Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: http://dx.doi.org/10.12957/reuerj.2021.55123

Nursing records as a tool for hospital clinical care management

Registros de enfermagem como ferramenta para a gerência do cuidado clínico-hospitalar

Los registros de enfermería como herramienta para la gestión de la atención clínica hospitalaria

Ramon Pacheco de Souza[I] *; Hérica Silva Dutra*[I] *; Sirleide Corrêa Rangel* [I] *;*
Poliana Novais Mendes[I] *; Fábio da Costa Carbogim*[I] *; Nádia Fontoura Sanhudo*[I]

[I]*Universidade Federal de Juiz de Fora, Juiz de Fora, MG, Brazil*

ABSTRACT

Objective: to understand the use of nursing records in hospital clinical care management. **Method:** this comprehensive qualitative study was conducted with 13 nurses at a public teaching hospital in Minas Gerais State, Brazil. Data were collected by semi-structured interviews, participant observation, and documentary research, between October and November 2017. The data were processed by IRaMuTeQ software and content analysis. The study was approved by the research ethics committee. **Results:** three categories emerged: the context in which the records are used and how care management takes place; the instruments adopted in preparing the records; and nursing records as a means of communication. **Conclusion:** nursing records contribute to management and to care, interrelatedly. However, participant observation made it evident that the nursing records were associated only with managing, and were divorced from care, making it difficult to use them as a tool for interprofessional communication and as evidence of the quality of care.

Descriptors: Nursing; Nursing Service, Hospital; Nursing Records; Organization and Administration.

RESUMO

Objetivo: compreender a utilização dos registros de enfermagem na gerência do cuidado clínico-hospitalar. **Método:** estudo qualitativo, de caráter compreensivo, realizado em um hospital público de ensino de Minas Gerais, com 13 enfermeiras. Os dados foram coletados por entrevistas semiestruturadas, observação participante e pesquisa documental, entre outubro e novembro de 2017, e tratados pelo *software IRaMuTeQ* e análise de conteúdo. Protocolo de pesquisa aprovado pelo Comitê de Ética em Pesquisa da instituição. **Resultados:** após análise, emergiram três categorias: contexto de utilização dos registros e o desenvolvimento da gerência do cuidado; instrumentos adotados na elaboração dos registros; registros de enfermagem como meio de comunicação. **Conclusão:** os registros de enfermagem contribuem para o gerenciar e o cuidar, de maneira articulada. Entretanto, por meio da observação participante, constatou-se que os registros de enfermagem estavam associados apenas ao gerenciar, desvinculados do cuidar, o que dificulta a utilização destes como ferramenta de comunicação interprofissional e evidência da qualidade do cuidado.

Descritores: Enfermagem; Serviço Hospitalar de Enfermagem; Registros de Enfermagem; Organização e Administração.

RESUMEN

Objetivo: comprender el uso de los registros de enfermería en la gestión de la atención clínica hospitalaria. **Método:** estudio cualitativo y exhaustivo, realizado en un hospital público de enseñanza en Minas Gerais, junto a 13 enfermeras. Se recolectaron los datos mediante entrevistas semiestructuradas, observación participante e investigación documental, entre octubre y noviembre de 2017. Los datos fueron procesados por el software IRaMuTeQ y el análisis de contenido. El estudio fue aprobado por el Comité de Ética de la Investigación. **Resultados:** después del análisis, surgieron tres categorías: contexto de utilización de los registros y desarrollo de la gestión del cuidado; instrumentos adoptados en la elaboración de los registros; registros de enfermería como medio de comunicación. **Conclusión**: los registros de enfermería contribuyen a la gestión y el cuidado, de forma articulada. Sin embargo, a través de la observación participante, se hizo evidente que los registros de enfermería estaban asociados apenas con la gestión, sin relación con el cuidado, lo que dificulta su utilización como herramienta de comunicación interprofesional y evidencia de la calidad del cuidado.

Descriptores: Enfermería; Servicio de Enfermería en Hospital; Registros de Enfermería; Organización y Administración.

INTRODUCTION

The records made in the patient's medical chart constitute an important legal document in the professionals' defense in case of legal and ethical processes. In addition to the legal evidence, they have other purposes: sharing information between the Nursing team and other professionals, care planning, evaluation of the care quality, data source for teaching and research, audit and permanent report of the care provided[1].

Acknowledgements to the Universidade Federal de Juiz de Fora, Brazil, for the financial support to carry out this research.
Corresponding author: Sirleide Corrêa Rangel. E-mail: sirleiderangel@gmail.com
Scientific Editor: Cristiane Helena Gallasch; Associate Editor: Sergio Correa Marques

Received: Oct 7th 2020 – Accepted: June 9th 2021

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: http://dx.doi.org/10.12957/reuerj.2021.55123

However, weaknesses in the Nursing records are present in many institutions and are mainly related to the following: non-use of a stamp, absence of the professional's signature, erasures, illegible writing and blank spaces[2]. In addition to that, the use of non-standard abbreviations can lead to misinterpretations, exposing the patient to risks, and compromising continuity of the service[3]. The use of acronyms, unconventional abbreviations, and trade names of devices such as Abbocath® referring to venous catheter was also observed in another study[4].

Superficial and incomplete records that do not portray the patient's reality and the Nursing interventions performed make it difficult to identify the Nursing Process (NP), contributing to professional invisibility[5]. Audits of medical charts evidenced that the records are still incipient and that there is a positive relationship between Nursing records and the quality of the care provided[6]. Accurate records allow the data to be transformed into pertinent information for care planning. Therefore, educational mediations and interventions applied to sensitize and instruct the professionals on the importance of clarity in the records can help improve the quality of the notes and exert an impact on continuity of safe care[3,7,8].

Consequently, nurses are responsible for ensuring that the records are precise and complete, as a tool for care management[9]. The Nursing record is understood as an inherent component of care management, in the sense that it involves aspects related to the managing/administrating and caring/assisting dimensions, as inseparable units[10].

Exercising Nursing care management becomes a complex action based on multidimensions that can involve individual, family, organizational, systemic and societal aspects, which encompass civil society and the State; therefore, the nurse needs to establish interactive relationships across all these dimensions to manage care[11].

The National Agenda for Research in Health Priorities of the Ministry of Health indicates Nursing management and interventions in individual and collective health care[12] as a priority for Nursing research in the Region of the Americas, in the topic linked to the Structure, Organization and Dynamics of the Health Systems and Services.

Discussions about Nursing records are recurrent; however, their use as a tool for care management lacks more scientific evidence. Studies with this approach are necessary for nurses to rethink and re-signify their practice in order to materialize Nursing records as a support for care management. Therefore, grounded on Edgar Morin's complex thinking[13], the objective of this study was to understand the use of the Nursing records in hospital care management.

THEORETICAL FRAMEWORK

Formulated by Edgar Morin[13], Complex Thinking was considered as a foundation for this study, for a better understanding of Nursing care management and its relationships and interactions with Nursing records. In this theoretical-philosophical view**,** Nursing care cannot be configured as a simplifying and reductionist attitude, but as a construction that needs reflections, interactions, and self-knowledge[14]. Under this approach, care must consider the human being in its unity and systemic plurality and health as a broad and interdependent phenomenon that involves different social systems[15].

Thus, the choice of Complex Thinking has the purpose of understanding some elements of the multidimensionality of the phenomena that involve the use of records in care management. With this, the aspiration is for non-fragmented and non-reductive knowledge, recognizing that any knowledge is incomplete, unfinished, and requires contextualization[15].

METHOD

This is a descriptive study with a qualitative approach and of a comprehensive nature. The data were collected in the medical clinic of a public teaching hospital in Minas Gerais. For data collection, the following were used: semi-structured interview, participant observation and documentary research, conducted by the main researcher, who established a previous approach to the study scenario. The interviews were conducted between October and November 2017. The inclusion criteria were as follows: being a nurse of the aforementioned sector and working in the institution for at least three months. Nurses who were on vacation, medical leave and study leave at the time of data collection were excluded, as well as those who, after three attempts at personal and/or telephone contact, did not answer to schedule the interview. Of the total of 14 nurses of the sector, 13 took part in the study.

The interviews were digitally recorded (audio) and the researcher submitted the transcription of the interviews for the participants' appreciation in order to validate them. A systematized script elaborated by the researchers was used, containing the following guiding questions: How do nurses understand the use of Nursing records for care management? Which are the types of records used by nurses for care management? How do nurses use Nursing records for care management? Which are the practicalities and difficulties for the use of Nursing records in care management?

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: http://dx.doi.org/10.12957/reuerj.2021.55123

After the interviews, participant observation was carried out on 21 occasions, permeated by constant interaction and dialog between the researcher and the nurses, totaling 150 hours. Subsequently, a systematized script was applied in which the following was observed: type and purpose of the Nursing records, practicalities and difficulties in the use of records for Nursing care management. The documentary research occurred concomitantly with the observation and involved the analysis of medical charts and other documents related to the Nursing records, following a script which included: type of record, content recorded, professional responsible, and purpose of the record.

The interviews were transcribed in *Word for Windows* and operationalized by means of the *Interface de R pourles Analyses Multidimensionnelles de Textes et de Questionnaires (IRaMuTeQ)* software. From the *corpus* of analysis, composed by the interviews, six classes emerged from the similarity and dissimilarity of the terms. Based on the core ideas of these classes, three categories of analysis were defined, as shown in Figure 1. The data obtained from the aforementioned three techniques were organized separately, although they were analyzed in an articulated and integrated manner through Bardin's content analysis[16].

Categories	Classes	Denomination of the Classes
Use context of the Nursing records and development of care management	Class 5	The Nursing records as a tool for care management
	Class 4	Insertion of the Nursing professionals in the care management environment
Instruments adopted in the elaboration of the Nursing records	Class 2	The types of instruments used
	Class 1	The NP and its implementation
Nursing records as a communication means	Class 6	The difficulties and practicalities of the Nursing records for care management
	Class 3	The importance of the Nursing records for shift changes

FIGURE 1: Categories emerging from the nurses' interviews. Juiz de Fora, MG, Brazil, 2017.

The study observed the ethical principles for research studies with human beings, according to the recommendations set forth in Resolution 466/2012 of the National Health Council, being initiated after approval of the Research Ethics Committee and signature of the Free and Informed Consent Form. To preserve the participants' anonymity, the ENF code (from "*Enfermeiro*" in Portuguese) was used for "Nurse", followed by Arabic numerals according to the order of the interviews.

RESULTS AND DISCUSSION

All the interviewees were female. The age group varied from 31 to 40 years old. Regarding the time of professional training, eight had from four to nine years and five had more than ten years of study. Seven had institutional contracts from three months to one year, thus demonstrating a team of newcomers to the hospital. The majority (ten) had *lato sensu or stricto sensu* post-graduate degrees, evidencing the professionals' qualification level.

The *corpus* of analysis consisted of 13 interviews, which were separated into 742 text segments (TSs), with leverage of 631 TSs (85.04%). A total of 25,931 occurrences (words, forms or terms) emerged, of which 2,667 were distinct words and 1,289 had a single occurrence.

> Figure 2, resulting from the analysis of the IRaMuTeQ software, allows us to visualize by means of the dendrogram the corpus of analysis that was divided into six classes named according to the most frequent and significant terms.

The TSs were organized and associated by affinity, branching out into the six classes that were organized into three categories, as shown earlier in Figure 1.

Category 1: Context of Nursing record use and the development of care management

Class 5: The Nursing records as a tool for care management

Fragility in the continuity of Nursing care and failures in the records were perceived, reflecting in damage to communication among the health professionals. In addition to that, the overload of activities results in inadequate and inefficient Nursing care management:

> *Records are very important, because it's where we can give continuity in the service, continuity of care [...]. So, today our Nursing records are a bit faulty sometimes, because we understand also due to the heavy workload, there are days [...] most of the days, that's hard [...]. (ENF 01).*

DOI: http://dx.doi.org/10.12957/reuerj.2021.55123

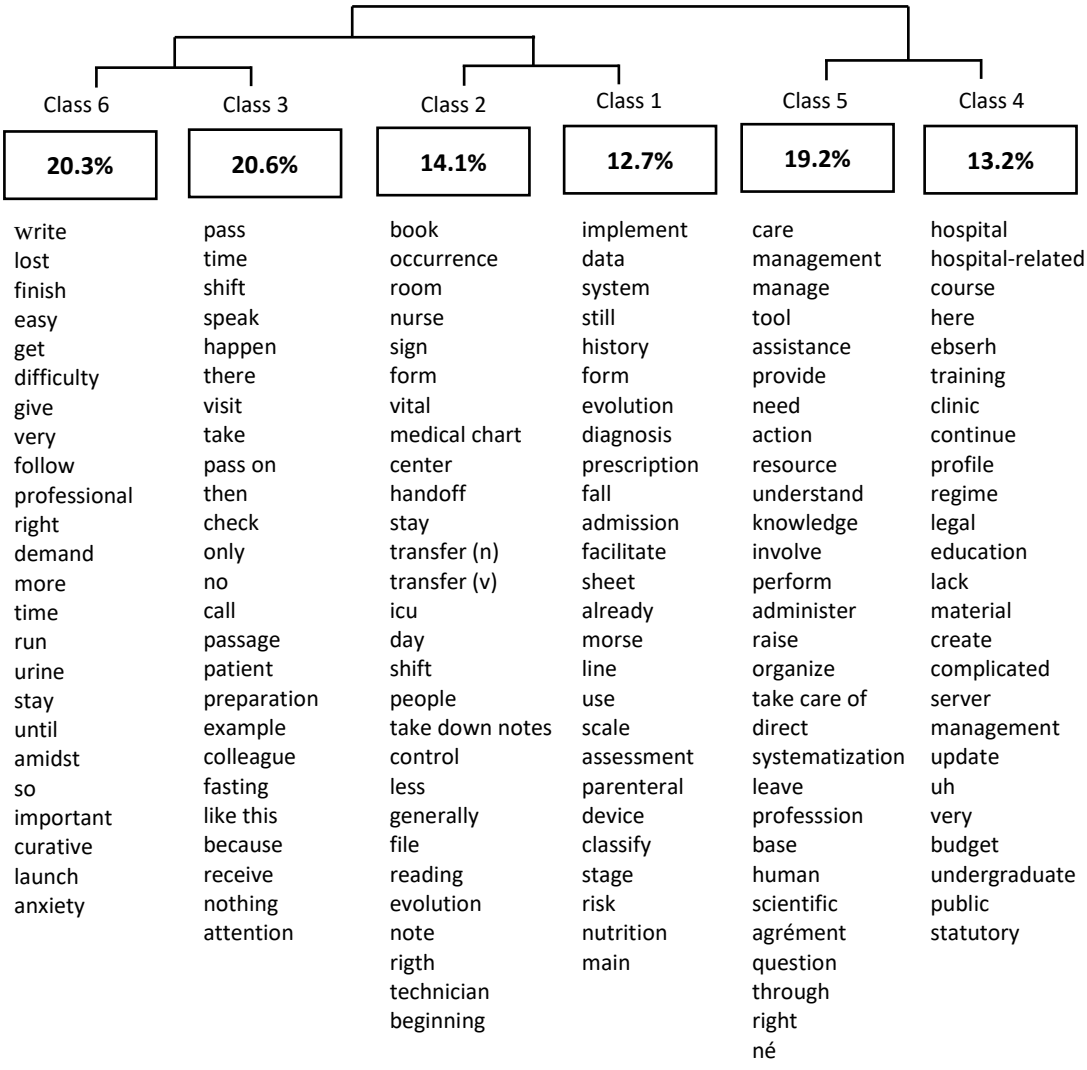

FIGURE 2: Dendrogram of the Descending Hierarchical Classification (DHC) performed in the *IRaMuTeQ* program. Juiz de Fora, MG, Brazil, 2017.

According to the Code of Ethics for Nursing Professionals, it is the Nursing team's duty to provide complete and truthful written and verbal information necessary for continuity of care and to maintain patient safety[17].

Concern in the nurses regarding the identification of the problems presented by the patient and the importance of recording them for good care resolution and patient safety through the correct, complete, clear, and objective record was noticed:

> *The record ensures patient safety, where everything must be correctly recorded there, what was done with him, clearly [...] sometimes there's no point in writing, writing and not being objective, not being clear (ENF 03).*

Low quality in Nursing records can cause serious problems, which exert a direct impact on quality of care and on patient safety, and involves both professionals in the care practice and managers, professional associations, researchers and professors[18]. The adoption of specific norms and routines for Nursing notes allows for the standardization of the recording practices, directly reflecting on quality of care, safety, and communication[19,20].

Through the documentary research, ratified in the statements, it was identified that the patient's medical chart and the other documents, such as occurrence and report books, are means that concretize the Nursing care process and allow for better planning of patient care:

DOI: http://dx.doi.org/10.12957/reuerj.2021.55123

> *It's from the records that I'm going to get organized, make the diagnoses, plan this care. The record will be there all the time, helping me to have assistance indicators to do the planning, either in one sector or at a larger scale. It will provide me with subsidies to do a good management and a good planning of this care (ENF 04).*

Nurses resort to the management instruments as fundamental tools to develop competences beyond the clinical scope. To do this, they must theoretically train themselves and improve their professional skills, in order to make care possible and strengthen the relational and interactive processes[21].

Care management is contextual and relational, and thus complex; it is established through interpersonal interactions produced and consumed in the act of caring. Consequently, it requires social skills from the nurses: communication, assertiveness and social working skills such as coordination and the art of public speaking. Therefore, the managerial practice involves subjective aspects in addition to the technical-scientific ones, as it is a social process[22].

Complex Thinking exerts an influence on Nursing care management, since it involves constant action-reflection-action, articulation and integration of various types of knowledge in the search of expanded, safe and effective care[14]. Therefore, it must be understood as a complex phenomenon marked by human connections and interconnections with its biological, social, cultural and political singularities and diversities, in constant disorganization and reorganization[13,23].

Class 4: Insertion of the Nursing professionals in the care management environment

The participants mentioned some topics that needed improvement to support Nursing care management, such as: standard operating procedures, hospital management, leadership, conflict management, and patient safety:

> *The theme of conflict management is important, and it always needs to be remembered, updated and reviewed, because here, there are days with eight Nursing professionals in the shift, so each person thinks differently [...]. Sometimes, it doesn't even need a serious conflict, but, maybe, a conflict because of a schedule, time off, how should we manage this? (ENF 13).*

Some of the managerial strategies and skills used by the nurses can assist in conflict resolution, namely: technical-scientific knowledge, organization, action planning, teamwork, flexibility, efficient communication, shared management, dialogic spaces that stimulate integration among the professionals and knowledge exchange[24]. Closeness between the team members and the opportunity to socialize at work are also important factors for improved interpersonal relationships[25]. Leadership is an important competence for the development of care management; nurses must exercise leadership by setting the example, leading, motivating and stimulating their team[26].

In the moments of participant observation, the existence of training for the Nursing team was verified, prioritizing procedures and techniques, disregarding the aspects that involve articulation between the management instruments and care. Training can contribute to improving the quality and understanding of the Nursing records not only as a bureaucratic service, but as an essential care component[8,19].

Nursing care management involves multiple tools, including records, and Complex Thinking assists in understanding Nursing knowledge/doing to transcend the reductionist, disjunctive and fragmenting thinking and attain interactive, associative and unifying knowledge/doing[27].

The need for an improvement course on the Systematization of Nursing Care (SNC) and the Nursing Process (NP) was mentioned by the interviewees:

> *One thing that needs to be improved is the part of the Nursing prescriptions, the care plans, in fact, the systematization of Nursing care as a whole, it's something that we learn in college, but then the institutions leaves it behind (ENF 08).*

The implementation of the NP requires knowledge and expertise to assess, diagnose, plan and produce Nursing assistance targeted at the users' health needs. This knowledge can be learned through permanent training and contributes to nurses' autonomy and visibility[28].

It is undeniable that the SNC and the NP are fundamental for qualified assistance; however, their realization goes beyond issues related to professional training. Some institutional characteristics need to be analyzed and adequate for their implementation, among them staff sizing adequate to the number and to the complexity of patients, favorable environment and material resources, professional appreciation, knowledge and quality of the records[29].

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: http://dx.doi.org/10.12957/reuerj.2021.55123

Category 2: Instruments adopted in the elaboration of the Nursing records

Class 2: The types of instruments used

Through the documentary research and interviews, it was possible to identify diversified modalities of Nursing records, among them: Nursing Process evaluation form, follow-up form, shift change list (list of the inpatients with record of the complications), preoperative checklist and sector's occurrence books, exams, record and control of Nursing shift change, surveillance culture and protocol.

> *The types are the Nursing evolution report, occurrence book, shift complications book [...]. In addition to that, each nurse records when the patients are referred for an exam, when they come back from the exam, how many patients we're receiving at the beginning of the shift, and how many we're passing on to the next shift (ENF 06).*

The creation and validation of printouts to support the systematization of Nursing care are essential, since they make it possible to identify human and care needs, recognize problems, support the clinical reasoning process, and detect indicators to evaluate the Nursing team's therapeutic interventions[30]. Thus, the use of the data recorded in the instruments and the incorporation of relevant information to support care management sustain the complexity of this process.

Class 1: The NP and its implementation

Some nurses reported the Nursing records coming from the NP as a subsidy for care management, as a tool for the care and evaluation plan:

> *The record is an important tool for the systematization of care, it's the knowledge produced by Nursing, having as its foundation care management, with quality (ENF 06).*

As a tool derived from the NP, the Nursing record is configured as a care technology that guides logical reasoning, qualifying care by systematizing the clinical evaluation, assisting in research, education and management[31].

However, during participant observation, fragmentation of the NP stages was noticed, as well as the lack of specific forms contemplating all of its stages, which was justified by the current implementation phase. It is understood that this is a complex process, since the study locus is a university hospital that integrates teaching and service. Implementing the NP can facilitate the teaching-learning process with the application of theory in the clinical practice. Thus, the university hospital represents a model place for practical undergraduate classes, contributing to the training of nurses[32].

The difficulties experienced in the teaching and practice of the SNC and NP are related to the operational characteristics involved in their conduction, the time spent in the elaboration of the NP, various demands, organizational factors and extensive instruments, as well as limitations of the professionals related to the necessary knowledge of semiotechnical/semiology for clinical and therapeutic reasoning[33].

Category 3: Nursing records as a communication means

Class 6: The difficulties and practicalities of the Nursing records for care management

The difficulties of Nursing records for care management pointed out by the participants were the following: lack of a Nursing evolution report, incomplete notes, lack of clarity in the notes and professionals' time, limited human resources, excessive number of patients, non-computerized records, and incomplete execution of the NP. These can exert an impact on the team's communication.

Having a good record is very important, so that no doubt arises for the entire Nursing team. A good record has to be clear, very concise, very detailed, use words and terms that everyone can understand, preferably use technical terms (ENF 12).

On the other hand, facilitating aspects of the use of Nursing records for care management were mentioned, such as: Nursing printouts and forms, as useful mechanisms for better organization, planning, and communication of the team's daily activities and the continuity of Nursing records made during each work shift.

A quasi-experimental study conducted in Rio de Janeiro showed that, after the training of nurses, the implementation of an instrument formulated from a standardized language system of Nursing diagnoses, interventions and outcomes directed to the cardiovascular area considerably increased the total score of the quality of the Nursing records, as well as the clinical evaluation made by nurses in decision-making, care planning and Nursing outcomes[34].

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: http://dx.doi.org/10.12957/reuerj.2021.55123

The participants identified that the Nursing records were useful to optimize time and to order work, as well as that they provided support, assistance, and guidance to the Nursing management:

> *A good record will always be great help in management, [...] a good record would be a daily evolution of the patient, complete, including the systematization of care, all the complications [...]. The records will help in order to do things in a more accurate time, reduce delays in some procedures, or in some other activity that I would need to performed, or a referral [...]. (ENF 04).*

These data converge with those of another study which verified that the use of diverse records, such as spreadsheets, patient classification system and indicators, among others, combined with professional competences such as communication, organization and planning, favored the Nursing management actions in critical hospital sectors[35].

Class 3: The importance of the Nursing records for shift changes

In the nurses' speeches, it was evidenced that communication during shift changes through the Nursing records proved to be an important ally in the conduction of care management, and was useful to improve the integration of the multiprofessional team, updating of information, and clarification of doubts.

However, in the observation of the study scenario, it was noticed that shift changes by the nurses occurred in a non-systematic manner, with reports of sector demands, with little or no written record of the patients' complications, only verbally reported. The “shift change list” form served as an ancillary instrument that facilitated the conduction of shift changes, without details of the patients' health condition, but with general and broad notes of their health conditions.

In this sense, a study that sought to know the view of the Nursing professionals about communication during shift changes and its impact on patient safety indicated the need to reduce the time used, systematization of records for the moment, and greater objectivity in the transmission of information[36].

Study limitations

The following are signaled as study limitations: its conduction in a single hospital sector (medical clinic) and the restricted number of participants. Therefore, the results preclude generalizations, fostering the need for new studies in other hospital areas.

CONCLUSION

The research results contributed to a contemporary reflection on Nursing care management from the perspective of Complex Thinking, for which multiple dimensions of the use of records were considered. The Nursing records were described by the nurses as a tool for care management but, in the practice, it was observed that these records played a protocol and bureaucratic role associated with management, disconnected from care, evidencing a dichotomous relationship between managing and caring.

It is hoped that this study may contribute to the service and to the academic environment, encouraging professionals to rethink and reflect on their practices, strengthening the understanding of the Nursing records as an essential tool for supporting and evaluating care quality for nurses to perform care management in the hospital environment, considering the SNC and the NP as priorities in this process.

REFERENCES

1. Conselho Federal de Enfermagem (COFEN). Guia de recomendações para os registros de enfermagem no prontuário do paciente [Internet]. Brasília (DF): Cofen; 2017. Available from: http://biblioteca.cofen.gov.br/guia-de-recomendacoes-para-registro-de-enfermagem-no-prontuario-do-paciente-e-outros-documentos-de-enfermagem/.
2. Figueiredo T, Silva PLN, Guimarães LF, Guimarães CF, Oliveira MKS, Alves ECS. Assessment of Nursing Records of Patients Admitted to the Medical Clinic of a University Hospital from the Northern Region of Minas Gerais State. J. res.: fundam. care. online [Internet] 2019 [cited 2020 June 06]; 11(2):390-6. DOI: https://doi.org/10.9789/2175-5361.2019.v11i2.390-396.
3. Carneiro SM, Dutra HS, Costa FM, Mendes SE, Arreguy-Sena C. Use of abbreviations in the nursing records of a teaching hospital. Rev. Rene (Online). 2016 [cited 2020 May 21]; 17(2):208-16. DOI: https://doi.org/10.15253/2175-6783.2016000200008.
4. Gomes DC, Cubas MR, Pleis LE, Shmeil MAH, Peluci APVD. Terms used by nurses in the documentation of patient progress. Rev. Gaúch. Enferm. [Internet]. 2016 [cited 2020 June 06]; 37(1): e53927. DOI: http://dx.doi.org/10.1590/1983-1447.2016.01.53927.
5. Silva TGD, Santos RM, Crispim LMC, Almeida, LMWS. The content of nursing records in hospitals: contributions to the development of the nursing process. Enferm. Foco. 2016 [cited 2020 May 21]; 7(1):24-27. DOI: https://doi.org/10.21675/2357-707X.2016.v7.n1.

DOI: http://dx.doi.org/10.12957/reuerj.2021.55123

6. Krauzer IM, Karal A, Bordignon M, Trindade LL. Records of nursing from the perspective of an integrative review. J. nurs. health. (Online). 2015 [cited 2020 May 21]; 5(1):68-79. Available from: https://periodicos.ufpel.edu.br/ojs2/index.php/enfermagem/article/view/3866.
7. Dutra HS, Mendes SE, Carneiro SM, Costa FM, Barboza RCP, Ribeiro LC. Nursing records at a teaching hospital: a quasi-experimental study. Online braz. j. nurs. (Online). 2016 [cited 2020 May 21]; 15(3): 351-360. DOI: https://doi.org/10.17665/1676-4285.20165470.
8. Barreto JA, Lima GGD, Xavier CF. The inconsistency of nursing records in audit process la incompatibilidad de los registros de enfermería em processo de auditoría. Rev. enferm. Cent.-Oeste Min. 2016 [cited 2020 May 21]; 1(6): 2081-2093. DOI: https://doi.org/10.19175/recom.v0i0.917.
9. Mutshatshi TE, Mothiba TM, Mamogobo PM, Mbombi MO. Record-keeping: Challenges experienced by nurses in selected public hospitals. Curationis. 2018 [cited 2020 June 06]; 41(1): 1931. DOI: https://doi.org/10.4102/curationis.v41i1.1931.
10. Lanzoni GMM, Magalhães ALP, Costa VT, Erdmann AL, Andrade SR, Meirelles BHS. Becoming nursing manager in the nested and complex border of caring and management dimensions. Rev. eletrônica enferm. 2015 [cited 2020 May 21]; 17(2): 322-32. DOI: http://dx.doi.org/10.5216/ree.v17i2.29570.
11. Siewert JS, Rodrigues DB, Malfussi LBH, Andrade SR, Erdmann AL. Management of Integral Care in Nursing: reflections under the perspective of complex thinking. Reme, rev. min. enferm. 2017 [cited 2020 May 21]; 21: e-1047. DOI: https://doi.org/10.5935/1415-2762.20170057.
12. Cassiani SHDB, Bassalobre-Garcia A, Reveiz L. Universal Access to Health and Universal Health Coverage: identification of nursing research priorities in Latin America. Rev. Latino-Am. Enfermagem. 2015 [cited 2020 May 21]; 23(6):1195-1208. DOI: http://dx.doi.org/10.1590/0104-1169.1075.2667.
13. Morin E. Introdução ao pensamento complexo. 5ª ed. Porto Alegre (RS): Sulina; 2015.
14. Cruz RAO, Araujo ELM, Nascimento NM, Lima RJ, França JRFS, Oliveira J. Reflections in the light of the complexity theory and nursing education. Rev. Bras. Enferm. [Internet]. 2017 Feb. [cited 2020 June 06]; 70(1): 236-239. DOI: https://doi.org/10.1590/0034-7167-2016-0239.
15. Backes DS, Zamberlan C, Colomé J, Souza MT, Marchiori MT, Erdmann AL, Maya AMS. Systemic Interactivity between Interdependent Concepts of Nursing Care. Aquichan [online]. 2016 [cited 2020 June 06]; 16(1): 24-31. DOI: http://dx.doi.org/10.5294/aqui.2016.16.1.4.
16. Bardin, L. Análise de Conteúdo. Tradução de Luís Antero Reto e Augusto Pinheiro. São Paulo: Edições 70; 2016.
17. Conselho Federal de Enfermagem (COFEN). Resolução COFEN nº 564, de 6 de novembro de 2017. Aprova o novo Código de Ética dos Profissionais de Enfermagem. Brasília (DF): Conselho Federal de Enfermagem; 2017. Available from: http://www.cofen.gov.br/resolucao-cofen-no-5642017_59145.html.
18. Melo LS, Figueiredo LS, Pereira JM, Flores PV, Cavalcanti AC. Effect of an educational program on the quality of Nursing Process recording. Acta Paul. Enferm. 2019 [cited 2020 June 06]; 32(3):246-53. DOI: http://dx.doi.org/10.1590/1982-0194201900034.
19. Borges FFD, Azevedo CT, Amorim TV, Figueiredo MAG, Ribeiro, RGM. Importance of nursing records according to nursing team: professionals and institutional implications. Rev. enferm. Cent.-Oeste Min. 2017 [cited 2020 June 06], 7(1): 1-8. DOI: https://doi.org/10.19175/recom.v7i0.1147.
20. Hardiker NR, Dowding D, Dykes PC, Sermeus W. Reinterpreting the nursing record for an electronic context. Int. J. Med. Inform. 2019 [cited 2020 June 06]; 127: 120-126. DOI: https://doi.org/10.1016/j.ijmedinf.2019.04.021.
21. Martins PF, Perroca MG. Care necessities: the view of the patient and nursing team. Rev. Bras. Enferm. [Internet]. 2017 [cited 2020 May 21]; 70(5): 1080-6. DOI: http://dx.doi.org/10.1590/0034-7167-2016-0197.
22. Montezeli JH, Haddad MCFL, Garanhani ML, Peres AM. Improving social skills in care management provided by nurses: intervention research. Rev. Bras. Enferm. [Internet]. 2019 [cited 2020 Sep 17]; 72(Suppl 1):49-57. DOI: http://dx.doi.org/10.1590/0034-7167-2017-0918.
23. Morin E. O método 2: a vida da vida. Porto Alegre (RS): Sulina; 2001.
24. Martins FZ, Dall'Agnol CM. Surgical center: challenges and strategies for nurses in managerial activities. Rev. Gaúch. Enferm. [Internet]. 2016 [citado 2020 June 06]; 37(4): e56945. DOI: http://dx.doi.org/10.1590/1983-1447.2016.04.56945.
25. Pinhatti EDG, Vannuchi MTO, Sardinha DSS, Haddad MCL. Job rotation of nursing professionals among the sectors of a hospital: a management tool in conflict resolution. Texto Contexto Enferm. [Internet]. 2017 [citado 2020 June 06]; 26(2): e1180015. DOI: http://dx.doi.org/10.1590/0104-07072017001180015.
26. Farah BF, Dutra HS, Sanhudo NF, Costa LM. Perception of nurse supervisors on leadership in primary care. Rev. cuid. (Online). 2017 [cited 2020 May 21]; 8(2): 1638-55. DOI: http://dx.doi.org/10.15649/cuidarte.v8i2.398.
27. Backes MTS, Carvalho KM, Santos EKA, Backes DS. New coronavirus: what does nursing have to learn and teach in times of a pandemic? Rev. Bras. Enferm. [Internet]. 2020 [cited 2021 May 17]; 73(Suppl 2): e20200259. DOI: https://doi.org/10.1590/0034-7167-2020-0259.
28. Benedet SA, Padilha MI, Peres MAA, Bellaguarda MLR. Essential characteristics of a profession: A historical analysis focusing on the nursing process. Rev. Esc. Enferm. USP. [Internet]. 2020 [citado 2020 Sept. 06]; 54:e03561. DOI: https://doi.org/10.1590/S1980-220X2018047303561.
29. Soares MI, Resck ZMR, Terra F de S, Camelo SHH. Systematization of nursing care: challenges and features to nurses in the care management. Esc. Anna Nery [Internet]. 2015 Mar. [cited 2020 June 27]; 19(1): 47-53. DOI: https://doi.org/10.5935/1414-8145.20150007.

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: http://dx.doi.org/10.12957/reuerj.2021.55123

30. Arreguy-Sena C, Marques TO, Souza LC, Martins NA, Krempser P, Braga LM, Parreira PMSD. Construction and validation of forms: systematization of the care of people under hemodialysis. Rev. Bras. Enferm. [Internet]. 2018 [cited 2020 May 21]; 71(2): 379-9. DOI: https://doi.org/10.1590/0034-7167-2015-0130.
31. Silveira DM, Nicola GDO, Chagas MC, Pereira FW, Ilha S, Magalhães M. Public university students' ease and/or difficulties in preparing nursing progress notes. Rev. Enferm. UERJ [Internet]. 2015 [cited 2020 May 21]; 23(6): 832-7. DOI: https://doi.org/10.12957/reuerj.2015.7267.
32. Benedet SA, Padilha MI, Gelbke FL, Bellaguarda MLR. The model professionalism in the implementation of the Nursing Process (1979-2004). Rev. Bras. Enferm. [Internet]. 2018 [citado 2020 Sept. 06];71(4):1907-14. DOI: http://dx.doi.org/10.1590/0034-7167-2017-0226.
33. Gutiérrez MGR, Morais SCRV. Systematization of nursing care and the formation of professional identity. Rev. Bras. Enferm. [Internet]. 2017 [cited 2020 May 21]; 70(2): 455-60. DOI: http://dx.doi.org/10.1590/0034-7167-2016-0515.
34. Belém ARSC, Figueiredo LS, Pereira JMV, Flores PVP, Cavalcanti ACD. Effect of a standardized instrument on the quality of nurses' records: a quasi-experimental study. Reme, rev. min. enferm. 2019 [cited 2020 June 06]; 23:e-1252. DOI: http://dx.doi.org/10.5935/1415-2762.20190100.
35. Vasconcelos RO, Bohrer CD, Rigo DFH, Marques LGS, Oliveira JLC, Tonini NS, Nicola AL. Means for nursing management used in critical hospital units. Enferm. Foco. 2016 [cited 2020 June 06]; 7 (3/4): 56-60. Available from: http://revista.cofen.gov.br/index.php/enfermagem/article/view/944.
36. Silva MF, Anders JC, Rocha PK, Souza AIJ, Burciaga VB. Communication in nursing shit handover: pediatric patient safety. Texto Contexto Enferm. 2016 [cited 2020 May 21]; 25(3): e3600015. DOI: http://dx.doi.org/10.1590/0104-07072016003600015.