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REFLECTIVE ANALYSIS ARTICLE

QUALITY OF NURSING RECORDS: ANALYTICAL REFLECTIONS ON ITS FORMS AND CONTENTS

QUALIDADE DOS REGISTROS DE ENFERMAGEM: REFLEXÕES ANALÍTICAS EM SUAS FORMAS E CONTEÚDOS

LA CALIDAD DE LOS REGISTROS DE ENFERMERÍA: REFLEXIONES ANALITICAS EN SUS FORMAS Y CONTENIDOS

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ABSTRACT

Objective: analyzing the quality of records kept by the nursing staff. ***Method:*** a descriptive and documental study conducted in inpatient unit of a university hospital in Rio de Janeiro/RJ/Brazil, from May to September 2012, with a sample of 626 reporting units. The study had the project approved by the Research Ethics Committee, CAAE 00836312.1.0000.5285. ***Results:*** there were found: only one note per shift (95%); indiscriminate use of abbreviations and acronyms (92,6%), date absence (56,7%), no hour (43,6%), deletions (18,2%) and absence of professional identification (10,1%). ***Conclusion:*** the inadequacies point to a weakness of the records, hindering communication between the teams, the incorporation of universal terms in nursing, the visibility of the given care, data collection for research and make the fragile document before ethical and legal process. ***Descriptors:*** Nursing Records; Nursing Care; Nursing.

RESUMO

Objetivo: analisar a qualidade dos registros efetuados pela equipe de enfermagem. ***Método***: estudo descritivo e documental, realizado em unidade de internação de um Hospital Universitário no Rio de Janeiro/RJ/Brasil, de maio a setembro de 2012, com a amostra de 626 unidades de registro. O estudo teve aprovado o projeto pelo Comitê de Ética em Pesquisa, CAAE 00836312.1.0000.5285. ***Resultados***: foram encontrados: apenas uma anotação por plantão (95%); uso indiscriminado de abreviaturas e siglas (92,6%), ausência de data (56,7%), ausência de hora (43,6%), rasuras (18,2%) e ausência de identificação profissional (10,1%). ***Conclusão***: os elementos inadequados apontam uma fragilidade dos registros, dificultando a comunicação entre as equipes, a incorporação de termos universais entre a enfermagem, a visibilidade do cuidado prestado, a coleta de dados para pesquisas e tornam o documento frágil diante de processo ético-legal e jurídico. ***Descritores***: Registros de Enfermagem; Cuidado de Enfermagem; Enfermagem.

RESUMEN

Objetivo: analizar la calidad de los registros que lleve el personal de enfermería. ***Método:*** un estudio descriptivo y documental en la unidad de hospitalización de un hospital universitario en Río de Janeiro/RJ/Brasil, de mayo a septiembre de 2012, con una muestra de 626 unidades de reporte. El estudio tuvo el proyecto aprobado por el Comité de Ética en la Investigación, CAAE 00836312.1.0000.5285. ***Resultados:*** encontramos: sólo una nota por turno (95%); el uso indiscriminado de las abreviaturas y acrónimos (92,6%), fecha de ausencia (56,7%), sin horas (43,6%), deleciones (18,2%) y la ausencia de identificación profesional (10,1%). ***Conclusión:*** las insuficiencias apuntan a una debilidad de los registros, lo que dificulta la comunicación entre los equipos, la incorporación de términos universales en la enfermería, la visibilidad de la atención recibida, la recopilación de datos para investigaciones y crea el documento frágil ante el proceso ético y legal. ***Descriptores:*** Registros de Enfermería; Cuidados de Enfermería; Enfermería.

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INTRODUCTION

In the hospital context the written record is presented as one of the main communication tools for information exchange between the teams involved in customer care, whose purpose lies in presenting clearly their needs and health status as well as the clinical management to take care of that have been implemented and continuous evaluation of the care provided, so register is a professional and social responsibility.

Discussions on ethics, justice and legal aspects have been growing and increasingly the professionals who make up the health teams have faced dilemmas related to these issues. To justice, nursing records form the basis of professional credibility.[1]

Nursing as part of the health team, remains more time/hours with the client and is involved in the care 24 hours daily. This makes it possible to recognize, in detail, the information related both to the client's conditions and needs of the family as the care and organizational environment. Thus emerges the Nursing registration term, which has meanings beyond the act of writing or mention, indicating a vital aspect for everyday nursing practice, as well as proving the care provided to the client who received it; it can reveal at the scene of caring responsible, its purposes and different graphical ways to register.

It is necessary that the nurse understands the importance of registration and make a clear, concise and objective manner. Commonly, they are vague and repetitive information terms in the records. These terms are unable to provide relevant information to assess the quality of care and the proper management of the service. In general, the records have little information of specific nursing care because they are impregnated with a biomedical model, in which the physical body, as edited similarity to a body in its entirety, consisting of feelings, emotions, desires and sensations.[2]

In this context, the nursing record has a significant value in the care process in health. The lack of registration makes the care provided directly to the customer having no visibility and recognition and preventing the intra-team and inter-team communication. Be careful not registered, there is part of the hidden work of nursing that does not receive due recognition.[3] The registry is a commitment and responsibility of nurses and expresses the technical and scientific competence and the rescue of their work.[4]

The ability of the nurse watching with depth and describing property gives new character, intellectual and scientific to nursing; however, if this observation is not registered, the information will be lost. Only with an effective shelf registration, the care provided has scientific basis and becomes, therefore, of quality.[5] However, the nursing records, even today, do not match the literature determinations.[6-7-8-9-10-11-12]

Studies point out some causes for limiting the record, such as a reduced number of professionals, lack of time to carry out the records, excessive administrative and bureaucratic activities, the absence of a working organization of institutions, still prevailing culture that nursing is a support service for the other categories.[13] The lack of adequate infrastructure for nursing practice in health institutions, in association with the growing demand for activities, causes the fundamental elements to record quality standards be unsuccessful.[14]

From these considerations, one can establish a synthesis on the one hand, the idea that the nursing registry when executed with quality is a document that represents and gives meaning to nursing care. On the other hand, when no or insufficient generates serious problems in practice, because it hinders decision-making and intervention either team running carefully beside the bed, as the occupying various managerial levels of the organizational hierarchy, with this communication and care quality may be impaired.

From this problem arises the following question of this study: How is presented the quality of records performed by the nursing staff in the medical records of customers? Faced with this guiding question, draw the following objective of this study: to analyze the quality of records kept by the nursing staff.

METHOD

This study was drawn from the dissertation << *Modus operandi* of recording: situational diagnosis and proposals >> intervention, presented the Program of Graduate Studies in Nursing, the Center for Biological and Health Sciences, Federal University of the State of Rio de Janeiro / UNIRIO in 2013.

This is a descriptive and documental study, in which it sought to analyze the records kept by nurses and technicians/nursing assistants, conducted an inpatient unit of a university hospital located in the city of Rio de Janeiro/RJ.

The analysis material consisted of customer records who were hospitalized in the period from 10th May 2012 to 09th June 2012 totaling 23 people. There were found and analyzed 220 records of nurses and 406 records of technical/auxiliary nurses, adding to a total of 626 records.

We used a data collection instrument adapted from a study[15] with modifications based on a comprehensive literature review on the area in question and previously tested, comprising customer identification data and hospitalization addition to indicators that analyzed the nursing records in form and content.

1) Call for annotation Frequency: analyzed the number of units records per shift of 12 hours.

2) Date and time at the beginning of each note: presence or absence;

3) Readable Letter: was considered readable when it was possible to understand all the words of record when their words were illegible, the number of words was counted and the illegibility interfered in understanding the message;

4) Blank: blank was considered any gap between one line and another;

5) Type: was evaluated for the presence or absence of at least one error;

6) Use of at least an abbreviation/acronym: if it were present in the registry, if analyzed, whether it was universally standardized (in Unity there is a listing of acronyms/standard abbreviations);

7) Erasure: if there was how to fix, hiding the original pen or corrective;

8) Professional Identification of the end of the record: distributed to professional identification quality in three areas: the right, the acceptable and the unacceptable. The correct form of identification consists of signature, category and professional registration number, framed in the acceptable category records that contained the signature and the number of professional registration. The unacceptable category fall into the records that contain only name, only initials and those containing signature and professional category.

Authorization request letters were forwarded to the General Director and the Superintendent of Nursing of the Hospital studied. After authorization from higher authorities cited, the research project was submitted to the Research Ethics Committee (CEP) of the Federal University of the State of Rio de Janeiro (UNIRIO).

The study followed determinations recommended by Resolution 466/12 of the National Health Council (CNS), which regulates research involving human subjects and was approved by Opinion 23646.

The identification of data collection scripts was performed by consecutive numbering whose connection to the client's name was known only from researchers. The typing process took place after the data collection.

It generated to a database through the EpiInfo computer program. For statistical analysis, the bank was exported and processed with the SPSS version 17.0. The contents were grouped by similarity or equality, and then recorded as frequencies and percentages.

Data will be presented and discussed as the sequence of items in the Data Collection Instrument.

RESULTS

From the 220 records conducted by nurses and 406 records conducted by technical/auxiliary nurses, there were analyzed the following items: number of notes per shift, the presence of date and time, legibility, blank, misspelling, use of abbreviations, erasures and professional identification (Table 1).

Table 1. Numerical and percentage distribution according to the characteristics of the records made by Nurses (Nurse) and Technician/Nursing Assistant (T/A) of a University Hospital in Rio de Janeiro-RJ, 2013.

Characteristics of the subjects	Nurses		Technician/Nursing Assistant		Nurse and T/A
	n	%	Frequência (nº)	%	Total (%)
Annotation by frequency shift					
One annotation	218	99,1	369	90,9	95
Two annotations	2	0,9	27	6,7	3,8
Three annotations	0	0	4	1,0	0,5
Four annotations	0	0	5	1,2	0,6
Five annotations	0	0	1	0,2	0,1
Absence of date	42	19,1	383	94,3	56,7
Absence of hour	76	34,5	214	52,7	43,6
Illegibility	3	1,4	28	6,9	4,1
In blank	3	1,4	72	17,7	9,5
Spelling error	2	0,9	29	7,1	4
Use of abbreviation	212	96,4	361	88,9	92,6
Presence of erasures	45	20,5	65	16,0	18,2
Absence of professional identification	1	0,5	80	19,7	10,1

Among the 220 records performed by nurses, 219 had only one note per shift. In the records of the technical/practical nurses identified that few in number, there was more than one note per shift. All records found nurses corresponded to day service, so there is no record of the night service. Annotations of technicians/auxiliary corresponded to two shifts.

The record date was present in 80,9% of the registered nurses and hours of presence represented 65.5%. It is noticed that the technical records/nursing assistant, 94,3% had no date and 52,7% did not have the time. With respect to technicians/nursing assistants, is noticed that 94,3% of the records did not contain the date.

The results show that 1,4% of the nurses showed record illegible words, but in none of the illegibility interfered in understanding the text, that is, one could understand the message analyzing the context.

In the record of the technical/practical nurses 6,9% of the records had illegibility, of these, only 3,2% interfered in understanding the text. It was found records containing 60 words with only 5 understandable, damaging the translation of ideas, aims and intentions by the message recipient.

Regarding the existence of space in blank, it was found 1,4% occurrences in the records of the nurses and 17,7% in the technical/auxiliary. For the presence of spelling mistakes, it was found 0,9% of errors in the registry of nurses and 7,1% in the registration of technicians/assistants.

The use of abbreviations was present in 96,4% of records kept by nurses and 88,9% of the records technicians/assistants.

The presence of erasure, the registration of nurses represented 20,5% of the notes, namely 14,1% hiding the original pen and 6,4% hiding the original with corrective. The record of technical/ auxiliary deletions were found in 16% of records, with 9,1% hiding the original with erasor and 6,9% hiding the original pen.

Regarding the identification of the professional performer, 99,5% of the registered nurses contained some kind of identification, of these, 0,5% had only the caption, 0,5% signature and professional registration number, 1,8% only signature 8,6% signature and professional category and 88,1% signature, professional category and professional registration number. As for technicians/ assistants, the data that identify the professional were absent in 19,7% of the records. As the qualification of identification, classified as correct, acceptable and unacceptable, 88,1% identifying the nurses are characterized as correct, acceptable 0,5% and 10,9% are unacceptable. Identification of technical/nursing assistants pointing an alarming fact, only 17,3% are correct, none is classified as acceptable and 63% are unacceptable (Table 2).

Table 2. Numerical and percentage distribution of quality professional identification at the end of the records made by nurses and technician/nursing assistant in a University Hospital of Rio de Janeiro -RJ, 2013.

Quality of professional qualification	Nurses		Technician/Nursing Assistant	
	n	%	n	%
Only rubrication	1	0,5	50	12,3
Signature and professional registration number	1	0,5	0	0
Only signature	4	1,8	141	34,7
Signature and professional category	19	8,6	65	16
Signature, category and number of professional registration	194	88,1	70	17,3
Total	219	99,5	326	80,3

DISCUSSION

Nursing is, among the multidisciplinary team which is involved in the care process, the category that stays with the customer 24 hours and their work process is permeated with routines, procedures, behaviors and interventions. The finding of (mostly) just one note per shift demonstrates that their performs are not actually logging everything running. The record is how to document the care provided making it visible. Inadequate records interfere in evaluating the quality of care.

It is observed that the nurse was attentive to insert the date at the beginning of the record, a fact that is not repeated in the matter of time. The lack of data in some records made it difficult to collect data; it was difficult to know which day the record belonged. Nursing technicians perform their record space intended to endorse the back of the prescription sheet. The prescription header is inserted the date, which does not exempt the placing on the beginning of the record.

The results show partial similarity to a previous study[2] in which it was observed that a total of 124 entries made by the nurse was 80,4% not 72,5% contained date and not a time. In the records of 53,5% nursing assistants had no date and 90,4% had not the time.

When starting the records properly should be mentioned times (hours and minutes) performing each procedure, in order to avoid ambiguity.[16]

Registry illegibility, the negative impact on the interpretation of information in the client's medical record, leading to losses, compromising client security and communication among the staff; the entire record made in the client's medical record constitutes legal document, it should soon be written legibly, in order to understand the text and message.

In a study that analyzed 489 notes, it was observed that 56.6% of the records performed by nurses were adequate, 24,1% and 19,2% partially inappropriate inadequate. In this study it was considered appropriate that the record was easy to understand and did not require effort to read, in part inadequate when allowed understanding with a little effort and inappropriate when writing difficult to read and/or understanding.[17]

Another study analyzed 1544 nursing notes and noted that, in clear and legible letter item, 76,4% of the records held by the nurses were classified in category Total, while the assistants, only 19,8% were in this category.[18]

For the presence of blank space, we can see that the occurrence was more present in the records of the technicians/nursing assistants, may be due to the fact that one of the most emphasized items in academia, in the nurse training process during the supervised internships and clinical placements. The blanks can generate risks and serious implications on the ethical and legal aspects.

Spelling mistakes expose the nursing front of other team members, as well as discourage reading the records by others. The number of errors was lower among nurses, this finding may be associated with higher levels of education of that category.

The institution investigated that there is no standardization of acronyms and abbreviations, allowing professionals to use them indiscriminately. Health professionals have the knowledge that there are some acronyms that are internationally standardized and can be freely used; however, in the analyzed records, there are numerous variations of acronyms, ie, the use of different acronyms for a term with the same meaning, for example, they found the MNZ acronyms, McNBZ and MNBZ for the word macro-nebulization. For peripheral venous access were found the following acronyms, PVP, AVP, and HVP.

The indiscriminate use of acronyms and abbreviations obstructs understanding between the teams. The messages in these records are for a coded language or a "tribal" language, which is decoded only by a few, or by those who know and control this space. In this context, the messages contained in the records of the professionals, are restricted to those who work in the same unit, depriving others (individuals who are not part of that

care environment) understanding of their texts.[19]

Communication is the comprehensive exchange of meaning through symbols, with reciprocity in the interpretation of verbal or non-verbal message[20] in this context it should be noted that the use of acronyms and nonstandard abbreviations can lead to different interpretations, creating risks and hindering the communication.

The globalization process eases of quick access to information generated by the media, especially the computer. We live in nowadays a digital age. The Internet, especially social networks, has been widely used impregnating the everyday with a different language. The culture of "computer language" which is a form of oralized writing, is strengthening in Brazil and worldwide.[19] This language originated this medium has gradually invaded the hospital and left marks on the records. It has been found in the texts analyzed the following expressions and symbols: Pct, vol, left, ext, int, +, ↑, ↓, s/, c / w/, reg, gde.

In this sense, it is necessary that the health institutions standardize the acronyms and abbreviations, because their use facilitates the work of professionals, as it streamlines the process, making the uniform registration and minimizing misinterpretation.

It can be seen that the most common form of correction by the nurses was writing about the wrong word, proven in another study.[2] For technicians/assistants use of corrective to conceal the original word was more prevalent.

Independent it is known that the form of erasure correction, their presence can make the document invalid and void in cases of legal and juridical processes. The Civil Procedure Code highlights in Article 386 that "the judge freely appreciate the faith that should deserve the document when in substantial point unqualified contains leading, amendment or cancellation distortion". Erasures characterize change made records. Consider the legal aspect of the records seems essential, so there is no standard limit for erasures, it is unacceptable.

For better understanding, in this study, we distributed to professional identification quality in three areas: the right, the acceptable and the unacceptable.

Resolution COFEN 311/07 approving the Code of Ethics of nursing professionals, provides in Article 54 that the professional must "Affix the number and registration category in the Regional Council of Nursing signature, while in professional practice".[21] This determination is characterized as responsibility and duty, not an option, failure to comply with that requirement entails serious ethical implications. Based on this principle, it is understood that a complete and accurate form of identification, consisting of signature, category and professional registration number.

Framed in category acceptable records where there were the signature and the professional registration number. The institution where the study data were collected, the chart content is organized in an integrated manner, ie it integrates observations per episode in chronological order, and regardless of the original source of the information.[22] Nurses record their activities in even space for the other team members. Technical/nursing assistants evolve in the back of the prescription sheet. Since the spaces intended for the performance of the records are different, when analyzing the medical records, it is possible to identify clearly and easily, which professionally executed. This leads to frame the records with the registration number and signature as acceptable. Added to this the fact, the registration number in the Council, be the best and safest way to locate and identify a professional.

The unacceptable category falls into the records that contain only name, only initials and those containing signature and professional category. It is understood that these items do not allow the identification of the professional safely and can, in the event of legal action, generate damage to the executing and the institution.

CONCLUSION

Among the many results of this study we highlight the following: reduced number of notes per shift, failure to date annotation and time preceding each record, illegibility of some records, presence of erasures and blank space between the notes, spelling errors and indiscriminate use of abbreviations.

The presence of the charts, even though poor and insufficient, demonstrates the progress and significant contribution to the history and memory of nursing. The quality of the notes is not yet at the desired level, but the presence of record indicates the concern of the nursing staff with the issue. The inadequacies of point to a failure/precariousness of records, hindering communication between the teams, the planning strategies for the optimization of the work process, the evaluation of quality of care, incorporating its own language and universal terms between Nursing also affect

the visibility of nursing care, data collection for research and make the fragile document on ethical-legal process.

The contents of the registers should be consistent, complete, organized, accurate, legible, without deletions to serve as memory in order to research, audit, legal, planning and other.

To maintain or achieve autonomy within care needs to first be understood and understood in all forms, including through the nursing records. It is essential to stimulate discussion on the topic among the team members involved in the daily care for and manage to enable improved customer service and communication among health professionals.

By all the above, we believe that this investigative essay portraying the indirect practices of care, represented by the quality of inspire new studies nursing records in other institutional research scenarios as a way of comparative analysis and thematic elucidation to the area the barrier: Fundamental Nursing.

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