NURSING RECORD OF DRESSINGS OF VENOUS ULCERS IN THE BASIC ATTENTION

REGISTRO DE ENFERMAGEM DE CURATIVOS DE ÚLCERAS VENOSAS NA ATENÇÃO BÁSICA

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ABSTRACT

Objective: analyzing the main nursing problems in nursing records performed in patients with venous ulcers attended at a basic health unit. Method: an analytical, observational, transversal and documentary study with a quantitative approach. The subjects were clients with venous ulcers assisted at the Polyclinic of Niterói / RJ. The research project was approved by the Research Ethics Committee, Protocol 04879712.0.0000.5243. Results: ten patients aged 65 to 80, in which 80% are overweight, 90% had hypertension, 60% diabetics and smokers. Of the 40 records analyzed, there are only specified the saline solution and the topic product used not pointing quantity. Data, such as the evolution of injury, appearance and health condition of the patient are not registered. Conclusion: there is a deficit in the quality of the record related to the aspect of the lesion and its evolution, in addition to the user who receives health care. Descriptors: Primary Health Care; Varicose Ulcer; Nursing.

RESUMO

Objetivo: analisar os principais problemas de enfermagem nos registros de enfermagem realizados em pacientes com úlceras venosas assistidos numa unidade básica de saúde. Método: estudo analítico, observacional, transversal e documental com abordagem quantitativa. Os sujeitos foram clientes com úlceras venosas assistidos na Policlínica do município de Niterói/RJ. O projeto de pesquisa teve a aprovação pelo Comitê de Ética e Pesquisa, Protocolo n° 04879712.0.0000.5243. Resultados: dez pacientes com faixa etária dos 65 aos 80 anos, nos quais 80% dos pacientes apresentam sobrepeso, 90% são hipertensos, 60% diabéticos e tabagistas. Dos 40 registros analisados, são apenas especificados a solução fisiológica e o produto tópico utilizado não apontando quantidade. Dados como evolução da lesão, aspecto e condição de saúde do paciente não são registrados. Conclusão: há déficit na qualidade do registro relacionado ao aspecto da lesão e sua evolução, além do estado de saúde do usuário que recebe atendimento. Descriptores: Atenção Primária à Saúde; Úlceras Varicosas; Enfermagem.

RESUMEN

Objetivo: analizar los principales problemas de enfermería en los registros de enfermería realizados en pacientes con úlceras venosas asistidos en una unidad básica de salud. Método: es un estudio analítico, observacional, transversal y documental con un enfoque cuantitativo. Los sujetos asistidos fueron clientes con úlceras venosas en la Policlínica de Niterói/RJ. El proyecto de investigación fue aprobado por el Comité de Ética en la Investigación, Protocolo 04879712.0.0000.5243. Resultados: diez pacientes con edades comprendidas entre 65 y 80 años, en los que el 80% de los pacientes tenían sobrepeso, 90% hipertensión, 60% diabéticos y fumadores. De los 40 registros analizados, sólo especifican la solución salina y el producto tópico utilizado no apuntando cantidad. Los datos, tales como la evolución de la lesión, la apariencia y el estado de salud del paciente no están registrados. Conclusión: hay un déficit en la calidad del registro relacionado con el aspecto de la lesión y su evolución, además del usuario que recibe cuidado de la salud. Descriptores: Atención Primaria de Salud; Úlceras Varicosas; Enfermería.
The Nursing Record is a tool to actions and nursing care, being an ally for assistance and support to professionals. The record favors the exercise of clinical reasoning, creativity, and the best grip and professional performance of nurses.1

From the record is possible to obtain qualitative and quantitative dimensions of the whole operation, providing subsidies to the assessment and implementation strategies in health care.

Records or nursing notes consist of the form of written communication of relevant information to the client and to its care. It is understood that records are indispensable in human care process, because when written in a way that depict the reality to be documented, enable the continuous communication and can be for various purposes (research, audit, legal, planning and others).2

In view of the impact it has on care, its reliability, clarity and efficiency, records must be constantly analyzed and assessed with the trained professional nurse.

Primary Care comprises the largest range of network user population regularly and in need of long term care and monitoring the units. Primary Care considers the person in its uniqueness, complexity, in full; and socio-cultural integration and seeks the promotion of its health, prevention and treatment of diseases and harm reduction or suffering that may compromise its ability to live healthfully.3

The absence of records may involve, among other things, duplication of procedures performed, the difficulty of monitoring of care, and even the non-implementation of certain activity, which can endanger the user’s own recovery.4

Venous ulcers are chronic in nature, and present often relapsed and accompanied by amputations, for having variable therapeutic responses. Given these issues, effective and forceful nursing record about the evolution of such ulcers is fundamental to nursing care; allowing a greater monitoring and making decisions regarding the optimal therapy.

As specified in nursing practice, nurses’ autonomy in care is based on the resolution of COFEN 311/2007, by the Code of Ethics of Nursing Professionals; it is the duty of the professional, expressed in articles 25, 41, 68 and 72 respectively: registering in the patient’s medical record the inherent and indispensable information to care process; providing information, written and verbal, complete and reliable in order to ensuring continuity of care; registering in the medical records, and other own nursing documents, information relating to the care process of the person; and record the inherent and indispensable information to the care process in a clear, objective and complete way.5

Nursing record guides professional practice based on care encompassing assistance, prevention, health promotion and health protection. The record provides data for decision making, planning and creating strategies for care, allowing the reliable monitoring of the client, together with evaluations and reviews from professionals, ensuring a comprehensive care.

The rationale of this study lies on the fact that the performance of nursing professionals in a primary care unit in the city of Niterói - RJ may favor to users with venous ulcers who belong to the municipality a complete record, clear and effective procedures performed during dressing; thus, the return to work activities by the assisted clientele.

It allows to the professional mobility and facilitating the performance, as well as increased monitoring of the evolutionary process of venous ulcer patients, supporting decision-making in relation to proposed therapy and providing favorable consequences in the short and long term in developed nursing care.

There was defined as guiding question of this study: How are held nursing records in conducting healing in patients with venous ulcers treated at a basic health unit of Niterói/RJ? In order to seek answers to this question, this study aims to:

- Analyzing the main nursing problems in nursing records performed in patients with venous ulcers attended at a basic health unit.

An analytical, observational, transversal and documentary study with a quantitative approach performed at the Regional Polyclinic located in Niterói/RJ, Brazil.

Regarding inclusion criteria, participated in the research customers with venous ulcers that perform dressing change in the Regional Polyclinic located in Niteroi, of both genders, giving the requirement to perform the dressing change at least weekly in the polyclinic. Exclusion criteria were people under the age of 18 and people who were not able to supplement the data not obtained by the record.
Although being a documentary research under the guidance of the Research Ethics Committee, there was developed the Informed Consent (IC). For accessing records it was provided to the polyclinic and the customers the IC, where customers, research subjects, were duly informed about the research and its objectives, ensuring the anonymity of clients and professionals who carried out the records in all stages of the research according to Resolution 466/12 of the National Health Council (CNS).

There was performed by using two techniques, document consultation of medical records and non-participant observation in the period from October to December 2012. In the collection of data, document research was subjected to an observation and recording instrument, of standard form type created by the own researcher, issues relating to customer’s identification data, service data (such as human and material resources), and the detected nursing problems.

Survey participants were selected through spontaneous demand, with no sample size calculation being a non-probability sampling. The data collection period and observation of records correspond to the sector office hours (Monday to Friday from 8:00 to 12:00); there were analyzed 40 records and recorded the materials used in each dressing.

Because it is a basic unit, with a growing demand, it is possible to find records of several nursing professionals, which is important, due to the possibility of change of registration forms.

Nevertheless, this research offered no risk or harm to the subjects involved. The research will benefit oriented strategies in nursing care in emergency services, contributing to the health of the elderly and better development of nursing care. The results will be returned to the place of research in order to contribute to the improvement of the service as a whole, through educational prevention activities.

Simple Statistical analysis was performed by analyzing the results according to the evaluation carried out for adequacy of the information content at the expense of clients assisted in the search scenarios. Later, the data were entered in Microsoft Office program - Excel/Windows. The analysis was descriptive.

The research project was approved by the Committee of Ethics and Research of the University Hospital Antônio Pedro, Fluminense Federal University, in accordance with Resolution 466 of 2012 of the National Health Council through its item II - II.2 of the Free and Informed Consent, with protocol 04879712.0.0000.5243, with record 125 282 of 18th October, 2012.

RESULTS

Data were collected from ten patients with venous ulcers, who perform weekly monitoring in primary care unit. Among the participants in this study highlights four female users with venous ulcers of an average age between 65-80 years old and men, totaling 6 users with venous ulcers with an average age between 55-65 years old.

Among the age group 30-39 there has been one (10%) male patient. No patients aged 40-49. From 50 to 59 years old totaled four patients (40%), three men and a woman. No patients aged 60-69 participated in the study. From 70 to 79 years old totaled 3 patients (30%), two men and a woman. And a female patient aged 80-89 years old (10%).

Comorbidities presented by patients also point out the health profile of the same. Hypertension (9 patients - 90%) and diabetes mellitus (6 patients - 60%) are the main comorbidities presented by users with venous ulcers treated at the polyclinic. There are also seven patients (70%) with obesity. Fewer patients was 02 (20%) with thrombosis.

All data about the users were obtained through the record located in the file of the polyclinic, record that the user acquires so the entrance to service the unit. In addition, the procedures are recorded in book ata.

The amount of each material was collected in the presence of the researcher’s own observation of dressings performed by the nursing technician. These data are not recorded per patient by the nursing technician. That is, by recording cannot know exactly how much material is used in each patient.

Based on the completion of the data collection instrument it was possible to give an overview of which materials are best used and the amount used. Materials such as gauze, surgical mask, saline, adhesive tape, plastic bags, and liquid soap present the same percentage for all users (10%). The glove procedure and surgical mask are personal professional use materials and standard use, and other commonly used products of users, not requiring the use of a product for each dressing change.

Variations in the percentage of materials are present in gauze quantitative (13,80% of patients), bandage (11,11% of patients) and topical product (collagenase and sulfadiazine -
33% of patients) used, and these materials most commonly used in view of the size of the lesions, the appearance, amount of exudate ranging from user to user. Those with larger lesions, or the size of limb, or still drain a greater amount of exudate, require a greater use of the product.

Besides the quantity of materials used, there are materials in the collection tool that are not used in the dressing room clinic, for example, the package clamp. Material which, though present in the room is not used in the procedure, since the mechanical debridement procedure is not inherent to the nursing technician. The needle also does not appear specified in the table, although its use is made to give to the saline a jet caliber with ideal pressure; this technique is not used in the room.

The identification of what factors or conditions act as hindering the nursing record in the scenario is relevant in order to investing in continuous and permanent education. Efforts should be directed by the institution and by the nursing team in search to regularize their work process, adopting the systematization of nursing care in all its fullness and complexity, to ensuring continuity and quality of care provided to users.6

The materials used (bandage pack, saline, needle, syringe, gauze, tape, bandage, surgical procedure glove and mask) point to the importance of registering the amount of material used per patient in order to scale the average and use costs. This prevents the accumulation of little or no materials used and allows the exact distribution of materials needed for the sector, according to the demand for treatment. In addition to material resources, the appearance of the lesion and patient data must be properly registered.

Among all patients in whom the records were analyzed, the name, the place and the material used (100%) are the only items recorded the procedures performed. Only 1 (10%) patients had the forwarding record for accompanying another service (for Diabetes and Hypertension clinic). It is noteworthy that the site of injury is specified only for the limb. There is no record on the anatomically affected region. The record of the etiology, appearance and size of the wound, presence/absence of exudate, exudate aspect and nursing diagnosis on the problems encountered in the wounds are also not registered.

**DISCUSSION**

The non-probability sample of this research in the basic unit is directly linked to the intense flow of care and at such a situation, it is necessary to combine quality service and care provided with greater mobility and convenience in the proceedings. Given this reality, nursing records should follow the standard for quality, especially with regard to the healing records, given its importance.

The sector's reality follows the profile of most dressing rooms of basic units in Brazil, save exceptions, where the flow is continuous and the demand variable. This has an impact on service, and consequently, the registration of the activities. In addition to the daily challenges of the country's health system; this is responsible for the infrastructure of operation of units.

During the study, it was observed that the records are held exclusively by the nursing technician and not by the nurse. In addition to the records, the absence of nurses in the sector is one of the highlights in view of the importance of systematization of nursing care to patients with ulcers. The nursing diagnoses do not appear in the record, since it is assigned by the same.

This is specified in Resolution COFEN-358/2009, which provides for the systematization of nursing care and the implementation of the Nursing Process in public or private environments that is professional care in nursing, which reports in its Article 2 that the Nursing Process is organized into five steps interrelated, interdependent and appellants, of these steps the Nursing Diagnosis, consisting of a process of interpretation and grouping of data collected in the first stage, culminating in the decision-making on the concepts of nursing diagnoses, which are, more accurately, the responses of the person, family or human community at a given time of the health and disease; and which form the basis for the selection of actions or interventions with which it aims to achieve the expected results.7 This activity is characterized as privative of the nurses.

It is worth noting the Resolution COFEN 311/2007, by the Code of Ethics of Nursing Professionals, being the professional duty, expressed in articles 25, 41, 68 and 72, respectively: registering in the patient's medical record and the inherent information essential to the process of taking care; providing information, written and verbal, complete and reliable, in order to ensure continuity of care; registering in the medical...
When evaluating ulcers it is important to take into account the ulcer and skin features around them, as they may indicate changes as pain, redness, warmth, edema, maceration, dryness, peeling, eczema, hyperpigmentation or other changes, too valuable to direct treatment. Beyond the exudate characteristics, this can be serous, serosanguineous, bloody, bloody form and purulent. The purulent exudate indicates infection. Still, states that a record of observation of the amount of exudate is important to evaluate the ulcer and can be estimated by clinical observation and quantified by drainage. Ends with the appearance of the ulcer by specifying this tissue type, as will be indicative of what phase of the ulcer healing process is.

Also in dealing with the evaluation of the patient and of the injury, include in this process the identification data, clinical history, physical examination, especially evaluation of the ulcer and the evaluation of the data record in proper form with determining treatment and co patient-responsibility, in addition to frequent completion of the registration data and approaches adopted and implemented.

Note that the necessary referrals made were recorded without, however, pointing to the cause or reason for referral.

To ensuring effective nursing record, first qualification is necessary, understanding of the work process and tools needed for the formulation of the record.

The evolution of continuous nursing performed by nurses offers a review about the state of the client and the actions that were performed. We understand that evolution should not be interpreted only as a record, but as a way to analyze and evaluate the proposed interventions and reshape them according to the care demands that varied during the hospitalization period.

The nurse plays a major role in the team qualifying and in the development of mechanisms that help to care routine. It can act as a facilitator and mediator of the qualification process and education of our team; it will act in order to have a positive impact on the service and in patient care.

We believe that the nurse manager must provide skills aimed at combining the supervision and control of a quality nursing care, a clear perception and expanded health facility, critical thinking about reality, initiative for production of new knowledge and technologies, development of strategies for resolving problems and actions on
identified weaknesses, motivational profile and relational skills.\textsuperscript{12}

Being the nursing record a tool for its performance, this research can achieve the purposes for analyzing nursing records performed in patients with venous ulcers, and identifying the main nursing problems in the same patients, which is not monitoring the health status in correlation with the evolution of the injury. Thus, it was suggested the institution of this study (through refresher courses) the preparation and proposal of a curative registration protocol for patients with venous ulcers, for routine care industry. In addition, training on the systematization of nursing care was referred to that nurses can work in wound repair facility of this basic health unit.

This suggested protocol should contain relevant information about the injury and the exudate (amount, odor, the wound bed, adjacent area), and additional data, such as: routes, stay in the sector, nursing diagnosis, scheduling, and signature of the professional. There is also the record of the materials used for control of the care provided and the prediction and provision of even better care of patients.

CONCLUSION

Performing a search comes from restlessness, a doubt in search for answers, in a proposal to be implemented, and a question to be defended. Despite the setbacks that scenario faces, given the poor the facilities to care, the research objectives were achieved. Nursing records performed in patients with venous ulcers were analyzed and we observed a large deficit in the quality of it, related to patient identification, the aspect of the lesion and its evolution, beyond the user who receives health care.

Already the identification of the main nursing problems, there is, besides the quality of the records, the absence of nurses in the scenario where there is no qualification of professionals who perform the procedures nor the application of the nurse’s duties in the care system, which in turn undertakes monitoring of patient care, and their health status correlated with the evolution of the injury.

Among the study’s limitations, the change of direction in the unit, in addition to material resources that were in short supply, exerted great impact on research, since the demand for curative suffered a significant drop, which influenced the data collection. Besides the difficulty of providing more specific and detailed data about the users with recorded data, since the records are difficult to access and have insufficient data. Still, the challenges of research, together with the data collected and analyzed showed even more the landscape of primary care networks, where there is plenty to explore and develop professional training of attending such a wide range of the population.

The study allowed as input, the identification of the profile of patients with venous ulcers treated at the dressing room of the clinic, as a real view of the industry structure, with its difficulties and challenges in treatment, in addition to the finding of a need for change in preparation of records of procedures performed. The research can contribute, without more, with the development of a protocol to facilitate and assist in the record.

Understood the importance of an effective, reliable and practical record in the action of the health professional, directed to care of ulcers, this research allows encourage future studies about the records in other primary care networks cared about users with ulcers of different etiologies.

REFERENCES


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