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Original Article

IMPORTÂNCIA DAS ANOTAÇÕES DE ENFERMAGEM SEGUNDO A EQUIPE DE ENFERMAGEM: IMPLICAÇÕES PROFISSIONAIS E INSTITUCIONAIS

IMPORTANCE OF NURSING RECORDS ACCORDING TO NURSING TEAM: PROFESSIONALS AND INSTITUTIONAL IMPLICATIONS

IMPORTANCIA DOS REGISTROS DE ENFERMERÍA SEGUNDO GRUPO DE ENFERMERÍA: IMPLICACIONES PROFESIONALES Y INSTITUCIONAL

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RESUMO

Objetivos: descrever a importância das anotações de enfermagem no prontuário do paciente para a equipe de enfermagem e discutir as implicações profissionais e institucionais dos registros de enfermagem. **Método:** pesquisa qualitativa delineada em estudo de caso com análise de conteúdo fundamentada em Bardin. Doze membros da equipe de enfermagem lotados em enfermaria clínica cirúrgica de hospital de ensino de Minas Gerais que foram entrevistados em fevereiro/março/2015. **Resultados:** emergiram do agrupamento das unidades de análise as categorias: As anotações conferem respaldo para a equipe de enfermagem e conhecimento acerca da evolução do paciente e Momentos e maneiras em que as anotações de enfermagem são realizadas. **Conclusão:** foi possível perceber que mesmo com grande parte da equipe reconhecendo a importância dessas anotações, a maioria desconhece a legislação e sanções ético-legais advindas das não conformidades. Reconhece-se a limitação desta pesquisa por ter sido desenvolvida em cenário único com número limitado de participantes, que não pretende gerar a partir de seus resultados a universalização dos dados, porém a generalização dos mesmos na medida em que sensibilizem os profissionais em busca da otimização das anotações de enfermagem reveladoras da qualidade assistencial.
Descritores: Registros de enfermagem; Cuidados de enfermagem; Equipe de enfermagem; Legislação de enfermagem; Gestão de Qualidade.

ABSTRACT

Objective: describe the importance of nursing records in the medical records to the nursing team and discuss professional and institutional implications of nursing records. **Method:** Qualitative research outlined in case study with analysis of content based on Bardin. Twelve members of the nursing team worked in clinical surgical infirmary of Minas Gerais teaching hospital were interviewed in February/March/2015. **Results:** Emerged from the grouping of units these categories: Notes give support to the nursing team and knowledge about the evolution of the patient and; Times and ways in which nursing records are performed. It was revealed that even with much of the team recognized the importance of these notes most unaware of the law, ethical and legal penalties arising from noncompliance. **Conclusion:** It recognizes the limitations of this research to have been developed in unique scenario with limited number of participants who do not intend to generate from its results the universalization of data, however the generalization of the same in that sensitize the professionals in search optimization about nursing records revealing the quality of care.
Descriptors: Nursing records; Nursing care; Nursing, team; Legislation nursing; Quality management.

RESUMEN

Objetivo: describir la importancia de los registros de enfermería para el grupo de enfermería y discutir las implicaciones profesionales e institucionales de los registros de enfermería. **Método:** Investigación cualitativa en el estudio de caso con análisis de contenido basado en Bardin. Doce miembros del grupo de enfermería que trabajan en sala de cirugía y clínica de un hospital universitario de Minas Gerais fueron entrevistados en febrero/marzo/2015. **Resultados:** Surgió de la agrupación de unidades de categorías de análisis: Registros dan apoyo al grupo de enfermería y conocimiento sobre la evolución del paciente; Tiempos y modos em que se realizan los registros de enfermería. **Conclusión:** Incluso con la mayor parte del grupo se reconoce la importancia dos registros más ignorantes de la ley, ética y las penalizaciones por incumplimiento. Reconoce las limitaciones de esta investigación que se han desarrollado en un entorno único, con número limitado de participantes que no tengan la intención de generar a partir de los resultados de la universalización de los datos, sin embargo, la generalización de los mismos en la que sensibilizar a los profesionales en búsqueda de optimización dos registros de la calidad de la atención.
Descriptores: Registros de enfermería; Atención de enfermería; Grupo de enfermería; Legislación de enfermería; Gestión de la calidad.

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INTRODUÇÃO

In regard the current increase of hospital health services offered to the population, a market competitiveness is required, which implies constant revision of management concepts and processes that express the quality of care through accreditation programs[1-2].

From this perspective, the Nursing work process is highlighted in actions aimed at the quality management of the Nursing Service through the organizational, administrative, care, teaching and research dimensions. This is because the theoretical and scientific foundations that enable them are able to meet the client's needs and the organizations through the establishment of indicators and goals towards the desired results[3]. We can associate this process as a reflection of the nursing care annotations that are configured as legitimating the care, besides representing a part of the quality of the hospital product, especially if they express in a clear, individualized and complete, the activities developed by the team during the patient's care/hospitalization[4-5].

In this way, the records of the assistance favor the audit of medical records, as well as the protection of the rights of professionals in judicial or administrative situations. These audits, which are mostly profitable, have focused in taking into account the complete nursing notes in accordance with the requirements of the health insurance agreements, guaranteeing hospital profits, besides decrease glosses and characterize glitches. They're implanted in institutions with the objective of investigating and minimizing waste, to bring benefits to clients and the healthcare team[6-8].

On the other hand, the non-conformity of the annotation, either by the absence of registration or incompleteness, contributes to the disruption of the health care process. This makes effective communication among professionals, continuity and integrality of care actions[9].

In addition to the institutional implications, they are added to the ethical-legal ones because the Code of Ethics of Nursing Professionals in Section I, article 25, defines as responsibility and professional duty "to record in the patient's medical records the information that is inherent and indispensable to the care process" (p.3). Article 35 deals with the ban on "recording partial and untruthful information about assistance" (p.5)[10]. At the same time, the Resolution of the Federal Nursing (COFEN) nº 358/2009 states that "the execution of the Nursing Process must be formally registered" (p.3), and the leadership of these actions is conferred for the nurse[11].

It is important to mention Article 11 of the Professional Act No. 7498/86, which affirms it is the responsibility of the nurse to "plan, to organize, to coordinate, to execute and to evaluate the nursing care services" (p.3). These organizational skills, associated with leadership, communication skills, among others, define the professional profile with continuous search for quality that the labor market wants nowadays. When the nurses act as the negotiator, innovator, facilitator and coordinator in charge of the nursing team, they have better possibilities to guide, to clarify and to supervise the team in nursing notes, exploring their competencies to meet the goals and greater visibility of the care provided to the patient [12].

In view of this, it was assumed that when it is attached importance to notes in patient's records, the nursing team attests to a safe compliance with the legislation and code of ethics, in addition to efficiently favoring institutional costs.

Therefore, in the following we elaborated as guiding questions: What are the professional and institutional implications related to nursing records? What is the importance that the nursing staff has in checking the notes on the patient's chart?

To answer such questions, the objectives were: to understand the importance of nursing notes in the patient's record for the nursing team; to analyze the professional and institutional implications of nursing records.

METHOD

This research was delineated in a case study, qualitative, descriptive and exploratory approach with analysis of thematic-category content based on Bardin. The qualitative research has gained space in the health area, especially in nursing. Its perspective is according to uncountable data with a view to describing the meanings and subjectivities that permeate the participants[13].

In this study, the approach finds methodical cohesion, since it is intended to describe the value and importance of nursing notes from those who execute them. The case study was presented as a method by which a particular situation can be comprehensively understood in order to show it in its entirety[14].

The provisions contained in Resolution 466/2012 were observed and the issues related to bioethics "autonomy, non-maleficence, beneficence, justice and equity" were respected individually and collectively in order to guarantee the duties and rights of the participants of this study, as well as the "scientific community and the State Government" (p. 2)[15].

The research project was approved under Opinion n°906,433 and the field stage occurred in February and March, 2015. The participants were 12 members of the nursing team filled in the research scenario comprised as a clinical-surgical ward of a teaching hospital of Minas Gerais.

The interviewees were previously informed about the research and its purpose. The anonymity, privacy and confidentiality of the information observed or revealed have been guaranteed in order to safeguard and preserve their rights.

As inclusion criterion, we chose nurses, technicians and nursing assistants of the masculine and feminine gender who acted in the hospitalization unit of institution. And as a criterion of exclusion, the professional of the nursing team that was on vacation or medical leave.

In order to achieve the objectives of this research, a semi-structured interview based on a script previously prepared with closed and open questions was used as data collection technique. These questions allowed the interviewee to express himself in greater depth through the dialogical opening.

The following open questions made up the instrument: For you, how important is it to make the nursing notes on the patient's chart? Why? When do you take the notes? In the sector where you work, do you have any annotation standards to follow? Which one? Do you always follow this pattern? Do you know any legislation or other legal document of the nursing profession that addresses this issue? Have you had any training in the institution about how to do the nursing notes?

The nursing professionals were personally invited to participate and the interview was scheduled on the day and time that best suited the participants. A pseudonym was given in the form of the letter "P" and in the alphanumeric sequence in which the interviews occurred (P1, P2, P3 etc.).

It was clarified that the interruption of participation could occur at any time, without any loss or damage. All these items were described in a simple and clear way in the Informed Consent Term (TCLE).

In order to maintain greater trustworthiness for transcripts of interviews, an electronic recording device was used. Another support measure was the field diary, in which, after each meeting, the non-verbal language about gestures, interjections and others was registered. As a criterion of reliability, the possibility of listening to interviews was offered. The quantitative of 12 participants was considered satisfactory, since the interview compositions approached and responded to the proposed objectives.

The analytical stage was based on Bardin, considering the three stages that compose the thematic-category content analysis: pre-analysis, material exploration or codification, treatment of results - inference and interpretation [16]. This type of analysis was confined to the guiding questions, to the object and objectives of this research, as it extended the possibility of interpretation of the speeches issued by the participants through the search of the senses contained in the corpus[14].

The data analysis began with transcription of the interviews for the *Word for Windows 98* software. Afterwards, there was a floating reading of the corpus through attentive listening and exhaustive readings of the transcribed material and the records of the field diary, worrying about this first moment with the whole language. The units of analysis were selected by approximation of the sentences, paragraphs and themes derived from the speeches of the participants.

RESULTS AND DISCUSSION

From the 26 employees on the sector work scale, two were on vacation, one on medical leave and 12 accepted to participate in the interview - nurses and nursing technician, all female and with a training time ranging from three to 27 years.

From these professionals, four have worked for less than a year in the institution and the others between one and five years. It was also possible to know how long these professionals have worked specifically in the sector and it was identified that only one professional has been in business for more than a year, pointing out the visible turnover in the sector.

The notes give support to the nursing team and knowledge about the patient's evolution

In this category, the nursing team meant the support that the nursing notes confer both in the professional and institutional spheres: "It's a document! This gives a feedback for us technicians and for the hospital too, for the institution! We must try to evolve as much as possible that we can write as much as possible about the patient"(P5). "For sure! Because it is the legal support we have for the procedures we carry out, and for the quality of care we provide, if we ever need any information, it is what will support our service" (P12).

In this context, the notes must be written correctly and with the greatest completeness possible, and must contain reliable information that shows the care provided [17]. This is because the patient's medical record can be used as evidence of recklessness, negligence and professional malpractice[18].

In the Nursing field, it is prohibited the partial and false registration of information regarding the assistance provided, providing penalties ranging from verbal warning to annulment of the professional exercise according to the seriousness of the infraction committed [18].

However, although they mentioned the support that the notes provided to the nursing team, the participants demonstrated in their speeches ignorance when asked about the legislation and/or documents that supported the records: "To be honest, it may even happens, but here I have never seen this"(P2). "Legal document… No! [...] No! There is not a law like this! "(P4).

Nursing records are an important representation of the quality of care provided to the patient. The Code of Ethics of Nursing Professionals, in addition to being essential and indispensable to the realization of these records, imposes that they are the responsibility and it is duty of the entire nursing team to be the leader of these actions conferred on the nurse[11].

The need to strengthen the spread of the code of ethics in the service is observed in the constituent parts of the interviews. This issue can be conveyed through education actions in service aimed at improving professional performance by improving knowledge, using tools that facilitate the understanding of the team and measuring the effectiveness of training[19].

Still on the meaning that the nursing team confers to the registries, reports about the importance related to the continuity of the care provided and communication between the health team are evidenced: "It is a support that we have to control who is to take the medical record of this patient [...] To know what happened to him, how his evolution was during the shift" (P1). "When any change or intercurrence happens, if there is not a nursing note my coworker will come to take on, how will he know what happened and what did not?" (P2). "I'm sure because I need to know how my patient is, if there are any intercurrences in my or in my coworker's evolution, this will be all written there, what happened to him, if he had high blood pressure, if there was bleeding, if he did not have…" (P8).

The verification and comparison of the records of the multi-professional team is a method that is configured to obtain information of greater reliability by evaluating the coherence of the notes and the assistance given to the patient, revealing its quality [3]. The continuity of information in the different shifts that follow each other in the 24-hour period ensures the nursing team, patient and institution [17].

In order to increase control over records, internal auditors have been introduced into the staffing of health facilities. Among these, we highlight nurse auditors who, when assessing systemically the quality of nursing notes, are faced with precarious records, incomplete or even non-existent Systematization of Nursing Assistance (SAE). Such situations are present in the routine of the nursing team that their employees no longer care about disciplinary sanctions related to the ethical and legal issues of the profession[20].

In addition, when nursing records are poor, it is not possible to evaluate the quality of care and control costs, making the negotiations more transparent and generating possible glosses[21].

Often audited, these notes are able to clarify the practices adopted by the team, thus reinforcing the importance of the registration being performed in a clear and reliable way. Some situations that may result as a negative impact on the financial repayment focus on "illegible handwriting, presence of erasures and inadequate corrections, lack of stamp use and signature of the professional who performed nursing care, as well as lack of checking for materials, drugs and the annotation of well-

executed procedures, such as probes, venous access, use of dressings, air mattress, oxygen therapy and diets"[21].

Important questions regarding the health impacts caused by the cost of the technology or by the quality of care are raised by nursing auditors in the face of the analysis of the medical records, and the relationship between effectiveness and efficiency[22] revealed through the registries, both in the Unified Health System as in the Plans and Hospitals operators[20].

In this way, the entire team must strive to ensure that the registration of the nursing care offered to the patient evidences of technical, scientific and ethical grounding, advancing to the professional competence desired by the employing institution.

Although they voiced their legal support for the practice, interviewees were unaware of the legislation that supported them and the consequences of incomplete or misleading annotations for the exercise and impact on institutional costs.

Moments and ways in which nursing notes are performed

This category emerged to demonstrate that nursing documentation has become one of the most deficient fields related to the nursing work process, being directly related to the lack of qualification of these professionals and the lack of time to accomplish it in a more complete way[23], as stated: "It is routine to do as I do, when I have time! At the time we cannot!"(P2). "[...] usually after the medications and bath, and at the end of the shift." (P4) "Unfortunately at the break time of care it is not it like this, there is not a pre-set timetable for that, do you understand? (P5). "[...] I do it in the morning. At midday, when I have to check BP again, we evolve to see if he had lunch, if he did not eat lunch, right? (P8) "Whenever there is a little time" (P10).

The way professionals are currently recording their records is in accordance with Resolution COFEN 358/2009, which predicts that all stages of the nursing process need to be registered and based on a theoretical basis in a systematized and continuous way[11].

Nurses have "the leadership in the execution and evaluation of the Nursing Process to achieve the results of nursing expected, Nursing diagnosis about the responses of the person, family or human group at a given moment in the health and illness process, as well as the prescription of nursing actions or interventions to be performed in the light of these responses" (p.3)[11].

Likewise, "the Nursing Technician and the Nursing Assistant, in accordance with the provisions of Law N°. 7,498 of June 25, 1986, and Decree 94406 of June 8, 1987, which regulates it, participate in the Execution of the Nursing Process, as far as they can, under the supervision and guidance of the Nurse"[3,11].

Because of the non-conformities related to nursing notes, nurses have a fundamental role of perceiving the deficiencies of the notes and leading strategies guaranteeing best practices that qualify the systematization of nursing care[24].

The reports also show weaknesses from the institutional point of view regarding training and qualifications to improve the quality of notes made by the nursing team, since it states the lack of formalization for the records: "No! It is only advised that we should write everything, for not leaving to write anything, for not forgetting, to be able to the other person who is taking the night shift, or the doctor who ask something, it cannot be blank. Do you understand it?!" (P1). "Oh, no! She did not speak because she was old enough to go to 'war', when she is old at 'home' it is like that... Nobody says anything" (P2). "No, I don't remember" (P3). "[...] no, there isn't a standard, I think we have to... When we learn to make evolution, we learn the order that it has to be evolved [...] regarding the evolution of nursing, that's no!" (P5). "No! We don't have it, each one has his own way of doing evolution, and we really have to evolve! "(P8). "The pattern is these paper sheets; oh.These are the notes" (P9). "We follow the same pattern, we do more or less a basic note, and give to each patient with the specifications" (P12).

To be considered quality, nursing notes need to address requirements such as organization, integrity, impartiality, consistency, and legitimacy. Accurate, adequate, current and mainly readable, without erasure and with a stamp and signature are still necessary to identify the professional[23,25].

Thus, the annotations should be periodically evaluated and the results found should be presented and discussed later with the team, which is a way of assessing the need for training so that records become current and become a habit. The training provides knowledge

and professional skills to increase the quality not only of these records, but also of the nursing process as a whole[26-27].

In this context, the adoption of a standard constitutes the most apt way to evaluate the quality desired[28]. Therefore, defining a model to perform nursing notes means promoting improvements in the flow of information, facilitating team leadership, multidisciplinary care, and ensuring patient safety. Following the practice of this model, monitoring is in order to further improve nursing documentation[29].

Thus, for the adoption of specific norms and routines for nursing annotations, with a standardized description of how, what, who and when records should be made that would make it possible to standardize this practice in the institution, directly reflecting the quality of the assistance.

FINAL THOUGHTS

The emergence of the categories allowed us to understand deficiencies related to nursing records, showing weaknesses in the work process and in the way these notes have been made.

It was possible to perceive that, even with a great part of the team recognizing the importance of these notes, the majority is unaware of the legislation and ethical-legal sanctions arising from nonconformities.

In the case of the research carried out in a teaching hospital, which is configured in the field of practice and curricular internship, it is intended that these results contribute to the nursing academic formation in the training institution. And beyond, with the practice of nursing records in the scenario investigated, in order to motivate awareness actions around nursing notes which are more sustained on the scientific, ethical and legal basis of the profession.

We acknowledge the limitation of this research because it was developed in a single scenario with a limited number of participants, who does not intend to generate the universalization of the data, but the generalization of the data to the extent that they sensitize the professionals for optimization of nursing notes revealing the quality of care.

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