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Quality Of Nursing Records In The Emergency Service Of The San Vicente De Paul Hospital

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Abstract.

Nursing records are the most reliable source of the quality provided by healthcare personnel; in them, all care provided is presented in an authentic, concise, and brief manner. They serve to monitor the continuity of patient care, as a bridge of information between health professionals, and as legal and legal support. The systems most used by nursing staff to carry out their records are the Nursing Care Process and the recording of subjective and objective data, Interpretations and analysis of the data, Care Plan, Intervention or execution, and Evaluation of the expected results. For the study of this article, the non-experimental direct observation technique was used on a sample of 150 medical records from the emergency area of the San Vicente de Paúl Hospital in Ibarra. The most notable results of this research are the deficiency in the application of the Nursing Care Process, the null existence of training in registries; the recording of information at the end of the shift (85%), poor use of abbreviations (64%), nursing notes with little scientific foundation (89%), intelligible records (55%), with marks and corrector, which highlights improved management of nursing records in the emergency service.

Key words: Nursing records, quality, nursing care process.

1.Introduction

The documentation of significant and transcendent events is direct action for the development and advancement of humanity. It has been a vital task in all ages until the construction of information is known today. Information is a vehicle for the transmission of knowledge that has become an essential factor for the advancement of society; which is characterized, in all sciences, by an acceleration in the collection, storage, processing, and transmission of information, which has generated positive effects by becoming a strategic element for the integral development of society [2]. Written words are fundamental since they make it possible to express ideas and reflections, communicate with the environment and achieve a better understanding between people; Regarding this, the Spanish philosopher José Luis Ramírez affirms that thinking and speaking is the fundamental activity that is present in every human action but especially in intellectual activities [22]. Words are used to create information records. Therefore it is vital to give them the importance they deserve and also choose them adequately. In the health area, the information registry is significant for advancing science and the adequate care of patients. The more information collected about a patient, the better the quality of care and care that the patient can receive and the quality care that health personnel will be able to

provide. For these reasons, it is imperative to have the right tools to collect and transmit information. One of the data collection instruments in the health area is the nursing records (SOPIAE). To carry out this registration, the assistance personnel must be familiar with a specialized technical term that argues for the writing of the registers since the terms used depend on the understanding that each person gives to the register.

It is crucial that the words are carefully chosen in the healthcare professional field, however specifically in the nursing area, the words have not been considered with the importance that the argument deserves [16]. It is common to meet different professionals giving different names to identical conditions and thus creating subjective interpretations that can create misunderstandings and unfavorable consequences for patients. Correctly carried out SOPIAE also contributes to the search and generation of knowledge, thus promoting research and teaching. From their reading or the information obtained from the data co-assigned in them, learning creates new knowledge. The latter allows the profession to progress since it encourages reflections on its means and resources [16]. At the end of the 9th century, nursing practice and education worldwide were neither organized nor regulated [5]. The first stage in which history records nursing writings as a formal document is at the end of the 19th century in the first monasteries. In the 21st century, nursing emerges as a profession. Likewise, an essential intellectual reflection on what to become a nurse is born based on the conceptual analysis that began during the Crimean War. Florence Nightingale was a pioneer in collecting data, organizing it, and controlling records. Florence Nightingale is considered the first Nursing researcher, as her writings and discoveries were based on careful research and the implementation of sciences such as statistics and administration for healthcare. In 1901, the Nurses Certification Act was approved in New Zealand, which is the first regulatory document of the SOPIAE, and following Nightingale's contributions emerge theorists who make notable contributions used to date, such as Hildegard Peplau in 1952, Virginia Henderson en1948 and Vera Fray in 1953 who with their contributions finally managed to incorporate into nursing practices the concept of the Nursing Care Process (PAE) [5]

Nursing records are documents that should be understood as a source to construct the patient's history and collect antecedents that lead to identifying the actions of health professionals, the way they are carried out, and the motivations they have to carry them out [3, 10]. There are several documents for which the nursing staff has responsibility. Among them are the nurse's notes and the SOAPIE that are part of the patient's medical history. According to García, Navío, and Valentín, nursing records are part of the work carried out by nurses in their care work for the care needs of patients. These instruments serve as a documentary record and communication tool when the patient goes to the care of another doctor; In addition, they are also helpful as a defense against a possible legal action because they are documentary testimony and guarantee the continuity and management of patient care, they are the best proof of the quality of care provided [11].

Nursing records can be defined as the documentary support where all the information on the activity of the nursing staff concerning a patient is compiled, as well as their assessment, treatment received, and evolution [15]. Its essence revolves around the patient and their needs. According to Vélez and García, the adequate recording of information in the nursing documents helps to provide comprehensive health care that the patient needs and prevent errors when diagnosing or medicating [26]. In other words, if the patient's symptoms are correctly recorded from the grassroots, the healthcare team has the possibility to focus its efforts to provide adequate and quality care. Healthcare institutions have an obligation to faithfully record, summarize and compile all information and share it with all those who work in the health organization. This profession strives for a

multidisciplinary structure in which several professionals coordinate with each other offer global attention. The SOAPIE is a professional and legal nursing responsibility since it includes a specific structure, a standardized care plan, and a canonized vocabulary. The information documented in the SOAPIE assists health personnel in increasing the quality of care provided to patients, smoothes the search for symptoms, helps the patient make decisions and enables analysis or treatment, thus allowing the prompt recovery of the patient. Registries also guarantee full communication between all healthcare team members and serve as a source for future research, teaching, and management [28, 24, 8, 7, 6, 4, 20, 1].

These records are essential because of their importance in terms of the ostensible improvement of patients' health and the descriptions of cases made by doctors from different times. Its relevance has been vital for the transmission of knowledge between different cultures and times in history. These records played an essential role in the education of health professionals. They contributed to the knowledge of diseases that in other times were unknown and that based on their description and the analytical thinking of the doctors of each era, they know of our days [4].

The SOAPIE allows access to information and data for daily practice by health professionals, being a fast and accurate tool to know the status of a patient. This document reflects the assessment, diagnosis, planning, and evaluation of the patient. The SOPIAE has three main functions: contribute to the continuity of care and facilitate written communication in the health team, develop nursing as a profession, and serve as legal-legal support [28, 24, 8, 7, 6, 20, 1]. The SOAPIE must be based on the PAE, which uses basic instruments such as observation, communication, and registration, taking into account the five stages that are: assessment, diagnosis, planning, execution, and evaluation [7], considered essential elements of the SOAPIE and that contain the subjective data of the patient, which include the feelings, symptoms, and concerns that are obtained after a conversation between the nurse and the patient. Objective data are findings collected from the physical examination or the assessment made in the patient interview. The analysis of subjective and objective data is necessary to plan effective measures in patient care and the nurse's intervention in mitigating problems, and finally, in evaluation [8].

The nursing records serve as a documented testimony of each action carried out during the care process of the assistance personnel in the face of any presumed medical negligence; said records adhere to the framework of the Ecuadorian law that in its Organic Health Law, says in Article 170: Scientific, technological research in health will be regulated and controlled by the national health authority, in coordination with the competent bodies, subject to bioethical and rights principles, with prior informed and written consent, respecting confidentiality [19].

Technology and science have developed so rapidly in recent years that humanity is facing a new era in which knowledge and technology represent social, political, and economic change [25]. Almost no area of knowledge has been free from this progress, much less the branch of nursing.

The accelerated technological and computer advances have forced the nursing professional to change their recording styles based on adaptations of nursing models such as Virginia Henderson's, common in the Ecuadorian environment, or nursing thought systematics. Today there are still assistance centers where notes are made on paper and by hand. The machines cannot replace the critical reflection necessary in nursing care and the meticulous detail of the patient; therefore, personnel using paper records must follow a structure with established guidelines for this purpose [28, 24, 8, 7, 6 20, 1].

Computerized records arise intending to improve the quality of patient care, since thanks to their uniformity, mistakes, and misunderstandings caused by the illegibility of the health personnel's handwriting reduce and thus shorten the time spent in bureaucracy, being able to use that time in the care of the patient; Although, other authors affirm that ambiguity can be created since there are studies that reveal discomfort among the nursing staff, where the care time is diminished by the duty to enter data on the computer and also on paper; that is, a double task that, instead of helping the nursing professional, takes even more time, as there are hospitals or health centers that continue to use paper or that the time is not considerably less than that used when writing the record on paper [28, 24, 8, 7, 6, 20, 1].

Although the systematization promises and is presented as a factor that facilitates the search, access to information, improvement of the quality of the records, the rapid analysis of the data, and the reduction of the time taken by the nurses to record it, it does not a great optimization or improvement is demonstrated compared to records made on paper. The nursing professional not only transcribes the situation and evolution of the patient but, in his writings, must reflect his knowledge and his critical reflection after clinical decisions. This is the great responsibility of nursing to provide the best quality care provision and enhance the nursing figure through formal writing of records [25].

Since the nursing profession encompasses a wide field of knowledge and techniques, specialization of studies by area is necessary [7].

Nursing professionals who work in the emergency service must have the ability to diagnose the situation in an agile way, to be able to solve and compensate the vital parameters that put the patient at risk of life, that is why the care of Emergencies require specialized actions and advanced technological equipment since the patient's life depends on receiving or not receiving immediate attention. Nursing intervention is essential in this area [28].

Given that the patients who come to this unit have experienced a sudden event with imminent risk of death, they require immediate intervention by the health team; Many times, and given the circumstances, the nursing records that are carried out in this area do not usually follow each of the protocols due to the urgency with which the patient must be intervened. There is a great demand in this hospital area; the life of the patient is at risk if it is not attended to immediately, but there are many impediments during the process, which cause dissatisfaction in the patient, and the quality of the service is related to the satisfaction of the patient. user [20]. The elements that are taken into account when making a SOAPIE are complex and take time. These are usually routine notes about the patient's condition, care, and observations made constantly. It is not a question of writing as much as possible, but rather recording only the relevant data, synthesizing and having the capacity to reflect on the essential events; but at the same time, all the activities carried out in terms of patient care must be recorded, since said documentation will be a map with which the evolution of the disease can be evaluated and where the necessary care is directed.

On the other hand, there are not only problems with the modality and time of recording the information, but there is a traditional resistance of the nursing profession to the use of records, this is due, among other reasons, to the lack of time, which is customary. , the care workload or lack of knowledge of the appropriate language. There are a few reasons why nursing records are not done properly. According to a study done in 2018, nurses spend between 35 and 140 minutes writing, with the aim of recording all processes and care given during the shift. One of the most common reasons why nurses do not comply with the records is that they are thought to be a waste of time, which, from their point of view, they could dedicate to the direct care of the patient; in addition, the nursing staff

alludes that they prioritize other tasks considered by them as more important, especially in the emergency area [18].

In order to solve these problems, electronic media has been thought of as a tool to help reduce the time spent filling out nursing records. Although research has been carried out that concludes that the use of new technologies dramatically reduces the time invested in making records [27, 28], more recent studies show that there is no evidence of this and that when using technological means, the time it does not decrease by a considerable percentage [9].

Nursing records need to be performed simultaneously with the care provided to the patient and holistically focus on him, treating not only the physical aspect, if not the psychological, emotional, and cultural; It should also be taken into consideration that the record is clear, understandable and decipherable. In case the documentation is done in writing, the handwriting must be signed by a person in charge and thought of as a tool that an entire interdisciplinary team can count on; therefore, it is a professional and legal obligation that is understandable to avoid delays and errors during patient care [1, 6, 7, 8, 20, 21, 24, 28]. Suppose the nursing records are not made promptly or are not made, or the quality of the information is bland or deficient. In that case, it affects the follow-up of patients, resulting in a poor diagnosis and treatment of the patient, which institutionally translates into long periods of hospitalization. The severity of the patient determines the time that is dedicated to recording the information. In reality, the nurse spends most of the time repeating notes of routine care and observations, leaving direct observations of symptoms, signs, and symptoms very frequently unrecorded. Vital and specific dialogues; due to lack of time, work overload, or lack of motivation. In this way, the importance of the records is diminished, which are a legal instrument whose absence would put in a situation of helplessness before the civil, criminal courts or, in the best of cases, before the commissions of medical or nursing audits. A document considered the safe conduct of health personnel caring for a particular patient [6].

The services that nursing records offer would not be possible if they were not thorough, accurate, and true to their documentation. To properly execute the practice of nursing records, they have some characteristics that must be met, including certain technicalities and standardized nomenclatures accepted by the scientific community. Some details may seem insignificant, but they have significant repercussions if they are ignored. These details are, among others: avoid studs, do not use another ink color to write other than blue (for daytime records) and red (for nighttime records), do not give value judgments or personal opinions, or express connotations negative, offensive, nonsensical, or irrelevant speculations about the patient or their condition [12]. It is advisable not to leave blank lines between registry entries, as it is not a retrospective exercise. It must be very precise in the annotations. It is essential to use technical, precise, and universal language as objectively as possible to do this. The accepted taxonomies for SOAPIE are those of NANDA (North American Nursing Diagnosis Association) or North American Nursing Diagnosis Association, whose objective is to standardize nursing diagnosis; the NOC (Nursing Outcomes Classification) or classification of nursing results, and finally the NIC (Nursing Intervention Classification), to classify the interventions by nursing in a grouped way. Thus, NANDA, NOC, NIC has been able to obtain a common language for the nursing profession [25].

Nursing records have to be protected, retrievable, and preserved to be used at any time necessary. They are or should be a total and faithful reflection of the care provided by the professional to the patient throughout their process in the hospitals or care centers where they went to be treated. This is achieved with clear and concise annotations, using quantifiable terms in the observations, and meticulous descriptions of the findings. So do not leave room for doubts. The nursing professional can

carry out all the care tasks during his shift, but by not documenting them in a record, it is as if he had never performed them. When patient information is passed from one healthcare professional to another verbally, the quality of care declines and could even have legal repercussions. Each record must be done in parallel to the care of the patient. Underreporting occurs when making a verbal prescription, changing from one professional to another, or being misrepresented [13]. According to the study carried out by Cunto, Priona, and Villalobos [8], the performance of nurses is benefited or affected by certain factors. Among them are work overload, lack of definition of functions, and lack of personnel; reasons for which the nursing records are not duly complied with, negatively influencing the daily work of health personnel and therefore the care provided to patients. Another factor that affects the quality of the records is the weaknesses in both the technical and professional training of the nursing staff, which is why training is so necessary to acquire, update and increase knowledge, skills, and abilities [14].

Professionals must be aware of the importance, relevance, and the proper way to comply with nursing records, as well as the professional and legal repercussions of their breach. To avoid incorrect registration of health information, it is necessary to apply the Nursing Care Process (PAE) as a methodological system within which scientific, planned, and evaluated care is provided. In such a way, it is possible to satisfy the care needs of patients in all areas of professional practice in a timely, dynamic and measurable manner [6]. According to Arratia [5] and Torrecilla [25], to improve nursing documents, it is necessary to train health personnel to manage the tools that organizations design to record the information of the patients they attend if they want to get the most out of it. In addition to training on how to prepare a registry, with this background and due to the importance of the subject, it is imperative that the factors related to the quality of nursing reports are known and that the quality of nursing reports improves. Health [7].

The objective of this research was to evaluate the quality of the nursing records in the emergency service of the Hospital San Vicente de Paúl, so those valid conclusions can be drawn to make recommendations to the health home for the benefit of the well-being of patients who There they are cared for and the medical and nursing personnel who work there.

2. Methodology

In this study, the research was descriptive and documentary, carried out in the emergency service of the San Vicente de Paul Hospital in the city of Ibarra, Ecuador. The data collection techniques used were the documentary analysis of files and non-experimental direct observations. A checklist was also used to record the characteristics and knowledge of the nursing staff.

The analyzed sample corresponds to 150 medical records of patients seen in the emergency service, using a simple random sampling.

For the suitability assessment, some of the parameters proposed by Chacón in 2019 were used, which states that all documentation carried out in this process must be: authentic, brief, complete, current, organized, confidential, exact, permanent, and signed by a responsible [7].

The forms to be evaluated within the clinical history were forms 020: vital signs; forms 005:evolution and medical prescriptions; and forms 022: medication administration (Kardex), in addition to the intake and disposal records. The detailed forms to be positively evaluated had to have the following parameters: registration of the patient's affiliation data, clarity of the letter, check of medical prescriptions, a signature of responsibility, narrative record, use of the corrector, use of international abbreviations, prescriptions of other professionals, use of medical terminology, application of the PAE, a moment of recording the information during or after the shift and recording

of compliance with medical prescriptions. Descriptive statistics (means and percentages) and figures made using Office tools were used for data analysis.

3. **Resultados y Discusión**.

The analysis, contrasting, and inferences of the collected data were carried out, according to the proposed methodology (Figure 1):

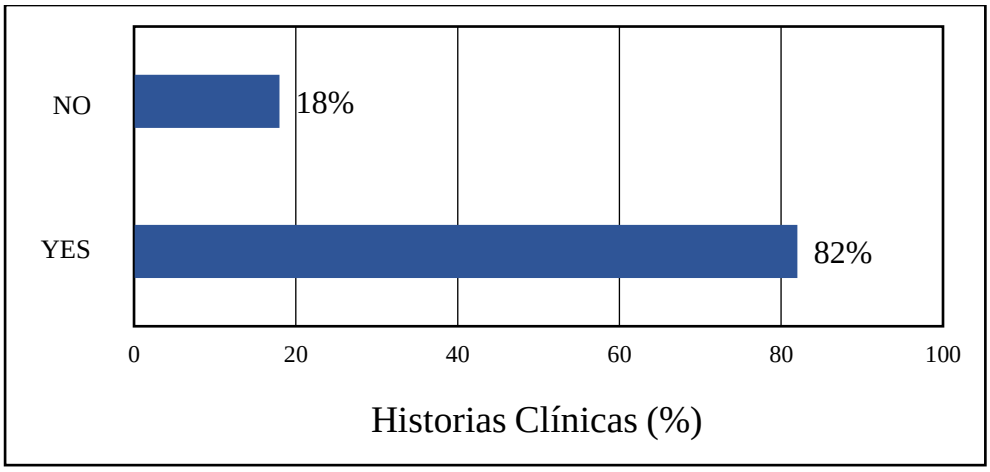

Fig 1. Registration of patient affiliation data.

As can be seen in Figure 1, 82% of the analyzed medical records comply with the registration of the affiliation data required in form 008; leaving 18% of the space corresponding to this section blank; space that must be filled in with the following information: name, nationality, identity card, address, telephone number, marital status, age, sex, occupation, and religion of the patient. This blank space is considered one of the negative factors to be scored about the rating given to the analyzed nursing records. While in the research that documents this article, 82% of the personnel complies with registering their patients' data, in Guayaquil, in 2015, 89% of the nursing personnel did not comply with the norms for filling in records correctly [6].

The data analyzed show variations between the different hospitals and periods of time and reveal an improvement in the registration of parentage data and the existence of an enormous gap in the comparison of one healthcare center with another possibly covered by the difference in the number of patients treated in the different health homes.

The triage service helps healthcare personnel to prioritize the patient based on the severity of their illness and to record routine information; This service provides clear information to the patient about their health status and the maximum waiting time for their care; generating user satisfaction and reducing anxiety and nervousness caused by the disease [6]. This information is relevant insofar as it is possible to correct the inconvenience of registering the patient's affiliation data by having an agile triage service while reducing the psychological symptoms caused by the physical symptoms of illness.

The lack of consignment of these data may correspond, as mentioned before, to the high demand of patients who enter the emergency room per shift, which can sometimes be in the emergency service of the Hospital San Vicente de Paúl, of up to 10 patients for each nurse on each shift.

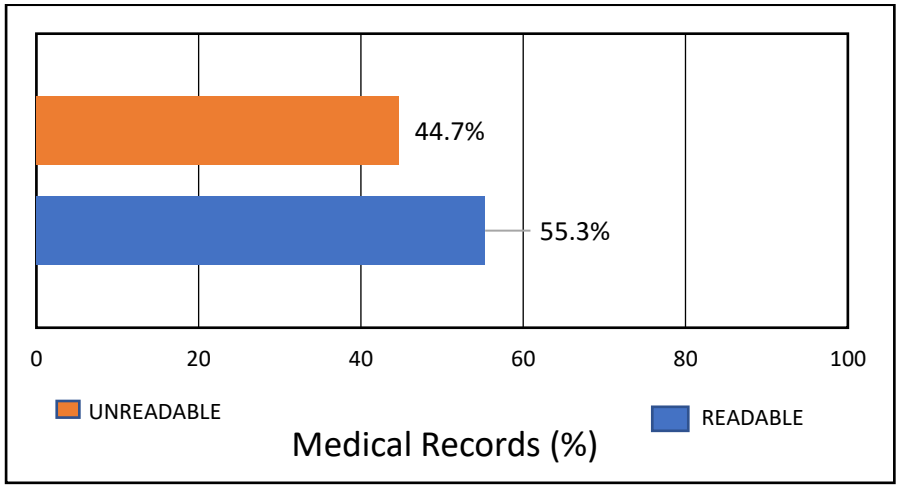

Fig 2. Quality of the nursing staff's letter

In the medical records analyzed, it was observed that 55.3% of them had a legible letter, compared to 44.7% who had unintelligible letter in the information record. In a 2020 research in an emergency room in Peru, it is stated that the nursing staff meets other requirements such as the recording of the hour of care, neatness or putting the seal or signature of the professional in the registry, but the readability of the letter is relegated to the background, with a percentage of 61% of people writing clearly [24]. Carranco, in 2017, made observations on the nursing records at the San Vicente de Paul Hospital in the city of Ibarra in which he highlighted that the percentage of professionals who strive to present a letter that is understandable was 96.15%, that is, with respect to that study, a negative difference of 41.15% can be inferred [6]. Nurses are increasingly concerned with submitting a record that is understandable and that streamlines the nursing care process that each patient requires. This figure has improved to add quality to healthcare [17].

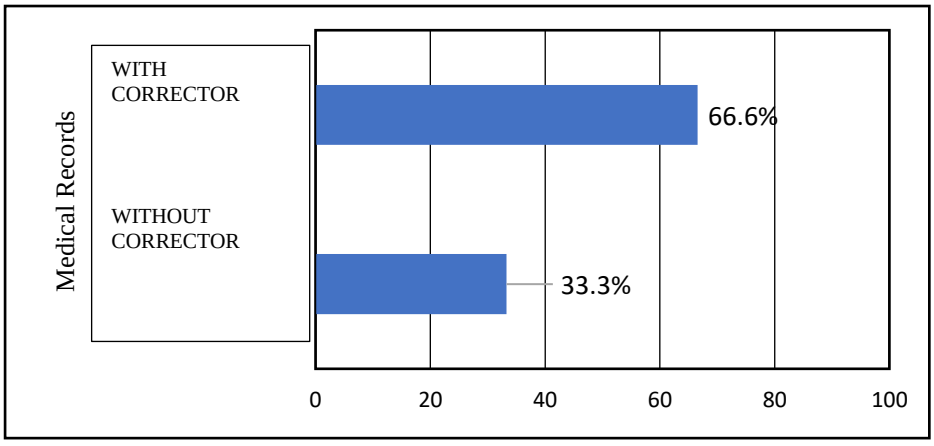

Fig 3. Using a checker in the logs

Figure 3 shows that 66.66% of the documents analyzed do not contain a corrector when registering the nursing notes, while 33.33% of the documents show its use.

Taking into account two studies carried out at the San Vicente de Paúl Hospital in which there is an ellipsis of 2 and 3 years since the study carried out, in this work, it is shown that

in 2014, 66.6% of the nurses made use of the corrector in their records; in 2017, that figure decreased to 22.3%, and in 2019 only 2% of professionals who document nursing records use a proofreader in their writing.

These figures show that the personnel who work in the nursing specialization of the San Vicente de Paúl Hospital have become more and more rigorous and assertive when making their records since the use of proofreaders to correct written errors has decreased in large numbers. This may be due to the Canadian accreditation in 2016, thus making their processes much more precise with better quality.

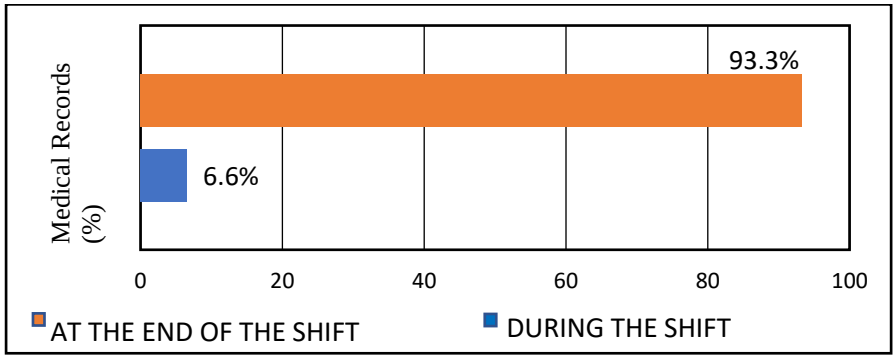

Fig. Time of registration of information

In Figure 4, it is observed that of the 150 medical records analyzed in the emergency department, only 6.6% are made during the shift, while the majority, 93.33%, are performed at the end of the shift.

In a study carried out in 2019 [7], 98% of nurses who work in emergencies of the Saint Vincent de Paul staff, the records are generally made at the end of each shift, data that is also reflected in another study carried out in 2017 in the same place [6]. This action should not be taken because conditions, symptoms, or appropriate care could be left out of the report for the continuity of patient care.

There is an immediate need to attend to patients who enter any healthcare center due to an emergency, all healthcare professionals are aware of this, and this may be one reason why it is preferred to attend to the patient in their urgency and fill in the records once for the patient to stabilize. Another possible factor that affects this timely registration decision could be the demand for incoming patients and the lack of personnel since it is sometimes said that each nurse attends an average of 20 patients per shift.

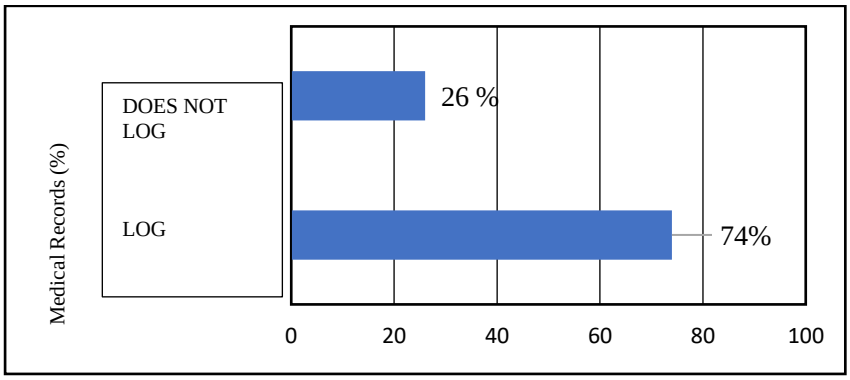

Fig 5. Record of compliance with medical prescriptions

In the last Figure 5, it can be seen that 74% of respondents register compliance with the medical prescriptions given to the patient, compared to 26% who do not. In the study carried out in 2017 in the same hospital, 49.18% of professionals were registered who did not carry out medical prescriptions. These were the second step in administering medicines [6]. When a prescription is given verbally and is not adequately recorded, underreporting occurs, which can harm patient care, as there is no documented evidence of the care prescribed by the doctor. Without an adequate prescription in the records, any error could generate problems in the care and treatment of the patient, this being a reason to extend the patient's stay in the health care center, in addition to being able to generate responsibilities to health professionals in case of negligence in medical care.

There are other parameters of this research, analyzed in the sample's medical records (Chart 1):

Table 1. Parameters analyzed in Medical Records

Parameters analizaded	**Meet**	**Does not meet**
Check-up of medical prescriptions	74%	26%
Responsibility signature	100%	0%
Narrative record	100%	0%
Misuse of abbreviations	64%	36%
Prescriptions from other professionals	56%	44%
Use of medical terminology	11%	89%
Implementation of the PAE	0%	100%

As Table 1 shows, the medical prescription check is fulfilled in 74%, the responsibility signatures are found in all the medical records, as well as the narrative use of language, the use of international abbreviations is fulfilled in 64% of the records, the prescriptions of other professionals are recorded in 56%. Practice shows that although the nursing records at Hospital San Vicente de Paúl consume between 35 and 140 minutes per shift, the nursing staff spends most of that time repeating notes of routine care and observations, neglecting influential records and specific dialogues due to lack of time [6]. In the Table, only 11% of the nursing records analyzed used medical terminology, which shows that the application of the PAE is entirely non-existent. Nursing professionals have significant work experience as a result of their daily activities. However, this strength is not evidenced in the formulation and preparation of nursing reports [6].

In the San Vicente de Paúl Hospital in Ibarra, despite having international accreditation for meeting organization and quality standards [23], according to a study carried out in 2019, 100% of the nursing professionals reported not using systematic methods for registration and interpretation of the problems and needs of the patient as the method in which subjective, objective, analysis, approach, hospitalization and evaluation data are analyzed (SOAPIE); this is due to lack of time and lack knowledge [7]. The San Vicente de Paúl hospital, in 2018, had 10,639 hospitalized patients and total attention in the emergency service of 37,804 visits from January to November, exceeding the capacity that the hospital currently has [28]. The emergency units are increasingly collapsed, and the demand for trained personnel who can quickly and efficiently resolve the cases that arise is unquestionable.

4. Conclusions

The results obtained allow us to conclude that:

The nursing staff is unaware of the registration regulations, which leads to the loss of important information and the registration of the continuity of care.

The narrative method is used in nursing records. However, fragmentary language is used, making use of medical abbreviations that are not international.

The lack of knowledge or training in the Nursing Care Process constitutes a tremendous barrier since it prevents the use of nursing diagnoses and their relationship with scientific evidence as support for the care provided; For this reason, it is necessary to train staff in the use of the PAE and the proper performance of the SOPIAE.

The high care burden results in a lack of time that forces the nursing staff to focus their efforts on direct patient care, neglecting the recording of their activities and losing essential details in the natural care process

The quality of the records is closely related to scientific evidence and the ability to record information based on a method appropriate to the requirements of patients and health professionals.

The nursing staff does not attach greater importance to the records since they develop them routinely, without precision, objectivity, describing very subjectively and not reflecting the quality of the service.

The study reveals the feeling of the nurse regarding the reports as something overwhelming, that they do not want to do because they consider it uninteresting, that it is not their function, but above all, because they consider that it does not contribute anything new to the quality of care. This problem has contributed to devaluing the quality of nursing records, currently being understood as paperwork that generates resistance at the time of its completion and consequently less involvement in its improvement.

Nursing records are an essential tool for communication within the health team capable of evidencing, optimizing, and accrediting the quality of care, considered key when justifying, holding accountable, and supporting decisions and activities inherent to the role.

Nursing notes should promote respectful interdisciplinary work, with a view to ensuring the quality of nursing care, noting that a good record should be one that collects enough information to allow another professional to assume, without difficulty, the responsibility of taking care of a patient.

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