



PATIENT'S MEDICAL RECORD: QUALITY OF THE RECORDS UNDER THE PERSPECTIVE OF THE MULTIPROFESSIONAL TEAM

PRONTUÁRIO DO PACIENTE: QUALIDADE DOS REGISTROS NA PERSPECTIVA DA EQUIPE MULTIPROFISSIONAL

REGISTRO MÉDICO DEL PACIENTE: LA CALIDAD DE LOS REGISTROS ANTE EL PUNTO DE VISTA DE EQUIPO MULTIPROFESIONAL

Lenilma Bento Araújo Meneses¹, Alyne Fernandes Bezerra², Flávia Maiele Pedroza Trajano³, Maria Júlia Guimarães Oliveira Soares⁴

ABSTRACT

Objective: identifying the quality of nursing records under the perspective of multiprofessional communication. **Methodology:** a documentary research with a qualitative approach developed between December / 2010 and June / 2011, in the medical clinical unit of the University Hospital Lauro Wanderley. The research universe consisted of medical records of patients hospitalized for more than a week and assisted by at least three professionals. There was used a pre-structured instrument consisting of objective questions. The project was approved by the Research Ethics Committee, Protocol 194/10. **Results:** it was possible to identify inadvertencies with regard to the organization of the records, objectivity, clarity, continuity of information, beyond the almost absence of multidisciplinary communication between the team members and the aspects that will subsidize the Systematization of Nursing Care. **Conclusion:** the results make us reflect on the assistance provided to the patient, and thus, seek for improvement of the same. **Descriptors:** Nursing Records; Continuity of Assistance to Patients; Patient Care Team; Nursing.

RESUMO

Objetivo: identificar a qualidade dos registros de enfermagem na perspectiva da comunicação multiprofissional. **Metodologia:** pesquisa documental com abordagem qualitativa desenvolvida entre dezembro / 2010 a junho / 2011 na unidade de clínica médica do Hospital Universitário Lauro Wanderley. O universo da pesquisa constou de prontuários dos pacientes internados a mais de uma semana e assistidos por pelo menos três profissionais. Foi utilizado um instrumento pré-estruturado constituído por questões objetivas. O projeto foi aprovado pelo Comitê de Ética em Pesquisa, protocolo 194/10. **Resultados:** foi possível identificar inadvertências quanto à organização dos prontuários, objetividade, clareza, continuidade das informações além da quase inexistência da comunicação multiprofissional entre os membros da equipe e os aspectos que fornecerão subsídio para a Sistematização da Assistência de Enfermagem. **Conclusão:** os resultados fazem refletir sobre a assistência prestada ao paciente, e dessa forma, buscamos melhoria a mesma. **Descritores:** Registros de Enfermagem; Continuidade da Assistência ao Paciente; Equipe de Assistência ao Paciente; Enfermagem.

RESUMEN

Objetivo: identificar la calidad de los registros de enfermería en términos de comunicación multiprofesional. **Metodología:** una investigación documental con enfoque cualitativo desarrollada entre diciembre de / 2010 a junio de / 2011 en la clínica médica del Hospital Universitario Lauro Wanderley. El universo de la encuesta consistió en históricos clínicos de pacientes hospitalizados en más de una semana y vigilados por al menos tres profesionales. Se utilizó un instrumento pre-estructurado que consta de preguntas objetivas. El proyecto fue aprobado por el Comité de Ética en la investigación, protocolo 194/10. **Resultados:** fue posible identificar inadvertencias cuando a la organización de registros médicos, objetividad, claridad, continuidad de la información, además de la casi ausencia de comunicación multiprofesional entre los miembros del equipo y aspectos que proporcionarán subvenciones para la Sistematización de la Atención de Enfermería. **Conclusión:** los resultados hacen reflexionar acerca la asistencia prestada al paciente y buscar la mejora de la misma. **Descriptor:** Registros de Enfermería; Continuidad del Cuidado al Paciente; Equipo de Atención al Paciente; Enfermería.

¹Nurse, Resident of Emphasis on Health Care for the Elderly of Integrated Multiprofessional Residency in Hospital Health, Federal University of Paraíba. João Pessoa (PB), Brazil. Email: alyne.fernandes@hotmail.com; ²Nurse, Master's Student of Cognitive Neurosciences and Behavior, Centre for Human Sciences, Letters and Arts of the Federal University of Paraíba. João Pessoa (PB), Brazil. Email: flaviamaiele@hotmail.com; ³Nurse, Master in Public Health Nursing, Doctoral Student at PPGENF/UFPB, linked Lecturer at Department of Clinical Nursing of the Health Sciences Center, Federal University of Paraíba. João Pessoa (PB), Brazil. Email: lenilmabento@yahoo.com.br; ⁴Nurse, Professor, Department of Clinical Nursing/Nursing Postgraduate Program, Federal University of Paraíba/PPGENF/UFPB. João Pessoa (PB), Brazil. Email: mmjulieg@gmail.com

INTRODUCTION

According to Resolution nº 1.638/02¹ of the Federal Council of Medicine, medical record is defined as a single document consisting of a set of recorded information generated from facts, events and situations about patient's health and assistance provided to him. It is legal, secretive and of scientific nature. The information is obtained from the report and the technical observation of the patient and should be organized in a systematic way, allowing them to be used by the team when necessary.²

The records of the assistance kept in the archives establish written communication of information on the conditions of health-disease and care that are necessary in order to ensure continuity of care. It also contributes for the identification of new changes, evaluation and monitoring of user responses to the care provided. This communication occurs daily, in a verbally and non-verbally way, in the dialogues among practitioners and in writing, reports and developments recorded in the medical records of patients.³ The patient's medical record, in its entirety, provides the necessary information to resolve any questions that perhaps appear on procedures performed to patient care.⁴

The communication within the health care essentially occurs through the records kept in the archive. These well-formulated records not only reflect the quality of the service, as it becomes fundamental elements for cases of financial compensation and Ethical and Legal purposes.³

The medical record allows planning an appropriate intervention, regardless of the professional who is assisting.⁵ They favor communication between the health team promoting the evaluation of the quality of the service provided.⁶

A survey conducted in Natal/Rio Grande do Norte State, claimed that the record of assistance in the patient, involves various aspects and supports the professional ethics and legally responsible for the care, as well as the patient. When this record is sparse and inadequate compromises patient care as well as the institution.⁷

It is noteworthy that the records belong to the patient, but it is up to the professionals and clinical directors and/or technical directors of health services, the responsibility for custody of the documents. It is also for the hospital and health unit the responsibility for the complete and correct completion of the

medical record, user's rights and requires that information regarding the same are recorded properly. Disorganization and lack of clarity in writing, insufficient data about the user and his diagnosis, can lead to physical and mental strain for the professional and reduce the time that could be dedicated to benefit the patient.⁸⁻⁹

The patient's medical record is a legal document in defense of users, professionals and institutions and should be imbued with authenticity and legal significance; it reflects the commitment and the work force of the health team, enhancing thus their actions, especially the nursing staff, because it has the largest number of professionals involved in the care.³

Importantly, the nursing professional working in promotion, prevention, recovery and rehabilitation, in line with the ethical and legal requirements, as determined by the profession's Code of Ethics. In relations with the nursing staff and other professions, the right of the professional part of the multidisciplinary and interdisciplinary practice with responsibility, autonomy and freedom.¹⁰

It is also guaranteed in *Article 25 of the Code of Ethics of nursing professionals* the record of the patient, all the information inherent to the process of caring.¹⁰ Thus nursing care aims to provide a safe, agile, creative, effective, legal and efficient users, family and community. "The nursing records are the records made by the nursing staff in the medical record and must meet the biopsychosocial and spiritual conditions in addition to all the facts of care, allowing conditions to give continuity of care".¹¹

The records kept by the nursing staff (nurses, technical and auxiliary) have the essential purpose of providing information on the given assistance, ensuring communication among team members and guaranting the continuity of information within 24 hours, a prerequisite for the understanding of the patient in a global way, constituting the "mirror" of care.

The notes of the patient are very important to ensuring the quality of care, support teaching and research, promote budget transfer to the hospital, exempt professional legal problems and enable the multi-communication between the health team. Being the professional nurse accompanying the patient in most of his hospital stay, his notes should contain information to help other professionals involved in the treatment, favoring the recovery process and reducing the hospitalization period.¹²

The records of care provided by nursing professionals should contain a set of information allowing the systematization of care as set out in Resolution of the Federal Council of Nursing 358/200911 on the Systematization of Nursing Care in Brazilian health institutions. The resolution states that the implementation of the Nursing Process is formally recorded, including: a) a summary of the data collected about the person, family or community a moment of the health and disease; b) nursing diagnoses related to the person answers, family or community at a time of the health and disease; c) actions or nursing interventions implemented on the identified nursing diagnoses; d) the results obtained as a result of actions or nursing interventions.

The Systematization of Nursing Assistance (SAE) provides, through records, communication between multidisciplinary and interdisciplinary team which ensures the professional nursing and the institution the legal support, an important means of ensuring the quality of care.¹³

We know that there is a great amount of information in hospital records that these build the user story from admission to discharge, written by several hands. It is worth noting that the nursing information is essential for the realization of the nursing process. However, there are many complaints related to eligibility and discontinuity of this information, bringing often irreversible damage to the user, the institution, health professionals and society as a whole. There are few inaccuracies and/or omissions records; grammatical and spelling errors; the factual relations; under general and can thus cause the commitment of information.

Given the above, this study has the following objectives:

- Identifying the quality of nursing records in the context of multiprofessional communication;
- Investigating the rules and regulations about the registration in the patient's record to allow the implementation of the Nursing Process.

METHOD

It is a documentary research with a quantitative approach developed in the medical unit of a federal public hospital in the city of João Pessoa - Paraíba, between the months of December 2010 to June 2011.

Although not directly research involving human subjects, the documents searched have private and confidential information about

these, so we tried to meet the regulatory standards established by the National Health Council defining research involving human subjects. The project was evaluated by the Research Ethics Committee of the University Hospital Lauro Wanderley and approved on June 3rd, 2010, under number 194/10.

There were analyzed 24 records of hospitalized patients, respecting the previously defined requirements, they are: inpatient *more than a week, assisted by at least 03 professionals*. The purpose of having been given the period of more than a week of hospitalization was due to the ease in assessing records, as with a lower period, the data may be insufficient to identify the information that was intended to research. As regards the criterion to be assisted by at least three distinct specialty professionals, was the intention of identifying the continuity of care, as well as communication between team members from what has been registered.

For data collection, it was designed a pre-structured instrument with objective questions concerning the organization of the record, multiprofessional communication and data that subsidize the Systematization of Nursing Assistance - SAE.

The research was structured in three stages as follows:

The first stage consisted of identifying the records in accordance with the proposed requirements. In the second stage, some records were selected for implementation of the pilot test in which it was perceived the need to recast the tool to better suit the objectives of the research.

In the third stage occurred collecting the data itself. We find it hard to meet the proposed requirements, because of the number of records that had only records of members of the medical and nursing staff; it was also perceived the need to adjust the instrument. Overcome the difficulties, it proceeded to collecting data, to the saturation of repetition of the things that were being evaluated.

After collection, the findings were organized as a result of the instrument and discussed based on the literature concerning the matter.

RESULTS

Data analysis aimed to evaluating the information recorded in the medical records, to identify its organization, the communication between the multidisciplinary team members from the notes and information from the nursing staff to provide

sufficient data for the systematization of nursing care.

Referring to the structure of the charts, respondents are paper, separated by specialties, divided into different folders (record itself and prescriptions), it was observed that the organization of records itself hinders the interaction between professionals, since that the output of the different professionals are arranged separately. Another finding was that the records are not made in the chart in chronological evolutionary order, ie the oldest to the most current, this factor also impair to evolving understanding about the health-disease process. It is noteworthy that the provisions folders are only prescriptions, with no printouts of diagnoses, interventions and nursing prescriptions.

There were selected and evaluated medical records of 24 patients admitted for more than a week in the medical unit of a federal public hospital and were as criteria, followed by at least three health professionals, among them 100% medical professionals (doctors, residents and interns) and 100% of nursing professionals (nurses and nursing assistants), 62,5% and 37,5% Physiotherapists and Nutritionist, respectively.

As regards the clarity of the information recorded, 75% of the notes of nursing assistants and nurses showed up clear, while the records of professionals and/or internals of medicine, we clearly identified in 50% of surveyed medical records, thus making it difficult to understand the care and the prescribed conduct, which directly interferes in the treatment.

Regarding the exemption of erasures, it was observed that 92% of nursing reports and 71% of medical staff developments had this type of error. Developments of nutritionists and physiotherapists were in line with the deletions exemption rule. Among the most common erasures, included: features and notes erased with corrective liquid, without due justification.

Another finding was the writing with red pen, the reports of night shifts, made only by the nursing staff; warning that the shades of red ranging from bright red, wine, pink, lilac, and colors glow and glitter. It is worth mentioning that to be the medical record a legal document, it should always be written in blue because red is not suitable for paper and black can be confused with xerox.

Regarding the multi-communication, it was observed that only 27% of the records had some kind of connection with what was written by another professional. Thus, it was

noticed that each employee was limited to make his notes, not taking into account the records of other team members, often not related to what they themselves had written earlier, so little, they showed continuity with the records the day before making discontinued and repetitive notes. It is important to emphasize that miscommunication between staff can harm the user, resulting in a discontinuity in care.

With regard to records that would favor the implementation of the Systematization of Nursing Assistance (SAE), we observed that these are deficient or nonexistent. Having been identified only two stages of the process, the History and the Nursing Report, however, this last stage basically written by nursing assistants, consisting exclusively of notes of vital signs, administering medications and procedures performed; the historicals that were incomplete, with illegible signature or line and not on the stamp of the professional or number of COREN.

DISCUSSION

Because they are willing records in paper form, have several limitations, both practical and logical in relation to computerized medical records. The records in paper form only stay in one place at one time, in addition, may occur illegibility problems, ambiguity in the records, loss of information, multiple folders, collective research difficulties, lack of standardization, difficulty of access and fragility of paper and can easily be destroyed, torn, defaced¹⁵. Corroborating the above authors also say that paper records must be arranged in chronological evolutionary way, easy handling and consultation, enabling an overview of the clinical status of the patient ensuring the continuity of information and facilitating communication between the various health teams.³

With regard to electronic records it is appropriate mentioning that studies in two hospitals in the city of Recife/PE ensures that there was a significant approval from the nurses regarding the application of computer technology at work.¹⁶

Regarding the objectivity of the information in the record, it was included repeated notes without continuity with the previous and use of routine and colloquial terms such as: *patient, the examination at the time, good general condition, follows under the nursing care*. We also found excessive abbreviations that do not follow any kind of standardization, thus making it difficult to understand.

The objectivity of the information "*the indiscriminate use, abusive and without criteria of abbreviations, acronyms or acronyms can often allow misinterpretation and undermine the objective and careful description of the texts.*" Thus, every record made in the patient's should be written legibly, if possible press, for its illegibility easily lead to misinterpretation and consequently may compromise the timely and adequate assistance.¹⁷

According to the nursing literature practice of writing in red ink dates back to the days of Florence Nightingale, when he made the first of nursing service organization tests during the Crimean War. From this time, the nursing staff went on to repeat the practice of red writing on night shifts. The laws regulating the nursing profession does not take decisions in this matter. However, we understand that the records being a legal document, written in "red" are not allowed because they are considered inadequate, injuring the legality of the document. And the "black" color written are easily confused with Xerox for this reason, they should also not be used. Being only permitted color writing in "Blue".^{10,11}

Regarding the nursing evolutions, these were found only in cases of patients with a serious or considered framework that presented complications. These findings contradict the Federal Nursing Council Resolution 358/2009 which determines the SAE should be implemented in health institutions and their steps formally recorded in the patient's medical records should consist of: History; Physical exam; Diagnosis of Nursing; Prescription of nursing; Development assistance; Nursing report.¹¹

In an evaluation study of nursing records at a private hospital in São Paulo, it was observed that nurses held records in only 44 (29%) medical records, while nursing aides recorded his activities in 76 (51%) medical records and nursing technicians in 30 (20%) records, for a total of 96 (71%) medical records filled by qualified professionals, ie, not more.¹⁸

The surveyed records, as spoken earlier, serves in part to Resolution 358/09 of COFEN, because the notes are present inconsistent and insufficient to implement the systematization of nursing care.¹¹

It is noteworthy that the record is a legal document, not being allowed blots, lines, erasures or phrases erased with corrective liquid, without the necessary corrections, under the risk of losing its legal value, as defends the Federal Council of Medicine.¹ It is

recommended that in case of errors '*be made an underline on the word*'; then it is written in parenthesis (say) 'and rewrites the correct word or phrase'.

It is worth mentioning that the records being done effectively enables continuity of care and facilitates multidisciplinary communication. Studies show that multidisciplinary care leave users satisfied with the assistance being provided.

CONCLUSION

The research has revealed that among the main problems found in the records, the illegibility (illegible handwriting), spelling erros, use of incorrect terminology and non-standard acronyms, stood out with greater frequency as well as the failure to identify the professional, either by lack of stamp, or name, or rubric illegible, or even the lack of signature and even the presence of blanks or excessive dashes and risks.

The notes made by the professional staff do not characterize multi-communication, nor allow the continuation of information between interdisciplinary and multiprofessional team, making the evolutions repetitive and disjointed, not thus, allowing an assistance of quality.

The findings also revealed poor understanding of the professionals about the rules governing one record, as well as ignorance of the laws that shape as a legal, ethical and confidential document, leading us to reflect on the quality of care, as regards continuity of treatment and procedures to be formalized.

REFERENCES

1. Conselho Federal de Medicina. Resolução CFM no 1638/ 2002. Define prontuário médico e torna obrigatória a criação da comissão de prontuário nas instituições de saúde. Available from: http://www.portalmedico.org.br/resolucoes/cfm/2002/1638_2002.htm
2. Thofehrn C, Lima WC de. Prontuário Eletrônico do Paciente - A Importância da Clareza da Informação. Rev Eletrônica do Sistema de Informações [Internet]. 2006 [cited 2010 Mar 30];5(1):1-5. Available from: <http://revistas.facecla.com.br/index.php/rei/nfo/article/download/168/65.pdf>
3. Possari JF. Prontuário do paciente e os registros de enfermagem. 1st ed. São Paulo: Látria, 2007.
4. Françolin L, Brito MFP, Gabriel CS, Monteiro TM, Bernardes A. A qualidade dos registros de enfermagem em prontuários de

pacientes hospitalizados Rev enferm UERJ [Internet]. 2012 [cited 2014 Oct 23];20(1): 79-83. Available from: <http://www.e-publicacoes.uerj.br/index.php/enfermagemuerj/article/view/3981/2763>

5. Barletta JB, Paixão ALR, Feitosa EPS, Oliveira KS, Santos LA. O prontuário psicológico como recurso para pesquisa e atuação: repensando a formação da competência profissional. Rev Psicol Saúde [Internet]. 2012 [cited 2014 Nov 12];4(2): 135-42. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S2177-093X2012000200006&lng=pt.

6. Seignemartin BA, Jesus LR, Vergílio MSTG, Silva EM. Avaliação da qualidade das anotações de enfermagem no pronto atendimento de Um hospital escola. Rev Rene [Internet]. 2013 [cited 2014 Nov 7];14(6):1123-32. Available from: <http://www.revistarene.ufc.br/revista/index.php/revista/article/view/1352/pdf>

7. Azevêdo LMN, Oliveira AG, Malveira FAS, Valença CN, Costa EO, Germano RM. A visão da equipe de enfermagem sobre seus registros. Rev Rene [Internet]. 2012 [cited 2014 Nov 7];13(1):64-73. Available from: <http://www.revistarene.ufc.br/revista/index.php/revista/article/view/18>

8. Peduzzi, M. Equipe multiprofissional de saúde: conceito e tipologia - atualização. Rev. Saúde Públ. [Internet]. 2001 [cited 2012 Oct 10] 35(1):101-9. Available from: http://www.scielo.br/scielo.php?pid=S003489102001000100016&script=sci_abstract&tlng=pt.

9. Teixeira, MCB. A dimensão cuidadora do trabalho de equipe em saúde e sua contribuição para a odontologia. Ciênc saúde coletiva [Internet]. 2006 [cited 2012 Oct 10];11(1):45-51. Available from: <http://www.scielo.br/pdf/csc/v11n1/29447.pdf>

10. Conselho Federal de Enfermagem. Resolução COFEN n° 311/2007. Aprova reformulação do Código de Ética dos Profissionais de Enfermagem. Available from: http://www.cofen.gov.br/resoluo-cofen-3112007_4345.html

11. Conselho Federal de Enfermagem. Resolução COFEN n° 358/ 2009. Dispõe sobre a Sistematização da Assistência de Enfermagem e a implementação do Processo de Enfermagem em ambientes, públicos ou privados, em que ocorre o cuidado profissional de Enfermagem, e dá outras providências. Available from: http://novo.portalcofen.gov.br/resoluo-cofen-3582009_4384.html

12. Patrício CM, Maia MM, Machiavelli JL, Navaes MA. O prontuário eletrônico do paciente no sistema de saúde brasileiro: uma realidade para os médicos? Scientia Médica [Internet]. 2011 [cited 2012 Oct 05]; 21(3):121-31. Available from: <http://revistaseletronicas.pucrs.br>

13. Gubiani JS, Rocha RP, D'Ornellas MC. Interoperabilidade Semântica do Prontuário Eletrônico do Paciente. Anais do II Simpósio de Informática da Região Centro [Internet]. 2003. Aug. [cited 2012 Oct 05]. Available from: <http://www.sirc.unifra.br/artigos2003/Artigo16.pdf>

14. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução nº196, de 10 de outubro de 1996: diretrizes e normas reguladoras de pesquisa envolvendo seres humanos. Brasília: Ministério da Saúde; 1996.

15. Dorileo ÉAG, Silva MP, Costa TM, Felipe JC. Estruturação da Evolução Clínica para o Prontuário Eletrônico do Paciente. Anais do X Congresso Brasileiro de Informática em Saúde [Internet]. 2006. Oct. [cited 2012 Oct 10]. Available from: <http://www.sbis.org.br/cbis/anaiscbis2006.htm>

16. Alves DS, Novaes MA. Perfil da equipe de enfermagem e grau de satisfação em relação à usabilidade do prontuário eletrônico do paciente. J Nurs UFPE on line [Internet]. 2013 [cited 2014 Oct 23];7(1):143-52. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/2971/pdf_1958

17. Reppetto MÂ; Souza MF. Avaliação da realização e do registro da Sistematização da Assistência de enfermagem (SAE) em um hospital universitário. Rev Bras Enferm [Internet]. 2005 [cited 2012 May 10];58(3): 325-9. Available from: http://www.scielo.br/scielo.php?pid=S003471672005000300014&script=sci_arttext

18. Draganov PB, Reichert MCF. Avaliação do padrão dos registros de Enfermagem. J Nurs UFPE on line [Internet]. 2007 [cited 2014 Nov 12];1(1):36-45. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/108766-1-pdf_165.

19. Wetmore S, Boisvert L, Graham E, Hall S, Hartley T, Wright L. Patient satisfaction with access and continuity of care in a multidisciplinary academic family medicine clinic. Can fam physician [Internet]. 2014 [cited 2015 Mar 10];60(4):230-6. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4046539/>

Meneses LBA, Bezerra AF, Trajano FMP et al.

Patient's medical record: quality of the records...

20. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. *BMJ* [Internet]. 2003 [cited 2014 Nov 07];327(7425):1219-21. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC274066/>

Submission: 2015/04/20

Accepted: 2015/07/04

Publishing: 2015/10/01

Corresponding Address

Alyne Fernandes Bezerra
Rua Bacharel Wilson Flávio Moreira Coutinho,
538 / Ap. 104
Jardim Cidade Universitária
CEP 58052-510 – João Pessoa (PB), Brazil