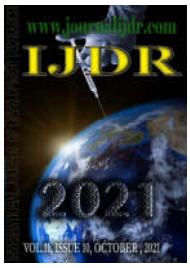
ISSN: 2230-9926

Available online at http://www.journalijdr.com

IJDR

International Journal of Development Research
Vol. 11, Issue, 10, pp. 51304-51307, October, 2021
https://doi.org/10.37118/ijdr.23029.10.2021



RESEARCH ARTICLE OPEN ACCESS

FAILURES IN NURSING NOTES THAT INTERFERE WITH THE QUALITY OF CARE: INTEGRATIVE REVIEW

Maurício José Almeida Morais[1], Reberson do Nascimento Ribeiro[1,] Jéssica Mykaella Ferreira Feitosa[2], Emmanuelle Novaes de Vasconcelos Brito[3], Marilene Evangelista Corrêa Noleto[4], Fernanda Cavalcante Macedo Candido[5], Suzana Portilho Amaral Dourado[6], Ilana Barros Moraes da Graça[7], Wildilene Leite Carvalho[7], Cristiane Costa Morais de Oliveira[7], Nívia Cristiane Ferreira Brandão Soares[7] , Maria Almira Bulcão Loureiro[7]and Maria Valneide Gomes Andrade Coelho[7], Maria Nauside Pessoa Da Silva[8] and Rafael da Silva Nascimento[8]

[1]UNIFACID University Center, [2]Facultaty of Technology and Higher Education (FATESP), [3]Fundação de Ensino Superior de Olinda- FUNESO, [4]Faculdade Santa Terezinha (CEST), [5]University Hospital of Maranhão–(HUUFMA), [6]University Center of Maranhao – UNICEUMA, [7]Federal University of Maranhao, [7]Mauricio of Nassau University Center (UNINASSAU)

ARTICLE INFO

Article History:
Received 07th August, 2021
Received in revised form
18th September, 2021
Accepted 23rd October, 2021
Published online 30th October, 2021

Key Words:
Audit,
Nursing Records,
Failures of Records.

***Corresponding author:**
Maria Lucilene dos Santos

ABSTRACT

Introduction: The nursing team is involved in all the stages of the assistance given to the patient, which generates a high quantity of registers related to the procedures. Objective: To analyze the failures in the nursing notes that interfere with the quality of care according to the literature. **Methodology:** This is Integrative Literature Review research in the LILAC, BDENF and SCIELO electronic library databases from original articles, in Portuguese language published in the period from 2010 to 2020. **Results:** The main flaws identified were: deficient content, which did not express the reality of the patients and the nursing care provided; absence of registration values of signs and symptoms, intercurrences and response to the nursing prescription. As for textual aesthetics, author identification and checking of items, the results were unsatisfactory. **Conclusion:** Hospital institutions need to invest more in training and health education courses for nursing professionals, since they are responsible for most of the records in patients' charts.

Citation: ***Maurício José Almeida Morais, Reberson do Nascimento Ribeiro, Jéssica Mykaella Ferreira Feitosa et al.*** "Failures in nursing notes that interfere with the quality of care: integrative review*", International Journal of Development Research*, 11, (10), 51304-51307.

INTRODUCTION

In the provision of health care, the Nursing team, due to the specificity of its work, is involved in all stages of patient care, which generates a high amount of records related to the procedures performed, such as: exams, medications, evaluations, intercurrences and expenses record (NAILA; CASTANHEIRA, 2015). The nursing records in medical records represent a primary tool to ensure the authenticity of the payment for materials, medications and procedures charged by the hospital medical institutions.

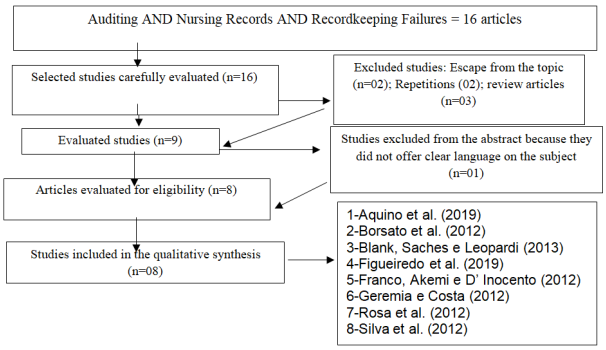
However, the absence of important records and/or the presence of inadequate, illegible or inconsistent nursing records can generate technical glosses of services, materials and drugs charged (OLIVEIRA; CARDOSO, 2017). The records of information on care are fundamental to the provision of services, its continuity will guide their remuneration, i.e., what will be paid. The patient's medical record is an essential tool in the audit of health services and should contain all the records of information relating to the assistance performed (ANDRÉIA; APARECIDA, 2014). These records will provide information that will guide the work of the nurse auditor to perform an evaluation from care to the management of costs arising

from health services. This professional in the evaluation of nursing records will adopt guidelines such as evaluation, accreditation, certification and correction of health practices, enabling the quality of care and reduction of hospital costs (LUZ *et al*., 2018). In this context, the auditor in nursing is responsible for ensuring quality care, through the evaluation of nursing records boosting reliability, safety and consistency by linking the information received with that shown in the medical record (AZEVEDO; GONÇALVES; SANTOS, 2018). It is also responsible for surveying care costs, making provision and adequacy of materials used, checking the correct use/collection of technical resources, providing permanent education to the operator and service providers, and conducting routine visits (IGNÁCIO; DIAS; ANDRADE, 2016). In this follow-up, we emphasize the importance of nursing professionals' awareness in recording information about the assistance offered in a consistent manner, in order to ensure adequate remuneration for the procedures performed and inputs used (LUZ *et al*., 2018). In addition, institutions providing health services should provide the sustainability of the services offered, with the main objective of reducing the costs associated with the assistance provided and at the same time, focus on increasing their excellence of performance (RODRIGUES, 2018). For a healthcare institution of excellence, a well implemented and conducted audit service is necessary, ensuring highly trained employees and excellence in quality of services offered (LUZ *et al*., 2018). The research aimed to analyze the failures in nursing notes that interfere with the quality of care according to the literature.

METHODOLOGY

This is an Integrative Literature Review, characterized as a method that provides the synthesis of knowledge and the incorporation of the applicability of the results of significant studies in practice, which is presented in six phases for the development process: development of the guiding question, literature search or sampling, data collection, critical analysis of the included studies, discussion of results and presentation of the integrative review (MENDES, SILVEIRA, GALVÃO, 2008).

Flowchart Method for the Selection of the Studies Included in the Integrative Review



Search: Author

The study arose from the guiding question: What are the failures in nursing notes that interfere with the quality of care? The research was conducted between October 2020 and January 2021 in the Scientifc Eletronic Library Online (SciELO), in the Latin American and Caribbean Literature on Health Sciences (LILACS) and the Nursing Database (BDENF) using the following controlled descriptors: "Audit; Nursing Records; Record Failures, according to the Health Descriptors (Desc), which were used in combination with the Boolean connective and. Original articles were included, in Portuguese language, which were published in the period from 2010 to 2020 and excluded repeated articles, monographs and theses.

For the search of articles, we used the combination of descriptors: Audit; Nursing Records; Records Failures that allowed the identification of 16 articles (LILACS=09; BDENF=06; SCIELO=01), of which only eight responded to the proposed objectives (LILACS=02; BDENF=06) and were selected to compose the study. Taking into account the inclusion and exclusion criteria, eight (08) articles were identified according to the flowchart. The analysis was built through the precepts proposed by Marconi and Lakatos (2016) that enabled the construction of two moments. In the first moment the collected data were submitted to a thorough reading for selection, then the results were presented in the form of tables. In the second moment the results were distributed discursively, making a comparison between the different findings through a standardization of the contents, which were grouped into categories.

RESULTS AND DISCUSSION

This research was built through the analysis and interpretation of eight articles. According to the data exposed in Table 1, it was observed that the year with the highest number of publications was 2012, followed by 2019. It was found that the articles presented different methodological approaches, with most articles being quantitative. The bases identified as having the highest predominance of studies were the BDENF. According to Chart 2, the main failures in nursing records were the absence of information on signs and symptoms of patients, prescriptions, nursing progression, and illegibility of information. These failures impacted directly on the audit work and cause economic consequences for the institution, as well as compromising the functionality of the record as a quality tool.

Failures in Nursing Records: According to Black; Sanches; Leopardi (2013), the main failures observed in the notes were fragility of the nursing records, which were incomplete and/or non-existent, hindering the audit work. These failures were attributed to the high turnover, inattention, the lack of commitment of the care nurse, the excessive workload in all units, and the non-existence or partial implementation of the Nursing Care Systematization (SAE). In the study conducted by Aquino *et al*., (2019) it was verified that the nursing notes in the medical records presented deficient content and did not express the reality of the patients and the nursing care provided. In this same study, it was observed the adequacy in the filling of data: date, time, and patient identification, but the filling of the Regional Nursing Council number and the professional's signature were not placed, signaling concern for the high percentage of non-compliance with ethical and legal aspects. It was also evidenced that illegible handwriting notes containing indistinct information with the nursing evolution and use of non-standard acronyms, records with erasures and blank spaces. Borsato *et al*. (2012) identified as failures in nursing records the absence of values for recording signs and symptoms, complications and response to the nursing prescription. They also showed failures regarding textual aesthetics, author identification, and item checking.

Silva *et al*. (2012) demonstrated the absence of records of procedures and nursing prescription, as well as records on the execution of medical orders in the care of patients admitted to intensive care units. Figueiredo *et al*. (2019) reinforce that the quality of records on the care provided to patients in emergency situations is a growing concern, considering that insufficient information affects and interferes with the quality of care provided, especially when related to identification data that, when incomplete, can compromise patient safety. In their research the following failures were shown: absence of descriptive annotation, date and time, rubric and stamp of the professional, admission, discharge and/or death, checking and legible handwriting. Rosa *et al* (2012) in their study conducted in a pediatric inpatient unit identified as failures in nursing records the large number of blanks, high percentage of absent notes regarding the nursing evolution and supplies performed. Another research that analyzed the quality of nursing records through retrospective audit identified medical records with inadequate records and the nursing prescription was non-existent (GEREMIA; COSTA, 2012). Franco, Akemi and D'Inocento (2012) also identified failures related to nursing evolution, prescription, absence of records and illegibility of information.

Chart 1. Description of articles according to title, author, year, journal and methodology

Title	Authors	Journals	Databases	Year	Methodology
Quality of nursing notes in the intensive care unit of a university hospital.	Borsato, Rossaneis, Haddad, Vannuchi e Vituri	Rev. Eletr. Enf	BDENF	2012	Descriptive-quantitative
Evaluation of nurses' records in medical records of patients admitted to a medical clinic unit.	Franco, Akemi e D' Inocento	Acta Paul Enferm.	BDENF	2012	Qualitative, exploratory and descriptive
Audit of the quality of nursing records in an inpatient clinical hospital unit.	Geremia e Costa	Rev. Adm. Saúde	LILACS	2012	Qualitative, quantitative-descriptive
Audit as a strategy for evaluating nursing records in a pediatric inpatient unit.	Rosa, Caetano, Matos e Reis	Rev Min Enferm	BDENF	2012	Cross-sectional, quantitative, retrospective
Evaluation of the quality of nursing notes in a semi-intensive care unit.	Silva, Martins, Lorenço e Silva.	Esc Anna Nery	SCIELO	2012	Qualitative, exploratory and descriptive
The practice of the hospital nurse auditor in the region of the Itajaí Valley.	Blank, Saches e Leopardi	Rev. Eletr. Enf	BDENF	2013	Qualitative, exploratory and descriptive
Nursing notes: quality assessment in intensive care unit	Aquino, Cavalcante, Abreu e Scopacassa	Enferm. Foco	BDENF	2019	Quantitative study
Evaluation of nursing records of patients admitted to the medical clinic of a university hospital in the north of Minas Gerais.	Figueiredo, Silva, Guimarães, Freitas, Guimarães, Freitas, Soares e Santos.	Rev. Pesqui. Cuid. Fundam	LILACS	2019	Descriptive, retrospective, documentary study with a quantitative approach.

Chart 2. Data on errors in nursing records and the impact of the absence of records

Author/ Year	Failure of nursing records	Impacts of missing nursing records
Borsato, Rossaneis, Haddad, Vannuchi e Vituri (2012)	Values for recording signs and symptoms, intercurrences, and response to the nursing prescription. As for textual aesthetics, author identification and checking of items, the results were unsatisfactory.	Hinders the work of the audit and economic consequences for the institution.
Franco, Akemi e D' Inocento (2012)	Failures related to the nursing evolution, the prescription, absence of records and illegibility of information.	Compromises the functionality of the registry as a quality instrument.
Geremia e Costa (2012)	Failures related to the nursing evolution, the prescription, absence of records, and illegibility of the information.	Compromises the functionality of the registry as a quality instrument.
Rosa, Caetano, Matos e Reis (2012)	Failures related to the nursing evolution, the prescription, absence of records and illegibility of the information.	Compromises the functionality of the register as an instrument of quality.
Silva, Martins, Lorenço e Silva. (2012)	Lack of records, procedures and nursing prescription, intensive care and medical orders execution.	Affects and interferes with the quality of care provided, especially when related to identification data.
Blank, Saches e Leopardi (2013)	Values for recording signs and symptoms, intercurrences, and response to the nursing prescription. As for textual aesthetics, author identification and checking of items, the results were unsatisfactory.	Hinders the work of the audit
Aquino, Cavalcante, Abreu e Scopacassa (2019)	Failures related to the nursing evolution, the prescription, absence of records and illegibility of information.	Hinders the work of the audit and economic consequences to the institution.
Figueiredo, Silva, Guimarães, Freitas, Guimarães, Freitas, Soares e Santos (2019)	Failures related to the nursing evolution, the prescription, absence of records, and illegibility of the information.	Compromises the functionality of the registry as a quality tool.

Strategies to Minimize Nonconformities in Nursing Records: To minimize the possible failures in nursing records, a research suggested the implementation of the SAE in the control and maintenance of these records in a manner consistent with the events that follow during hospital care, because the nursing audit manifests itself as an important management tool for the quality of care provided, and should be widely used for the evaluation of the care process (BLANK; SANCHES; LEOPARDI, 2013). Aquino *et al*. (2019) recommend that in the nursing records of patients admitted to the ICU, due to the complexity of care, it is necessary to improve written communication, avoiding errors in records or omission of records among nursing professionals and/or multiprofessional team to be efficient and reliable. Borsato *et al*. (2012) in another study conducted with nursing records in the ICU, found that the strategy suggested for change the need for educational measures and technical and care improvement of professionals. Three other studies point out the importance of health education actions to reinforce the nursing records properly and the need to improve the quality of records, with more complete information with data about the care that was performed with the patient. This will allow the records made to be reliable parameters for the achievement of levels of care excellence (FIGUEIREDO *et al*., 2019; FRANCO; AKEMI; D'INOCENTO, 2012; GEREMIA; COSTA, 2012). Figueiredo *et al*. (2019) also reinforce the need for efforts by the institution and the nursing team in the search for regularizing its process of records and multi professional communication, adopting, for example, the Systematization of Nursing Care in all its fullness and complexity, to ensure the continuity and quality of care provided to users; training by the Continuing Education team; and continuous monitoring of notes through the Audit of medical records. In addition to the previous studies, Silva *et al*. (2012) and Rosa *et al*. (2012) reinforce the need for a more thorough monitoring of the records made in the daily work and also the implementation of in-service education courses for all members of the nursing team working in this sector, in order to make them aware of the importance of recording information related to the patient's condition and, in particular, to the activities and actions performed for their care. All studies agree that a better documentation of the actions and interventions performed by the nursing team is important, remembering that the records should translate the maximum knowledge about the health conditions of the individuals, including both the aspects related to procedures and the needs, complaints and evolution of the patients, because the notes prove the nursing work, and the nurses' function is to lead and follow up the effectiveness of this record.

CONCLUSION

It was possible to reach the proposed objectives and it was evidenced that the main flaws in the nursing records were deficient content, which did not express the reality of the patients and the nursing care provided; absence of values for recording signs and symptoms, complications and response to the nursing prescription. As for textual

aesthetics, author identification and checking of items, the results were unsatisfactory. The impacts generated by these failures in nursing records generate difficulties in the audit work and economic consequences to the institution, compromising the functionality of the record as a quality tool, directly affecting the care provided. As interventional strategies, the selected studies brought the importance of training and improvement actions for the health team, in which the hospital institutions should invest in this follow-up, because the nursing records should translate the maximum knowledge about the health conditions of individuals. The limitation of this study is the limited amount of research in this area. In addition, there are many more review studies than field studies. Further research is suggested to address the usefulness of auditing in the evaluation of nursing record gaps, as this will enable the planning of interventional strategies. Studies such as these are relevant because they analyze published research in this segment and evaluate its results, in order to leverage new findings and discussions.

REFERENCES

Andréia, F., Aparecida, M. A Auditoria de Enfermagem como Possibilidade da Melhoria do Cuidado. Estudos, Goiânia, v. 41, especial, p. 43-58, out. 2014.

Aquino, M. J. N. *et al*. Anotações de enfermagem: avaliação da qualidade em unidade de terapia intensiva. Enferm. Foco, v. 9, n. 1, p. 07-12, 2019.

Azevedo, G. A., Gonçalves, N. S., Santos, D. C. A relação entre a auditoria e o sistema público em saúde. Rev. Adm. Saúde. Rio de Janeiro, v. 18, n. 70, set. 2018.

Blank, C.Y., Sanches, E. M., Leopardi, M. T. A prática do enfermeiro auditor hospitalar na região do Vale do Itajaí. Rev. Eletr. Enf. v. 15, n. 1, p. 233-242, 2013.

Borsato, F. G. *et al*. Qualidade das anotações de enfermagem em unidade de terapia intensiva de um hospital universitário. Rev. Eletr. Enf. Rio de Janeiro, v. 14, n. 3, p. 610-17, mai. 2012.

Figueiredo, T. *et al*. Avaliação dos registros de enfermagem de pacientes internados na clínica médica de um hospital universitário do norte do Estado de Minas Gerais. Rev. pesqui. cuid. fundam. Belo Horizonte, v. 11, n. 2, p. 390-96, set. 2019.

Franco, M. T. G., Akemi, E. M., D´Inocento, M. Avaliação dos registros de enfermeiros em prontuários de pacientes internados em unidade de clínica médica. Acta Paul Enferm. v. 25, n. 2, p. 163-170, 2012.

Geremia, Daniela Savi; Costa, Lediana Dalla. Auditoria da qualidade dos registros de enfermagem em uma unidade de internação clínica hospitalar. Rev. adm. saúde ; 14(55): 57-64, abr.-jun. 2012.

Ignácio, A., Dias, J., Andrade, M. O Papel do Enfermeiro na Auditoria de Enfermagem. Revista Ciência e Sociedade. Macapá, n. 1, v. 1, jan-jun. 2016.

Luz, A. M. *et al*. Características de anotações de enfermagem encontradas em auditoria. Rev Eletrônica Enferm. Rio de Janeiro, v. 9, n. 2, p. 344-61, set. 2018.

Naila, T., Castanheira, N. A Atuação do Profissional Enfermeiro na Auditoria em Saúde. Revista Saúde e Desenvolvimento. São Paulo, v. 7, n.4, p. 33-41, jan-dez 2015.

Mendes, K. D. S., Silveira, R. C. C. P., Galvão, C. M. Revisão integrativa: método de pesquisa para a incorporação de evidências na saúde e na enfermagem. Texto e contexto enfermagem. Florianópolis, v. 17, n. 4, p. 758-764, out./dez., 2008.

Oliveira, N.J., Cardoso, K.E. O papel do enfermeiro frente à auditoria hospitalar. Rev. Adm. Saúde. Rio de Janeiro, v. 17, n. 68, jul-set. 2017.

Rodrigues, J. A. R. M. Glosas em contas hospitalares: um desafio à gestão. Rev. Bras. Enferm. Brasília, v.71, n.5, set-out. 2018.

Rosa, L. A. *et al*. Auditoria como estratégia de avaliação dos registros de enfermagem em unidade de internação pediátrica. Rev Min Enferm. Belo Horizonte, v. 16, n. 4, p. 1-5, 2012.

Silva, J. A. *et al*. Avaliação da qualidade das anotações de enfermagem em unidade semi-intensiva. Esc Anna Nery. Rio de Janeiro, v. 16, n. 3, p. 576-81, 2012.

****