REVIEW ARTICLE

REVISTA ENFERMAGEM ATUAL IN DERME

# *REGISTRATION OF CARE BY THE NURSING TEAM IN THE PATIENT'S ELECTRONIC MEDICAL RECORD: INTEGRATIVE REVIEW*

# *REGISTRO DE CUIDADOS POR PARTE DEL EQUIPO DE ENFERMERÍA EN LA HISTORIA CLÍNICA ELECTRÓNICA DEL PACIENTE: REVISIÓN INTEGRADORA*

# REGISTRO DA ASSISTÊNCIA PELA EQUIPE DE ENFERMAGEM NO PRONTUÁRIO ELETRÔNICO DO PACIENTE: REVISÃO INTEGRATIVA

**Bruna Stein do Lago Sales**[1]
**Kátia Elaine Aparecida Pereira** [2]
**Jhuliano Silva Ramos de Souza** [3]
**Roberta Garcia Gomes**[4]
**Roberta Seron Sanches**[5]
**Zélia Marilda Rodrigues Resck**[6]

[1]Orcid: https://orcid.org/0009-0006-3848-1673
[2]Orcid: https://orcid.org/0009-0001-9842-2302
[3]Orcid: https://orcid.org/0000-0002-4338-4433
[4]Orcid: https://orcid.org/0000-0002-0277-4371
[5]Orcid: https://orcid.org/0000-0001-7557-5560
[6]Orcid: https://orcid.org/0000-0002-3752-8381
[1,2,3,4,5,6] Universidade Federal de Alfenas, Alfenas, Minas Gerais, Brazil.

**Corresponding Author**
**Jhuliano Silva Ramos de Souza**
R. Gabriel Monteiro da Silva, 700 - Centro, Alfenas - MG, Brazil. CEP: 37130-001. E-mail: jhulianoramoz@hotmail.com Tel: +55(35)3701-9471.

**Submission:** 12-11-2024
**Approval:** 02-04-2025

**ABSTRACT**
**Objective**: Identify scientific evidence on current records and resources used by the nursing team in the patient's electronic medical record. **Methods**: This is an integrative literature review, based on the research question: what is the current status of nursing care records by the nursing team in the Electronic Patient Record? **Results**: Through the database search, 1253 studies were found, with seven articles ultimately being selected. It was possible to choose a category entitled "Nursing records of patient care: advantages and disadvantages in the electronic medical record approach", with two subcategories, the first "Advantages of electronic records as tools to systematize patient care and communication between professionals" and the second, "Disadvantages and challenges in the use of electronic patient records in the light of nursing team professionals". **Conclusion:** It is pointed out that nursing records in the patient's electronic medical record allow for systematization of care, less time for notes and thus more contact time between nursing team professionals and patients, bringing benefits. However, there are still difficulties and challenges regarding the use of the tool, which requires training of the nursing team to optimize the applicability of computerization for nursing records.
**Keywords:** Electronic Health Record; Electronic Patient Record; Nursing Record; Assistance Record; Nursing Team.

**RESUMEN**
**Objetivo**: Identificar evidencia científica sobre registros y recursos actuales utilizados por el equipo de enfermería en la historia clínica electrónica del paciente. **Métodos**: Se trata de una revisión integradora de la literatura, basada en la pregunta de investigación: ¿cuál es el estado actual de los registros de cuidados de enfermería por parte del equipo de enfermería en el Registro Electrónico del Paciente? **Resultados**: A través de la búsqueda en las bases de datos se identificaron 1.253 estudios, de los cuales se seleccionaron siete artículos para el análisis. A partir de esta selección se logró establecer una categoría denominada "Registro de Enfermería de la Atención al Paciente: Ventajas y Desventajas de la Historia Clínica Electrónica". Esta categoría se dividió en dos subcategorías: la primera, "Ventajas de la Historia Electrónica como Herramientas para Sistematizar la Atención al Paciente y la Comunicación entre Profesionales"; y el segundo, "Desventajas y desafíos en el uso de registros electrónicos de pacientes desde la perspectiva del equipo de enfermería". **Conclusión:** Se destaca que los registros de enfermería en la historia clínica electrónica del paciente permiten la sistematización de los cuidados, menor tiempo para notas y, por tanto, mayor tiempo de contacto entre los profesionales del equipo de enfermería y los pacientes, trayendo beneficios. Sin embargo, aún existen dificultades y desafíos en cuanto al uso de la herramienta, lo que requiere la capacitación del equipo de enfermería para optimizar la aplicabilidad de la informatización de los registros de enfermería.
**Palabras clave:** Historia clínica electrónica; Historial Electrónico del Paciente; Registro de Enfermería; Registro de Asistencia; Equipo de Enfermería.

**RESUMO**
**Objetivo:** Identificar as evidências científicas sobre os registros e recursos atuais utilizados pela equipe de enfermagem no prontuário eletrônico do paciente. **Métodos:** Trata-se de uma revisão integrativa da literatura, baseada na questão da pesquisa: qual a situação atual dos registros da assistência de enfermagem pela equipe de enfermagem no Prontuário Eletrônico do Paciente? **Resultados:** Por meio da busca na base de dados, foram identificados 1.253 estudos, dos quais sete artigos foram selecionados para análise. A partir dessa seleção, foi possível estabelecer uma categoria intitulada "Registro de Enfermagem da Assistência aos Pacientes: Vantagens e Desvantagens do Prontuário Eletrônico". Esta categoria foi dividida em duas subcategorias: a primeira, "Vantagens dos Registros Eletrônicos como Ferramentas para Sistematizar o Cuidado ao Paciente e a Comunicação entre Profissionais"; e a segunda, "Desvantagens e Desafios no Uso do Prontuário Eletrônico do Paciente sob a Perspectiva da Equipe de Enfermagem". **Conclusão:** Aponta-se que os registros de enfermagem no prontuário eletrônico do paciente permitem sistematizar o cuidado, menor tempo para as anotações e assim, maior tempo de contato dos profissionais da equipe de enfermagem com os pacientes, trazendo benefícios. No entanto, ainda há dificuldades e desafios presentes quanto ao uso da ferramenta, o que requer a capacitação da equipe de enfermagem para otimizar a aplicabilidade da informatização para os registros de enfermagem.
**Palavras-chave**: Registro Eletrônico de Saúde; Prontuário Eletrônico do Paciente; Registro de Enfermagem; Registro da Assistência; Equipe de Enfermagem.

REVISTA ENFERMAGEM ATUAL IN DERME

## INTRODUCTION

Nursing records are a vital form of written communication that contains crucial information about the patient and the care provided by the nursing team, assisting in the preparation of the care plan, providing support for the evaluation of care, monitoring the patient's progress, facilitating nursing audits and contributing to teaching and research in the area [1].

In 2012, the Federal Nursing Council (COFEN) established that it is the responsibility and duty of nursing team professionals to record, in the patient's medical records and other specific documents, information inherent to the care process and the management of work processes [2].

To this end, nursing notes are a means of communication between the teams that participate in the comprehensive treatment of patients, in addition to being important care and epidemiological indicators, thus used in statistics [1].

It is worth noting that electronic medical records assist in prevention, diagnosis, treatment, health recovery, and provide data for indicators. Furthermore, electronic records provide information and legal evidence to medical institutions and pharmaceutical companies [3].

Nursing produces a lot of information related to patient care on a daily basis, and it is estimated that it is responsible for more than 50% of the information contained in patient records. Therefore, there is an undeniable need for adequate and frequent records in the medical record [4].

In 2024, the Federal Nursing Council will align the computerized information system and standardize the use of electronic medical records and digital platforms in the nursing field, making it the responsibility and duty of nursing professionals to record, in the patient's medical record, the information related to the care process and the management of work processes, in order to allow continuity of care [5].

It is recommended that the medical records include data related to the patient identification protocol, such as full name and date of birth, medical history, treatment plan, reports of complementary exams, medical prescription and nursing progress, consent forms, reasons for transfer, discharge or death and various documents [6].

It is important to emphasize that the lack of information related to the care provided to patients and the absence of a standard in the descriptions of clinical conditions and patient progress hinder communication between multidisciplinary health teams and have a negative impact on the quality of care [1]. In addition, a properly completed medical record, in a technical and organized manner, can serve as a legal basis to refute allegations of malpractice, recklessness or negligence [7-8].

It confirms that this instrument can be used as a legal document to defend or incriminate professionals in various legal spheres, since, having performed the procedures safely and within technical, ethical and legal principles, the nursing professional is protected in cases of doubts or future questions [9].

REVISTA ENFERMAGEM ATUAL IN DERME

From this perspective, it evolved into a computerized information system that provides all members of the nursing team with the data necessary for the development of care, as well as optimizing the communication process between the members of the multidisciplinary team and the client [10].

In this context, the objective of this work is to identify scientific evidence on the current records and resources used by the nursing team in the patient's electronic medical record.

## METHODS

This is an integrative literature review that allows us to understand a specific issue or event, while contributing to evidence-based practice through relevant studies that support decision-making and identify gaps for new research [11].

The research protocol was registered in May 2024 by the Fighsare repository (https://figshare.com), following the methodological framework [11], in which the respective Digital Object Identifier (DOI) was generated: 10.6084/m9.figshare.25748946.

Data collection was performed through six steps described in the literature: I) elaboration of the guiding question; II) search or sampling in the literature; III) data collection; IV) critical analysis of the included studies; V) discussion of the results and VI) presentation of the integrative review [11].

The research question was defined using the PICo strategy (acronym for Patient-Intervention-Context)[12] to describe the following elements: P (population/problem): Nursing Team, I (intervention): Nursing care records; Co (context): Electronic Patient Record. This research aims to answer the following question: What scientific evidence is available on the current status of nursing records by the team in the Electronic Patient Record?

The Virtual Health Library (VHL) was used as the database for searching for primary studies: LILACS (Latin American and Caribbean Literature in Health Sciences), PUBMED (National Library of Medicine), SCIELO (Scientific Electronic Library Online), Web of Science (WOS) and SCOPUS (Elsevier).

The search was conducted using controlled and uncontrolled descriptors and combinations with the Boolean operators “AND”, “OR”: Electronic Health Record OR Electronic Nursing Record; Nursing Record OR Care Record; “AND” Nursing Team.

Full primary articles in Portuguese, English and Spanish, published in the last ten years, available free of charge online, were included. Studies from gray literature such as books, theses, dissertations, monographs, abstracts, editorials, and reviews were excluded.

Data collection took place in March and April 2024, and was carried out blindly by two independent researchers. Throughout the searches in the databases, the collected articles were exported to the EndNote x9 reference manager, online version, for the inclusion and exclusion criteria mentioned above. The search was guided by the crossing of the elements of the PICo strategy.

REVISTA ENFERMAGEM ATUAL IN DERME

The Rayyan Systems Inc. web application was also used, which assists researchers in selecting studies in review methods. It is an agile and effective tool, according to the blinding performed by the researchers [13]. The collected data were reread by the third researcher, the advisor.

Immediately after using the tools, the information was aligned in order to highlight the title, author, year, methodology, results and conclusion.

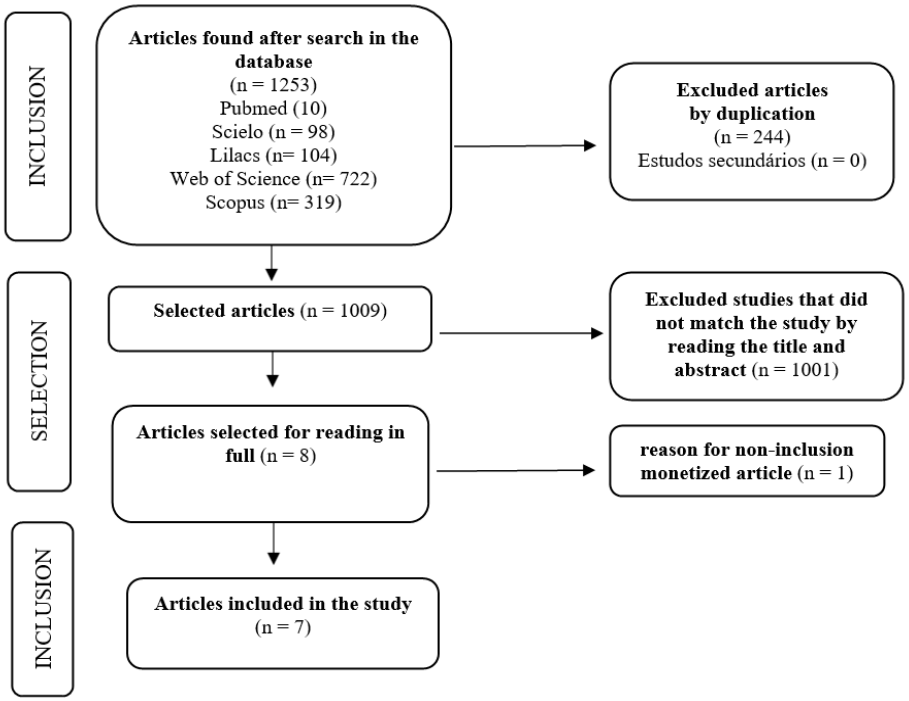
The criterion for analyzing the levels of evidence was the classification into seven levels, namely: level 1 - systematic review or meta-analysis of a randomized controlled clinical trial; level 2 - randomized controlled clinical trial; level 3 - controlled clinical trial without randomization; level 4 - case control or cohort; level 5 - systematic review of qualitative and descriptive studies; level 6 - qualitative and descriptive studies; level 7 - opinion [14].

Next, the data were interpreted and categorized in a succinct and methodological manner for this integrative review presents a total of 1,253 articles found in the databases (Lilacs=104; themes related to the objective of the study, for discussion.

## RESULTS

Pubmed=10; Scielo=98; Scopus=319; Web of Science=722). Of this total, 244 duplicates were excluded. After reading the title and abstract, eight articles remained, which were selected for full reading. After reading, one article was excluded because it was monetized. The final sample consisted of seven articles, which were included in this review (Figure 1).

**Figure 1** - Flowchart for selecting primary studies. Alfenas, Minas Gerais, 2024.



REVISTA ENFERMAGEM ATUAL IN DERME

Table 2 summarizes the main evidence from the seven selected studies, including information on study titles, authors, year of publication, journal, objective, type of study, main results and level of evidence. Regarding the years of publication, only two studies were published in the last 5 years and the others are from previous years.

| Title and Journal | Year | Objective | Design | Outcomes | NE* |
|---|---|---|---|---|---|
| Adopting an American framework to streamline nursing admission documentation in an Australian healthcare organization.<br><br>JAMIA Open. [20] | 2022 | Apply and modify the American Essential Clinical Dataset approach to optimize the data elements of an electronic nursing admission assessment form in an Australian metropolitan local health district. | Descriptive and documentary research | The localized approach could be used by other healthcare organizations to optimize nursing documentation and could potentially be shared with other medical and clinical disciplines for future optimization work. This could transform clinical and nursing data into meaningful information and maximize technology to support communication, efficiency, and timeliness in patient care. | 5 |
| Use of the patient's electronic medical record by the nursing team..<br><br>Rev. enferm. UFPE on line. [17] | 2020 | Describe the use of the patient's electronic medical record by the nursing team. | Quantitative, descriptive and cross-sectional research | The results reinforce the need for investments in relation to “system error” or “connection failure”, since this was the biggest problem reported by professionals and is highlighted in the literature as a disadvantage of the patient's electronic medical record. | 4 |
| Construction and validation of a clinical record for nursing care.<br><br>University Nursing. [16] | 2017 | To describe the construction and adaptation of the Nursing Clinical Record format in a private health institution in the city of Xalapa, Veracruz, Mexico. | Descriptive qualitative research | The results obtained represent a significant advance in improving the quality of clinical records and this helps to improve the quality of patient care. | 4 |
| Electronic patient record: usability assessment by the nursing team.<br><br>Cogitare Enferm. [15] | 2015 | To assess the quality, based on usability criteria, of nursing professionals in using an electronic medical record | Quantitative exploratory research | The evaluated system, despite the advances made, still appears complex for users who have not received training, despite having a consistent and interactive interface. | 4 |
| Electronic health records and supporting teamwork in primary care.<br><br>JAMIA Open. [19] | 2014 | Identify how electronic health records facilitate and pose challenges to primary care teams, as well as how practices are overcoming these challenges. | Descriptive qualitative research | Electronic records vendors in the United States need to work together with primary care teams to create clinically useful records that support dynamic care plans, integrated care management software, more functional and interoperable practice records, and greater ease of tracking data over time. | 4 |

| Title and Journal | Year | Objective | Design | Outcomes | NE* |
|---|---|---|---|---|---|
| Use of electronic health record documentation by healthcare professionals in an acute care hospital system.<br><br>J. Healthc. Manag.[22] | 2014 | Determine what electronic health record information is viewed and how that information is used by different types of clinicians. | Descriptive and exploratory research | Clinical care professionals from a variety of disciplines spend a significant amount of time reviewing electronic record information; and only a few areas are reviewed frequently. | 4 |
| Defining and Incorporating Basic Nursing Care Actions into the Electronic Health Record.<br><br>J. Nurs. Scholarsh. [18] | 2014 | Develop a definition of basic nursing care for the hospitalized adult patient and drive adoption of this definition through the implementation of an electronic health record. | Descriptive research | The use of electronic health records can help clarify, document and communicate elements of basic care and improve acceptance among nurses. | 4 |

Source: Created by the authors (2024). Level of evidence *

REVISTA ENFERMAGEM ATUAL IN DERME

## DISCUSSION

The articles selected in this integrative literature review indicate that, in the current situation, nursing care records are concentrated in the Electronic Patient Record. For the discussion, a main category was identified, subdivided into two subcategories.

### Nursing records of patient care: advantages and disadvantages of the electronic medical record approach

This is the only category in which the Electronic Patient Record (EPR) is presented as an essential tool for recording health and disease data, indispensable for communication between the multidisciplinary team and the patient [15].

Considering that the nursing team is responsible for most of the records in the patient's medical record, these must always be updated and regulated so that they are effective in their function of demonstrating the care provided and reflecting, objectively, the application of each of the stages of the Nursing Process [16].

It is shown that nursing professionals indicate advantages and disadvantages in relation to the EPR, constituting the two subcategories.

### Advantages of electronic records as tools to systematize patient care and communication between professionals

In this subcategory, it is shown that in the usability assessment, the EHR presented positive points regarding suitability for the task, in accordance with the user's expectations and tolerance to error. And, it is also related to the use, satisfaction and acceptance of the system, as well as the time required to record the data [15].

In addition, it has the capacity to store all of the patient's health, administrative and clinical information, in contrast to the conventional medical record. The security offered by the use of an electronic record is observed when the EHR allows for backups to be made, to avoid loss of information, and the legality of the records, in relation to the physical medical record, since the typed record allows for greater understanding [17].

Concerning the use of the EHR by nurses and nursing technicians, it is noted that it is easy to use, since people with better computer skills can handle technological tools more easily. Furthermore, it was identified that the operating system used facilitates recall, manipulation and access, which favors the fact that a small portion of the population studied reported having difficulty in understanding or handling the EHR [17].

It is also noted that electronic records enable more efficient interdisciplinary collaboration through the availability of data and synthesis of information, as well as improving patient safety, since the use of the EHR is an efficient way to clarify, document and communicate basic care elements to the health

REVISTA ENFERMAGEM ATUAL IN DERME

team, in addition to organizing and guiding nurses' thinking and clinical decision-making [18].

It is also noted that the electronic health record has been described as a factor that facilitates teamwork in primary care, capable of improving communication within the team through better access to information, as well as facilitating the redefinition of tasks and team functions [19].

Another advantage of electronic records is that by applying a systematic approach, a set of essential clinical data on patient admission, recorded on other forms required for admission, can be brought together in a single electronic form, making it easier for nursing staff to complete admission documentation [20].

**Disadvantages and challenges in using electronic patient records in light of nursing team professionals**

One disadvantage and challenge that institutions must face is that the EHR is part of the daily routine of health services and many nurses and nursing technicians still do not feel confident in using it, requiring assistance to access basic commands [15].

It is attributed that the need for help to work with information resources came from the lack of training and qualification of professionals [17]. It is also worth noting that if professionals are not trained, communication failures may occur between members of the multidisciplinary health team, which may impair patient care. Therefore, for the EHR to be an effective technological tool, it must be the object of training, facilitating the qualification of professionals [15].

It is therefore emphasized that there is a close relationship between training and the use of the EHR and its use without difficulties by health professionals [17]. It is also corroborated as a disadvantage of the EHR, the system failures, that is, when the system becomes inoperative. These failures end up compromising access to patients' electronic documents and, consequently, quality care. To this end, there is a need for greater investment in systems, equipment and software, which are essential to ensure that failures become less frequent [17].

It is argued that excessive documentation and information in electronic records does not add value to the healthcare team's processes. It is considered that optimizing the choice of content for items and information that make up the EHR and presenting them in a way that best supports decision-making processes is an issue that is still not well understood, which becomes a disadvantage in the use of the EHR [20-21].

Healthcare professionals report spending time reviewing information in electronic records and only a few specific areas are frequently reviewed, which contain important data for patient care. Many areas of the EHR are rarely accessed for review, requiring the reformulation of electronic records in order to streamline and reduce complexities and redundancies in documentation [22].

Professionals noted that the form was also perceived as inflexible, as it did not allow

REVISTA ENFERMAGEM ATUAL IN DERME

the user to access other sections of the electronic record while it was open and after it was started. Repetition of information and duplication of tasks were frequently cited as challenges [20].

To this end, many electronic health records require improvements in their functionality to support teamwork, particularly with regard to comprehensive care plans and longitudinal tracking of patient data [19].

## CONCLUSIONS

It was possible to consider that currently, most records are being made in a computerized manner, through the use of the EHR, allowing the systematization of care, reducing the time spent on documenting patient information, eliminating redundancies, improving communication time between the team, optimizing access to information and providing information to the multidisciplinary team. It is pointed out that the facilitators of the use of the EHR converge to increase contact between the care team and the patient, which is fundamental for comprehensive care and patient safety.

This integrative review was limited by the few studies found on the topic addressed, thus limiting the understanding of the current situation of nursing records in a broad way. It is inferred that there is a need for scientific productions aiming at greater scientific evidence, since this review identified articles with level four and five evidence.

It is expected that this study will contribute to the training of future nursing professionals and in their qualification regarding the importance of nursing records and the use of the EHR. Furthermore, it is expected to reach professionals working in clinical nursing practice so that the challenges regarding the use of electronic records can be overcome.

The evidence from this study has implications for nursing services, nursing education and administration, as well as in the scientific context, since it brings relevant contributions to future research. However, it is worth highlighting that all these advantages are not achievable if nursing team professionals do not receive constant training and qualifications to equip them with the tools to use the EHR and master the computerization of nursing records.

## REFERENCES

1. Omizzolo JE, Ramos KS. Registros de enfermagem: um instrumento para a qualidade da assistência. Inova Saúde [Internet]. 2021 [acesso 2024 Abr 12];11(1):1-16. Disponível em: https://periodicos.unesc.net/ojs/index.php/Inovasaude/article/view/5254/5622.

2. Conselho Federal de Enfermagem (BR). Resolução COFEN Nº 429/2012. Dispõe sobre o registro das ações profissionais no prontuário do paciente, e em outros documentos próprios da enfermagem, independente do meio de suporte - tradicional ou eletrônico [Internet]. Brasília: DF: COFEN; 2012 [acesso 10 jan 2024]. Disponível em: https://www.cofen.gov.br/resoluo-cofen-n-4292012/

3. Sun J, Yao X, Wang S, Wu Y. Blockchain-based secure storage and access scheme for electronic medical records in ipfs. IEEE Access [Internet]. 2020 [acesso 2024 Abr 12];8:59389-401. Disponível em: http://dx.doi.org/10.1109/access.2020.2982964.

4. Ferreira LL, Chiavone FBT, Bezerril MS, Alves KYA, Salvador PTCO, Santos VEP. Análise dos registros de técnicos de enfermagem

e enfermeiros em prontuários. Rev Bras Enferm [Internet]. 2020 [acesso 2024 Abr 12]; 73(2):e20180542. Disponível em: https://doi.org/10.1590/0034-7167-2018-0542

5. Conselho Federal de Enfermagem (BR). Resolução COFEN nº754 de 16 de maio de 2024. Normatiza o uso do prontuário eletrônico e plataformas digitais no âmbito da Enfermagem: digitalização, utilização de sistemas informatizados para guarda e armazenamento nesta tecnologia. [Internet]. Brasília: DF: COFEN; 2024. [acesso 2024 Jan 10]. Disponível em: https://www.cofen.gov.br/?p=128256&preview=true.

6. Conselho Federal de Enfermagem (BR). Resolução COFEN nº 358/2009. Dispõe sobre a Sistematização da Assistência de Enfermagem e implementação do Processo de Enfermagem em ambientes, públicos ou privados, em que ocorre o cuidado profissional de Enfermagem, e dá outras providências [Internet]. Brasília: DF: COFEN; 2009 [acesso 2024 Jan 10]. Disponível em: https://www.cofen.gov.br/resoluo-cofen-3582009/

7. Conselho Federal de Enfermagem (BR). Resolução COFEN nº 564/2017. Aprova novo Código de Ética dos Profissionais de Enfermagem. [Internet]. Brasília: DF: COFEN; 2017. [acesso 2024 Jan 10]. Disponível em: http://www.cofen.gov.br/resolucao-cofen-no-5642017_59145.html.

8. Brasil. Lei nº 10.406, de 10 de janeiro de 2002. Institui o Código Civil [Internet]. Brasília: DF; 2002 [acesso 2024 Jan 10]. Disponível em: https://www2.camara.leg.br/legin/fed/lei/2002/lei-10406-10-janeiro-2002-432893-publicacaooriginal-1-pl.html

9. Conselho Regional de Enfermagem de Santa Catarina (BR). Legislação comentada: lei do exercício profissional e código de ética. v. 3 [Internet]. Florianopolis: SC: Coren-SC; 2016; 140 p. [acesso 2024 Jan 10]. Disponível em: http://www.corensc.gov.br/wp-ontent/uploads/2016/11/Legisla%C3%A7%C3%A3o-Comentada_site.pdf.

10. Oliveira AF de S, Lopes Junior HMP, Silva LG da. Impacto da auditoria de enfermagem na gestão de recursos e custos em instituições de saúde. REASE [Internet]. 2024 [acesso 2024 Nov 12];10(10):26-38. Disponível em: https://doi.org/10.51891/rease.v10i10.15835

11. Souza MT, Silva MD, Carvalho R. Revisão integrativa: o que é e como fazer. Revista Einstein [Internet] 2010 [acesso 2024 Nov 12]8(1):102-6. Disponível em: http://www.scielo.br/pdf/eins/v8n1/pt_1679-4508-eins-8-1-0102.pdf.

12. Araújo W, Oliveira C. Recuperação da informação em saúde: construção, modelos e estratégias. Conv. Ciênc. Inform [Internet] 2020 [acesso 2024 Maio 23]3(2):100-34. Disponível em: https://doi.org/10.33467/conci.v3i2.13447.

13. Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan-a web and mobile app for systematic reviews. Systematic Reviews [Internet] 2016 [acesso 2024 Nov 12];5(210). Disponível em: https://doi.org/10.1186/s13643-016-0384-4

14. Fineout-Overholt E, Stillwell SB. Asking compelling, clinical questions. In Evidence-Based Practice in Nursing & Healthcare: A Guide to Best Practice (Melnyk BM & Fineout-Overholt E eds). Wolters Kluwer, Lippincott Williams & Wilkins; 2011 [acesso 2024 Nov 12]; 2:25-39.

15. Lahm JV, Carvalho DR. Prontuário eletrônico do paciente: avaliação de usabilidade pela equipe de enfermagem. Cogitare Enferm. [Internet] 2015 [acesso 2024 Nov 12]; 20(1):1-11. Disponível em: http://dx.doi.org/10.5380/ce.v20i1.36485. 13

16. López-Cocotle JJ, Moreno-Monsiváis MG, Saavedra-Vélez CH. Construcción y validación de un registro clínico para la atención asistencial de enfermería. Enferm. Universitaria [Internet] 2017. [acesso 2024 Nov 12]14(4):293-30. Disponível em: http://dx.doi.org/10.1016/j.reu.2017.08.00

17. Barros MMO, Damasceno CKCS, Coelho MCVS, Magalhães JM. Utilização do prontuário eletrônico do paciente pela equipe de

enfermagem. Rev. enferm. UFPE on line [Internet] 2020. [acesso 2024 Nov 12] Disponível em: http://dx.doi.org/10.5205/1981-8963.2020.241496.

18. Englebright J, Aldricj K, Taylor CR. Defining and incorporating basic nursing care actions into the electronic health record. J. Nurs. Scholarsh. [Internet] 2014 [acesso 2024 Nov 12];46(1):50-7. Disponível em: http://dx.doi.org/10.1111/jnu.12057

19. O'Malley AS, Draper K, Cross DA, Scholle AH. Electronic health records and support for primary care teamwork. JAMIA Open. [Internet] 2015 [acesso 2024 Maio 20];22(2):426-34. Disponível em: http://dx.doi.org/10.1093/jamia/ocu029

20. Shala DR, Jones A, Fairbrothe G, Davis J, Macgregor A, Baysari M. Adopting an American framework to optimize nursing admission Documentation in an Australian health organization. JAMIA Open. [Internet] 2022 [acesso 2024 Maio 20];11;5(3):ooac054. Disponível em: https://doi.org/10.1093/jamiaopen/ooac054.

21. Pickering BW, Gajic O, Ahmed A, Herasevich V, Keegan MT. Data utilization for medical decision making at the time of patient admission to ICU. Crit Care Med [Internet]. 2013. [acesso 2024 Maio 20];1(6):1502-10. Disponível em: https://doi.org/10.1097/CCM.0b013e318287f0c0.

22. Penoyer DA, Cortelyou-Ward KH, Noblin AM, Bullard T, Talbert S, Wilson J, Schafhauser B, Briscoe JG, et al. Use of electronic health record documentation by healthcare workers in an acute care hospital system. J Healthc Manag [Internet] 2014[acesso 2024 Maio 20];59(2):130-44. Disponível em: https://journals.lww.com/jhmonline/abstract/2014/03000/use_of_electronic_health_record_documentation_by.8.aspx

**No funding**

**Authorship criteria (authors' contributions)**

1. contributed substantially to the design and/or planning of the study: Sales BSL, Pereira KEAP.
2. in obtaining, analyzing, and/or interpreting the data: Sales BSL, Pereira KEAP, Souza JSR, Resck ZMR.
3. as well as in the writing and/or critical review and final approval of the published version: Sales BSL, Pereira KEAP, Gomes, RG, Sanches, RS, Souza JSR, Resck ZMR.

**Declaration of conflict of interests**

The manuscript is extracted from the final course work "Recording of care by the nursing team in the patient's medical record: integrative literature review", defended in 2024, in the Undergraduate Course in Nursing, at the Federal University of Alfenas

**Scientific Editor:** Ítalo Arão Pereira Ribeiro. Orcid: https://orcid.org/0000-0003-0778-1447