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REVIEW ARTICLE

Nursing notes: an important tool for health auditing

Notas de enfermería: una herramienta importante para la auditoría en salud

Anotações de enfermagem: uma importante ferramenta para a auditoria em saúde

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Abstract

This research seeks to make nursing professionals aware of the appropriate composition of their care reports. Narrative literature review, exploratory and descriptive. It identified a great difficulty for nursing professionals in carrying out their records. During the search and analysis period, three types of audits were encountered: pre-audit; concurrent audit and hospital calculation audit. It was concluded from the research that the high rates of failures in nursing records entail serious consequences in terms of care, administration and finances. It was understood that the audit is an activity that uses exclusive technical methods with the objective of attesting to the adequacy of a fact in order to establish reliability characteristics. Therefore, the role of the auditor goes beyond the classic concept of supervision. When issuing an opinion without collecting all the basic facts that support such a conclusion, the auditor may fail to point out errors in statements, records, procedures and end up issuing a technically incorrect opinion.

Descriptors: Nursing; Health Services Administration; Nursing Audit; Nursing Records.

Resumén

Esta investigación busca concienciar a los profesionales de enfermería sobre la composición adecuada de sus informes de atención. Revisión de literatura narrativa, exploratoria y descriptiva. Se identificó una gran dificultad para los profesionales de enfermería en la realización de sus registros. Durante el período de búsqueda y análisis, se encontraron tres tipos de auditorías: pre-auditoría; auditoría concurrente y auditoría de cálculo hospitalario. Se concluyó de la investigación que los altos índices de fallas en los registros de enfermería conllevan graves consecuencias en términos asistenciales, administrativos y económicos. Se entendió que la auditoría es una actividad que utiliza métodos técnicos exclusivos con el objetivo de atestiguar la adecuación de un hecho para establecer características de confiabilidad. Por tanto, el papel del auditor va más allá del concepto clásico de supervisión. Al emitir una opinión sin recopilar todos los hechos básicos que sustentan tal conclusión, el auditor puede dejar de señalar errores en las declaraciones, registros, procedimientos y terminar emitiendo una opinión técnicamente incorrecta.

Descriptores: Enfermería; Administración de los Servicios de Salud; Auditoría de Enfermería; Registros de Enfermería.

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Resumo

Esta pesquisa busca conscientizar os profissionais de enfermagem sobre a adequada composição de seus relatos assistenciais. Revisão narrativa de literatura, de caráter exploratório e descritivo. Identificou uma grande dificuldade dos profissionais de enfermagem em realizarem seus registros. Durante o período de buscas e análises, deparou-se com três tipos de auditorias: pré-auditoria; auditoria concorrente e auditoria de cálculo hospitalar. Concluiu-se com a pesquisa que os altos índices de falhas nos registros de enfermagem, acarretam graves consequências de ordem assistencial, administrativa e financeira. Entendeu-se que a auditoria é uma atividade que se utiliza de métodos técnicos exclusivos com o objetivo de atestar a adequação de um fato com a finalidade de fixar características de confiabilidade. Sendo assim, o papel do auditor vai além do clássico conceito de fiscalização. Ao se emitir uma opinião sem a coleta de todos os fatos de base que apoiem tal conclusão, o auditor poderá deixar de apontar erros nas declarações, registros, procedimentos e acabar emitindo um parecer tecnicamente incorreto.

Descritores: Enfermagem; Administração de Serviços de Saúde; Auditoria de Enfermagem; Anotações de Enfermagem.

Introduction

Originally used in accounting, the practice of auditing dates back to 2600 BC. having gained management features during the industrial revolution. In Brazil, the exercise of this function was only regulated in 1972 by the Federal Accounting Council. In order to support an action plan to evaluate and improve the effectiveness of procedure management, the audit corroborates the construction of favorable results, both in the financial and logistical areas, of the various service institutions that use it[1,2].

In the health area, the audit appears for the first time in 1918, in the United States, with the objective of evaluating the medical practice, verifying the quality of the assistance provided to the patient through the records in the medical records. In Brazil, the nursing audit has been developed as a tool for controlling the quality of work in the health service, evaluating the provision of services in this category through its records, which elevates nursing notes to the status of importante source of data in this inspection process[3,4].

This new concept, which incessantly seeks to benefit health services, ended up becoming a phenomenon all over the world, regarding the awareness of its great importance for permanence. In this way, auditing in nursing in health institutions, both in the private and public sectors, has become extremely relevant in view of the indispensability of reducing costs without harming care, providing excellent conditions for the services provided[5].

In light of the theories that govern the auditing process, this research aims to make nursing professionals aware of the proper composition of their care reports, with the specific objective of identifying in the literature the importance of each of the processes that surround this tool.

Methodology

It is a narrative review of the literature, with an exploratory and descriptive character. It was based on publications in the SciELO, LILACS, PubMed and Medline databases with the following keywords: “Audit”, “Nursing” and “Nursing Notes”, without temporal or linguistic restrictions.

Twenty-eight articles were analyzed and 17 were selected for the work. Due to the low number of articles retrieved in the search, the specificity of the topic addressed and availability for free were used as the only inclusion criteria. Literature identified as relevant and obtained as a reference in the selected articles were also analyzed. With the selected material, the following steps were followed: reading, categorization into thematic areas, writing, analysis and conclusion of the bibliographical research.

Results and Discussion

Several quantitative analyzes were found regarding the theme, discussing the financial impact of this production on services and the human capacity to carry out such processes, but analyzes that, in the authors' understanding, did not contribute to the objective, of a reflective nature, proposed.

The little literature found that could contribute to the analysis in question identified a great difficulty for nursing professionals in carrying out their records, and the literature observed a routine absence of information about the patient and his clinical situation, which is a worrying finding, see the audit process is built based on these reports.

During the search and analysis period, four types of audits were encountered that can impact the understanding of the process as a whole. They are: pre-audit (or prospective audit); concurrent audit (proactive or supervisory); hospital calculation audit (also known as retrospective or calculation review) and; quality audit.

- Pre-audit: consisting of any estimation of the medical methods again transpires effectuation, i.e. a prior audit in the proper way for the client. Improvement is evaluated with the analysis and exams obtained.
- Concurrent audit: consist of an assessment connected to the event in which the client is linked. It means the review by the auditor nurse during the client's hospitalization to verify the record.
- Hospital calculation audit: it is a critique of medical methods achieved with or without medical record. Usually achieved at the patient's hospital discharge. exercised with as much constancy in the hospital environment as by the additional health care provider.

- Quality audit is a systematic, formal and documented activity, carried out by qualified personnel and independent of the audited area, to determine, in order to verify the effectiveness of the implemented quality system and its results satisfy a planned action, if they were effectively implemented and if they are able to guarantee the achievement of the intended quality objectives for a given sector or unit of the company.

In the light of the proposal to make nursing professionals aware of the proper composition of their care reports and understand their association with the audit process, a discussion was proposed based on the presentation of the process "Audit in Nursing" followed by an understanding of the tool “Nursing Notes”, including its relationship with the Systematization of Nursing Care (SAE).

According to authors[6], the audit acts as an important tool for measuring the quality and costs demanded by health institutions, which are called, respectively, audit of care and audit of costs. According to these, the audit methods are based on a systematic and formal weighting by individuals not directly involved in the fulfillment of the activity, carrying out a conference of whether the activity carried out is in accordance with the proposed objectives.

According to a study[7], in the last few years, there has been an increase in expenses and an increase in the number of beneficiaries in terms of the health offer, which is increasing, devoid of high investments in cutting-edge technologies. Those responsible for Private Plans and the Public Health Care System in the country bring about high precision in controlling hospital clinical debts, imposing new dimensions on the audit process over the years.

Therefore, the weighted audit standards need to be achieved in depth with the assessment of the client's hospital record or debt and within the support of the complementary health operator, outside, or even in the place where they are obtained in the releases of ex officio requests, that is, the nurse auditor takes himself to the hospital, clinic, laboratory, and others, to analyze the client's records or losses after discharge. Similarly prone to external audit[8].

The auditor nurse acts in the intervention of contracts, with the aim of providing a peculiarity in the help with a legitimate value and addressing established goals, always sustaining political and professional ethics, based on the constitutional, technical, scientific and legal principles of the profession. The development of an instrument for execution in command of data focuses on a challenge for the nurse, inducing in concept the importance of the data of the objectives of combination with the structure, delimiting the way to discover and to reach the goals[9].

Nowadays, the audit service has been used as a great tool to identify inconsistencies found in nursing records. In addition to researching and finding any flaws in the control systems and the organization plan, the auditor must also pay attention to the maintenance of these systems, so that disagreements are reduced, acting preventively and providing proposals for quality improvement. The general audit risk is the one that aims to conclude and express your opinion about the company and its true representativeness. Rather, it is the likelihood that the auditor will issue a technically inappropriate suggestion for clarification.

The nursing audit plays a respectable role in the systematic consideration of the characteristics of the service provided to clients in different aspects. In view of this scenario, from a broader perspective, the nursing audit evaluates the characteristic of the service given to the patient through general assessments such as monitoring the client in loco and specific ones such as checking the medical records, verifying the conformity between the execution of the activities and the elements that make up the hospital bill charged. Therefore, the success of the nursing audit reinforces the importance of preparing a well-constituted medical record, which includes nursing notes, medication checks, notes on procedures and materials used, correctly reported[10,11].

The topic of nursing notes has been the subject of study by many researchers and scholars in the area. Florence Nightingale wrote in 1856 in her book, “Notes on Nursing”, that "it was essential that the facts observed by the nurse be accurately and correctly reported to the physician"; which allows us to assume that the record in the medical record was a way of rendering accounts to the physician[12].

Over time, the records acquired certain particularities in health institutions, becoming computerized, and being used as instruments that help in the idealization of the nursing team's performance. The main objective of nursing notes is, above all, to pass on information about the assistance provided, in order to guarantee an optimization in the communication between the nursing team, ensuring the veracity of information and, therefore, of the assistance provided[13].

Nursing notes are of great importance, as they help, primarily, in patient care. Its relevance is given through medical and nursing records of information regarding the type of treatment and surveillance during hospitalization. Everything must be registered in a clear and precise way, clarifying the facts reactive to the progress, the way of reacting and even the patient's concern. Nursing staff should recognize the time required to annotate each patient's records as part of their nursing job responsibilities[4].

Under the concept of recording care in the patient's medical record, there is often no information to achieve an adequate analysis of the care and a foundation for the institution, in the case of a lawsuit. When evaluating the nursing process, the systematization of nursing care is the frame member. As a result of this procedure, nursing explanations are the cause of distinguished care actions resigned to the patient. Thus, the systematization of nursing is connected with the audit, as it aims to be a well-founded tool that helps the auditor nurse in carrying out the data collection, since their activities show the evolution in the quality of care[14,15].

For this reason, professional teams must be adequate enough to carry out SAE tasks, although it is still of paramount importance for the audit, since the auditor nurse

must maintain contact with the clinical nurse, in order to adopt a collection method data, and have effective results in the quality of work[16]. Resolution No. 358/2009, of the Federal Nursing Council (COFEN)[17], points out about the SAE, that through this procedure the nursing audit measures the characteristics of the care provided, and that it suits the auditor nurse to manage and improve nursing care in a systematic and efficient way, in which it should be highlighted in every health institution[18].

The SAE refers to a scientific procedure used as a form of organization and implementation with care, assuring patients, quality and autonomy for nurses. However, it can be said that it is an exclusive instrument of the nurse's work process, which allows the expansion of actions that modify people's life and health/disease conditions[18].

The SAE is a scientific method available to professional nurses in order to apply their knowledge in patient care. According to a study, SAE is:

> *"The method in which it enables the nurse to exercise the art of caring, providing individualized care to the patient, planning their proper conduct, analyzing the patient's history with a comprehensive view, performing a physical examination, in order to diagnose and conduct comprehensive and individualized care for each human being"[18:38].*

In addition, the SAE prioritizes better quality patient care, providing a personalized welcome and the real importance of such a method for nursing. COFEN asserts that the stages of the nursing process presented as: nursing history, nursing diagnosis, planning, implementation and evaluation, have the function of contributing to the promotion, prevention, recovery and rehabilitation of the patient's health. The objective of the nursing history is to ascertain the patient's conditions through the use of a specific script, which should meet the specificities of the clientele for which it is intended, knowing the individual and biopsychosocial habits aimed at adapting the patient to the unit and to the treatment, as well as how to identify certain problems[17].

In this way, it can be said that matters related to SAE currently establish a relevant purpose of concern in the most diverse areas of nursing activity in teaching, research and assistance to human beings. Nursing notes should also provide patient safety which, according to research[19], it is about reducing acts that are not safe in the health care system, in addition to the use of good practices that aim to obtain optimal results for patients.

With the document published by the IOM, entitled "To err is human: building a safer health system" (To err is human: building a safer health system)[20], there was an increase in the concern and quality of patient safety, exposing the topic through data, which provoked anger in some, but positively stimulated several segments to rethink ways of acting and resume the discussion of care failures and improvements to be applied to provide efficient assistance[21].

For the World Health Organization, security is a global public health issue. It is estimated that in developing countries, harm is caused to one in ten individuals who receive hospital care. Many problems in organizations are related to human error. Despite the negative consequences, these errors can bring benefits to the organization when the causes are identified and thus stimulate learning and the implementation of changes to reduce or prevent future errors.

The importance of patient identification occurs throughout the hospital history, referenced mainly in the annals of nursing, being a care practice. Patient safety is a critical point in the quality of health care. In the continuous improvement process, it is important to establish a safety culture in the organization, analyzing its values, beliefs and norms[22].

Conclusion

It was concluded from the research that the high rates of failures in nursing records entail serious consequences in terms of care, administration and finances. It was understood that the audit is an activity that uses exclusive technical methods with the objective of attesting to the adequacy of a fact in order to establish reliability characteristics. Therefore, the role of the auditor goes beyond the classic concept of inspection.

During the execution of this research, an improvement in the quality index of the nursing notes was sought, exposing the nursing audit in an expressive way in the representation of the researched universe. In this way, it may happen that, when issuing an opinion without collecting all the basic facts that support such a conclusion, the auditor may fail to point out errors in the statements, records, procedures and end up issuing something technically incorrect.

References

1. Scarparo AF, Ferraz CA. Auditoria em enfermagem: identificando sua concepção e métodos. Rev. Bras. Enferm. 2008;61(3). https://doi.org/10.1590/S0034-71672008000300004
2. Attie W. Auditoria. São Paulo: Atlas; 1992.
3. Faraco MM, Albuquerque GL. Auditoria do Método de Assistência de Enfermagem. Rev. Bras. Enferm. 2004;57(4). https://doi.org/10.1590/S0034-71672004000400007
4. Setz VG, D'Innocenzo M. Evaluation of the quality of nursing documentation though the review of patient medical records. Acta Paul Enferm. 2009; 22(3):313-7. https://doi.org/10.1590/S0103-21002009000300012
5. Polizer R, D'Innocenzo M. Satisfação do cliente na avaliação da assistência de enfermagem. Rev. bras. enferm. 2006;59(4). https://doi.org/10.1590/S0034-71672006000400014

6. Rodrigues VA, Perroca MG, Jericó MC. Glosas hospitalares: importância das anotações de enfermagem. Arq Ciênc Saúde [Internet]. 2004 [acesso em 10 fev 202];11(4):210-4. Disponível em: https://repositorio-racs.famerp.br/racs_ol/Vol-11-4/03%20-%20id%2070.pdf
7. Fernandes IA, et al. Análise Comparativa da Auditoria Aplicada pela Enfermagem. Revista Gestão & Saúde [Internet]. 2013 [acesso em 10 fev 2023];8(1):13-24. Disponível em: https://docplayer.com.br/5151381-Revista-gestao-saude-issn-1984-8153-analise-comparativa-da-auditoria-aplicada-pela-enfermagem-comparative-analysis-of-audit-applied-for-nursing.html#:~:text=A%20auditoria%20de%20enfermagem%20pode,hospitalares%20e%20planos%20de%20sa%C3%BAde
8. Motta ALC. Auditoria de Enfermagem nos Hospitais e Operadoras de Planos de Saúde. São Paulo: Iátria; 2006.
9. Matos E, Pires D. Teorias administrativas e organização do trabalho: de Taylor aos dias atuais, influências no setor saúde e na enfermagem. Texto & Contexto-Enfermagem. 2006;15(3):508-514. https://doi.org/10.1590/S0104-07072006000300017
10. Faraco MM, Albuquerque GL. Auditoria do Método de Assistência de Enfermagem. Rev. Bras. Enferm. 2005;57(4). https://doi.org/10.1590/S0034-71672004000400007
11. Galante AC. Auditoria Hospitalar do Serviço de Enfermagem. 2.ed. Goiânia: AB; 2005.
12. Nightingale F. Notas sobre enfermagem. Editora Bibliomundi; 2022.
13. Gonçalves VLM. Anotação de Enfermagem. In: Cianciarullo, TI, Gualda, DM, Meleiro, MM, Anakubi, MH. Sistema de assistência de enfermagem: evolução e tendências [Internet]. São Paulo (SP): Cone; 2001 [acesso em 10 fev 2023]. Disponível em: http://webcache.googleusercontent.com/search?q=cache:1JRh1dsXdHAJ:www.scielo.br/scielo.php%3Fscript%3Dsci_arttext%26pid%3DS0034-71672006000700012+&cd=1&hl=pt-BR&ct=clnk&gl=br
14. Munhoz S, Ramos LH, Cunha ISKO. Custo padrão dos procedimentos de enfermagem na assistência ao paciente em terapia intensiva. Acta Paul Enferm [Internet]. 2003 [acesso em 10 fev 2023];16(4):77-85. Disponível em: https://acta-ape.org/wp-content/uploads/articles_xml/1982-0194-ape-S0103-21002003000160005751982-0194-ape-S0103-21002003000160005751.x65718.pdf
15. Kurcgant P, et al. Gerenciamento em enfermagem. 2.ed. Rio de Janeiro: Guanabara Koogan; 2005.
16. Santos CAD, Santana EDJ, Vieira RP, Garcia EG, Trippo KV. A auditoria e o enfermeiro como ferramentas de aperfeiçoamento do SUS. Revista Baiana de Saúde Pública. 2012;36(2). https://doi.org/10.22278/2318-2660.2012.v36.n2.a475
17. Conselho Federal de Enfermagem (COFEN). Resolução n.º 358/2009. Dispõe sobre a Sistematização da Assistência de Enfermagem e a implementação do Processo de Enfermagem em ambientes, públicos ou privados, em que ocorre o cuidado profissional de Enfermagem, e dá outras providências [Internet]. Brasília (DF): COFEN; 2009 [acesso em 10 fev 2023]. Disponível em: http://www.cofen.gov.br/resoluo-cofen-3582009_4384.html
18. Bittar DB, Pereira LV, Lemos RCA. Sistematização da assistência de enfermagem ao paciente crítico: proposta de instrumento de coleta de dados. Texto e Contexto Enferm. 2006;15(4):617-28. https://doi.org/10.1590/S0104-07072006000400010
19. Bohn MLS, Lima MADS, Duro CLM, Abreu KP. Nurses' perception on the use of the manchester risk classification system protocol. Ciência, Cuidado e Saúde. 2015;14(2):1004-1010. https://doi.org/10.4025/ciencuidsaude.v14i2.21359
20. Kohn LT, et al. To err is human: building a safer health system. Washington: National Academies Press; 2000.
21. Maciel LSB, Neto AS. A educação brasileira no período pombalino: uma análise histórica das reformas pombalinas do ensino. Educação e pesquisa. 2006;32:465-476. https://doi.org/10.1590/S1517-97022006000300003
22. Neves LAC, Melgaço RMT. A identificação do paciente como indicador de qualidade. (Dissertação) Mestrado. Universidade Federal do Estado do Rio de Janeiro/Consórcio Brasileiro de Acreditação; 2011.