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EVALUATION OF RECORDS IN PREGNANT WOMEN'S PRENATAL CARD

AVALIAÇÃO DOS REGISTROS NO CARTÃO DE PRÉ-NATAL DA GESTANTE

EVALUACIÓN DE LOS REGISTROS EN LA TARJETA DE PRENATAL DE LA EMBARAZADA

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ABSTRACT

Objective: to evaluate the records made by health professionals during prenatal care on pregnant women's cards. **Method:** a descriptive, quantitative, cross-sectional study of 241 prenatal cards in a public reference maternity hospital. The descriptive statistical analysis was used, based on the percentages of the variables and interpreted by the comparison with the literature and official documents on prenatal care. **Results:** the age register corresponds to 93.4%, mean age of 25 years. There were no records in the fields of live newborns (61.8%), newborns weighing <2,500 kg (67.2%) and breastfeeding (77.2%). **Conclusion:** most of the card records were made by nurses, showing unilateral care. It was verified that the records found on the prenatal cards surveyed are filled in an unsatisfactory and incomplete manner, impairing the continuity of the care provided, demonstrating the need for the valuation of the records on the prenatal card of the pregnant women by health professionals. **Descriptors:** Nursing; Prenatal Care; Triage Card.

RESUMO

Objetivo: avaliar os registros feitos pelos profissionais de saúde durante o pré-natal nos cartões das gestantes. **Método:** estudo descritivo, de abordagem quantitativa, com delineamento transversal, feito em 241 cartões de pré-natal em uma maternidade pública de referência. Utilizou-se a análise estatística descritiva, a partir dos percentuais das variáveis e interpretados pelo confronto com a literatura e documentos oficiais sobre o pré-natal. **Resultados:** o registro da idade corresponde a 93,4%, idade média de 25 anos. Não havia registros nos campos de recém-nascidos vivos (61,8%), de recém-nascidos com peso <2.500kg (67,2%) e amamentação (77,2%). **Conclusão:** a maioria dos registros dos cartões foi feito por enfermeiros, mostrando uma assistência unilateral. Verificou-se que os registros encontrados nos cartões de pré-natal pesquisados são preenchidos de forma insatisfatória e incompleta, prejudicando a continuidade da assistência prestada, demonstrando a necessidade da valorização dos registros no cartão de pré-natal das gestantes pelos profissionais da saúde. **Descritores:** Enfermagem; Consulta Pré-Natal; Cartão de Triagem.

RESUMEN

Objetivo: evaluar los registros hechos por profesionales de la salud durante el período prenatal, en las tarjetas de las mujeres embarazadas. **Método:** estudio descriptivo de un enfoque cuantitativo, con delineamiento transversal, hecho en 241 tarjetas prenatales en una maternidad pública de referencia. Se utilizaron análisis de estadística descriptiva, a partir de porcentajes de las variables e interpretada por la confrontación con la literatura y documentos oficiales sobre atención prenatal. **Resultados:** el registro de edad corresponde a 93,4%, promedio de edad de 25 años. No había ningún registro en los campos de los recién nacidos vivos (61,8%) de los recién nacidos pesa 2.500 kg (67.2%), < y lactancia (77.2%). **Conclusión:** la mayoría de los registros de las tarjetas fue realizada por enfermeros, mostrando una ayuda unilateral. Se ha verificado que los registros encontrados en las tarjetas de prenatales investigados, son rellenos de forma insatisfactoria e incompleta, poniendo en peligro la continuidad de la asistencia prestada, demostrando la necesidad de la evaluación de los registros en la tarjeta prenatal de las embarazadas por profesionales de la salud. **Descriptores:** Enfermería; Atención Prenatal; Tarjeta de Triaje.

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INTRODUCTION

Pregnancy is a biological process involving women, men, their families, the community where the pregnant woman is included, and health professionals who act as coadjuvants in the pregnancy-puerperal process.^{1,2}

Prenatal care is associated with the reduction of maternal and infant mortality, ensuring the health of the mother, the fetus or the newborn through the early prevention, identification and diagnosis of undesirable events.^{1,4}

The pregnant woman's card is a primary source of information to assess the care provided during prenatal care. It is used to record all the interventions performed with the pregnant woman. It is a document of mandatory use in health services and should be kept available for adequate follow-up, and should be updated at each visit, allowing the integration of primary care with hospital care professionals.¹

There is a great devaluation in relation to the adequate filling of records on the pregnant woman's card, generating a loss of prenatal care, preventing the analysis of the relationship between the obstetric changes and the quality of the prenatal care offered, and leading to the repetition of procedures and interventions, since an unregistered procedure is an unrealized procedure.^{1,5}

The interest in this study arose from the lack of scientific publications regarding the importance of the pregnant woman's card as an instrument for the evaluation of the gestational process and, by observing the consequences of not filling in the records on the pregnant woman's card, affects the work of childbirth and postpartum, which may be irreversible for both the mother and the baby, contributing to the awareness of the health professionals in the continuity of the care, through the appropriate records on the pregnant woman's card. Thus, guide the managers so that they can offer courses of improvement for the professionals who perform prenatal care. Improvement of the filling of the prenatal card aiming at a higher quality in the follow-up of the gestational period, with a qualified and humanized approach.

This study aims to:

- Evaluate records made by health professionals during prenatal care on pregnant women's cards;
- Identify the records in the identification fields, sociodemographic aspects, family, personal and obstetrical antecedents;

- Check the notes of prenatal appointments and exams recorded on the pregnant woman's card;
- Associate sociodemographic variables with obstetric history and current pregnancy.

METHOD

A descriptive study, with a quantitative approach, with a cross-sectional design, with 241 prenatal cards of pregnant women attended at a state referral public maternity unit, located in the Ishotos neighborhood, in Teresina-Pi.

The criteria for participation in the study were: pregnant women admitted to the maternity hospital where the study was performed; older than 18 years and who agreed to participate in the study.

Data were collected from October to November 2014, with all pregnant women admitted to the maternity ward and who met the inclusion criteria. Firstly, the pregnant women were informed about the purpose of the study and that their prenatal card would be analyzed for research purposes. After acceptance of the study participation, a written consent was requested to sign the Informed Consent Form. Data collection was then performed by completing a form, according to the data filled in the analyzed prenatal cards. The form covered the following data: personal, family and obstetric data, notes made on the card and examinations requested during the consultations, as well as other data recorded on the card.

After the collection of all the data, descriptive statistical analysis was used, based on the percentage of the categories of variable responses and interpreted through the comparison with the literature and with official documents about prenatal care.

The study was carried out based on the precepts of Resolution 466/12, whose project was approved by the Research Ethics Committee of the Santo Agostinho School, under the number 869.501 / 2014.

RESULTS AND DISCUSSION

Data was collected on 241 pregnant women's prenatal cards. Records related to identification fields, sociodemographic aspects, family, personal and obstetrical antecedents, as well as the annotations made during the consultations and records of the exams performed during prenatal care were observed. Sociodemographic variables were associated with obstetric history and current gestation.

In the identification field, the variable age corresponds to 93.4% of the records filled in the cards. Regarding marital status, 88.4% were satisfied, 30.3% were married and 35.7% were in the stable union. Most of the participants present some level of education, corresponding to 83.4% of the literacy records.

As far as filling the field on family history, a greater number of records referring to arterial hypertension (89.6%) and diabetes (89.7%) were observed. With regard to the personal history, a greater number of records regarding hypertension (87.2%) and diabetes (87.5%) were observed.

The family history should be observed and noted, since they constitute a non-modifiable and independent risk factor, besides showing a predisposition for the development of some diseases, such as diabetes and arterial hypertension, which is a highly prevalent disease considered the The main factor of morbidity and morbidity and mortality in cardiovascular diseases.^{7,8}

These data should be duly recorded, since, during the anamnesis, the tracing and the diagnosis are performed, through the identification of risk factors.

Table 1. Frequency of records on the pregnant woman's card. Teresina (PI), Brazil, 2014.

Variables	Yes		No		No Record	
	N	%	N	%	n	%
Num. Gestation	220	91.3	1	0.4	20	8.3
Num. Childbirth	120	49.8	63	26.1	58	24.1
Num. Abortion	55	22.8	104	43.2	82	34.0
Num. Vaginal labor	75	31.1	62	25.7	104	43.2
Num. C.section	54	22.4	41	17.0	146	60.6

It was verified that 91.3% of the cards present the registered number of pregnancies and 8.3% of the cards do not present any record. It was observed among the analyzed records that only 22.4% presented cesarean delivery, a relevant data, since the rates of cesarean deliveries performed in Brazil are

high, even with the improvement of the delivery model and the health of the modern woman.⁸ The WHO recommends a 15% number of cesarean deliveries in relation to the total number of deliveries performed in a health service.¹

Table 2. Distribution of the number of pregnancies according to age, marital status and literacy. Teresina (PI), Brazil, 2014.

Variables		Num. Gestation								Total
		0		1		2-3		4 ou +		
		n	%	n	%	n	%	n	%	
Age group	17-25 years	1	0.9	53	48.2	43	39.1	13	11.8	110
	26-32 years	0	0.0	17	25.8	32	48.5	17	25.8	66
	33 or more	0	0.0	3	8.8	14	41.2	17	50.0	34
Marital status	Married	1	1.4	29	40.8	24	33.8	17	23.9	71
	Stable union	0	0.0	23	28.7	35	43.8	22	27.5	80
	Solteira	0	0.0	17	37.0	23	50.0	6	13.0	46
	Others	0	0.0	0	0.0	1	100.0	0	0.0	1
Literate	No Record	0	0.0	8	34.8	12	52.2	3	13.0	23
	Yes	1	0.6	63	34.8	81	44.8	36	19.9	181
	No	0	0.0	2	33.3	2	33.3	2	33.3	6
	No Record	0	0.0	12	35.3	12	35.3	10	29.4	34

According to table 2, among the age groups of 17 to 25 years, the highest prevalence of pregnant women with only one gestation is found. The occurrence of 2-3 pregnancies per participant (48.5%) and, in the age group of 33 years or more, the occurrence of four or more pregnancies per participant (50 %).

The result shows a higher number of pregnancies among women with stable marital status and married women, with a total of 80% and 70% of the records found, respectively. The study, conducted by Carniel et al.⁹, shows that the partner is quite significant in the life of the pregnant woman, offering psychological and financial support. The presence of a

partner is associated with greater adherence to prenatal care.

The table shows that most women are literate, totaling 75.1% of the study participants. Low maternal schooling may predispose the pregnant woman to risk situations, since it is associated with low birth weight, prematurity, neonatal mortality, infant mortality, as well as an increase in the number of pregnancies.¹⁰

The research showed that there were no records in the neonatal (61.8%), neonatal (79.3%), neonatal (<2.500kg) (67.2%) and breastfeeding (77, 2%), being the field of NB with greater weight that had the greatest number of filling, corresponding to 99.2% of

the evaluated cards. These fields are of great relevance for the evaluation of the risk level of the pregnant woman, since the previous history of low birth weight infants and the number of stillbirths are risk factors for conception.¹

Table 3. Mean, standard deviation, minimum and maximum variables of age, pre-pregnancy weight, number of consultations performed, stature, BMI, gestation, delivery and abortion. Teresina (PI), Brazil, 2014.

Variables	Average	Standard deviation	Minimum	Maximum
Age	25.28	6.032	17	42
Pre-pregnancy weight	58.47	11.294	38	105
Nº of Consultations	6.10	2.629	0	21
Stature	1.5570	0.06489	1.33	1.75
BMI	27.30	12.86981	9.06	25.70
Gestation	2.43	1.578	0	9
Childbirth	1.31	1.424	0	8
Abortion	0.45	0.816	0	7

Knowledge of the maternal age is essential for adequate prenatal care. It was observed that the majority of the participants were young, with the mean age of 25 years, being 42 years the maximum age (Table 3). This average age is considered ideal because it constitutes a risk pregnancy in which the maternal age is less than 15 years and more than 35 years.¹¹ According to Ceolin, Casarin and Heck¹², there is a relationship between the age group of pregnant women and health conditions. Hence the importance of registering the maternal age to provide care directed to the real needs of the same according to their age, thus improving the quality of prenatal care.

Regarding pre-gravid nutritional status, we observed a mean of 58.47 kg, a mean height of 1.55 cm, a suitable BMI of 27.30. Current pregnancy data such as height and pre-gravid weight indicate parameters for further evaluation of the evolution of pregnancy, since weight gain is related to the increase in body mass as well as to the increase of measures related to the physiological changes of pregnancy, increased fetal growth weight, increased amniotic fluid, placenta, fetal weight, and increased blood volume. The Ministry of Health¹ recommends total weight gain according to the initial nutritional status of the pregnant woman, performed according to the BMI calculation, in which there is a need to know the weight (kg) and the height (m). Therefore, the need to register these two information. Women who are underweight should have a weight gain of 12.5kg to 18kg. Pregnant women of adequate weight, from 11.5kg to 16kg; Overweight women, from 7kg to 11kg, and obese pregnant women, gaining less than or equal to 7kg. The presence of anthropometric data recording for nutritional assessment at the beginning of gestation is important in the detection of nutritional risks

and gives the professional the opportunity to establish adequate nutritional interventions.¹

Regarding the number of consultations, an average of 6.1 consultations were obtained. It can be observed that there were an adequate number of prenatal consultations. Considering the importance of prenatal care, the Ministry of Health¹ recommends a minimum of six prenatal consultations, which should be interspersed between doctors and nurses.

The frequency of registrations on the cards referring to the current gestation field was 90% of LPD (Last Period Date) and 85.5% related to PDD (Probable Date of Delivery). The LPD and PDD are important in the identification of the possibility of preterm or post-datistic delivery. These data allow better planning for delivery and puerperium.

The results of this study showed inadequacy of records, as well as in a study carried out in the city of Rio Branco-AC, which shows, in its results, the percentage of 94.12% of records referring to LPD and 82.35% of records related to PDD.¹³

In the registry of the variable on smoking, 67.2% of the cards had no records. The record of this variable is important, since smoking is related to low pre-gestational weight. There is great concern about this relationship between smoking and gestation, as it is associated with intrauterine growth retardation and low birth weight, and smoking also entails fetal risks due to early placental maturation associated with the premature displacement of the placenta and reduced nutritional intake, causing risks to the mental, intellectual and behavioral development of children exposed to smoking during their fetal life.¹⁴⁻⁶

Table 4. Distribution of variables referring to the first and sixth queries. Teresina (PI), Brazil, 2014.

Variables	Average	Standar deviation	Minimum	Maximum
IG1	13.675	6.8180	3.0	39.0
PESO1	60.318	11.4735	19.5	100.0
IMC1	24.7935	4.47047	10.00	33.00
EDEMA1	1.91	0.294	1	2
AU1	18.000	7.1540	7.0	43.0
BCF1	146.750	10.2665	128.0	161.0
MF1	2.138	0.6688	1.0	3.0
PROF1	2.254	0.6051	1.0	3.0
IG6	31.304	5.0571	17.0	42.0
PESO6	67.480	12.2354	45.0	110.0
IMC6	28.6504	5.78318	18.40	44.10
EDEMA6	1.44	0.512	1	2
AU6	29.537	7.0032	20.0	83.0
BCF6	141.926	19.3455	1.0	176.0
MF6	1.462	0.8116	1.0	3.0
PROF6	2.145	0.7904	1.0	3.0

It was observed that the onset of prenatal care was on average 13.67 weeks of gestational age. The Ministry of Health1 recommends starting prenatal care until the 12th gestational week, even in the first trimester of gestation. The adequate onset of prenatal care has positive influences on the good development of gestation, through health promotion and early identification of factors that may cause risks to the mother and the concept, guaranteeing actions that corroborate the good evolution of gestation.

In the evaluation of the records of the variables observed on the first consultation, it was observed that, in 90.9% of the cards, there were no records of the variable referring to edema. The frequency of consultations performed by each professional (doctor and nurse) who provided prenatal care was evaluated. As a result, it was observed that in all the cards evaluated, in the first consultation, 8.7% of the consultations were performed by physicians, 56.8% by nurses and, in 34%, there were no records of identification of the professionals. Since physicians and nurses have specific characteristics in their consultations, it is recommended that prenatal consultations be interspersed among these professionals.¹⁷

In the data referring to the sixth consultation, 93.4% of the information regarding the presence or absence of edema can be observed; 54.8% referring to uterine height; 71.8% for BCF; 52.2% of non-registries of the fetal movement variable. As for the professionals who performed the care in the sixth consultation, 14.9% were doctors; 21.6%, nurses and 63.5% did not contain a registry of professionals who performed the care.

In the evaluation of the records of the examinations performed during the prenatal period, 90% of the blood typing and Rh factor information were found from the records found on the cards; 89.2% on fasting blood

glucose test; 88% of anti-HIV; 87%, hemoglobin and hematocrit; 85.5%, VDRL; 83.4%, urine type I and 46.1%, other exams. The Ministry of Health recommends that laboratory examinations be requested for adequate gestational follow-up, since the request for examinations and analysis of the results by health professionals, in a timely manner, are essential in detecting possible changes, allowing the early diagnosis of diseases and favoring the accomplishment of treatment and cure, avoiding complications for the mother and the concept.¹

From the data on tetanus vaccination of pregnant women, it was observed that 52.3% received the vaccine: 7.1%, only the 1st dose; 6.6%, the second dose; 18.7%, the third dose and 19.9%, the reinforcement. Vaccination of the pregnant woman with tetanus toxoid provides a level of antitoxin for the protection of obstetric and accidental tetanus. Compulsory administration of the tetanus vaccine is important for the prevention of neonatal tetanus, which is shown to be a public health problem in most of the developing countries.¹⁸⁻²⁰

Among the results found in the evaluation of the variable corresponding to hepatitis B vaccination, 45.2% of the cards had the record of this vaccine, 6.2%, only the 1st dose; 12.4%, up to the 2nd dose; 26.6%, until the third dose and 54.8% did not present vaccination records. Because there is a risk that pregnant women who are not vaccinated against hepatitis B will contract the disease and / or transmit it vertically, the NIP (National Immunization Program) reinforces the importance of having the woman vaccinated after the first trimester of pregnancy, regardless of age. The vaccination schedule should be followed according to the adolescent and adult vaccination schedules. The NIP recommends to pregnant women, after the first trimester of pregnancy, three

doses, with the interval of 30 days between the first and second, and 180 days between the first and third. Hepatitis B vaccination does not offer any additional risk to the fetus.¹⁸⁻²⁰

CONCLUSION

Most of the prenatal cards of the pregnant woman presented a satisfactory fulfillment of the records of the variables corresponding to the fields: identification, sociodemographic aspects, family history, personal antecedents and laboratory tests requested in the first prenatal visit of the pregnant woman. However, in the analysis of the records made in the field of the variables of the obstetric history, it is noticed that there is a huge lack of filling of the records. Regarding the records made at each visit, it was found that the majority of the variables were inadequate, highlighting the recording of heartbeat, edema, uterine height and fetal movements.

Most of the records of the cards were made by nurses, showing unilateral assistance, since the pregnant woman should receive multiprofessional care and guidance.

Failure to fill in the records of the variable vaccination showed that the professionals are not giving real importance to the due completion of this variable, due to the high number of unregistered cards.

The records on the prenatal cards were not satisfactorily completed, since they were incomplete, impairing the continuity of the care provided and demonstrating the need for the health professionals to value the registration of information on the prenatal card of the pregnant women.

It is worth emphasizing the importance of expanding the studies about this subject, since the researches with the focus on the prenatal card of the pregnant woman are still very insufficient. Therefore, it is suggested that more field research be carried out.

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