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Compliance of Nursing Records on Pressure Injuries in Primary Health Care in a Municipality in Amazonas, Brazil**

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ABSTRACT

Objective: To analyze the technical and formal compliance of nursing records related to pressure injury assessment in primary health care, considering current regulatory, ethical, and scientific standards. **Method:** A descriptive documentary study with a quantitative approach was conducted at a Family Health Unit in the state of Amazonas, Brazil, from October to December 2024. Data were collected by the researchers through medical record reviews using a previously developed checklist. **Results:** Appropriate terminology was used in 78.6% of the records. Writing errors were identified in 42.9% of the medical records, while the use of correction fluid was observed in 14.3%. No records containing blank spaces were identified. **Conclusion:** The findings demonstrated that most nursing records related to pressure injuries in primary health care complied with the assessed standards. However, documentation weaknesses were identified, highlighting the need to implement educational initiatives aimed at improving the quality of nursing records.

DESCRIPTORS: Primary Health Care. Nursing Records. Stomatherapy.

Conformidade dos registros de enfermagem sobre lesão por pressão na atenção primária em um município amazonense

RESUMO

Objetivo: Analisar a conformidade técnico-formal dos registros de enfermagem na avaliação de lesões por pressão na atenção primária à saúde, considerando critérios normativos, éticos e científicos vigentes. **Método:** Estudo documental, descritivo, com abordagem quantitativa, realizado em uma Unidade de Saúde da Família localizada no estado do Amazonas, de outubro a dezembro de 2024. Os dados foram coletados pelos pesquisadores por meio da análise de prontuários, utilizando um instrumento do tipo *checklist* previamente elaborado. **Resultados:** Observou-se o uso adequado de terminologia em 78,6% dos registros. Erros gráficos estiveram presentes em 42,9% dos prontuários, enquanto o uso de corretivos foi identificado em 14,3%. Não foram encontrados registros com espaços em branco. **Conclusão:** Os achados evidenciaram, em sua maioria, conformidade nos registros de enfermagem relacionados a lesões por pressão na atenção básica. Entretanto, identificaram-se fragilidades que apontam para a necessidade de implementação de ações educativas voltadas à qualificação dos registros.

DESCRITORES: Atenção primária à saúde. Registros de enfermagem. Estomaterapia.

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Conformidad de los registros de enfermería sobre lesiones por presión en la atención primaria de salud de un municipio de Amazonas, Brasil

RESUMEN

Objetivo: Analizar la conformidad técnico-formal de los registros de enfermería relacionados con la evaluación de lesiones por presión en la atención primaria de salud, considerando los criterios normativos, éticos y científicos vigentes. **Método:** Estudio documental, descriptivo, con enfoque cuantitativo, realizado en una Unidad de Salud de la Familia ubicada en el estado de Amazonas, Brasil, entre octubre y diciembre de 2024. Los datos fueron recopilados por los investigadores mediante la revisión de historias clínicas, utilizando una lista de verificación previamente elaborada. **Resultados:** Se observó un uso adecuado de la terminología en el 78,6% de los registros. Se identificaron errores de escritura en el 42,9% de las historias clínicas, mientras que el uso de líquidos correctores se detectó en el 14,3%. No se encontraron registros con espacios en blanco. **Conclusión:** Los hallazgos evidenciaron que la mayoría de los registros de enfermería relacionados con las lesiones por presión en la atención primaria de salud cumplían con los criterios evaluados. Sin embargo, se identificaron deficiencias en la documentación que ponen de manifiesto la necesidad de implementar acciones educativas orientadas a mejorar la calidad de los registros de enfermería.

DESCRIPTORES: Atención Primaria de Salud. Registros de Enfermería. Estomaterapia.

INTRODUCTION

Over the past few years, there has been a significant increase in the global incidence of pressure injuries (PIs). These injuries are defined as damage to the integrity of the skin, underlying tissues, and/or structures caused by sustained or prolonged pressure. PIs are classified according to their depth and the degree of tissue involvement presented by the patient. Accordingly, they are categorized as Stage 1, Stage 2, Stage 3, and Stage 4 pressure injuries; deep tissue pressure injuries; unstageable pressure injuries; medical device-related pressure injuries; and mucosal membrane pressure injuries[1].

Although PIs constitute a major public health problem, associated with increased morbidity and mortality and high healthcare costs, they are largely preventable through the use of risk assessment tools, continuing education, and appropriate documentation of patients' health status and the care provided[2-5].

In this context, primary health care (PHC), due to its close connection with local territories and communities, plays a central role in the care of individuals with PIs. This care is provided comprehensively by the PHC multidisciplinary team, particularly nurses, who play a fundamental role in the prevention, identification, classification, treatment, and monitoring of PI progression[5].

As the first point of access to the Brazilian Unified Health System (SUS), PHC represents an important setting for the care of individuals with skin injuries, who require individualized attention both in healthcare facilities and at home. Continuity of care at this level of healthcare facilitates patient education, treatment, and monitoring of wound progression, highlighting the importance of nursing care in this context[6].

Thus, the quality of nursing documentation is essential, as its evaluation makes it possible to identify weaknesses in work processes and support improvements in care delivery[5,7]. Resolution No. 514/2016 of the Brazilian Federal Nursing Council (COFEN) establishes guidelines for nursing documentation practices, aiming to standardize and ensure the quality of information recorded in patient medical records. These records facilitate communication among healthcare professionals, contribute to the organization of care, and provide a basis for teaching, research, auditing, legal protection, and statistical analyses[7,8].

In this regard, within the PHC context, the findings of this study revealed gaps in the documentation of essential information related to PIs, particularly concerning the detailed description of wound characteristics. Similar findings were

reported in a hospital-based study, in which the absence of essential information about PIs was identified as a barrier to documentation quality. Strategies such as protocol reviews, nursing staff training, and leadership support were implemented to improve documentation practices[9,10].

Despite the importance of nursing documentation for effective care delivery, studies addressing the quality of nursing records related to PIs in PHC remain scarce, particularly in the Amazon region.

In the Amazon region, access to healthcare services may be influenced by factors such as distance, travel time, available transportation, and difficulties in obtaining healthcare[11].

These territorial specificities reinforce the need for complete and high-quality nursing documentation, particularly in PHC, where documentation is essential to ensuring continuity of care and communication among healthcare professionals.

Recognizing the importance of nursing documentation for effective care delivery, as well as the scarcity of studies on this topic, it is essential to analyze the quality and compliance of the information recorded by healthcare professionals to identify potential weaknesses and contribute to improving nursing care documentation in PHC.

OBJECTIVES

To analyze the technical and formal compliance of nursing documentation in the assessment of pressure injuries in primary health care, considering current regulatory, ethical, and scientific standards.

METHODS

This is a descriptive, quantitative documentary study conducted through a secondary analysis of nursing records obtained from a previous study entitled "Evaluation of Nursing Records Made by Primary Health Care Nurses in the Assessment of Pressure Injuries."While the original study aimed to evaluate nursing records completed by nurses in the context of pressure injury assessment, the present analysis was based on previously collected documentary data, focusing on the assessment of the compliance and formal quality of these records.

The reporting of this study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines, as recommended by the EQUATOR Network.

The study was conducted at a Family Health Unit (FHU) located in a municipality in the central region of the state of Amazonas, Brazil, situated along the middle Solimões River. Access to the municipality is provided by river and air transportation[11]. According to the 2022 Demographic Census conducted by the Brazilian Institute of Geography and Statistics (IBGE), the municipality has a population of 70,616 inhabitants and a territorial area of 57,970.77 km^2[12]. The unit was intentionally selected due to its extensive territorial coverage.

Eligible records included the medical charts of patients aged 18 years or older who received care at PHC units and had documentation related to PI assessment between October and December 2024. Medical charts lacking sufficient information to apply the criteria established in the data collection instrument were considered ineligible. Initially, 19 medical charts were identified, of which 14 were included in the study and five were excluded because they contained only records completed by nursing technicians. In the 14 medical charts included, nursing progress notes and nursing notes related to PI assessment were analyzed, with each medical chart considered a unit of analysis. All nursing records documented by registered nurses in each medical chart were considered, regardless of the number of records available.

The data collection instrument consisted of a checklist developed by the researchers as part of a research subproject, based on criteria established in the scientific literature and on current resolutions and regulations issued by the COFEN regarding standards and requirements for nursing documentation. The instrument included variables related to the use of appropriate terminology, the presence of writing errors, incomprehensible or incomplete information and blank spaces, clarity and coherence of records, the use of correction fluid and abbreviations, and professional identification through a

stamp and signature. Each item was assessed according to the presence or absence of the corresponding criterion, based on the parameters previously established in the checklist. Before the final data collection, the checklist underwent a pilot test (pretest) to assess the clarity, comprehensibility, and applicability of its items. No modifications to the instrument were necessary following this stage, and its original version was retained for data collection.

After the medical records were reviewed, the data were organized into a database and subjected to descriptive statistical analysis, with absolute and relative frequencies presented for the variables analyzed. Data processing was performed using the Statistical Package for the Social Sciences (SPSS), version 23.0. The results were presented in tables to describe the frequency of aspects related to the quality and compliance of nursing documentation.

The project was submitted to the Research Ethics Committee (REC) of the Federal University of Amazonas, in accordance with the guidelines established by the National Health Council and the ethical principles set forth in Resolution No. 466/2012, which governs research involving human participants in Brazil. The study was approved by the REC under approval No. 7,086,068.

RESULTS

A total of 14 medical records were analyzed, considering nursing documentation related to PI assessments performed by nurses. The results are presented descriptively, based on the number of medical records analyzed.

Appropriate use of terminology was observed in 11 of the 14 medical records analyzed (78.6%), whereas the remaining three (21.4%) showed inappropriate use of terminology. Regarding writing errors, these were identified in 6 (42.9%) medical records, while 8 (57.1%) showed no such occurrences (Table 1).

The use of correction fluid was identified in 2 (14.3%) of the 14 medical records, whereas 12 (85.7%) showed no such occurrences. Regarding the presence of blank spaces, no records containing this issue were identified among the medical records analyzed, corresponding to 14 (100.0%) (Table 2).

Clarity of nursing notes was identified in 10 (71.4%) medical records, whereas 4 (28.6%) did not meet this criterion. Regarding coherence, 11 (78.6%) medical records contained coherent documentation, while 3 (21.4%) contained records considered incoherent (Table 3).

Incomprehensible information was identified in 5 (35.7%) of the 14 medical records, whereas 9 (64.3%) showed no such occurrences. Regarding documentation completeness, 5 (35.7%) medical records contained incomplete information, while 9 (64.3%) showed no such occurrences (Table 4).

Standardized abbreviations were observed in 11 (78.6%) of the 14 medical records analyzed, whereas 3 (21.4%) showed no standardization of the abbreviations used. Regarding professional identification, 11 (78.6%) medical records contained a professional stamp and signature, while 3 (21.4%) did not include these elements (Table 5).

Table 1. Use of terminology and writing errors. Amazonas (AM), Brazil, 2024.

Use of terminology	**Frequency (n)**	**Percentage (%)**
Yes	11	78.6
No	3	21.4
Total	14	100.0
Writing errors	**Frequency (n)**	**Percentage (%)**
Yes	6	42.9
No	8	57.1
Total	14	100.0

Source: Research data, 2024.

Table 2. Use of correction fluid and presence of blank spaces. Amazonas (AM), Brazil, 2024.

Use of correction fluid	Frequency (n)	Percentage (%)
Yes	2	14.3
No	12	85.7
Total	14	100.0
Presence of blank spaces	**Frequency (n)**	**Percentage (%)**
No	14	100.0
Total	14	100.0

Source: Research data, 2024.

Table 3. Clarity of nursing notes and coherence. Amazonas (AM), Brazil, 2024.

Clarity of nursing notes	Frequency (n)	Percentage (%)
Yes	10	71.4
No	4	28.6
Total	14	100.0
Coherence	**Frequency (n)**	**Percentage (%)**
Yes	11	78.6
No	3	21.4
Total	14	100.0

Source: Research data, 2024.

Table 4. Incomprehensible and incomplete information. Amazonas (AM), Brazil, 2024.

Incomprehensible information	Frequency (n)	Percentage (%)
Yes	5	35.7
No	9	64.3
Total	14	100.0
Incomplete information	**Frequency (n)**	**Percentage (%)**
Yes	5	35.7
No	9	64.3
Total	14	100.0

n: number of medical records analyzed.
Source: Research data, 2024.

Table 5. Use of standardized abbreviations and professional stamp/signature. Amazonas (AM), Brazil, 2024.

Use of standardized abbreviations	Frequency (n)	Percentage (%)
Yes	11	78.6
No	3	21.4
Total	14	100.0
Professional stamp/signature	**Frequency (n)**	**Percentage (%)**
Yes	11	78.6
No	3	21.4
Total	14	100.0

n: number of medical records analyzed.
Source: Research data, 2024.

DISCUSSION

Nursing records constitute an important communication tool for healthcare professionals and a means of documenting the care provided, contributing to continuity of care and the security of patient information. In PHC, nursing documentation is particularly important because it enables the longitudinal monitoring of patients and the sharing of information among different healthcare professionals and levels of the healthcare network involved in patient care. In this context, aspects related to the formal quality of documentation, such as clarity, coherence, appropriate terminology, and professional identification, are essential for effective communication and continuity of care[13].

The appropriate use of technical terminology observed in the present study may be related to healthcare professionals' knowledge of nursing-specific language and health documentation practices. However, the occurrence of inappropriate terminology and writing errors highlights weaknesses in the formal aspects of documentation. Studies indicate that deficiencies in written records may compromise the understanding of information and affect their documentary and legal validity[7,14].

The occurrence of writing errors may be related to several factors, such as work overload, limited time for documentation, failure to review information before finalizing records, and weaknesses in professional training or continuing education regarding nursing documentation. However, since this was a documentary analysis, the present study does not allow the causes of these findings to be determined. Therefore, these factors should be understood as possible explanations reported in the literature rather than as causes directly established by the data from this study.

Regarding the use of correction fluid, the identified occurrence highlights the need to reinforce guidance on appropriate corrections in nursing records. Professional regulations establish criteria to ensure that any corrections preserve the integrity and traceability of documented information. A previous study also identified the use of correction fluid and the presence of blank spaces as aspects related to documentation quality and record integrity[9].

On the other hand, the absence of blank spaces observed in the present study should be understood as a specific aspect of the way documentation is completed and cannot, by itself, be associated with information completeness. The absence of blank spaces and informational completeness are distinct aspects, since a record may contain no physical gaps and still lack sufficient information to adequately document the care provided.

Regarding the clarity and coherence of nursing records, the findings indicate that these aspects were present in most of the medical records analyzed. However, the identification of unclear documentation and information considered inconsistent in some medical records demonstrates that certain formal aspects still require attention. This finding is relevant to care documentation, considering that unclear or inconsistent records may hinder the understanding of information by healthcare professionals who access the medical records. In this regard, COFEN emphasizes the need for objective, clear, and organized documentation, while also highlighting problems related to lack of clarity, disorganized information, and the use of nonstandardized abbreviations[15].

The presence of incomprehensible and incomplete information warrants attention in the context of pressure injury assessment and follow-up. Incomplete records may limit the retrieval of information regarding wound condition, progression, and the interventions implemented throughout follow-up. This finding highlights a documentation weakness that may hinder communication among healthcare professionals and the continuity of care-related information.

This issue may be particularly important in PHC, especially when patients require follow-up by different healthcare professionals or services. In the Amazon region, territorial characteristics, distances between communities, and transportation challenges may make documentation an important source of information for the healthcare team, particularly when continuity of care at home is required. However, the present study did not directly assess working conditions, territorial characteristics, or healthcare professionals' perceptions; therefore, it is not possible to establish a causal relationship between the Amazonian context and the identified documentation deficiencies.

Regarding the use of standardized abbreviations, this criterion was observed in most of the medical records analyzed. This finding demonstrates the adoption of standardized abbreviation practices in the records evaluated. However, the

presence of nonstandardized abbreviations in some medical records warrants attention, considering that their use may hinder the understanding of information by other healthcare professionals. The literature highlights that improperly used or nonstandardized abbreviations may contribute to communication failures and compromise the interpretation of nursing records[8].

Regarding professional identification, the presence of a professional stamp and signature was observed in most of the medical records analyzed, whereas some records lacked these elements. This finding indicates that, although professional identification was present in most records, deficiencies in this aspect of documentation were still observed. Identification through a professional stamp and signature is important for recognizing the professional responsible for the documentation and ensuring the traceability of recorded information, as established by current professional regulations, including COFEN Resolution No. 514/2016.

Overall, the findings reveal the coexistence of appropriate practices and weaknesses in the formal quality of the nursing records analyzed. The identified deficiencies reinforce the importance of ongoing professional development initiatives, particularly regarding knowledge of documentation standards and the incorporation of clear, coherent, and comprehensive documentation practices into routine nursing care.

Study Limitations

The present study has limitations related to its context and design, particularly the small sample size associated with the investigation being conducted at a single FHU. Although the unit was selected because of its extensive territorial coverage, which consequently allowed access to a broader set of records within the study context, conducting the investigation in a single healthcare service limits the diversity of care settings represented and requires caution when generalizing the findings to other PHC units and contexts.

Regarding the instrument used, the checklist was structured based on technical and formal, regulatory, ethical, and scientific criteria relevant to the assessment of nursing records related to PIs. However, no specific formal validation of the instrument was performed, which should be considered when interpreting the results.

As this was a documentary investigation, the findings reflect the information available and actually documented in the medical records during the period analyzed. Therefore, the absence of specific information in the records does not necessarily indicate that the corresponding care was not provided, but rather demonstrates documentary noncompliance according to the criteria adopted. Thus, the results allow for an assessment of the technical and formal compliance of nursing records but do not, in isolation, support inferences regarding the overall quality of care provided.

Recommendations

Based on the findings, strengthening continuing nursing education initiatives aimed at improving documentation related to PI assessment is recommended, with an emphasis on information completeness, standardization of technical and scientific language, appropriate use of terminology, and formal accuracy of nursing notes.

Strengthening institutional protocols and tools to guide PI assessment documentation is also recommended, addressing essential documentation elements and aspects related to the use of abbreviations, corrections, and professional identification, in accordance with current regulations.

Periodic audits of nursing records are suggested as a strategy for monitoring documentation compliance, identifying weaknesses, and evaluating the effects of implemented educational initiatives.

Finally, considering the specific characteristics of the setting investigated, multicenter studies involving larger sample sizes and different PHC services are recommended to broaden the understanding of the technical and formal compliance of nursing records related to PI assessment across diverse healthcare settings.

CONCLUSION

The present analysis made it possible to identify the technical and formal compliance of nursing records related to PI assessment, revealing greater adequacy in certain aspects of documentation and weaknesses in others. The findings indicate that, although elements that promote clarity, coherence, and appropriate documentation are present, certain documentation aspects still require improvement, particularly those related to the completeness of recorded information.

In this regard, the results reinforce the importance of continuing nursing education as a strategy for improving care documentation and strengthening the use of nursing records as tools for communication, continuity of care, and professional protection.

Future studies should expand the number of units and settings investigated, encompassing different PHC contexts, as well as develop and validate specific instruments to enable standardized and comparable assessments of the compliance of nursing records related to PIs.

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Research Data Availability: All data were generated or analyzed from the research project entitled "Evaluation of Nursing Records Made by Primary Health Care Nurses in the Assessment of Pressure Injuries."

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