

IMPACT OF THE NONCONFORMITY OF NURSING NOTES IN THE CONTEXT OF HOSPITAL GLOSSES

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ABSTRACT

Objective: to describe the impact of nonconformity of nursing notes in the context of hospital glosses. **Method:** retrospective, documental and descriptive study, carried out by analyzing financial statements of patients' records of the hospital's sector of private health insurance. The data were collected between April and May 2017, which were later analyzed using descriptive statistics. **Results:** a total of 194 financial statements of the medical records were analyzed and, among the found glosses, the nursing notes stand out, being responsible for the hospital glosses, mainly: the absence of nursing notes and evolutions; absence of medication check; and absence of evidence of accomplishment or exchange of dressings. Although the financial impact has been almost inexpressive, the impact on the quality of care can be immeasurable. **Conclusion:** it is concluded that it is important to use strategies such as applicability of concurrent auditing to reduce hospital glosses, to provide improvements in health outcomes and ensure quality in nursing care.

Keywords: Financial audit. Hospital administration. Nursing records. Quality control. Quality assurance. Health care.

INTRODUCTION

The audit is understood as a process capable of verifying, through a detailed analysis of the facts, whether certain actions and their follow-ups are in accordance with the planned and with the requirements established by law. In the health area, the Nursing audit, through a systematic examination, acts in the supervision of the quality of care provided and assists in the reduction of unnecessary expenses, since it is known that the investment in nursing resources to improve care delivery can reduce disparities in hospital readmissions^(1,2). This critical analysis results in the benefit of having positive repercussions in the health sector and reassessing the planning for budgetary control, once the nurse's empowerment in healthcare processes culminates in a better economic and accounting return, focusing on the economic sustainability and the control of the executed processes^(1,2).

The nursing auditing exercise has been spotlighted in the face of the economic reality of

institutions, especially in the area of supplementary health, in which the provider and the Health Plan Operator have common objectives in relation to financial interests and the quality of care⁽³⁾. Thus, to better control the results, the audit can be divided in terms of execution, such as: prospective, with the objective of identifying an alarm situation and preventing problems; retrospective, when the results already achieved are evaluated to correct the failures occurred; or concurrent, when it occurs during a process, accompanying activities to ensure the quality of execution⁽⁴⁾.

Within this context, the activities of the Nursing Auditor were regulated by the Federal Nursing Council in resolution no. 266, on January 5, 2001⁽⁵⁾. In the health services audit, the nursing records are the target instrument used, because the nursing team is the twenty-four hours of the day in the care of the patient throughout their hospitalization, due to this, the care provided is characterized by several actions and procedures performed and these should be duly recorded in the medical record⁽⁶⁾, which, in addition to contributing to the follow-up of care,

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is an important way of communication among team members⁽⁷⁾. However, some points that have generated the most financial losses for health services are related to failures in nursing notes and records⁽⁶⁾.

When a record raises doubts due to inconsistencies in the notes, the result will be the total or partial deletion of the payment, called the gloss. The institution that received the gloss may appeal, if it has a justification, thus, a new analysis will be made, and the gloss may be withdrawn or kept⁽⁶⁾.

In this context, the absence of this information and/or inadequate filling interferes directly with the quality of care, as well as generating financial losses, since it is not possible to verify if certain inputs were used⁽⁸⁾. Nursing records should therefore be based on certain requirements such as organization, coherence, legitimacy, objectivity, among others, in order to be considered a quality record⁽⁹⁾.

This way, identifying the main reasons that generate the glosses, can provide strategies, so

that failures in this process are avoided and the efficiency of the service rendered is as large as possible. From this, the present study aims to describe the impact of nonconformity in nursing records in the context of hospital glosses.

METHODOLOGY

This is a retrospective, documental and descriptive study. The records analyzed were financial statements of patient records of the hospital's sector of private health insurance hospitalization in a municipality in the Northwest region of Paraná. The records analyzed were from October to December 2016.

A total of 390 financial statements were audited from patients' medical records, of which, 194 were analyzed from a simple sample calculation, with significance level (α) of 0.05 and statistical power of the 95% test. The selection of the medical records was made from a simple random sample, through lottery, using Microsoft Excel 2013 as a tool.

REQUIREMENTS	Was there any gloss due to incomplete and / or wrong information?			If yes, what is the reason?
	No	Yes	Does not apply	OBSERVATIONS
1. Signature and/or stamp of the requesting professional				
2. Patient's signature				
3. Doctor's prescription				
4. Doctor's evolution				
5. Nursing notes/evolution				
6. Absence of medication check/other procedures				
7. Dressing (Evidence or exchange)				
8. Venous access (Evidence or exchange)				
9. Oxygen therapy (Evidence or exchange)				
10. Bladder Catheter (Evidence or exchange)				
11. Nasogastric and/or enteral catheterization (Evidence or exchange)				
12. Exams (Orders/Result/Date/Time)				
13. Report of anesthesia and surgery				
14. Other nursing procedures (report which ones on the observations)				

Figure 1. Checklist for data collection, Northwest region, Paraná, Brazil, 2017.

Source: Author data.

The data collection took place in April and May 2017, through a checklist prepared by the researchers based on the Manual of Consultations of the Standards of Medical Audit and Nursing, respecting the precepts of COFEN Resolution no. 266/2001. The checklist was

individually employed, and it has a minimum of 14 requirements that should be in the patient records. In addition, a research question "Was there any gloss due to incomplete and/or erroneous information?", For which the answers were objective: "no"; "yes"; and "does not

apply". Where applicable, the reason for the requirement that has been glossed (Figure 1).

The data collection was done after approval by the Research Ethics Committee of the State University of Londrina, no. 1,949,642, in 2017, respecting the ethical precepts contained in CNS Resolution 510 of April 7th, 2016. The Participating Institution was informed on all the proposed elements of the study, in addition, the Term of commitment of data utilization and the Authorization of the institution were also applied.

The information collected was stored and transcribed to a spreadsheet, using Microsoft Excel 2013 software and analyzed through

simple descriptive statistics expressed in frequency and percentage.

RESULTS

Most of the analyzed requirements of the 194 financial statements of patients' medical records did not have a significant percentage of glosses, but the most prevalent glosses were inconsistencies and nonconformities in the nursing notes: absence of notes and nursing evolutions (16.5%); absence of medication check (13.4%); and absence of evidence accomplishment or exchange of dressings (11.3%) (Table 1).

Table 1. Identification of glosses expressed in the statements of analyzed medical records. Northwest region, PR, Brazil, 2017 (n = 194)

Variables	n=194	%
Signature and/or stamp of the requesting professional		
Yes	010	5.2
No	184	94.8
Patient's signature		
Yes	001	0.5
No	193	99.5
Doctor's prescription		
Yes	008	4.1
No	185	95.4
Does not apply	001	0.5
Doctor's evolution		
Yes	014	6.2
No	180	93.8
Nurses' notes and evolution		
Yes	032	16.5
No	161	83.0
Does not apply	001	0.5
Absence of medication check/other procedures		
Yes	026	13.4
No	166	85.6
Does not apply	002	1.0
Dressing (Evidence or exchange)		
Yes	022	11.3
No	166	85.6
Does not apply	006	3.1
Venous access (Evidence or exchange)		
Yes	002	1.0
No	190	98.0
Does not apply	002	1.0
Oxygen therapy (Evidence or exchange)		
No	174	89.7
Does not apply	020	10.3
Bladder Catheter (Evidence or exchange)		
Yes	002	1.0
No	143	73.7
Does not apply	049	25.3
Nasogastric and/or enteral catheterization (Evidence or exchange)		
Yes	002	1.0
No	132	68.0
Does not apply	060	31.0
Exams (Orders/Result/Date/Time)		
Yes	006	3.1
No	172	88.7
Does not apply	016	8.2
Report of anesthesia and surgery		
Yes	003	1.5
No	167	86.1
Does not apply	024	12.4
Other nursing procedures		
Yes	006	3.1
No	162	83.5
Does not apply	026	13.4

Source: Author data.

The financial impact due to the glosses was not expressive, being a total of three hundred and twenty reais in payments glossed by actions

that corresponded with absence of notes and nursing evolutions. Thirty reais were identified in payments due to the lack of checking of the

medicines and/or procedure, and twenty-five reais in payments due to the inexistence of evidence to justify the accomplishment or exchange of dressings.

There were also other inconsistencies that were not part of the requirements, but which resulted in glosses, these being: lack of justification of the number of sterile gloves used; visit gloss for lack of medical evolution; and lower dose of medication in relation to the time of administration due to drug stability.

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DISCUSSION

Although the glosses identified in the statements studied do not present such a significant percentage and financial reflection, it was possible to observe that, among the glosses presented, actions of nursing responsibility such as lack of records of nursing and checking of medications deserve attention and concern. These data are similar to the results found in other research⁽¹⁰⁾, which pointed out that the nonconformities in the nursing records reflect negatively on the quality of care, besides being important causes of financial loss.

Regarding the absence of notes/nursing evolutions, it was observed that the inconsistencies of the records may point to the lack of knowledge by the professionals about the importance of making adequate records, and that, regarding the reasons for these inconsistencies, is the demotivation of the professional in continuing the care cycle, lack of awareness of the legality of medical records and work overload, often justified by the scarcity of human resources⁽¹¹⁾.

Nevertheless, the nursing team is often aware of the importance of the records, but it does not have knowledge about the seriousness of the consequences that may result from the lack of notes⁽¹²⁾.

Among the absence of nursing notes/evolutions, is the lack of evidences of

accomplishment or exchange of dressing, similar to another article⁽¹³⁾, which, in turn, pointed out as a strategy to minimize these glosses the elaboration by the institution of a protocol to standardize the description of dressings.

Regarding the lack of medication checks, studies indicate^(14,15) that the assessment of care is influenced by this nonconformity, which negatively impacts the patient's safety, as well as resulting in financial damages for the institutions. Lack of checking is an uncertainty, which may directly reflect on therapy, leading to meds non-administration or duplicity.

Regarding the catheters and oxygen therapy, although the study⁽¹³⁾ shows a prevalence of inconsistency due to failures in nursing records, the results of the present study point as a positive factor to be seen as an incentive for the improvement of other deficient requirements.

In this context, the nursing audit becomes an effective management tool, covering financial issues and enabling the verification of the level of quality of care through nursing notes. Based on this evaluation, the nurse can and should take on a daily role as educator, enabling and interacting with professionals about the lack of knowledge and, sometimes, disengagement with nursing notes and records, so that there is a change in service planning, with objective of improvements in the quality of care and, consequently, in the communication between the team^(16,17).

The nursing audit exercise has grown expansively, but this performance is still limited when performed only retrospectively. The audit becomes unproductive when centered only on the patient's chart. Studies show the need for an action, in which the focus is on both financial issues, as well as the patient and the quality of the care provided, for this, it is necessary to be inserted in the care context, observing and accompanying the care in real time through of the concurrent audit^(16,18).

Corroborating with the other authors^(16,18,19), the concurrent audit allows not only the contact with the medical record, but also the patient and the entire team. This type of audit is an effective tool capable of improving actions, but in order to be seen not only as an auditor, the auditor nurse needs to expand his role with the nursing teams, assuming his role as an educator.

As a strategy for improvement, continuing education and continued meetings with health professionals, through a reasoned discussion with suggestions regarding shifting indexes occurring each shift and records with non-conforming notes are key factors to reduce hospital glosses and improve the quality of care, certain that individual proactivity and the professional's commitment to collective action changes the reality of service^(13,20).

This study had as a limitation the fact that the research was carried out only in a private health insurance agreement, and it is possible that the results were influenced by a specific management form. Future studies may compare results from other agreements and the implementation of surveys through concurrent audit to evaluate long-term results.

CONCLUSION

It is concluded that the hospital glosses were of low prevalence, however, those existing refer to the nonconformity of records such as the absence of nursing notes and checking of medications and/or procedures, which directly impacts on the quality of care provided. These results are often devalued by the institution as it does not have an economically relevant impact.

Given the position of the nurse professional as a team manager and the presentation of such a situational diagnosis, it is suggested the implementation of the concurrent audit in nursing to assist in the resolution of failed acts. In this sense, the feedback is immediate, for greater agility in correcting misconceptions, thus having the constant contact nurse with patient and the responsible party, reinforcing even more the daily professional education. In this way, the proposal of this work is that there is a permanent education before the routine and progress of the whole assistance.

IMPACTO DA INCONFORMIDADE DOS REGISTROS DE ENFERMAGEM NO CONTEXTO DAS GLOSAS HOSPITALARES

RESUMO

Objetivo: descrever o impacto da inconformidade dos registros de enfermagem no contexto das glosas hospitalares. **Método:** estudo retrospectivo, documental e descritivo, realizado por meio de análise de demonstrativos financeiros de prontuários de pacientes de um Hospital de Convênio privado de saúde. A coleta dos dados ocorreu entre os meses de abril e maio de 2017, os quais, posteriormente, foram analisados por meio de estatística descritiva. **Resultados:** 194 demonstrativos financeiros dos prontuários foram analisados e, dentre as glosas encontradas, destacam-se os registros de enfermagem, sendo responsáveis pelas glosas hospitalares, preponderantemente: a ausência de anotações e evoluções de enfermagem; ausência de checagem de medicações; e ausência de evidências de troca ou realização de curativo. Embora o impacto financeiro tenha sido quase inexpressivo, o impacto na qualidade da assistência pode ser imensurável. **Conclusão:** conclui-se que é importante o uso de estratégias como aplicabilidade da auditoria concorrente para reduzir as glosas hospitalares, proporcionar melhorias nos resultados de saúde e, em especial, assegurar qualidade nos cuidados de enfermagem.

Palavras-chave: Auditoria financeira. Administração hospitalar. Registros de enfermagem. Controle de qualidade. Garantia da qualidade dos cuidados de saúde.

IMPACTO DE LA INCONFORMIDAD DE LOS REGISTROS DE ENFERMERÍA EN EL CONTEXTO DE LAS GLOSAS HOSPITALARIAS

RESUMEN

Objetivo: describir el impacto de la inconformidad de los registros de enfermería en el contexto de las glosas hospitalarias. **Método:** estudio retrospectivo, documental y descriptivo, realizado por medio de análisis de demostrativos financieros de registros de pacientes de un Hospital de Convenio privado de salud. La recolección de los datos ocurrió entre los meses de abril y mayo de 2017, los cuales, posteriormente, fueron analizados por medio de estadística descriptiva. **Resultados:** 194 demostrativos financieros de los registros fueron analizados y, entre las glosas encontradas, se destacan los registros de enfermería, siendo responsables por las glosas hospitalarias, predominantemente: la ausencia de apuntes y evoluciones de enfermería; ausencia de chequeo de medicaciones; y ausencia de evidencias de cambio o realización de apósito. Aunque el impacto financiero haya sido casi inexpressivo, el impacto en la calidad de la atención puede ser incommensurable. **Conclusión:** se concluye que es importante el uso de estrategias como aplicabilidad de la auditoría concorrente para reducir las glosas hospitalarias, fomentar mejoras en los resultados de salud y, en especial, garantizar calidad en los cuidados de enfermería.

Palabras clave: Auditoría financiera. Administración hospitalaria. Registros de enfermería. Control de calidad. Garantía de la calidad de atención de salud.

