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RESEARCH

Avaliação do processo de enfermagem em um hospital universitário em Campina Grande

Evaluation of nursing process at a university hospital in Campina Grande

Evaluación del proceso de enfermería en un hospital universitario en Campina Grande

Gerlane Ângela da Costa Moreira Vieira [1] , Marta Miriam Lopes Costa [2] , Maria Angélica da Silva Santos [3] , Thalita Lisboa de Menezes [4]

ABSTRACT

Objective: Identifying the nursing process application and analyzing the records of each step. **Method**: this is a retrospective and descriptive study with a quantitative approach, realized from the reports and registration forms process present in the clinical ward b and at area "same" at a university hospital in campina grande. after collection, the data were analyzed by descriptive method and calculated the absolute and relative frequencies. **Results**: of the 115 (100%) collected medical charts; the records show all stages of the process, except for the expected results. the most frequent diagnoses were: ineffective breathing pattern, activity and interventions intolerance, checking vital signs and oxygen saturation. in only 68 (59,1%) recorded the actions taken, 114 (99,1%) had no patient responses after care provided and 71 (61,7%) made changes to care plans when necessary. **Conclusion**: we conclude that it is necessary to improve the registration of the nursing process. **Descriptors:** Record of nursing, Nursing care, Nursing process.

RESUMO

Objetivo: Identificar aplicação do processo de enfermagem e analisar os registros de cada etapa. **Método:** trata-se de um estudo retrospectivo e descritivo com abordagem quantitativa, realizado a partir dos relatórios e das fichas de registro do processo presentes nos prontuários da ala b e que se encontravam no same de um hospital universitário em campina grande. após coleta, os dados foram analisados pelo método descritivo, e calculadas as frequências absolutas e relativas. **Resultados**: dos 115 (100%) prontuários levantados, os registros apresentaram todas as etapas do processo, exceto a dos resultados esperados. os diagnósticos mais frequentes foram padrão respiratório ineficaz e intolerância à atividade e às intervenções, aferir sinais vitais e a saturação de oxigênio. e apenas 68 (59,1%) registraram as ações implementadas, 114 (99,1%) não apresentaram respostas do paciente após o cuidado prestado e 71 (61,7%) fizeram modificações dos planos de cuidados quando necessário. **Conclusão**: concluiu-se que se faz necessário o aprimoramento do registro do processo de enfermagem. **Descritores:** Registro de enfermagem, Cuidados de enfermagem, Processos de enfermagem.

RESUMEN

Objetivo: Identificar la aplicación del proceso de enfermería y analizar los registros de cada etapa. **Método:** se trata de un estudio retrospectivo y descriptivo con enfoque cuantitativo, realizado desde los relatorios y de las fichas con registro del proceso presentes en los prontuarios del bloque b y que se encontraban en el same de un hospital universitario en campina grande. tras la coleta, los datos fueron analizados por el método descriptivo, y calculadas las frecuencias absolutas y relativas. **Resultados:** de los 114 (100%) prontuarios levantados, los registros presentaron todas las etapas del proceso, excepto la de los resultados esperados. los diagnósticos más frecuentes fueron padrón respiratorio ineficaz e intolerancia a la actividad ya a las intervenciones, verificar señales vitales y la saturación de oxígeno. en 68 (59,1%) registraron las acciones implementadas, 114 (99,1%) no presentaron respuestas del paciente después de la atención celebrada y 71 (61,7%) hicieron modificaciones de los planos de cuidados cuando sea necesario. **Conclusión:** se concluyó que hace necesario el aprimoramiento del registro del proceso de enfermería. **Descriptores:** Registro de enfermeira, Cuidados de enfermeira, Proceso de enfermeira.

1 Nurse, Master of Nursing (UFPB), Teaching at the Center of Biological and Health Sciences of the Federal University of Campina Grande. Campina Grande, Paraíba, Brazil. Address: Av Juvêncio Arruda, 795 - Bodocongó - Campina Grande - CEP: 58430-800. Email: gerlaneejc@hotmail.com. 2 Nurse, Doctorate in Sociology (UFPB). Teaching at Federal University of Paraíba. João Pessoa, Paraíba, Brazil. Email: marthamiryam@hotmail.com. 3 Student of the Nursing Course, Center of Biological and Health Sciences of the Federal University of Campina Grande. Campina Grande, Paraíba, Brazil. Email: angelica__santos@hotmail.com. 4 Student of Nursing Course, Center of Biological and Health Sciences of the Federal University of Campina Grande. Campina Grande, Paraíba, Brazil. Email:thalitalisboa.m@gmail.com.

INTRODUCTION

The nursing knowledge began to be built around the 1950's when there was a considerable advance in the construction and organization of conceptual models of nursing. These models served as reference for the development of nursing theories, which aim to establish a relationship between different concepts, and then explain and therefore direct nursing care provided to humans.[1]

The effectiveness of nursing theories is made through the Nursing Process (NP), which is defined as an intentional technical problem solutions, based on the scientific method, to develop, explain and predict their exercise, as well as their results, in order to validate their practice.[2] The process is a "[...] a methodological tool that enables us to identify, understand, describe, explain and/or predict how the client responds to the problems of health or life processes, and determine which aspects of these responses require a nursing intervention ".[3]

The process consists of five phases: research, nursing diagnosis, planning, implementation and evaluation.[4] From the use of the nursing process in practice linked to professional care, the nursing profession has been developed based on scientific reasoning, earning strength, making it a better quality and efficiency. This requires that professionals possess cognitive, technical and interpersonal skills to meet the needs of the client/family/community.

Given the complexity of the nursing process is necessary for the development of its phases, the effective recording of nursing activities directed to customer care. These notes provide information for care planning, implementation of care and evaluation of the care provided, apart from being linked object for legal purposes.

According to the Decree 94.406/87, which regulates Law of Professional Practice, article 14, section II, the annotation of nursing is the record in the patient performed by nursing staff regarding the conditions of the client, allowing continuity of care by reporting the events with it.[5] Also worth noting that there are aspects legal record/ annotation nursing through Art. 311/07 of Resolution 25, which provides for the Code of Ethics of Professional nursing, and determines who should register in the patient information inherent and essential to the process of care; and Art. 72 that determines who should register the information inherent and essential to the process of care in a clear, objective and complete.[6]

Thus, it may be noted that the responsibility of all nurses is unique and that they can/should contribute to the effective registration of the steps of the nursing process as a clinical methodological tool. Before the relevance of this theme the following questions arose: nursing professionals make the registration of the nursing process? The steps of the nursing process are recorded in the health? And the information recorded to allow continuity of nursing care and demonstrate quality of care provided? From the exposed problems we observed the need to investigate, from medical records, the information recorded by nurses at a university hospital in Campina Grande in order to identify the existence of the application

of the nursing process, completion of the registration each step of the nursing process and analyze the records of Nursing, based on the guidelines for the record, described by Alfaro-Levefre.

Despite the knowledge of nurses about the care, scientific and legal role of the care process records, studies indicate that this activity does not actually performed due to absence or quality of such records, causing damage in team communication, continuity and assessment assistance.[7,8] Therefore, this study is justified by the need to identify the gaps that impede its implementation in order to contribute to the implementation process in health institutions since their efficiency and effectiveness is intrinsically linked to quality of nursing records.

METHOD

This is a retrospective descriptive study with a quantitative approach, held in ward B and Service Medical and Statistical Archive (SAME) at a university hospital in the city of Campina Grande, Paraiba State, from June 2012 to August 2013.

The B side is one of the hospital clinics, for the care of patients with lung and was chosen to perform the research as a unit where the Systematization of Nursing is deployed from the second half of 2011 and the SAME to be the department responsible for filing all patient charts.

The population and the sample consisted of all reports and registration forms for the steps of the nursing process attached to the medical records of patients seen in the B wing of the hospital, in the period June to December 2011, were included in the survey only the records that had the record of all steps of the nursing process and that were filed in the SAME. According to this criterion, 131 medical records were evaluated, but only 113 were analyzed because 07 did not have a record of all steps of the nursing process and 09 were not in the service file of the institution at the time of collection.

For data collection, a roadmap collection prepared based on the guidelines for the registration of the steps of the nursing process described by Alfaro-Lefevre to assess the hospital records of patients who were admitted to the ward that was used.[4]

Initially, it was formally requested to University Hospital for permission to conduct the survey in ward B. Then the project was submitted to the Ethics and Research of the University Hospital Alcides Carneiro, Federal University of Campina Grande and subsequently approved on 30 November 2012, following a favorable opinion No. 159.885. After approval by the Ethics and Research Committee, was requested from Coordination Nursing ward B release to do the survey, from the book of admission, patients who were admitted in this hospital during the period from June to December 2011.

After the survey of all patients admitted with their respective numbers of records, there was duplication of the numbers of records due to the existence of cases of readmission of these patients, thus avoiding the analysis of the same record more than once. Later, it was requested to Medical Service and Statistical Archive (SAME) hospital permission for data collection, which occurred in the period from April to July 2013.

Filling script collection was done through the systematic observation of the registration forms of process steps and nursing reports from medical records evaluated by script collection that addressed data for each phase of the process, as described below.

In research step was verified the form of writing, the presence of erasures and corrections, signature and registration at the Regional Council of Nursing (COREN), and the presence of a research instrument based on a theory of nursing. In the diagnosis phase, were directed to use and the type of taxonomies to identify diagnoses, the correct construction of the diagnosis, the most frequent diagnoses, Regarding the planning stage, checked-up data regarding the presence of results of Nursing the taxonomy used for its establishment, the most common results and the presence of important items for their formulation, as measurable and observable verbs, deadline for achieving the goals and existing human and physical resources. Still in the planning, the instrument addressed the presence of interventions and relation to diagnosis, the use of taxonomy for its preparation, the most frequent and the presence of structural items such as: date of prescription, tense action, and person responsible by the action, manner and time of performance of action, and the signature and COREN professional. With regard to the implementation stage, the questions referred to the presence of prescribed and actions taken, the variations of normal and patient refusals, comes as if the actions were described in an objective, organized, precise, specific, concise and it had the signature and COREN. Finally, in the evaluation stage, the script addressed questions about the existence of the patient forward responses to the actions implemented the changes in the plan of care during the hospital stay and the presence of signature and COREN professional. In addition, the instrument also addressed the existence of policies and procedures of the health institution guide record of all steps of the nursing process.

After collection, the data were analyzed using descriptive statistics from the calculation of absolute and relative frequencies with the aid of Microsoft Office Excel 2007 program. Then, the results were presented in tables and discussed from the literature.

RESULTS E DISCUSSION

Analyzing the records of 113 B wing of the university hospital, it was found that patients attended this sector is characterized by being male (59/52,2%), aged entre80 to 89 years (18/15,9%), and among the reasons for hospitalization were the most frequent pneumonia and chronic obstructive pulmonary disease, respectively.

With regard to the nursing process, it was observed that in all there was the records of the investigation stage, nursing diagnosis, care planning, implementation and evaluation (Table 1). However, it was observed that nurses do not plotted the results of nursing, leading to partial realization of the planning stage considering that implementation occurs through the establishment of priorities, determining the expected outcomes and interventions and

their proper registration.[4] In addition, the same author adds that the provision of effective health care occurs when actions are focused on results.

Adding to this author affirmative, the COFEN Resolution No. 311/07, which provides for the Code of Ethics of Professional Nursing, provides in Art. 71 and 72 that is right, duty and responsibility of the nurse in the patient record information regarding and indispensable to the process of care in a clear, objective and complete.[5] Thus, the results of nursing also need to be plotted and recorded.

Table 1 - Absolute and relative Frequency of the record of the steps of the nursing process in B-side of a university hospital, Campina Grande, 2013.

		Records evaluated (n=113)	
Steps of the nursing process	**Performance**	**N**	**%**
Research	Yes	113	100
	No	0	0
Nursing diagnoses	Yes	113	100
	No	0	0
Results of Nursing	Yes	0	0
Planning assistance	No	0	0
Nursing interventions	Yes	113	100
	No	0	0
Implementation	Yes	113	100
	No	0	0
Evaluation	Yes	113	100
	No	0	0

In the research stage, the information recorded were analyzed for writing, the presence of erasures and corrections, how to fix the existing errors and the theoretical background in the construction of the instrument for data collection. With regard to the strict, it was observed that the registers were not readable in 109 (94,8%) of the medical records and 06 (5,2%) were unreadable, demonstrating that the nursing staff has the ability in spelling.

Importantly, the information inherent to the patient must be written legibly, because it facilitates the interpretation of data and consequently favors the planning and execution of an appropriate and safe care. Soon, unreadable registry can result in damage to the client, the professional and the institution.[6]

In this context, it is worth emphasizing that in Brazil there is a program that aims to evaluate the quality of health services, known as Hospital Accreditation. This evaluation occurs through the Manual of Hospital Accreditation of the Ministry of Health, which determines the "Professional Services and Care Organization" and subsection "Nursing" section, the Nursing Records must be complete, legible and signed.[9]

There were identified 23 (20%) erasures and correcting errors, and of these, 03 (13%) were corrected without obscuring the original words, while in 20 (87%), the corrections occurred incorrectly. In this respect, the data contradict the literature, which directs that

the errors must be corrected using the terms "say" or "correction," and then write the correct to go after the record, and the use of lime, rubbers and crossed lines are not allowed.

This orientation is partly because of nursing records consist of means of communication for multidisciplinary team to evaluate the assistance and administrative data, and can therefore not be erased.[10,11,12,13] Other authors add also that this recommendation is necessary because the records can be used in situations involving scientific and educational aspects as well as ethical and/or legal action in order to endorse the professional responsible for the care.[6,14]

Regarding the use of a conceptual framework, it was observed that in 113 (100%) of the charts, the data collection instrument was justified based on the Theory of Basic Human Needs Wanda de Aguiar Horta. These instruments were constructed from workshops conducted by teachers of Federal University of Campina Grande along with nurses from the university hospital, which identified this as the theoretical framework that better catered to their clients and their service profile.

Thus, it can be stated that the hospital has mechanisms to organize customer data, to analyze and interpret these data, to intervene and evaluate the care provided since used a theory to direct the care provided because nursing theories guide and improve the practice, directing the identification of diagnoses, interventions and expected outcomes, making care more efficient.[15]

From the data collected in the research stage, the nurse identifies the nursing diagnoses, which are defined as a clinical judgment about individual responses, the family or the community to health problems/life processes and real potential.[16] then the nurse goes into the preparation of the plan of care, which is nothing more than the establishment of priorities for diagnosis, setting goals and prescription of interventions.[17]

To do so, nurses use of rating systems, such as North American Nursing Diagnosis Association (NANDA), Nursing Interventions Classification (NIC) and the International Classification of Nursing Practice (ICNP®). Note that these taxonomies were constructed with the aim of developing a common language among nursing professionals to assist in identifying problems of the patient and choice of prescriptions, as well as evaluation of care prescribed.[18] Thus, the charts also were analyzed for their use for the construction of these steps, as shown in Table 2.

Table 2-absolute and relative Frequency of use of classification systems for the construction of the diagnoses, interventions and outcomes of nursing in medical records of patients admitted to the B wing of a hospital universitário Campina Grande, 2013.

Classification System / Taxonomy	Nursing diagnosis (n=113)		Nursing interventions (n=113)	
	N	%	N	%
NANDA	113	100	0	0
NIC	0	0	113	100
CIPE	0	0	0	0

In analyzing the use of taxonomies, it was verified that all had care protocols for the diagnosis and prescription of nursing, of which presented problems and interventions more commonly found in patients assisted in this service and that all taxonomy used to identify those aspects but was not seen the establishment of nursing outcomes, consequently was not raised employing a rating system in the construction of this stage.

These protocols are assistance guides to describe the problems, goals and actions detailed and allow for secure identification of a diagnosis and appropriate interventions.[18]

As for the systems used, we observed the use in all protocols use the taxonomies of NANDA and NIC for the elaboration of the phases of diagnosis and prescription of care, respectively. Thus, one can verify that these steps were built from scientific reasoning given that were drawn from classification systems, however, in 111 (98,3%) medical records, diagnoses were not built correctly because the diagnoses were incomplete since they only had the title of diagnostic taxonomy of NANDA, contradicting the study that says the complete wording of a NANDA diagnosis should include the title, a set of defining characteristics and one or more factors.[20]

Several authors argue that the identification of nursing problems allows the development of an effective plan.[4,21] Thus, the construction of an incomplete diagnosis can affect the proper development of expected results and the prescriptions of nursing interventions. Therefore, the nurses, to choose the taxonomy of NANDA diagnoses should build correctly.

Regarding the most common diagnoses identified, it was found that the ineffective breathing pattern, activity intolerance and risk of infection were the most commonly reported (Table 3).

Table 3 – Most frequent nursing Diagnoses recorded in medical records of patients admitted to the B wing of a university hospital, Campina Grande, 2013.

Nursing Diagnoses titles	Absolute value
Ineffective breathing pattern	**89**
Activity intolerance	**70**
Risk for infection	**50**
Imbalanced nutrition: less than body requirements	32
Impaired gas exchange	24
Constipation	19
Impaired physical mobility	17
Impaired sleep pattern	12
Pain	09
Impaired skin integrity	09
Ineffective airway clearance	06
Risk of impaired skin integrity	05
Risk of stable blood glucose	05
Aspiration hazard	05
Impaired dentition	05
Self-care deficit	04
Impaired bed mobility	03
Insomnia	02

Anxiety	01
Self neglect	01
Provision for increased comfort	01

According to NANDA, ineffective breathing pattern is defined as the inspiration and/or expiration that does not provide adequate ventilation, activity intolerance match insufficient to supply or complete required or desired daily activities physiological or psychological energy, which may be caused by an imbalance between supply and demand of oxygen. The risk of infection is the condition of being at increased risk for being invaded by pathogenic organisms, which may be related to the existence of chronic disease, inadequate secondary defenses (decreased ciliary action) and invasive procedures.[16]

Thus, it appears that the problems raised corroborate the type of service provided in this unit, which provides assistance to patients with respiratory diseases, showing that nurses are prepared to identify the nursing diagnoses. However, the problems identified found themselves focused mostly subject to the carrier of physical changes by examining only a problem focused on psychological aspects, and none related to social and spiritual problems (Table 3).

Still analyzing the protocols, we found that nurses reported in 78 (69,6%) medical records, diagnostic potential for complications and 42 (36,5%) included diagnoses other than those present in care protocols. We attempted to also raise the often prescribed interventions, among them, it was found measuring vital signs and oxygen saturation, keep elevated head, cough monitor and monitor bladder and bowel eliminations (Table 4).

Table 4 – Most frequent nursing Interventions recorded in medical records of patients admitted to the B wing of a university hospital, Campina Grande, 2013.

Nursing interventions	Absolute value
Assess vital signs 04 times per day	**110**
Assess oxygen saturation 04 times per day	**101**
Maintain high decubitus	**93**
Monitor cough	**72**
Monitor vesical and intestinal eliminations	**63**
Note pattern of sleep and rest	40
Note acceptance of diet	36
Observe respiratory pattern	35
Observe phlogistic signs at the puncture site of AVP or AVC	13
Administer oxygen through nasal catheter wet or Venturi mask	13
Change circuit of oxygen therapy	05
Note date of venipuncture	05
Change of peripheral venous access system	05
Pay attention to complaints of pain	04
Assess evolution of edema	03
Control blood glucose	03
Monitoring diuresis	02
Monitor blood pressure closely	02
Watch for signs of alteration in tissue perfusion	02
Drain debit note	01

Monitor signs of pulmonary aspiration	01

Still evaluating the record of interventions, it was observed that the treatment was prescribed based on nursing diagnoses, corroborating authors claim prescription care should be determined based on the defining characteristics and related factors identified in the development of diagnostics, this because, the requirements should be directed to the causative factors of the disease process.[22]

It should be added also that all records of nursing prescription had date of realization, action to be taken, information about the manner and frequency that the actions should be performed, but there was no appointment of a person to perform the activity, contradicting the literature since that intervention should be drafted taking into consideration that the verb must be in the infinite and must contain a descriptive phrase, who should perform it and the signature of the nurse in order to provide greater security to the customer.[21]

According to the data presented above, 113 records had the record of the implementation phase, but only 67 (59,3%) described the prescribed actions and incurred other information corresponded to record care not systematized. Moreover, were found in only 04 (3,5%) records, variations of normality and refusals to treatment.

Some researchers argue that the absence of the record of the procedures performed by nursing can put in doubt its implementation, since it has no way to prove that they were performed. Moreover, it can generate gaps in communication between nurses, thus compromising the continuity of care.[22]

The evaluation of nursing care aimed at the monitoring of the patient care provided and implemented responses, allowing the detection of interventions that should be kept, those to be modified and that can be finalized.[22] However, the research showed that in 112 (99,1%) records did not contain the patient's responses in the face of actions taken and in 70 (61,9%) there were also no changes in care plans during the patient's hospitalization, demonstrating an underestimation, the nurses, the front of the patient care responses, and the relationship of that record with diagnoses and modification of care plans.

In this context, a study that evaluated medical records of 240 patients at a hospital in Sao Paulo, found that 58,7% of the records had no conformity between diagnoses with the evolution of nursing. As was also observed nurses cannot be reassessing patients daily.[23]

Table 5 – presence of signature and number of COREN on the charts of patients interned in B-side of a university hospital, Campina Grande, 2013.

Stage of the nursing process	**Present (n)**	**Absent (n)**	**Partially (n)**
Research	**101**	**12**	**0**
Planning (interventions)	**57**	**21**	**35**
Implementation	**58**	**19**	**36**
Evaluation	**111**	**0**	**2**

With regard to the presence of signature and registration number of the Regional Council of Nursing (COREN), it was observed that the stages of research and evaluation were

those that had higher frequency of signature and the COREN (101 and 111 record respectively) and a lower proportion of interventions and implementation (57 and 58, respectively), but it is noteworthy that in some records there was the number of COREN or chips nursing reports, contrary to Resolution No. 191/1996 COFEN, which determines the compulsory registration number on all signed document when the trader is exercising its functions.[24]

Also found that the university hospital did not have policies and procedures that guide the registration of the nursing process, but the Coordination of Nursing has conducted training courses for the nursing staff in order to implement and carry out the registration process in the hospital since there are legal grounds to determine that the record of the steps of the nursing process, as is the case of Resolution No. COFEN 358/09, which provides for the Systematization of Nursing and the implementation of nursing process in health institutions public or private.[25] Therefore, it becomes mandatory and independent of the existence of institutional regulations for its implementation by nursing teams.

CONCLUSION

The study helped to find, through the nursing records, which the university hospital nurses use the nursing process as a guide for its assistance given instrument, however, found that the lack of results of Nursing, demonstrating that the planning stage not became fully effective.

In this respect, it is worth emphasizing that the nursing process is a method that provides organization of nursing, helping nurses to make decisions, predict and evaluate the results, it is essential to note all its stages. In addition to this function, the record also allows tracking of patient progress, communication between other professionals, and serves as the legal basis and source of data for evaluating the quality of nursing services.

However, the survey indicated the absence in all records of the results of nursing in the planning stage and the lack of assistance in some of the records and reports prescribed and actions taken, the patient's response to care provided, the amendments to the care plan as well as professional signature and the number of COREN, demonstrating the weaknesses in the effectiveness of the nursing process, the quality of care and compliance with the legal aspect by professionals.

In short, the results indicate a need for improvement of records made and the development of other studies in order to meet the difficulties encountered by nurses to perform the actual registration in the university hospital. Possible but also strengthen the role of the nursing process in the medical records of patients for continuity of care and legitimacy of the work of the nurse registry.

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Contact of the corresponding author:
Gerlane Ângela da Costa Moreira Vieira
Endereço: Av. Juvêncio Arruda, 795 – Bodocongó – Campina Grande – CEP: 58.430-800. E-mail: gerlaneejc@hotmail.com.