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COMPLETENESS OF THE BOOKLETS OF PREGNANT WOMEN: REALITY OF THE NORTHWEST REGION OF PARANÁ

COMPLETUDE DAS CADERNETAS DE GESTANTES: REALIDADE DA REGIÃO NOROESTE DO PARANÁ

COMPLETUD DE LAS CADERNETAS DE GESTANTES: REALIDAD DE LA REGIÓN NOROESTE DEL PARANÁ

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ABSTRACT

Objective: This study aims to evaluate the completeness of completing the pregnant woman's portfolios, verifying the completeness of the information by the health team. **Method:** This is a field research based on qualitative and quantitative documents, carried out in a Maternity from northwestern Paraná. **Results:** An analysis was performed in the profile records, obstetric history, physical examination, consultations and examinations. Incomplete records and the lack of completeness of information relevant to health demonstrates that there are failures in the care offered, as well as that care for pregnant women is not being paid and consistent with current recommendations. **Conclusion:** It is evident that the lack of information on pregnant woman's handbooks interferes significantly in the final outcome of the gestational process and in the outcome of all care, being essential that health professionals are aware of the real situation so that they can improve the quality of care service offered.

Descriptors: Health assessment; Prenatal care; Nursing records; Medical records.

RESUMO

Objetivo: Este estudo tem por objetivo avaliar a completude do preenchimento das carteiras de gestante, verificando o preenchimento das informações por parte da equipe de saúde. **Método:** Trata-se de uma pesquisa de campo baseada em documentos de natureza quali-quantitativa, realizada em uma Maternidade da região noroeste do Paraná. **Resultados:** Realizou-se uma análise nos registros de perfil, antecedentes obstétricos, exame físico, consultas e exames. Os registros incompletos e a ausência de preenchimento das informações relevantes à saúde demonstra que existem falhas na assistência oferecida, bem como que o atendimento a gestante não está sendo integralizado e condizente com as recomendações vigentes. **Conclusão:** Evidencia-se que a carência de informações nas cadernetas de gestante interfere significativamente no desfecho final do processo gestacional e no resultado de toda assistência, sendo fundamental que os profissionais de saúde, estejam em conhecimento da real situação para que possam melhorar a qualidade de atendimento ofertada.

Descritores: Avaliação em saúde; Cuidado Pré-natal; Registros de enfermagem; Registros médicos.

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RESUMEN
Objetivo: Este estudio tiene como objetivo evaluar la integridad de completar las carteras de la mujer embarazada, verificando la integridad de la información por parte del equipo de salud. **Método**: Esta es una investigación de campo basada en documentos cualitativos y cuantitativos, realizada en una Maternidad del noroeste de Paraná. **Resultados**: se realizó un análisis en los registros de perfil, antecedentes obstétricos, examen físico, consultas y exámenes. Los registros incompletos y la falta de integridad de la información relevante para la salud demuestra que hay fallas en la atención ofrecida, así como que la atención a las mujeres embarazadas no se paga y es consistente con las recomendaciones actuales. **Conclusión**: se evidencia que la falta de información en los manuales de las mujeres embarazadas interfiere significativamente en el resultado final del proceso gestacional y en el resultado de toda la atención servicio ofrecido.
Descriptores: Evaluación en salud; Cuidado prenatal; Registros de enfermería; Registros médicos.

INTRODUCTION

Pregnancy conceptualized as a process of body and emotional transition, is a complex, transformative and dynamic stage, in which women experience moments of pleasure, doubts and anxiety, and must be based on a support base that provides encouragement in insecurities that may experience.[1]

This foundation is obtained during prenatal care, as it is a phase of intense health monitoring, whose care minimizes the anxieties present during the pregnancy-puerperal cycle.[2] However, it is observed that the quality of maternal care child care is fragile, mainly due to failures in care records.[3]

Thus, it is important to highlight that the pregnant woman's booklet is a means of transcribing care, performed throughout the gestational cycle, so the records are indispensable to maintain a quality prenatal care, and should include all conducts and procedures performed, so that the professionals involved are aware of the case.[4] The pregnant woman's card is a document that allows professionals to identify risk factors, women's health conditions, providing information storage both during pregnancy and in the process of delivery and later in the postpartum period, enriching care.[5]

The evaluation of the booklets is a very important process to analyze the prenatal quality, since it is possible to identify failures in care as well as partial records of care.[4] The initial step of filling in the booklet begins in the first prenatal consultation, where a registration is made in SISPRENATAL (Monitoring and Evaluation System of prenatal, childbirth and puerperium), which will be inserted in the follow-up pregnancy more information of the mother and her baby, until the process arrives which will include data on the conception and conditions of birth of the newborn.[5]

It is pointed out that the professionals who are involved in gestational care, despite knowing the importance of the records, do not value the importance of the correctly completed booklet. which implies the care process, hindering communication between the health team and interfering with the quality of care provided.[4] Thus, it is essential to rethink strategies that reduce prenatal lapses, as well as measures that bring the completion of care as an indispensable practice for the care of pregnant women.[3]

Thus, the objective of the present study is to evaluate the completeness of the pregnant woman's booklets, verifying the completeness of the information by the health team.

METHODOLOGY

This is a field research, quantitative in nature, which used the documentary analysis of gestational portfolios. This study was conducted from April 1, 2018 to June 30, 2018, in a maternity ward located in the northwest of Paraná state.

For the data collection, a specific form was elaborated, elaborated especially for this research and developed according to the recommendation established in the Guide Line of the Paranaense Network in its sixth edition, which involves the pregnant woman's profile, the risk stratification, obstetric antecedents, number of consultations and examinations to be performed.6 It is noteworthy that all records of the gestational process in the booklet, involving prenatal, delivery and postpartum period, were evaluated.

All puerperal women awaiting hospital discharge were included, agreed to participate in the study by signing the informed consent form and allowed the researchers to access their gestational booklet. The target population consisted of all pregnant women hospitalized during the research period who met the inclusion criteria. Thus, the final sample consisted of 244 gestational books.

For data analysis, the information collected was transcribed to a spreadsheet, where subsequently the quantitative data were analyzed and tables and graphs were elaborated.

Data were collected only after approval by the Research Ethics Committee Involving Human Beings of UNIPAR (Universidade Paranaense), under opinion no. 2,214,786, in accordance with current resolution no. 466/2012 issued by the National Health Council (CNS).

RESULTS AND DISCUSSION

The pregnant woman's booklet is an information and communication tool for the team, which favors care in prenatal care, as

it has significantly important data throughout the gestational process. Thus, completing and recording each care provided contributes to the quality of care, reducing the likelihood of complications and severe risks to maternal and fetal health.[5]

Regarding the profile of women, the age group in which the highest percentage was obtained was 19 to 30 years old (63.5%), as shown in the following graph. According to the Risk Stratification established in the Guide Line of the Paranaense Network (6th edition)[6], only pregnant women over 40 years are classified as intermediate risk, however, obtained in the research few women who had this age group.

It is noteworthy that late pregnancy is an aggravating factor that can compromise the health of the mother and fetus binomial, besides, it is a trend, increasingly present in the world, due to the feminine incorporation of the labor market, the questions of studies and improvement of design methods.[7]

Graph 1 - Age range of pregnant women attended at the maternity hospital in northwestern Paraná, 2018.

Source / Illustration: the authors, 2018.

Regarding education, we can analyze in the table below that there was a highlight for high school, which obtained a percentage of 34.83%. It is emphasized that education reflects directly on the degree of understanding of women regarding their health status and care during pregnancy, and is an indicator that stratifies pregnant women at intermediate risk when she is illiterate or has less than 3 years of age. study.[6]

Table 1 - Level of education of pregnant women attended at the maternity hospital in northwestern Paraná, 2018.

Level	Complete	Incomplete	Total

Not literate	1	-	1
Elementary	34	35	69
Medium	85	67	152
Higher	8	11	19
No registry	3	-	3
Total	131	113	244

Source / Illustration: the authors, 2018.

Regarding the marital status of the pregnant women, most (66%) of the women were married or have a steady partner, 20% were single, 0.40% were widows and 14% had a blank record. It is noteworthy that paternal participation during pregnancy provides a closer relationship of the couple, increasing the woman's safety, and consequently contributing to the increase of bonds during pregnancy.[8]

Regarding race, it was found that most women were brown (39.34%), 33.60% of pregnant women were white, 10.24% were black, 0.40% yellow, and 16.66 which did not have color-related records. As in some of the characteristics described above, the black or indigenous race is an indicator that stratifies pregnant women as intermediate risk, due to the higher risk of infant mortality in black women, as well as diseases such as sickle cell anemia.[9]

Another extremely relevant data is the gestational history, which directly influences the risk stratification of the pregnant woman and during the gestational process and delivery. When evaluating the portfolios, it was possible to find a great negligence in the notes related to obstetric antecedents, as shown in table 2.

Table 2 - Obstetric history of pregnant women attended at the maternity ward of northwestern Paraná, 2018 (*).

Background	Yes	No	No registry	Total
Abortion	36	83	125	244
Normal birth	49	71	124	244
Cesarean section	72	55	117	244
Ectopic pregnancy	0	49	195	244
Immuno	1	48	195	244

(*) 88 pregnant women had the complete physical examination and 156 did not have the complete physical examination.

Source / Illustration: the authors, 2018.

The relevance of completing the background is that it is information that can classify women into an intermediate degree of risk, such as a previous history of abortion, stillbirth or death. It is only quantified in the history of abortion that 51.22% of the books had blank records. Added to this, the issue of the routes of delivery is another factor that did not obtain significant records (normal birth - 50.80%; cesarean section - 46.72%). This omission of data demonstrates that there are failures in the assistance offered or that the care to pregnant women is focused only on some aspects, not using the principle of comprehensive care.

The table above also presents the records of physical exams, which must be done in a cephalo-caudal manner and carefully analyzed by the health professional. According to the Manual of prenatal and postpartum care, physical examination is a grouping of techniques (inspection, palpation, percussion and auscultation) performed by professionals to the pregnant woman, seeking to identify signs related to diseases or factors that compromise the well. being maternal-fetal, therefore, it is recommended that a detailed examination be performed at the first visit and, at the subsequent consultation, an examination directed to the systems that complain and register on the pregnant woman's card.[10] identification of risk factors that may interfere during pregnancy, favoring the detection of suggestive changes.[11]

When measuring the percentage of this factor, 63.93% of pregnant women did not obtain a complete physical examination, which seriously implies during all assistance. It can be inflicted that many times the professional performed the exam, however did not make the record in the booklet, thus implying the quality of all care and emphasizing the gaps in gestational care.

Regarding the number of consultations registered on the pregnant woman's card, only the minimum number of consultations was considered (7), in accordance with the recommendations of Rede Mãe Paranaense.

Table 3 - Consultations performed by pregnant women attended at the maternity hospital in northwestern Paraná, 2018.

Consultations	Date	Risk	Weight	IMC	PA	IG	Uterine height	BCF	Healthcare professional
C1	234	199	215	149	227	185	152	149	107
C2	232	183	216	91	230	203	171	189	87
C3	220	185	206	1	212	209	201	196	76
C4	234	183	199	73	212	198	202	206	73
C5	210	164	195	64	208	205	201	206	14
C6	196	167	193	69	206	200	193	201	66
C7	169	156	175	63	181	170	183	180	60

Source / Illustration: the authors, 2018.

It is during clinical consultations that the pregnant woman is stratified according to the present findings, so at each meeting the threshold, that is, the risk classification the pregnant woman is in can be changed.[6] Regarding the risk stratification It was observed that it is more accomplished in the first consultations, however it is easy to perceive the oscillation in all data released in table 3, compromising the quality of the consultations.

Together with this result it is possible to find disparity found in the number of consultations, where there was an average of four to five consultations by pregnant women during a normal term period of nine months. Other studies show this factor, indicating low adherence in relation to gestational follow-up and number of consultations.[2]

It was noted that there were few notes identified with the professional category in the portfolio, in 244 analyzed portfolios the average professional who noted and identified was 63.22%, emphasizing that most were registered by nurse. Correlating with other studies, a significant portion of the booklets did not contain complete records, including attendance without professional signature.[4]

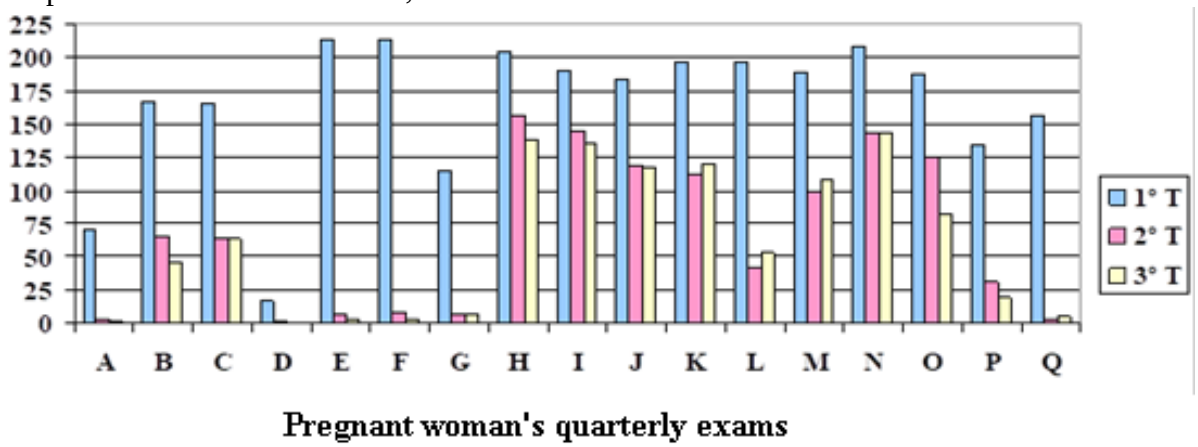
For laboratory tests recommended in Guide Line 6, the pregnant woman should perform the pregnancy test (1st trimester), rapid test for HIV or Elisa (1st, 2nd, 3rd trimester), Syphilis rapid test (1st, 2nd, 3rd trimester), VDRL (1st, 2nd, 3rd trimester), proteinuria dosage (only when necessary), blood typing and Rh factor (1st trimester), hemoglobin electrophoresis (1st trimester), Urine I (1st trimester), hematocrit (1st trimester) , 2nd, 3rd trimester), complete blood count (1st, 2nd, 3rd trimester), HBS AG (1st trimester), Obstetric Ultrasonography (1st trimester), cervicovaginal cytopathology (1st

trimester), toxoplasmosis (1st, 2nd, 3rd trimester), stool parasitology (1st trimester).

Through this recommended listing, it is necessary for the health professional to record the values of the exam results in the gestational card so that throughout the care there can be a consistent transmission of information. However, the results obtained in the research show that the effort to inform the performance / results of the exams is only verified in the first trimester (Graph 3).

Correlating with the findings of other authors[3], which reinforce the greater emphasis on the question of exam records only in the first routine, leaving the other quarters without adequate completion.

Graph 2 - Examinations performed by trimester by pregnant women attended at the maternity hospital in northwestern Paraná, 2018



Legend: Pregnancy Test (A), HIV Rapid Test (B), Syphilis Rapid Test (C), Proteinuria (D), Blood Typing (E), RH Factor (F), HB Electrophoresis (G), Urine Type I (H), VDRL (I), Hematocrit (J), Blood count (K), Anti HBS (L), Elisa (M), Toxoplasmosis (N), Obstetric USG (O), Cytopathology (P), Stool Parasitology (Q)
Source / Tabulation: the authors, 2018.

Corroborating the findings of the present research, another study states that the performance of gestational exams were not in accordance with the recommendations of the Ministry of Health.[2] Only a few exams obtained an average of 50% adequacy, as was the case of blood typing / Rh factor, HBs and Toxoplasmosis.

Highlighting the relevance of the blood typing test, the Prenatal Care Manual elucidates that blood incompatibility causes the formation of maternal antibodies that will act against the fetal antigen, resulting in diseases that caused health damage to both mother and fetus. , such as fetal erythroblastosis.[10]

Regarding the blood count and hematocrit tests, researches show a relative frequency of records, such as blood typing, HIV and syphilis. Regarding HIV specifically, the importance of diagnosing is that transmission can occur either during pregnancy, childbirth or the postpartum

period (breastfeeding), highlighting the higher risk of transmission (65%) during labor and delivery. syphilis, the risk of transmission increases during pregnancy, so the rapid screening test is oriented, however, due to the specificities of each region, the VDRL test is available.[10]

Regarding the parasitological examination, when it is not performed in the first trimester of pregnancy, it compromises the mother's health and fetal well-being, amplifying the risk of a premature and low birth weight newborn. Graph 2 shows that although 64% of pregnant women had the exam, a significant portion (36%) did not have a prenatal card record.

Access to health services is an obstacle that interferes with the early diagnosis of comorbidities, the treatment of those involved, and increases the possibility of vertical transmission to the fetus.[12] Therefore, the importance of knowing each reality and developing strategies is emphasized. so that the population is getting closer to access to health.

It is also mentioned some difficulties that interfere with the exam, such as the cost of the exams by each municipality, the doctors' resistance in the request and the organization of the laboratory process.[13] As a health team, it should be implemented ways to facilitate population access and minimize obstacles that prevent pregnant women from prenatal care.

It is pointed out that both laboratory and imaging tests add factors for the development of an adequate prenatal, so it is necessary to establish strategies that facilitate the access of pregnant women to both consultations and examinations, through free transportation to the location, resources related to availability and agility, as well as increased coverage of examinations in the public concerned.[13]

Through all the results that demonstrate the lack of notes on specific points of the card, it is emphasized that for quality care and reduction of indicators of infant morbidity and mortality, it is essential to improve actions that help the prenatal effectiveness, improving the training of professionals.[2]

CONCLUSION

When observing a gestational card and verifying how lacking information they may present, it causes concern about what the outcome of this woman's pregnancy / puerperal cycle will be, as it can be deduced that the follow-up was not performed correctly.

In this sense, the research elucidated some relevant aspects of prenatal care that were not adequately completed, which is

directly related to the quality of care offered.

It is noteworthy that the professionals should be qualified and committed in each new meeting they have with the pregnant woman, noting and performing each action performed, as well as the future mother to worry and understand that their adherence in all phases is essential for her health. and your baby's.

Therefore, it is worth mentioning continuing education as well as a good qualification of professionals who come into contact with prenatal care, to perform quality gestational consultations and also to captivate the pregnant woman to adhere to their periodic monitoring in a pleasant and conscious way.

Thus, it is concluded that the completeness of the pregnant woman's booklets in the evaluated region is flawed, and the managers should be aware of the real importance of each record to subsequently identify the necessary changes.

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