

AUDITING THE QUALITY OF NURSING CARE THROUGH HOSPITAL RECORDS

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Abstract: The quality and completeness of nursing records are fundamental for traceability of care, patient safety, and care management. This study aimed to analyze the quality of nursing records in the medical records of patients hospitalized in a university hospital in Northeast Brazil, through a retrospective audit. This is a descriptive, cross-sectional, quantitative, and documentary study, carried out based on the audit of 151 medical records of patients hospitalized in 11 clinical-surgical units, between December 2022 and February 2023. Data collection was carried out between June 2024 and December 2025 by nurses from the Nursing Division, using a structured instrument. Data

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were analyzed using descriptive statistics and the McNemar test for paired comparison of record completeness between the first and fourth day of hospitalization. Low quality nursing notes were identified, classified as fair in 47.0% and poor in 46.4% of the medical records, as well as vital sign records, classified as fair in 60.9% and poor in 31.1%. Although nursing progress notes were present in 95.4% of the medical records, nursing diagnosis (9.9%), implementation (4.6%), and nursing evaluation (4.6%) were poorly documented, highlighting weaknesses in the continuity of the Nursing Process. The completeness of daily progress notes decreased from 74.2% on the first day to 46.4% on the fourth day of hospitalization ($p < 0.001$). Gaps were also observed in the application of risk scales, especially the Fugulin Scale, absent in 84.1% of the medical records, followed by the Morse (30.5%) and Braden (27.8%) scales. The findings reveal a pattern of documentary fragility that intensifies throughout hospitalization, compromising the traceability of care, patient safety, and support for decisions related to care and workforce sizing. Strengthening continuing education is recommended, especially during periods of higher risk of under-documentation, coupled with systematic monitoring of quality indicators through periodic audits. These measures can contribute to improving nursing documentation and supporting the management of care in hospital institutions.

Keywords: Nursing Audit. Quality of Healthcare. Nursing Process.

INTRODUCTION

Nursing records are the main instrument through which the Nursing Process becomes visible, verifiable and subject to evaluation, documenting the stages of care provided and translating, in technical language, the clinical reasoning and professional judgment of the nurse. Inserted in the patient's medical record, the main instrument of communication among the professionals who are part of the health team, with legal, care, administrative and teaching and research purposes, these records constitute a primary source of information for the continuity of care, for auditing and for the evaluation of the quality of care provided, so that their documentary quality works, in the final



analysis, as an indirect indicator of the quality of nursing care itself. Studies on auditing nursing records indicate that, although documentation is sometimes criticized for evaluating the record and not directly evaluating the care provided, there is a positive correlation between the quality of records and the quality of nursing care, which justifies the audit of medical records as a strategy for indirect evaluation of care (SETZ; D'INNOCENZO, 2009).

In Brazil, the registration of professional nursing actions is regulated by the Federal Nursing Council (COFEN), which, through COFEN Resolution No. 429/2012, provides for the registration of professional actions in the patient's medical record and in other nursing documents, regardless of the means of support, traditional or electronic (COFEN, 2012). At the same time, the Systematization of Nursing Care (NCS) organizes professional work in terms of method, personnel and instruments, making it possible to operationalize the Nursing Process (BARROS; LOPES, 2010). During the period to which the records analyzed in this study refer, the NCS and the Nursing Process were regulated by COFEN Resolution No. 358/2009, which organized the Nursing Process into five interrelated, interdependent, and recurrent stages: data collection (or nursing history), nursing diagnosis, nursing planning, implementation, and nursing evaluation (COFEN, 2009). This resolution was later revoked by COFEN Resolution No. 736/2024, which updated the regulation and redefined the stages of the Nursing Process as evaluation, diagnosis, planning, implementation, and evolution, without changing the requirement for systematic and deliberate documentation of care in all environments in which professional nursing practice occurs (COFEN, 2024a).

The quality of nursing records has direct implications for patient safety. The Ministry of Health instituted, through Ordinance No. 529/2013, the National Patient Safety Program (PNSP), structured based on six international safety goals that include, among others, the correct identification of the patient, the improvement of communication between health professionals, and the reduction of the risk of falls and pressure injuries (BRASIL, 2013). The institution of this program resulted, among other factors, from the recognition that Brazil lacked systematic mechanisms for reporting and monitoring care incidents, many of which were associated with communication and recording failures



among health professionals (CAPUCHO; CASSIANI, 2013). Nursing documentation constitutes the informational support that evidences the fulfillment of these goals, so that incomplete or low-quality records compromise the traceability of care and hinder the early identification of care risks. In this sense, risk assessment instruments widely used in Brazilian hospital nursing practice, such as the Braden Scale for pressure injury risk, adapted and validated for Portuguese by Paranhos and Santos (1999), the Morse Scale for fall risk, developed by Morse (2009), and the Fugulin Scale for classifying the degree of dependence of patients in relation to nursing care, developed by Fugulin, Gaidzinski and Kurcgant (2005), depend on the systematic recording of their scores and classifications so that they fulfill their function of supporting clinical and managerial decisions.

The Fugulin Scale, specifically, in addition to its function in identifying care risks, constitutes the technical basis for the dimensioning of the nursing staff (FUGULIN; GAIDZINSKI; KURCGANT, 2005), currently regulated by COFEN Resolution No. 743/2024 and Normative Opinion No. 1/2024/COFEN, which establish minimum parameters of nursing hours per patient according to the degree of dependence identified by the Patient Classification System (COFEN, 2024b, 2024c). The absence of systematic recording of this scale, therefore, not only compromises individual care, but also the institution's ability to technically support the planning of the nursing workforce.

Nursing auditing, understood as the systematic and critical analysis of the records produced by the nursing team, is recognized in the national literature as a relevant tool for identifying documentary weaknesses and proposing strategies for continuous improvement of care quality (LOPES; ASCARI, 2016). Brazilian studies conducted in teaching hospitals and public hospitals in different regions of the country have repeatedly shown weaknesses in the completeness of nursing records, especially in the stages that are more dependent on nurses' clinical reasoning, such as nursing diagnosis and assessment, even though the evolution stage, which is more descriptive, has a higher frequency of completion (SETZ; D'INNOCENZO, 2009; SILVA et al., 2019; DODO et al., 2020). A more recent study, conducted in a large hospital in the Midwest region, reinforced this panorama by identifying low quality scores for all dimensions of the Nursing Process: diagnosis, interventions, and outcomes,



with statistically significant variation between the different inpatient units of the same institution (PIMENTEL et al., 2023), which suggests that document fragility does not result only from individual factors of professionals, but also from specific organizational determinants of each care unit. These findings reinforce the need for periodic audits as an instrument for managing the quality of care in teaching hospitals, particularly those linked to the network of Federal University Hospitals, in which the quality of documentation is also relevant for teaching, research, and hospital accreditation processes.

In view of this scenario, the present study aimed to analyze the quality of nursing records in the medical records of patients hospitalized in a university hospital in the Northeast of Brazil, through a structured retrospective audit, characterizing the completeness and quality of nursing notes, vital signs records, risk assessment instruments and stages of the Nursing Process, in order to support the management of care quality and the prioritization of continuing education strategies in the institution studied.

METHOD

Study design and setting

This is a descriptive, cross-sectional, quantitative study, with a documentary design, carried out from a retrospective audit of medical records of patients hospitalized in a federal university hospital in the Northeast of Brazil, which is part of the Federal University Hospitals Network. The study was conducted within the scope of the institution's nursing care quality management, as part of the activities of monitoring quality indicators of nursing records conducted by the Nursing Division.

Population, sample and collection period

The study population consisted of medical records of patients hospitalized in eleven clinical-



surgical hospitalization units of the institution, identified in this study by alphanumeric coding (Unit 1 to Unit 11) in order to preserve the identification of care units, referring to hospitalizations with admission date concentrated between December 2022 and February 2023. The analyzed sample corresponded to 151 different medical records; data collection was carried out between the years 2024 and 2025, treated in this study as a single cross-sectional sample, since all records refer to the same universe of hospitalizations that occurred between December 2022 and February 2023 and were collected with the same structured instrument, with no change in criteria between the collection periods.

Instrument and variables analyzed

Data were collected using a structured electronic instrument, applied to each audited medical record. Information regarding the hospitalization sector, admission and discharge dates, and identification of the nurse responsible for the record were evaluated. Nursing evolution was analyzed in the first four days of hospitalization (1st to 4th IHL), considering eight systemic domains: general, neurological, respiratory, circulatory, digestive, nutritional, genitourinary, and locomotor status. In addition to complementary aspects, such as length of hospitalization, eliminations, catheterizations, probes, drains, care performed, prescribed conducts, new problems identified, and application of scales.

The quality of dressing records, nursing notes and vital signs were also evaluated, classified as good, regular, poor, not evaluated or not applicable, according to the item. Risk classification was verified using the Braden, Morse and Fugulin Scales. In addition, checklists were used to verify the presence of the components of the Nursing Process: evolution, diagnosis, planning, implementation and evaluation, as well as records related to precautions and patient safety, intra- and intersectoral transfers and referrals. The instrument also included the verification of records of venous access, fluid control, dressings and nursing discharge.



Data analysis

The data were exported to an electronic spreadsheet and processed and analyzed in a Python programming environment, with descriptive statistics. Categorical variables were expressed in absolute and relative frequencies. The variable length of hospital stay was calculated by the difference between the dates of admission and discharge and expressed as mean, standard deviation, median, and interquartile range. For the multiple-choice variables (checklists), the frequency of each item was calculated in relation to the total of 151 audit records, assuming that the same medical record could present more than one item simultaneously. To analyze the completeness of the daily nursing evolutions, the mean number of items recorded per evolution and the proportion of evolutions in which the eight systemic domains evaluated were fully documented were calculated for each of the four days of hospitalization analyzed; additionally, to test whether the variation in completeness between the first and fourth days of hospitalization (same sampling unit, measured at two moments) was statistically significant, the McNemar test was applied for categorical paired data, with continuity correction and calculation of the exact p-value, adopting a significance level of 5% ($\alpha = 0.05$). During the data consistency check, a typing inconsistency was identified in one of the 151 records (discharge date prior to the date of admission), which was excluded exclusively from the calculation of the length of hospital stay, being maintained in the other analyses, as it did not compromise the other variables; this inconsistency is discussed as a limitation of the study.

Ethical aspects

The study was conducted based on data from medical records audited already collected within the scope of the institution's nursing care quality management, with the purpose of internal monitoring of care indicators, under the authorization and supervision of the Nursing Division. The data were treated in aggregate and anonymized form for the purposes of this analysis, without nominal



identification of patients or care professionals in the results presented. The project was submitted to and approved by the Research Ethics Committee of the institution, in accordance with the Resolution of the National Health Council No. 466/2012 and its complementary Opinions, under Consolidated Opinion No. 5.047.322 and CAAE No. 51228621.2.0000.8807.

RESULTS

Sample characterization

A total of 151 records from the medical records of patients hospitalized between December 2022 and February 2023 were analyzed, distributed in eleven clinical-surgical hospitalization units, identified in this study by alphanumeric coding (Unit 1 to Unit 11) to preserve the identification of the care units. Unit 1 concentrated the largest number of audited records (22; 14.6%), followed by Units 2 (20; 13.2%) and 3 (19; 12.6%); the other units had between 8 and 17 records each (Table 1).

The length of hospital stay, calculated based on the dates of admission and discharge in the medical records, had a median of 3 days (interquartile range: 2 to 3.75 days) and a mean of 4.46 days (standard deviation of 5.20 days), ranging from 1 to 35 days, calculated on 150 of the 151 records; one record was excluded from this analysis because it had a discharge date prior to the date of admission, a typing inconsistency discussed in the limitations section of the study.

Table 1 – Distribution of audit records according to detention unit

Inpatient unit	n	%
Unit 1	22	14,6
Unit 2	20	13,2
Unit 3	19	12,6
Unit 4	17	11,3
Unit 5	14	9,3
Unit 6	13	8,6
Unit 7	11	7,3



Unit 8	10	6,6
Unit 9	9	6,0
Unit 10	8	5,3
Unit 11	8	5,3

Source: prepared by the authors (2026).

Quality of dressing records, nursing notes and vital signs

Nursing records were classified as regular in 71 medical records (47.0%) and poor in 70 (46.4%), with only 10 (6.6%) classified as good; that is, 93.4% of the audited medical records presented nursing records with quality below what was considered adequate by the audit instrument. The recording of vital signs showed a similar pattern, with 60.9% of the records classified as regular and 31.1% as poor, totaling 92.0% of records not fully adequate, and only 7.9% classified as good. Regarding dressing records, 74 of the 151 medical records (49.0%) had an indication for an applicable dressing; among these, 59 (79.7% of the applicable tests) were classified as poor, 12 (16.2%) as regular and only 3 (4.1%) as good, constituting the item with the worst relative performance among those evaluated when considering exclusively the cases in which the item was pertinent to the patient's clinical condition (Table 2).

Table 2 – Classification quality attributed to dressing records, nursing notes and vital signs records

Rated Item	Category	n	%
Dressing Records	Bad	59	39,1
	Regular	12	7,9
	Good	3	2,0
	Not applicable	77	51,0
Nursing notes	Bad	70	46,4
	Regular	71	47,0
	Good	10	6,6



Vital signs recording	Bad	47	31,1
	Regular	92	60,9
	Good	12	7,9

Source: prepared by the authors (2026).

Registration of risk assessment scales

The registration of the risk assessment scales presented the most critical standard among the items audited. The Fugulin Scale, used to classify the degree of dependence of the patient in relation to nursing care and the technical basis of personnel sizing, was not recorded in 127 of the 151 medical records (84.1%); among the medical records recorded, 18 (11.9% of the total) were classified as minimum care, 5 (3.3%) as intermediate care, and only 1 (0.7%) as high dependence. The Morse Scale, used to assess the risk of falls, was not recorded in 46 medical records (30.5%); among those evaluated, 48 (31.8%) were classified as non-risk, 42 (27.8%) as moderate risk, and 15 (9.9%) as high risk. The Braden Scale, used to assess the risk of pressure ulcers, had the lowest proportion of no records among the three scales, although it was significant: 42 medical records (27.8%) did not have a recorded classification; among those evaluated, 92 (60.9%) were classified as low risk, 13 (8.6%) as moderate risk and 4 (2.6%) as high risk (Table 3).

Table 3 – Risk classification recorded on the Braden, Morse and Fugulin Scales

Scale	Category	n	%
Braden (pressure injury risk)	Not rated	42	27,8
	Low risk (>17)	92	60,9
	Moderate risk (13–16)	13	8,6
	High risk (<12)	4	2,6
Morse (risk of falling)	Not rated	46	30,5
	Risk-free (0–24)	48	31,8
	Moderate risk (25–44)	42	27,8
	High risk (>45)	15	9,9



Fugulin (degree of dependence)	Not rated	127	84,1
	Minimal care (12–17)	18	11,9
	Intermediate Care (18–22)	5	3,3
	High dependency (23–28)	1	0,7

Source: prepared by the authors (2026).

Recording of the stages of the Nursing Process

Regarding the stages of the Nursing Process identified in the audit checklist, nursing evolution was the most frequently present item, appearing in 144 of the 151 medical records (95.4%). Nursing planning was identified in 93 medical records (61.6%). The other stages, which were more dependent on the nurse's clinical reasoning, had a substantially lower frequency: the nursing diagnosis was included in only 15 medical records (9.9%), implementation in 7 (4.6%) and nursing evaluation in 7 (4.6%). In 6 medical records (4.0%), none of the items of the Nursing Process were present (Table 4).

Table 4 – Nursing Process Items identified in the audit checklist

Item	n	%
Evolution of nursing	144	95,4
Nursing planning	93	61,6
Nursing diagnosis	15	9,9
Nursing Implementation	7	4,6
Nursing evaluation	7	4,6
No record of any items	6	4,0

Source: prepared by the authors (2026).

Note: percentages do not add up to 100% because each medical record can present more than one item.



Precautionary items, patient safety, transfer, and general checklist

Among the items related to precautions and patient safety, the registration of the identification bracelet was the most frequent (125; 82.8%), followed by the registered controls (94; 62.3%). The recording of vital signs in all shifts was present in 66 medical records (43.7%) and the recording of nursing notes in all shifts in only 41 (27.2%); infection prevention measures were included in 23 medical records (15.2%). Regarding the record of transfer or referral, 48 medical records (31.8%) did not have any record of the item, even though the transfer was pertinent to the case, which represents the largest proportional gap between the checklists analyzed. In the general checklist, the record of venous access (103; 68.2%) and fluid control (97; 64.2%) were the most frequent items, while the record of dressings (34; 22.5%) and, above all, the record of nursing discharge by the nurse (54; 35.8%) or by the nursing technician/assistant (42; 27.8%), showed reduced frequency; in 15 medical records (9.9%) no item from the general checklist was present (Table 5).

Table 5 – Precautionary and patient safety items, transfer log, and general checklist identified in the audit checklist

Item	n	%
Precautions and patient safety		
ID Wristband Registration	125	82,8
Registered controls	94	62,3
Vital signs in all shifts	66	43,7
Nursing notes on all shifts	41	27,2
Infection prevention measures	23	15,2
No record of any items	7	4,6
Transfer Logging/Forwarding		
No registration (where applicable)	48	31,8
Readmission to the operating room	44	29,1
Not applicable	39	25,8
Referral to the operating room	26	17,2
Intersectoral referral (exams/consultations/transfer)	20	13,2
General checklist		



Venous access logging	103	68,2
Water control	97	64,2
Nurse discharge record	54	35,8
Registration of discharge by the technician/assistant	42	27,8
Dressing registration	34	22,5
No record of any items	15	9,9

Source: prepared by the authors (2026).

Note: percentages do not add up to 100% within each group because each medical record may have more than one item.

Completeness of nursing evolution over the first four days of hospitalization

The analysis of the completeness of the content of the nursing outcomes recorded in the first four days of hospitalization (1st to 4th IHL) showed a progressive decline in both the presence and completeness of the records over the days of hospitalization. On the first day, 9 medical records (6.0%) did not show any recorded evolution, a proportion that increased to 11 (7.3%) on the second day, 32 (21.2%) on the third day and 66 (43.7%) on the fourth day. The mean number of items documented by evolution followed this downward trend, from 9.68 items (standard deviation of 3.62) on the first day to 5.95 items (standard deviation of 5.61) on the fourth day. Consequently, the proportion of evolutions in which the eight systemic domains evaluated (general, neurological, respiratory, circulatory, digestive, nutritional, genitourinary, and locomotor status) were fully documented fell from 74.2% on the first day to 46.4% on the fourth day (Table 6). Of the total of 151 medical records, 55 (36.4%) presented completeness on the first day that was not repeated on the fourth day, whereas only 13 (8.6%) presented the inverse pattern (incomplete on the first day and complete on the fourth); this asymmetry was tested by the McNemar test for paired data, which confirmed that this was a statistically significant difference, and not a random variation (χ^2 with continuity correction = 24.72; $p < 0.001$). Of the total number of medical records audited, 78 (51.7%) had recorded evolution on all four days evaluated, and



only 3 medical records (2.0%) had no evolution recorded on the four days analyzed.

Table 6 – Completeness of nursing evolution from the 1st to the 4th day of hospitalization (IHL) (n = 151)

Day of hospitalization	Missing developments n (%)	Average Registered Items (SD)	Developments with the 8 full domains n (%)
1st IHL	9 (6,0%)	9,68 (3,62)	112 (74,2%)
2nd IHL	11 (7,3%)	10,13 (3,84)	117 (77,5%)
3rd IHL	32 (21,2%)	8,61 (5,05)	104 (68,9%)
4th IHL	66 (43,7%)	5,95 (5,61)	70 (46,4%)

Source: prepared by the authors (2026).

Note: the difference in completeness between the 1st and 4th IHL was statistically significant (McNemar's test, $\chi^2 = 24.72$; $p < 0.001$).

DISCUSSION

The findings of this audit show that the quality of nursing records in the university hospital studied presented relevant weaknesses, converging with what the national literature has repeatedly described in retrospective audits of medical records carried out in Brazilian hospitals, including in more recent publications. The study by Setz and D'Innocenzo (2009), carried out in a university hospital in São Paulo, identified that 26.7% of the medical records analyzed had nursing records classified as poor and 64.6% as regular, with only 8.7% classified as good; the magnitude of these proportions is close to that observed for the nursing records in the present study (46.4% poor and 47.0% regular), suggesting that documentary weaknesses of this nature are not a one-off phenomenon, but a persistent pattern in the production of nursing records in Brazilian hospital records, even when the studies are conducted in different institutions, regions and periods. In the same direction, Dodo et al. (2020), in an audit of 248 medical records from a public hospital in the northern region of Brazil, classified only 25.9% of the records as complete, with 67.1% incomplete, an even more critical result than that



observed in the present study and which reinforces the persistence of the problem even in publications from the 2020s. Similarly, Silva et al. (2019), in an audit conducted at a university hospital in Salvador, identified weaknesses in the checking of nursing prescriptions, concluding that the quality of the records only partially met the recommendations of COFEN, a finding qualitatively consistent with what was observed in this study for the set of items on the general checklist and precautions.

The most significant finding of this audit refers to the discontinuity of the stages of the Nursing Process: while the evolution of nursing, a predominantly descriptive stage, was present in 95.4% of the medical records, the stages of diagnosis (9.9%), implementation (4.6%) and nursing evaluation (4.6%) were recorded in a substantially smaller proportion. This pattern is consistent with that described by Pimentel et al. (2023), who, when evaluating 258 medical records from a large hospital in the Midwest region with the Quality of Diagnoses, Interventions and Outcomes instrument, validated for Brazil, identified low mean scores for both nursing diagnoses as a process and as a product, and for the dimensions of nursing interventions and outcomes, with a statistically significant difference between the hospitalization units analyzed ($p < 0.001$). The convergence between the two studies, carried out in different institutions and regions, suggests that the discontinuity of documented clinical reasoning; present in the evolution, but absent in the diagnosis and evaluation, it is not an institutional particularity, but a structural pattern of nursing documentation in Brazilian hospitals. This pattern suggests that the nursing care provided was not being fully documented in the light of the methodological model in force at the time of the audited hospitalizations, which, according to COFEN Resolution No. 358/2009, then in force, provided for the organization of the Nursing Process in five interrelated, interdependent and recurrent stages: data collection, diagnosis, planning, implementation and nursing evaluation (COFEN, 2009). The concentration of records in the stages of evolution and, to a lesser extent, planning, without the corresponding record of diagnostic reasoning and evaluation of the results achieved, compromises the formal demonstration of the nurse's clinical judgment and reduces the visibility of the contribution of nursing to the outcomes of care, a purpose that the COFEN regulation itself attributed to the documented operationalization of the Nursing Process (COFEN,



2009). The update promoted by COFEN Resolution No. 736/2024, which began to structure the Nursing Process in evaluation, diagnosis, planning, implementation, and evolution, maintains this requirement for systematic documentation of all stages (COFEN, 2024a), so that the identified weakness remains relevant for the current care practice and for any new audits of the institution.

The progressive decline in the completeness of nursing outcomes over the first four days of hospitalization from 74.2% of outcomes with the eight complete systemic domains on the first day to 46.4% on the fourth day, associated with an increase in the proportion of days without any recorded evolution, from 6.0% to 43.7%, is an original finding of this study. Contrary to a simple sample oscillation, this decrease was statistically significant when tested in a paired manner by the McNemar test (χ^2 with continuity correction = 24.72; $p < 0.001$), which allows us to state, with statistical rigor, that the probability of a medical record losing completeness between the first and fourth days was significantly higher than the probability of the reverse movement. This pattern suggests a real discontinuity of documented care throughout hospitalization, potentially related to the nursing team's work overload, the variation in care complexity throughout hospitalization, or gaps in the culture of systematic recording regardless of the patient's length of stay. This finding is compatible with the national literature, which associates the fragility of nursing records with the high demand for care in relation to the number of professionals available (LOPES; ASCARI, 2016), and reinforces the relevance of personnel dimensioning instruments based on patient classification systems (FUGULIN; GAIDZINSKI; KURCGANT, 2005), since underdocumentation tends to be more pronounced on hospitalization days when, presumably, the team's workload is more intense.

The low frequency of recording risk assessment scales is another finding with direct implications for patient safety and nursing care management. The lack of registration of the Fugulin Scale in 84.1% of the medical records is particularly relevant because this scale constitutes, in Brazil, the main Patient Classification System used to support the dimensioning of the nursing staff (FUGULIN; GAIDZINSKI; KURCGANT, 2005), currently governed by COFEN Resolution No. 743/2024 and Normative Opinion No. 1/2024/COFEN, which establish minimum parameters for hours of care per



patient according to the degree of dependence identified (COFEN, 2024b, 2024c). The documentary underuse of this instrument compromises the institution's ability to technically demonstrate the adequacy of the staff to the care needs of hospitalized patients, with potential repercussions on the technical responsibility of the nurse responsible for the service. Similarly, the lack of recording of the Braden Scales (PARANHOS; SANTOS, 1999) and Morse (MORSE, 2009) in 27.8% and 30.5% of the medical records, respectively, compromises the fulfillment of patient safety goals related to the prevention of pressure injuries and falls, incorporated into the National Patient Safety Program since its inception by Ordinance No. 529/2013 of the Ministry of Health (BRASIL, 2013). The documentary gap identified may mask both the actual underuse of the instruments and their application without the corresponding formal record.

The record of intra- and intersectoral transfer or referral presented the largest proportional gap between the checklists analyzed, with 31.8% of the medical records without any record of the item when it was pertinent to the case. Secure communication during the transition of care is one of the international patient safety goals incorporated into the National Patient Safety Program (BRASIL, 2013), and the national literature points out that communication and registration failures between health professionals are among the causes most frequently associated with incidents and adverse care events (CAPUCHO; CASSIANI, 2013), which gives additional relevance to this finding, particularly in a large hospital institution, with multiple hospitalization units and an intense flow of intersectoral referrals, as evidenced by the sample distribution of this study, in which 14 medical records were audited in more than one unit as a result of patient transfer during hospitalization.

Among the precautionary and patient safety items, the registration of the identification bracelet had the highest relative frequency (82.8%), which is consistent with the historical prioritization of this goal as the first of the six international patient safety goals adopted by the Ministry of Health, aimed at the correct identification of the patient before the provision of any care (BRASIL, 2013). Even so, the persistence of 17.2% of medical records without this basic record indicates that the goal of safe patient identification, despite being widely disseminated institutionally, was not fully consolidated in



the documentation of the nursing team in the period analyzed.

The limitations of the present study include: the documental and retrospective design, which depends on the quality of the data collection of the audit originally carried out and does not allow us to infer whether the absence of records corresponds to the effective absence of care or only to the failure of documentation; the impossibility of evaluating interobserver agreement among the three nurses of the Nursing Division (COPENF) responsible for data collection, which may introduce variability in judgment between the records qualitatively classified as good, regular or poor; the identification of a typing inconsistency in the original database (date of discharge prior to the date of admission in one of the 151 records), treated by means of punctual exclusion from the respective analysis, which reinforces the need for consistency validation routines at the time of data collection the use of McNemar's test restricted to the comparison between the first and fourth days of hospitalization, without modeling the complete trajectory of completeness over the four days or adjusting for confounding variables such as hospitalization sector, length of stay, or clinical complexity; and the impossibility of establishing causal relationships between the quality of the records and the clinical outcomes of the patients, given the predominantly descriptive design of the study. The scientific nursing community is invited to use the data, the audit instrument and the statistical approach used here as a starting point for future studies, with an analytical design, with evaluation of interobserver agreement and multivariate modeling of the completeness of the records over time, in order to deepen the understanding of the determinants of the quality of nursing records, in the institution studied and in other Brazilian hospital settings, as well as to evaluate the impact of educational interventions on the indicators described here.

FINAL CONSIDERATIONS

A retrospective audit of 151 medical records of patients admitted to a university hospital in the Northeast of Brazil showed relevant weaknesses in the quality and completeness of nursing records, corroborating, with statistically robust data, a pattern already described in other Brazilian



institutions. Nursing notes and vital signs records were classified as regular or poor in more than nine out of ten medical records evaluated. The stages of the Nursing Process that were most dependent on the nurse's clinical reasoning: diagnosis, implementation and evaluation of nursing, were recorded in a substantially lower proportion than the evolution stage, evidencing structural discontinuity, and not incidental, in the documentation of the care method. The completeness of daily evolution decreased statistically significantly over the first four days of hospitalization (McNemar's test, $p < 0.001$), and the risk assessment instruments, especially the Fugulin Scale, the basis for nursing staff dimensioning, showed a high proportion of absence of records.

The main original contribution of this study is to demonstrate, with statistical and not just descriptive rigor, that the quality of nursing documentation is not uniform throughout hospitalization: it is concentrated in the first days and deteriorates measurably and significantly thereafter, a temporal pattern rarely quantified with paired tests in the national nursing audit literature. This finding shifts the focus of the discussion from 'if' the records are incomplete to 'when', along the line of care, incompleteness sets in; directly actionable information for nursing management, which can direct document reinforcement strategies to the most vulnerable hospitalization days, instead of generic and undifferentiated interventions in time.

These findings reinforce the relevance of nursing auditing as a tool for managing the quality of care and support the prioritization, by the institution studied, of permanent education strategies aimed at the systematic recording of all stages of the Nursing Process and the completion of risk assessment scales, as well as the implementation of continuous, and not just punctual, monitoring of documentary quality indicators, in order to strengthen the traceability of care, technically support the dimensioning of the nursing staff and contribute to the fulfillment of the goals of the National Patient Safety Program. It is also recommended that periodic audits be carried out, with evaluation of interobserver agreement and stratified analysis by day of hospitalization and by care unit, to verify the effectiveness of any interventions implemented based on the findings described here.

Finally, it is reaffirmed that nursing records are the link that makes the Nursing Process



auditable, communicable and scientifically investigable: without systematic documentation, the care provided remains invisible to management, research and the professional category itself. It is expected that the data, the audit instrument and the statistical approach presented here will serve as a methodological basis for researchers interested in the quality of nursing records, in the Systematization of Nursing Care and in patient safety, encouraging the realization of comparative studies between institutions, educational interventions tested experimentally and investigations that deepen the relationship between documentary completeness and clinical outcomes, a research agenda that is still little explored in the national nursing literature.

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