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RESEARCH

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Assessment of Nursing Records of Patients Admitted to the Medical Clinic of a University Hospital from the Northern Region of *Minas Gerais* State

Avaliação dos Registros de Enfermagem de Pacientes Internados na Clínica Médica de um Hospital Universitário do Norte do Estado de Minas Gerais

Evaluación de los Registros de Enfermería de los Pacientes Ingresados en la Clínica Médica de un Hospital Universitario en el Norte del Estado de Minas Gerais

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ABSTRACT

Objective: The study's purpose has been to assess the nursing records of patients hospitalized in the medical clinic of a university hospital from the Northern region of *Minas Gerais* State. **Methods:** It is a descriptive, retrospective, and documental study that has a quantitative approach. The study was carried out with 189 medical records of patients hospitalized in the medical clinic of a university hospital over the period from July to December 2012. Data collection was performed through a form, and data handling was done by simple random probabilistic sampling. **Results:** It was observed both minimum and maximum hospitalization time of one and 97 days (19.58±13.65), respectively. There has been a prevalence of conformities in the nursing records, as follows: bed, descriptive annotation, date and time, presence of rubric and stamp of the professional, admission, hospital discharge and/or death, check and legible handwriting. **Conclusion:** The presence of divergences observed in the nursing records compromises the registration functionality as a quality instrument.

Descriptors: Nursing Records, Quality Control, Nursing Audit.

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RESUMO

Objetivo: Avaliar os registros de enfermagem de pacientes internados na clínica médica de um hospital universitário do norte do Estado de Minas Gerais. **Método:** Trata-se de um estudo descritivo, retrospectivo, documental, com abordagem quantitativa, realizado com 189 prontuários de pacientes internados na clínica médica de um hospital universitário durante o período de julho a dezembro de 2012. Utilizou-se um formulário como instrumento de coleta de dados. O tratamento dos mesmos se deu por meio de amostragem probabilística aleatória simples. **Resultados:** Observou-se tempo de internação mínimo e máximo de um e 97 dias (19,58±13,65), respectivamente. Houve prevalência das conformidades nos registros de enfermagem, sendo estas: leito, anotação descritiva, data e horário, presença de rubrica e carimbo do profissional, admissão, alta e/ou óbito, checagem e letra legível. **Conclusão:** A presença de não conformidades observadas nos registros de enfermagem compromete a funcionalidade do registro como instrumento de qualidade.

Descritores: Registros de Enfermagem, Controle da Qualidade, Auditoria de Enfermagem.

RESUMEN

Objetivo: Evaluar registros de enfermería de pacientes ingresados en la clínica médica de un hospital universitario del norte de Minas Gerais. **Métodos:** Se trata de un estudio descriptivo, retrospectivo, documental, con un enfoque cuantitativo, realizado con 189 registros de pacientes ingresados en la clínica médica del hospital durante el periodo de julio a diciembre de 2012. Fue utilizado un formulario como herramienta de recolección de datos. El tratamiento de ellos fue por muestreo aleatorio simple probabilidad. **Resultados:** Hubo una longitud mínima de la estancia y el máximo de uno y 97 días (19,58±13,65), respectivamente. Había prevalencia de conformidades en los registros, que son: la cama, la anotación descriptiva, fecha y hora, la presencia de la línea y profesional sello, admisión, descarga y/o la muerte, la comprobación y legible. **Conclusión:** La presencia de los incumplimientos observados en los registros se encarga de la función de registro como un instrumento de calidad.

Descriptores: Registros de Enfermería, Control de Calidad, Auditoria de Enfermería.

INTRODUCTION

The records made by the nursing team consist of the most important instrument of proof of the quality of their performance, since it is through the written information that reflects the care and all the care provided during the hospitalization. Furthermore, nursing records have value not only as a source of research, but also as an educational tool and legal document.[1] The audit is of great relevance for assessing the quality of nursing care provided, and the records are the main form assessment of this care, since it is the records of the information about the client in the medical record the main mode of communication among the other members of the health team.[2]

There are currently a number of Organizations that practice the global assessment of health quality in institutions, for instance, the International Organization for Standardization (ISO) and the *Organização Nacional de Acreditação (ONA)* [National Accreditation Organization], as well as internal committees that enable evaluation to be carried out. The nursing audit committee is responsible for acting in several hospitals systematizing and monitoring the records.[3]

The nurse auditor is responsible for ensuring the quality of care provided to the user, then providing him with reliability and security in this relationship; making the company economically viable; carrying out a survey of assistance costs to determine managerial goals and subsidize decisions of the company's management; making provision and adequacy of the materials used; verifying the correct use/collection of available technical resources; educating the operator and service providers; providing a space for ongoing dialogue between the provider and the company and provider/company/user.[4]

Studies indicate that, in relation to the quality of nursing records, this is one of the most deficient fields of the nursing care process in Brazil, because even though nurses have a recognized importance, adequate registration has several limitations. The principal ones are the following: insufficient human resources; work overload for the team; lack of time to record in detail the assistance provided; and even ignorance of the importance due to the shortage of continuing/permanent education.[5,6]

Hence, this study aimed to assess the nursing records of patients hospitalized in the Medical Clinic (MC) of a university hospital from the Northern region of *Minas Gerais* State.

METHODS

Article derived from the monograph titled "Assessment of nursing records from a teaching hospital" presented to the Nursing Department from the *Universidade Estadual de Montes Claros/UNIMONTES, Montes Claros* city, *Minas Gerais State (MG)*, Brazil, 2013.

It is a descriptive, retrospective, and documental study that has a quantitative approach. The study was performed at the *Serviço de Arquivo Médico e Estatístico (SAME)* [Medical and Statistical Archive Service] from the *Hospital Universitário Clemente de Farias* at *Universidade Estadual de Montes Claros (HUCF/UNIMONTES),* located in the *Montes Claros* city, *MG.* The study sample consisted of 189 medical records of patients hospitalized in the MC A from the aforesaid hospital. Considering the medical records collected for the study, a total of 5,217 records were analyzed.

The following inclusion criteria were adopted for participation in the study: records of patients hospitalized in the CM sector during the period from July to December 2012. After collecting all the medical records, 289 medical records were totaled as the universe of the research. After sample calculation, 189 medical records were defined for sampling.

The CM has 32 beds in its infrastructure, presents seven nursing technicians who work in 12/60 hours shifts, has a managerial nurse with a workday of 40 hours a week, and

three more nursing assistants, two of whom work on a 6x1 scale, one on the morning shift and one on the evening shift, and the other on the night shift.

A presentation letter and an Institutional Consent Form were sent to the Clinical Office from the *HUCF/UNIMONTES* in order to authorize the study. The institution was duly orientated regarding the guidelines of the research and the same signed the Institutional Consent Form in order to authorize the accomplishment of the research. Data collection was carried out in the second half of 2013, during the month of September, and by the researcher responsible under the supervision of the sector's supervisor.

For sample calculation of the medical records, they were treated by means of simple random probabilistic sampling. The stipulated confidence interval was 95% (95% CI), the p-value adopted was 50%, as there were no expected differences between the medical records, and the allowed error was 5% (sensitivity level) for either more or less ($p<0.05$).

A self-elaboration form was used as a data collection instrument, composed of identification data and items of classification of the records based on the general guidelines considered in the theoretical reference and referred legislation, and also researches in the same topic already performed and validated by the *Conselho Regional de Enfermagem (COREN)* [Regional Nursing Council] from MG.[7-9]

The variables analyzed through the form were the following: patient identification data; descriptive customer annotations; date, time, rubric and stamp in each annotation; descriptive annotation of admission, transfer, and hospital discharge and/or death; unchecked medications; medications not initialed; records of the *sinais vitais (SSVV)* [vital signs]; readability, spaces; erasures; methods of correction.

The collected data were stored in a database of the Statistical Package for the Social Sciences (SPSS®) software, version 18.0, Windows for Windows. The data were then tabulated, analyzed and showed using the tables created by the Microsoft Excel® software, Windows for Windows, version 2010. Statistical analysis was performed through the representation of absolute and percentage frequencies, as well as measures of central tendency and dispersion measures.

The study followed the ethical precepts established by the Resolution No. 466/2012 from the National Health Council in which it regulates research involving human beings.[10] The research project was appreciated and approved by the Research Ethics Committee of the *Universidade Estadual de Montes Claros (CEP UNIMONTES)*, via *Plataforma Brasil* and under the Legal Opinion no. 249.984/2013, *Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Appraisal] No. 12842313.1.0000.5146.

RESULTS AND DISCUSSION

It was observed that during the patient's hospitalization period in CM, the patient remains in the hospital environment for a minimum of 24 hours. During this period, the patient is under observation for clinical monitoring of any symptom according to the complaint presented. After this period, if there is new clinical data for research, it is hospitalized. In case of stability of the complaint during the period of 24 hours, the patient is hospital discharged. Concerning the maximum time of hospitalization, there were patients who were hospitalized during 97 days (**Table 1**).

Table 1 – Hospitalization time of the patients admitted in the CM from the HUCF/UNIMONTES. Montes Claros, 2013.

Variable	Minimum	Maximum	Average	SD	CI (*p*-value)
Hospitalization Time (days)	01	97	19.58	±13.95	*p*=0.005

Source: SAME.

SD = Standard Deviation, CI = Confidence Interval.

All records had patient identification data in order to be in compliance. The record was considered within compliance by submitting the number note on each prescription sheet. This annotation was not verified in the nursing notes, since, in their header does not exist this item for annotation. Of the annotations analyzed, 66.85% were not within the standards.

Regarding the identification of the bed, 70.30% were in conformity. All records contained date, time, and patient descriptive annotations, but no standard annotation model was observed. Considering the medical records analyzed, 56.1% had some of their records with rubrics. At the end of the analysis, 3.8% were recorded without heading. It was observed that in 81.5% of the medical records there were no records with a stamp. At the end of the analysis, 14.52% of the annotations and/or procedures without a stamp were counted.

In the investigation, patients' admission of 96.3% of medical records was in compliance. In the transfer question, 48.7% had transfers performed, 2.1% were not recorded and 49.2% went directly to the referred clinic. From these notes, the notation of discharge and/or death was 94.7%. In 55.6% of the analyzed registries, compliance was observed in the medications reviewed. It should be noted that 198 unchecked medications were counted. Regarding the 2,762 records of suspended medications, only 822 were justified.

The erasures are not feasible, but are allowed as long as they follow the specific guidelines of the *Conselho Federal de Enfermagem (COFEN)* [Federal Nursing Council], through the Resolution No. 191, May 31st, 1996, as a form of correction.[11] Considering the erasures found, only 18.71% (n=64) were as stated by the *COFEN*. The readable letter was observed in 82% of the annotations (**Table 2**).

Table 2 – Profile of records annotation conformity of the patients admitted in the CM from the *HUCF/UNIMONTES. Montes Claros*, 2013. (n=5,217).

Variable	Conformity		Divergence	
	n	%	n	%
Registration number (medical prescription)	1,729	33.15	3,488	66.85
Bed identification	3,667	70.3	1,550	29.7
Descriptive annotation of the patient	5,217	100	-	-
Date and time of service	5,217	100	-	-
Heading of professional (annotations and/or checked procedure)	5,021	96.2	196	3.8
Professional stamp (notes and/or procedures)	4,459	85.48	758	14.52
Patient admission	5,023	96.28	194	3.72
Transfer not performed	110	2.1	5,107	97.9
Transfer performed	2,539	48.66	2,678	51.34
Transfer does not apply	2,568	49.22	2,649	50.78
Hospital discharge and/or death	4,940	94.7	277	5.3
Medication checked	2,898	55.54	2,319	44.46
Medication suspended with justification*	822	29.76	1,940	70.24
Presence of erasure**	64	18.71	278	81.29
Readable handwriting	4,278	82.01	939	17.99

Source: SAME.

*Considering the 189 charts analyzed, only 2,762 records of suspended medications were found.

**Considering the 189 charts analyzed, only 342 records of erasures were found.

The main forms of correction used by the professionals in the notes with erasure was the use of "parentheses" and "quotation marks", 5.26% each; use of the term "I mean" (44.74%); and "scratch the wrong note" (50%). In the 189 records searched, 582 spaces were found between the annotations. These were characterized as white lines between one annotation and another. They were found, in noncompliance, 474 records of *SSVV* (blood presure (BP), cardiac frequency (CF), respiratory frequency (RF), body temperature).

Table 3 – Principal forms of correction and annotation failures detected in the patients' records from the CM. *Montes Claros (MG)*, Brazil. (n=5,217)

Variable	Conformity		Divergence	
	n	%	n	%
Methods of correcting annotations with erasure*				
Using parentheses	340	99,42	02	0,58
Using quotation marks	340	99,42	02	0,58
Using the term "I mean"	325	95,03	17	4,97
Scratching the wrong annotation	323	94,45	19	5,55
Spaces between annotations (white lines)	4635	88,84	582	11,16
SSVV records	4743	90,92	474	9,08

Source: SAME.

SSVV = vital signs.

*Considering the 189 charts analyzed, only 342 records of erasures were found.

The analysis of the hospitalization period indicates that the average hospitalization rate in this CM is high (19.58 days), when compared to the Hospital Information System data, in which the average length of hospital stay in the study was 6.3 days, and in the State of MG it was 6.8 days.[12] The increase in length of stay leads to a greater number of annotations in the medical record, allowing also an increase in the number of divergences in the registries.

Patient identification data and record sheets are extremely important in order to avoid the exchange of tasks and medication among patients. An example of this is the pharmacy service at this hospital, which requires that all medication prescriptions are properly identified for correct dispensing of materials and medicines, and data entry in hospital accounts, avoiding glosses. In this item, 100% of the records contained the patient's name, 33.15% the registry number, and 29.7% the bed number. The latter two data are alarming, since the absence of registration interferes directly with the patient's recognition, which can generate adverse events, such as the exchange of medicines and care between them.

It is highlighted as a teaching hospital, where the flow of academics and professionals responsible for these records is high, generating more volume and excessive manipulation, leading to risks of loss and loss of information, thus corroborating another study carried out in a Hospital from *João Pessoa* city, *Paraíba* State *(PB)*, in which similar data were found.[13]

It was noticed that in 100% of the records there was date, time, and at least one annotation per shift. This finding is characterized as a breakthrough in the service, since a previous study in the referred hospital found that 96.8% of the records were dated and 90.5% were scheduled.[9] In comparison with other institutions in the country, There was disagreement with a study carried out in a teaching hospital in the interior of *Paraná* State, since most of the records analyzed did not contain date and time.[14]

The results confirm the awareness of nursing professionals of the importance of such information, considering that registration is an instrument to manage care and evaluate the quality of care performed by the nursing team.[15] Studies performed in a medium-sized hospital (n=23) of their initialed registries, compared to 56.1% (n=106).[14]

The Resolution No. 191/96 from *COFEN* establishes that the nursing team must identify after each registration using name, category and registration number in *COREN*, present in the professional's stamp.[11] Nevertheless, in the records observed, the habit of the use of the stamp (81.5%) and signature and/or heading (43.9%). These data are of concern and require rapid interventions with the team considering the ethical-legal importance of professional identification in the records, since it is the professional's obligation to sign the records immediately after the last sentence of each one.

It should be emphasized that the fact that some professionals do not correctly identify themselves when carrying out the records in the medical records can cause, in case of legal actions, damages both the institution and the employees and clients. The Brazilian Penal Code, in its Article 299, classifies the omission of information in public or private document as "criminal misrepresentation".[16]

There was a descriptive annotation of admission in 96.3% of the medical records. Attention is drawn to the fact that there

is no standard annotation adopted by the aforementioned clinic, ranging from incomplete annotations to complete ones such as arrival conditions (walking, stretcher, wheelchair, etc.); presence of accompanying person or person in charge; hygienic conditions; complaints related to the reason for hospitalization; procedures/care performed, according to institutional prescription or routine (*SSVV* measurement, venous access puncture, exams collection, grids elevation, etc.); provided guidelines, as recommended by the *COFEN* No. 191/1996.[11]

Studies and standards of quality management consider the importance of the standardization of tasks through Standard Operating Procedures aiming to establish the guidelines for the control and continuous improvement of quality.[17]

It is known that registration of the transference is important for the multidisciplinary team to know the care provided previously, guaranteeing continuity of care. Of the total number of patients in the study, 48.7% were transferred to the referred clinic, 49.2% entered directly, and in 2.1%, there was no entry.

It was found that 94.7% of records with annotations referring to hospital discharge and/or death, showing indices similar to the data obtained in a survey carried out at the regional university hospital from *Maringá* city,[17] which described 85.8%. Nonetheless, the records of this study did not present all the items that should be included in the annotation, such as the general state of the patient, level of consciousness, if they were with companion, if walked, among other important information.[18] Thus, similar with this study, a study conducted at a teaching hospital in *Ribeirão Preto* city, *São Paulo* State, has identified that the hospital discharge notes were not filled correctly in a small portion of the notes.[19]

Regarding the medicine therapy, there was a high percentage of 70.1% of non-existence of records of justifications for non-administration of medications prescribed in a teaching hospital from Londrina city, *Paraná* State,[20] data similar to this study, where 70,23 % of drugs suspended and not justified.

These findings are worrying and unacceptable when they become frequent, as it puts the established therapy at risk. Legally and ethically, if a drug was prepared but could not be administered, there should be a nursing note indicating which other reason led to non-administration of the medication. It was observed that the most common situations to circulate prescription drugs were the following: absent in the pharmacy, patient having reported allergy to the drug or refusal of drug therapy. This may be justified in that the hospital does not have specific norms for checking, evidencing that professionals do not obey the norms of *COFEN*.[11]

Another item investigated in this study was the measurement of *SSVV*, a procedure that is recommended in the hospital at least one registry per shift. A total of 474 records were recorded per shift in the total of 189 medical records, which means that in each medical record there is a lack of 2.5 *SSVV* notes per shift.

The results showed that there is a habit of checking BP and body temperature, without pulse check and RF. Nevertheless, it is a fact that is important measures to evaluate body function and its response to treatment, and must understand all the parameters, which are: temperature, pulse, RF and BP.[21]

There was a great deal of erasure in this study, demonstrating fragility in the nursing records at the institution researched. However, when compared to a similar study, 41 erasures were observed in 71 annotations.[14] It can be seen that the values found resemble the reality of many institutions.

It can be noticed that there was an increase of nursing notes with illegible handwriting of 12.6%,[9] to 18% in this study. So, it is considered a significant prevalence of legible letter, consisting of one of the main aspects to be considered in any documentation, since it can result in damages to the client, the professional and the institution.

There was a considerable increase of whitespace in nursing technician annotations, when we considered previous studies in the same institution surveyed in 15 of 241 medical records,[9] to 582 in 189 medical records. This demonstrates that professionals should have little or no knowledge of what they are applying in their work, as recommended by the institution's literature and Standard Operating Procedures, in other words, blanks may lead to the inclusion of untruthful information, resulting in compromise of legal or ethical verification processes.

Although this is one of the most emphasized items in the school environment, when addressing the topic of records, many professionals disregard the risks that failures of this type can cause and insist on leaving large spaces. In this aspect, the importance of the legal aspect of the registers is emphasized, therefore, not allowing erasures or blanks between the annotations.[11]

Compared to the study carried out with records from the same institution,[9] there was an improvement in the number of corrections that went from 13 to 17. It is interesting to note that one of the forms of correction used was the corrective expression "I mean", compatible with the recommended by the *COFEN*.[11]

The handwriting illegibility, found in 18% (n=34), constitutes a disrespect to the client, to whom the medical records belong and to the teamwork itself, insofar as it induces errors and deviations, characterizing the lack of commitment and care of the professionals towards the communication within the institution, then disfavoring administrative, clinical, legal, teaching and research processes.

When the medical record is correctly filled in with legible handwriting and signed by the professional, it becomes the main piece of defense of the team, in cases of denunciation of care compromised by signs of malpractice, recklessness or negligence. The *COFEN* Resolution No. 311, February 8th, 2007, reinforces that it is the duty of all nursing professionals to maintain perfect annotation on the clinical records when it is related to the patient and to nursing.[22]

CONCLUSIONS

Herein, some of the records are in compliance with *COREN-MG* standards, yet, it should be emphasized that some items deserve attention by the Nursing Supervision team, such as annotation of the registration number and bed, use of the stamp, standardization of admission and hospital discharge and/or death annotation, registration of the justification of not administering prescribed drugs, and standardization of medication check.

Overall, the need to improve the quality of nursing records, with more complete information and that really bring data about the care that has been performed with the patient, is perceived. This will allow the records made to be reliable parameters to reach levels of health care excellence.

Researches are needed in order to identify which either factors or conditions act as impairments to the nursing record in the scenario of this study, aiming to make investments in continuing and permanent education. Efforts should be made by the institution and the nursing team in order to regularize their process of registration and multiprofessional communication, adopting, for instance, the Nursing Care Systematization in its fullness and complexity, aiming to ensure the continuity and quality of care provided to users; training by the Continuing Education team; and continuous monitoring of the notes through the medical records Audit.

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