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THE IMPORTANCE OF NURSING NOTES IN DECREASING HOSPITAL GLOSSES

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ABSTRACT

This study aimed to describe the importance of nursing notes in decreasing hospital glosses, through a bibliographic survey conducted on the Latin American and Caribbean Literature in Health Sciences databases (www.lilacs.bvsalud.org) and Scientific Electronic Library Online (www.scielo.org), with publications in the vernacular, from 2007 to 2014, and the sample being composed of 8 publications. The results revealed that after all the problems were raised based on the studies, the main cause for the glosses to happen is the deficiency in nursing notes, often caused by the lack of knowledge of the real need for complete and quality records by the team of nursing. In this way, it is possible to highlight the need for continuing education for the nursing team in order to awaken the importance of nursing audit to provide quality nursing care.

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INTRODUCTION

Audit is the verification of the transactions, operations and procedures performed in an entity, where records, documents and other elements related to accountingsare examined. Its objective is to verify the veracity of the records and the resulting financial statements, in order to present opinions, criticisms, orientations and conclusions (GOMES, 2009). Nursing audit is understood as the process where nursing activities are evaluated, measured, examined and confronted with pre-established standards, based on the nursing notes made in the medical record (FARACO, ALBUQUERQUE, 2004). The Federal Nursing Council (COFEN) through DRC 429/12, provides for the registration of professional notes in the patient's medical records, and in other nursing documents, either traditional or electronic medium of support (COFEN, 2012). According to the Resolution of COFEN 191/96, to carry out the nursing notes, it is necessary to emphasize attention to some details: verify the header of the form; work with administrative hours instead of shifts; when correcting errors, use terms such as "meant" or "correction" and never spell check; do at the beginning of the shift and supplement during this; the handwriting of the person making the notes must be legible; following a cephalocaudal sequence; use only standard acronyms and, at the end of each annotation, use the stamp, signature and COREN (The State Nursing Concil) number responsible for annotations (COFEN, 1996). Nursing is a profession that relies on accurate information to perform the various interventions involved in care. Nursing annotations are essential elements in the care process, so they need to be drawn up in such a way as to portray reality in order to establish effective communication among the health team. They also serves other purposes such as teaching, researches, auditings, legal processes, among others (SETZ; D'INNOCENZO, 2009). The records of the client's records are fundamental sources of statistical datarelated to the activities carried out and institutional analysis for internal or external auditing. Part of the payment for materials, medications, proceduresare related to nursing records. In this way, any situation that raises doubts regarding the rules and practices endowed by health institutions is clear to the auditor (RODRIGUES, PERROCA, JERICÓ, 2005). Glossis defined as a partial or total cancellation of the budget, account or money for being understood as illegal or improper.This results in non-payment of the services or materials used in the

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assistance provided to the client (GOTO, 2001). In the existence of doubts related to the material used or assistance provided, the glosses are applied. Thus, the presence of the nurse as an educator of the nursing team is justified in order to have quality in the nursing records (OLIVEIRA; JACINTO; SIQUEIRA, 2014).In a study carried out by means of a bibliographical survey with 12 articles, which addressed the difficulties found by the audit of medical accounts, it was verified that there is a lack of complete records in the patient's medical record, ranging from the identification of the current status of the patient to the proper medication and procedures checking. (RODRIGUES, BAPTISTA, 2016). Considering that one of the objectives of the audit is to identify the veracity of the nursing records in the client's chart and in the financial statements of the client, the nursing notes are extremely important to reduce the resources of glosses. In this way, the development of this work is due to the high index of glosses that occurred in health institutions related to the deficiency of nursing notes. Therefore, the purpose of the present study is to describe the importance of nursing notes in decreasing hospital glosses.

Table 1 below lists the year, title, authors and approach of the selected articles. According to the above table, it is observed that the articles address the importance of the nursing record for quality auditing. Oliveira (2014), corroborates with the other authors because it confirms that nursing records are the main tool for quality measurement and collection methods, where the nurse is the determining agent to guide the nursing team in relation to these records. In this way permanent and continuous education is fundamental in order to train and improve these professionals of this. It is observed that there is a deficiency in relation to the nursing performance when carrying out the records in the medical record, where incomplete annotations are often found and there is not enough quality that offers subsidies for nursing audit analysis (OLIVEIRA; JACINTO; SIQUEIRA, 2014). In the study carried out, Venturini (2008), when evaluating the quality of the nursing notes of surgical patients of a school hospital, after selecting 143 records randomly, found that 73% of the annotations were incomplete, which were related to the aspect and evolution of the lesions cutaneous and high notes. The observed results identify that the education, monitoring and

Table 1. Articles found in databases according to the year of publication, authors, title and approach, Campo Grande – MS, 2018

Authors	Year	Title	Approach
Luz, Martins, Dynewicz	2007	Characteristics of notes about nursery found in audit	Identified the quality of nursing records in hospital bills
Scarparo, Ferraz	2008	Nursing Audit: identifying notions and method	Identified the opinion of audit experts working in the context of nursing and systematized trends in the conception, method and purpose of the nursing audit for the next five years
Venturi, Marcon	2008	Nursing reports in a surgical unit at a school hospital	Evaluation of the quality of the nursing notes of surgical patients of a school hospital
Szetz, D'Innocenzo	2009	*Evaluation of the quality of nursing documentation though the review of patient medical records*	Evaluation of the quality of nursing records in patient records attended in a university hospital
Ferreira, Braga, Valente, Souza, Alves	2009	Nursing audit: The impact of nursing annotation in the context of hospital gloss	Identified the impact of non-registration of nursing, providing possible hospital glosses
Passos, Borges, Cavalcante, Gurgel, Costa, Alves	2012	Nursing audit : profissionals' knowledge in a public hospital of reference	Identified professional knowledge nurses in relation to the audit process
Silva, Silva, Dourado, Nascimento, Moreira	2012	Limites e possibilidades da auditoria em enfermagem e seus aspectos teóricos e práticos	The objective of the nursing audit carried out in public and private institutions is to minimize wastage of materials, drugs, equipment, among others, which should be properly reported in the nursing notes
Oliveira, Jacinto, Siqueira	2014	Audit of nursing in the operating room	Nursing records are tools important in the measurement of quality and adequate collection carried out by the audit, but most of the time they are trivialized by the nursing team

MATERIALS AND METHODS

The methodology used to develop this research was a bibliographical survey carried out through the Latin American and Caribbean Literature in Health Sciences data bases (www.lilacs.bvsalud.org) andScientificElectronic Library Online (www.scielo.org). The inclusion criteria were defined with papers published in the Portuguese between 2007 and 2014 about notes made by the nursing team (nurse, technician and nursing assistant) thatwereperformed in hospital units. On the other hand, theexclusioncriteriaadoptedwereworkpublished in otherlanguages, that was outside the years of search and that it was carried out in primarycareunits. The researchwascarried out in August 2018 andthefollowingdescriptorswereused: Nursing Audit; Nursing Records and Hospital Costs.

RESULTS AND DISCUSSION

According to the key words used, a total of 20 articles were found and only 8 publications met the inclusion criteria.

permanent evaluation of the nursing records is necessary. In a similar study to that cited above, after analyzing 424 medical records where the quality of nursing notes was verified, it was observed that 26.7% of the charts analyzed were bad; 64.6% were regular and only 8.7% considered as good and none of the charts received the excellent classification. The problems found in the reports were related to nursing notes and evolutions, as to the content and the flaws found were illegibility, spelling errors, incorrect terminology, non-standard acronyms (SETZ; D'INNOCENZO, 2009). Nursing notes are a fundamental part of the Nursing Care Systematization, so it is important to highlight that the better it is implemented in the health services, the more efficient the nursing service will become (LUZ; MARTINS; DYNEWICZ, 2007). Permanent Education should be implemented in the nursing team, in order to promote growth and improvement to propose improvement in the quality of records, as demonstrated by Luz; Martins; Dynewicz (2007), in a study in which the objective was to identify the quality of nursing records in hospital accounts. Passos *et al*. (2012), corroborate with the authors of the study cited above, because after analyzing the nurses' knowledge

about the audit process, they identified that knowledge is limited, having a lack of understanding about the subject, suggesting the need for investment in professional training, to that the importance of the nursing audit is aroused in nursing professionals. In analyzing the impact of nursing notes on hospital glosses, Ferreira et al. (2009), evidenced that these annotations contribute considerably to a high percentage of recovery of glossed items. Approximately R $ 8,551.07 of the gloss funds were related to the medicines and R $ 3,614.80 to the materials. Thus, it is concluded that the lack of information in nursing notes has repercussions on the glosses and institutions are penalized in relation to financial results. It is important to mention that the nursing team needs to recognize the real importance of filling the nursing records with quality, in order to generate accurate information since unresgistered or incorrectly recorded procedures result in glosses (FERREIRA et al. 2009). After evaluations, studies have shown that the design of the audit is aimed at accounting and financial vision, aiming the economic sustainability of the hospital, based on a business and marketing approach. There is a tendency to change the market-oriented approach to the cliente based on the quality of the service rendered, adequating the nursing auditing actions at this direction (SCARPARO; FERRAZ, 2008). The nursing audit aims to reduce the waste of materials, drugs and equipment and human resources. Therefore, registration by the nursing team is fundamental in the audit process, which uses for the development of the work, control instruments and analysis of the records, being considered safer to prove and receive the amount spent during the care rendered, thus reducing the glosses (SILVA et al., 2012). Given the importance of quality nursing notes in relation to the services rendered during the care, it is evident that it is necessary to make the nursing professionals aware of the responsibility for the complete and adequate preparation of the records, in order to reduce the hospital glosses.

Conclusions

Considering all the problems raised based on the study, the main cause for the glosses to happen is the deficiency in nursing notes, often caused by the lack of knowledge of the real need for complete and quality records by the nursing team. Nursing care is evaluated through medical records, which should contain data pertinent to the service provided. The records should be clear, objective, concise, containing the nursing check and procedures performed. There are many challenges regarding the understanding by the nursing professional that the nursing records prove and validate the practice of the nursing team, as well as, they are fundamental in the nursing audit, which meets the needs of the hospitals in increase their revenues and health care providers in lowering costs. According to the results presented, there is a need for continuing education for the nursing team, in order to awaken the importance of nursing audit, to provide quality nursing care.

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