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Preview Notes

The quality of nursing records at a maternity hospital: a descriptive study

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ABSTRACT

Aim: To identify non-conformities related to nursing records; to present proposals for team training with regard to the quality of nursing records. **Method:** This is a descriptive study using a quantitative approach. The study uses data from medical records to be collected from November 2015 to June 2016. An instrument was developed to collect data and the notes described will be compared to expected annotation standards. The collected variables will be analyzed using descriptive statistics. **Expected Results:** Acknowledging the importance of nursing records and how it affects nursing staff.

Descriptors: Nursing Records; Pregnant Women; Postpartum Period; Newborn.

PROBLEM SITUATION AND ITS SIGNIFICANCE

Nursing care must be provided with quality and dignity to all patients. Increasingly research is a way to systematize and organize quality nursing practices[1].

Based on the nursing process as part of nursing care, we highlight the importance of nursing records as instruments to highlight the concepts inherent in nursing practice[1].

Besides contributing to the construction of an assistance plan, nursing records are legally considered to be very important documents in terms of providing support for litigation, education and research matters. Moreover, the act of recording the nursing care provided complies with the ethical-legal requirements of the regulatory agency of the class[2].

When the nursing staff performs some activities but does not make any record of these activities, it hinders the quality of care and prevents the collection of data for the planning of actions for the patients in their care. Professionals need to value the importance of their notes in order to organize and plan their assistance. This requires always maintaining their records in full[3].

Although necessary and mandatory in most health services, nursing records are still being developed. This fact contributes to the lack of visibility of professional nursing staff in health care[2].

Assuming that the nursing record is a measure of care quality, some authors reiterate the importance of observing certain aspects in these notes, such as the readability of the notes, their completeness (features, particularity or condition of what they are, presented in full mode), authenticity and organization[2].

In this sense, this study presents the following guiding question: What is the quality of nursing records in the maternity service under consideration? Following this line of thought, the aim of identifying the degree of non-compliance related to nursing records were set, and proposals for staff training regarding the issue in terms of data quality were presented.

METHOD

This is a descriptive piece of research using a quantitative approach. The study uses, as a source for data, the records of the Maternity School of UFRJ. The proposed study is planned for the period from November 2015 to June 2016.

Each sector has an exclusive tab for each professional category. The records made by the nursing technical assistants, by nurses, as well as the prescriptions, will be analyzed in order to investigate the notes related to medication administration and the checking of these.

A specific instrument was developed to collect data with variables that allow the evaluation of the described notes, comparing them with expected standards of annotation according to the literature on the subject. The records will be evaluated for every 12-hour shift. We intend to conduct a pilot test with 5% of the sample, allowing a refinement of the instrument.

The study population was calculated from the number of admissions in the institution, from September 2014 to February 2015.

The sample size calculation was obtained by the formula $n=N.Z2.p.\ (1-p)\ /\ Z2.p.\ (1-p)\ +\ e2.\ (N-1)$, where n refers to the calculated sample, N to the population, Z to the standard normal variable associated with the level of confidence, p to the true probability of the event, and e the sampling error. Consequently, two hundred and ninety five records will be investigated.

The sample will be classified by convenience. The medical records of mothers who

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obtained hospital discharge from the rooming and underwent the usual therapeutic itinerary, or have been assisted and, as a consequence, have nursing records in outpatient departments, obstetric emergency, obstetric centers and rooming will be included in the study. Regarding the records of the newborn, it was decided to include those in the Neonatal Unit and also in the rooming. The records of all pregnant women, mothers and newborns who have been rehospitalized will be excluded. The removal of such medical records from the study is justified in terms of not wanting data to be collected twice from the same source, since the pregnant women will have already been included in the study during the first hospitalization.

The items contained in the data collection form will be tabulated and checked by two different people (involving a double check review). The data will be entered and analyzed in a Microsoft Excel® spreadsheet, through the use of descriptive statistics with presentation in the form of tables and graphs.

The study was approved by the Research Ethics Committee (REC) of the institution under CAEE No 47158915.7.0000.5275.

EXPECTED RESULTS

The research will provide an improvement in the quality of nursing notes, since the recognition of the particularities of these notes will enable the development of strategies such as educational interventions and training, to improve the mastery of the subject.

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