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Research Article

Criteria Used in the Performance of Medical Records Audits: A Literature Review

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Abstract

Auditing is nothing more than a method used to systematically measure some action, whether in the health or business sphere, in the case of nursing records, the care recorded by the nursing team is audited, based on standards determined and stipulated by the class councils and hospital institutions. The study aimed to describe the criteria evaluated by auditing the nursing records in the patient's medical records, in order to ensure the quality of the information that will be used by the entire health team of the institution. This is an integrative review of the literature, where consultations were made throughout the national literature (laws, decrees, articles) in relation to the theme auditing the records of patients, in order to describe the criteria used by auditors of hospital quality and internal audits regarding the registration of nursing care. It is concluded that the authors who are scholars of the theme of nursing records, conduct research without and focused on the analysis of medical records, determine the failures of records and are based on the legislation of the COFEN-CORENs system to discuss the findings of their studies and that they bring in their research criteria and concrete data for auditing records of entering.

Keywords: *Nursing Audit; Nursing Record; Hospital Records*

Introduction

Health-related professions are strongly linked to the records of care provided. Nursing is a profession highly dependent on information provided by nurses, technicians, auxiliaries and other professionals who are not ill in supporting their practice [1].

Thus, nursing records legally referenced by the Systematization of Nursing Care (NCS) are essential elements to the care process and, therefore, should be written/registered in a way that portrays the reality, enabling communication between all members of the health team [1].

It is known that the records in medical records referring to nursing teams, especially the nursing team, in addition to reporting the care provided to the patient, also serve for teaching, research, audits, legal processes, planning, statistical purposes and others [2].

Also, according to Matsuda., *et al*. [2] nursing records have been representing 50% of the information inherent to patient care recorded in the medical records.

The audit process is a method used to systematically measure some action, whether in the health or business sphere. The audit of the patient's records in audits the registered care that was provided by the nursing team, based on standards determined and stipulated by the class councils and hospital institutions [1].

The audit is an efficient and efficient tool used to examine institutional records and processes in order to improve costs and care processes in hospital institutions [1].

Audit also conducts surveys, study and systematic analysis of procedures, operations and routines to assist managers in decision making [3].

In this sense, it is now essential to apply the audit continuously so that hospital quality is evaluated and ensured in terms of management and care [4].

According to art. 368 of the Code of Civil Procedure (CPC) [5] the records made in the patient's medical records are considered as a legal document of professionals and must therefore be imbued with authenticity and legal significance. When we talk about nursing, the entire performance of the team is reflected through the records of the care provided.

Aim of the Study

In this sense, this study aims to describe the criteria evaluated by auditing the nursing records in the patient's medical records, in order to guarantee the quality of the information that will be used by the entire health team of the institution, based on a systematic review of the literature.

Methodology

This is a systematic review of the literature. Where consultations were made to the national literature (laws, decrees, articles) in relation to the theme auditing of nursing records, in order to describe the criteria used by audits of hospital quality and internal audits regarding the registration of nursing care. The journals referring to legislation were searched on the website of DATASUS, SIGTAP and Google scholar. The keywords used were: health audit, nursing record, nursing record audit, medical records audit. An analysis of the legislation was performed to perform a detailed table of legal criteria used by the nursing record audit for the approval of care processes.

For research of scientific articles, the research question was: what are the criteria used to audit nursing records? The search for articles was carried out in the electronic databases Latin American Literature on Health Sciences (LILACS) and Scientific Electronic Library Online (SciELO), through the keywords selected according to the classification of descriptors in Health Sciences (DeCS): nursing audit, nursing record and medical records hospitalar. For the selection of articles, it was first performed to read the abstracts of the publications selected with the refine the sample through inclusion and exclusion criteria. Original articles from developed studies in Brazil and with temporality from 2010 to 2018 were included.

Following the inclusion criteria of the sample, 186 articles with the theme dating from 2010 to 2018 were collected, but which were related to nursing auditing and records in medical records were selected. After reading the abstracts, 07 articles were selected that mention the key words of this article and reporting in their text on the criteria for auditing the nursing subject, because they described criteria used to audit nursing records in patient records according to criteria defined by SIGTAP.

Contextualization

The theme portrays work of many years, therefore a theme widely addressed and used in all areas of patient care and who acts in the nursing team. Even though it is a theme frequently addressed and for many years, it is still a challenge to implement hospital audits and enforce a reliable record that reports care practice. There were more than a thousand articles found with the theme in the national literature, the legislation is also vast, published by COFEN/COREN and CFM since 1988 with the construction of the SUS and after the Federal Constitution of 1980.

Versa., *et al.* [6] describes the nursing registry as an instrument that assists both in the situational diagnosis of the sector/service, and in the application of educational actions mainly on the correct realization of the nursing prescription. Canavezi, Barba and Fernandes [7]

reports in their research that the documentation of and fermagem, inserted in the patient's medical records, is important as a source of teaching and research, thus assisting in the audit process, evaluation of care and ethical and legal issues, which determines the need for knowledge of the duties and obligations on the part of nursing professionals.

This documentation or medical records of the patient that the authors cite and which is widely reported in national and international literature ensures the patient's constitutional right to decide about his life and autonomy, as well as assures the health professional in his/her office. Among the ways to improve the quality of nursing notes is the Systemtization of Nursing Care (SAE) through the Nursing Process (PE), where the PE is a working method consisting of steps that allow nurses to better organize and coordinate nursing activities [8].

When to the nursing annotation, Law 7,498, of June 25, 1986 in article 14(10) [9], emphasizes the task of all nursing staff of the need to write down in the patient's medical records all nursing care activities, deven to organize the documents related to the patient in relation to nursing [10].

Results and Discussion

During the analysis of the articles and the relevant legislation, some criteria used by the external and internal audit systems of health institutions were observed, the most used criteria for auditing nursing records are table 1 and 2, in a macro and micro form of the care process. It is noteworthy that the criteria recorded in table 1 are for recording the care provided by nurses, while table 2 presents the criteria used for evaluation or audit of the records performed by the other members of the nursing team (nursing technicians and auxiliaries). Table 3 refers to the database used to draw the criteria.

Macro criteria Process	Micro process criteria
History of nursing	• Standardized instrument; • Instrument completed for all patients or for the percentages of patients agreed upon by TAC; • Completion of all information contained in the instrument; • Signature and stamp; • Routine to repeat the realization of the history
Diagnosis of institution	• Standard nomenclature used by the nursing (NANDA, CIP, NIC, NOC); • Problems identified in convergence with the diagnoses determined by the nurse; • Daily review of diagnoses; • At least 3 nursing diagnoses per patient/community/family; • Signature and stamp.
Prescription of nursing	• Held once a day; • Pleasantness according to institutional routine; • Validity of 24 hours; • Signature and stamp.
Interventions diagnosis; nursing	• At least 03 interventions per nursing; • Problem-based interventions; • Possible interventions; • Signature and stamp;
Evolution of evaluating nursing	• Daily performance, with the purpose of need to change diagnoses and interventions; • Signature and stamp.

Supervision of	• Evaluate whether POPs and POs are being followed; • Check temporality of records; • Check consistency of records; • Check compliance with indicators weekly; • Check routine log.
Management risk scales	• Establish risk assessment scales; • Establish protocols; • Care risk assessment routines such as patient identification, fall, phlebitis, PPL, DVT; • Check feeding of care risk indicator; • Patient identification and signaling of patient beds with colors to understand the multidisciplinary team.
Procedures	• Instruments for registration; private • The data was met according to PO; nurse • Training; • Signature and stamp;

Table 1: *Macro and micro criteria for the analysis of nursing care records provided by nurses.*
Source: Sant'Ana, C. São Paulo,2018 (COFEN, 1986).

Macro criteria process	Micro process criteria
Prescription of nursing and medical prescription	A. Correct check;
Nursing annotation	B. Absence of sororrhages;
Nursing supervision	C. When not checked used correct code and registration of reasons for non-compliance with the prescription;
Care risk management	
Procedures	D. Stamp and signature; E. The annotation follows the cephalocaudal direction; F. Record of complications, change of condition; G. At least one record every 06 hours; H. Well-recorded vital signs in monitoring or in proper form as established routine; I. Signature and stamp; J. Assess whether POPs and POs are being met; K. Check temporality of records; L. Check consistency of records; M. Check routine log; N. The procedures and protocols for each risk are being followed; O. Care routines such as patient identification, fall, phlebitis, PPL, DVT are being fulfilled to avoid risk; P. Patient identification and signaling of patient beds with colors to understand the multidisciplinary team; Q. Instruments for registration; R. The technique was fulfilled according to PO; S. Training; T. Signature and Stamp.

Table 2: *Macro and micro criteria for the analysis of nursing care records provided by nursing assistants and technicians.*
Source: Sant'Ana, C. São Paulo, 2018. (COFEN, 1986).

Title of the article	Year	Objectives	Local Publication
The practice of nurses in health audit	2010	Knowing the practice of nurse in health audit.	Rev Esc Enferm USP
Nursing auditing: the impact of nursing notes in the context of hospital glosses	2010	Identify the impact caused by the non-registration of nursing in contrast to the hospital glosses	Chía, Columbia.
Trends in the role of nurse auditors in the health market	2010	Identify current and future trends (next five years) of the nurse's function	Text Context Enferm.
		Non-market auditor work.	
Evaluation of the quality of nursing records in the medical records through auditing	2010	Evaluate through the audit, the quality of nursing records in the medical records of patients treated in units of a university hospital in the city of São Paulo	Paul Sick Act
Nursing auditing: systematic literature review	2011	To analyze the scientific production about nursing auditing published in national articles between 1998 and 2008.	*Brazilian Journal of Nursing*
Health audit and duties of the nurse auditor	2014	To know and base the aspects inherent to health auditing and the role of nurses in this context, in order to contribute information to the nurse-auditor about their role in the process of Audit.	Health and Development notebook
Hospital gloss: Importance of nursing notes	2015	Investigate the factors involved in the glosses that occurred in a hospital teaching.	Arq Ciênc Health

Table 3: *Journals used to define the criteria.*

Based on the criteria determined in this study through literature investigation, it is clear the importance of the nursing team's registration, fundamental to the audit process, which uses as instruments the control and analysis of records considered the safest means to prove and receive the amount spent from the care provided, avoiding glosses. The glosses are applied when any situation generates doubts regarding the rules and practices adopted by the health institution, being defined as the cancellation or partial or total refusal of budget and/or payment considered illegal or improper, that is, this related to items that the auditor of the health plan operator does not consider fit for payment [5].

According to researched articles and current legislation of the COFEN/COREN system since 1993, it is essential that during the audit of nursing care records some concepts are envisioned, such as: patient's medical records (rights, duties and legal triggering), difference between annotation and nursing evolution and the importance of care and legal registration [11].

A study conducted by Franco., *et al.* [12] in relation to the presence of nursing care records highlighted the nursing history and physical examination with 99.6% and 94.6%, respectively, as the records performed completely, thus being considered an important result when compared to the results of the literature. In the study, the main justification pointed out by 72% of nurses for not performing their nursing history was also the lack of time. A study conducted by Farias (1998) pointed to failures in care records were lack of organization (20.7%), non-involvement of nurses (13.8%), non-recognition of their value (6.9%) and lack of collection (6.9%).

When in 2008, Venturini and Marcon [13] analyzed 369 medical records in a public hospital, they showed that although some criteria (already present in the results of table 1 and 2) used for auditing in medical records have reached filling levels above 80%, there is a need to improve the quality of records, with more complete information and that actually bring data on care performed for and with the patient. This will allow the records made to reach levels of excellence.

In the research conducted by Franco, Akemi and D'Inocento [12] were analyzed 424 medical records of patients from a public hospital, therefore a similar sample used by Venturini and Marcon [13], found that 75.2% had the prescriptions for nursing patients, and only 3.5% were complete, 41% had nursing diagnoses and, of these, only 5.2% were complete. However, already in 1999 Dalri, Rossi and Carvalho [14] observed that in the nursing records of 12 medical records, in the trans-operative period, in 16.7% the information about the surgery performed was incomplete, including in this research a reference was found to the removal of organs, in a medical record, but these were not specified by the nursing and had not withdrawal findings of this body.

Therefore, this is not a new theme, it is about remote discussions, but in which the failures go through the decades and remain rooted in the professional. It is worth noting that these professionals have the record as a scientific and legal basis for their professional practice, but still there is no faithful record of the facts. The explanations for not trusting the records are diverse and multiple, but we will not stick to this fact in this study [15-18].

Conclusion

It is known that in hospital institutions, the implementation of audits and evaluations of health services have been providing invaluable support, as a strong vehicle for improving quality to care and a relevant source of evaluation indicators, evidencing errors and correct answers. In this sense, the criteria pointed out in this study corroborate in an easy and systematic way for improvement and awareness of the nursing team to perform complete and continuous records.

In this sense, it is concluded that the authors who are scholars of the theme of nursing records, carry out research always focused on the analysis of medical records, determine the failures of records and are based on the legislation of the COFEN-CORENs system to discuss the findings of their studies and that they bring in their research criteria and concrete data for auditing in nursing records.

In this sense, the criteria defined within this study can facilitate the audit process of nursing records as well as make the training and educational process not seek the person responsible for the failure to hold it responsible, but questions the reason for the adverse outcome. Therefore, the service audit can be seen as an educational process in which it is not sought responsible for the failure but questions the reason for non-compliance. This change in perception stimulates the participation of the team in the identification and resolution of adverse events.

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