Abstract

Nursing records are all systematized registers made by the nursing team, with legal and ethical implications on research, patient safety and communication among health professionals. This quantitative and retrospective cross-sectional study was conducted in a school hospital dedicated to the woman’s care, aiming at evaluating by auditing the quality of the nursing records. The 168 medical records were evaluated according to the standard established by the literature and the legislation of the Professional Council from January to June 2011. The importance of early contact with the patient, incomplete records or lack of information on the assistance rendered, besides nonconformities related to what is expected, were identified. The conclusion is that there is the need of periodic evaluations of the quality of the records and discussions on the results with the nursing team, on its importance regarding legislation, literature and the safety of patients.

Keywords

Nursing Records, Nursing Assessment, Nursing Care.