NURSING CARE SYSTEMATIZATION IN THE PERIOPERATIVE PERIOD: ANALYSIS OF RECORDS

Sistematização da assistência de enfermagem no período perioperatório: análise de registros

Sistematización de la asistencia de enfermería en el período perioperativo: análisis de registros

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ABSTRACT: **Objective**: To analyze records on the perioperative nursing care systematization (PNCS) according to recommendations of the Brazilian Society of Surgical, Anesthesia Recovery, Sterilization and Material Center Nurses (SOBECC). **Method:** Descriptive, documentary, and quantitative study developed in August 2018 on a hospital in the state of Rio Grande do Sul. The sample consisted of 50 medical records of patients who underwent anesthetic-surgical procedures, randomly selected from a surgical inpatient unit. Using the research instrument, we collected data on ten attributes, subdivided into perioperative phases, according to the practices recommended by SOBECC. The results are expressed as absolute and relative frequencies. The study was approved by the Research Ethics Committee of the institution. **Results:** The highest percentage of records was fully complied with (61.40%). However, 25.79% of records were not followed, especially those related to nursing care. **Conclusion:** According to SOBECC's recommendations, records and adherence to PNCS were inadequate.

Keywords: Nursing care. Perioperative nursing. Quality of health care.

RESUMO: **Objetivo:** Analisar os registros da sistematização da assistência de enfermagem perioperatória (SAEP) conforme recomendações da Associação Brasileira de Enfermeiros de Centro Cirúrgico, Recuperação Anestésica e Centro de Material e Esterilização (SOBECC). **Método:** Estudo descritivo, documental e quantitativo desenvolvido em agosto de 2018 em um hospital do Rio Grande do Sul. A amostra foi composta por 50 prontuários de pacientes submetidos a procedimentos anestésico-cirúrgicos, selecionados aleatoriamente em uma unidade de internação cirúrgica. O instrumento de pesquisa coletou dados referentes a 10 atributos, subdivididos entre as fases do perioperatório, conforme as práticas recomendadas pela SOBECC. Os resultados estão apresentados por frequências absolutas e relativas. O estudo foi aprovado pelo Comitê de Ética em Pesquisa da instituição. **Resultados:** O maior percentual de registros foi totalmente atingido (61,40%). Porém verificou-se que 25,79% dos registros não foram realizados, principalmente aqueles relacionados aos cuidados da enfermagem. **Conclusão:** Conforme as recomendações da SOBECC, observou-se deficiência nos registros e na adesão à SAEP.

Palavras-chave: Assistência de enfermagem. Enfermagem perioperatória. Qualidade da assistência à saúde.

RESUMEN: **Objetivo:** Analizar los registros de la sistematización de la atención de enfermería perioperatoria (SAEP) según lo recomendado por la Asociación Brasileña de Enfermeras del Centro Quirúrgico, Centro de Recuperación Anestésica y Material y Esterilización (SOBECC). **Método:** Estudio descriptivo, documental y cuantitativo desarrollado en agosto de 2018 en un hospital de Rio Grande do Sul. La muestra consistió en 50 registros médicos de pacientes sometidos a procedimientos anestésico-quirúrgicos, seleccionados al azar en una unidad de pacientes internados quirúrgicos. El instrumento de investigación recolectó datos referentes a 10 atributos, subdivididos entre las fases perioperatorias, de acuerdo con las prácticas recomendadas por SOBECC. Los resultados se presentan por frecuencias absolutas y relativas. El estudio fue aprobado por el Comité de Ética en Investigación de la institución. **Resultados:** El porcentaje más alto de registros se logró completamente (61,40%). Sin embargo, se encontró que el 25,79% de los registros no se hicieron, especialmente aquellos relacionados con la atención de enfermería. **Conclusión:** De acuerdo con las recomendaciones de SOBECC, hubo una deficiencia en los registros y el cumplimiento de SAEP.

Palabras clave: Atención de enfermería. Enfermería perioperatoria. Calidad de la atención de salud.

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INTRODUCTION

In patient care, the nursing staff follows a methodological instrument called nursing process (NP). This systematic and humanized instrument is used to guide nursing care[1]. The operationalization of the NP occurs when the nursing care systematization (NCS) is implemented, making the work process more efficient. In the perioperative period, which involves the whole surgical experience of the patient, NP is called the perioperative nursing care systematization (PNCS)[2].

NP is deemed a methodological instrument that guides nursing care and the documentation of the professional practice, improving the quality of care and increasing professional visibility and recognition. This instrument has five stages: nursing history/data collection, nursing diagnosis, nursing care prescription/planning, implementation of nursing care and nursing evolution/evaluation[1].

PNCS is a model that promotes the interaction of care between the pre-, intra-, and postoperative periods, enabling planning and control in each phase of the operative care development. It supports nursing actions within the surgical center (SC) aiming at integrally assisting patients and their relatives, and at providing a quality nursing care[1]. In addition, it promotes an adequate, planned, and founded intervention, focused on the problems of each patient in the perioperative period as well as on the evaluation of results[3].

The perioperative period, according to the Brazilian Society of Surgical, Anesthesia Recovery, Sterilization and Material Center Nurses (SOBECC)[1], can be defined as the time interval that comprises activities developed in each surgical period. It is divided into:

- Mediate preoperative: it begins at the time of surgery definition and extends up to 24 hours before the procedure;
- Immediate preoperative: it begins 24 hours prior to the surgical procedure until patient's admission to the SC;
- Intraoperative: encompasses the period from the moment the patient is welcomed in the SC until they leave the operating room;
- Transoperative: it is inserted in the perioperative period, beginning with the anesthetic-surgical procedure and extending up to its end;
- Postoperative: it comprises the entire period after the anesthetic-surgical procedure, being subdivided into three moments — anesthetic recovery, from the patient's arrival at the post-anesthesia care unit (PACU) to their discharge to the unit of origin; immediate postoperative period, from the end of the anesthetic-surgical procedure up to 24 hours later; and mediate postoperative, after the first 24 hours of the anesthetic-surgical procedure until hospital discharge or the patient's return to their home.

The evaluation of perioperative nursing care should be performed at the end of each period of surgical development, considering patients' satisfaction, activities performed by the nurse, and the team performance, according to the care model defined by both the team and the institution[4].

Most professionals believe that PNCS is indispensable in providing a quality care to patients; however, they face difficulties in implementing it. Such difficulties are related to lack of time, work overload, and the administrative staff, which sometimes does not understand the importance of nurses' performance in patient care over the perioperative period, deviating the professional from their care function to management-related functions[2,5,6].

Authors of studies indicate that the quality of nursing care in the perioperative period interferes with the outcome of the anesthetic-surgical procedure. Thus, we seek to understand the role of nursing in a surgical hospitalization unit, highlighting its relevance to the quality of health care[2].

In Brazil, even with recommendations by SOBECC and the Association of Perioperative Registered Nurses (AORN) regarding the adoption of a care model to guide the nurses' actions in the SC, authorities of most hospitals have not adopted a formal model yet. The planning based on surgery schedule is used, according to which nurses manage material and human resources for predicting and providing the anesthetic-surgical procedure; nevertheless, the major criticism against this model is the lack of records, impairing the planning of individualized care and the adequacy of human and material resources to perform the anesthetic-surgical procedure. Moreover, the lack of records delegitimizes the work developed by the nursing team and does not support nurses in case of legal incidents[4].

Researchers show that, even though the legislation emphasizes the importance of nursing records to document and support the profession, even though these professionals are

aware of such condition, they do not keep quality records, neither consider them as a work instrument, thus hindering its operationalization[7].

According to researchers, there are few studies related to the evaluation of patients and the perioperative care provided, of instruments for records, and of the patients' perception[6]. Thus, we raise the following question: how is NCS being used in the perioperative period?

OBJECTIVE

To analyze records of NCS performed in the perioperative period considering SOBECC's recommendations.

METHOD

This is a descriptive, documentary, and quantitative study that was developed in 2018 based on the analysis of nursing data found in medical records of patients who underwent several anesthetic-surgical procedures at a hospital in the countryside of the state of Rio Grande do Sul, Brazil. This is a philanthropic institution with 138 beds, assisting 70% of its patients via the Brazilian Unified Health System (SUS).

Medical records were randomly selected from a surgical hospitalization unit after patients' hospital discharge. At this institution, 259 surgeries are performed per month on average, and 8 surgeries are performed per day. Thus, for the study, 20% of the medical records of surgeries performed in August 2018 were selected, composing a sample of 50 medical records. We included medical records of patients aging over 20 years of both sexes who underwent several anesthetic-surgical procedures, being medium or high-complexity surgical procedures. We excluded outpatient procedures.

Data were collected through an instrument prepared by the researchers themselves. It consists of ten attributes, subdivided in perioperative phases, according to the practices recommended by SOBECC guidelines[1].

Attributes were sorted into four categories: fully complied with (FC), partially complied with (PC), not complied with (NC), and not applicable (NA). The NA category was used only in cases with no need for performing the respective procedure. Since this is a documentary study, we considered as FC only what had been recorded. Absolute and relative frequencies of attributes were analyzed in Microsoft Office Excel 2013 spreadsheets, which we present as tables.

The study was developed after authorization by the authorities of the research site, through a letter of consent, and approval by the Research Ethics Committee, under Certificate of Presentation for Ethical Consideration (CAAE) no. 93498218.1.0000.5310, in accordance with the National Health Council Resolution no. 466/2012, which regulates research involving human beings[8]. Ethical aspects regarding the confidentiality of the institution's and the patients' identification were respected due to dissemination of the study results.

RESULTS

The preoperative period comprises four attributes. Although the highest frequency in all attributes was for FC, records on the nursing history and diagnoses were fulfilled in over 50% of medical records, according to Table 1. The attribute recorded with the highest frequency was physical examination (88%), while

Table 1. Frequency of records on attributes in the preoperative period.

Procedures	FC		PC		NC		NA	
	N	%	N	%	N	%	N	%
1. History	26	52	3	6	21	42	0	0
2. Physical examination	44	88	6	12	0	0	0	0
3. Identification of nursing diagnoses	26	52	0	0	24	48	0	0
4. Nursing prescription for preoperative and intraoperative periods	31	62	0	0	19	38	0	0
Total	127	63.5	9	4.5	64	32	0	0

FC: fully complied with; PC: partially complied with; NC: not complied with; NA: not applicable.

the total number of attributes recorded in this period accounted for 63.50%.

The intraoperative period is composed of attributes no. 5 with 9 procedures; no. 6 with 15 procedures; and no. 7 with 1 procedure. FC records were found in 57.44% of the medical records, as seen in Table 2. In attribute no. 5, all procedures (100%) were recorded.

Attribute no. 6, which refers to nursing evolution, accounted for the lowest frequency of record, 47.06%. For this attribute, procedures with NC records in over 80% of the medical records were: positioning of the patient during anesthesia and surgery, use of protection pads, type of heating used, and sites for monitoring and placing of electrocautery plate. We found that the highest-frequency records (100%) accounted for procedures of greater interest for physicians and the institution, such as: type of anesthesia, start and end times of anesthetic-surgical procedure, record of materials and equipment used during the anesthetic-surgical procedure, among others.

The record of attribute no. 7, beginning of postoperative nursing prescription at the end of surgery, was NC in 100% of medical records.

The postoperative period comprises attributes no. 8 (with 1 procedure), no. 9 (with 6 procedures), and no. 10 (with 1 procedure), as listed in Table 3. In this period, 72.75% of the records were FC; however, attribute no. 10 was 100% NC.

Although for attribute no. 7 in the intraoperative period, concerning the beginning of postoperative nursing prescription at the end of surgery, the records were NC in 100% of the cases, we considered, for attribute no. 8, records related to the postoperative nursing prescription, even though they were not a continuity of the same prescription.

Considering the entire perioperative period, the highest percentage in the medical records analyzed accounted for FC (61.40%), according to Table 4. Nevertheless, 25.79% of the records were not followed, especially those related to specific nursing care.

Table 2. Frequency of records on attributes in the intraoperative period.

Procedures	FC		PC		NC		NA	
	N	%	N	%	N	%	N	%
5. Care implementation								
Patients' welcoming and identification at the SC	50	100	0	0	0	0	0	0
Measurement of vital signs	50	100	0	0	0	0	0	0
Conducting simplified physical examination	50	100	0	0	0	0	0	0
Producing a checklist	50	100	0	0	0	0	0	0
Placing of electrocautery plate in appropriate site	50	100	0	0	0	0	0	0
Control of blood loss, diuresis, and stomach secretion, when the patient's NGT is open during the surgery	50	100	0	0	0	0	0	0
Urinary catheterization when necessary	10	20	0	0	0	0	40	80
Identification and referral of anatomicopathological sample	5	10	0	0	0	0	45	90
Record of all nursing care provided to the patient	50	100	0	0	0	0	0	0
Total	365	81.11	0	0	0	0	85	18.89
6. The nursing evolution must comprise								
Identification of the patient, the surgical team, circulating nurses, and the nurse	3	6	33	66	14	28	0	0
Start and end times of anesthetic-surgical procedure	50	100	0	0	0	0	0	0
Surgery name	37	74	0	0	13	26	0	0
Type of anesthesia	50	100	0	0	0	0	0	0

Continue...

Table 2. Continuation.

Procedures	FC		PC		NC		NA	
	N	%	N	%	N	%	N	%
Positioning of the patient during anesthesia and surgery	10	20	0	0	40	80	0	0
Use of protection pads	1	2	0	0	49	98	0	0
Type of heating used	0	0	0	0	50	100	0	0
Sites for monitoring and placing the electrocautery plate	4	8	0	0	46	92	0	0
Sites for venous and arterial punctures, drainage, catheter, and type of probes	50	100	0	0	0	0	0	0
Referral of samples and examinations to the laboratory	7	14	0	0	0	0	43	86
Recurrences, whenever the case	8	16	0	0	0	0	42	84
Blood loss and transfusions	8	16	0	0	0	0	42	84
In the very form of the institution, there must be multi-parametric indicators ensuring that the used material was sterilized	50	100	0	0	0	0	0	0
In case of implants, in the form, there must be codes regarding the inserted materials and their expiration date	25	50	0	0	0	0	25	50
Records of materials and equipment used during the anesthetic-surgical procedure	50	100	0	0	0	0	0	0
Total	353	47.06	33	4.40	212	28.27	152	20.27
7. Beginning of postoperative nursing prescription at the end of the surgery	0	0	0	0	50	100	0	0
Overall total	718	57.44	33	2.64	262	20.96	237	18.96

FC: fully complied with; PC: partially complied with; NC: not complied with; NA: not applicable; SC: surgical center; NGT: nasogastric tube.

Table 3. Frequency of records on attributes in the postoperative period.

Procedures	FC		PC		NC		NA	
	N	%	N	%	N	%	N	%
8. Continuity of postoperative nursing prescription	24	48	0	0	26	52	0	0
9. Verification of the patient's clinical conditions				0			0	0
Interview	29	58	0	0	21	42	0	0
Physical examination	38	76	0	0	12	24	0	0
Measurement of vital signs	50	100	0	0	0	0	0	0
Verification of dressing conditions, venous access, and probes or catheters	50	100	0	0	0	0	0	0
Control of water and food intake	50	100	0	0	0	0	0	0
Observation of bladder and intestinal eliminations	50	100	0	0	0	0	0	0
10. Evaluating the provided care, verifying the need for or improvement in any conduct, and the PNCS performance	0	0	0	0	50	100	00	00
Total	291	72.75	0	0	109	27.25	0	0

FC: fully complied with; PC: partially complied with; NC: not complied with; NA: not applicable; PNCS: perioperative nursing care systematization.

Table 4. Frequency of records on the attributes of the perioperative period.

Perioperative Period	FC (%)	PC (%)	NC (%)	NA (%)	N
Total	61.40	2.27	23.52	12.81	50

FC: fully complied with; PC: partially complied with; NC: not complied with; NA: not applicable.

DISCUSSION

Results showed that in the preoperative period, although the percentage of FC attributes have occurred more frequently, there was great inadequacy and need for improvement in nursing care records, since this period refers to the beginning of the perioperative period, which involves the welcoming of patient and relatives, the establishment of bonds, and the preparation for the anesthetic-surgical procedure.

The nursing preoperative visit is the basis of PNCS, and contributes to satisfying the physical and emotional needs of the patient, besides helping decrease levels of stress and anxiety, assisting in overcoming the surgical trauma in recovery, and in resuming well-being. In addition, it helps establishing a bond between professional, patient, and family, enabling a systematized and continuous care directed at each individual in an integral and individualized way, respecting values, experiences, and expectations[9]. In the intraoperative period, care initiatives should be developed by the entire nursing team, meeting the patients' activities and expectations, conveying support and attention, respecting their beliefs, values, fears, and needs with safety, dexterity, and efficacy[1].

Results point to inadequacy of nursing records in general, especially in the following attributes: positioning and protection of the patient on the operating table, heating and temperature maintenance, sites for monitoring and placing electrocautery plate, and identification of the patient and the team. Furthermore, the lack of postoperative nursing prescription at the end of the anesthetic-surgical procedure was evident. These procedures are key for covering a successful and safe surgical period and are the responsibility of all team members. To this end, professionals should be aware, identify risks, and maintain patients' safety, protecting them from trauma and possible adverse events[1].

The whole team involved in the care of a surgical patient is responsible for adopting prevention measures to avoid the aforementioned events. Nurses should be aware of complications, identifying patients at greater risk in the preoperative nursing evaluation, since prevention measures can reduce the risk of associated complications, which involve surgical site infection, bleeding during surgery due to coagulation disorders, cardiovascular diseases, skin lesions, burns, among others[10-12].

Hence, the use of protection resources, such as air mattresses, pads or cushions on the operating table promotes pressure relief, in addition to avoiding friction and preventing skin lesions, neuromuscular compressions or distensions, burns, among other injuries[11,12].

The nursing prescription consists in a set of actions or interventions determined by nurses in order to achieve the expected results for patients to prevent, protect, promote, recover, and maintain their health[1]. Thus, its importance in nursing care and in the PNCS development is clear, regardless of the patient's perioperative period.

Nursing records are key for developing the quality of nursing care, validating the care provided by the team, considering the continuity of care in an individualized and planned manner as well as the safety of patients and the team assisting them. Some studies report that, although records are the only way to analyze professional care, confirm and validate the practice of the nursing team, there is inadequacy in the nursing practice evidenced by notes or records, as well as in the quality of these records, which often contain incomplete notes, thus getting in the way of the nursing audit analysis[7,13].

In the postoperative period, we point out the inadequacy of records concerning the nursing prescription and an evaluation of the care provided. Therefore, we clearly perceived the professionals' major focus on the record of care related to medical procedures rather than care measures for patients' comfort, thus impairing the continuity and quality of care and NP. Likewise, the record on equipment and materials used was also prioritized. According to a study conducted by narrative review, nursing records are performed with abbreviations, in a reduced and incomplete manner, and comprising contents that favor biomedical knowledge[14].

At the SC, based on nursing notes and the prescribed care measures, the use of equipment, materials, and medications is justified. Debts should be recorded in expense notes. Therefore, errors in collections are related to failures in the records by both nursing and medical teams. Hence, nursing notes in medical records are very important for the institution, and are used in audit processes so

one can pinpoint inadequacies in services, raise invoicing, and review disallowances[13,15].

In the postoperative period, based on nursing prescription, the nursing team should provide intensive and semi-intensive care to patients, directed to the recovery of consciousness, stabilization of vital signs, motility, and homeostasis[1]. The nursing postoperative visit is the stage that completes the NP in the SC, the moment when failures and the success of the care provided in the preoperative and intraoperative periods are evaluated, that is, the care evaluation. Thus, the visit outstands as a method for evaluating the provided care, aiming at following the quality requirements according to patient's or the technical objectives established[4].

Previous studies have reported nurses' difficulties regarding NCS implementation being justified by work overload, deviation of function, lack of understanding and knowledge by the professionals themselves, or institutional reasons[16,17]. According to researchers[2], low adherence to PNCS may be related to the professionals' low demand for updating on the subject, and demotivation and lack of stimulus by the institution. Moreover, the same authors demonstrated that only one stage of PNCS had been performed, which was the preoperative visit.

We highlight the importance of nurses' awareness regarding the need for nursing records and the NCS implementation. Nurses should avoid activities that are not part of their functions and commit to better working conditions, which enables fulfilling nursing records, making systematization active[16].

Within this context, professionals need to constantly update themselves, aiming at the qualification of clinical and critical reasoning, essential to implementing the NP, ensuring a safe and quality care. It is important that the nursing professionals working at the SC propose the NP implementation daily and adequately, since, in some cases, this instrument is applied in a fragmented way, disconnected from reality[18].

It is noteworthy that the NCS and PNCS implementation is a requirement of the Federal Nursing Council, and that "the records support the nursing care provided to the patient in the SC"[1]. According to Law No. 8.078[19], the professional and/or the institution are responsible for confirming the performance of adequate patient care, free of risks and damages.

CONCLUSION

According to SOBECC's recommendations for nurses in the perioperative period, based on the analysis of nursing records, there was inadequacy in the records and adherence to PNCS, considering the high technology available in the market nowadays and legislation requirements.

It was evident that care measures related to medical procedures were the most recorded, at the expense of the record of care concerning patients' comfort. Similarly, records on equipment and materials were also found to be prioritized.

As a limitation of this study, we highlight that it is based on records only instead of direct observations. Therefore, it is impossible to conclude whether the procedure was not completed or if its fulfilling was not accurate.

Thus, we emphasize the completion of nursing records, as well as the need for professional qualification, considering the legal support of nurses' work, the professional satisfaction and recognition, contributing to the better quality of nursing care provided to patients and their relatives.

The need for nurses to prioritize the development of care provided to patients and family members over other specific nursing functions is noteworthy, rejecting activities that are not part of their functions, considering NP validation and NCS implementation.

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