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NURSING RECORDS AND THE QUALITY OF PATIENT CARE: EVALUATION BY METHODS TRIANGULATION

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ABSTRACT

From the nursing notes on the patient's chart it is possible to identify how the care to the user is performed. Therefore, it is essential that the nursing record be readable, organized, chronological, concise, signed and stamped. Recognizing that nursing annotation is an essential tool in comprehensive patient care, this manuscript aimed to perform a bibliographic review to list the main theoretical and practical contributions on nursing records and the quality of care adopted in the therapies of nurses and technicians of nursing. With the review carried out, the importance of nursing records in the process of treating patients in health institutions is perceived.

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INTRODUCTION

Florence Nightingale founded modern nursing and stood out not only in patient care, but also in hospital organization, statistics and the use of visual representations of information. To do this, it organized and analyzed data collected from the assistance performed, in order to obtain information that would subsidize the improvement of care. In addition, it presented relevant aspects that should be observed and reported in a precise and correct way by the nurse in her book "Notes on Nursing", released in 1856. From this, the nursing records were valued, which are characterized as annotations destined to all the health team, being, therefore, fundamental for the effectiveness of the process or systematization of care and / or nursing care (CARRIJO; OGUISSO, 2006). Nursing records are essential elements for patient care, since they allow interdisciplinarity for continuity of care, having economic, legal and scientific relevance (MATSUDA, ÉVORA, 2006). In order to provide information about the care provided, nursing annotation promotes communication among team members, enabling the continuity of information in the next 24 hours, and is an indispensable resource for understanding the clinical picture of the patient (RODRIGUES; PERROCA, JERICÓ, 2004). The nursing team should be made aware of the importance of the annotation in their records that serve as legal support on the quality of the care provided (COFEN, 1996; ITO *et al.,* 2004). In this way, the more and better the nursing workers record their actions, the greater the value of their work, besides favoring patient safety (FLORIZANO; FRAGA, 2007). Therefore, it is important that nursing notes are not understood as a simple bureaucratic norm compliance. It is necessary to have an idea of its real importance and the implications of its inadequate realization (FERREIRA, *et al.,* 2007). The annotations made by nursing professionals are the most important instrument of proof of the quality of the nursing team's performance, since approximately 50% of the information inherent to patient care is provided by the nursing team. Thus, the need for adequate and frequent records in the patient's records is undisputed (MATSUDA *et al.,* 2006).The records are sources of documentation of the actions and activity carried out by the nursing team, becoming a way to guarantee and prove the care delivery and the quality of care

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provided by the nursing team. The records provide specific information for continuity of care, as well as subsidize the development of an effective and individualized care plan. From the legal point of view, records are considered as documents to support legal, educational and research issues. The act of recording actions performed by the team indicates the quality of the assistance being provided and proves the good professional practice, in addition to the ethical compliance required by the nursing profession (MATSUDA *et al.,* 2007). Failure to perform nursing records or inadequate nursing records demonstrates uncompromised care and can lead to damages to the health care institution and difficulties in identifying how care is given by the nursing staff and the nurse. The evaluation of the quality of care provided also includes analyzing the way this care is registered. The annotations reflect how care is provided and demonstrate the quality of service. (SETZ *et al.,* 2004). In this perspective, recognizing that nursing annotation is an essential tool in comprehensive and interdisciplinary patient care, the objective of this article was to perform a bibliographical review in order to identify the production of knowledge about the nursing record, that is, how these workers usually carry out their notes and also understand how the care of the patient is carried out from the analysis of the nursing notes.

Nursing records and the quality of care for patients

In the hospital environment, communication in order to favor patient care occurs through observation, spoken or written language. Therefore, it is important that communication is done effectively, so that the patient's needs are observed, understood and fulfilled. In the context of patient care, registration for nursing is an essential tool that has evolved in quality and form over time (MATSUDA *et al.,* 2006). The quality of nursing services includes the training of the professional, the process of rehabilitation of the patient's health, improvement of the life condition, guidelines regarding care, and safety in nursing procedures. In addition, this is also the result of the care produced by the health team, which is known through the analysis of documentation and registration of all nursing actions. That is, the record of care actions reflects the quality of care and the productivity of work. In this way, from the registries it is possible to improve the assistance practices, besides potentializing the results (SETZ and D'INNOCENZO, 2009). Within the aforementioned context, periodic evaluations of nursing notes and discussions about the results found with the entire team are needed, in order to highlight their importance. In fact, the discussions offer training and guidance so that the activity of recording the assistance provided in which is based on the norms of legislation and literature is a habit in the work process. Such circumstances become relevant since the work can build a solid base of theoretical and practical knowledge for scientific development, as well as a good professional nursing training (SEIGNEMARTIN *et al.,* 2013). The nursing record consists of a form of written communication, where the information related to the patient and the care provided to him during the hospital stay is exposed. Registration is an essential element in the process of human care, because when written in a complete way according to the reality, it enables the permanent communication. In addition, it can be used for several other purposes, such as research, audits, legal processes and planning (MATSUDA *et al.,* 2006). The medical record that contains daily information in the multiprofessional and / or interdisciplinary scope related to the services rendered is essential for a hospital audit. The records in the medical records are assistance instruments and play the role of administrative support for the billing sectors, since all the procedures and actions performed are recorded and generate costs for the health institution. In this context, it should be noted that nursing records are linked to a large part of the payments of materials, medicines and procedures, which are the main sources of profitability of hospital institutions. Thus, the main means of ensuring the receipt of the amount spent is through nursing notes, since when these are inconsistent, illegible and subjective can generate glosses of billing items (PELLEGRINI, 2004). Nursing produces, daily, many information inherent in the care of patients, being responsible for more than 50% of the information presented in the medical record. In this way, adequate and frequent registration is essential, since nursing cannot do without the annotations related to the activities performed, since the recorded information is necessary for the continuity of the care and the quality of the same (SANTOS *et al.,* 2014). The nursing technicians perform the majority of the care provided to the patient in the hospital network, since they are guided by the prescription of the doctor and the nurse. In this context, the annotations of the technicians represent an important source of research on the care given to the hospitalized individual. However, when this procedure of registering nursing care departs from compliance with ethical-legal norms and institutional protocols, it is not possible to identify the actual care provided, since the registry presents incomplete, non-contextualized, dispersed and inadequate information (SETZ and D'INNOCENZO, 2009).

The registration in the patient's medical records of information is indispensable to the care process, and it is a duty and responsibility in accordance with article 25 of COFEN Resolutionn° 311/07 (COFEN, 2007). Information not correctly registered may be susceptible to misunderstandings and errors, which makes it necessary to guide the team permanently, showing the importance of appropriate records of nursing actions. Registration in the medical record is an ethical and legal guarantee for both the professional and the patient, and when not correctly performed can put at risk the care performed by all nursing staff, making it difficult to monitor and / or analyze the care provided (SETZ and D'INNOCENZO, 2009). From the ethical and legal point of view, only the record of the execution of an activity can actually ensure that it was performed by the nursing professional (BRASIL, 2011). Thus, registration of activities performed is always necessary because it promotes greater visibility to the professional category and contributes to the integrality of the care provided to the patient (PIMPÃO, *et al.,* 2010). Decree No. 5,0387 of March 28, 1961, which regulated the nursing practice and its auxiliary functions in the national territory, focused on its article 14, which is the duty of every nursing professional to maintain perfect annotation of everything that is related to the patient and with himself (BRASIL, 1961). Therefore, nursing records must be legible, free of erasures, splices, spaces, between blank lines or lines. The records must contain only the abbreviations provided in the literature, must have the professional stamp, as well as the signature and number of the Regional Nursing Council (COREN) to prove the authenticity of the document in judicial process. The records must be written in chronological order, in a complete and concise manner, and present the observations made, the care provided, the patient's responses to the care taken, the intercurrences, the signs and symptoms observed. In

addition, they should prioritize the description of the characteristics of the debts, specifying quantity, color and shape, and should not contain terms that denote connotation of value, such as: bad, good, very, little (BRAZIL, 2011). Several factors may influence the achievement and quality of nursing records such as high demand for services, work overload and insufficient number of professionals. In addition to these factors, there is a lack of continuous education, lack of motivation related to poor working conditions, low salary, low socio-educational level, language complexity and ineffective team communication (MAGALHÃES *et al.,* 2013). In the practice of care, written communication has been neglected by nursing professionals, since the records, when performed, are scarce and incomplete. Even acknowledging the importance of written communication for the continuity of patient therapeutics, especially with regard to interdisciplinarity, nurses are unable to carry out this practice in their daily practice, and this makes communication among nursing professionals more difficult among themselves and among others professionals in the health area (MATSUDA *et al.,* 2006). There are some aspects that can limit nursing records such as the lack of human resources, lack of time to perform the registration performed by professionals allied to the excess of administrative and bureaucratic activities and the existence of the culture that nursing is only a service in support of other health professionals, especially physicians (PIMPÃO *et al.,* 2010).

Nursing records are considered instruments of care communication that have repercussions on economic and legal issues. They also provide historical analysis and provide information for teaching and research. Added to this, there are the indispensable information for the team seeks a humanized care to the patient (CLAUDINO et al, 2013). Another argument in favor of nursing registration is the Accreditation of Health Institutions, which is a process to evaluate the quality of care in a systemic and global way. This procedure aims at the creation and consensus of standards and levels of quality that guarantee the credibility of the whole process related to health care. Among the conditions defined for obtaining this title is the record in the medical procedures, nursing and pertinent procedures which must be legible, complete and signed (BRASIL, 2002). Research is needed to identify the factors or conditions that act as impediments to the nursing record, as well as to invest in continuing and continuing education about the importance of nursing notes (Barral *et al.,* 2012). It is also important to review how the records are performed, with the purpose of improving the work process developed by the nurse and his / her team, enabling reliable records. In order to do so, the evaluation of the quality of the records can be used to reinforce the desire of the professionals to improve the way in which the care given to the patient is documented (MAZIERO *et al*, 2013; PADILHA *et al.,* 2014). Audit is a method that evaluates the quality of nursing work through the notes made by the nurse. Evaluating its content is essential for obtaining a vision based on reality and for a reflection of the professionals based on the coherence of the information recorded in the patient's chart and the practice performed. Therefore, to analyze nursing records in terms of clarity, readability, and completeness, it is possible to evaluate the ducts and give greater visibility to the nursing work (SEIGNEMARTIN *et al.,* 2013). Another argument in favor of nursing registration is the Accreditation of Health Institutions, which is a process to evaluate the quality of care in a systemic and global way. This procedure aims at the creation and consensus of standards and levels of quality that guarantee the credibility of the whole process related to health care. Among the conditions defined to obtain this title, is the record in the medical records, nursing and pertinent procedures, which must be legible, complete and signed (BRASIL, 2002). It is necessary to recognize that annotation is a complex activity, requiring clarity as to form and content, in order to guarantee readability, comprehension and quality of information. It is essential that nursing be sensitized on these aspects, in addition it is valuable that the institution's prints are able to make feasible the execution of nursing an notation, not in the sense of mechanization of care, but with the purpose of improving the care provided to the patient. The quality of the registry refers to a series of attributes determined by the regulatory bodies by institutional norms and by the commitment and responsibility of the worker in their professional practice (BARBOSA *et al.,* 2011). The quality of health services has been changing, and has gradually incorporated new elements so that the search for quality must be constant in the different ways of producing goods and services (TRONCHIN *et al.,* 2010). At present, the audit is adopted as a tool for controlling costs and evaluating the quality of health care. Audit practice has been expanded and is used by the public sector as an essential tool for controlling and regulating the use of health services and, in the private sphere, has been recognized as a cost control instrument for patient care (PINTO and MELO, 2010). Considering the well-being of the human being as a patient, the exercise of the nursing audit should include a holistic view, with quality of management, quality of care provided to the patient and quantum-economic-financial. The nursing audit systematically evaluates the nursing records and the quality of care observed through the annotations in the patient's chart (CAMELO, *et al.,* 2009). Thus, a quality audit service in accredited hospitals is a critical tool to evaluate care and standards of excellence, which can be analyzed from the observation of the records in the medical record, favoring the identification of problems and solutions (MORAIS *et al.,* 2015).

Final considerations

Nursing records should not be understood as a simple fulfillment of bureaucratic norms, in which it can be forgotten. It is necessary to have a sense of its real importance and of the implications of not correctly completing this document. In some cases, it is possible to highlight the lack of information, and this shows the devaluation of the registry, the lack of knowledge that many professionals have about this communication tool (PEDROSA *et al.,* 2011). Nursing records should reflect the biopsychosocial and spiritual conditions of the patient, and must include the occurrences that allow the follow-up and the evolution of the case. Nurses' records should allow referral to other health professionals, favoring the elaboration of an individualized care plan, with a view to comprehensive care and not only based on clinical protocols (VENTURINI and MARCON, 2008). When nursing notes are inaccurate, they may or may not correspond to the reality of professional practice. If care is not adequately recorded, important information can be neglected, making it difficult to continue care (SEIGNEMARTIN *et al.,* 2013). The inexistence or incomplete annotation makes it difficult for the health team to understand, which may be reasons that lead the patient to hospitalization, making it difficult to continue and plan the care, follow up of hospitalization, limiting integrative and humanized actions. Moreover, when this registry is scarce and

inadequate, it damages the care provided to the patient, as well as the institution and the nursing team. In addition, impairment of patient safety and care may occur, as well as difficulties in measuring the results of nursing care provided (SETZ and D'INNOCENZO, 2009). Communication among health professionals is fundamental to the organization and planning of the human care process. In this field, the written communication, represented by the nursing annotation aims at the continuity of the assistance provided, and allows to foment researches and audits, contributing to a more scientific nursing. Thus, if the communication domain is a facilitating instrument, the patients' needs will be more observed, understood and answered by health professionals (SEIGNEMARTIN *et al.,* 2013).

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