ABSTRACT
Objective: to characterize the operationalization of the audit in the assessment of nursing records. Method: integrative review, performed from the question << How the audit is operationalized in the assessment of nursing records? >> through the search of articles published from 2002 to 2012 in LILACS, MEDLINE and BDENF databases, with use of controlled descriptors “nursing records” and “nursing auditing”. Data collection occurred in October 2012, treated with the aid of “Microsoft Office Excel” software. Results: the records are the instruments for the assessment of nursing more used, the Haddad method was the most evidenced in the audit practice in nursing records and the permanent and continuing education of health team were highlights of intervention to improve the quality. Conclusion: the audit is able to support the guidelines for improving the process of nursing work related to their records. Descriptors: Nursing Records; Audit of Nursing; Information Management; Indicators of Quality in the Health Care.

RESUMO
Objetivo: caracterizar a operacionalização da auditoria na avaliação dos registros de enfermagem. Método: revisão integrativa, realizada a partir da questão << Como a auditoria se operationaliza na avaliação dos registros de enfermagem? >>, por meio de busca de artigos publicados no período de 2002 a 2012, nas bases de dados LILACS, MEDLINE e MEDLINE, com uso dos descritores controlados “registros de enfermagem” e “auditoria de enfermagem”. A coleta de dados ocorreu em outubro de 2012, tratados com auxílio do software “Microsoft Office Excel”. Resultados: os prontuários são os instrumentos para avaliação dos registros de enfermagem mais utilizados, o método de Haddad foi o mais evidenciado na prática de auditoria em registros de enfermagem e a educação permanente e continuada da equipe de saúde foram destaque s de intervenção para a melhoria da qualidade. Conclusão: a auditoria é capaz de apoiar as orientações para melhoria do processo de trabalho da enfermagem relacionado aos seus registros. Descritores: Registros de Enfermagem; Auditoria de Enfermagem; Gerenciamento de Informação; Indicadores de Qualidade na Assistência à Saúde.

RESUMEN
Objetivo: caracterizar la operacionalización de la auditoría en la evaluación de los registros de enfermería. Método: revisión integradora, realizada a partir de la pregunta << ¿Cómo se operationaliza la auditoría en la evaluación de los registros de enfermería? >> a través de la búsqueda de los artículos publicados desde 2002 hasta 2012 en las bases de datos LILACS, MEDLINE y BDENF, con el uso de descriptores controlados “registros de enfermería” y “auditoría de enfermería”. La recolección de datos ocurrió en octubre de 2012, tratados con la ayuda del software “Microsoft Office Excel”. Resultados: los registros son los instrumentos para la evaluación de la enfermería más utilizados, el método de Haddad fue el más evidente en la práctica de auditoría en los registros de enfermería y la educación permanente y continua de la equipo de salud fueron destacas de intervención para mejorar la calidad. Conclusión: la auditoría es capaz de apoyar las directrices para la mejora del proceso de trabajo de enfermería en relación a sus registros. Descriptores: Registros de Enfermería; Auditoría de Enfermería; Gestión de la Información; Indicadores de Calidad en la Asistencia de la Salud.

Nurse, Federal University of Mato Grosso do Sul/UFMS. Campo Grande (MS), Brazil. Email: brendacordeirobcj@hotmail.com; Nurse, PhD Professor, Department of Nursing, Federal University of Mato Grosso do Sul/UFMS. Campo Grande (MS), Brazil. Email: mdfcheade@uol.com.br; Nurse, Specialist in Intensive Care and Urgency and Emergency, Master and PhD at the Post-graduate Program in Health and Development in the Midwest Region, Faculty of Medicine Dr. Hélio Mandetta, Federal University of Mato Grosso do Sul/UFMS. Campo Grande (MS), Brazil. Email: marisarolan@gmail.com; Nurse, PhD Professor, Department of Nursing, Federal University of Mato Grosso do Sul/UFMS. Campo Grande (MS), Brazil. Email: marisarolan@gmail.com; Nurse, Master and PhD student at the Post-graduate Program in Nursing, Federal University of Rio Grande do Norte/UFRN. Natal (RN), Brazil. Email: diana.regol@hotmail.com; Nurse, PhD Professor, Graduate/Post-graduate Program in Nursing, Federal University of Rio Grande do Norte, PGENF/UFRN. Natal (RN), Brazil. Email: marcojunior@ufnet.br.
Communication represents the message exchange and understanding among people, since it communicates facts, thoughts, and values; it is taken as a human process of sending and receiving messages through the verbal way (spoken and written language) and nonverbal (gestures, body expressions, and touch).1

The Federal Nursing Council, through Resolution No. 311 of 2007 approving the reformulation of the Code of Ethics for Professional Nursing, points out in several articles the importance of nursing for the performance of the team in their care process.

Nursing records, where scarce or incomplete, directly affecting the quality of care3. Nevertheless, as a means of verbal communication used by nursing staff, when well designed, they provide individualization user and reflect the quality of care.4

Society has increasingly sought by quality of service and essential goods including in the area of health services when consumers of this type of care have increasingly desired them, when it is humanized and qualified. To meet this situation to ensure positive results and customer satisfaction it is required to the organizations to know low costs associated with excellence and quality5 to such institutions resorted to as an audit of resources evaluation of services.

The audit is an orderly evaluation of the quality of care performed by nursing staff provided to the client, through analysis of medical records, customer follow-up and on-site investigation of the compatibility between the processes performed and charged items that make up the hospital bill.6

Therefore, the audit also proposes to evaluate the quality of nursing records and the actors involved in its implementation because when evaluated, it becomes possible to fill gaps, make adjustments in order to promote improvements in the working process of the whole team and in addition, of course, to serve as a thermometer for the level of training and professional practice found in the market.

Despite the audit nursing judgment and involve a detailed review of records, as more variables methods employed in the process of implementation of the audit evaluated object and relevant factors of nursing, they have not yet been synthesized and individually discussed in the available scientific literature. Based on these, the aim of this study is:

- To characterize as the audit operationalize when the evaluation of nursing occurs.

### METHOD

Study of integrative review, developed in six phases: 1) defining the guiding question; 2) search of the literature; 3) data collection; 4) critical analysis of included studies; 5) discussion of the results; and 6) the presentation of an integrative review.7,8 Thus, as a starting point, the following question was formulated: “How the audit operationalize the evaluation of nursing?”

We conducted research in databases Medical Literature Analysis and Retrieval System Online (MEDLINE), Literature Latin American and Caribbean Health Sciences (LILACS) and Database of Nursing (BDENF), with controlled use of keywords: “nursing records” and “nursing auditing”, combined and alone. We included articles written in English; published between the period of January 2002 to September 2012; presenting abstract for initial examination and were also available in full by their own databases and speaking about the theme. Exclusion criteria were studies of dissertations and theses, experience reports, editorials, letters to the editor, review type studies and those in duplicity. Data collection occurred in October 2012.

From these elements, the process of selection of studies was divided into two stages. At first, according to the selection criteria, the analytical refinement occurred by reading the titles and abstracts of their detailed study, when 66 relevant manuscripts were identified. In the second, they were subjected to critical analysis of the full content. At the end of the analysis, 11 articles remained that constituted the final review sample, from them eight articles were indexed in LILACS, one in MEDLINE and two in BDENF.

Para extrair os dados dos artigos selecionados, foi utilizado um instrumento de coleta de dados eletrônico no software “Microsoft Office Excel”, versão 2007. Tal instrumento permite avaliar separadamente cada artigo, por meio de um formulário que contempla os seguintes itens: elementos de identificação do artigo, características metodológicas do estudo, avaliação do rigor do método, métodos empregados para avaliação na auditoria, objeto da avaliação, itens do objeto avaliado e principais discussões/conclusões.
To extract data from the selected articles, an instrument to collect electronic data on the "Microsoft Office Excel", version 2007 software was used. This instrument allows to evaluate each item separately through a form that includes the following items: identification elements of the article, methodological characteristics of the study, reviewed the accuracy of the method, the methods employed to review the audit object of evaluation, the evaluated object items and main discussions/conclusions.

**RESULTS**

Figures 1 and 2 show the 11 articles included in this review. Figure 1 shows the evaluation of audit records by care and Figure 2 presents the review of the records for the audit costs.

Regarding methods identified in the study used in audit practice in nursing records, the method of Haddad was the most evident, followed by the method of building spreadsheets.

Among the notes as an intervention for permanent and continuing education of health professionals. Authors inferred that faults found in nursing records are justifiable quantitative lowered personal and non-recovery of the records for more cultural than technical issues.

**DISCUSSION**

In general, the audit in nursing is a process of systematic and formal evaluation of the quality of watching, which can be verified by the nursing records present in the medical record or from the conditions of the customer, in order to analyze whether the actions taken are in agreement with the proposed review and monitor development programs and effectiveness of them. 9-11 It is worth noting that the audit is not restricted to the
purpose of establishing the situational diagnosis or point out the flaws and problems, it works as a tool that supports develop solutions with therefore exercise the role of educator.9

The audit of nursing records allows identifying fragility to be improved in the nursing work process, which allow generating measures for improving care points, as is the final revision of the effects of health care.12,13

Also, in this same perspective it is observed its role in the financial evaluation, the assessment of costs in cost control, quality customer service, fair payment of hospital bill and transparency of trading with ethical basis.10,11

Nursing records for audit fees are to check and control the billing sent to health plans and procedures related to routine visits, comparing the received data with the medical record brings, and identify materials and patent medicines the health team, noted in three studies.10,14,15 Thus, all procedures and actions performed by the nursing staff costs and generate a means of ensuring the return of them and the adequacy of records, which show the care provided and when done correctly can prevent occurrence glosses,16 ie, the partial or total cancellation of a budget, to be assessed by the auditor of a particular health plan as illegal or improper, because it presents items not considered eligible for payment.10

We used the resources of glosses in an article with the objective to be assessed by the audit, which arise when the health institution has determined the costs of services provided to the client disallowed by health plans and then the institution requires resources in order to recover economic losses.14

Nursing records in the audit practice of care received greater representation and yet there was a purpose to review and quality control.17,18 In addition, three studies agree in defining the audit of care as a systematic evaluation of the quality of the watch of the nursing team, evidenced by the nursing records in the chart and assessing the condition of the client.10,14,15 Therefore, the records kept by the nursing staff are an important tool to prove the quality of their performance, ie, it is extremely necessary to submit adequate and frequent charts client.12

In the literature, there are reports that support the existence of many non-conformities in relation to the proper professional identification, according to the legal requirements of the Federal Council of Nursing (COFEN). The most mentioned are the mistakes due to lack of balance, lack of stamping and illegibility of the name.9,12,19,20

However, a study conducted in southern Brazil, to evaluate the quality of nursing notes performed in semi-intensive care unit of a University Public Service and found that although the item in question does not meet the quality, criteria proposed not distanced from the values considered satisfactory. In this study, the record of the name and stamp of the nurse and/or nursing technician who has attended allowed the identification of professionals, which would make the valid registry for possible doubts and questions that might arise after the service.13

Other studies have confirmed that the absence of rubric of the one who did nursing care can result in difficulties in communication among care team members who assist the customer and implementing future research, in addition to derail data source for legal and ethical support.12

Of the studies included in this review, three showed many flaws in the nursing records as to checking: illegibility, errors in spelling, correction fluid, incorrect terminology and nonstandard abbreviations and confrontation between nursing records and checks of medications and procedures.9,11,15

Different from the others, one study stated that the results demonstrated an excellent standard as the non-use of abbreviations or acronyms in nonstandard nursing records, showing therefore that the nursing unit assessed is aware not to use of them and cares not to incur the error.12

Two items have the same conclusion when reporting that glosses occurred were mainly consequences of errors observed in checking and justification of nursing, medicine and materials.10,14 A study conducted in a medical and surgical private hospital of Belo Horizonte showed some clinical failures on the part of the nursing team: First, regarding the high number of erasures in checks; second, a lack of checks or erasures in times of drugs and; third, the lack of checking procedures.13 This finding is of concern, given that most of the non-payment of medicines and materials by the covenants is due to error checking nursing.21

Based on the failures observed by most research that explored these items, the authors suggest that nursing checks should happen during the process of generation of the product, in this case, the care and nursing records, so that corrective measures can be made to avoid that the result is negative or inappropriate.22 As for this item, two studies

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found that they were not of good quality, there is a perceived lack of articulation that is prescribed by the nurse and what is recorded.\textsuperscript{12-3} They still refer that the identified problem is due to the nursing staff did not make a systematic and routine reading prescription as a tool; and also that although only nurses can prescribe, it can be performed in an integral way, so this should be a collaboration of all who make up the team, since the client care has mainly been performed by the average level of nursing staff.

The requirements, in most cases, were recorded in the medical record appropriately and in accordance with the requirements of the institution. Further describes the correct way to prescribe is of paramount importance, but of equal importance is the correct implementation of nursing diagnosis, since both are closely related and the quality result. Four studies found flaws in developments in nursing because they had indistinctness as to content or even similar to medical developments. Inadequate identification and possible lack of understanding it as a result of the care process was also observed, do outlines the results of this in relation to diagnosis and prescription of nursing.\textsuperscript{9,5,19,22} Therefore, when writing the evolution of nursing illegible and incomplete, so they do not provide necessary information and lead to doubts about the treatment to be applied.\textsuperscript{10} Other authors have also assumed that the evolution of nursing can be confused with the changing medical or nursing records. The nurse did not reassess the client and their daily risks and if they have done, it was not properly registered.\textsuperscript{19}

It became evident flaws in nursing records of discharge and death, they presented relatively clearly not performing certain prescription item, also filling was lower than expected (the default is 80%) for admissions, discharges and transfers/or internal transport.\textsuperscript{9,12}

Data indicated that nurses need to improve the description of nursing diagnoses, since sometimes presents disagreement with the evolution of nursing. This, according to data and observations from the study of medical records of patients admitted to the medical clinic, which may be related to a possible failure of the nurse to not reevaluate the customer daily.\textsuperscript{19}

It was observed that the methods used in the articles were: criteria and standards of the Brazilian Accreditation Manual for Hospitals,\textsuperscript{25} adapted Haddad instrument\textsuperscript{54}, instrument adapted by Labbadia\textsuperscript{25} and tabs through the Microsoft Excel Spreadsheet.

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It was proposed in a study five levels of assessment completion of nursing: Not applicable, complete, incomplete, incorrect and not filled.\textsuperscript{24} In the checking to be considered complete level must obtain a percentile less than 80%, since the incomplete a percentile of 15% and not 5% filled.\textsuperscript{12,22}

It complements even the process of evaluating the records using the criteria of quality, adapted and elaborated by Haddad follows the proposal made by Cianciarullo you use to judge the quality of nursing records four criteria (complete, incomplete, incorrect and not filled) and a percentage of positivity with values of 80% (full), 15% (incomplete), 5% (not filled) and 0% (incorrect assessment items) standard.\textsuperscript{12}

Another reference used to evaluate nursing records, an instrument adapted by Labbadia,\textsuperscript{25} which contains items: time of admission, reason for admission, the patient's general conditions, medications, monitoring of vital signs, classification of records as the form, physical state, mental, personal hygiene, dietary, eliminations, injuries, catheters / drains, signs / symptoms, nursing / other professional examinations / treatments performed, guidelines given to patients / families / caregivers, control procedure, medicines, hospital discharge and death.\textsuperscript{15}

It was used in data collection criteria and standards for registration of the Brazilian Accreditation Manual for Hospitals and nursing records on the subject with statistical treatment literature. Hospital accreditation is a system of external evaluation that determines if the service includes previously established standards;\textsuperscript{25} also reported that the Brazilian Accreditation Manual for Hospital they show three levels of acceptance standards for the accreditation process and the “Professional Services Organization and Assistance” section that subsection nursing is inserted, each subsection is composed of the proposed evaluation standards they present a list of items that guides the identification that seeks to evaluate a structure, process and outcome of a service sector or unit and assists in the preparation of the accreditation process of Organizations Providing Health Services

**FINAL REMARKS**

Given the results, discussions and reflections presented, we conclude that the Brazilian scenario uses the audit as an assessment tool for health professionals, particularly in vocational nursing area. It is
perceived shortage of Brazilian publications in relation to the theme in the set period of research, mainly in nursing among others health.

The study revealed that nursing records were used to assess quality of care and well-focused financial review, despite the reduced number of national studies. It is also noticeable that the chart has been the primary means by which the audit nursing has evaluated your records, quality of care and costs.

In the records, nursing records contained significant flaws endowed with historical presenting smaller representation and errors that invalidate their documentary, legal and ethical character. With this, the audit provides troubleshooting and assists, through actions assessment, the advancement of the nursing process mainly related to their records. The auditor nurse plays a key role to exercise full and effective education in a multidisciplinary team. In this context, the systematization of nursing care appears as one of the tools that make the work planned and directed the activities of staff, promotes and organizes nursing records therefore arose as to overcome the flaws found.

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Corresponding Address
Marcos Antonio Ferreira Júnior
Programa de Pós-graduação em Enfermagem Centro de Ciências da Saúde
Universidade Federal do Rio Grande do Norte
Av. Senador Salgado Filho, s/n - Campus Lagoa Nova
CEP 59072-970 – Natal (RN), Brazil