursing terminologies in health records in computerized systems, assisting in forming diagnostic expressions and nursing actions. The protocol for this scoping review outlines the strategy of a future study that could support an assessment of nursing terminologies in health records in computerized systems, assisting in forming diagnostic expressions and nursing actions to list the concepts and the methodologies of the area of knowledge being researched.

It should be noted that, as the data will be obtained from databases of already published material, it is not necessary to be assessed by a Research Ethics Committee as there is no direct research with human beings, but all rigors will be followed in preparing the protocol of research. The results of this investigation will be published in open-access journals or presented at relevant scientific events.

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