



Evaluation of the nursing records in the medical records of patients hospitalized in an internal medicine unit*

Avaliação dos registros de enfermeiros em prontuários de pacientes internados em unidade de clínica médica

Evaluación de los registros de enfermeros en historias clínicas de pacientes internados en una unidad de clínica médica

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ABSTRACT

Objective: To analyze the nursing records (RE) completed by nurses in patients' records of an internal medicine (CM) unit of a public hospital. **Methods:** The study sample consisted of 240 (100%) records of patients who were discharged or died, between February and April, 2008. The classification criteria for completion were based on those established by the institution being researched. **Results:** The records were filled out completely for the majority of the items: nursing history (99.9%); multidisciplinary progress (80.0%) and risk assessment (99.6%). Regarding the consistency of the completion, the highlights were: 88.4% of nursing prescriptions classified as compliant; diagnosis and nursing progress 58.7% and 64.6% as non-conforming, respectively. As to the identification of nursing: 98.3% completed the nursing history, 87.9% were in progress, and 75.4% of the diagnosis and nursing prescription. **Conclusion:** The detected nonconformities confront the importance given by the institution for completion of the records, training and vigilance of the audit committee of nursing.

Keywords: Evaluation; Medical records; Nursing records; Nursing process; Inpatients

RESUMO

Objetivo: Analisar os registros de enfermagem (RE) realizados por enfermeiros em prontuários de pacientes da Clínica Médica (CM) de um hospital público. **Métodos:** A amostra do estudo foi composta de 240 (100%) prontuários de pacientes que tiveram alta ou óbito, de fevereiro a abril de 2008. Os critérios de classificação para o preenchimento, basearam-se nos estabelecidos pela instituição pesquisada. **Resultados:** Os registros foram preenchidos de forma completa na maioria dos itens: histórico de enfermagem (99,9%); evolução multidisciplinar (80,0%) e avaliação de risco (99,6%). Quanto à conformidade do preenchimento, destacaram-se: 88,4% de prescrições de enfermagem classificadas como conforme, diagnóstico e evolução de enfermagem 58,7% e 64,6% como não conformes, respectivamente. Quanto à identificação do enfermeiro: 98,3% completa no histórico de enfermagem, 87,9% na evolução e 75,4% no diagnóstico e prescrição de enfermagem. **Conclusão:** As não conformidades encontradas confrontam a importância dada pela instituição para realização dos registros, treinamentos e a vigilância da comissão de auditoria de enfermagem.

Descritores: Avaliação; Registros médicos; Registros de enfermagem; Processos de enfermagem; Pacientes internados

RESUMEN

Objetivo: Analizar los registros de enfermería (RE) realizados por enfermeros en historias clínicas de pacientes de la Clínica Médica (CM) de un hospital público. **Métodos:** La muestra del estudio estuvo compuesta de 240 (100%) historias clínicas de pacientes que tuvieron alta u óbito, de febrero a abril del 2008. Los criterios de clasificación para el llenado, se basaron en los establecidos por la institución de la investigación. **Resultados:** Los registros fueron llenados de forma completa en la mayoría de los items: historia de enfermería (99,9%); evolución multidisciplinaria (80,0%) y evolución de riesgo (99,6%). En cuanto a la conformidad del llenado, se destacaron: 88,4% de prescripciones de enfermería clasificadas como conforme, diagnóstico y evolución de enfermería 58,7% y 64,6% como no conformes, respectivamente. En cuanto a la identificación del enfermero: 98,3% fue completa en historia de enfermería, 87,9% en la evolución y 75,4% en el diagnóstico y prescripción de enfermería. **Conclusión:** Las inconformidades encontradas confrontan la importancia dada por la institución para la realización de los registros, entrenamientos y la vigilancia de la comisión de auditoría de enfermería.

Descriptor: Evaluación; Registros médicos; Registros de enfermería; Procesos de enfermería; Pacientes internos

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INTRODUCTION

The development of nursing care systematization (NCS) is the format in which the nurse has to apply her technical and scientific knowledge and document patient care, characterizing her professional practice and collaborating in the definition of its role among the multidisciplinary health care team ⁽¹⁾.

It is worth noting that the process of auditing nursing records (NR) in patient charts has been playing an important role in hospital institutions and provides another opportunity for the nurse in the labor market, especially in relation to assessing the quality of services, documents and processes ⁽²⁻⁴⁾.

Having the NR as a source, the indicators are also used as evaluation criteria, in order to establish a set of information necessary for monitoring the quality of nursing care ^(2,5).

The NR is one of the means of demonstrating the work performed by the nursing staff and is a quality indicator of relevant care; the incorrect completion and, above all, the lack of periodicity and continuity are factors that irreversibly preclude any type of evaluation, certification, creation of indicators and even inquiries and expertise that can legally support the professional and the institution ⁽⁶⁾.

The notes taken by several members of the nursing team have been the target of criticism, and even today it is possible to observe that they do not correspond to the requirements in the literature ⁽⁷⁻⁹⁾. Nevertheless, the lack of adequate infrastructure for providing nursing in many institutions, coupled with the growing demand of health services, lead to neglect of the implementation of requirements inherent in the quality standards of care ^(10,11).

Moreover, the literature recommends attention for use of forms in hospital units ^(12,13). The nurse, according to researchers, should not be restrained with respect to his creativity and the pursuit of clinical reasoning, but results of recent studies have shown that professionals are increasingly restricted to the implementation of nursing diagnoses and prescriptions that do not correspond to these, that is, they make diagnoses, but do not prescribe a related action; the opposite is also true ^(14,15).

Studies have shown that intelligently designed, non-standardized forms, that offered space for the nurse to create, and which are directed toward the implementation of activities essential to care, have been facilitating the employment of clinical reasoning on the part of the professional, in order to optimize the relationship between prescription and diagnosis ^(6,10,14,16).

The literature demonstrates that the creation of intelligent forms is not sufficient for solving the difficulties encountered in relation to achieving the NRs ^(16,17). The effective scope of deployment and implementation of the

NCS is recognized as a measure that develops permanent educational strategies, capable of solving the problems of a mandatory and bureaucratic practice ⁽¹⁸⁾.

In this sense, the Division of Nursing of the hospital studied, in order to deploy the NCS, initiated a process on the adequacy of NRs in the medical records of patients, considering, particularly, the fragile acceptance of the nurse about the responsibilities for the NCS, as the professionals identified their responsibilities as being only in relation to management of the unit and not about the care. In August 2004, the Division of Nursing introduced the NCS into the internal medicine and pediatric units. The nursing process was implemented as proposed by Wanda Horta ⁽⁹⁾, the classification of nursing diagnoses was from NANDA International ⁽¹²⁾ and the documentation followed the guidelines of the Joint Commission International and the National Organization for Accreditation ⁽⁴⁾.

Professionals from the Division of Nursing developed standardized forms, so as to direct the actions of nursing diagnoses and prescriptions. To this end, the nurse obtains a brief guide that facilitates recording, with open fields for completing, favoring the exercise of his clinical reasoning, creativity, and better adherence and professional performance. In particular, recent graduates benefit from the guide to the forms, that have required fields that indicate the need to report, for example, the risks of the patient.

In order to adopt improvement measures and to identify problematic situations, the Nursing Audit Committee was established in the hospital studied. The professionals of this committee observed the difficulties of nurses about recording the NCS on the institutional forms. The hospital's Medical Records Committee, consisting of medical and nursing auditors, performed random monthly audits on 10% of closed charts (discharge or death) to evaluate multidisciplinary records, and deployed improvement measures based on these evaluations.

Risk assessment of the patient was also incorporated into the activities of the nurse as a measure to improve nursing care. The initial training was conducted for the risks of falls, phlebitis, nutrition, and pressure ulcers, introducing the concept of specific risk to the nurses, according to the criteria established by the hospital studied. Inserted in the nursing history and an integral part of patient assessment, this care has become a required activity in the nursing prescriptions, and requires daily assessment and validation through the nursing progress notes.

In this light, it became necessary to evaluate the NRs within the medical records of patients, analyzing the results of work undertaken over four years, in order to support decision making about changes and improvements to be implemented.

OBJECTIVES

To analyse nursing records completed by nurses in patient charts of the medical unit of a public hospital.

METHODS

Following approval of the Education Commission of the hospital studied and the Ethics Committee on Research of UNIFESP, this study was conducted at the *Hospital das Clínicas Luzia de Pinho Melo* (HCLPM) in Mogi das Cruzes in São Paulo (Brazil), which is managed by the Paulista Association for the Development of Medicine (SPDM), since 2004, and classified as a large general hospital, with 100% of users being within the Unified Health System (SUS).

The choice of the inpatient clinical medical unit (CM), with 46 beds, considered the following aspects: number of patients admitted; average patient length of stay; diversity of diagnoses and nursing care; number of nurses, based on the Patient Classification System; and, implementation of the NCS among all inpatients.

It should be noted that in order to obtain records of nursing care, the Division of Nursing has developed specific forms; for identification of failures in completion, the Nursing Audit Committee also uses forms created specifically for this purpose.

The study population consisted of charts of patients admitted to the CM. The sample, conforming to the statistical guidance, consisted of 240 charts, representing 100% of closed patient charts from CM (discharges and deaths), for the period of February to April, 2008.

For data collection, the nurses of the Audit Committee selected 100% of the closed charts (discharge or death) of the CM, during the stated period, and recorded the data in a spreadsheet, identifying the record of nursing care, conforming to the phases of the NCS.

In order to analyze the presence and conformity of the records of care, the nursing auditor used part of the form by the Audit Committee for Nursing to assess the NRs, in the patient medical records, including categorization and classification of the presence and conformity of records, according to the criteria of the Division of Nursing (Table 1).

Since the implementation of the NCS in the Institute, all nurses are trained to complete the records of care, through the period of admission and periodically thereafter, considering the criteria required by the Division of Nursing. Thus, a guide is available to orient nurses on completion, especially of the nursing progress notes.

We emphasize that the criterion for non-compliance was also considered, through registry error at any step of the NCS, on any one day of hospitalization. It was not possible to identify the conformity of the record of the nursing history, to be the first step performed on the patient's arrival to the unit, based on interviews and physical examinations.

RESULTS

As seen in the data in Table 1, we can highlight the history and physical examination, as well as the risk assessment performed in almost all of the records analyzed with a significant result.

In relation to the conformity of the records demonstrated in the data in Table 2, we can highlight the nursing prescription as the most significant result.

In regard to the adequacy of nurse identification, there is a significant result in the nursing history.

We could observe that in relation to Table 1 and Table 2, we have the most significant results in the history, which is the first contact of the nurse with the patient. In Table 1, we observed that the risk assessment is another

Table 1. Classification criteria for analysis of the nursing care record, completed in patient charts in the clinical medical unit of the research hospital

Type of Evaluation	Classification	Steps of NCS
Analysis of the presence of the nursing care records, in the patient charts	Complete Incomplete Absent	History of nursing (physical examination); diagnosis and prescription of nursing; multidisciplinary progress notes*; risk assessment; validation of risk assessment; nutritional screening**; continuation of treatment / post-discharge instructions; relationship of examinations received / delivered; discharge / death record.
Analysis of the conformity of the nursing care records, in the patient charts	Conforming Nonconforming	Nursing progress notes; prescription and nursing diagnosis
Analysis of professional identification on the nursing care records, in the patient charts	Complete Incomplete	Signature with stamp in the nursing history, prescription and nursing diagnosis and nursing progress notes.

* The multidisciplinary progress note was evaluated considering only the record completed by the nurse.

** Nutritional screening is performed, initially, by a nurse.

Table 1. Classification of NRs of patients in the clinical medical unit of a public hospital, from February to April, 2008.

Records	Complete N ^o – %	Incomplete N ^o – %	Absent N ^o – %	TOTAL N ^o – %
Nursing history	239 – 99.6	1 – 0.4	-	240 – 100
Physical examination	227 – 94.6	13 – 5.4	-	240 – 100
Nursing diagnosis and prescription	130 – 54.2	110 – 45.8	-	240 – 100
*Multidisciplinary progress notes	192 – 80.0	48 – 20.0	-	240 – 100
Risk assessment	239 – 99.6	-	1 – 0.4	240 – 100
Validation of the risk assessment	48 – 20.0	191 – 79.6	1 – 0.4	240 – 100
Nutritional screening **	232 – 96.7	6 – 2.5	2 – 0.8	240 – 100
Continuation of treatment / post-discharge instructions	232 – 96.7	4 – 1.7	4 – 1.7	240 – 100
Relationship of exams received/delivered	230 – 95.8	6 – 2.5	4 – 1.7	240 – 100
Discharge / death record	239 – 99.6	-	1 – 0.4	240 – 100

* For the multidisciplinary progress notes only the nursing registry was evaluated.

** Nutritional screening is performed initially by a nurse.

Table 2. Identification of the conformity of the NCS in the medical records of patients admitted to the clinical medical unit of a public hospital, from February to April, 2008.

Records	Conforming N ^o – %	Nonconforming N ^o – %	TOTAL N ^o – %
Nursing diagnosis	99 – 41.3	141 – 58.7	240 – 100
Nursing prescription	212 – 88.4	28 – 11.6	240 – 100
Nursing progress notes	85 – 35.4	155 – 64.6	240 – 100

Table 3. Identification of the signature record with stamp of the nurses in the medical records of patients admitted to the clinical medical unit of a public hospital, from February to April, 2008.

Records	Complete N ^o – %	Incomplete N ^o – %	TOTAL N ^o – %
Nursing history	236 – 98.3	4 – 1.7	240 – 100
Nursing diagnosis	181 – 75.4	59 – 24.6	240 – 100
Nursing prescription	181 – 75.4	59 – 24.6	240 – 100
Nursing progress notes	211 – 87.9	29 – 12.1	240 – 100

item with a significant result, which like the history occurs during the first contact. Table 2 reflects the record quality; and conformity of prescription in relation to diagnosis was the most significant result that reflects the practical actions of nurses on a daily basis.

DISCUSSION

In university hospital institutions, the implementation of audits and evaluations of health services have provided invaluable support, as a strong vehicle for improving the quality of care and a relevant source of evaluation indicators, highlighting successes and failures ⁽³⁾.

In this sense, the outcomes of this study support data in the literature in promoting the awareness of nurses to ensure continuous and complete records ^(8,9-10,16).

Regarding the presence of nursing care records (Table 1) findings highlighted the nursing history and physical examination with 99.6% and 94.6%, respectively, as the records fully completed. We consider this an important outcome when compared to the literature results.

In one completed study, the principal justification mentioned by 72% of the nurses for not conducting the nursing history was a lack of time. Other causes also attracted attention, such as lack of organization (20.7%),

non-involvement of nurses (13.8%), non-recognition of its value (6.9%), and lack of collection (6.9%)⁽¹⁸⁾.

There were authors of an investigation that obtained unsatisfactory results in relation to the nursing history, who showed that the type of form used in the institution was the main cause of this result⁽¹⁶⁾.

In relation to nursing diagnosis and prescription, considered to be the steps of the NCS that require time, knowledge and clinical reasoning, this study showed 54.2% of the records were completed for the nursing diagnosis. It should be noted that this result was not significant because they were present, but because they were complete.

In this sense, the authors of a study that evaluated 424 patient charts showed that 75.2% had a nursing prescription, and only 3.5% were complete; 41% had nursing diagnosis and, of these, only 5.2% were complete⁽¹⁹⁾.

In another study, which analyzed the records of NCS in 150 charts, the results showed that 45% of charts had nursing prescriptions adequately recorded, thereby concluding that, based on this phase, a professional can determine proactive planning of an individualized form, resulting in precise interventions for the provision of individualized nursing care⁽²⁰⁾.

The literature has also shown that nurses are aware of the importance of nursing diagnosis^(16,21). This is evidenced by the outcomes of a study on the analysis of 115 patient charts, in which 62% of nurses considered the nursing diagnoses to be an important phase of the NCS for the possibility of career advancement (41.4%), depth of knowledge (34.5%), development of clinical reasoning (20.7%), and professional development (20.7%)⁽¹⁸⁾.

Another surprising result of the present study was that 99.6% of the patient charts had a completed risk assessment form. Considering that this is a relatively recent hospital assessment (implemented in early 2007) and that it requires time and dedication on the part of nurses, the risk assessment of the patient, although not completely consolidated, provided outstanding contributions to promote patient safety.

We also assume that the result of the risk assessment was achieved due to the fact that it was present in the nursing history record form. Thus, upon admission to the unit, the nurse who has more time to record data, conducts the patient risk assessment including the placing of colored bracelets, representing the possible risks, for example, for pressure ulcers, falls, and phlebitis.

Thus, it was established that the introduction of the risk assessment in the printed record of the institution has established a parameter by which it will be possible to adopt measures for prevention, control and treatment, and the creation of indicators of care for this activity.

The validation of risk assessment presented a worrying and contradictory result, because 79.6% of records were classified as incomplete, in comparison to the

results of the risk assessment item, whose records were completed in 99.6% of the charts.

It was observed that the nurses of the CM are not reassessing patient risks on a daily basis and, if they were, they were not recorded in the nursing progress record on a daily and diligent basis. Given this scenario, the Audit Committee and the Division of Continuing Education, through the results of this study, should be more aware of this responsibility.

Currently, the literature is scarce regarding effective methods of validating the risk assessment of the patient, so it is not possible to compare these results with other studies.

In relationship to the other items of nursing care that were completely recorded and considered to be important results, even though they are activities that demand the nurse's time, these included: multidisciplinary progress notes, nutritional screening, continuation of treatment / post-discharge instructions, examinations received / results delivered, with 80%, 96.7%, 96.7%, 95.8%, respectively, of the records fully completed.

As for the results of analysis of the presence of NRs, in patient charts in the CM, it is noteworthy that there were no records encountered without a history (physical examination), nursing diagnoses and prescription, and multidisciplinary progress notes, completed by nurses.

Regarding the results arising from the identification of conformity of the NR (Table 2), this study showed that the nursing prescription was present in 88.4% of nursing notes in the charts in an adequate fashion, as they conformed to the nursing diagnosis, in accordance to the requirements of the hospital studied

The results showed that nurses still need to improve the way they are describing the nursing diagnosis, with 58.7% non-compliance noted in records regarding the nursing progress notes. This action also had an unsatisfactory result with 64.6% of the records found to be of noncompliant regarding the nursing diagnosis and prescription.

It should be noted, however, that the criterion for non-conformity was also considered when any step of NCS was not adequately completed on any one day of hospitalization.

It was also observed that, in practice, the nurse may not be re-evaluating the patient daily. Moreover, it was assumed that these professionals record the plan of care taking into account the medical diagnosis. It is possible that nurses also have not exercised the reasoning and clinical judgment regarding the nursing problems that can generate diagnoses and evolved their own nursing clinical interpretation.

The nursing progress record may not be understood, as an outcome of the systematic process of care, because it does not describe the outcome of care in relation to diagnosis and nursing prescription. It is also assumed that the nursing progress record is being confused with

the medical progress record or nursing annotations, described without clinical analysis and without proper reference to the care prescribed ⁽²²⁾.

We also note that the nurse recorded the clinical features of patients, described in the medical progress note in detriment to the inherent aspects of the care provided by nurse.

In this context, a study that evaluated 130 patient charts of a public hospital, concluded that the activities related to medical prescriptions were recorded in a complete manner in most charts evaluated. The records of nursing procedures that required observation and were independent of the medical prescription, reached values of less than 40%, demonstrating the valuing, on the part of the nursing staff, of the activities dependent on medical prescriptions ⁽²¹⁾.

Another recent study that evaluated 424 patient charts, concluded that the problems encountered in the records of care resulted from developments in nursing indistinguishable in substance, or, similar to medical developments, including prescriptions. Only 8.7% of charts were classified as good, also demonstrating that only 45.8% of charts had nursing progress notes, but, only 2.6% of these were complete ⁽¹⁹⁾.

Conforming to research conducted about the evaluation of NCS in 150 patient charts, results showed that only 40 contained the daily assessment of patient response to therapy, and in 51 charts, this documentation was not encountered ⁽²⁰⁾.

Regarding the identification of nonconformity of the nursing diagnosis in relation to the nursing progress notes in the present study, it was assumed that the nurse does not reevaluate the patient daily.

The study findings suggest, therefore, that such activity has been performed repeatedly and automatically, without considering the daily observation of the patient and the individual patient's progress during hospitalization. And, the diagnosis and recording of incoming patients at the time of hospitalization, were similar to those at the hospital discharge.

The correct performance of nursing prescription is of great importance, but equally important is the correct execution of the nursing diagnosis, since both are closely related, and the result of the quality of care depends, effectively, on the quality of care prescribed.

A study with 29 nurses from two hospital institutions in Porto Alegre about the difference between theory and practical experience in making the nursing diagnoses showed that the nurses did not perform this phase of the process, they merely gave the progress of the patient for recording some of their actions. It was observed that the diagnosis was developed, according to data collected in the first phase of the nursing process and that all actions were planned, according to this step ⁽¹⁵⁾.

In another study about the difference between theory and practice of nursing documentation, it was concluded that the professional education focuses on the technique, superseding the contents of the fundamentals of nursing, neglecting, in many cases, the conceptualization of care for which the professional is able to exercise careful clinical interpretation ⁽²³⁾.

In this sense, the analysis of the quality of NRs was also an objective of research about the number of publications that highlight the poor quality of NRs in Brazil. The study revealed that nurses are entering the labor market without an education grounded in solid foundations of education, technical training, and incentives for research; factors that increase the capacity for observation and decision making, fundamental to the art and science of care ⁽²³⁾.

Regarding the analysis of identification of the nurses (Table 3) in the records of the hospital studied, the results of this study showed that nurses still incur the error of not identifying themselves with the stamp or signature, even though they are aware of the requirement of this task, conforming to the resolutions of the Federal Council of Nursing (COFEN) ⁽²⁴⁾.

Data from this study showed that the identification was classified as complete, in 240 patient charts analyzed, it was found in 98.3% of the nursing history records, 87.8% in the nursing progress notes, and 75.4% of records in the nursing diagnosis and prescription, suggesting that these nurses are more aware of this responsibility, especially when compared with the results from the literature ^(20,25).

In a study that analyzed 150 charts, the results showed that 65% of the notes were incomplete as to the identification of professionals in accordance with the requirements of COFEN. In this study, it was concluded that the identification in the NR was incorrect or missing in the majority of the charts ⁽²⁰⁾.

Another investigation that analyzed three inpatient units and 432 nursing annotations showed that, approximately, 140 lacked a signature, and about 120 contained no stamp; also observed were illegible names, nicknames, and annotations that did not contain the name of the professional responsible for the action recorded ⁽²⁵⁾.

COFEN, in its Resolution n° 191/96, determined that the nursing staff must be identified after each entry using name, category and registration number in COREN that must be present on the stamp of the professional, but the literature demonstrates opposite results ^(3,8-9,20,24).

In a study about strategies for adapting the NRs, the authors proposed an analysis during the shift change, among the nursing staff. For researchers, the moment could be substantial for an efficient management of the documentation of nursing care. The following items were highlighted: the need for integration of the strategies in the shift change, the care model used, the type of scale of division of services and quality of notes in the chart ⁽²⁶⁾.

Considering the results of the present study, it was possible to assess that, in practice, the nurses responded satisfactorily to training conducted by the Division of Nursing.

On the other hand, the results also revealed that the form used by nurses in the hospital researched may have contributed to directing and guiding care, and that they highlight and enhance the record of the steps of the systematization of nursing care.

In this context, a study conducted about the quality of nursing annotations in charts of 150 patients, results showed that the nurses' records were irregular, because 73% of records did not present the NCS in all steps and only 27% of charts presented certain steps, however, they were incorrect or absent, which made the record of nursing discontinuous. The authors concluded that one of the factors identified as the cause of these results was the lack of an adequate form used by the institution⁽²⁰⁾.

CONCLUSION

We observed that the erratically documented steps of NCS suggest that the nurse prioritizes day to day actions

at the expense of the NCS, whereby, effectively it is possible to guarantee and to identify the field of action of the nurse. Thus, this professional will not be interpreting the outcome of care, as a result of NCS.

Since the steps were performed in an appropriate manner, in relation to the requirements of the institution, these are targeted tasks that may be considered as priorities and to be relevant.

Resulting from the implementation and training about the NCS for nearly five years, the institution researched established criteria for use of printed forms representing the requirements of the hospital. Nevertheless, findings of this study demonstrated that nurses still need guidance from the Division of Continuing Education and Audit Committee.

The importance of NCS in the organization of nursing services, the process of implementation, the choice of a theoretical framework, the development of an intelligent and practical form, as well as the creation of a adequate methodology for qualification and training are still needed, and its occurrence must be continuous and repetitive.

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