

Manual for monitoring the quality of nursing home care records

Manual de monitoramento da qualidade dos registros de enfermagem na assistência domiciliar
Manual de monitoreo de la calidad de los registros de enfermería en la atención domiciliar

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ABSTRACT

Objective: to build and validate an instrument aimed at monitoring the quality of nursing records in the Home Care Program (HCP) of a university hospital. **Method:** methodological study involving the elaboration of a manual, whose content was later submitted to six experts for validation, reaching a $\geq 80\%$ consensus. The data collection process was carried out in 2012 by means of a questionnaire comprised of the following issues: nursing evolution, nursing diagnosis, and nursing prescription, and standards for the nursing team recommended by the Regional Nursing Council of São Paulo and by the assessed institution. Manual items were judged according to the following variables: relevance, pertinence, clarity and simplicity. **Results:** of the 39 propositions, 100% achieved $\geq 80\%$ agreement in the relevance, pertinence and clarity variables; 92.3% in the simplicity variable. Sleep/rest, Mobility and Check-out variables did not reach a favorable minimum consensus in the prescribed activities and were improved following suggestions from the experts. **Conclusion:** we believe that the instrument will enable the improvement of the HCP's work process.

Key words: Home Nursing; Information Management; Nursing.

RESUMO

Objetivo: construir e validar um instrumento para monitorar a qualidade dos registros de enfermagem no Programa de Assistência Domiciliar (PAD) em um hospital universitário. **Método:** estudo metodológico envolvendo a elaboração de um manual e submetido à validação de conteúdo por seis juízes sob consenso $\geq 80\%$. A coleta ocorreu em 2012 por meio de questionário contendo: evolução de enfermagem, diagnóstico e prescrição de enfermagem e normas para os registros da equipe de enfermagem preconizadas pelo Conselho Regional de Enfermagem-SP e pela instituição. Os itens do manual foram julgados de acordo com as variáveis - relevância, pertinência, clareza e simplicidade. **Resultados:** das 39 proposições 100% atingiram consenso $\geq 80\%$ em relevância, pertinência e clareza; 92,3% em simplicidade. Os itens sono/repouso, mobilidade e checagem nas atividades prescritas não atingiram consenso mínimo favorável, sendo aprimorados pelas sugestões dos juízes. **Conclusão:** acreditamos que o instrumento possibilitará a melhoria dos processos de trabalho no PAD.

Descritores: Assistência Domiciliar; Gerenciamento de Informação; Enfermagem.

RESUMEN

Objetivo: construir y validar un instrumento para monitorear la calidad del registros de enfermería en Programa de Atención Domiciliar (PAD) de un Hospital Universitario. **Metodo:** estudio metodológico. Fue construido un manual y sometió a validación de contenido por seis jueces bajo el consenso $\geq 80\%$. La recogida currió en 2012, con un cuestionario que contiene: evolución de enfermería, diagnóstico y prescripción de enfermería y normas para los registros del personal de enfermaria establecidas por Consejo Regional de Enfermería-SP y por la institución. Los artículos del manual fueran juzgado conforme las variables relevancia, pertinencia, claridad y sencillez. **Resultados:** de las 39 proposiciones 100% alcanzó consenso $\geq 80\%$

en la relevancia, pertinencia y claridad; 92,3% en la simplicidad. Los ítems sueño/resto, movilidad y verificar las actividades prescritas no alcanzó consenso favorable, siendo mejoradas por las sugerencias de los jueces. **Conclusión:** creemos que el instrumento permitirá la mejora de los procesos de trabajo en PAD.

Palabras clave: Cuidado en el Hogar; Gestión de la Información; Enfermería.

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INTRODUCTION

The conceptual definition of “quality” and the strategies toward achieving it have been gradually transforming lately, and new meanings have been incorporated. However, such issue has not received the attention it deserves in the home care area, thus hindering the establishment of parameters that can meet quality demands.

Quality stands out as a social product represented by conceptions and values, as well as expectations concerning the correlations between patients and service providers, and the way such roles are carried out by these players in the health system. In this sense, the assurance of quality care consists of a permanent effort toward improving healthcare conditions by means of a continuous surveillance and assessment of the health framework, process and results⁽¹⁾.

In the nursing service, the quality management area is expected to ensure that improvements are steadily brought to the rendered care. Such action is achieved by the employment of evaluating measurements, in such a way that the identification of non-conformities in the execution of health care processes is favored, thus enabling work procedures to be readapted and improved, aiming at meeting the needs and expectations of patients and consequently the achievement of the desired quality⁽²⁻³⁾.

The home care area - consisting of a set of programmed outpatient-based activities executed by means of preventive care actions, and counting on a multiprofessional team, which, whenever necessary, also provides emergency care or transport - does not escape from this reality. Healthcare procedures are carried out at the patient’s home following the diagnosis of the reality in which the patient is inserted⁽⁴⁾.

The purposes of this model are as follows: to diminish the patient’s hospitalization time, hence optimizing the use of hospital beds; to prevent re-hospitalization processes, thus decreasing the risk of infections; to orient caregivers and family members; to promote the participation of families in the patient’s daily activities, thus reinserting the patient into the social-family environment; to improve the patient’s quality of life, as well as that of his/her relatives; and to offer opportunities for the continuing education of healthcare professionals in this specific type of care⁽⁵⁾.

The nursing practice represents one of the major pillars of such care modality. For this purpose, care records are indispensable for the legitimization of all actions performed by healthcare professionals toward the patient and his/her family. These actions should be made clear, objective and readable, in order to guarantee effective communication between the nursing team and the multiprofessional team involved in the

care process. Additionally, such actions may serve as source of information in legal, research and educational issues⁽⁶⁾.

Due to these reasons, nursing records need to comply with established norms, taking into account their ethical and legal aspects, as nursing records are part of the nursing team’s legal obligations. Any mistake must be corrected in accordance with the norms recommended by the institution. It is worth highlighting that these records may also serve as facilitators and may be determinant in court proceedings⁽⁷⁾.

At the University of São Paulo’s teaching hospital (HU-USP), the Nursing Department adopted the Nursing Care System (NCS) as the methodology applied to safe and quality care. The NCS is carried out in four phases, namely: nursing history, diagnosis, evolution and prescription, based on the rendered nursing care⁽⁸⁾.

In the Home Care Program (HCP), the scenario of the present study, nursing evolution and prescriptions have a two-fold development. One remains in the patient’s home record, and the other is forwarded to the record of the HU-USP. The content of prescriptions is legitimized by both the nurse and caregivers/family members, and the document is valid up to the next consultation⁽⁹⁾.

A study carried out at the referred program, aimed at analyzing the quality of nursing records at the HU-USP’s HCP, observed that although the reports were adequately filled in, most of the assessed items were incomplete. The research also verified that only half of the records showed a readable handwriting, which may lead to mistaken interpretations of the information contained in the nursing records and thus compromise the quality of the rendered care⁽¹⁰⁾.

Aiming to minimize the consequences of non-conformities in face of the nursing records, the professional may employ evaluative instruments grounded on theoretical, scientific and practical tools in order to monitor the quality of the rendered care⁽¹¹⁾.

The construction of instruments directed to assess the quality of nursing care should systematically monitor the service practice, aiming at generating both quality and quantity of nursing care⁽¹²⁾.

Hence, we realized that there still is a long pathway to be covered toward assessing and guaranteeing that nursing records are a reflection of care models and of a type of care that allows for monitoring the quality of nursing services.

Bearing the aforementioned facts in mind, the purpose of this study was to contribute to the assessment of the quality of nursing records, specifically at the HCP-USP, by means of the construction and validation of an operational manual aimed at the creation of care and managerial indicators in the home care area.

OBJECTIVE

To build and validate an instrument for the surveillance of the quality of nursing records in the Home Care Program of the University of São Paulo's teaching hospital.

METHOD

This methodological applied study was approved by the research ethics committee of the HU-USP 997/10, as per protocol SISNEP – CAAE 0015.0198.196-10. This type of study proposes investigations on potential methods toward achieving, organizing and analyzing data, thus addressing the elaboration, validation and assessment of instruments and techniques⁽¹³⁾.

The research was carried out at the HU-USP, a state institution connected with the University of São Paulo's Dean's Office, a secondary level health reference with the mission of stimulating and promoting teaching, research and socially-based programs to the community.

The HCP was created in 2002 and adopted home care as its care modality. Patients and families who comply with the program's criteria receive the visit of healthcare teams at home. The team evaluates the physical structure of the house and the family's social and economic condition, and defines the periodicity of visits, which occur from Monday through Friday⁽¹⁴⁾.

The instrument named Operational Manual, built by the researchers, was grounded on the NCS developed by the nurses of the HU-USP, as well as on the results of a study related to the quality of the nursing records carried out at the HCP-USP⁽¹⁰⁾.

The data collection process took place between March and April of 2012 through a questionnaire comprised of the following issues: characterization of the professional and assessment of the materials produced by nursing records.

The validity of a given instrument is related to the accuracy with which it is able to measure what it is proposed to. The major employed techniques involve the validity of contents, appearance, criterion and construct⁽¹³⁾.

The present study addressed the validity of contents, which determines the representation of items expressing a given content based on the assessment of experts in a certain area of knowledge. This type of validation will determine whether or not the instrument's content will effectively explore the requirements toward the measurement of the researched phenomenon⁽¹⁵⁾.

The validation of a content results from converging opinions from the participants, known as group consensus. Therefore, a minimum content validation index (CVI) – also known as consensus index or favorability - must be established. The present research had the literature review as its reference, and consensus was defined as \geq than 80%⁽¹⁵⁾.

The sample was comprised of six nurses, thus constituting an intentional sample⁽¹⁶⁾, which prioritizes the experience and knowledge of subjects. The experts had vast experience in the HC area and in the teaching and quality services, and participated in the HCP's planning and implementation, as well as in training programs to nursing professionals. Each item of the instrument was assessed in accordance with the following criteria: Relevance - meaningful to the nursing care quality; Clarity

- understandable, expressions are objective and unequivocal; Pertinence – reproduces the recommendations of the NCS, the institution's Nursing Department and the Nursing Regional Council of São Paulo (COREN-SP); and Simplicity – expresses one single idea, with no possibility of diverse interpretations.

By means of personal contact, professionals were educated on the study's objectives and methodology, and a deadline was set for them to deliver the contents to be assessed. All experts accepted to participate in the study. In addition, they received the Operational Manual to be analyzed, two copies of the free and informed consent form, and established a 30-day deadline for the contents to be returned. Only one participant did not return the material.

Resulting data were organized in an electronic sheet and subsequently analyzed based on their descriptive statistics. Relative and absolute frequencies were employed to the quantitative variables, and mean, median and standard deviation were applied to qualitative variables.

RESULTS

In the characterization of the experts, all participants were women, with a mean age of 52 years ($SD \pm 4.38$), median of 53 years; their mean time of graduation was 29.2 years ($SD \pm 4.91$), median of 30 years. From the total amount of participants, three worked in the teaching and quality services and three at the Home Care Program. As per their position or function, five participants were nurses and one was a nursing department director. The researchers noticed a predominance of experts with *stricto sensu* graduate degrees, corresponding to four masters and one doctoral degree.

Table 1 shows that from all 15 variables involving the nursing diagnosis, prescription and evolution, 12 (80%) reached maximum consensus (100%), except for the check out prescribed activities item, which presented a percentage lower than 80% in the simplicity attribute (66.7%). This same item led one expert to suggest the replacement of the verb *round* for the expression *make a circle*.

The identification of the nursing diagnosis and prescription variables achieved 83.3% in the clarity attribute. The judges suggested an improvement to the first attribute, namely: point out the defining characteristics in accordance with the patient's healthcare need.

It is worth highlighting that both proposals were accepted by the author.

As per the 13 propositions suggested by the nursing evolution variable, Table 2 shows that the majority (61.6%) achieved 100% consensus. The condition of the residence and emotional status variables displayed 83.3% and the sleep, rest and mobility variables reached a CVI of 80% in the simplicity attribute. There was no suggestion for improvement.

Analysis of Table 3 indicates that from all 11 propositions related to the norms recommended by the COREN-SP and by the institution concerning the nursing record, 9 (81.8%) presented 100% consensus among the experts. The two remaining ones referred to a graphic mistake in the clarity and simplicity attributes, as well as their correction. It should be

Table 1 - Consensus among experts concerning nursing records – nursing diagnosis and prescription in the hospitalization of patients at the HCP, HU-USP, São Paulo, 2012

Manual's items	Relevance		Clarity				Pertinence				Simplicity					
	Yes		No		Yes		No		Yes		No		Yes		No	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Patient identification	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Identification of nursing diagnosis	6	100	0	0	5	83.3	1	16.7	6	100	0	0	6	100	0	0
Date of nursing diagnosis	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Nursing evolution	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Record of probes, catheters and others	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Record of vital signals	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Signature after nursing diagnosis	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Stamp after nursing diagnosis	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Identification of nursing prescription	6	100	0	0	5	83.3	1	16.7	6	100	0	0	6	100	0	0
Record of prescribed activities (nursing or family)	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Check out prescribed activities	6	100	0	0	6	100	0	0	6	100	0	0	4	66.7	2	33.3
Date of nursing prescription	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
There is at least one nursing prescription for each nursing diagnosis	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Signature after nursing prescription	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Stamp after nursing prescription	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0

Table 2 - Consensus of experts concerning the nursing evolution at the time of the hospitalization of patients, HCP, HU-USP, São Paulo, 2012

Manual's items	Relevance		Clarity				Pertinence				Simplicity					
	Yes		No		Yes		No		Yes		No		Yes		No	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Patient's identification data	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
First assessment home visit	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Previous history	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Home conditions	6	100	0	0	6	100	0	0	6	100	0	0	5	83.3	1	16.7
Medical diagnosis at hospitalization	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Family structure (caregiver)	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Physical exam	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Emotional status	6	100	0	0	6	100	0	0	6	100	0	0	5	83.3	1	16.7
Communication sources	6	100	0	0	5	83.3	1	16.7	6	100	0	0	6	100	1	16.7
Food	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Elimination	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Sleep and rest	6	100	0	0	5	83.3	1	16.7	6	100	0	0	4	66.7	2	33.3
Mobility	6	100	0	0	5	83.3	1	16.7	6	100	0	0	4	66.7	2	33.3

Table 3 - Consensus among experts concerning the nursing records at the time of hospitalization of patients at the HCP, HU-USP, São Paulo, 2012

Manual's items	Relevance		Clarity				Pertinence				Simplicity					
	Yes		No		Yes		No		Yes		No		Yes		No	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Clear information	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Objective information	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Readable handwriting	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Blank lines or spaces	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Information written with a pen	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Date of first home visit	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Time of first home visit	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Signature	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Stamp	6	100	0	0	6	100	0	0	6	100	0	0	6	100	0	0
Erasure	6	100	0	0	5	83.3	1	16.7	6	100	0	0	5	83.3	1	16.7
Adequate erasure correction	6	100	0	0	5	83.3	1	16.7	6	100	0	0	5	83.3	1	16.7

highlighted that all items reached a CVI $\geq 80\%$ in all four attributes.

The restricted Operational Manual shown below complies with the suggestions of the experts, and counts on the addition of the source of information and qualification criteria phases.

A) OPERATIONAL MANUAL TO MONITOR THE QUALITY OF NURSING RECORDS AT THE HCP, HU-USP

Part I – Data collection of the nursing evolution variable at the time of hospitalization of patients at the HCP

1. Patient's identification data: patient's full name and age;
2. First assessment visit: the first assessment home visit must display patient, family and home data (the HCP's care tripod);
3. Previous history: patient's previous disease history;
4. Home conditions: home's physical structure (hygiene conditions, healthiness, lighting, ventilation, access staircase) and physical structure on the way to the house (paved street, hill, close to water streams);
5. Medical diagnosis for hospitalization: major pathology responsible for the patient's hospitalization at the HCP;
6. Family structure (caregiver): main person responsible for the patient's caregiving process (primary caregiver);
7. Physical exam: cephalocaudal exam to assess alterations in each system;
8. Emotional status: patient's psychoaffective and mental conditions;
9. Communication ways: verbal and non-verbal expressions the patient employs to communicate (adapt the tool in accordance with growth and development, in case of children);
10. Food: ways through which patient ingests solids, liquids and medications;

11. Elimination: patient wears diapers, makes use of probes, ostomy or the toilet basin;
12. Sleep and rest: refers to the quality and quantity of rest and sleep during day time and night time;
13. Mobility: refers to in-bed patients and those who make/do not make use of any type of locomotive support (adapt the tool in accordance with growth and development, in case of children).

Part II – Nursing records at the time of hospitalization of patients comply with the recommendations of the COREN-SP or the institution's Nursing Department – teaching hospital of the University of São Paulo (HU-USP).

1. Information is clearly written: the content is adequately understood;
2. Information is objectively written: information must be synthesized, concise, specific and complete;
3. Readable handwriting: handwriting can be easily read;
4. Blank lines or spaces: nursing records neither skip lines nor leave blank spaces;
5. Information is written with a pen: nursing records were written with a pen;
6. Date of first home visit: date must contain day, month and year;
7. Time of the first home visit: the document must contain the exact time of the home visit, not the period of the day (morning or afternoon);
8. Signature: a signature of the professional who performed the visit must follow the nursing record, without leaving blank spaces. In case a student performed the visit, the document must be signed by the student and the responsible nurse;
9. Stamp: a stamp must follow the nursing record, without leaving blank spaces. In case a student performed

the visit, the document must be stamped by the responsible nurse;

10. Erasures: mistakes made during the writing process;
11. Adequate correction of erasures: if a mistake was made, the correction was adequately carried out without compromising the legal value of the record.

Part III – Nursing diagnosis, evolution and prescription

1. Patient's identification data: patient's full name and age;
2. Identification of nursing diagnosis: nursing diagnosis, number corresponding to the diagnosis, and defining characteristics must be somehow identified by means of circles, lines or other signals;
3. Date of nursing diagnosis: date must contain day, month and year;
4. Nursing evolution: identify which nursing diagnoses are present at the first home visit. In case of the Braden Scale, take note of the total corresponding value;
5. Record of probes, catheters and others: identify whether the patient makes use of a probe, catheter or ostomy; identify whether the patient suffers from ulcer pressure – if affirmative, take note of the stage; identify whether the patient makes use of hydrocolloid dressing – if affirmative, take note of the region;
6. Record of vital signals: take note of vital signals (blood pressure, breathing, pulse and pain. At the HCP, temperature is only recorded for children and complaining patients);
7. Signature following nursing diagnosis: a signature of the professional who performed the diagnosis must follow the nursing record. In case a student performed the diagnosis, the document must be signed by the student and the responsible nurse;
8. Stamp following nursing diagnosis: a stamp must follow the nursing diagnosis. In case a student performed the diagnosis, the document must be stamped by the responsible nurse.
9. Identification of nursing prescription: nursing prescription and the corresponding number of such prescription must be somehow identified by means of circles, lines or other signals;
10. Record of prescribed activities (nursing professional or family): activities prescribed by the nurse must identify if the family or the nurse should carry them;
11. Check out prescribed activities: check out which activities were carried out or signal those which were not – in this case, identify the reason;
12. Date of nursing prescription: date must contain day, month and year;
13. There is at least one nursing prescription for each nursing diagnosis: for each identified nursing diagnosis there has to be at least one nursing prescription (activity) to be carried out;
14. Signature following nursing prescription: a signature of the professional who recorded the nursing prescription must follow the nursing record. In case a

student performed it, the document must be signed by the student and the responsible nurse.

15. Stamp following nursing prescription: nursing prescription must contain the stamp of the professional who recorded it. In case a student performed it, the document must be stamped by the responsible nurse;
16. Information source: assessment of nursing records related to the first home visit described in the reports of patients cared for at the Home Care Program;
17. Qualification criteria for all 39 items variables contained in the three portions of the Operational Manual: employed legend: C (conformity) – whenever the record complies with recommendations; NC (non-conformity) – whenever the record does not comply with reference parameters or whenever there is no record.

DISCUSSION

The length of training of the experts approached by the present study meets the selection criteria for the experts, or in other words, express their professional and academic experience^(11,15,17). All experts invested in their professional qualification and development and were skilled enough to validate the instruments aimed at monitoring the quality of nursing records.

Nursing records in patients' reports are indispensable elements both concerning the nursing communication sphere and ethical and legal aspects. These data are aimed at the following objectives: to establish a communication process between the nursing team and the multiprofessional team involved in patient care and in the continuity of the care process; to subsidize the elaboration of care plans; to assess the quality of rendered services; to follow up the evolution of the participants in the program; to represent a legal document both for patients and the institution; and to be a source of information in auditing, teaching and research processes⁽¹⁸⁾.

Nursing records articulate the legal duties of the occupation; additionally, being a legal document, they should not contain any erasure. In case corrections are made necessary, they should occur in compliance with the norms and guidelines established by the institution and by COREN-SP's, in order to guarantee their reliability and legality⁽⁶⁾.

In addition, nursing records stand out as a quality monitoring instrument of the rendered care and the communication of the nursing professional team; as such, the writing, structure and content of data are expected to be accurate⁽¹¹⁾.

Certain healthcare records, such as sleep, rest and mobility displayed low conformity indexes as a result of inaccurate and incomplete information in the patient's hospitalization reports filled in by the nurses, thus indicating that professionals have difficulties to fill them in⁽¹⁰⁾. The subjectivity of these needs leads us to highlight that they should be expressed based on concrete quantity and quality features, as this fact may influence the nurse's assessment.

In the present study, we showed that items such as sleep, rest and mobility presented consensus indexes of nearly 67%

in the simplicity and clarity attributes. This finding may be a result of the subjectivity involved in the detection and interpretation of health needs related to the patient's psychoemotional and social aspects.

It is up to the nurse to identify alterations in the sleep and rest pattern of patients while operating the NCS, as sleep disorders bring about daily damages to the patient's environment and health. Signs, such as attention deficits, memory damages, irritability, increase of pain, and reduction of response speed may point out low quality sleep and rest. In face of such information, the nursing practice may promote actions toward providing support to these disorders, thus contributing to the improvement of the patient's clinical status⁽¹⁹⁾.

Another vulnerability in the validation of the instrument was the verification of prescribed care. The nursing prescription represents an instrument that enables a clinical rationale and the individualization of the rendered care, thus encouraging nurses to question and modify their practice⁽⁸⁾.

The systematization of the nursing care stands out as a scientific instrument that promotes care planning and the conducts of nurses. The nursing prescription is one of the phases in this process. Whenever properly carried out, it favors the quality of the rendered care, as it subsidizes promotion, prevention, recovery and rehabilitation health actions to individuals, besides providing professionals with autonomy⁽²⁰⁾.

Surveillance instruments to nursing records are a crucial step, as they allow for the evaluation of the quality of nursing records, which must be systematized and have the maximum amount of information possible concerning the rendered care. Additionally, they enable the planning of future actions and serve as a tool toward monitoring and assessing the rendered care⁽²¹⁾.

In this sense, the quality of nursing records must be valued and incorporated to managerial and care processes of nursing professionals.

CONCLUSION

The results achieved by this research showed that the participating nurses were committed to the study, bearing in mind the high percentage of professionals who returned the instrument filled in. The participants were predominantly females with more than 29 years since graduation, and who invested in their professional development.

The Operational Manual was validated by experts, as the CVI reached 100% for the majority of the criteria.

Taking into account that the alterations suggested by the professionals did not modify the interpretation of the assessed component, they were carried out without being once again forwarded to the experts. The sleep, rest, mobility and check out prescribed activities in the nursing prescription variables deserve more attention on the part of nurses working at the HCP.

The creation of an instrument toward monitoring the quality of nursing records stands out as a major challenge. It should be added that the employment of the Operational Manual will allow for the identification of a series of problems that may be solved with the establishment of immediate corrective measures, such as the sensitization of the nursing team toward quality care and the training programs carried out by the continuing education service.

Hence, we believe that the findings of the present study will certainly contribute to the improvement of care practices, as well as to ratify the relevance of the construction, validation and implementation of operational manuals capable of establishing quality standards in healthcare services.

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