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Original Article

EVALUATION OF THE QUALITY OF NURSING RECORDS IN THE EMERGENCY DEPARTMENT OF A TEACHING HOSPITAL

AVALIAÇÃO DA QUALIDADE DAS ANOTAÇÕES DE ENFERMAGEM NO PRONTO ATENDIMENTO DE UM HOSPITAL ESCOLA

EVALUACIÓN DE LA CALIDAD DE LOS REGISTROS DE ENFERMERÍA EN UNIDAD DE EMERGENCIA DE UN HOSPITAL ESCUELA

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Nursing records are all systematized registers made by the nursing team, with legal and ethical implications on research, patient´s safety and communication among health professionals. This quantitative and retrospective cross-sectional study was conducted in a school hospital dedicated to the woman's care, aiming at evaluating by auditing the quality of the nursing records. The 168 medical records were evaluated according to the standard established by the literature and the legislation of the Professional Council from January to June 2011. The importance of early contact with the patient, incomplete records or lack of information on the assistance rendered, besides nonconformities related to what is expected, were identified. The conclusion is that there is the need of periodic evaluations of the quality of the records and discussions on the results with the nursing team, on its importance regarding legislation, literature and the safety of patients.
Descriptors: Nursing Records; Nursing Assessment; Nursing Care.

Anotação de enfermagem é todo registro sistematizado realizado pela equipe de enfermagem, tendo importância ética-legal, na comunicação da equipe de saúde, pesquisa e segurança do paciente. Objetivando avaliar a qualidade das anotações de enfermagem do Pronto Atendimento de um hospital escola especializado no atendimento à mulher, este estudo quantitativo, retrospectivo e transversal auditou as "Fichas de Atendimento de Enfermagem". A amostra de 168 prontuários teve os itens da ficha analisados de acordo com padrão estabelecido pela literatura e legislação do Conselho Profissional, no período de janeiro a junho de 2011. Identificou-se a importância do contato precoce com a paciente, anotações incompletas ou ausências de informações sobre a assistência prestada, além de não conformidades em relação ao esperado. Conclui-se que há necessidade de avaliações periódicas da qualidade das anotações e discussões sobre os resultados com a equipe de enfermagem sobre sua importância em relação à legislação, literatura e segurança das pacientes.
Descritores: Registros de Enfermagem; Avaliação em Enfermagem; Cuidados de Enfermagem.

Registro de enfermería es la anotación sistematizada realizada por el equipo de enfermería, con implicación ética y legal, en la comunicación del equipo de salud, investigación y seguridad del paciente. Objetivando evaluar la calidad de registros de enfermería en unidad de emergencia de hospital universitario especializado en la atención a la mujer, este estudio retrospectivo y transversal investigó las "Fichas de Atención de Enfermería". Muestra de 168 registros tuvo ítems analizados según estándar establecidos por la literatura y el Consejo Profesional, de enero a junio de 2011. Se identificó la importancia precoz de contacto con la paciente, registros incompletos o falta de informaciones acerca de la atención ofrecida, además de no conformidades con el esperado. Hay necesidad de evaluaciones periódicas de la cualidad de las anotaciones y discusiones acerca de los resultados con el personal de enfermería sobre su importancia cuanto a la legislación, literatura y seguridad de las pacientes.
Descriptores: Registros de Enfermería; Evaluación en Enfermería; Atención de Enfermería.

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INTRODUCTION

The nursing record is the ordinate and systematized register of all information, procedures, orientations and assistance which the nursing team carried out during the period in which the patient was under their care in health institutions[1]. These registers favor the communication within the health team, promoting the evaluation of the quality of the service rendered. Besides that, they serve as ethical /legal instrument to clarify negligence by part of the health professionals or by the institution itself[1-2].

The normatization of Decisão do Conselho Regional de Enfermagem (Decision of the Regional Council of Nursing) (COREN-SP), in the state of São Paulo, Brazil - DIR/001/2000, of January 18th, 2000 homologated by the Conselho Federal de Enfermagem (Federal Council of Nursing) (COFEN) by Decision 019/2000, of March 13th 2000, establishes that the register of nursing must: be clear, objective, precise, with legible handwriting, without erasures; have the identification of the author, with his name, function and number of the professional register in a stamp; have all the data of the patient in a printed form dully identified and complemented with the date and time; have subsidies to allow the continuity of the planning of nursing care in the different phases and for the assistance planning of the multiprofessional team; allow and favor administrative and clinical elements for the nursing auditing; make part of the patient´s medical records and serve as a source of data for administrative, legal, learning and research process. The register can be handwritten, by ink, never electronic or with a pencil, according to the valid legislation[3].

Besides that, researches state that the nursing register must reflect the bio-psychic- social-spiritual conditions of the patient, including occurrences which make the supervision and evolution of the case possible, as well as directing the patient to other professionals, favoring the elaboration of a plan of care facing the integrality of the assistance[4].

When imprecise, the records show deficiency in their quality and they may or not correspond to the reality of the professional practice. The care rendered, when not registered, makes important information difficult for the continuity of the assistance, as well as to obtain data for researches, auditing and judicial analysis.

Auditing is a method to evaluate the quality of the work of the nursing team through their records of the medical record. Assessing its content becomes indispensible for a reasoned vision of the reality for the reflection of the health professional on the coherence of the information registered in the patient´s medical register and on the practice effectively rendered. Analyzing the nursing records as to their legibility, clarity and completeness will allow the assessment of the adopted conduct and provide more visibility of the nursing work.

Therefore, this research was made with the aim at evaluating the quality of the nursing records at the Emergency Department of a teaching hospital specialized in the assistance to the woman.

METHOD

This is a cross-sectional, retrospective and quantitative study developed in the Emergency Department (ED) of a public university hospital, with exclusive assistance by the Sistema Único de Saúde (Unified Health System) (SUS), of average and high complexity, in the countryside of the state of São Paulo, Brazil.

The choice to make the research in a university hospital was due to its vocation in scientific development, aiming at the qualification of the practices of care. The venue is due to the recognition which the nursing team agrees with when having adequate documentation to provide continuity of the care. Specialized in the assistance to the woman, this ED

provides assistance to pregnant women, with gynecological and onco-gynecological complications, puerperas and newborn from immediate post-partum in situations of urgency and emergency[5].

The assistance of the patients begins at the reception, and from then on, two distinct flows for the patients with obstetric and gynecological/oncological complaints. The pregnant women are assisted by the nurse in the selection room for their classification of risk. Afterwards, they have medical assistance according to the priority of urgency. The patients with gynecological complaints or the ones who had supervision in the service due to the gynecological/oncological problems are first assisted by the resident physician and afterwards by the nurse, whenever some procedure is necessary.

Besides the immediate attention predicted in emergency rooms, this ED offers assistance to cases which require the need to collect exams and return for the establishment of the conduct according to their results. Pregnant women are sent to the basic net of health in order to have a fetal cardiac monitoring and glycemic profile, besides reporting situations of social order. The unit has the local support for such situations like the 'Casa de Repouso', where the patients can stay overnight or wait during the day for conduction for their case. With these characteristics of assistance in which there is the possibility to return, it is fundamental to value the nursing records on the procedures, data and care rendered to the patient, in a chronological way, for the continuity of the assistance without the repetition or negligence of necessary conduct.

The records made in the 'File of Nursing Assistance – ED' were chosen to be assessed, using the method of retrospective auditing by medical record sampling[6], although there are registers in the books of after-hours care in a computerized system developed to register the assistance provided at the ED. This file was developed by the nursing team of the ED in 2010, and it is the *check list* kind, having the objective to be practical, agile and make the acess to information of the paciente easy. The audited items of the 'File of Nursing Assistance – ED' were: identification of the patient, complaints presented according to the specialist. For the obstetric patients, the referred complaints are regarding the prenatal, vaginal losses, contractions and fetal movement; for the patients of the gynecological-oncological specialist, the investigated complaints are algia, bleeding and other information reported by the patient. Other items which are in the nursing file are: nursing diagnosis, nursing prescription, control of the vital signs, glycemic profile, observations, laboratory exams, conduct, data, time, signature of the author of the register and complementary observations (for example: data of the patient´s hospitalization, such as allergy to medicine and food; intestinal and urinary habits and vices). It is worth highlighting that this file is filled when the patient needs hospitalization, assistance procedures or diagnosis.

The initial motivation of the team, for the development of this file, was to have an own document to register the nursing actions, once in the informatized system of the unit, there was no room for that. So, it was believed that it would make the continuity of the nursing assistant easy by the registering of the actions and especially by the possibility of developing the Sistematization of Nursing Assistance (SNA) focused on the main diagnosis of nursing, reasoned in the needs of the patients of ED, a coherent fact with another hospital reality[7].

The nursing team of the ED has seven nurses and 16 nursing technicians distributed in the 24 hours of work to assist an average of 650 patients monthly. This number of assistance was the basis of the calculation of the sample to develop auditing of the files of nursing assistance.

The sample was calculated from the general formula: $n = (N.P.Q.Z^2)/[(N-1)e^2 + P.Q.Z^2]$[8]. Being 'n'

the size of the sample, N, the total size of the medical records, P, the percentage in which the phenomenon occurs, considering equals to 0.5 when the proportion is not known, Q, the complementary percentage, Z, the level of trust which was adopted as 95% in the research, equals to 1.96, and as maximum acceptable error, in this case, 5%. So, the value of 'n', from 126 medical records, was obtained[8].

In order to guarantee a safe sample, 25% of the medical registers were added and so, 168 medical records were analyzed through the means of process of systematized sampling from January to June 2011. From an interval previously defined by the formula k=N/n, being k the interval among the medical record and the total number of medical records and 'n' the size of the sample, and the value of k was 30. In order to avoid the bias of selection, the first medical record, in the first interval of the list was selected by assortment. The criteria used for the exclusion of the medical record was the absence of the 'File of Assistance of Nursing – ED', being substituted by the next medical record immediately subsequent.

A specific instrument was developed for the collection of data with variables that allowed the analysis of the records of each item of the file evaluated comparing them with the predicted standards of register, according to the decision of COREN-SP DIR 001/2000 and the literature[1,3].

In order to have homogeneity in the auditing, the four researches were trained for the collection of data. Before beginning the collection of data, pre-tests of the instrument of collection were made in 10 medical records, thus making its improvement possible. A guiding manual was also developed for this auditing.

The items of 'File of Nursing Assistance – Emergency Department' were assessed following an established criterion, according to its level of filling, as follows: [1] Complete, [2] Incomplete, [3] Not filled, [4] Incorrect and [5] Not applicable, and the data collected in each instrument were inserted in an electronic sheet in the Microsoft Excel program. To ensure the reliability of the data, each file audited and the sheets typed by a researcher were revised by double checking facing the correction of occasional errors.

When studying the association between the variables and the kind of patient these tests were used: Fisher´s exact[9] and Chi-Squared[10].

These tests are used to verify the existence of association between the two categorical variables. The analysis were initially made using the Chi-squared test, and in the cases where, at least 20% of the results found had value lower than five, the Fisher´s exact test was applied.

Due to the fact that the flow of assistance is different for the patients of specialized professionals, as described, the analysis of the files were made separately, that is, files of the obstetric patients and files of the gynecological-oncologic patients.

This research was approved on May 26 2011 by the Committee of Ethics and Research (CER) of the Faculdade de Ciências.

RESULTS

Of the 168 medical records selected to compound the sample, most of them were obstetric patients, that is, 127 (75.6%) and 41 (24.4%) were from gynecological-oncologic patients, being coherent with the daily demand of the assistance.

The results were organized into three tables which are presented as follows. Table 1 presents the results of the filling of the 'File of Nursing – Emergency Department' regarding the items of identification, complaints and diagnosis of nursing separated by specialty.

Table 1 - Level of filling of the identification, complaints and diagnosis of nursing of the 'File of Nursing – Emergency Department', by specialty, Campinas, SP, Brazil, 2011

Item of the file of nursing - ED	Level of filling	Obstetric patients		Gynecologic-oncologic patients	
		n	%	n	%
Date, time and identification	Complete	84	66.8	21	51.2
	Incomplete	43	36.2	20	48.7
	Total	127	100.0	41	100.0
Complaints according specialty	Complete	110	86.8	10	23.8
	Incomplete	---	---	02	5.6
	Not filled	17	13.2	29	70.5
	Total	127	100.0	41	100.0
Diagnosis of nursing	Complete	31	24.4	06	5.8
	Incomplete	15	11.8	05	12.2
	Not filled	81	63.8	32	78.0
	Total	127	100.0	41	100.0

Table 2 reveals the level of filling of the items related to assistance procedures or the collection of exams for diagnosis, with the respective signatures of the health professionals that made them. Not necessarily all the 168 patients were submitted to procedures related in the items of the evaluated file, that is why there is a variation in the number of the sample, as the laboratory exam shows.

Table 2 - Level of filling of procedures and signature of the professionals of 'File of Nursing – Emergency Department'

Item of the file of nursing - ED	Level of filling	Obstetric patients		Gynecologic-oncologic patients	
		n	%	n	%
Vital Signs	Complete	10	7.9	16	39.0
	Incomplete	7	5.5	3	7.3
	Not filled	110	86.6	22	53.7
	Total	127	100.0	41	100.0
Signature of the health professional	Complete	9	7.1	8	19.5
	Incomplete	6	4.8	11	26.8
	Not filled	112	88.1	22	53.7
	Total	127	100.0	41	100.0
Laboratory exams	Complete	30	24.8	11	32.3
	Incomplete	2	1.6	0	0
	Not filled	89	73.6	23	67.7
	Total	121	100.0	34	100.0
Signature of the laboratory exams field	Complete	5	4.1	3	9.1
	Incomplete	1	0.8	2	6.0
	Not filled	113	93.4	29	84.9
	Incorret	2	1.7	0	0
	Total	121	100.0	34	100.0
Observations (registers)	Complete	5	3.9	4	9.8
	Incomplete	118	93.0	35	85.3
	Not filled	3	3.4	2	4.9
	Incorret	1	0.8	0	0
	Total	127	100.0	41	100.0
Signature in the observation field	Complete	67	52.8	27	65.8
	Incomplete	11	8.7	5	12.2
	Not filled	47	37.0	9	21.9
	Incorret	2	1.6	0	0
	Total	127	100.0	41	100.0
Conduct	Complete	96	75.6	28	68.3
	Incomplete	3	2.4	0	0.0
	Not filled	28	22.0	13	31.7
	Total	127	100.0	41	100.0

The results of the records of the 'File of Nursing – ED' are presented in Table 3, evaluated according to the standard established in the resolution COREN-SP DIR/001/2000[3], as to its legibility, erasures, handwriting in ink and use of initials.

Table 3 - Register in the File of Nursing – ED. Campinas, SP, Brazil, 2011

Records	Legible leter		Erasures		Writing in ink		Initials	
	n	%	n	%	n	%	n	%
No	28	16.7	138	82.2	--	--	05	3.0
Yes	140	83.3	30	17.8	168	100.0	163	97.0
Total	168	100.0	168	100.0	168	100.0	168	100.0

DISCUSSION

The results of the quantitative analysis of the files of nursing assistance of ED showed that the records related to the obstetric patients showed to be more complete than the records of the patients of the specialties of gynecology and oncology, according to the standard of literature and legislation (Table 1). This fact can be attributed to the flow of work of ED, where the pregnant women are first assisted by the nurse of the service and, only after that, they go to the health team which will establish conducts and procedures. The initial contact nurse-patient makes the questioning of the reason why they came for help possible, as well as the facts of her history and relevant observations for the comprehension of her needs and, therefore, generates a reflexive nursing record for the bio-psycho-social conditions which will help in the planning of an objective and individualized assistance, not only based on clinical protocols[4]. Adequate records of this moment, constitute communication to the continuity of the assistance work in the different after-hours care or to other units of the institution when it is the case of hospitalization.

The communication among the health team for the continuity of the assistance and the documentation in itself were the main purposes of the appointed records under study of the perception of nursing professionals on their registers and the way they were developed. In this research, also made in a university hospital at Natal, RN, Brazil, with the nursing team, the authors noticed that the interviewed subjects did not reach the amplitude of the purposes that the registers presented, such as the auditing itself and the production of new knowledge[11].

Although the files evaluated present better filling of the obstetric patients, in the item 'complaints' it is possible to observe the lack of the diagnosis of nursing, when compared to the gynecological-oncological specialties.

This fact shows that the work of the nurse is turned to the collection of data related to the reason (complaint) which took the user to the assistance and direct her to the medical appointment, establishing priorities according to the urgency to define conducts. The lack of information on the Systematization of Nursing Assistance (SNA) suggests that it is directed to the organization of the medical clinic without the concern with the register of the human needs of the patients predicted in the construction of diagnosis and prescription of nursing.

Under this perspective, the researches confirmed the analyzed content of registers, which were centered, in most cases, on the data regarding procedures such as dressings, probes, maintenances of accesses and vital signs. This information appears more frequently when compared to data related to the study of the conscience, breathing, diet and psycho-emotional status of the patients, which should be registered based on the enhanced concept of health, integrality and care[11].

The practice of nursing is reasoned in their own theoretical references which go beyond the biomedical model. When rendering individualized assistance, the nurse needs to make the collection of data which enables an evaluation of the current situation of the patient and so plan a more adequate and effective care, in order to subsidize the definition of the diagnoses and prescriptions, which are incipient in the reality researched and in the literature[12-13].

Another study which evaluated the SNA showed deficiencies in some stages and its documentation[13]. Despite finding registers of diagnoses and nursing prescription, there are faults in the filling of the nursing record and the register of the evolutions of the patients. The author questions the possibility of the nurses to observe the needs of the patients assisted, but not to register, justifying the time spent for that activity.

It is known that the implementation of SNA is not something easy, especially in an Emergency Department, in which there is a high turnover of the users. But one cannot think in continuity of assistance, possibility of production of knowledge and evaluation of the professional practices without adequate documentation[2,4,7,11].

The incomplete or inexistent record makes the understanding of the reasons which took the patients to hospitalization by the health team difficulty, hampering the continuity and planning of the assistance after her hospitalization thus limiting integrated and humanized actions. Besides that, when this register is scarce and inadequate, this jeopardizes the assistance rendered to the patient, as well as the institution and the nursing team. It can also jeopardize the security and care of the patient, besides the difficulty to measure the assistance results that have occurred in the performance of the nursing practice[14].

In Table 2 only 26 files analyzed (10 patients from the obstetrics and 16 from gynecology/oncological) presented complete records and 10 incomplete (07 from obstetrics and 03 from gynecology/oncology) in the item on vital signs, once the checking of blood pressure, pulse and temperature are part of the routine of the ED for all the patients assisted, therefore, there should have been registered. This fact suggests that the actions taken routinely by the team do not have registers and this jeopardizes the evaluation of evolution of the health framework of the patient and the adequate identification of the assistance rendered.

Another relevant factor is the registry made with illegible handwriting (16.7%) or erasures which favor assistance error by the lack of comprehension of what is registered, hampering communication, besides having ethical, legal complications (Table 3). The legislation pertinent to the nursing records highlights the importance of having quality in the writing once they are legal documents that can accuse of defend the health professionals or the institutions when under investigation by adverse events involving acts of negligence, imprudence or incompetence[1]. So the registry is a vital aspect to show that the assistance was provided and the protocols complied with.

It is understood that the communication among the health professionals is fundamental for the organization and the (re)planning of the process of the human care, once adequate register aims at the continuity of the assistance rendered and allows to promote researches and auditing in order to contribute to a more scientific nursing.

Studies show that illegible handwriting is a fact that results in damage to the patient, discourage the reading and the comprehension of the medical record by other health professionals. To search for true information observing clarity, objectivity, concision, legibility to transmit a correct message is essential so that the data are transformed into information and found good practices and pertinent interventions[11,15].

The records made by the nursing consist in the most important instrument of evidence of the quality of

the work of the nursing team once 50% of the information inherent to the care of the patient is provided by them. Therefore, the need of adequate and frequent registers in the medical records of the patient becomes unquestionable[15]. So, if there is the domain of the communication as a facilitating instrument of the assistance, the needs of the patients will be more observed, understood and attended by the health professionals.

The quality of the nursing services includes not only the education of the nurse, the process of restoring health of the patient, or, when it is no possible, the improvement of the condition of life, the orientation regarding self care, simplification and the security in the nursing procedures of nursing, but also the result of the care produced by the health team for the organization, through the analysis of the documentation and register of all the nursing actions. That is, the quality of the register of assistance actions reflects the quality of the assistance and the productivity of the work. And, based on these registers it is possible to build better assistance practices permanently, besides implementing actions that aim at the improvement of the operational results[14].

In the present situation in which the world nursing seek recognition of the impact of their work, in a publishing to celebrate the international day of the nurse by an organ of world representation, it is relevant to know who the nursing professionals that take care are, what care is rendered, and which characteristic and which under circumstances. The benefits resulting from nursing care, the approaches and interventions made, at which cost, and how the results of the care benefit the patients, their families and communities, whether in countries of high or low *per capita* income, must be known and divulged widely to allow evaluation of nursing taking into consideration all the factors that can perpetuate problems or establish the health of our patients[16].

CONCLUSION

The evaluation of the records of the file of assistance of nursing of ED, according to the audited results, shows that the quality of the registers is jeopardized, once the lack of information on the assistance rendered was identified, besides the non-conformities regarding the standard established by the legislation of COREN–SP.

The lack of registry of the action effectively taken by the nurse and the team showed the lack of visibility of the daily work, a fact that many times, does not reflect the reality of the attention rendered to the user and their accompanies.

The data analyzed suggest that the organization of the work made by the nursing of the ED is turned to the biomedical model without considering the aspects of integrality and to the specificity of the care of nursing turned to the needs of the patients.

It is considered that the scenario of this ED is differentiated from other hospital units, by the characteristics, by the specialized attention to the woman with frequent returns for the continuity of the treatment or for her hospitalization. Therefore, the lack or incomplete filling of medical records of the patients jeopardize their assistance and the sequence planned for their treatment.

It is also highlighted that, medical records with data of anamnesis, results of exams for diagnoses and procedures made, among other information, clarify allegations of negligence or lack of assistance, especially in the units of urgency and emergency, in which the actions must assure the preservation of life, reduction of damages and complications in the health-disease-care process.

Periodic evaluations of the nursing records and discussions on the results found with the whole team in order to highlight their importance, are necessary, offering them training and orientation so that the activity

of registering the assistance rendered, based on the rules of legislation and literature is a habit in their daily work. Only the work which is visible can build a solid basis, of theoretical and practical knowledge, for the scientific development and a good professional education of nursing.

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