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Documental management and its importance in intensive care units

La gestión documental y su importancia en las unidades de cuidados intensivos

A importância da gestão documental em unidades de terapia intensiva

ABSTRACT
Objectives: To describe how document management occurs in the Intensive Care Unit and to identify factors that facilitate and hinder document management in daily work. Method: Narrative review of the literature carried out from July to September 2020, in the databases of the Ministry of Health, Google Scholar, SciELO and Medline. 198 articles were found and selected 04. The data were organized and analyzed in the light of the scientific literature. Results: The diversity of journals that the analyzed articles were published stands out: Revista Acervo; Digital Health and Educational Technology Magazine; Text and Context in Nursing and Scientific Initiation Magazine.Conclusion: The present study provided an insight into the documentary and archival processes in the intensive care unit and the importance of document management considering its definition as well as its stages and aspects.
DESCRIPTORS: Data management; Intensive care unit; Medical Records; Electronic Health Records.

RESUMEN
Objetivos: Comprender cómo se produce la gestión documental en la Unidad de Cuidados Intensivos e identificar los factores que facilitan y dificultan la gestión documental no diaria del trabajo. Método: Revisión de literatura narrativa realizada de julio a septiembre de 2020, con base en las bases de datos del Ministerio de Salud, Google Académico, SciELO y Medline. Se encontraron 198 artículos y seleccionaron 04. Los datos se organizan y analizan a la luz de la literatura científica. Resultados: Destacamos la diversidad de periódicos en los que se publicaron los artículos analizados: Revista Acervo; Revista digital Tecnología sanitaria y educativa; Revista Texto y contexto en enfermería e iniciación científica. Conclusión: El presente estudio permitió conocer los procesos documentales y de archivo en la unidad de cuidados intensivos y la importancia de la Gestión Documental considerando su definición así como sus etapas y aspectos.
DESCRIPTORES: Manejo de Datos; unidad de cuidados intensivos; história clínica; Registros Electrónicos de Salud.

RESUMO
Objetivos: descrever como ocorre a gestão documental na Unidade Terapia Intensiva e identificar fatores facilitadores e dificultadores da gestão documental no cotidiano de trabalho. Método: Revisão narrativa da literatura realizada no período de julho a setembro de 2020, nas bases de dados do Ministério da Saúde, Google acadêmico, SciELO e Medline. Foram encontrados 198 artigos e selecionados 04. Os dados foram organizados e analisados à luz da literatura científica. Resultados: Destaca-se a diversidade de periódicos que os artigos analisados foram publicados: Revista Acervo; Revista Saúde digital e tecnologia educacional; Texto e Contexto em Enfermagem e Revista de Iniciação Científica. Conclusão: a gestão documental se mostrou capaz de aprimorar o arquivamento e utilização de documentos de forma qualificada, diminuindo o tempo e a mão de obra empregada na busca de documentos perdidos.
DESCRITORES: Gerenciamento de dados; Unidades de terapia intensiva; Prontuários; Registros Eletrônicos de Saúde.

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INTRODUCTION

In organizations, 90% of their information is contained in documents and as 70% of them are not able to withstand a catastrophe, such as fire or flood, most of the time, there is a massive loss of their documentation. Therefore, in order to maintain order and guarantee the integrity of such documents, it is essential to implement an effective document management (DM) system in public or private companies. [1,2]

According to Law 8.159, of January 8th, 1991, DM is defined as a "set of procedures and technical operations for its production, processing, use, evaluation and filing in the current and intermediate phase, aiming at its elimination or collection for permanent guard". [3] These are routine measures that seek to rationalize and enhance efficiency in the production, classification, analysis, preservation, access and use of information recorded in archival documents, which goes through three stages, namely: production, use and destination of documents. [4]

In the area of health, although little is said about DM, the United States Department of Labor pointed out that there is a loss or misuse of documents essential to the continuity of assistance in health services, which triggers a series of costs and errors in the work process. For example, for every 20 documents, one can be lost and it takes about 25 hours to recover it. In addition, 10 to 12% of documents are not found on the first attempt, occupying an average of 400 hours per employee each year. It is noteworthy that these hours spent in addition to generating unnecessary expenses for the company could be better used in the provision of services. [2]

Thus, in order to improve work processes, using health information technologies, in Brazil, guidelines for DG and file systems were established in the National Policy for Health Information and Informatics (PNIIS) and in the 2nd Master Plan for the Development of Information and Information Technology in Health (2nd PlaDITIS 2013 - 2017), thus defining its objectives, purposes and responsibilities that should be followed by public and private entities within the scope of the Unified Health System (SUS)), in order to improve the governance of information and computer resources. [5,6]

The Intensive Care Unit (ICU), consists of a sector that gathers complex and important information, mainly in the medical records of patients, which provide technical and legal subsidies for assistance. The medical record with reliable information constitutes tools that enable the health team to obtain guidance and guidance for their highly complex therapeutic conducts, so we see the importance of the evolution of information technologies applied to maintaining legibility, and good use of these documents. Law No. 13.787, of December 27th, 2018, establishes that such documents must be kept in the period of 20 years after the last note taken, being mandatory during this period, even if the patient dies, therefore, it is more than essential perform a detailed and organized storage process, as proposed by the DM. [7,8]

The objectives developed for this study were: to describe how document management occurs in the ICU and to identify factors that facilitate and hinder DM in daily work.

METHOD

The present study is a narrative review of the literature carried out from July to September 2020, based on a survey in the databases of the Ministry of Health, Google Scholar, SciELO and Medline.

This type of review "presents a more open theme; hardly part of a specific, well-defined issue, not requiring a rigid protocol for its preparation; the search for sources is not predetermined and specific (...)". [9] It has the advantage of allowing the researcher to appropriate his object of stu-

dy, based on a comprehensive search on the phenomenon to be studied. [10]

Inclusion criteria were adopted: articles in full and indexed that dealt with the proposed theme, published in the period from 2010 to 2020, in Portuguese. And as exclusion criteria: duplicate articles, theses, monographs and abstracts from annals.

From the material found, the titles of 198 articles were read and those that met the theme were selected. After reading the abstracts, 08 were selected that met the inclusion criteria. Then, a complete and careful reading of 07 articles was made, but only 04 were selected, using an instrument to synthesize the information necessary for the study.

The data found were organized and analyzed critically, based on the interpretation of the compiled results comparing them with the scientific literature. The results were presented through a description for possible comparison between all selected studies. Below is the flowchart of the methodological path (Figure 01).

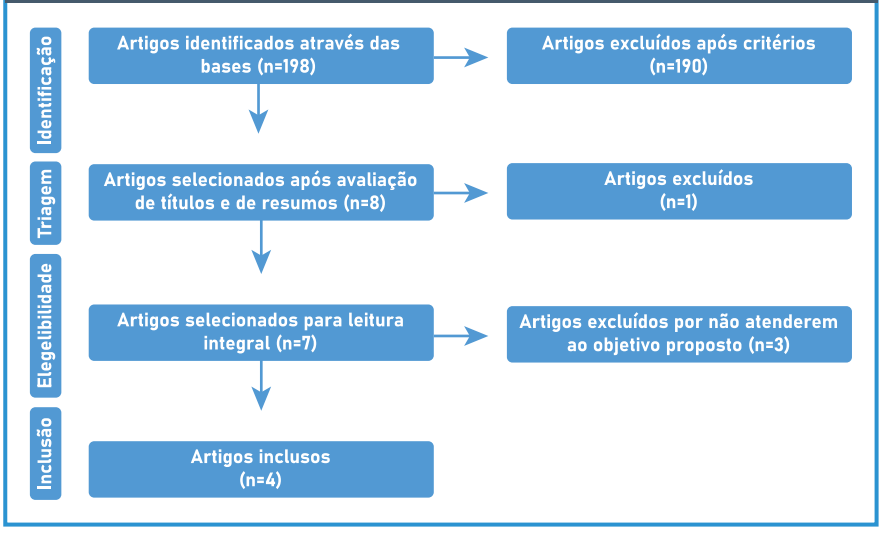
RESULTS

Figure 2 shows the 04 selected articles, with their respective authors, titles, study location, year and journals in which they were published.

It appears that 03 studies were carried out in Santa Catarina and 01 in the state of Bahia. The year of publication ranged from 2009 to 2018.

We highlight the diversity of journals that the analyzed articles were published: Revista Acervo; Digital Health and Educational Technology Magazine; Text and Context in Nursing and Scientific Initiation Magazine.

Figure 1. Flowchart of research information in the databases, mapping the number of identified, included and excluded records, and the reasons for exclusions, according to the PRISMA Flow Diagram. Cachoeira, BA, Brazil, 2020.



DISCUSSION

The steps of DM in the context of intensive care units

In general, GD is divided into three stages that are articulated to promote the proper functioning and optimization of services [4], in order to assist the functions of the administrative and legal/tax sectors, given their historical value respectively after their assessment. [11,12]

The initial stage, entitled document production, comprises the creation, preparation and management of records, and makes it possible to prevent the production of irrelevant documents, here also the implementation of technologies in the document creation process. In the health area, it is at this stage that health professionals from the most varied areas of activity welcome the patient and make their directions and prescriptions in medical records, this being a permanent maintenance document. [7,4,12]

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Chart 1. Results found in studies according to the author, title, year of publication, place of study and periodical in which it was published. Cachoeira (BA), Brazil, 2020.

CÓDIGO	AUTOR	TÍTULO	LOCAL	PERIÓDICO/ANO
01	Cunha FJAP, Oliveira LAF, Lima GLQ	A função de avaliação na gestão documental em hospitais	Bahia	Acervo 2015.
02	Oribka R, Cruz ASC, Bahia, EMS	Procedimentos da gestão documental aplicados no arquivo de prontuários dos pacientes do hospital universitário da Universidade Federal de Santa Catarina	Santa Catarina	Re. saúd. digi. tec. edu. 2018.
03	Lorenzetti J, Trindade LL, Pires DEP, Ramos FRS	Tecnologia, inovação tecnológica e saúde: uma reflexão necessária	Santa Catarina	Texto e Contexto em Enfermagem.2012.
04	Rocha EL, et al.	Prontuário eletrônico para acompanhamento médico dos pacientes de uma unidade de terapia intensiva.	Santa Catarina	Revista de Iniciação Científica. 2009.

stage that health professionals from the most varied areas of activity welcome the patient and make their directions and prescriptions in medical records, this being a permanent maintenance document. [4] This phase seeks to ensure the proper selection of materials and the moment when professionals have access to the information already registered in the medical record, with the aim of continuing the care process based on the patient's history. In this stage, there may also be modification and addition of new information, where it is important to be quick in the provision of these in a documented manner and with the proper filing. [4,12,13]

Finally, the third stage deals with the destination of documents that refers to the description of the documentary series, in the evaluation of documents, their destination for archiving, and the elimination or collection of files, classifying them as permanent. In this stage, the unit will adopt methods to dispose of the contents of the medical record, making revisions, deletions or directing the documents to the permanent ICU files. [4,11]

Understanding how DM takes place in the ICU enables a better understanding of the sector's difficulties as well as the opportunities for improvement at the same time, enabling an effective management of the unit.

Facilitating and difficulting factors of DM in the daily work of the ICU

DM is a factor of great influence on the vitality of health organizations, as the archives of the institutions are not purely administrative, but also have great importance in the historical context, bases for learning, organizational innovations and scientific development. [4,12] It is extremely important to point out that the DG in its evaluation stage allocates documents according to its primary or secondary objective, and provides great improvements, allowing the selection of documents that are really indispensable, thus eliminating those that are not useful, making that there is a decrease in the accumulation of documents, favoring their functionality and operationalization. [11]

The countless advances and investments in the technical-scientific area in the field of health have become increasingly increasing, information and instant communication, a single national and integrated electronic medical record for international access, are some of the main contributions. Several studies involving ICUs as a specific field, have shown the constant challenges and complex situations experienced within this environment that require a posture of greater security and control by health professionals. It is in this context that the correct integration of technological innovations has contributed to better patient care with greater ease and resourcefulness in the organization of the team that will assist them. [14]

Among the main technological innovations integrated with health care, we can mention Electronic Document Management (EDM), which is able to assist in the second stage of DM development. EDM makes it possible not only to save documents that have already been created digitally, but also contributes to solving the problem created by the excessive production of paper (supporting documents), in public and private institutions. In addition, EDM improvements are a major turning point among teams in the hospital environment, among which we mention the Electronic Patient Record (EPP), which has become a great ally in assisting users who are part of the ICU wards. [15]

The implementation of the EPP offers numerous benefits to its users, such as security, quality, cost optimization, in addition to facilitating the permanent storage and retrieval of information, ensuring their safety, also allowing the sharing between components of the same team and/or others institutions in a fast, organized, individualized and effective way. [13,16]

The treatment process in this sector is too complex, requiring the use of data in different situations. The manipulation of medical records accentuates the possibility of errors and the loss of important data, in addition to making it impossible for more than one professional to access and update a patient's clinical condition simultaneously. [17] The medical record for being a single document shared by the entire health team, being an important method for the qualification of work processes, contributing to the effectiveness of care for critical patients. [12,18] DM in this context is an important tool for the provision of health care, contributing to the management of hospital units. [11,19]

It is emphasized that for the functioning of the ICU`s it is necessary that the assistance provided by the professionals of the unit is recorded, signed and dated in the patient's medical record, in a legible manner and containing the professional stamp, showing the importance of the GD archival processes, and the unit is responsible for in-hospital transfers to make the medical record data available to the destination sector. [4,12,20]

Therefore, electronic medical records make it possible to achieve a higher level of quality in relation to health care, after all, some of these interact with the prescriber, indicating inappropriate drug interactions, blocking incorrect routes of administration, in addition to facilitating multidisciplinary communication with clear data regarding the standardizing medical processes and enabling support for diagnostics, allowing error prevention, unlike conventional medical records, especially in the ICU. [21]

In this perspective, the DM when properly implemented and used properly benefits the administrative development, adding efficiency in audits, whether external or internal, after all, one of the main tools used in these audits are the medical records. [22,23]

The central focus of auditing in the hospital environment, whether internal or external, is to contribute in all areas to the management of the organization, thus working to improve assistance, efficiency and the provision of health services. The audit always makes a broad, systematic and formal assessment of the activities of the professionals, aiming at valuing the education system and continuous improvement offering quality and safety, where the DG has an irreplaceable role for the achievement of these objectives, considering that its correct application favors a better archival process and its proper use. [4,22,23,24]

CONCLUSION

The present study provided an insight

into the documentary and archival processes in the ICU and the importance of DM, considering its definition as well as its stages and aspects, highlighting the value and use of the information kept in documents used in this sector, which provide support for both professionals and users. In addition, they provide a basis for the evolution of scientific studies that enable improvements in the provision of care.

DM proved to be a tool capable of improving the filing and use of documents in a qualified manner, bringing practicality and organization to the institutions, in addition to reducing the time and manpower employed in the recreation or search for lost documents, thus allocating these resources for the provision of other services, such as patient care. ■

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