







NURSING RECORDS AND THE CHALLENGES OF THEIR IMPLEMENTATION IN THE ASSISTANCE PRACTICE

REGISTROS DE ENFERMAGEM E OS DESAFIOS DE SUA EXECUÇÃO NA PRÁTICA ASSISTENCIAL

REGISTROS DE ENFERMERÍA Y RETOS DE SU EJECUCIÓN EN LA PRÁCTICA ASISTENCIAL

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Funding: No funding.

Submitted on: 2018/09/05

Approved on: 2019/07/07

ABSTRACT

Objective: to understand the nurse's perception on the relevance of the Nursing records when providing customer care. **Method:** this is a descriptive and exploratory study of a qualitative nature, developed in a hospital in a municipality in the North of the state of *Espírito Santo*. Seven nurses participated in this study. Data was collected through semi-structured interviews. Content analysis was used. **Results:** the results were organized into empirical analytical categories, namely: definition and relevance of the Nursing records, difficulties encountered in the realization of the Nursing records and improvement of the quality of the Nursing records in daily work. It was observed that Nursing is concerned with the doing, to the detriment of the systematic records of its care. **Conclusion:** considering that Nursing records contribute to improve the quality of care, there is a need for a more rigorous monitoring of the records made in the health services. The need for continuing education regarding the technical, ethical and legal aspects of Nursing records is highlighted.

Keywords: Nursing Records; Nursing Process; Patient Safety.

RESUMO

Objetivo: compreender a percepção do enfermeiro sobre a relevância dos registros de Enfermagem na prestação da assistência ao cliente. **Método:** trata-se de estudo descritivo, exploratório de natureza qualitativa, que foi desenvolvido em um hospital do município do norte do estado do Espírito Santo. Participaram deste estudo sete enfermeiros. A coleta de dados se deu por meio de entrevista semiestruturada. Utilizou-se a análise de conteúdo. **Resultados:** foram organizados em categorias analíticas empíricas, a saber: definição e relevância dos registros de Enfermagem, dificuldades encontradas para a realização dos registros de Enfermagem e melhoria da qualidade dos registros de Enfermagem no cotidiano de trabalho. Observou-se que a Enfermagem se preocupa com o fazer, em detrimento aos registros sistemáticos de sua assistência. **Conclusão:** considerando que os registros de Enfermagem contribuem para a melhoria da qualidade da assistência, evidencia-se a necessidade de um acompanhamento mais rigoroso dos registros efetuados nos serviços de saúde. Destaca-se a necessidade de uma educação continuada no que concerne aos aspectos técnicos, éticos e legais dos registros de Enfermagem.

Palavras-chave: Registros de Enfermagem; Processo de Enfermagem; Segurança do paciente.

RESUMEN

Objetivo: comprender la percepción de los enfermeros sobre la relevancia de los registros de enfermería en la atención al cliente. **Método:** estudio descriptivo, exploratorio de naturaleza cualitativa, llevado a cabo en un hospital del norte del estado de Espírito Santo. Siete enfermeros participaron en este estudio. Los datos fueron recogidos a través de entrevistas semiestructuradas. Se utilizó el análisis de contenido. **Resultados:** se organizaron en categorías analíticas empíricas, a saber: definición y relevancia de los registros de enfermería, dificultades encontradas en la realización de los registros de enfermería y mejora de la calidad de los registros de enfermería en el trabajo diario. Se observó que la enfermería se preocupa por ejecutar tareas, perjudicando los registros sistemáticos de las mismas. **Conclusión:** teniendo en cuenta que los registros

How to cite this article:

Barreto JJS, Coelho MP, Lacerda LCX, Fiorin BH, Mocelin HJS, Freitas PSS. Nursing records and the challenges of their implementation in the assistance practice. REME – Rev Min Enferm. 2019[cited ____ - ____];23:e-1234. Available from: ____ DOI: 10.5935/1415-2762.20190082

de enfermería contribuyen a mejorar la calidad de la atención, existe la necesidad del seguimiento más riguroso de los registros realizados en los servicios de salud. Destacamos la necesidad de la educación continua en lo referente a los aspectos técnicos, éticos y legales de los registros de enfermería.

Palabras clave: Registros de Enfermería; Proceso de Enfermería; Seguridad del Paciente.

INTRODUCTION

The medical record is an instrument used by health professionals to record, store and collect patient-related information. Nursing team records are one of the main forms of multi-professional communication, where the information is provided to the entire team, so that the customer needs are observed, understood and met. Thus, in addition to monitoring the patient's evolution, they are also a legal document for both the patient and the Nursing team.¹⁻³

Considered to be the pillar for the legal backing of all customer care, an appropriate medical record also promotes the evaluation of recorded cares which, in turn, will reflect the quality of such cares.²

In this sense, inefficient communication becomes one of the relevant factors of failure in the patient safety process and quality, and can easily be reversed through the Nursing records in the medical charts, as these correspond to the most efficient way for effective communication among the different teams.³

To ensure care continuity and quality, it is up to the Nursing professionals, in accordance with Resolution 429/2012 of the Federal Nursing Council (*Conselho Federal de Enfermagem*, COFEN), to record in the patient's medical charts and in other documents of the area the information inherent to the care process and to the management of the work process.¹

Regarding the care process, the records made by the Nursing team are part of a systematized process that generates care, called the Nursing Process (NP), regulated by Resolution COFEN 358/2009. The NP emerged as a form of care consolidation, as a method of applying a Nursing theory, favoring the organization of care and the practice based on the scientific method.⁴

The said resolution deals with the NAS (Nursing Assistance Systemization) and with the implementation of the NP in public or private environments, and establishes the obligation of the NAS in health facilities, since it systematizes assistance and organizes professional work through protocols, instruments and personnel, operationalizing the NP and conferring autonomy and legal backing for the professional.^{4,5}

In addition to the aforementioned resolutions, COFEN 429/2012 and COFEN 358/2009, reference should be made to Resolution COFEN 564/2017, which provides for the code of ethics of the Nursing professionals and establishes that it is

the responsibility of these professionals to record information, inherent and indispensable to the care process in the patient's medical record. These laws also require that such information be clear, objective, chronological, legible, complete and without erasures, ensuring continuity and quality of care.^{1,4,6}

One of the records that support the NP is the Nursing notation, as it provides data for the establishment of the Nursing prescription and support for a reflexive analysis of the care provided.^{3,4} It is also worth mentioning the fundamental character that this register has for the development of the NAS of a health institution.⁴

Thus, assuming that the nurse is the care manager in the Nursing team, he becomes the central pillar to register the management of the work process and responsible for his team to develop Nursing records through his awareness as for its importance for the NAS and the NP.^{5,7}

Therefore, it is important to know the nurse's perception on the possible challenges faced for registering the work management and the care provided in the professional daily life since, without their opinion, it is not possible to establish difficult points and correct them.

Given the above, this study aims to understand the perception of nurses on the relevance of the Nursing records in providing customer care.

METHOD

This is a descriptive and exploratory study of a qualitative nature, developed in a public emergency hospital located in the Northern region of the state of *Espírito Santo*. The above referenced hospital has 197 hospitalization beds divided between open and closed units.

To define the study participants, the following criteria were considered: professional statutory and employment-bond nurses, with at least one year of professional experience – in view of the need for such experience to identify difficulties and challenges in practice – and who would agree to participate in the research after being informed of its purpose and method.

Sample closure was achieved by saturation. This method is based on the interruption of data collection when it is found that new elements to support the research saturate it, analyzed by empirical method.⁸ Thus, based on this assumption, data saturation was observed after the fifth interview. However, the collection continued to prove this inference, thus totaling a sample of seven nurses.

Data collection took place from January to March 2018, through semi-structured interviews, using a semi-structured script with guiding questions that included the perception of the professionals on the Nursing records, their knowledge and the encountered difficulties.

The interviews were individual and were conducted during the workday in private settings chosen by the participants. The right to confidentiality, anonymity and withdrawal from participation in the study was guaranteed at any time. For this, signature was requested in the Free and Informed Consent Form (FICF) in two ways. A voice recorder was used to record the audios and their transcription in full, respecting the speech of each participant. The nurses were identified with the acronym "Enf" (*Enfermeiro* in Portuguese) and with a number assigned at the time of the interview.

The analysis method chosen was the content analysis proposed by Bardin, in the so-called categorical thematic content analysis. This method corresponds to a set of communication analysis techniques that use systematic and objective procedures to describe the message content.⁹

After data treatment and analysis, they were unveiled so that they became significant to the nurses' perception on the relevance of the Nursing records. In this sense, the results and discussion were organized into empirical analytical categories, i.e., categories that emerged from the data and not defined *a priori*, in order to facilitate the analysis and observance of the nuances of the object under study, namely: definition and relevance of the Nursing records, difficulties encountered in the realization of the Nursing records and improvement of the quality of the Nursing records in daily work.

The study was conducted after the approval of the Research Ethics Committee of the Northern University Center of *Espírito Santo* (*Centro Universitário Norte do Espírito Santo*), *Universidade Federal do Espírito Santo*, under Opinion No. 2,364,497, dated November 3rd, 2017, and the data were analyzed and discussed based on the relevant literature.

RESULTS

To capture the biographical data of the respective study participants, questions were used that allowed the profile of the nurses to be characterized.

As regards, they are predominantly female, five (71.4%) being women and two (28.58%) men, with a mean age of 35.8 years old. Regarding marital status, four (57.15%) participants were married and three (42.85%) were single; three (42.85%) had eight to ten years from graduation and four (57.15%), from 11 to 23 years. There was a variation of two and a half to 17 years in terms of working time in the hospital area, four (57.15%) working up to eight years and three (42.85%), over 10 years. It should be noted that the time worked in the hospital followed the time worked in the area.

Regarding the unit of operation, the nurses revealed no defined sector, due to the high turnover of professionals. At the time of the study, one nurse worked in the medical clinic,

another in the emergency room, two in the surgical clinic (at different scales), another two in the intensive care unit (ICU) at different scales and one worked in three different locations (dividing their time among them): orthopedic clinic, emergency room and ICU. All the participants reported having at least one postgraduate degree when asked on their background.

Continuing the study, the meanings that the nurses attributed to the relevance of the Nursing records were classified into the following categories.

CATEGORY 1. DEFINITION AND RELEVANCE OF THE NURSING RECORDS

NAS and NP are care processes that must be performed systematically and deliberately; however, for this to occur, it is necessary to get the understanding of the Nursing team on these. When there is no such understanding, they will not define what records they should make, even if they know the stages of the NP which, consequently, also brings about the relevance of these records.

In this sense, the participants were asked on what they mean by records and what their implication is in their care processes.

[...] it encompasses both the detailed assessment of the patient's condition, state, physical description. Anamnesis, physical examination, all that context, beyond the description of this condition, the description of all [patient's] behavior throughout the shift, all the complications, all the situations that involve care during the shift (Enf. 1).

[...] there is the part of the technicians and mine, everything comes in, we have a little model so far. They are the vital signs, temperature, BP, respiratory rate, blood glucose, so that the high complexity dressings fall on the nurse. As for the annotations, they don't have a specific field, so, for me, Nursing records are this, I record what I do, which is up to me and follow the Nursing technician's record in this case (Enf. 2).

[...] you write down everything related to the patient, the team, everything you do you have to register (Enf. 3).

In defining the records, the participants showed a superficial and mistaken knowledge on the subject. It can be noted that there was no differentiation between NAS and NP. It is also noted that there are mentions of process stages as history and evolution of Nursing only. The participants did not mention any NP stages such as diagnosis, planning (Nursing prescription) and implementation, and there was no mention

of the NAS as a tool for managing the work process. It is also observed that most of the participants define records as notes of Nursing procedures.

Regarding the perception of Enf. 2, when describing the Nursing records as procedural notes, it is known that they are not just simple notes, but essential elements for the care process.

Regarding the perception of nurses as for the importance and purpose of the records, the following should be noted:

Totally important, [...] because, when one talks about continuity in Nursing, if there are no records of all evolutions, everything that happens to the patient, there is no way for knowing what happened, and on the next day to know how to act, how to intervene (Enf. 1).

[...] this serves both in the legal form, so that the institution follows the patient's clinical condition, the improvement, so these records are fundamental (Enf. 6).

Nursing support. You recorded, wrote, this is a way of reaffirming to the colleague that this was really passed on to her (Enf. 5).

It is noted that the main purposes cited by the participants are: Nursing care evidence, patient follow-up, evaluation of care provided, legal support and continuity of care through information sharing.

In addition to the nurses understanding the importance and purpose of the records, when argued on their relevance to the Nursing team, they reported the following:

The team is aware of the importance of these records (Enf. 1).

You know? The institution cares a lot about this, but we don't have the support. They [Nursing team] take notes, once, twice or three times, but the really due, we charge, but it's fictitious (Enf. 6).

Although the nurses and the team claim to understand the importance of the records, Enf. 6 reveals that, in the practice, there are obstacles to their execution and, when executed, the process of registering occurs superficially.

When accused, the participants agreed with the following statement: "little documentation suggests bad practice in Nursing", they asserted:

Yes! With certainty! When you have little registration you lose the legal backing (Enf. 1).

[...] we do much more than we write down, but precisely because of the lack of time, we end up overloaded and you end up writing little, because it is more urgent for you to assist the patient than to write (Enf. 5).

[...] you will not stop assisting in order to record what you are doing. Sometimes you can reconcile one thing with another, but between registering and executing you will always choose to execute, but you will come back and forth, because if you do not register it is as if you had not, but at the time of emergency you will always choose to perform (Enf. 7).

In short, by observing the definitions and purposes given by the participants regarding the records, it is noted that Nursing has certain knowledge and discusses their importance.

CATEGORY 2. DIFFICULTIES ENCOUNTERED IN THE REALIZATION OF THE NURSING RECORDS

Despite showing certain knowledge on the Nursing records, when asked on the realization of these records, they recognize that they do not develop them properly. As you can see below, according to their speeches.

No! We do much more than register, unfortunately! (Enf. 2).

No! Either you provide care or you make the records, at the end, you can't do anything in the whole way as you wanted it, you end up doing it all fractionally (Enf. 7).

Not either! Three Nursing technicians to assist more than 30 patients, that is 11 or 12 [patients] for each [technician], so it's a little unfeasible to do all the records (Enf. 6).

The reasons for not completing all the Nursing records were justified by the professionals:

No time. Number of employees, number of patients, and time to complete these evolutions (Enf. 1).

Lack of professionals, lack of instruments. However, the materials eventually enter the hospital as permanent material, and it is not so (Enf. 2).

Among the difficulties described for executing the Nursing records, the participating professionals concisely expose the same problems, even in different sectors. They stated that

professional overload is one of the main impediments to the implementation of systematized Nursing records, as follows:

Insufficient number of nurses and even technical professionals, that ends up overloading the whole team (Enf. 5).

[...] the space is bad, many patients overlapping, we end up having no way to circulate. We don't have enough material or staff (Enf. 7).

The epitome of the speeches reveals that the management of the work process directly impacts on the Nursing records, due to work overload.

CATEGORY 3. IMPROVING THE QUALITY OF THE NURSING RECORDS IN DAILY WORK

In order to have resoluteness, it is necessary to know where the root of the problem lies, and then be able to correct it. Since nurses deal daily with the difficulties of registering the care provided, it is understood that they can propose solutions to these barriers.

First, the nurse needs to be freed from some bureaucratic assignments that we have to do. We have many bureaucratic duties that could be delegated to other people or another nurse, so you would have free time to do what is really important, which is the oversight of records and the most careful attention to the patient (Enf. 1).

There would be a need for more professionals, because there are a lot of patients, many critical patients for one professional, I can't get out on time, it's a lot to do (Enf. 2).

It would be needed to have more skilled labor. Decreasing the number of patients for each nurse, so maybe we could record everything (Enf. 3).

In the speech of Enf. 1, it is noted that, in order to achieve quality Nursing records, it is necessary that the nurse's role be established in the institution, so that there is no deviation in their work process and that the private activities inherent to the profession are prioritized.

In addition to the overlapping of roles inherent in the Nursing work process, Nursing dimensioning falls short of what is necessary, as described in the statements of Enf. 2 and Enf. 3.

Still regarding insufficient human resources, the nurses stated what is essential for improving the records and for the adequacy of the Nursing area sizing:

Manpower. More skilled workers. Because today, if you had manpower, you would have how to charge and you would charge backed up. For COFEN this is not the demand, we know what is the quantity, everyone knows! (Enf. 6).

[...] if we had adequate number of professionals, adequate physical space, sufficient input, we would be able to (Enf. 7).

DISCUSSION

PROFILE AND CHARACTERIZATION OF THE NURSES

Although turnover is defined as the entry and exit of people from a given organization, in this study it emerges as the internal movement of professionals in an institution, given that the nurses cross all sectors, impairing better professional qualification.¹⁰

In this sense, this turnover, when it occurs without desire on the part of the worker, can cause demotivation, as well as training costs and new adaptation to the work process.^{10,11}

The fact that all the participants claim to have at least one postgraduate degree corroborates a current study that states that about 80% of the Brazilian Nursing staff have completed or attended a postgraduate degree, which demonstrates their interest in expanding their scientific knowledge.¹²

CATEGORY 1. DEFINITION AND RELEVANCE OF THE NURSING RECORDS

The results showed a superficial and divergent knowledge regarding the concept of NAS, NP and Nursing records, despite certain knowledge of their purposes and attribution of relevance and importance.

According to Federal Nursing Council (*Conselho Federal de Enfermagem – COFEN*) Resolution 429/2012, it is responsibility and duty of the Nursing professionals to record, in the patient's medical records and in other documents related to the area, the information inherent to the care process and the management of the work processes.¹

Concerning the management of the work process, the essential information on the environmental conditions and human and material resources must be recorded, aiming at the production of an expected result: a decent, sensitive, competent and resolute Nursing care.^{1,3}

The nurses' deep understanding on NAS and NP as care processes has direct consequences as to the relevance of these records to them. However, the articles found regarding the perception of nurses on NAS and PE are scarce, divergent and mostly with more than five years of publication.^{7,13}

In the NAS and NP legal scope, Resolution COFEN 358/2009 governs in its article 1 that NAS and NP are conducts that must be carried out systematically and deliberately in all settings, public or private, where the professional Nursing care takes place.⁴

Corroborating the findings of this study regarding the superficiality of the NAS and NP concepts in all their phases and the mistaken understanding of Nursing registration as a synonym for Nursing annotation, a study that investigated the importance attributed by nurses to the NP verified ignorance on some stages of the process, considering them independent stages, and most did not fully apply the process.¹⁴

In another study that reiterates these findings, the Nursing professionals demonstrated a lack of knowledge on the NP, as well as its records, not using them in their professional practice or using them incompletely and incorrectly.¹⁵

The COFEN states that the purpose of the Nursing records is to be one of the ways for written communication used by the Nursing team in the development of their actions. When well elaborated, they allow individualized care, reflecting the quality of the care provided. It is also a legal document for the health care team, the client and the institution and is legal backing and defense. Through it the provided care is proved.⁶

In short, the purposes of the Nursing records are the following: information sharing, continued reporting, legal evidence, teaching, research and auditing. In this sense, it is observed that the participating nurses understand the importance and purposes of the Nursing records.¹⁶

The COFEN points out that these records are the most important tool for evaluating the quality of care developed by Nursing, as well as enabling communication between the multidisciplinary team and serving for legal support, statistical purposes, teaching, research and others.¹⁶ Corroborating this finding, another study reveals that the Nursing records are somewhat systematized and categorized.²

In this research, it was found that the professionals provide more care than what they register. Another study that converges with this result found that the evaluated records were superficial and did not reflect the professionals' performance.²

CATEGORY 2. DIFFICULTIES ENCOUNTERED IN THE REALIZATION OF THE NURSING RECORDS

The results showed that, despite understanding the importance of the Nursing records, in the practice, Nursing does not implement them or does it incompletely and partially.

This result is a reflection of the culture rooted in the Nursing work process, which is concerned with doing, to the detriment of the systematic records on its assistance. However, it is known that the Nursing records are the way to demonstrate

the work done, reflecting the efficiency and effectiveness of care offered to the patient. The inadequacy or insufficiency of these records may compromise care.^{15,17}

In line with this study, it was found in a research that nurses use the Nursing records incompletely and incorrectly in their professional practice.¹⁵ Still in this context, another author suggests that patient safety may be compromised when there is no patient care documentation in their medical chart.¹⁷

Nursing dimensioning and professional overload were the reasons for the non-realization or partial realization of the records and appear as preponderant factors in the execution barrier.

In this sense, it is understood that proper dimensioning favors a Nursing process in which nurses privilege activities that are private to their profession and contribute to a less bureaucracy of records. Another major difficulty encountered in the realization of the Nursing records is work overload, as an overloaded professional is unable to provide quality care and manage his work.¹⁸

One of the ways to break professional overload is through the correct dimensioning of Nursing. It is understood that staff dimensioning is a systematic process that underlies the planning and assessment of the number of professionals, with a view to providing assistance that ensures the safety of users and workers, proving to be fundamental to the quality of any service.¹⁹

In addition to work overload, other authors describe the difficulty in applying Nursing, NP and NAS records, namely: deficiency in academic background, the professional does not deem it essential and improper printouts.²⁰

Several factors may influence the quality of the Nursing records, among which the following stand out: excess of patients under their responsibility, administrative and managerial overloads, inclusion of forms and instruments without proper staff training, ignorance of the ethical and legal implications of lack of records, lack of adequate infrastructure and well-trained and led teams.²¹

CATEGORY 3. IMPROVING THE QUALITY OF THE NURSING RECORDS IN DAILY WORK

The results indicate that, for the effective and systematic realization of the Nursing records, it is necessary to have a clearly delineated work process of nurses, detailing the private role of the professional, in order to avoid function overlap and deviations.

In this sense, it is important to highlight that the work process of nurses is different from other health workers, due to the uniqueness of the place that nurses occupy in health work, by overlapping roles in coordinating the work process in Nursing and directing the health work process, besides performing care activities. This overlapping of activity and a historically broad role has led to a denial of managerial and bureaucratic work at the expense of care, with valuing the care actions and technical procedures.²² This professional context

has impacts on the quality of the Nursing records, since care overlaps with administrative activities.

It was demonstrated in the statements that the whole team recognizes that the lack of professionals is the greatest difficulty encountered. In this sense, once again it is inferred that the inadequacy of the Nursing staff dimensioning causes the inadequate survey for the patient needs, in addition to developing a lower care standard and, consequently, lower quality of records for the work performed.²³

FINAL CONSIDERATIONS

This study reiterates that nurses have a superficial knowledge on the differences between NP and NAS. Although they value the Nursing records and recognize their purposes, in the practice, the records remain little used in the care routine, which can compromise quality of care and patient safety.

The Federal and Regional Councils of Nursing have published booklets and manuals on Nursing records. However, it is necessary to stretch the health services for constant training and qualification, apart from investing in working conditions that enable the realization of the Nursing records.

The already-mentioned challenges cited by the nurses in recording the care provided in a systematic manner, the lack of time, scarce human resources and the absence of adequate forms are identified. It is known that these difficulties may come to contribute to the non-applicability of the Nursing records in the health institutions.

In this sense, reorganizing the work process of the nurse and the adequacy of Nursing dimensioning are indispensable, so that Nursing records are established in the professional's daily life because, without the adequate number of professionals, it is not possible to maintain the quality of the Nursing records.

In order for Nursing dimensioning to be adequate in the institutions, there is a need for inspections and surveys regarding the number of professionals, in order to promote patient safety and decent working conditions for the Nursing professionals.

Finally, it is understood that the Nursing records contribute to improving the quality of care and to legitimize Nursing work. Therefore, there is a need for a more rigorous monitoring of the records made in daily health practices, with constant audits.

In this sense, the importance is highlighted of investing in contents that concern Nursing records in a powerful way in the training courses, focusing on the technical, ethical and legal aspects of Nursing records.

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