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Original

Evaluation of the nursing sheet of an Intensive Care Unit

Evaluación de la hoja de enfermería de una Unidad de Cuidados Intensivos

Avaliação das anotações de enfermagem de uma Unidade de Terapia Intensiva

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Resumen

Objective: To evaluate the level of compliance with the nursing clinical record sheet of an Intensive Care Unit in Mexico. ***Materials and methods:*** A quantitative, descriptive cross-sectional study was carried out in an Intensive Care Unit of a hospital in San Luis Potosí, Mexico, in December 2020-January 2021, with a sample of 150 nursing clinical record sheets, the 40 basic standards of the registry, with the instrument "Cedula to evaluate the effectiveness of nursing practice" of the National Commission of Medical Arbitration in Mexico, the data were analyzed with descriptive statistics in the SPSS program. Version 18, and the recommendations of the Declaration of Helsinki and ethical principles of confidentiality established by the institution were followed. ***Results***: A deficient level of compliance with standards is identified, where 2 standards partially comply, 23 fully, 11 do not comply with what, established by the National Medical Arbitration Commission, and 4 that the format does not contain, are attached to it A statistical analysis was performed by the nursing staff through descriptive statistics, where the mode and median of general compliance was 100%, and a mean compliance of 67.26%. ***Conclusions***: Upon finding a deficient level of compliance with standards, a proposal for a new format is built for the health institution, which achieves full compliance with the elements established in the Official Mexican Standard 004-SSA3-2012, of the Clinical Record and the National Commission of Medical Arbitration.

Keywords: Compliance level; records; nursing care; critical care.

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Resumen

Objetivo: Evaluar el nivel del cumplimiento de la hoja de registros clínicos de enfermería de una Unidad de Cuidados Intensivos en México. ***Materiales y Métodos:*** Se realizó un estudio cuantitativo, descriptivo transversal, en una Unidad de Cuidados Intensivos de un hospital en San Luis Potosí, México, en diciembre 2020-enero 2021. Se utilizó una muestra de 150 hojas de registro clínicos de enfermería, evaluando los 40 estándares básicos del registro, con el instrumento "Cedula para evaluar la eficacia de la práctica de enfermería" de la Comisión Nacional de Arbitraje Médico en México; seguidamente los datos se analizaron con estadística descriptiva en el programa SPSS, versión 18. Se siguieron las recomendaciones de la Declaración de Helsinki y los principios éticos de confidencialidad que establece la institución. ***Resultados***: Se identifica un nivel de cumplimiento deficiente de estándares,

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donde: 2 estándares cumplen parcialmente, 23 totalmente, 11 no cumplen con lo que establece la Comisión Nacional de Arbitraje Médico, y 4 que el formato no contiene, se anexan al mismo por el personal de enfermería, a través de estadística descriptiva. Igualmente, se realizó un análisis estadístico, donde se obtuvo como moda y mediana del cumplimiento general el 100%, y una media de cumplimiento de 67.26%. ***Conclusiones***: Al encontrar un nivel deficiente de cumplimiento de estándares se construye una propuesta de nuevo formato para la institución de salud, que logre dar cumplimiento total con los elementos establecidos en la Norma Oficial Mexicana 004-SSA3-2012, del Expediente Clínico y la Comisión Nacional de Arbitraje Médico.

Palabras clave: Nivel de cumplimiento; registros; atención de enfermería; cuidado critico.

Resumo

Objetivo: Avaliar o nível de cumprimento das anotações de enfermagem nos prontuários de pacientes de uma Unidade de Terapia Intensiva no México. ***Materiais e métodos:*** Realizou-se um estudo quantitativo, descritivo, transversal, numa Unidade de Terapia Intensiva num hospital em San Luis Potosí, Mexico, entre dezembro de 2020 e janeiro de 2021. Usou-se uma amostra de 150 folhas de anotações clínicas de enfermagem, avaliando os 40 padrões básicos de registro, com o instrumento "Cartão para avaliar a eficácia da prática de enfermagem-CERCE" da Comissão Nacional de Arbitragem Médica em México; posteriormente os dados foram analisados usando o programa SPSS, versão 18. Seguiram-se as recomendações da Declaração de Helsinki e os princípios de confidencialidade estabelecidos pelo hospital. ***Resultados***: Identificou-se um nível de cumprimento deficiente de padrões, onde: 2 padrões cumprem parcialmente, 23 totalmente e 11 não cumprem os requerimentos estabelecidos pela Comissão Nacional de Arbitragem Médica, 4 que o instrumento não contem, são anexados pelo pessoal de enfermagem usando estatística descritiva. Igualmente a analise estatística mostrou que a moda e mediana do cumprimento geral foi do 100% e uma media de 67,26%. ***Conclusão***: Ao identificar a deficiência no cumprimento de padrões se constrói a proposta de um novo formato para o hospital, que consiga cumprir totalmente os critérios estabelecidos na Norma Oficial Mexicana 004-SSA3-2012, do prontuário clínico e a Comissão de Arbitragem Médica.

Palavras-chave: Fidelidade a diretrizes; registros; cuidados de enfermagem; cuidados críticos.

Introduction

Nursing clinical records can be traced back to the 19th century, with Florence Nightingale, the highest representative of nursing worldwide, who upon observing the deplorable and unhygienic conditions in which soldiers were treated during the Crimean War, (1) pointed out in her nursing notes, that nursing staff is responsible for caring and helping the patient suffering from any disease to live and maintain health, care that should go from a child or a healthy person, to protect them from the susceptibility of suffering from any disease (2). The above content shows the importance of the nursing note, where the conditions in which the patients are found are indicated.

It should be noted that the formats and nursing records guarantee a permanent follow-up of the patient's treatment and the legal protection of the nurse; they also allow the identification of the personnel who were in charge of a given patient, analyze the timeliness of care and perform nursing surveillance, also involving professional ethics, revealing evidence of the history and professional culture (3-6). Although their importance is fully identified, given that they respond to legal, institutional and professional commitment requirements, the reality shows that nursing professionals do not comply with their registration, due to the low value given to

them (7-8).

On the other hand, scientific guidelines suggest that nursing records should be carefully evaluated by the International Joint Commission (JCI) (9), to assess the quality of care and safety of care, which should be a permanent objective of analysis. For its part in Mexico, the Mexican Official Standard 168-SSA1-1998, of the Clinical Record, indicates that it is considered as a document of any medical record made by health personnel, where the facts and acts related to the care provided to a particular person are presented. In this sense, the nursing record is a fundamental element (10) that according to the Mexican Official Standard 004-SSA3-2012, of the Clinical Record, states that the sheet of nursing clinical records, must contain five elements such as: external habitus, vital signs chart, administration of medicines, procedures performed and nursing observations (11).

It should be noted that the intensive care unit (ICU) is a specialized health area, where care is provided to unstable patients who require continuous monitoring and surveillance. This nursing care began to develop in the 1960s in the United States, with strong development in England, Australia and Canada, and later in Latin America (12-13). Technological sophistication and evidence of the nursing registry have positively impacted the evolution of critically ill patients (14). In Mexico, hospitals offer two care options: conventional hospitalization units and ICUs, where the intensive nurse represents the major user of technology and health information (15) who, by making complete nursing records, will ensure the flow of information between the different actors involved, improving the quality and safety of care (16-17).

It can be indicated that the legislation of nursing clinical records improves a regulatory framework, improves the quality of care and generates risk-free care (18). In Mexico, currently within the legal framework of nursing clinical records, there is the Mexican Official Standard 004-SSA3-2012, of the Clinical Record (11), which establishes the 40 basic standards of the National Commission of Medical Arbitration referred to in the "Sheet to evaluate the effectiveness of nursing practice". This standard was created in 2017, to respond comprehensively to the performance of the nursing professional (19).

Similarly, it can be said that clinical records are documents that are prepared for all patients upon admission to a health institution, which must contain general and specific data of the disease such as: diagnosis of the patient, medical history and observations, among others. Therefore, this is a medical-legal document, and one of the most important that contains the clinical record, because it is basic for its content. In this context, the nurse is the person who has the greatest capacity to make known the evolution of the patient, through his/her records, a function that he/she performs at least three times a day (20). In other words, the medical record should record the patient's needs, the implemented clinical care behaviors, and the continuous evaluation of the care provided (21).

Hence, the formats and nursing records are currently of utmost importance, due to the increase in medical-legal situations, for which it is essential to have a backup of the work performed, which should ideally be: objective, precise, clear, legible and simultaneous (22). In 2001, the nurses formed a quality group to evaluate how nursing records were being kept at the Clínica Alemana. In 2002 the nursing assistants joined this group, with which better results were achieved (23).

On the other hand, they must be legible and easily accessible, since they are fundamental pieces in the care provided to the patient, since they support, maintain and promote the quality of clinical care; they also represent a source of information on the patient's state of health. It should be noted that they can be important for the evaluation in decision making and are also considered as legal documents that support the actions of the health team. Likewise, they should allow them to be analyzed for research purposes, since the record in the format makes it possible to identify the personnel in charge of a given patient, analyze the form of care, and carry out nursing surveillance (24).

The characteristics and quality of the nursing clinical record formats in the ICU area have been the object of research, since they are defined as a form of written communication that should be clear and concise, which has made possible a better interaction between the members of the health team (25), since they reflect in a significant way the process of continuity of care provided by the nursing professional to the patients.

It should be noted that the elements that make up the

nursing clinical record sheet in some Intensive Care Units are different concerning the criteria established by CONAMED since, in these units, it has been possible to identify that the format lacks, in some cases, these criteria.

It is necessary to emphasize that the documentation of the nursing practice is indispensable that it is correct in format and information, in such a way that it serves to evaluate, to improve the effectiveness and the productivity of the health professionals; to this respect the central axis of this study is to evaluate the level of fulfillment of the nursing sheet of an Intensive Care Unit in a public institution.

Objectives

To evaluate the level of compliance with the Intensive Care Unit nursing chart.

Specific objectives

- To identify the level of compliance with the standards in the clinical nursing records in the ICU.
- To identify the measures of central tendency of compliance with the standards in general, on the format of the nursing clinical record sheet referred by the National Commission of Medical Arbitration (CONAMED).

Materials y Methods

A quantitative and descriptive cross-sectional study was carried out focusing on the level of compliance with the Intensive Care Unit (ICU) nursing chart.

The study population consisted of nursing clinical record formats from an ICU in San Luis Potosí, Mexico, during the period between December 2020 and January 2021. For this purpose, a review of compliance with each of the standards was carried out, with a duration of 10 minutes for each nursing record.

Next, the nursing record sheets belonging to the ICU, which were found in the archive area of the selected institution, at the same time, the nursing record sheets of institutional services that did not belong to the ICU and those formats of sheets of patients with a diagnosis of SARS-Cov2 were excluded, for the safety of the researcher.

Finally, the sample consisted of 150 nursing clinical record sheets. This sample was made by convenience based on access to the institution due to the COVID-19 pandemic; therefore, its size was calculated according to the universe of the nursing chart formats (26).

The level of compliance was measured according to the chart to measure the effectiveness of nursing practice, referred by CONAMED, which is made up of 40 standards that evaluate overall compliance with the nursing chart formats. From this point of view, levels of compliance were adapted, where the 40 standards present 2 response options: 100% compliance and non-compliance; however, 2 more options could be identified, which showed partial compliance and the standards attached by the nursing staff to the sheet. Therefore, the level of compliance with greater adherence to the CONAMED criteria is evaluated as excellent, while the level of lesser compliance is evaluated as deficient. In the same way, the "Form to evaluate the efficacy of nursing practice" was used, designed and created by CONAMED, made up of 40 standards that jointly evaluate the compliance of the nursing sheet formats, which present 2 response options: 1=100% compliance and 2=no compliance.

Taking into account the above, the evaluation of the level of compliance with the nursing chart was based on the "Questionnaire to evaluate the effectiveness of nursing practice" to determine the effectiveness of the nursing practice referred to by CONAMED. However, 2 more response options not included in the questionnaire were added, to complete the standards: 3=standards with partial compliance and 4=standards attached. Therefore, since there was no scale for their evaluation, the following was used: Excellent evaluation: 100-91% compliance with the standards as a whole; Very Good evaluation: 90-81% compliance with the standards as a whole; Good evaluation: 80-71% compliance with the standards as a whole; Regular evaluation: 70-61% compliance with the standards as a whole; and Deficient evaluation: less than 60% compliance with the standards as a whole.

The data were analyzed using the statistical program SPSS Version 18, by means of inferential statistics

with frequency tables and percentages, in relation to the general level of compliance with the 40 basic standards of CONAMED, as well as the level of adaptation of compliance.

It should also be mentioned that the research was approved by the Ethics and Research Committee of the Faculty of Nursing and Nutrition (CEIFE) of the Autonomous University of San Luis Potosi (CEIFE-2020-329). Similarly, approval was obtained from the Ethics and Research Committee of the Social Security Hospital where the study was conducted in San Luis Potosi with internal registration: 007/2020. For all of the above, it is demonstrated that the Helsinki declaration code established by the 18th World Medical Assembly, Helsinki, Finland, June 1964, and amended by the 29th World Medical Assembly, was respected, respecting the importance of the validity of the study sample. Likewise, it is clarified that the research was conducted for educational purposes and under the knowledge and review of scientific literature, therefore the results obtained were published respecting the provisions of the Helsinki declaration (27). Likewise, the dispositions of the Second Title of the General Law of Health in Research Matters were followed, where it is established that all research will have the favorable opinion of the Research, Research Ethics and Biosafety Committees (Chapter I, Art. 14 Fracc. VII). Based on the characteristics and considerations stipulated in the regulations, the study was considered as research with risk, since documentary research techniques and methods were used, through the review of clinical records and others, (Title II Chapter I Art. 17, Fracc. I) (28). It is for this reason that the letter of no conflict of interest was taken into account, which states that there should not be any kind of problem before, during and after the research (29). In this sense, the points of the Decalogue of the Code of Ethics for Nurses in Mexico were followed, taking as a basic principle in the research the confidentiality and privacy of the information contained in the nursing forms. For this reason, the instruments were retained during data collection and were discarded when they were digitally transcribed into the statistical data package. In addition, the provisions of Chapter V, Nurses' duties to their profession, Art.24 which mentions the contribution to the development of the profession through research (30), were put into practice. Similarly, a letter was sent requesting authorization from the institution to use the information that would be used in the research. Finally, for the rationale of the study, the Mexican Official Standard NOM-004-SSA3-2012 of the Clinical Record was taken into account, which in its section 9.1 mentions that the sheet of nursing clinical records must contain at least 5 important elements such as external habitus, vital signs graph, administration of medications with date, time, amount and route, procedures performed and nursing observations; from which the questionnaire to evaluate the effectiveness of nursing practice related to the 40 basic standards of the National Commission of Medical Arbitration (CONAMED) is derived later (19).

Resultados

Table 1 shows the percentages of compliance with each of the 40 basic standards established by the National Medical Arbitration Commission. It can also be seen that the nursing clinical record sheet format for the Intensive Care Unit of a hospital in San Luis Potosí, Mexico, contains only 23 standards that comply 100% with the requirements of CONAMED, which represent 57.5%; therefore, the level of compliance of the format is evaluated as deficient.

Table 1. "General compliance with the standards of the nursing clinical record format of the Intensive Care Unit of a hospital in San Luis Potosí, Mexico, as established by the National Commission of Medical Arbitration"

Standard	Name of Standard	f	%
1	Identification	150	75
2	Medical diagnosis	150	100
3	Heart rate	150	100
4	Blood Pressure	150	100
5	Central Venous Pressure	150	0
6	Respiratory Rate	150	100
7	Alterations in vital signs	150	100
8	Height	150	0
9	Weight	150	0
10	Perimeters	150	0
11	Formula/Dietary/Oral Fluids	150	100
12	Patient intake	150	100
13	Fasting	150	0
14	Parenteral Fluids	150	100
15	Blood Elements	150	100
16	Timeliness of blood element administration	150	100
17	Total parenteral admissions	150	100
18	Liquid control	150	100
19	Outgoings: Uresis	150	100
20	Outputs: Evacuations	150	100
21	Outputs: Bleeding and suctioning	150	100
22	Total Income	150	100
23	Total Expenses	150	100
24	Laboratory collection and requisitioning	39	26.0
25	Reagent Collection: Destrostix/Glucocetonurias	150	50
26	Scheduling of surgical intervention	150	0
27	Medication administration	150	100
28	Performing treatments	150	100
29	Signs and symptoms	150	100
30	Nursing care	150	100
31	Identification of needs	150	100
32	Nursing interventions	150	100
33	Response and evolution to treatment	61	40.7
34	Responsible for providing care	111	74.0
35	Responsible for overseeing care	150	0
36	Sufficient staff according to quality indicators	150	0
37	Professional profiles	150	0
38	Material	150	0
39	Results: No complaints or lawsuits	150	0
40	Results: Absence of adverse events	150	0

Source: Own elaboration (July 2021) n=150

On the other hand, Table 2 shows that 23 standards are fully adapted to the clinical record format, with a frequency of 150, being the following: Medical Diagnosis; Heart Rate; Blood Pressure; Respiratory Rate; Alterations in Vital Signs; Formula/Diet/Oral Fluids; Patient's Intake; Parenteral Fluids; Blood Elements; Timeliness of Administration of Blood Elements; Total Parenteral Admissions; Fluid Control; Exits: Uresis; Exits: Evacuations; Exits: Bleeding and Suctioning; Total Admissions; Total Exits; Taking Reagents; Administering Medications; Performing Treatments, Signs and Symptoms; Nursing Care; Identifying Nursing Needs and Interventions

Table 2. Compliance with the standards of the nursing clinical record format of the Intensive Care Unit of a hospital in San Luis Potosi, Mexico, according to the National Commission of Medical Arbitration

Standar	Name of the standard	Compliance with standards							
		100% compliance		They do not comply		Partially compliant		Attachments by staff	
		f	%	*f*	%	*f*	%	*f*	%
1	Identification					150	100		
2	Medical diagnosis	150	100						
3	Heart rate	150	100						
4	Blood Pressure	150	100						
5	Central Venous Pressure			150	100				
6	Respiratory Rate	150	100						
7	Alterations in vital signs	150	100						
8	Height			150	100				
9	Weight							150	100
10	Perimeters			150	100				
11	Formula/Dietary/Oral Fluids	150	100						
12	Patient intake	150	100						
13	Fasting			150	100				
14	Parenteral Fluids	150	100						
15	Blood Elements	150	100						
16	Timeliness of blood element administration	150	100						
17	Total parenteral admissions	150	100						
18	Liquid control	150	100						
19	Outgoings: Uresis	150	100						
20	Outputs: Evacuations	150	100						
21	Outputs: Bleeding and suctioning	150	100						
22	Total Income	150	100						
23	Total Expenses	150	100						
24	Laboratory collection and requisitioning							39	26.0
25	Reagent Collection: Destrostix/Glucocetonurias					150	100		
26	Scheduling of surgical intervention			150	100				
27	Medication administration	150	100						
28	Performing treatments	150	100						
29	Signs and symptoms	150	100						

30	Nursing care	150	100				
31	Identification of needs	150	100				
32	Nursing interventions	150	100				
33	Response and evolution to treatment					61	40.7
34	Responsible for providing care					111	74.0
35	Responsible for overseeing care			150	100		
36	Sufficient staff according to quality indicators			150	100		
37	Professional profiles			150	100		
38	Material			150	100		
39	Results: No complaints or lawsuits			150	100		
40	Results: Absence of adverse events			150	100		

Source: Own elaboration (July 2021) n=150

In addition, 11 standards were identified that do not comply with those established by the National Commission of Medical Arbitration, which are: Central Venous Pressure; Height; Perimeters; Fasting; Scheduling of surgical intervention; Responsible for supervising care; Professional profiles; Material; Results: Absence of complaints or claims; Results: Absence of adverse events, with a frequency of 150 sheets, representing 100% of each of the standards.

It should be noted that 2 standards can be observed with partial compliance: standard 01 called Identification, in which the nursing clinical records should be indicated only presents: the Name of the Medical Unit, Name and surname of the patient, Service, Bed and Date; omitting the Affiliation Number, Age and Sex. Regarding standard 25, where the following reagents should be indicated: dextrostix/glucocetonurias, it only complies with dextrostix.

And finally, it was found that 4 standards with which the nursing clinical record sheet does not comply were attached by the nursing staff as follows: the weight standard, with a frequency of 150 sheet formats, equivalent to 100%; the standard for taking and requesting laboratories, with a frequency of 39 sheet formats corresponding to 26.0%; the standard for response and evolution to treatment with a frequency of 61 and a percentage of 40.7%; and finally, the standard for the person responsible for providing care, with a frequency of 111 and a percentage of 74.0%.

Discussion

The general level of compliance of the nursing clinical record sheet of the ICU of a public hospital in San Luis Potosi is deficient since it only complies with 23 basic standards, which represents 57.5%. In this regard, we can mention what Villa Suarez M. says in his research article entitled "Nursing Records as Evidence of Care" where he states that the absence of complete nursing record formats of care provided to patients can be understood as a legal and ethical fault; hence the importance of having quality formats that allow nursing staff to assume the task of caring for patients in a responsible manner (31). On the contrary, López et al. (32), refer in their research entitled "Construction and validation of a clinical record for nursing care", that in the evaluation they performed, a level of excellence was observed, with a total percentage of 95.59% of compliance with the sheet. From which it is concluded that it is of vital importance to have in the UCIS formats of nursing clinical records, which allow the nursing professional to capture in its entirety the care provided.

It should be pointed out that the ICU nursing clinical record sheet format has two standards of partial compliance, such as: Identification, where the Name of the Medical Unit, Name and surname of the patient, Service, Bed and Date are located, but the Affiliation Number, Age and Sex are not placed. The same happens with the standard on taking the reagents: dextrostix/glucocetonurias complying only with the taking of dextrostix. About what is said about the two previ-

ous reagents, Schachner B, et al. mentioned in the IX Brazilian Congress of Health Informatics, in 2004, that when the written forms of the services provided are not complete and accurate, they can be used as a legal basis to prove that the assistance has not been performed according to the accepted standards for its implementation, and therefore can become proof or evidence to sue the institution and the health personnel (33). On the other hand, Cáceres et al. (8)e, refer that despieven though the importance of the nursing clinical record formats is fully identified, incomplete records have been observed; that is, their partial non-compliance may be due to lack of adequate formats, work overload or detachment to them; from where it is important to have complete nursing clinical record formats that help to improve the continuity of patient care.

It should be mentioned that 23 basic standards referred to by CONAMED were identified, which implies that the ICU nursing clinical record sheet does comply with them, representing 57.5% of the totality of said format. On the other hand, García et al. (34), mention that the main function of the nursing notes, through their formats, is to prioritize the well-being of the patient, which is why they are essential, specific, so that they contribute to the health care of people, making possible the development of the discipline. From another point of view, López et al. (32), in their research article entitled "Construction and validation of a clinical record for nursing care", conducted in Mexico, specify that the formats for recording nursing care should respond to current updates in regulatory matters, so that they allow nursing staff to reflect the interventions made to the patient and recognize the role of professionals in the field of health, and thus achieve improve the care provided in the ICUs to patients.

As a counterpart, 11 standards were located with which the nursing clinical record sheet of the ICU of a public hospital in San Luis Potosi does not comply; hence Aguilar Garcia and Martinez (15), point out in their research article entitled "The reality of the Intensive Care Unit", conducted in 2017, that in Mexico, hospitals only offer two care options: the applicable in conventional hospitalization units and intensive care, services of health units where patients require constant care and specialized attention 24 hours a day; in addition, the format of the ICU of the institution where the research study was conducted is ambiguous coupled with the infrastructure of the unit, which makes the sheet fails to comply in its entirety with the standards required by CONAMED.

Finally, 4 standards were found to be attached by the nursing staff to the nursing clinical record sheet of the ICU of a public hospital in San Luis Potosí. In this regard Carrillo, cited by Santana y Bauer (20), in his research article "Quality of Nursing Care and Patient Satisfaction in a Teaching Hospital" conducted in 2014, refers that the documentation of nursing practice is necessary to evaluate, improve efficiency and productivity. However, the standards added to the sheet by the nursing staff, as pointed out by Villa (31), become important due to the complexity of the care provided through health care, the limits of health professionals and the ability to communicate effectively about patient care. In this regard, it should be added that the nursing clinical record formats are important because through them it is possible to demonstrate the implementation and compliance of essential actions for patient safety; they also allow improving the actions of nurses and their work performance, for the health of patients.

Conclusions

The level of compliance with the nursing clinical record sheet in the Intensive Care Unit of a second-level public hospital in San Luis Potosí was evaluated; it was found that some standards are compliant and others are not. At the same time, there are nursing clinical record forms that do not comply with the requirements of the National Medical Arbitration Commission (CONAMED).

With these results, a new sheet of nursing clinical records was proposed and designed for these Intensive Care Units, containing the provisions of the Mexican Official Standard 004-SSA3-2012, of the Clinical Record, in addition to the guidelines established by the 40 basic standards of the National Commission of Medical Arbitration (CONAMED), which assists the nursing staff in their work of recording in a comprehensive manner the care provided to the patient

Conflict de interest

The authors declare that they have no conflict of interest

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