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Nurses Records in Medical Records of a School Hospital: Theory Vs Practice

ORIGINAL

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Abstract

Objective: Describe the characteristics of the evolution of nurses in the medical records of patients admitted to a school hospital in the city of João Pessoa, PB, Brazil.

Methods: This is a descriptive, exploratory and documental, embodied in a quantitative approach. The source of study data were the records of patients of the Pediatric Clinic of Infectious and Parasitic Diseases (IPD), who were in the Statistical and Medical Archive Service (SMAS), in a time frame from April to October 2015. The analysis the data was performed, from the descriptive statistics, using a statistical software.

Results: Through the data collected, two characteristics were observed in the records: the general aspects and the focus of care. In general aspects, the developments were characterized as being absent from erasures, use of correctives, grammatical errors, non-standard abbreviations and generic terms. They proved to be legible and clear, using scientific terminology, the date and time stamp. However, it was found that there are many blanks. As the focus of care, the records contemplated the general condition, level of consciousness, respiratory pattern and eliminations.

Conclusions: Based on the foregoing, the concreteness of this study shows us that nurses need to be aware in order to provide a more qualified registration and, above all, standardized, ensuring continuity of care and promoting the evaluation of the implemented care.

Keywords
Medical records; Nurse; Hospital; Care.

Introduction

The care provided to the patients of a health institution should involve a multiprofessional team, which has as one of its functions in common, the unprocessed registration of the practices developed with the patient, as well as their clinical status. On the one hand, the analysis of a set of reports provided, since it allows the planning, continuity and evaluation of the services rendered [1, 2].

According to Resolution No. 1,638/2002, of the Federal Medical Council, the medical record is defined as:

> A single document consisting of a set of registered information, signs and images, generated from facts, events and situations on the patient's health and the care provided, of a legal, confidential and scientific nature, that enables communication between members of the Multiprofessional team and the continuity of care provided to the individual [3]

Most of the records related to patient care are performed by nursing professionals, whose category consists of nurses, technicians and nursing assistants, all registering the actions of their responsibility, in the medical record. In this sense, nursing notes constitute an indispensable practice for professional practice and, over the years, it has undergone changes in its form and quality, in order to provide a record of the most qualified and integral care. Thus, the medical record must contain information, procedures and care related to the patient during hospitalization and must be ordered and systematized, so that, portraying the documented reality, it can become a permanent communication medium between the team [2, 4-7].

Nurses should value their notes, since they consider the process and the quality of care provided. Thus, records need to be performed with clarity and objectivity, conciseness, and can not present errors and erasures. In general, all information should be written as fully and reliably as possible, with a date and time, and at the end, contain the signature of the professional that registered [6, 2, 4].

Despite such relevance, the literature points out that although professionals recognize the importance of records, they sometimes behave in ways that are alien to them, which generates deficient records that are incomplete and susceptible to doubts as to their quality, entailing the commitment of planning, evaluation and continuity of care [2, 4-7].

There are many reasons to justify such attitudes, among them: the reduced number of professionals in the nursing services, insufficient to meet the demand of patients; work overload, which results in lack of time for registration; distancing from direct care due to excess administrative activities, among other causes [7, 2, 4].

In this context, it is observed that the studies related to this theme do not show good perspectives regarding the registrations made by the nurses. Therefore, considering that a School Hospital should be a reference for teaching, research and extension activities, it was sought to carry out this study, in order to understand how nurses are developing their records, especially their evolutions, in the medical records of patients admitted to the referred Hospital.

In view of the above, the following objective was outlined: to describe the characteristics of the evolution of nurses in medical records of patients hospitalized in a School Hospital in the city of João Pessoa, Paraíba, Brazil.

Methods

This is a descriptive-exploratory and documentary study, based on a quantitative approach, developed in a School Hospital, located in the city of João Pessoa, Paraíba, Brazil.

The data source was the medical records of patients hospitalized at the Pediatric and Infectious-Parasitary Diseases Clinics (IPD), from April to October 2015, which were filed at the hospital's Medical and

Statistical Archive Service (MSAS). The study sample consisted of 142 (n) records, of which 60 were from the IPD Clinic and 82 from the Pediatric Clinic

The data collection was carried out from March to April 2016, using an instrument prepared by the researcher, by reading the basic prerequisites in force in the specific legislation and in the relevant literature, structured in two categories: general aspects and focus of care. Data analysis was performed from the descriptive statistics.

The following inclusion criteria were used: records made by nursing professionals who had the title of nurse, and exclusion: records of technicians, undergraduate students in nursing and records that did not have the professional category object of this study. As a way of evaluating the nurses evolutions in the three work shifts, we adopted as strategy, to intercalate the assessments by medical records, as follows: first medical record released by MSAS - the morning's evolution was evaluated; According to medical records released by MSAS - the evolution of the afternoon was evaluated; Third chart released by MSAS - the evolution of the night was evaluated.

It is worth mentioning that, although it is not a research that directly involves human beings, the documents researched have private and confidential information of patients, so it was sought to respect the ethical aspects recommended by Resolution No. 466/2012 of the National Health Council, on the involvement of human beings in research. Therefore, the project was evaluated and approved by the Research Ethics Committee of the Hospital, under the opinion of n ° 1,435,073 and CAAE 51759015.4.0000.5183.

Results

Characterization of nurses records in a school hospital

To better understand the results of the research, a categorization of the analyzes of the evolutions developed by the nurses was carried out, in two dimensions: general aspects of registration and registration with a focus on care, this subdivided into: more addressed aspects of care; different aspects of care among the clinics studied; less addressed aspects of care; records of wound/injury care; records of venous access care; and, notes of care related to psychosocial and spiritual aspects.

Dimension: General aspects of the registry

In order to identify the general aspects of annotations performed by nurses in medical records, it was sought to verify items such as the presence of erasures, use of corrective, clarity and objectivity, among other aspects relevant to an adequate registry. The results obtained can be seen in **Table 1**.

In both clinics, the evolutions were legible and clear, regarding what was proposed to expose, using scientific terminologies in the evolutions, always recording the date and time of the evolution. Only in a small part of the evolution carried out in the IPD (13.3%) did not record the date, being recorded only the time. However, regarding the blanks, there

Table 1. General aspects of the registry.

General aspects	Clinic							
	Parasitic Infectious Diseases (PID) - n (60)				Pediatric - n (82)			
	Freq.	% Yes	Freq.	% No	Freq.	% Yes	Freq.	% No
Rasuras	7	11.7	53	88.3	4	4.9	78	95.1
Using Corrective	4	6.7	56	93.3	2	2.4	80	97.6
Legibility	58	96.7	2	3.3	70	85.4	12	14.6
Clarity	57	95	3	5	79	96.3	3	3.7
Grammatical errors	1	1.7	59	98.3	11	13.4	71	86.6
Scientific Terminology	56	93.3	4	6.7	81	98.8	1	1.2
Non-standard abbreviation	1	1.7	59	98.3	0	0	82	100
Blank spaces	26	43.3	34	56.7	72	87.8	10	12.2
Generic Terms	2	3.3	58	96.7	3	3.7	79	96.3
Date and time	56	86.7	-	-	82	100	0	0
Just hour	8	13.3	-	-	0	0	0	0

was a relatively high number in the IPD (43.3%) and, significantly, in the Pediatric Clinic (87.8%).

Dimension: Care-focused registry

The second dimension sought to verify the main aspects recorded by the nurses in the medical records, regarding the health conditions of the patients, as can be observed in **Table 2**.

Among the aspects most discussed in the studied clinics, it was observed that there were only 4 aspects in common, whose percentages were above 50% in the nurses evolutions: the general state in which the patient was, the level of consciousness, the intestinal and vesical eliminations, and a respiratory evaluation, almost as a priority, since it indicates the respiratory pattern, however there is no evaluation through auscultation. Only 4.9% of Pediatric Clinic charts had performed a complete respiratory evaluation. It is observed, therefore, that the aspects of care most addressed in the medical records are summarized in observable contexts, which do not require time demand and are therefore analyzed and recorded in a fast and succinct way.

In **Table 3** it is possible to visualize the distinct aspects addressed in the nurses' registers, according to the clinic in which it is inserted.

It is noticed that in some aspects, different results were observed, according to the clinic. In addition to the items discussed in **Table 2**, the evolution of IPD nurses also included aspects such as diet and nutrition (70%), skin and mucosa (58.3%), and patient complaints (63.3%), relevant in their records. Differently, in the Pediatric Clinic, these aspects presented a percentage lower than 50%, being, therefore, little approached.

It was also observed that important information on nursing care was little contemplated in nurses' registers of both clinics, as can be seen in **Table 4**.

Among the aspects of care less addressed, regarding factors such as sleep and rest and thermoregulation, it is observed that, although with a quantitative of less than 50% of the evolutions, it

Table 2. Record with focus on care: aspects most covered, 2016.

Aspects of care	Clinic							
	Parasitic Infectious Diseases (PID) - n (60)				Pediatric - n (82)			
	Freq.	% Yes	Freq.	% No	Freq.	% Yes	Freq.	% No
General state	37	61.7	23	38.3	77	93.9	5	6.1
Level of Consciousness	47	78.3	13	21.7	75	91.59	7	8.5
Respiratory system	38	63.3	22	36.7	68	82.9	14	17.1
Evaluation of the partial respiratory system	38	63.3	22	36.7	64	78	18	22
Evaluation of the complete respiratory system	0	0	0	0	4	4.9	78	95.1
Eliminations	45	75	15	25	75	91.5	7	8.5

Table 3. Registry focused on care: distinct aspects, according to the clinic studied.

Aspects of care	Clinic							
	Parasitic Infectious Diseases (PID) - n (60)				Pediatric - n (82)			
	Freq.	% Yes	Freq.	% No	Freq.	% Yes	Freq.	% No
Diet and Nutrition	42	70	18	30	33	40.2	49	59.8
Skin and Mucosa	49	58.3	25	41.7	39	47.6	43	52.4
Patient Complaints	38	63.3	22	36.7	13	15.9	69	84.1

Table 4. Registry focused on care: aspects less addressed.

Aspects of care	Clinic							
	Parasitic Infectious Diseases (PID) - n (60)				Pediatric - n (82)			
	Freq.	% Yes	Freq.	% No	Freq.	% Yes	Freq.	% No
Emotional state	11	18.3	49	81.7	5	6.1	77	93.9
Sleep and rest	28	46.7	32	53.3	26	31.7	56	68.3
Thermoregulation	28	46.7	32	53.3	40	48.8	42	51.2
Locomotion	11	18.3	49	81.7	8	9.8	74	90.2
Cardiac system	6	10	54	90	2	2.4	80	97.6
Evaluation of the partial cardiac system	6	10	54	90	2	2.4	80	97.6

Aspects of care	Clinic							
	Parasitic Infectious Diseases (PID) - n (60)				Pediatric - n (82)			
	Freq.	% Yes	Freq.	% No	Freq.	% Yes	Freq.	% No
Evaluation of the complete cardiac system	0	0	60	100	0	0	82	100
Abdominal evaluation	3	5	57	95	15	18.3	67	81.7
Presence of edema	8	13.3	52	86.7	2	2.4	80	97.6
Procedures performed	11	18.3	49	81.7	4	4.9	78	95.1

can be inferred that there is a relevant percentage, although, in relation to IPD, the Pediatric Clinic presents a relatively low approach in sleep and rest (31.7%).

Among the other aspects, it is important to highlight that cardiac evaluation, in both clinics, as an extremely relevant aspect, was not addressed, being evaluated in a partial way in only 10% of the IPD medical records and 2.4% of the pediatrics. Undoubtedly, raw data on this system are obtained either by a recorded and recorded blood pressure, or by an evaluation of the pulse, peripheral perfusion or heart rate, however, critical analyzes of such data should be part of the evolution of Nurses, but they were not found.

It was emphasized in the study, the evolutions that contained information about the presence of wounds in the patients, and, if the characteristics were described in the evolution, as shown in **Table 5**.

It was observed that, when the presence of wounds and/or lesions was identified, most of the nurses, 59.2% of the IPD and 63.6% of the Pediatric Clinic, described the location and characteristics of the lesions and/or wounds patient. This result is favorable and satisfactory, since it allows the monitoring by the multidisciplinary health team, the evolution and treatment of the wound/injury.

It was also sought to verify if the records emphasized the presence and important aspects in the

Table 5. Record with focus on care: wounds/injuries.

Aspects of care	Clinic							
	Parasitic Infectious Diseases (PID) - n (60)				Pediatric - n (82)			
	Freq.	% Yes	Freq.	% No	Freq.	% Yes	Freq.	% No
Presence of wound/injury	27	45	33	55	11	13.3	71	86.7
Wound/Injury Description	16 (n27)	59.2	11 (n27)	40.8	7 (n11)	63.6	4 (n11)	36.4

Table 6. Care-focused registry: venous access.

Aspects of care	Clinic							
	Parasitic Infectious Diseases (PID) - n (60)				Pediatric - n (82)			
	Freq.	% Yes	Freq.	% No	Freq.	% Yes	Freq.	% No
Presence of venous access	39	65	21	35	42	51.3	40	48.7
Date and location	12 (n39)	30.8	-	-	0 (n42)	0	-	-
There is neither date nor place	4 (n39)	10.2	-	-	13 (n42)	31	-	-
It is only local	23 (n39)	59	-	-	29 (n42)	69	-	-

care management of patients with venous access. The main findings can be seen in **Table 6**.

Regarding the venous access, a large part of the evolutions indicate the presence of venous access of the patients, however, in the Pediatric Clinic (51.3%), there was a registry quantification lower than the IPD (65%). However, only in 59% of the IPD registered and 69% of the pediatrics, were included the place of access was recorded. It is worth mentioning that in the IPD a small number of records was found, but relevant, from those who recorded the date and place of access (30.8%). However, in the Pediatric Clinic there was no record with the date. Of those who registered the access, but did not mention either the date or the location, were found in 10.2% of the IPD and 31% of pediatrics.

It is known that the psychosocial and spiritual aspects are relevant for the improvement of the pa-

tients' health conditions, and that their investigation by the nursing team is of great importance, since it allows a care that considers the client in all their needs, seeing As a holistic being and contributing to humanized assistance. Despite this, the study showed that these aspects are not being emphasized in the patient's chart by nurses, as shown in **Table 7**.

It is observed, therefore, that the psychosocial and spiritual aspects are scarcely noted, with a considerably low register in both clinics investigated.

Table 7. Care-focused registry: psychosocial and spiritual aspects.

Aspects of care	Clinic							
	Parasitic Infectious Diseases (PID) - n (60)				Pediatric - n (82)			
	Freq.	% Yes	Freq.	% No	Freq.	% Yes	Freq.	% No
Patient-team interaction	0	0	60	100	0	0	82	100
Patient-companion/ family interaction	1	1.7	59	98.3	2	2.4	80	97.6
Psychospirituality	1	1.7	59	98.3	0	0	0	0

Discussion

During their work process, the nurse is surrounded by administrative and assistance obligations, which must function synergistically, without one canceling the other. All these processes generate diverse information that needs to be documented, in order to support the professional in its accomplishment [8].

This characteristic highlights the importance of registration by the nurse, a record related to care, after all, nursing is a science that is based on patient care, developed from signs and symptoms, which need to be evaluated continuously, in order to Estimate the effectiveness of its assistance, but it is a registry that follows the basic prerequisites in force in legislation and literature, since the only guarantee that its assistance has been performed is registration.

According to the Resolution of the Federal Nursing Council (COFEN) nº 311/2007, Articles 25, 41, 71 and 72, it is the responsibility and duty of the nursing professional to record in the patient's medical records the information that is inherent and indispensable to the caring process, for this, such information must be written and verbal, complete and reliable, in order to guarantee the continuity of the assistance, being carried out in a clear, objective and complete manner [9].

Decision No. 115/2006 of COREN of Rio Grande do Sul ratifies and complements, in its articles 1, 3, 5, 7 and 13, that nursing records must contain precise information, legibly written, with no erasures and blanks. Avoiding the use of colloquial words [10].

Such aspects were found in most of the medical records investigated, so it is considered positive regarding the general aspects. Thus, the evolution of nurses was characterized in both clinics as being absent from erasure, use of correctives, grammatical errors, non-standard abbreviations and generic terms, however, they presented the presence of blanks in their majority.

The presence of spaces in white allows the insertion of data that have not been evaluated by the professional, giving margin for other people to add untrue data, being able to, thus, to harm him and to charge him with something that he did not do and could end up compromising processes of legal or ethical investigation [8].

A study developed in the medical clinic of a Federal Public Hospital, between December 2010 and June 2011, in the city of João Pessoa, Brazil, 75% of the nurses records were clear about the information recorded, however, 92% had erasures [11]. In a Public University Hospital, in the interior of the State of São Paulo, a low number of illegibility was observed (16.7%) and, unlike the previous research, a low number of erasures (17.8%) [5]. Another study carried out at a Teaching Hospital of Montes Claros - MG found that, in the records made by nurses, no spelling errors were found,

only 5.9% of the nursing records had blank spaces, 5.1% used abbreviations non-standardized and high percentage recorded date (96.8%) and hour (90.5%) [8].

The observance and positive results regarding clarity, legibility and absence of erasures in the studies related to nursing records, ensures a reliable understanding of the data regarding the assistance provided [12], favoring the continuity of care and higher quality in communication between the multiprofessional team.

When it comes to care registration, it is understood that registration must be based on the care provided, and that care must be based on the needs of the patient. Such an approach reflects needs by priorities, and can be understood from the hierarchy of Maslow's needs, interdisciplinary theory that is useful to indicate priorities in nursing care.

Maslow states that a person moves to satisfy from their most basic needs to the highest levels. Thus, according to him, basic human needs include five levels of priorities: physiological needs (oxygen, hydration, nutrition, body temperature, eliminations, among others); protection and security (physical and psychological); property and affection; self-esteem and self-love; self-realization [13, 14].

This concept influenced the theory of the Brazilian Wanda Horta, who classified the basic human needs into three categories: psychobiological (instinctive and unconscious needs that are manifested, for example, in the need to feed), psychosocial (need to socialize, to talk, to stand before oneself and society) and psychospiritual (necessity of that which transcends what can be explained by science) [15].

Corroborating with such aspects the American Nurses Association (ANA) points out some phenomena that need to be included in the focus of care: physiological and pathophysiological processes such as sleep and rest, skin, breathing, circulation, nutrition, elimination, reproduction, sexuality and communication; self-care processes; comfort, pain and discomfort; emotions that are related, as well as meanings attributed to the health-disease process; decision-making and the ability to make choices [13].

Therefore, nursing care aims to meet the physiological, psychological, sociocultural, developmental and spiritual needs of patients [14]. Addressing the needs affected, consciously or unconsciously, and that are in imbalance, demanding solution [15]. In this holistic perspective, it was possible to conclude that there was not a complete record, regarding the evaluated evolutions.

In a Maringá School Hospital, Brazil, it was observed the general state registry in 100% of the evolutions of the nurse in the Intensive Care Unit and 90% in the medical and surgical clinics. However, of the 8 evolutions of the medical and surgical clinics, only two records were found that highlighted the level of consciousness [16]. Differently, our results showed an assessment of 78.3% in the IPD and 91.5% in the Pediatric Clinic, regarding the level of consciousness.

In a clinical hospitalization unit in Caxias do Sul, Brazil, when compared to other body systems, the respiratory evaluation was presented in a larger number of records, through the evaluation of the respiratory pattern, as well as the evaluation of the skin and mucous membranes, both with 81.1%. In addition, intestinal (56.6%) and bladder (79.2%) eliminations [17] were also highlighted, corroborating such results with the present study.

Diet and nutrition are factors that favor a good recovery, since, the body acquires nutrients essential to its proper functioning. Especially in childhood, there is a great energy requirement and, consequently, a greater need for nutrient intake [14]. Therefore, the non-observance of such registration in the Pediatric Clinic of the study in question, is worrisome, because it is a factor of extreme importance in the health-disease process of the developing individual.

It is also known that understanding and evaluating the patient sleep pattern is necessary, since this factor contributes to the psychological and physiological restoration, favoring, above all, the restoration of the corporeal tissues. On the other hand, changes in thermoregulation are indicative of several metabolic dysfunctions, therefore, it should be observed with caution and frequency, especially in children, whose regulation is unstable [14]. These factors had a relatively low number of registries, as observed in the results of both clinics.

As for the other questions: emotional state, locomotion, abdominal evaluation, presence of edema and procedures performed with the patient, it was observed that little are addressed in the daily evolutions of nurses.

Corroborating with data on locomotion, a study pointed out that, in an inpatient unit, only 7.5% of the registries approached motor function, however, abdominal data were present in 69.7% of them. The records of the conditions on physical mobility and degree of dependence are of extreme importance, since it help in the staff sizing and adequacy of clinical resources [17].

Regarding procedures, two studies corroborate the findings, since they presented low percentages in this aspect [4, 16]. Such an explanation can be given by the annotation, for some procedures, only in nursing report books, being, therefore, an exclusive registry of the team and that ends up not being informed in the patient's medical record. In addition, some procedures may not be registered by negligence.

Regarding the presence of venous access, a study performed in a private hospital in the interior of São Paulo presented satisfactory results regarding the records of place and date of access, where 95% reported the site and 89% inserted date and time of the puncture [2], that is, a more satisfactory result than that found in the present study.

Authors point out that some complications are frequently related to the use of peripheral venous catheters, such as: phlebitis, infiltration and extravasation, therefore it is recommended to switch in adults in the period of 72 to 96 hours in order to reduce the risk of infection and other complications, however, in pediatric patients it is recommended that it be maintained until the end of intravenous therapy or when clinical signs of complications are observed [18]. Thus, recording and monitoring the signs present in the catheter and its length of stay is necessary, so that all the team has knowledge and access to the information regarding the device, with a view to avoid and control infections and complications related to it.

Finally, the study showed that psychosocial and spiritual aspects are poorly recorded, with a rather low register. Corroborating with these findings, a study carried out at a Maringá School Hospital, Brazil, which evaluated the evolution of the ICU, Medical and Surgical Clinics, it was observed that, in the analysis of the ICU records, there was no annotation about the psychosocial and spiritual dimension, while in the Medical and Surgical Clinics, only one evolution dealt with this aspect. Such a condition exposes that the records referring to these aspects are not considered as part of the recovery process, being neglected, disfavoring the affective, social and spiritual balance of the individual [16].

Conclusion

In view of the above, it was possible to describe the characteristics of the nurses evolution in medical records of patients hospitalized in a School Hospital in the city of João Pessoa, thus reaching the objective of the present study.

Thus, taking into account the holistic perspective, it was possible to conclude that, according to the analyzed evolutions, there was not a integral record. Such condition compromises nursing care, since it becomes hidden, in that it has not been registered. Hence the importance of a quality registry, as it

provides continuity of care, guarantees the work performed, and provides legal subsidies, through a need.

Therefore, the results of this study are considered relevant, because they showed how the nurses records are recorded in two hospitalization units with different clientele characteristics. Generally, it was observed that, in the general aspects, the records were successful, mostly following the prerequisites in force in the legislation, except for some aspects such as white space, which are present in most of the evolutions.

Regarding the care focus, unfortunately, superficial records are still available, focused on observable aspects, without critical analysis and presenting inconsistencies. Thus, it is understood that nurses need to be sensitized about their records and practice in order to provide an increasingly qualified, complete and, above all, standardized registry, guaranteeing the continuity of care and favoring the evaluation of the care implemented.

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