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REVIEW

The scientific literature on nursing audit and quality of records

A produção científica sobre auditoria de enfermagem e qualidade dos registros*

La literatura científica sobre la auditoría y la calidad de los registros de enfermería

Cecília Nogueira Valença[1], Lorena Mara Nóbrega de Azevêdo[2], Aline Galúcio de Oliveira[3], Samuel Sóstenes Araújo de Medeiros[4], Fernanda Aparecida Soares Malveira[5], Raimunda Medeiros Germano[6]

ABSTRACT

Objectives: To know about the scientific production about nursing audit and to identify the importance of the nursing record in medical records for the audit. **Method:** Narrative literature review, it was selected articles related to nursing audit and nursing records in the electronic databases Scientific Electronic Library Online, and Latin American Literature and Caribbean Health Sciences, published between 2000 and 2010. **Results:** The articles analyzed indicated that there are few studies about this subject. It was identified that nursing audit is currently conducted by the retrospective method in the medical records and it is facing the accounting framework, and that nursing records are unsatisfactory quality as a tool to collect data. **Conclusion:** There are prospects that pass the audit to investigate the quality of care and to have an educational character that will enable the quality of care. **Descriptors:** Nursing audit, Nursing, Nursing records.

RESUMO

Objetivos: Conhecer a produção científica sobre auditoria em enfermagem e identificar a importância do registro de enfermagem no prontuário para a auditoria. **Método:** Revisão bibliográfica narrativa. Para qual foram selecionados artigos relacionados à auditoria em enfermagem e registros de enfermagem nas bases eletrônicas Scientific Electronic Library Online, Literatura Latino-Americana e do Caribe em Ciências da Saúde, publicados entre 2000 e 2010. **Resultados:** Os artigos analisados indicaram que há poucos estudos sobre a temática. Foi identificado que auditoria de enfermagem, atualmente, é realizada pelo método retrospectivo no prontuário e está voltada para o âmbito contábil e que os registros de enfermagem possuem qualidade insatisfatória para servir de instrumento de coleta de dados. **Conclusão:** Há perspectivas que a auditoria passe a investigar a qualidade do cuidado, pois possui um caráter educativo que possibilite a qualidade da assistência. **Descritores:** Auditoria de enfermagem, Enfermagem, Registros de enfermagem.

RESUMEN

Objetivos: Conocer la producción científica de enfermería en la auditoría y determinar la importancia de los registros de enfermería en los registros de pacientes para la auditoría. **Método:** Revisión de la literatura narrativa, fueron seleccionados artículos relacionados con la auditoría y de los registros de enfermería en bases de datos electrónicas Biblioteca Electrónica Científica Online, y Literatura Latinoamericana y del Caribe en Ciencias de la Salud, publicados entre 2000 y 2010. **Resultados:** Los artículos analizados indicaron que hay pocos estudios sobre este tema. Se identificó que la auditoría de enfermería se lleva a cabo actualmente por el método retrospectivo en los registros de pacientes y se enfrenta al marco contable, y los registros de enfermería son de mala calidad como una herramienta para recopilar datos. **Conclusión:** Hay posibilidades que la auditoría pase a investigar la calidad del cuidado y tener un carácter educativo que permita la calidad del cuidado. **Descriptores:** Auditoria de enfermería, Enfermería, Registros de enfermería.

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INTRODUCTION

Currently, an important tool to support the planning of health actions, its implementation, management and evaluation of qualitative results is the audit.

This tool consists of systematic and independent examination of the facts obtained through observation, measurement, test or other appropriate techniques, an activity, element or system to verify the suitability requirements advocated by the laws and regulations, and to determine whether health actions and their results are in accordance with the planned arrangements. Therefore, it is necessary to control application, assessment, monitoring inspection, supervision and monitoring.[1]

The audit first emerged in 1918, in health area, in a study conducted by Dr. George Gray Ward, in the United States, which was observed the quality of medical care provided to patients through medical records.[2]

Thus the beginning of the audit in healthcare has focused on evaluating the quality care provided to patients, as this is fundamental to the practice of professionals. However, nowadays, with increasing competition between hospital services, they offer treatments more economic, and thus they concern in optimizing the costs.[3]

In this context, there was the need for the trained professionals in this area, thus requiring an economic/accounting vision in order to operationalize the audit process. Therefore, in order to assess the qualitative aspects of care, internal processes and hospital bills, the audit participates of the routine of hospital institutions.[3]

In Brazil, in 1990, the law n° 8080, responsible for the creation of the Unified Health System (SUS) presenting its principles and guidelines, established the need for creation of the National Audit Office (SNA) as a tool for monitoring and assigning this coordination of technical and financial analysis of SUS nationwide. Decree Nº. 1651 of 28 September 1995, regulated the SNA, and defined competencies in the three management levels: Federal, State and Municipal. And the law n° 9649 of 27 May 1991, defines areas of competence, legal function as the coordination, surveillance SUS.[1]

Thus, the audit is not limited to private health institutions, but it also happens in public ones, being a set of activities both for control and for evaluating specific aspects of the system.

Over time, the audit has undergone changes and has been incorporated gradually in health care practice, especially in hospitals. It is noteworthy that in the hospital field, nursing is a profession that keeps most contact with the patient, and therefore it is responsible for most assistance. It is considerable the development of nursing audits and evaluation process in healthcare.

Audit of nursing was presented in publications for the first time in the 50s, in the United States by a nurse, a teacher at Wayne State University in Detroit. The Phaneuf's Nursing Audit was a tool developed for the audit of nursing, and it was applied retrospectively to the medical records to assess quality of care.[4]

Currently, the audit has been a management tool, used by healthcare professionals, especially nurses, in order to assess the quality of nursing care and the costs of providing this activity.[3]

Given these considerations, some questions emerge regarding this subject: How does the audit nursing happen? What is the importance of nursing in the medical records to the audit process?

Considering the applications of audit institutions in nursing and in health care, this study is relevant for contributing to the understanding of technical / scientific community about the role of nursing audits on the quality of care and management of nursing records.

Therefore, the objective is: to know the scientific literature on the nursing audit and to identify the importance of nursing record to the audit.

METHODOLOGY

This is a theoretical study based on a literature review of the type narrative, allowing the analysis of the literature in books, magazine articles printed and/or electronic on a particular subject, aiming to describe it and discuss it under a theoretical perspective or context.

This category of articles has a key role in continuing education because it allows readers to acquire and update knowledge on a specific topic in a short time[5]. Besides that, it presents more openly, without questions or specific protocols for their production[6]. Thus, it allows a more comprehensive discussion of the subject, without imprisoning themselves in proving questions.

Selected articles indexed in databases Scientific Electronic Library Online (SciELO) and Latin American and Caribbean Literature on Health Sciences (LILACS), using as descriptors in seeking studies: audit of nursing and nursing records.

The inclusion criteria used were the following items: texts available online in Portuguese, published from 2000 to 2010 in order to present these publications, and to provide approach to the theme. Thus, we excluded studies incompatible objectives of the study and not fully available in electronic format.

The phases of the research occurred, respectively, from the identification and location of the theoretical framework that addressed the topic under study, the cataloging and archiving the material found on obtaining relevant information to the study, and finally, the writing of the paper. In the literature review we used the qualitative approach, since it allows entering deep into the essence of the theme.

RESULTS AND DISCUSSION

It was found 43 articles, and of these 11 were selected according to the inclusion criteria. Books were used in auditing nursing to support the discussions. In literature could not find many current publications relating to audit nursing.

However, we found in the articles selected three surveys conducted with nursing audit, identifying their process, design and prospects. In one study it was found the work process of the nurse auditor in different fields of work: internal and external audits in the private and public audit. In the other two studies we conducted in accordance with the Delphi technique, a survey of experts about the concepts, methods and perspective purpose about current and nursing audits.

About this same thematic of concepts, methods and goals, as well as legislation, it was also found a literature that described the current considerations on these points.

We also analyzed two experience reports on the development of audits, which showed the process in general and descriptive.

And in most articles we found studies on nursing records to identify the inefficiency of these for constant communication, and thus ineffective in the audit process. We also found six studies that analyzed the quality of nursing record and used to audit for this review.

The audit enables the development of care indicators, evaluation criteria and the consequent generation of new knowledges.[7] In general, the audit can be classified according to the type or method, form of intervention, time limit and nature.

The methods or type of audit are: retrospective, which is held in the medical reports after discharge; and operational which analyzes records in the medical records, interview the patient and family, and observes the environment *in loco*.[8]

Regarding the form of intervention, the audit can be internal, when done by professionals of the institution; external, when auditors don't work in the institution; and mixed, when there's participation of all these members.[8]

The classification in regard to the time is divided in continuous, when it is carried out in periods when there is some revision of the previous process; and periodical when there is no continuity review, i.e., there are independent processes in certain time periods. As for the limit, the audit can be: total which cover all sectors of the institution, or in part which merely happen in some sectors of the institution. And, in relation to nature, it can be classified as normal, when it is carried out during specific and regular periods and fixed targets; and specifies, that it is performed by a particular purpose.[8] Specifically, the nursing audit also ranks in: a care audit and audit of costs.[9]

The audit of care aims to assess the quality of nursing care through the records of nursing staff in the customer record. Thus, this method is required for the adoption of standards to compare the expected result with the desired. These patterns are plotted in standards that refer to fill the forms for nursing; and care standards that relate to meeting the needs of patient.[8]

The costs auditing aims to check and control the billing sent to health plans, considering procedures performed and routine visits, crossing the information obtained from those recorded in medical records. Thus, these different types of nursing audit may indicate alternative preventive and corrective, being an educational process, not looking for those responsible, but it asks the motives of various results.[10]

Among the purposes of the nursing audit, we can mention: the identification of areas of deficiency of nursing services (for relocation or staff increase), providing data and programs to improve the quality of nursing care, and obtaining data to program the upgrade of the nursing staff through a program of continuing education for the staff.[2]

A recent study showed that the purpose of the audit in nursing, at present, is restricted to the proof of payment of hospital bills, reviewing glosses through the technical report and conducting negotiations between representatives of the hospital and the covenant. In the future, associated with the first purpose, the intention is to point out inadequate nursing care, reshaping their practices, indicating processes in-service education and outlining correct actions.[3]

Legally, COFEN resolution No. 266/2001 approving activities nurse auditor. This has the exclusive competence of the nurse as auditor in the exercise of their activities: organize, direct, plan, coordinate and evaluate, advise, audit and opinion on services of Nursing Audit.[11]

As the primary tool for this activity are nursing records, the auditor nurse, in the exercise of its function, has the right to request clarification on the fact that interferes with clarity and objectivity of records, with order to correct the misinterpretation that can generate disallowances / unfounded[11] discontinuities.

Thus, the nurse auditor has the right to access spot all documentation necessary for the exercise of their function, and it sealed the removal of records or copies of the institution. If necessary, they can examine the patient, duly authorized by him or his legal representative. Having identifying signs of irregularities in customer service, the proof requires analysis of patients' records, it is permitted to withdraw copies only for instructional purposes audit.[11]

These measures, regarding to restricted access to the patient record in the hospital, ensure reliability of information prepared by the nurse auditor in his analysis.

It is important to highlight that the nurse auditor must have a holistic view, such as quality of management, quality of care and quantum-economic-financial, keeping in view the welfare of the human being as patient / client.[11]

For this it is essential that the nurse auditor does not have a practice focused only on expenses incurred in the health services, but also to be aware of the impact that these represent the quality of nursing care provided by the health service. As well, it is important that the nurse auditor has a penchant for healthcare professionals and nursing of these services, to enable media to correct possible errors that are impeding a desired quality of nursing care in health institutions.

Under the ethical prism, the nurse auditor should act with clarity, smoothness, always grounded in constitutional, legal, technical and ethical principles, considering the Brazilian legislation and nursing force. As an educator, should participate in interdisciplinary and multidisciplinary interaction, contributing to the good understanding and development of nursing audits, and auditing in general, however, without delegating or transferring what is private for the nurse auditor.[11]

Thus, this work should also contact and work together with the sector of continuing education of institutions in order to contribute to the training of nursing staff and, consequently, to improve the quality of care.

Whereas nursing audit includes an integrated analysis of the actions developed by the nursing staff and that the evidence of these activities are documented in the nursing records, these shall have to reflect faithfully the quality nursing care and therefore are efficient tools for analysis of the nurse auditor.

Thus, about the quality of nursing records to be analyzed by nurses auditors, it reinforces that the records are responsible for the support and defense of nursing professionals, it is the way to verify the work done, since it is a service, and because of this, it is consumed at the time it's performed.[12]

The nursing records are essential to the process of human care, they constitute a form of written communication of patient information and assistance. Furthermore, when drafted reliably about reality being documented, they provide permanent communication, serving for various purposes such as surveys, audits, lawsuits, and other planning.[13]

It should be emphasized that the information from clinical record should be objective, clear and complete to be useful, to enable the monitoring, evaluation and (re) planning of global and continuous care.[13]

Regarding the legal aspect, the code of ethics of nurses, according to Resolution No. COFEN. 311/2007, establishes the responsibility of the nurse, as stated in the Article 25, to register in the patient record inherent and essential information to the care process. And yet in this work it is prohibited, according to the same resolution, in Articles 35 and 42, to record partial and untrue information about the care provided and to sign the nursing actions that did not perform, as well as allow their actions to be signed by another professional.[14]

Although there is a whole ethical/legal framework to sustain the necessity of quality of nursing records, they are often detected in audits absences of key data to clarify the actions taken by healthcare professionals, as well as records made improperly.

Much of payment for materials, medicines, procedures and other services are related to the notes or records of professional nursing. Thus, due to the nursing notes mostly of them were inconsistent, subjective and unreadable, the practice of glossing billing items of hospital bills have been routine and very important to the budget of hospitals.[15]

Therefore, it is clear that nursing records have a strong impact on the quality of health care provided not only by the nursing staff, but also by the health team.

Therefore, despite the standardization of procedures aimed at nursing staff, it has been reported in several recent studies regarding the problems in the records and nursing notes in the medical records.

Every day the patient's chart has established itself legally as an important tool in assessing the quality of care provided to clients in the hospital, providing vital information for litigation and health insurances.[16] Their records are also used for billing/collection, to internal or external audit to obtain statistical data on activities performed and institutional analysis.[17]

Thus, before the studies, we may be concluded by the need to invest in continuing education in health care, with special attention to the area of nursing records in order to contribute for improving the quality of care and at the same time, to attend the needs required by audits.

CONCLUSION

Given these considerations, it is clear that there are few publications about audit of nursing and the published studies do not yet cover research about the audit process.

Audit identified that nursing can be classified according to the type or method, form of intervention, time limit and nature, and each type is implemented in situations with different purposes.

In relation to the purposes of the audit of nursing, it was observed that although the audit in health has arisen from the need to evaluate the quality of care it currently faces the accounting / financial institutions, detecting errors in budgets. However, in most studies they presented the perspective that nursing audits also become a tool for assessing the quality of care. What will be possible only with the assistance of trustworthy record thus becomes essential quality in nursing records, i.e., with complete information, readable and reliable.

Therefore, it is expected that this study will contribute to the emergence of subsequent research on the theme of nursing audit, as well as stimulate a reflection on the act of improving the nursing register. Thus it will enable better the performance of nursing in care, the ongoing communication between the professionals and the critical evaluation of activities, research and management by proper documentation and reliable information about the patient and nursing interventions.

REFERENCES

1. Ministério da Saúde (BR). Departamento Nacional de Auditoria do SUS. Orientações técnicas sobre auditoria na assistência ambulatorial e hospitalar no SUS: caderno 3. Brasília: Ministério da Saúde; 2005.

2. Kurcgant P. Administração em enfermagem. São Paulo: EPU; 1994.

3. Scarparo FA, Ferraz CA. Auditoria em enfermagem: identificando sua concepção e métodos. Rev Bras Enferm. 2008;61(3):302-5.

4. Pinto KA, Melo CMM. A prática da enfermeira em auditoria em saúde. Rev Esc Enferm USP. 2010;44(3):671-8.

5. Rother ET. Editorial: revisão sistemática x revisão narrativa. Acta Paul Enferm. 2007;20(2):V.

6. Cordeiro AM, Oliveira GM, Rentería JM, Guimarães CA. Revisão sistemática: uma revisão narrativa. Rev Col Bras Cir. 2007;34(6):428-31.

7. Abdon JB, Dodt RCM, Vieira DP, Martinho NJ, Carneiro EP, Ximenes LB. Auditoria dos registros na consulta de enfermagem acompanhando o crescimento e desenvolvimento infantil. Rev Rene 2009;10(3):90-6.

8. Faraco MM, Albuquerque GL. Auditoria do método de assistência de enfermagem. Rev Bras Enferm. 2004;57(4):421-4.

9. D'innocenzo M, Feldman LB, Fazenda NRR, Helito RAB, Ruthes RM. Indicadores, auditorias, certificações: ferramentas de qualidade para gestão em saúde. São Paulo: Martinar; 2006.

10. Rodrigues VA, Perroca MG, Jericó MC. Glosas hospitalares: importância das anotações de enfermagem. Arq ciênc saúde. 2004;11(4):210-4.

11. Conselho Federal de Enfermagem. Resolução 266 de 05 de outubro de 2001: aprova atividades de enfermeiro auditor. Portal COFEN, [Internet] [acesso dia 06 abril 2011.]. Disponível em: http://www.enfermagemesaude.com.br/legislacao/110/resolucao-cofen-266-2001-aprova-atividades-de-enfermeiro-auditor

12. Oliveira VC, Cadette MMM. Anotações do enfermeiro no acompanhamento do crescimento e desenvolvimento infantil. Acta paul enferm. 2009;22(3):301-6.

13. Matsuda LM, Silva DMPP, Évora YDM, Coimbra JAH. Anotações/registros de enfermagem: instrumento de comunicação para a qualidade do cuidado? Rev Eletrôn Enferm. 2006;8(3):415-21.

14. Conselho Federal de Enfermagem. Resolução n. 311 de 08 de fevereiro de 2007: aprova reformulação do Código de Ética dos profissionais de enfermagem. Portal COFEN, [Internet] [acesso dia 07 mar 2011]. Disponível: http://site.portalcofen.gov.br/node/4394

15. Massaro M, Chaves LDP. A produção científica sobre gerenciamento em enfermagem hospitalar: uma pesquisa bibliográfica. Cogitare Enferm. 2009;14(1):150-8.

16. Peon AU, Amarante ST. Proposta de um instrumento para auditoria retrospectiva da assistência de enfermagem. In: ENFTEC; 2000. São Paulo; Brasil. São Paulo: Anais do ENFTEC; 2000.

17. Azevedo SS. Auditoria em enfermagem: proposta de implantação no hospital municipal Lourenço Jorge. In: ENFTEC; 2000. São Paulo; Brasil. São Paulo: Anais do ENFTEC; 2000.

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