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RESEARCH

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Annotations of the nursing team: the (dis) appreciation of care for the information provided[1]

Anotações da equipe de enfermagem: a (des)valorização do cuidado pelas informações fornecidas

Anotaciones del equipo de enfermería: a (des) valorización del cuidado por la información suministrada

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ABSTRACT

Objectives: to analyze the annotations of the nursing team in the charts of hospitalized children and to discuss the information described by nursing and its implications for child care. **Methods**: Qualitative research developed in pediatric ward of General Hospital. Data extracted from the consultation in medical records. Thematic analysis. **Results**: The annotations were related to data indicating gastrointestinal functioning, motor activity, interpretation of vital signs alterations, use of technological devices, and nursing care as dressings and body hygiene. The space destined to the annotation of the nursing team was restricted to medical prescription sheet that was insignificant and there was no identification of the professional. **Conclusion**: Nursing professionals only described in the medical prescription sheet information that did not reflect their care and the actual clinical condition of the child regarding the quality of nursing care. On the other hand, there was no movement of the nursing professionals themselves to guarantee a space in the medical record as a member of the health team.

Descriptors: Nursing records, Child, Pediatric nursing, Nursing care.

1 Artigo elaborado a partir do trabalho de conclusão de curso intitulado: A qualidade das anotações de enfermagem: A realidade de um cenário hospitalar pediátrico. Apresentado na Escola de Enfermagem Anna Nery (EEAN) da Universidade Federal do Rio de Janeiro (UFRJ), em 2014. Estudo recebeu o 3º lugar do prêmio Dulce Neves da Rocha, fornecido aos melhores trabalhos de conclusão de curso de graduação e oferecido pelo Núcleo de Pesquisa de Enfermagem em Saúde da Criança e do Adolescente (NUPESC) do Departamento de Enfermagem Materno-Infantil da EEAN/UFRJ.

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RESUMO

Objetivo:Analisar as anotações da equipe de enfermagem nos prontuários de crianças hospitalizadas e discutir as informações descritas pela enfermagem e suas implicações para a assistência à criança. **Método**:Pesquisa qualitativa desenvolvida em enfermaria pediátrica de Hospital Geral. Dados extraídos da consulta em prontuários. Análisetemática. **Resultados**: As anotações estavam relacionadas a dados que indicavam funcionamento gastrintestinal, atividade motora, interpretação das alterações dos sinais vitais, uso de dispositivos tecnológicos, e cuidados de enfermagem como curativos e higiene corporal. O espaço destinado à anotação da equipe de enfermagem era restrito a folha de prescrição médica que era ínfimo e não havia identificação do profissional. **Conclusão**: Os profissionais de enfermagem se limitavam a descrever na folha de prescrição médica informações que não refletiam o seu cuidado e a real condição clínica da criançaquanto à qualidade da assistência de enfermagem. Em contrapartida, não havia um movimento dos próprios profissionais de enfermagem para garantir um espaço no prontuário como membro da equipe de saúde.

Descritores: Registros de enfermagem, Criança, Enfermagem pediátrica, Cuidado de enfermagem.

RESUMEN

Objetivos: analizar las anotaciones del equipo de enfermería en los prontuarios de niños hospitalizados y discutir las informaciones descritas por la enfermería y sus implicaciones para la asistencia al niño. **Métodos**: Investigación cualitativa desarrollada en enfermería pediátrica de Hospital General. Datos extraídos de la consulta en fichas. Análisis temático. **Resultados**: Las anotaciones estaban relacionadas con datos que indicaban funcionamiento gastrointestinal, actividad motora, interpretación de las alteraciones de los signos vitales, uso de dispositivos tecnológicos, y cuidados de enfermería como curativos e higiene corporal. El espacio destinado a la anotación del equipo de enfermería era restringido a la hoja de prescripción médica que era ínfimo y no había identificación del profesional. **Conclusión**: Los profesionales de enfermería se limitaban a describir en la hoja de prescripción médica informaciones que no reflejaban su cuidado y la real condición clínica del niño en cuanto a la calidad de la asistencia de enfermería. En cambio, no había un movimiento de los propios profesionales de enfermería para garantizar un espacio en el prontuario como miembro del equipo de salud.

Descriptores: Registros de enfermería, Niños, Enfermería pediátrica,Atencion de enfermería.

INTRODUCTION

Nursing annotations are a legal instrument and assume various functions in the care context, such as: providing information about care provided, ensuring communication among health team members, ensuring information continuity within 24 hours, and allowing planning of the assistance. They can be a source of data for research, audits and legal processes.[1] Moreover, the annotations are an important tool for client evaluation, and it is part of the Nursing Assistance Systematization. In the care practice of hospitalized children, these notes should contribute towards systematizing care and the care quality.[2]

Accordingly, nursing notes should be composed of technical and subjective information, which allow the implementation of both the nursing process and decision-making process, by being based on information about admission, nursing diagnoses, interventions, evaluation of progress and results of the hospitalized child.[3] The lack of a universal language in nursing notes, which establishes the definition and description of the professional practice, may compromise the development of nursing as a science.[4]

In the pediatric hospital practice, nursing notes are still undervalued, being performed more frequently by nursing professionals of medium or fundamental level,[5] and subjective information such as the presence and participation of the accompanying family member during the hospitalization of the children are restricted.[5,6] This corroborates poor written communication, which is a frequent cause of adverse events in health care settings and results in problems ranging from delayed treatment to errors in surgeries and medication.[6]

A systematic review study with the objective of exploring the quality of nursing documentation, which was carried out in Australia with quantitative and qualitative articles, published in the English language during the years 2000 to 2010, points out that nursing professionals should pay more attention to the accuracy of records were identified. The scenarios investigated were hospitals that provide assistance to the adult population, primary care, school health center, mixed institutions between hospital and nursing home.[3]

In Brazil, an integrative review of the literature that aimed to analyze the scientific production about the audit of nursing records in national journals, over the period from 1995 to 2011, identifies that the articles pointed out several errors in the nursing annotations referring to ethical and legal aspects, among others, namely: illegible handwriting, erasures, use of graphic broker, annotations by shift and not by schedule, absence of dates, incomplete records and incorrect identification of professionals. There was also a high index of incomplete nursing notes regarding the physical state, mental state and body hygiene of the patient.[7]

Considering that the annotation of nursing in the pediatric hospital care scenario has not been researched nowadays, it is believed that the theme needs to be better explored, considering that the annotations are part of the nursing process; help to share information; provide support for improving the care quality; is a permanent report; has legal evidence as well as provides data for teaching and research. Health professionals, in particular the nursing team, should know the importance of the quality of their notes as an integral part of a multidisciplinary team in search of the quality of care and in ensuring the child's safety.

Given the aforementioned issue, the study's objectives are the following: to analyze the nursing team annotations in the medical records of hospitalized children, as well as to discuss the information described by nursing professionals and its implications towards child care.

METHODS

It is a descriptive research with a qualitative approach. The study scenario was a Pediatric Hospitalization Unit at a General Hospital from the Municipal Health Network that has as an entrance door either the Emergency or the Regional Emergency Coordination of the *Rio de Janeiro* city.

The Pediatric Hospitalization Unit is composed of 28 beds and assists children within the age group from 1 month to 12 years old, with clinical and surgical diagnoses, were the majority of the cases are by a traumatic event.

The nursing team in this study scenario is composed of 1 nurse and 3 nursing technicians whose shifts are 12 hours worked for 60 hours of rest, making up a total of 6 nurses and 18 nursing technicians. It should be noted that there is one head nurse who stays daily in the morning (7 a.m. to 1 p.m.).

The empirical data were composed of nursing records in 26 medical records of children who were hospitalized in January 2014. All medical records were used in the period of data collection.

Data collection was done by reading the entire medical record of the hospitalized child, searching for nursing notes and using a form with the following information: date, time and place of the notes, signature and professional category, registered content, number of daily notes. The study was submitted to thematic analysis.[8] For purposes of describing the results, which were related to the sections found in the medical records, they were identified as P.1, P.2, and so on.

The research was approved by the Ethics Committee from the Municipal Department of Health and Civil Defense of *Rio de Janeiro* city under the Legal Opinion No. 217A/2013, and respected the recommendations from the Resolution No. 466/12 that addresses researches involving human beings.[9]

RESULTS AND DISCUSSION

The medical records used in the study scenario were composed by the identification sheet, Free and Informed Consent Term, sheets called "medical evolution", medical prescription, results of laboratory tests, radiography and others.

It was verified that all the members of the nursing team recorded information about the child in the medical prescription sheet, whose space had the following items: front - identification of the unit, name, enrollment, infirmary and child's bed, besides three columns destined to the medical prescription (left column), nursing appointment (middle column) and observation (right column), containing 22 lines; verse - 29 rows without columns. The use of the prescription sheet was valid for every 24 hours. During the reading of the medical records, nursing notes were not found in other forms.

The fact of having a leaf that has the denomination "medical evolution" can be a justification to create a reserve of space for the notes of a certain health professional.

When analyzing the contents of nursing notes, it was verified that the dates were recorded daily and the schedules were restricted to the first and last hours of the 12-hour shift. In other words, two records were frequently found per turn. It should be noted that the names, categories, professional registration number and signature of the person who made the notes were not found.

The nursing notes in the children's medical record must contain the time and care should be described immediately at the end of it. At the end of the registration, the name and registration number of the class council of the person who performed it should also be clearly entered.[1,10]

A record that does not have schedules and the identification of the professional that wrote down can make it difficult or impossible to determine legal actions or audits, thus losing one of the meanings it serves.[1,2,5] Article 54 from the *Resolução do Conselho Federal de Enfermagem - COFEN* 311 of 2007[10] establishes that it is necessary to sign with a legible name, professional category to which belongs and number in the class council.

Regarding the content of the information registered by the nursing team, it was verified that they were based on food acceptance and presence of eliminations; the state of motor activity of the child; interpretation of altered vital signs values and/or pain complaints, use of technological devices, as well as curative and bodily hygiene care, as presented below, in the analysis topics[8] - Clinical status of hospitalized children: objective data assisting the professional assessment, and Nursing Care: bandages and body hygiene.

Clinical status of hospitalized children: objective data assisting the professional assessment

It is noteworthy that all 26 medical records studied had the same annotation characteristics, so the segments that best represented the results were selected.

Considering the acceptance of food and intestinal eliminations, there were nine notes:

Accepting the diet. (P.15)
Accepted the offered diet. (P.9)
Accepting the diet, present physiological eliminations (...) (P.21)
Sucking MB (maternal breast) and accepting the offered diets, diuresis present (...) (P. 1)
In zero diet, waiting for plastic surgery bandage. (P.25)
Sucking MB (maternal breast), present eliminations (...) (P.5)
Present diuresis, liquid feces (...) (P.3)
Physiological eliminations present (...) (P.23)
(...) physiological eliminations present (...) (P. 14)
(...) diuresis present (...) Under observation. (P. 17)

The notes about food acceptance and physiological eliminations do not express qualitative value, since there are no descriptions such as: quantity, both type and route of feeding offered, as well as frequency, characteristics of the eliminations (quantity, color, odor, consistency and changes) and date of the last evacuation.

The description of acceptance of the diets should include meal times, volume/quantity offered and route of administration. The annotation only of feeding is not enough to demonstrate the effectiveness of care. It is essential that the notes about all the care provided are clear and complete.[11]

Children need food in quantity and quality to maintain their normal growth and development. When they are hospitalized, their protein-calorie demands increase considerably and may

result in: malnutrition, reduced immunity, increased risk of infections and thereby length of hospital stay.[12]

Annotation of the characteristics of the eliminations, aims to contribute to the medical and nursing evaluation and diagnosis, since it is possible to identify a variety of diseases.1 However, incomplete nursing notes suppress important information and generate doubts about the care performed.[13]

It is also worth noting that, as a unit of pediatric hospitalization, it is usually the companions who administer the oral diets or make the diaper change, being under the responsibility of the nursing professional to request such information so that they can enter in the medical record. In other words, because the nursing professional is not in the moment of these care, he must request that the companion describe verbally for him or request his presence by the time the care is provided.

There were notes related to the motor activity of the hospitalized child, according to five excerpts from the notes:

Active child (...) (P.22)
Active child (...) (P16)
Child a little active (...) (P.4)
Child active and reactive to handling (...) (P.10)
Active child (...) (P.18)

In this group of notes, there was a concern of the nursing team to record the child's motor activity. It is assumed to be reproduced information, without an effective evaluation of it, then demonstrating the lack of knowledge about the repercussion and importance of this clinical evaluation. Also noteworthy was the note of a nursing professional that described the motor activity in the diminutive, not representing the formality that has this document.

In the notes regarding the consciousness level, it is indispensable to evaluate and note the responses (eyes opening, verbal response and motor response) of the children to the sensorial stimuli (pain, heat, touch, sound, others), avoiding the use of non-universals abbreviation and jargon.[1]

In this study, it became clear that nursing professionals recorded the child's motor activity without effectively creating the stimuli for the evaluation, that is, the record was relative to what the professional found when approaching the child.

From the notes, we also found descriptions regarding the interpretations of altered vital signs values and pain complaints:

(...) with slight tachypnea (...) (P.10)
(...) eupneic, hydrated (...) (P.18)
No pain complaints (...) (P. 13)
(...) Bedridden, hydrated (...) (P. 17)

Changes in vital signs are important components of the clinical evaluation of the child, however, because they are objective, it is not possible to record "mild tachypnea". The term "slight" is subjective and has no meaning for evaluation of the respiratory system, which in children should be evaluated according to age, that is, the smaller the child the greater the respiratory rate.

The respiratory pattern should be accompanied by information on cyanosis, respiratory effort, cough, and fever.[14] Still other important indicators of the general state of the child, such as hydration and coloring of the skin, have a low frequency of annotations. These data are consulted by health professionals in order to compose complete information about the child and to guide therapeutic behaviors,[15] emphasizing that the assessment of vital signs alone is not part of a quality clinical assessment.

In addition to describing the general clinical situation of the child, descriptions were found regarding the types of venous devices used.

(...) With salinized catheter jelco for therapy with ATB (antibiotic). (P.14)
(...) Catheter jelco salinized in URL (upper right limb). (P.1)

The concern of nursing professionals, especially regarding the use of a venous device and in this case, the annotations should be related to the location, size of the device, length of stay, characteristics of the puncture ostium and permeability. The empirical material of this study points out that the nursing professional is only concerned with describing that the child is in use, not paying attention to these other information.

Puncture of the intravenous route is the responsibility of the nurse, and its annotation should contain the characteristics of the procedure.[5,10] In children with venipuncture, the type, location, and size of the device used, what is being infused, the date of the puncture, and the type of dressing and fixation should be recorded.[1]

The knowledge of the nursing team about the mechanisms involved in the installation and maintenance of venous access is extremely important, since they provide safety to the child, as well as guarantee preservation and early detection of possible complications. Due to the fragility characteristics of the venous network in children, the puncture and maintenance of venous devices present a challenge for the nursing team, and sometimes several puncture attempts are necessary.[17]

According to the section found in P.2, the nursing professional reported on the reason for not administering the prescribed medication and the various puncture attempts.

(...) medication was not administered because the venous access was gone and numerous attempts were made to re-puncture without success. Punctured new venous access into ULL (upper left limb). (P.2)

It was also found that there was a concern to justify the delay of the drug administration. Nevertheless, there was a lack of information such as: type and number of the venous device used, number of puncture attempts, skin characteristics at these sites, the approach that was taken, site of the anterior route, etc.

Furthermore, with regards to technological devices used by the child, we have found excerpts describing the use of macronebulization and tracheostomy.

(...) using intermittent macronebulization (...) using TCT (tracheostomy) [...] (P. 17)

It is understood that if the child with tracheostomy still uses macronebulization, a description is necessary that can inform the characteristics of the secretion and the ostium of the tracheostomy, as well as, the flow of oxygen and saturation of the child, because in the face of the use of such device, it is assumed that the child is being monitored.

According to the recommendations from *COFEN* for making nursing records, work management 2015/2018 and based on the Resolutions No. 429/12 and No. 311/07, the nurse should note date and time, type and number of tracheostomy cannula, skin conditions, exchange or cleaning of the endocannula, intercurrences and measures adopted.[18]

Hence, the contents of the annotations were considered trivial and incomplete, as they did not describe the nursing care provided to the child with this device, nor did they value their health status.

Nursing Care: bandages and body hygiene

The information about the nursing care provided to hospitalized children was restricted to body hygiene and bandages.

With regards to body hygiene, four sections were highlighted:

(...) Performed the bath + general care (P.20)
(...) Performed the bath in the bed. Under observation (P.8)
(...) Completed corporal hygiene (...) (P.6)
(...) Performed the bath and other nursing care (...) (P.11)

It was found in these notes that the information was empty, without professional value, since it was exempt from clinical data or from the health condition of the child or, properly, the type of care provided to the pediatric clientele.

It is also added that citing "general care" and "other care" of nursing, does not allow effective communication and legal value of the notes made.[1,2,10] The expression "under observation" is subjective and does not provide objective data for assessing the health situation and guide nursing care.[5]

As the *COFEN* recommends, the date and time of the procedure, the type of bath (immersion, spraying, in the bed), length of time in the bath (immersion - tolerance and resistance of the patient; bed changes - skin changes, soap allergy and hyperemia in bony prominences) and measures adopted (comfort massage, passive movements, application of ointments or gel) should be part of the information recorded.[18]

Likewise, with regards to the corporal hygiene, it can be affirmed that it was done by the familiar/companion. In other words, with the exception of bathing in the bed, which requires the presence of the nursing professional because it is a complex care, immersion and sprinkler baths were done by the family/companion in the pediatric hospitalization scenarios, therefore, they must inform to the professional by the consultation time. In this sense, it was understood that it is only up to the nursing professional to effectively note the care provided by him.

In a study developed at a Pediatric Hospitalization Unit, it was shown that the children's body hygiene is done by the family member/companion; however, the nursing professional does not value the care given by the other person when writing on the medical record.[19]

The literature recommends that nursing professionals include the family in their care plan, favoring their conviviality and promoting actions that take into account the singularities of the caregiver, such as attentive listening, respect, bonding with the family and fostering care. Nonetheless, in addition to this, it is necessary to record the care taken by the caregivers and the shared care among the staff.[20]

Also related to nursing care, records related to dressings were also found.

(...) Clean and dry bandage in LRL (lower right limb). (P. 19)
(...) Silver sulfadiazine bandage + 0.9% SF (saline solution 0.9%) (P. 24)
(...) Performed dressing in URL (upper right limb) with SF 0,9% (saline 0.9%) (...) (P. 26)

It is noteworthy in these excerpts that there is no concern in specifying the site, the characteristics of the lesion in order to guarantee a more careful evaluation as to the evolution and effectiveness of the performed dressing, as well as there is no standard of the information provided.

In Brazil, the nursing record is part of the routine nursing care, however, the team often does not use a standardized language for this purpose and does so in an unsystematic way.[21]

Nursing annotations should ensure the transmission of information for continuity of care, assess how it is being developed, and the repercussions on the health of the hospitalized child, as well as, should encompass all the procedures performed and materials used.[2] Dressing is a technical responsibility and legal status of the nurse, who at the end of the procedure must perform the registration, seeking to describe the anatomical location and characteristics of the lesion, as well as the material used.[1,10]

The location of the injury, its size, date and time, signs and symptoms observed (presence of secretion, coloration, odor, quantity), need for debridement, type of bandage (occlusive, open, material used and level of pain to the procedure are information that must be included in the nurse's notes on the medical record.[18]

The Brazilian Code of Ethics of Nursing Professionals[5] that legally protects the rights and duties of professional practice, specifically in Resolution 311/2007, Section IV, Relations with Employer Organizations - Rights, in its Article 68 should " record in the medical records and other documents specific to the nursing information related to the process of caring for the person."[10]

As of 2009, according to the Resolution No. 358 from *COFEN*, all hospitals should implement the Nursing Care Systematization and that in its Art. 6, the execution of the Nursing Process should be formally recorded, recommending the annotation of a summary of the collected data about the

person, family or human collectivity, as well as the nursing diagnoses, actions or nursing interventions and their achieved results.[22] Then, the resolution ends up obliging the nursing professionals to qualify and apply their scientific knowledge to better serve the assisted clientele.

Hence, the quality of the notes shows the degree of preparation of the professionals that provide the care, as well as, inaccurate records can be interpreted as a deficiency in the quality of care without this being true.[1,5]

The study presents limitations due to the restricted number of medical records studied and because it is a unique scenario. Nevertheless, it can be inferred from the results found that there is still a lot to be done, not only because there is an urgency of the nursing team to implement the Nursing care Systematization, but mainly because the annotations are fundamental and part of this process.

FINAL CONSIDERATIONS

This study pointed out that the nursing team makes annotations looking to describe some clinical data and also the care provided to the child. Nonetheless, because the annotations were incomplete, they turned out to have poor quality. One can suppose that the annotation space intended to this professional justifies the use of abbreviations, low frequency of the annotations and quality of its content, therefore, not reflecting effectively the provided care.

It should be emphasized that the characteristics of nursing reports have ethical and assistance implications that significantly compromise their quality, since it does not reproduce effectively what is developed as nursing care.

This study has supported the nursing managers from the study scenario with regards to the need to qualify nursing professionals regarding the quality of their notes, as well as to seek the recognition of these notes in the spaces of the medical records.

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