Nursing notes and quality of care: experiences of the Nursing care team in the hospital context

Anotações de Enfermagem e qualidade da assistência: vivências da equipe assistencial de Enfermagem no contexto hospitalar

ABSTRACT

Objective: to analyze the experiences of the nursing care team in the hospital context regarding the nursing notes taken in the patient's medical records, with a focus on the quality of care. Method: a qualitative, inductive study with 17 nursing professionals using the snowball sampling technique. Data was collected through semi-structured interviews. The theoretical-methodological framework used was hermeneutic-dialectics. Thematic Analysis was used to organize and analyze the data. Results: the evidence of the nursing professionals' experiences were consolidated into a thematic map made up of the following themes: Nursing notes in patient records: interface with the quality of care; Legal backing for nursing notes; Computerization of notes: limits and possibilities; Work overload reflects on the quality of notes. Final considerations: based on the experiences of nursing professionals, the relationship between nursing notes and quality of care was identified. Although few participants expressed in-depth theoretical knowledge of nursing notes and current legislation on the subject, there is a general understanding of the relationship between notes and the continuity and quality of care; however, work overload and computerization without professional training can be barriers to drawing up adequate notes.

Descriptors: Nursing Records; Quality of Health Care; Nursing Team; Hospital; Qualitative Research.

RESUMO

Objetivo: analisar as vivências da equipe assistencial de Enfermagem no contexto hospitalar sobre as anotações de Enfermagem realizadas no prontuário do paciente, com foco na qualidade da assistência. Método: estudo qualitativo, indutivo, com 17 profissionais de Enfermagem usando a técnica de amostragem snowball. A coleta de dados foi realizada por meio de entrevista semiestruturada. Utilizou-se como referencial teórico-metodológico a hermenêutica-dialética. Para a organização e análise dos dados, procedeu-se a Análise Temática. Resultados: as evidências das vivências dos profissionais de Enfermagem foram consolidadas em um mapa temático composto pelos temas: Anotações de Enfermagem no prontuário do paciente: interface com a qualidade da assistência; Legal backing for nursing notes; Computerization of notes: limits and possibilities; Sobrecarga de trabalho reflete na qualidade das anotações. Considerações finais: identificou-se, a partir das vivências dos profissionais de Enfermagem a relação entre as anotações de Enfermagem e a qualidade da assistência. Embora poucos participantes tenham expressado os conhecimentos teóricos profundos sobre as anotações de Enfermagem e a legislação vigente sobre o tema, há um entendimento geral da relação das anotações com a continuidade e a qualidade da assistência, no entanto, a sobrecarga de trabalho e a informatização sem a capacitação dos profissionais podem constituir em barreiras para a elaboração das anotações adequadas. Descriptores: Registros de Enfermagem; Qualidade da Assistência à Saúde; Equipe de Enfermagem; Hospital; Pesquisa Qualitativa.

HOW TO CITE THIS ARTICLE:

INTRODUCTION

Nursing records deal with all the information relating to the physical, psychological, social, and spiritual aspects of the patient, as well as the multidisciplinary care provided by the team. The ethical and legal aspects of these records can be found in the provisions that regulate the profession, in particular, the Nursing Professional Practice Act and the new Code of Ethics, which states that it is a duty to record information relevant to the care process.

The quality of nursing professionals' records reflects the quality of care, since care can be verified through the records and, consequently, the record reflects the care provided. Despite this, weaknesses in medical records and flaws in the notes are often observed, including incomplete, incorrect, ambiguous records and the absence of technical terms, making nursing care difficult.

It should be emphasized that nursing records provide patient safety since they explain the elements of care and contribute to its continuity; likewise, they can indicate the occurrence of negligence or lack of care on the part of the team. In view of the above, quality notes can reduce damage and complications in the care process, as well as support the activities of professionals from an ethical and legal point of view.

Several factors have been identified as contributing to shortcomings in nursing notes in patient records, such as lack of time, work overload, and lack of understanding of their importance.

In view of the above, the guiding question of this study was: What are the experiences of the nursing care team in the hospital context regarding the nursing notes taken in the patient's medical records, with a focus on the quality of care? It is understood that one of the ways to overcome the problems related to nursing records necessarily involves listening to all the actors involved, especially those who experience care on the front line as key elements.

Thus, knowing these experiences can contribute to professional training and awareness and to the development of strategies for improving nursing care in the context of the study. In addition, there are several reports in the literature of flaws in nursing notes in medical records; however, in-depth reports on this subject from the point of view of the care team are not common.
OBJECTIVE

To analyze the experiences of the nursing care team in the hospital context regarding the nursing notes made in the patient's medical records, with a focus on the quality of care.

METHOD

This is a qualitative, inductive study, using hermeneutics-dialectics as its theoretical-methodological framework. Hermeneutics proposes clarifying the way different people think and act, pointing out the reason and responsibility present in the languages that permeate communication, reporting facts, making judgments, and conveying their position on them, while dialectics studies dialogue, questions, and differences of opinion, contextualizing them.10

The participants were nursing technicians and nurses working in a hospital environment, aged 18 or over, with at least three months of experience in a hospital environment and working in care units. Professionals with less than three months' experience, coordinators, auditors, and professionals working in administrative sectors were excluded.

It should be noted that the minimum experience of three months was adopted in analogy to the Consolidation of Labor Laws (CLL), and because this was considered an adequate minimum period to allow nurses to experience the object of the study, regardless of the type of institution in which the participants worked.11

The interviews lasted two months and were carried out with 17 professionals, using the snowball sampling technique. A semi-structured interview script drawn up by the researchers was used for data collection, consisting of a questionnaire on personal and professional characteristics and the question "Tell us about your experience / your daily life in relation to nursing notes in the patient's medical record, with a focus on the quality of care".

The interviews were conducted using Google Meet and lasted an average of nine minutes. The statements were transcribed in full by automatic transcription using Microsoft® Word's "DICTATE" feature, simultaneously with the scrolling of the interview video, and reviewed by repeating fragments of the video from the beginning to the end of the interview. The interlocutors were identified with an N (Nurse) and NT (Nursing Technician), followed by an Arabic number from 1 to 17, guaranteeing the anonymity of the participants.
Thematic Analysis (TA) was used to organize and analyze the data, a method that aims to identify, analyze, and report patterns of meaning \(^{(12-13)}\). There were six phases: 1) familiarization with the data, through repeated reading of the interviews to immerse the researchers in the data collected; 2) identification of initial codes; 3) organization of similar initial codes into themes and sub-themes; 4) review of the themes, checking their coherence and consistency; 5) definition and naming of the themes; 6) preparation of the research report.\(^{12}\)

This work followed the guidelines of the Consolidated Criteria for Reporting Qualitative Research translated into Portuguese.\(^{14}\) The study complied with the ethical precepts of research involving human beings.\(^{15}\) It was approved by the Research Ethics Committee (REC), opinion no. 5.291.716 and CAAE 55506922.0.0000.5142.

**RESULTS**

Seventeen nursing professionals were interviewed. In terms of personal and professional characterization, 58.8% were nurses and 41.2% were nursing technicians. There was a predominance of female participants (64.7%), married or in a stable union (70.6%), aged between 30 and 40 years old (58.8%), working in the Emergency Room or Urgent Care sectors (41.1%), in private institutions (76.5%), with up to 10 years of professional experience (58.8%) and in the current sector (76.5%), concentrated in the municipality of Itajubá (MG) (76.5%).

Chart 1 summarizes the personal and professional characteristics of the participants.

**Chart 1.** Characterization of the sample according to variables. Itajubá (MG), 2022.

<table>
<thead>
<tr>
<th>Variables</th>
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<th>Variables</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>35.3%</td>
<td>Nursing Technician</td>
<td>7</td>
<td>41.2%</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>64.7%</td>
<td>Nurse</td>
<td>10</td>
<td>58.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>100%</td>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age group</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Over 20 to 30 years old</td>
<td>3</td>
<td>17.6%</td>
<td>Single</td>
<td>4</td>
<td>23.5%</td>
</tr>
<tr>
<td>Over 30 to 40 years old</td>
<td>10</td>
<td>58.8%</td>
<td>Married / Stable union</td>
<td>12</td>
<td>70.6%</td>
</tr>
<tr>
<td>Over 40 to 50 years old</td>
<td>4</td>
<td>23.5%</td>
<td>Divorced</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>100%</td>
<td></td>
<td>1</td>
<td>5.9%</td>
</tr>
<tr>
<td>Length of time in the career</td>
<td></td>
<td></td>
<td><strong>Sector of operation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 10 years</td>
<td>10</td>
<td>58.8%</td>
<td>Surgical Clinic</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>Over 10 to 20 years</td>
<td>6</td>
<td>35.3%</td>
<td>Hemodynamics</td>
<td>1</td>
<td>5.9%</td>
</tr>
<tr>
<td>Over 20 years</td>
<td>1</td>
<td>5.9%</td>
<td>Oncology</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>100%</td>
<td>Emergency Room</td>
<td>7</td>
<td>41.1%</td>
</tr>
<tr>
<td>Length of time working in the sector</td>
<td></td>
<td></td>
<td>Inpatient Unit</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>Up to 10 years</td>
<td>13</td>
<td>76.5%</td>
<td>ICU/Newborn ICU</td>
<td>3</td>
<td>17.6%</td>
</tr>
<tr>
<td>Over 10 years</td>
<td>4</td>
<td>23.5%</td>
<td><strong>Total</strong></td>
<td>17</td>
<td>100%</td>
</tr>
</tbody>
</table>
The TA allowed the central theme to be defined: "Experiences of nursing professionals in relation to notes in patient records", which brings together four secondary themes, and sub-themes where relevant. These were organized into a thematic map, shown in figure 1.

Figure 1. Thematic map. Source: Prepared by the authors (2023).

It was found that nursing notes in patient records can have different interfaces with the quality of care.

Theme 1 - Nursing notes in patient records: interface with quality of care

Protocols for nursing notes: checklist

The nurses discussed the importance of using protocols and checklists to keep nursing notes in the hospital.
so as not to give divergent information [...] we’re working on protocols (checklists) to make note-taking more efficient and with better quality. You can't work without a protocol, because everyone will want to do it one way." (N3)

Those who work in public institutions reported that the notes are still handwritten, while in private institutions electronic medical records have already been adopted in the form of a checklist, focusing on the pathology.

[...] in the (public) institution, we still didn't do the complete Systematization of Nursing Care, but the notes were always there, [...] it was almost a note of the evolution of the condition of that pathology that he was presenting. (N7)

[...] at the (private) institution [...] we have an electronic medical record in which we no longer make (describe) nursing notes. It's all tied up in the patient's chart, according to the type of pathology [...] our note-taking is a checklist [...]. (N7)

Unreliable notes and the impact on quality of care

It is also common for technicians to point out unreliable notes that lead to discrepancies in the shift report.

In the duty roster it says that the patient has a device (SVD) [...] and I see that they don't [...] . It’s important to know if the patient has had spontaneous urination or not, and what time the tube was removed. (NT6)

The lack of notes is worrying because it impacts the quality of care and can represent a risk to the patient and the team itself.

 [...] the patient arrives, [...] if their heart rate isn't written down when they notice it's between 190 and 200, then the first question that comes to the team is: how high was the rate when the patient arrived? [...] they have to write it down. (N9)

If everything isn't written down properly, the information is lost [...] it can harm the patient [...] if it isn’t written down, care hasn’t been taken [...] we can’t have notes that create doubts. (N10)
Nursing notes: continuity of care

The nurses highlighted the importance of notes for the continuity of care and their relationship with quality and noted that there are good and bad notes when providing continuity of care.

"I've noticed both sides: very good notes, where you can understand everything that was done to care for the patient and what you need to do [...] when the notes aren't taken correctly [...] we can't provide quality continuity of care [...] you're not with the patient all the time [...] when you take over a shift [...] you need to know everything that was done, all the care [...]." (N1)

"The emergency room [...] is a very busy environment, we don't have much time to make a note as it should be, a complete note [...] through the note we [...] can get an idea of the care given to the patient, how the nursing team is working. It helps other professionals to improve the patient's diagnosis [...]." (N2)

One nurse commented on the incompleteness of the notes and their impact on the continuity of care, saying that "depending on what you fail to report, you won't be able to observe any changes in the patient". (N7)

Poor nursing notes

The superficiality of the notes was also reported by the participants and led to a lack of understanding of the care provided to the patient. In the nurse's view, the nursing technician may not fully understand the importance of the notes, even though he or she has provided the care, not clearly demonstrating the assistance.

"I've seen incomplete notes, notes that you can't understand [...] what was provided to that patient [...] notes that we can't give quality continuity to the patient's care [...]." (N1)

"you can see that the notes are still very vague, that the technicians still have a lot of difficulty making these notes [...] they are very succinct, they do the basics and don't understand the importance of a nursing note [...]." (N2)
Some staff have very flawed nursing notes, lacking in various aspects of the care they provide to the patient. Sometimes the care is provided, but the nursing notes don’t show that the care was provided. (N3)

**Theme 2: Legal backing for nursing notes**

The importance of nursing notes in the patient's medical records is understood in the sense of continuity of care and legal support in the present and future, in legal matters, or even in internal investigations, as written documentary evidence.

 [...] if you make a well-done, well-detailed note, and if something happens in the future, you’ll have backing. The note backs up everything that happens inside the unit with the patient [...] speaking verbally doesn’t prove that you carried out a certain activity if it’s not written down in the nursing note. (N3)

 [...] often the lack of a note even leads to an investigation [...] you may have provided brilliant care, 100% care, but if it's not written down, it doesn't guarantee that you did it. (N4)

 [...] Nursing notes [...] are important for both sides [...] everything has to be in the medical record [...] it’s a document [...] it helps with the legal side [...] the patient, the family member, has the right to a copy of the medical record. (NT2)

**Theme 3: Computerization of nursing notes: limits and possibilities**

Some institutions have adopted electronic medical records for the nursing team's notes. This practice has encountered some barriers in terms of training professionals, but on the other hand, when protocols and standard forms have been used, they have helped professionals with their notes.

**Electronic medical records as a hindrance to nursing notes**

It was reported that older professionals found it more difficult to use the computer to take notes, and that handling electronic medical records is a time-consuming process.

 [...] older staff find it very difficult to write on the computer [...] they try to put in as many things as they can, but nursing notes are leaner [...] they are in the process of adapting to the electronic medical record, even though it's been two years since they implemented the system [...] there are still a lot of people who have difficulties with the electronic medical record. (N4)
To overcome the difficulty, standardized notes were suggested as a reference, but even standardization can be complex to use.

 [...] on the computer desktop there is already a semi-ready annotation [...] to copy and paste into the annotation and edit according to what the patient is presenting [...] they still have difficulty copying this file and pasting it into the Nursing annotation. (N4)

 [...] marking a "check" yes or no, so it’s practical [...] but the system is complex and there’s a difficulty because there’s a lot of information. (N9)

Electronic medical records as a facilitator for nursing notes

It was identified that when the professional has experience with the computer, the notes are better, more reliable, and help in the management of nursing processes.

 [...] a younger collaborator has more experience with the computer, her notes are already excellent [...] everything is complete. She doesn’t make many mistakes in Portuguese. (N4)

 [...] the electronic record has evolved a lot [...] it’s more reliable, they’re being more objective, much more precise and this helps with care and management [...] it can be said that much more is recorded in relation to the patient’s evolution, a clinical process than was recorded before. (N8)

Theme 4: Work overload and the impact on the quality of notes

The high demand for health services without a balance in the number of professionals in the nursing team was reported as a factor that was reflected in the nursing notes.

 [...] either because of the time and the size of the team [...] technicians don’t take on one or two patients on duty, but five or six patients, [...] try to cut down a little on patient care notes. (N4)

 [...] in the Emergency Room, the great difficulty [...] is that we don’t have time to take notes properly [...] they try to provide care in the best possible way. But the notes are superficial [...] if they were to write them down [...] as they should, they wouldn’t be able to cope with the number of patients they take on [...]. (N6)
The big problem [...] with note-taking is that it takes up time [...], especially in the UHS, which has an excessive number of patients [...] you spend time making notes and you can't provide care for the patient [...] you have five to seven patients and you're alone [...]. How are you going to stop to take notes? (NT3)

**DISCUSSION**

The majority of the study participants were female, aged between 30 and 40 years old, and with up to 10 years of professional experience, which is in line with the data from the Profile of Nursing in Brazil survey. They work mainly in private institutions and in the emergency care sector, which may be related to the snowball sampling technique, which used the chain of references based on the participants' own contacts.

It emerged that the nursing notes in the patient's medical records, with a focus on the quality of care, are related to the protocols for nursing notes with regard to the checklist as a guideline for the continuity of care. On the other hand, unreliable and superficial notes have a negative impact on quality.

A survey carried out on the Systematization of Nursing Care (SNC) and the Nursing Process (NP) shows that more than 80% of nursing professionals have an incipient knowledge of how to implement the stages of the NP. They point out that the use of electronic and printed checklists, in an attempt to make it easier, ends up mechanizing the process, making it superficial.

To corroborate this, one of the nurses interviewed mentions that the institution has started using electronic medical records and no longer makes conventional nursing notes, but uses a standard checklist based on the pathology.

It is understood that nursing notes permeate the entire EP; however, software with taxonomies that systematize care, presented in the form of a checklist, with reduced space for individualized complementation of the patient, can contribute to nurses passively following the fields of the computerized instrument, which can result in brief, incomplete and insufficient records.

There is also a misconception among nursing staff about the importance of records since they prioritize care over notes. In this sense, there are reports from nurses indicating that technicians find it difficult to take notes, seeing them as the fulfillment of an obligation that is dissociated from care, and the brief notes end up having an impact on the quality and continuity of care.

It is important to point out that an evaluation of nursing notes in a university hospital identified an improvement in the quality of the records, except in the Intensive Care Units.
(ICU), which was justified by the characteristics of the team, which is more concerned with observing the patient than with the notes, which are taken to fulfill an obligation. 

It should be added that flaws in nurses' records are also pointed out in the literature, identifying that nurses' notes were restricted to the procedures carried out and complications, with the recording of the physical examination being one of the weak points. 

It should be emphasized that written communication is part of the activities of nursing professionals. However, one study shows that unsystematic writing compromises the functionality and usefulness of the record as an instrument for promoting quality care.

It is consistent with the results of this study that the records kept by nursing technicians and nurses in the medical records reveal non-conformities and are far from meeting the recommendations of the Federal Nursing Council (COFEN).

It can therefore be seen that ensuring that records are kept and that the NP is fully implemented is a safe way of organizing nursing work, guaranteeing effective team communication through documentation, and promoting continuity and quality of care.

With regard to the legal backing of nursing notes, it was identified in the participants' statements that the lack or incompleteness can lead to the absence of a legal basis for defending the work done.

A study that evaluated the legal outcomes of errors in perioperative care explains the relevance of nursing notes by identifying that they contributed to the accountability and condemnation of professionals and/or health services.

In this sense, nurses and technicians corroborate the importance of the legal backing of the notes, emphasizing that detailed and precise notes provide support for possible questions in the future. One nursing technician reported that the notes "are important for both sides", referring to the professional and company side and the patient and family side.

According to the Code of Ethics for Nursing Professionals, recording activities is a practice inherent to nursing. Recording is both an obligation when the professional takes responsibility for their actions and a right when it generates evidence of their conduct.

Regarding the computerization of nursing notes, limits, and possibilities were mentioned by the participants. Although computerized systems facilitate the work of the team, paradoxically, they are also related to a deterioration in the quality of the notes, especially for professionals who are unfamiliar with the use of information technology.

It should be noted that computerized systems are mechanisms for collecting, processing, and analyzing information, capable of helping to reduce documentary nonconformities and increase the time available to professionals for clinical care and humanization. Thus, their implementation is still a major challenge, given that in the
The majority of health institutions in Brazil, the notes in medical records are manual. This reinforces the need for training strategies on how to use these systems so that they can become allies for professionals and their potential can be reflected in the quality and safety of care and, consequently, in improvements in records.29

Finally, the effects of work overload on nursing notes were also discussed by the participants. Faced with overload, the professionals reported that they prioritize care and write down what they can since note-taking "takes up time".

It is acknowledged that the completion or quality of records is influenced by factors such as high demand for services, work overload, insufficient number of professionals, and the culture of bureaucratic obligation to take notes.23 In this regard, COFEN Normative Opinion 1/2024 recommends parameters for sizing nursing teams, based on the characteristics of the health service, the nursing service, and the profile of the patients.30

It is considered that without an adequate number of staff, the quality and safety of care, as expressed by the nursing notes in the medical records, will be jeopardized. Thus, reflections on nursing notes with a focus on the quality of care must go beyond the working conditions of the teams and, specifically, the staffing levels.

Finally, dialectical hermeneutics allowed for a discussion between the experiences of the participating professionals and the literature, identifying that although few expressed more in-depth theoretical knowledge about nursing notes or even current legislation on the subject, there is a general understanding of the relationship between notes and the continuity and quality of care, and as legal support for the professional. However, the overload of work, the devaluation of the record in relation to the execution of care, and technological barriers indicate that there are challenges for nursing notes to comply with ethical and legal aspects, reflect care, guarantee safety and quality, and provide greater visibility for the profession.

The limitations of this study involve the sampling technique and the sample size. A greater diversity could have been achieved in a scenario with more time and sample, characterizing other care sectors, and is recommended for future work.

CONCLUSION

Based on the experiences of nursing professionals, this study found that few of the participants said they had in-depth theoretical knowledge of nursing notes or even of the current legislation on the subject.
There is a general understanding of the relationship between notes and the continuity and quality of care; however, work overload and computerization without adequate training for professionals can be barriers to drawing up adequate notes.

The research makes contributions to the theoretical and practical field, highlighting the importance of nursing notes and scientific knowledge for the benefit of patients, enabling quality and continuity of care while maintaining mutual legal support.

There is an urgent need for professional training as a way to improve the quality of care records in order to raise standards of quality and patient safety and the need to reinforce concepts about legislation, legal backing, scientific knowledge, and practical skills for nursing records.

There is also a need for institutions to provide adequate working conditions for staff so that they can provide quality patient care, and carry out medical records using systematized protocols, focused on the person and not the disease, including staff sizing.

CONTRIBUTIONS

Angiliani Nogueira Guardia: conception and planning of the study, collection, analysis and data interpretation; writing and/or critical review of the manuscript; Roberta Seron Sanches: conception and planning of the study, collection, analysis and interpretation of data; writing and/or critical review of the manuscript; Mirelle Inácio Soares: writing and/or review manuscript critique; Fábio de Souza Terra: writing and/or critical review of the manuscript; Zélia Marilda Rodrigues Resck: conception and planning of the study, collection, analysis and data interpretation; writing and/or critical review of the manuscript.

CONFLICTS OF INTERESTS

Nothing to declare.

REFERENCES


Correspondence:

Zélia Marilda Rodrigues Resck
E-mail: zelia.resk@unifal-mg.edu.br

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