artigo

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Completeness of occurrence cards of SAMU advanced support units

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Integridad de las tarjetas de ocurrencia de las unidades de soporte avanzado SAMU

Completude das fichas de ocorrência das unidades de suporte avançado do SAMU

ABSTRACT
Objective: to analyze the completeness of the attendance files of the Advanced Support Units of the SAMU Regional Metropolitano / PR. Method: documentary, retrospective, quantitative study, carried out with 385 notification forms from the mobile emergency care service. The collection took place between March and August 2020, with data from August 2018 to July 2019. The completeness of the occurrence records was measured by the proportion of fields filled. Results: the completeness of the data was excellent for 10 variables, these referring to the identification of the call and patient (100%), clinical (6.7%) and outcome (14.3%); very bad in the fields of demographic identification; predominantly bad and very bad for clinical variables. Conclusion: there is a failure to fill out the occurrence forms, regardless of the location of the call. It highlights the importance of developing mechanisms to establish complete completion, either through training or developments in new technologies for data collection.
DESCRIPTORS: Ambulances; Emergency Nursing; Emergency Medical Services; Records.

RESUMEN
Objetivo: analizar la integridad de los archivos de asistencia de las Unidades de Soporte Avanzado del SAMU Regional Metropolitano/PR. Método: estudio documental, retrospectivo, cuantitativo, realizado con 385 formularios de notificación del servicio móvil de urgencias. La recolección se llevó a cabo entre marzo y agosto de 2020, con datos de agosto de 2018 a julio de 2019. La integridad de los registros de ocurrencia se midió por la proporción de campos llenados. Resultados: la completitud de los datos fue excelente para 10 variables, estas referidas a la identificación de la llamada y paciente (100%), clínica (6,7%) y resultado (14,3%); muy malo en el campo de la identificación demográfica; predominantemente malo y muy malo para las variables clínicas. Conclusión: hay una falla al completar los formularios de ocurrencia, independientemente de la ubicación de la llamada. Destaca la importancia de desarrollar mecanismos para establecer el llenado completo, ya sea mediante capacitación o desarrollos en nuevas tecnologías para la recolección de datos.
DESCRIPTORES: Ambulancias; Enfermería de Urgencia; Servicios Médicos de Urgencia; Registros.

RESUMO
Objetivo: analisar a completude das fichas de atendimento das Unidades de Suporte Avançado do SAMU Regional Metropolitano/PR. Método: estudo documental, retrospectivo, quantitativo, realizado com 385 fichas de notificação do serviço de atendimento móvel de urgência. A coleta ocorreu entre março e agosto de 2020, com dados de agosto de 2018 à julho de 2019. A completude das fichas de ocorrência foi mensurada pela proporção de campos preenchidos. Resultados: a completude dos dados foi excelente para 10 variáveis, estas referente a identificação de chamado e paciente (100%), clínicas (6,7%) e de desfecho (14,3%); muito ruim nos campos de identificação demográfica; predominantes ruim e muito ruim para as variáveis clínicas. Conclusão: evidencia-se falha do preenchimento das fichas de ocorrência, independente da localidade do chamado. Destaca-se a importância de desenvolver mecanismos para estabelecer o preenchimento completo, seja por capacitação ou desenvolvimentos de novas tecnologias para coleta de dados.
DESCRITORES: Unidades Móveis de Urgência; Enfermagem em Emergência; Serviços médicos de emergência; Registros.

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artigo

Ferreira, J.G.; Chevonik, I.E.; Batista, J.; Lenhani, B.R.; Marcondes, L.;
Completeness of occurrence cards of SAMU advanced support units

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INTRODUCTION

It was noticed, over time, that lives could be saved if they were quickly assisted by trained and qualified people, even in the environment outside the hospitals, and transported to a place where they could receive assistance with more specific support for each case. [1]

The health scenario is constantly changing and some factors are decisive for the entities that offer health services. New population epidemiological traits, improvement of diagnostic medicine, highly complex treatments, growth of the pharmaceutical industry, multiplicity of health plans and national health policies are some factors that are related to the current scenario and maintain a close relationship with the quality of services provided. [2]

The quality of nursing services includes not only nursing education, records are essential elements in the care process. When written in a way that portrays the reality to be documented, they enable communication between the health team and serve several other purposes, such as teaching, research, audits, legal proceedings, planning, statistical purposes and the process of restoring the health of the client or, when this is not possible, the best living conditions, guidance on self-care, simplifi-

cation and safety in procedures. As the records in the patient's medical record are a legal defense document for professionals, they must be imbued with authenticity and legal meaning in accordance with Resolution 0514/2016 of the Federal Nursing Council. [3]

So, the quality of the record of care actions reflects both the quality of care and the productivity of their work. It is not allowed to write in pencil or use liquid corrections; they must not contain erasures, leading, blank lines or spaces. [4]

In the mobile emergency Pre-Hospital Care (APH), these records are not made at the time of care delivery, but after the patient has been stabilized, although still during care. The notes are made in the absence of the patient, which requires the professional's commitment to recover and systematize the information. Given this specificity, difficulties arise in the registration of care provided at the Mobile Emergency Care Service (SAMU). The difficulties encountered are related to the patients' lack of information, for example: identification, pathological history, lifestyle habits; lack of standardization of annotations; illegible records and lack of professional identification. [5]

Health areas need information for decision making, [6] with this, the completeness of the data in medical records

or information sheets has been shown to be an area of growing interest to assess the quality of information transmitted among professionals. [7]

Given the above, the question arises, what is the percentage of completeness of records in the records of advanced life support ambulances at SAMU Curitiba and metropolitan region? And its objective is to identify the completeness of the attendance records of the Advanced Support Units of the SAMU Regional Metropolitano do Paraná.

METHOD

This is a documentary, retrospective study with a quantitative approach, carried out with data obtained from pre-hospital care records of the Advanced Support Units of SAMU Regional Metropolitano/PR.

The survey was conducted in municipalities that have Advanced Support Units and are part of the SAMU Metropolitan Regional of Curitiba, Paraná, Brazil. They are Curitiba, Pinhais, Almirante Tamandaré, São José dos Pinhais, Araucária and Campo Largo, totaling 14 ambulances. Data collection took place on the premises of each of these locations, where the attendance records are stored, from March to August 2020.

artigo

Ferreira, J.G.; Chevonik, I.E.; Batista, J.; Lenhani, B.R.; Marcondes, L.;
Completeness of occurrence cards of SAMU advanced support units

Incident forms attended by SAMU Metropolitan/PR Advanced Life Support were included, filled out by health professionals during the period from August 1st, 2018 to July 31st, 2019. Damaged forms were excluded. The establishment of the temporality of the searches referred to the period of the last year with accessible complete records. To calculate the sample size, the number of monthly consultations of the SAMU Advanced Support Units in the period from August 1st, 2018 to July 31st, 2019 (30.951 assistances) was considered. For this research, a stratified sample was used, which was calculated using the total number of consultations, with 95% confidence and a margin of error equal to 5%. After selecting the files by sample calculation, the sample consisted of 385 records, which were chosen according to a random drawing.

The variables collected in the attendance record refer to the identification of the call (city, date, time, advanced support unit (USA) activated, base), patient identification (gender, age) demographic (neighborhood, place of occurrence), clinical (purpose of the call, history, surgeries performed, medications, main symptoms, clinical examination, onset of symptoms, vital signs, Glasgow scale, Trauma scale, airway, breathing, pul-

monary ausculation, expansiveness, findings, circulation, edema, perfusion, pulse characteristic, cardiac auscultation, electrocardiogram (ECG), neurological examination, neck physical examination, urogenital physical examination, abdomen physical examination, gynecological/obstetrical), outcomes (diagnosis, procedures performed, therapy, evolution, referral, death, transport position).

The completeness of the data from the occurrence records was measured by the proportion of fields correctly filled out without ignored information, in a given field. The values have been adapted, [8] information above 95% being considered excellent; Good ≥90 to 95%; Regular ≥ 70 to 90%; Bad ≥ 50 to 70% and Very bad ≤ below 50%. Data were tabulated and coded in Microsoft Office Excel® 2010, using descriptive statistical analysis procedures with results expressed as simple and absolute frequency (%).

Respecting the ethical aspects, the research was submitted to the Research Ethics Committee of the Health Department of Curitiba-PR, for the approval of ethical aspects and feasibility of research with human beings, being registered with CAAE: 26483119.2.0000.0101 and approved with the opinion number: 3.764.811.

RESULTS

A total of 385 pre-hospital care records were analyzed, 258 from the advanced unit bases in the city of Curitiba, 39 from São José dos Pinhais, 23 from Campo Largo, 28 from Pinhais, 19 from Almirante Tamandaré and 18 from Araucária.

The completeness of filling out the call identification variables in the attendance records, being five variables, was excellent if all services were considered, but if you stratify the filling by call municipality, it is highlighted that Curitiba had a good schedule. (90,7%), Araucária had a good filling for the base (94,4%) and Pinhais had a regular filling for the service base (89,3%), as shown in Table 1.

According to the identification of the patient, when considering all municipalities, completeness is excellent, however, there is a regular completeness for filling in age and gender in the municipality of Almirante Tamandaré (89,5%) and regular only for gender in the municipality of Araucaria (88,9%) (Table 1).

For demographic identification (neighborhood and place of occurrence), all municipalities had a very poor completeness, especially Araucária, which did not fill in any of the occurrence forms for the neighborhood variable (Table 1).

Table 1. Completeness of the fields for filling in the attendance records of the Advanced Support Units of the SAMU Regional Metropolitano/PR of the call identification, patient and demographic variables. Curitiba, Paraná, Brazil, 2018-2019

VARIABLE	TOTAL N=385 (%)	CURITIBA N=258 (%)	SÃO JOSÉ DOS PINHAIS N=39 (%)	CAMPO LARGO N=23 (%)	PINHAIS N=28 (%)	ARAUCÁRIA N=18 (%)	ALMIRANTE TAMANDARÉ N=19 (%)
Identificação do Chamado							
City	384 (99,7)	257 (99,6)	39 (100)	23 (100)	28 (100)	18 (100)	19 (100)
Date	385 (100)	258 (100)	39 (100)	23 (100)	28 (100)	18 (100)	19 (100)
Time	369 (95,8)	234 (90,7)	38 (97,4)	23 (100)	28 (100)	18 (100)	19 (100)
ASU	385 (100)	257 (99,6)	39 (100)	23 (100)	28 (100)	18 (100)	19 (100)
Base	381 (99)	257 (99,6)	39 (100)	23 (100)	25 (89,3)	17 (94,4)	19 (100)
Identificação do Paciente							
Sex	372 (96,6)	251 (97,3)	38 (97,4)	23 (100)	27 (96,4)	16 (88,9)	17 (89,5)

Age	375 (97,4)	252 (97,7)	39 (100)	23 (100)	27 (96,4)	17 (94,4)	17 (89,5)

(continued)

Age	375 (97,4)	252 (97,7)	39 (100)	23 (100)	27 (96,4)	17 (94,4)	17 (89,5)
			Identificação demográfica				
District	131 (34)	105 (40,7)	13 (33,3)	5 (21,7)	8 (28,6)	3 (16,7)	0 (0)
Place of occurrence	148 (38,4)	110 (42,6)	12 (30,8)	1 (4,3)	10 (35,7)	7 (38,9)	8 (42,1)

Source: The authors, 2021.

In view of the clinical variables of the patient, 30 variables collected, present in the occurrence form, the completeness of filling were excellent for the purpose of the call (99,7%), main symptoms (98,7%) and very poor for antecedents (42 .1%), surgeries performed (10,9%), medications in use (17,4%), general clinical examination (23,1%), neurological (48,6%) and urogenital (10,4%), time of symptom onset (34%), temperature (33,8%), trauma scale (15,1%) and findings (1,8%). It is noteworthy that Campo Largo was the municipality with the highest number of variables with very poor completeness of filling (n=15) (Table 2).

Table 2. Completeness of the fields for filling in the attendance records of the Advanced Support Units of the SAMU Regional Metropolitano/PR of the patient's clinical variables. Curitiba, Paraná, Brazil, 2018-2019.

VARIABLE	TOTAL N=385 (%)	CURITIBA N=258 (%)	SÃO JOSÉ DOS PINHAIS N=39 (%)	CAMPO LARGO N=23 (%)	PINHAIS N=28 (%)	ARAUCÁRIA N=18 (%)	ALMIRANTE TAMANDARÉ N=19 (%)
Purpose of the call	384 (99,7)	257 (99,6)	39 (100)	23 (100)	28 (100)	18 (100)	19 (100)
Background	162 (42,1)	5 (1,9)	*	0 (0)	2 (7,1)	0 (0)	0 (0)
Surgeries performed	42 (10,9)	4 (1,6)	*	2 (8,7)	0 (0)	0 (0)	0 (0)
Medications in use	67 (17,4)	41 (15,9)	23 (59)	1 (4,3)	3 (10,7)	0 (0)	1 (5,3)
Main symptoms	380 (98,7)	254 (98,4)	39 (100)	23 (100)	27 (96,4)	18 (100)	19 (100)
Clinical Examination	89 (23,1)	36 (14)	*	5 (21,7)	5 (17,9)	3 (16,7)	3 (15,8)
Onset of symptoms	131 (34)	44 (17,1)	*	6 (26,1)	28 (100)	7 (38,9)	10 (52,6)
Blood Pressure (BP)	341 (88,6)	234 (90,7)	31 (79,5)	20 (87)	24 (85,7)	16 (88,9)	16 (84,2)
Heart rate (HR)	362 (94)	249 (96,5)	31 (79,5)	21 (91,3)	26 (92,9)	17 (94,4)	18 (94,7)
Respiratory rate (RR)	397 (77,1)	192 (74,4)	32 (82,1)	16 (69,6)	26 (92,9)	16 (88,69)	15 (78,9)
O2 saturation	357 (92,7)	245 (95)	32 (82,1)	20 (87)	26 (92,9)	17 (94,4)	17 (89,5)
Temperature (T)	130 (33,8)	70 (27,1)	22 (56,4)	10 (43,5)	13 (46,4)	12 (66,7)	5 (26,3)
Glasgow scale	286 (74,3)	197 (76,4)	28 (71,8)	17 (73,9)	21 (75)	15 (83,3)	8 (42,1)
Trauma Scale	58 (15,1)	28 (10,9)	17 (43,6)	2 (8,7)	5 (17,9)	6 (33,3)	3 (15,8)
Airways	340 (88,3)	227 (88)	35 (89,7)	21 (91,3)	25 (89,3)	15 (83,3)	17 (89,5)
Breathing	349 (90,6)	234 (90,7)	36 (92,3)	21 (91,3)	26 (92,9)	15 (83,3)	17 (89,5)
Pulmonary Auscultation	336 (87,3)	227 (88)	39 (100)	18 (78,3)	21 (75)	16 (88,9)	16 (84,2)
Expansiveness	263 (68,3)	166 (64,3)	39 (100)	14 (60,9)	15 (53,6)	14 (77,8)	15 (78,9)
Findings	7 (1,8)	8 (3,1)	0 (0)	1 (4,3)	0 (0)	1 (5,6)	0 (0)
Body circulation	349 (90,6)	237 (91,9)	35 (89,7)	20 (87)	25 (89,3)	15 (83,3)	17 (89,5)
Edema	318 (82,6)	209 (81)	39 (100)	12 (52,2)	0 (0)	15 (83,3)	15 (78,9)
Perfusion	300 (77,9)	200 (77,5)	39 (100)	13 (56,5)	17 (60,7)	15 (83,3)	16 (84,2)
Pulse Characteristics	297 (77,1)	197 (76,4)	33 (84,6)	15 (65,2)	21 (75)	14 (77,8)	17 (89,5)
Cardiac Auscultation	248 (64,4)	156 (60,5)	*	9 (39,1)	17 (60,7)	13 (72,2)	15 (78,9)
ECG**	211 (54,8)	137 (53,1)	*	5 (21,7)	12 (42,9)	10 (55,6)	8 (42,1)
Neurological Exam	187 (48,6)	116 (45)	*	10 (43,5)	11 (39,3)	4 (22,2)	10 (52,6)

artigo

Ferreira, J.G.; Chevonik, I.E.; Batista, J.; Lenhani, B.R.; Marcondes, L.;
Completeness of occurrence cards of SAMU advanced support units

Physical Examination of the Neck	244 (63,4)	164 (63,6)	*	6 (26,1)	12 (42,9)	15 (83,3)	8 (42,1)
Urogenital Physical Examination	40 (10,4)	4 (1,6)	*	0 (0)	0 (0)	0 (0)	0 (0)
Physical Examination of the Abdomen	238 (61,8)	150 (58,1)	*	6 (26,1)	21 (75)	15 (83,3)	9 (47,4)
Gynecology/Obstetric Physical Examination	327 (84,9)	258 (100)	*	1 (4,3)	28 (100)	0 (0)	1 (5,3)

*Variable not present in the occurrence record. **Carrying out an Electrocardiogram (ECG) Source: The authors, 2021.

Among the variables related to the outcome of care (n=seven), it is observed that completeness is a failure in relation to five variables, good for filling out the death field (94%) and excellent for the diagnosis field (95,3%) (Table 3).

DISCUSSION

In the analysis of the attendance records of the SAMU Regional Metropolitano/PR, it was evidenced that the identification of the call and identification of the patient was excellent, but regarding the demographic identification, which comprises neighborhood and place of occurrence, the completeness was characterized as very bad for all municipalities. Corroborating a study carried out in the southeast region of Brazil, São Paulo, [9] which analyzed the records of care provided by the SAMU 192 of the municipality, between August 2011 and January 2012, totaling 2635 records, describes that 33,7% of the records have incom-

plete address data and that they did not allow the identification of the service sector, however, the present study presents a much higher percentage when these variables are not filled out.

Variables related to call identification and demographic are important for responsible managers to plan actions with the population, respecting their particularities. The high number of cases not being filled in may be justified by the lack of knowledge about the importance of this information, or even the seriousness of the patient who is receiving care, due to the fact that the professional does not have enough time for this filling to occur properly. [9]

The study carried out in northeastern Brazil, Paraíba, [10] with the objective of characterizing the victims and their injuries, based on data from SAMU care, carried out in 2010 with 4.514 visits to traffic accident victims, in 266 (5,9%) the neighborhood was not informed, which is why these events were not included in the spatial

analyses. The variable place of occurrence', informing the corresponding street, had a filling rate of less than 80% and, therefore, was not included in the study, signaling a good completeness for filling the neighborhood and regular for the place of occurrence, disagreeing in numbers with the data presented by this research in which the items of demographic identification had a very poor completeness, regardless of whether the service was in the capital or the metropolitan region.

We can observe that in the study carried out in central-western Brazil, Mato Grosso, [11] by documentary research, with data collected from January 2012 to December 2013, in the SAMU database, there was a variation in the percentage of non-completion of systematized care forms (FAS), the same observed in this study, with failure to complete the data . The authors pointed out that the variables where the completion was performed in the checklist format were more completed

Table 3. Completeness of the fields for filling in the attendance records of the Advanced Support Units of the SAMU Regional Metropolitano/PR of the variables according to the outcome of the assistance. Curitiba, Paraná, Brazil, 2018-2019.

VARIABLE	TOTAL N=386 (%)	CURITIBA N=258 (%)	SÃO JOSÉ DOS PINHAIS N=39 (%)	CAMPO LARGO N=23 (%)	PINHAIS N=28 (%)	ARAUCÁRIA N=18 (%)	ALMIRANTE TAMANDARÉ N=19 (%)
Diagnosis	367 (95,3)	253 (98,1)	38 (97,4)	23 (100)	28 (100)	14 (77,8)	17 (89,5)
Procedures performed	52 (13,5)	44 (17,1)	9 (23,1)	0 (0)	0 (0)	0 (0)	2 (10,5)
Therapy	192 (49,9)	128 (49,6)	23 (59)	7 (30,4)	15 (53,6)	11 (61,1)	10 (52,6)
Evolution	243 (63,1)	179 (69,4)	7 (17,9)	17 (73,9)	18 (64,3)	12 (66,7)	13 (68,4)
Forwarding	259 (67,3)	194 (75,2)	13 (33,3)	15 (65,2)	16 (57,1)	8 (44,4)	13 (68,4)
Death	362 (94)	235 (91,1)	39 (100)	23 (100)	28 (100)	18 (100)	19 (100)
Transport Positioning	272 (70,6)	181 (70,2)	*	15 (65,2)	15 (53,6)	7 (38,9)	16 (84,2)

*Variável não presente na ficha de ocorrência. Fonte: Os autores, 2021.

than the ones in full, the best filling was for the fields "reason for request", "victim's data", corroborating this study in which it presented completeness excellent for purpose of calling and victim identification.

With regard to patient identification, age and gender variables, this study disagrees with the data presented by Fernandes and Tanaka, [12] collection carried out in October 2012, at the SAMU Regulation Center in the state of São Paulo with 37.457 occurrences, highlights low completeness of the records of age and sex (42,3%), in this research the identification of the patient showed excellent completeness.

At any time, especially at the beginning of care, it is extremely important to know the patient's history (history, surgeries performed and medications used), in the study we observed that these variable fields are not completely filled out, regardless of the municipality. For proper conduct, knowing the patient that the professional is treating is essential to understand the evolution of the case or even what led to that emergency care. The information provided by the patient is not always clear and complete, so performing a complete physical examination, measuring vital signs (heart rate, respiratory rate, temperature, O2 saturation, blood pressure) and anamnesis is essential in patient care. Therefore, we emphasize the importance of this completeness, which was not demonstrated in this research, as only heart rate and O2 saturation had good completeness, so that the next care professional can continue correctly without placing the patient's life and his work at risk.

The study showed that among the seven indicated outcome variables, two have adequate completeness, field of diagnosis (excellent) and death (good), both in Curitiba and in the metropolitan region. The completeness of the death variable in this study is similar to the research carried out in Paulo Afonso, Bahia, Brazil, in which 6,94% of the 331 records of occurrences of SAMU care regarding accidents involving motorcyclists did not contain death records. [13]

The diagnosis or hypotheses of a probable one, which is the responsibility of the USA physician, helps to establish what care or procedure should be adopted, as a way to improve understanding and conduct in the face of occurrences. In the study by Silveira and Taneda, [11] it reports that the diagnostic hypotheses were filled with greater efficiency, with five to 6% of the variables not being properly filled.

The five outcome variables that had inadequate completeness (<90%) were procedures performed, therapy, evolution, referral and transport position. Each of these items is essential for continuity of care in the subsequent service. Among them are the procedures performed during the service, which designates the next step forward. Recording the therapy performed in the service prevents incidents and provides greater safety to the patient, prevents incidents such as overdoses and helps in making the next clinical decision.

Regarding the evolution of the attendance record, this completeness was flawed, corroborating the study from São Paulo, [14] which highlights the lack of stamps and lack of signature, reporting of start and end time of care and lack of nursing evolution in the hospital environment, authors 13 point out as a limitation in their study the failure of nursing records and the underreporting of the data contained in the SAMU care records, which are necessary to understand the care provided to victims. It is worth noting that nurses have great responsibility for nursing records. The execution of the nursing process (NP) is a fundamental duty, this document ensures all the legality of the care provided by nurses and backing them up against any contradictions in the future. It is noteworthy that the records of occurrences of the ASUs of the SAMU Regional Metropolitano/PR do not have a specific field for recording the NP, the fields are intended for recording both professionals, physicians and nurses.

Among the 46 variables analyzed in this research, when the completion of Curitiba and the metropolitan region was evaluated together, only 14 had adequate completion (>90%), with good or excellent completeness, matching the data from the study carried out in Pernambuco, Brazil, [15] that among 100 SAMU records from Patos, Minas Gerais, Brazil, 95 did not comply with at least one of the filling criteria, requiring the implementation of a program to improve the quality of the records. The authors highlight, as a justification for failure in the completeness of the records, the inappropriate conditions offered to the professional, such as lack of light, unhealthy environments and, as it is an urgent and emergency service, the need for greater flexibility in patient care leaving little time to fill in the information.

The difficulty of filling in information by health professionals is also highlighted in the study carried out in Paraná, corroborating the data presented, where the completeness of the data was excellent only for the mandatory fields of the information system, with this authors highlighting that specific systems facilitate filling in and makes the information more reliable and complete. [16]

This study highlights as a limitation, the performance in six different cities, but all are part of the same coordination and region of the state, needing to be replicated in other services in Brazil, for data analysis and comparison.

CONCLUSION

The study showed a failure in filling in the ASU's occurrence forms of the SAMU Regional Metropolitano/PR in general, regardless of the location of the call, with adequate completeness in only 14 of the 46 evaluated variables. Curitiba had greater completeness than municipalities in the metropolitan region in the call identification, patient

artigo

Ferreira, J.G.; Chevonik, I.E.; Batista, J.; Lenhani, B.R.; Marcondes, L.;
Completeness of occurrence cards of SAMU advanced support units

and demographic variables, however, for clinical and outcome variables, municipalities in the metropolitan region had greater completeness.

The occurrence form is the patient's medical record in pre-hospital care, being extremely important and necessary for the patient and for the professional. It guarantees that the care and safety of the patient are efficient, the excellent completeness guarantees to the patient, a quality of care and its continuity, generating legal support for the nurse and the client. It also helps in research that contributes to a more scientific nursing.

It is necessary, therefore, to develop mechanisms to establish the correct and complete completion of the SAMU occurrence form, either through continuous training activities demonstrating the importance of such information, as well as developing a faster and easier way of filling it out. The use of technological devices, such as a tablet or cell phone, with forms to be filled out by checklist of mandatory fields, could be an option. ■

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