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RESEARCH ARTICLE (ORIGINAL)

Content of shared information: From discourse to documentation in clinical decision-making in nursing

Teor da informação partilhada: Do discurso à documentação na tomada de decisão clínica em enfermagem

Contenido de la información compartida: Del discurso a la documentación en la toma de decisiones clínicas en enfermería

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Abstract
Background: Quality of care depends on the information shared orally during shift handovers and documented in the clinical records.
Objective: To analyze the verbal and written information shared in shift handovers and its impact on clinical decision-making in nursing and the continuity of care in a pediatric emergency ward, as well as identify the emerging paradigm for care.
Methodology: Qualitative approach, based on Yin's case study process, using three methods: transcription of the shift handover, documented process, and process carried out by the expert.
Results: The results show increased sharing of information about unintentional body processes, especially in oral transmission. Although documented data includes more detailed information about adaptive processes, it is incipient for a structured and intentional conception of nursing care.
Conclusion: The verbal and written information shared in shift handovers mainly focuses on the disease rather than the individual as a whole. Autonomous nursing information does not address the dimension of the person, the human responses to transitions, and the life processes.

Keywords: handover; nursing records; continuity of care; nursing theory

Resumo
Enquadramento: A qualidade dos cuidados depende da informação partilhada oralmente nas transições de cuidados e documentada no processo clínico.
Objetivo: Analisar a informação partilhada (oral e escrita) e a sua implicação no âmbito da tomada de decisão clínica em enfermagem e da continuidade de cuidados no serviço de urgência pediátrica, e identificar o paradigma emergente da conceção de cuidados.
Metodologia: Abordagem qualitativa, através do estudo de caso, baseado em Yin recorrendo a três métodos: transcrição da passagem de turno, processo documentado e processo realizado pelo perito.
Resultados: Maior valorização de dados respeitantes a processos corporais não intencionais, sobretudo na transmissão oral. A informação documentada evidencia maior detalhe no âmbito dos processos adaptativos, contudo incipiente para uma conceção estruturada e intencional da assistência de enfermagem.
Conclusão: Sobressai que a informação partilhada oral e escrita, esta focalizada maioritariamente na doença e não tanto na pessoa como um todo. A informação autónoma de enfermagem parece omissa relativamente à dimensão da pessoa, nas respostas humanas às transições e aos processos de vida.

Palavras-chave: passagem de turno; registos de enfermagem; continuidade de cuidados; teoria de enfermagem

Resumen
Marco contextual: La calidad de los cuidados depende de la información compartida oralmente en las transiciones de cuidados y documentada en la historia clínica.
Objetivo: Analizar la información compartida (oral y escrita) y su implicación en la toma de decisiones clínicas en enfermería y en la continuidad de los cuidados en urgencias pediátricas, e identificar el paradigma emergente del diseño de cuidados.
Metodología: Enfoque cualitativo, a través del estudio de casos, basado en Yin, en el que se utilizan tres métodos: transcripción del cambio de turno, proceso documentado y proceso llevado a cabo por el experto.
Resultados: Mayor valoración de los datos sobre procesos corporales involuntarios, especialmente en la transmisión oral. La información documentada muestra más detalle sobre los procesos adaptativos, pero aún es incipiente para una concepción estructurada e intencional de los cuidados de enfermería.
Conclusión: Cabe señalar que la información oral y escrita compartida se centra, sobre todo, en la enfermedad y no en la persona en su conjunto. Parece que falta información autónoma de enfermería en relación con la dimensión de la persona, las respuestas humanas a las transiciones y los procesos vitales.

Palabras clave: cambio de turno; registros de enfermería; continuidade de la atención; teoría de enfermería

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Introduction

There is increased awareness of the importance of information as an essential resource for quality in health. The information nurses produce reveals the areas of professional practice on which they make decisions. At the hospital level, the transmission of information between different caregivers is a critical process to ensure continuity of care and patient safety (Giske et al., 2018).
Shift handovers between nurses on the same team generally occur three times a day for each patient, and responsibility for care is transferred at each of these moments. However, deciding which information needs to be passed on is a challenge for professionals. While some nurses tend to transfer too much information, others share insufficient, irrelevant, and unnecessary information, or omit essential aspects (Sousa et al., 2019).
Both oral transmission of information and the care plan ensure the continuity of care through the use of the information collected in previous shifts and the implementation of a therapeutic plan (Ordem dos Enfermeiros, 2015).
Nurses' clinical decision-making is supported by the nursing models and theories that shape the specific knowledge of the discipline. This knowledge is translated into the information systems used in different contexts and reflects nurses' clinical decision-making using the nursing process.
Despite the growing interest in using theory to guide nursing practice, the weaknesses of this process have led to advances and retreats, with different outcomes in different clinical settings (Ribeiro et al., 2018).
This study aimed to analyze the information shared by nurses and its impact on nursing clinical decision-making and continuity of care by identifying the emerging paradigm for care.
Considering that information should be a resource for the promotion and introduction of continuous improvement programs in health care, particularly those in the area of nursing decision-making, an analysis of the information shared in this context will improve nursing care.

Background

In today's societies, information plays a crucial role in health care, to the extent that institutions need it to accomplish their mission and objectives.
Nurses are the health professionals who create, process, and use more information, those closest to patients, and those with a high level of knowledge about them and their families/communities (Jesus & Sousa, 2011). Thus, adequate information sharing is a central aspect in care delivery to ensure the continuity and quality of care (Sousa et al., 2019).
The relevance of information is directly dependent on the perception of the end user (nurse), who is responsible for decision-making, and its relevance to meeting their needs. Thus, the value of information will depend on its potential to produce results (Sousa, 2006).
The shift handover is one of the most important moments for nurses to share information. In a typical shift handover, information is usually transmitted orally and complemented by written documentation (Sexton et al., 2004).
Nursing handovers aim to transfer relevant information for the continuity of patient care, but there is no consensus on its content (Johnson et al., 2012).
In Greece, Rikos et al. (2018) found that the information in the nursing handover was not based on nursing diagnoses or consistent with best clinical practices in 81.8% of cases. They also found that most handovers focused on responding to the various biological and clinical problems or patient needs, neglecting other aspects of nursing care.
The Portuguese Directorate-General for Health (Direção-Geral da Saúde, 2017) advocates using the Identify, Situation, Background, Assessment, and Recommendation (ISBAR) technique to promote effective communication and ensure patient safety in handovers.
The oral transmission of information and the care plan documented in the nursing information system ensure the continuity of care. This system is essential to ensure safety and quality in clinical practice and a highly relevant tool to support decision-making because it integrates evidence-based knowledge and provides important decision-making algorithms for excellence in clinical practice (Jesus & Sousa, 2011).
However, despite the scientific evidence and the instruments supporting clinical practice, nurses' attitudes and practices towards patients and families reveal the gap between the models in nursing theory and the professional models used in clinical settings (Fernandes et al., 2015).
Although documentation is clearly relevant, some studies found omissions in nursing records.

Research question

What is the content of the information shared in the nursing handover and documented in the nursing information system, and the information necessary to ensure continuity of care by nurses in a pediatric emergency ward.

Methodology

This study used a qualitative approach, based on Yin's case study process (2010). Considering the objectives outlined for this study, the analysis could only be conducted in nurses' clinical settings. Several factors, including personal and contextual factors, may influence the information transmitted orally and documented.
The unit of analysis is the nursing record (of the documented process and the process carried out by the expert) and the nursing handover information of the children/adolescents received by the researcher. Data were subjected to a documentary and content analysis based on Bardin (2014).
The population consisted of all children received by the researcher while working in the Short-Term Inpatient Unit. The children could have been from the outpatient ward, been under observation for less than 24 hours, or

been admitted to the emergency ward (more than 24 hours) for a period of one month after February 25th, 2020. Thirty-one handovers and children's records were assessed against the inclusion criteria.

Data collection started with the transcription of the nursing handover. The researcher transcribed the transmitted information and compared it with the audio record to check the quality of the transcription. All nurses were informed of the audio recording and its purpose and authorized it.

Then, the researcher collected information about 31 children from the nursing records produced in the SClinicoV2®. This analysis focused on the representations of professional practice in the records produced about nursing care.

Finally, on that same shift, the expert prepared the nursing process of the children under analysis based on the information available at that moment of care provision. The available information refers to the data from the nursing handover, the data recorded in the process, and the information that the researcher had from a previous contact with the child and family. Therefore, although the expert's process always involves a more rigorous data analysis, it is not ideal, given that no other information was obtained from the family and the child to plan more targeted interventions. This analysis aimed to identify the information necessary for decision-making and continuity of care for the children/families under study.

Data were analyzed according to Bardin's technique (2014). The transcribed handovers were subjected to a pre-analysis through skimming. Next, in the phase of material exploration or codification, there was already a theoretical framework of evidence-based themes that served as a starting point for codification, that is, for the identification of categories. Thus, the nursing process emerged (initial assessment; diagnostic activity; diagnosis; nursing interventions); interdependent interventions; reason for admission, and other notes. The last phase corresponds to making inferences from data.

The triangulation technique was used. It consists of using a combination of more than one strategy in the same study (Streubert & Carpenter, 2013, p. 351). Therefore, the data obtained in the nursing handover, the documented information, and the process carried out by the expert were triangulated.

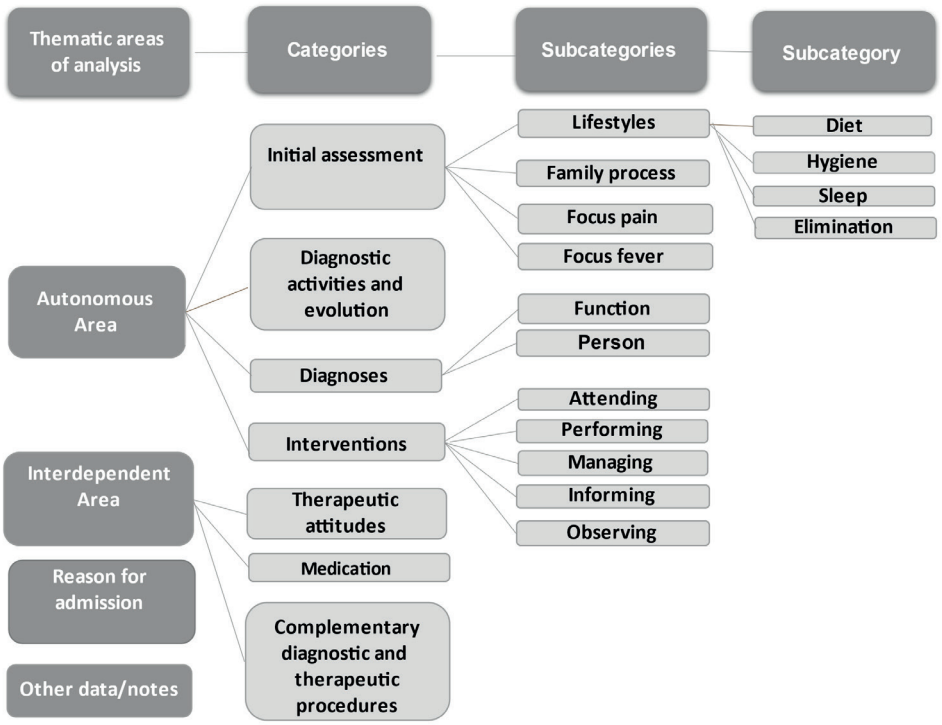
This study obtained a favorable opinion (No. 011/CES) from the Ethics Committee of the hospital in the center region of Portugal.

Results

This study aimed to identify the information shared in the nursing handover, documented in the nursing process, and omitted in the nursing clinical decision-making process. The analysis identified the thematic areas in Figure 1: autonomous area; interdependent area; reason for admission; and other data/notes (data on organization, logistic, and administrative aspects that emerged from the general notes in the documented process).

Figure 1

Schematic representation of the thematic areas, categories, subcategories, and subcategory



Nursing handover information
It is centered on body processes and functioning. The transmission of a high volume of information related to diagnostic monitoring/activity was evident. The diagnoses do not differ from the medical language and are associated with the main complaint, which shows that the information about the child/adolescent/family's adaptive processes is scarce. The was a large amount of information about interdependent interventions, namely medication and complementary diagnostic procedures, and other data/notes.

Documented information
Documented information was largely focused on aspects related to the child's illness, namely the management of signs and symptoms. The importance assigned to monitoring interventions for the prevention of complications was highlighted.
The parental role and the care partnership were highly valued, which led to decisions about parenting in the hospital and gave visibility to family-centered care.

Missing information
There was a lack of information on autonomous nursing activity regarding the dimension of the person, the human responses to transitions, and the life processes. The care partnership with parents was insufficient regarding outcome-oriented therapeutic intentions. Thus, the detailed prescription of nursing care, which reflects intentionality, was omitted.

Discussion

The purpose of nursing handovers is to transmit relevant information that ensures the continuity of care and the quality of patient care (Rikos et al., 2018). In this study, the information is largely focused on aspects related to the management of signs and symptoms of the child's disease, guided by the executive logic of care. It also includes data from monitoring/observations of these body processes. The documented nursing interventions considered relevant for transmission refer to the recovery of the child's physical condition.
As for nursing diagnoses, several diagnostic activity data are transmitted without mentioning the nursing diagnosis, so the nurse who receives the information must often guess the nursing focus. Rikos et al. (2018) found that the information in nursing handovers did not follow the best practices because it did not include data based on nursing diagnoses. Thus, it can be concluded that nurses select the information they want to share based on their own nursing conceptions.
The transmission of information related to the diagnostic activity, with a focus on the parental role, "The mother wishes to do the puffs that she already does at home" (PT8), was also observed in several nursing handovers but only randomly and inconsistently. This fragmented view of partnership work was also corroborated in the study of Mendes and Martins (2012) on partnership in pediatric nursing care. Sousa (2012) also found that although nurses provided information and showed availability to be with parents, there was no formal dialogue about the importance of their participation in care.
The child's hospitalization is a critical event in parenthood, which was also highlighted in the following excerpts: "When they arrived ... a very anxious mother with a very strong emotional lability" (PT10); "These parents are very anxious because there is still no exact diagnosis" (PT27). Parents often experience feelings of fear, anxiety, and frustration during hospitalization. Anxiety is associated with the trauma and pain experienced by the child (Sousa, 2012). These critical events increase parents' awareness and, consequently, their vulnerability.
The verbalization of data about parents' awareness, as a universal property of transition, was sometimes observed. Awareness is a defining characteristic of transition (Meleis, 2010). Therefore, a person needs to be aware of the changes that are occurring to experience a transition. In the excerpt, ". . . but she is convinced that she will go home tomorrow" (PT2), the mother does not seem to be aware of her child's condition, which is an important aspect for defining the parental role and implementing nursing therapies to promote awareness.
In view of the above, it can be concluded that the emerging conceptions are not systematic about the data transmitted to implement the care partnership, nor is the way in which hospitalization is impacting role performance consistently transmitted, both in terms of parents' awareness of changes and involvement. There are sometimes references to difficulties, particularly related to the socioeconomic status. The philosophy of family-centered care does not emerge from the nurses' discourse, given that there are few references to the family and its organization. This aspect may be associated with the short stay in the emergency ward.
In the interdependent area (medical prescriptions, therapeutic attitudes, and complementary diagnostic procedures), the reason for admission and other data/notes were relevant for nurses during the nursing handover.
The oral method is still the most popular method of communication during handovers (Kim & Oh, 2016). However, several studies reinforce the importance of using other tools, such as the computer-based process, to improve the content and reduce omissions.
The documented information revealed that the initial assessment was performed in almost all the records analyzed. Nurses prioritize children and adolescents' eating habits over other habits, becoming a pattern of documentation in the emergency ward, even when they remain hospitalized for more than 24 hours.
As regards the documentation of nursing diagnoses, there was a predominance of diagnoses related to body processes/functioning, in line with what is orally transmitted and consistently with studies developed by several authors in the last two decades. According to Silva (2006), some factors influence the content of nursing documentation and are directly associated, among other aspects, with the conception of nursing care. Therefore, it is correct to infer that we are still fundamentally based on the biomedical model of care. Diagnoses of adaptive processes focused mainly on the parental role, which was identified in almost all the re-

cords. Thus, nursing documentation confirms that parents are also nurses' patients, and not only the children. From here emerges the idea that child- and family-centered care is the paradigm of pediatric nursing.

The scarce reference to central aspects for the performance of caregiving activities - cognitive learning (potential to improve knowledge - documented in two records) and skills demonstrated by parents (not documented) - show that the promotion of parenting seems to be a dimension of nursing care that is still not systematically documented. The results also show that there is a low number of informing-related interventions. According to Sousa (2012), these interventions are one of those interventions associated with the needs identified in the area of learning for parental exercise. This evidence may be associated with patients' short stay in the emergency ward.

The most documented autonomous nursing interventions were observing-related interventions, which refer to diagnostic activities resulting from patient monitoring/observation. Attending-related interventions were mostly associated with the parental role, mainly with "supporting and negotiating the parental role".

In the documentation of the interdependent area, the information produced by nurses showed compliance with the prescriptions. In the Other data/notes category, the information is documented in general notes, mainly referring to the child's destination (ward or transfer", which was documented in almost all records.

Based on the expert's description, it should be noted that, although pain diagnosis is highly valued in an emergency setting, the omission of information on this diagnosis stood out, namely the intensity of pain, the non-pharmacological pain relief strategies, and the planning of interventions in this area. Therefore, it is important to assess pain intensity on a continuous and regular basis to optimize treatment.

Information related to the diagnostic activity criteria of the parental role focus is also missing. Although the data indicate that parents want to participate in care, they do not indicate the extent to which they wish to be involved and the care they wish to provide. Negotiation tends to be done on an ad hoc basis rather than as part of a planned process, implying that the partnership occurs as needs arise. The records mentioning the parental role show that the interventions "Support and Negotiate the Parental Role" were prescribed but without any specification to meet the identified needs. How does the support that nurses will provide to these parents differ from the support provided to other people? What type of care is negotiated? Both the nature and level of parental involvement in care do not provide insight into the dynamics of this negotiation. This evidence is corroborated in the study by Sousa (2012).

It seems distant to mention in a nursing handover that the mother prefers to perform developmental care (diaper changing, feeding, sleeping, among others), except at night. For the expert, it is important to include this information in the record because it gives intentionality to care and promotes continuity of care.

In partnership care, knowledge of the family is necessary, and it is one of the premises of the assessment phase in the Partnership Model. Therefore, the Calgary Family Assessment Model is a useful tool for this purpose. Although there is data on the structural dimension (the family's internal structure), no references were made to developmental and functional assessment. The questions arise: How do parents organize themselves to cope with hospitalization? What developmental tasks do they perform? How is the family context? Are there beliefs associated with role performance? In this context, it is important to know if both the father and the mother develop the same activities and in what way, especially when they alternate hospital stays. Based on the documental analysis of the results, the intentionality of nurses' therapeutic action in the diagnostic identification and prescription of interventions for ensuring the best response to families' needs was not evident.

Regarding self-care, it should be noted that this area is not a focus of attention in this emergency ward. Of the nine records of adolescents, the expert found self-care deficits in four of them; however, no nursing diagnosis of this nature was identified. Therefore, the nursing diagnosis and the basic conditioning factors of self-care were not considered relevant for nursing care, compromising the continuity of care to adolescents in their self-care activities.

Even if they have no self-care deficit (deficit theory), adolescents' habits are poorly documented, as well as the information on how they perform self-care activities/actions (theory of self-care) and whom they choose to help them in their limitations (theory of nursing systems). The continuity of care is at risk if this information is not documented.

Aspects related to the domain of emotions were also not identified, such as fear and anxiety (identified in only one adolescent). One of the most traumatic hospital experiences for children is emergency hospitalization. In this case, fear is a dominant emotion in the child's experience and should be managed to promote the use or development of comfort mechanisms (*coping*; Diogo et al., 2016).

Gains in knowledge and skills of parents and children/adolescents are also scarce, both in nursing documentation and verbal information, as well as aspects related to self-care in the developmental transition. Thus, all interventions that address nursing problems in this area may be omitted.

The conclusions of this study cannot be generalized because the phenomenon in this case study has very specific characteristics.

Another limitation was that the expert's process was not an "ideal" process, as it was only based on the data available to the expert at the time (nursing record) and did not explore other relevant data on the child and family, which are essential for autonomous nursing decision-making.

Conclusion

The verbal and written information focuses mainly on aspects related to the management of signs and symptoms of children's diseases. Although the study was conducted in a pediatric emergency ward and these aspects are une-

quivocal and urgent areas of attention, the dimension of nursing care goes far beyond the biomedical model, to the extent that we are dealing with children/adolescents and parents managing the critical event of hospitalization and the change in their parental performance, sometimes for the rest of their lives.

In relation to planned interventions, the importance assigned to monitoring interventions to prevent complications is highlighted. Thus, there is a comprehensive and realistic description of the child's clinical status in the records, raising no doubts to the nursing care provided in this area, which is a positive aspect of nursing care in this study.

Some of the information transferred during nursing handovers is different from the documented information, given that the parental role (assessment of the condition and partnership) is rarely mentioned in the nursing handover. The evolution in the care partnership in terms of documentation is another positive aspect that stands out in this study. However, there is still a way to go, since nurses' intentions in planning the care partnership with parents are incipient in terms of outcome-oriented therapeutic intentionalities.

The emerging conceptions are not systematic because autonomous nursing information does not seem to include the dimension of the person, the human responses to transitions, and the life processes. In adaptive processes, nurses need more premises for clinical decision-making, and the lack of structured theoretical frameworks is a factor hampering care delivery. There is also difficulty in introducing aspects from the identified models into the models used in clinical practice.

The identification of the content of shared information allows reflecting on its importance for improving care.

Author contributions

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Methodology: Esteves, R. P.
Project administration: Esteves, R. P.
Supervision: Amaral, A. F.
Writing – original draft: Esteves, R. P.
Writing – review and editing: Amaral, A. F.

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