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PERMANENT EDUCATION AS A STRATEGY FOR IMPROVING NURSING RECORDS

EDUCAÇÃO PERMANENTE COMO ESTRATÉGIA PARA APRIMORAMENTO DE REGISTROS DE ENFERMAGEM

LA EDUCACIÓN PERMANENTE COMO ESTRATEGIA PARA EL MEJORAMIENTO DE LOS REGISTROS DE ENFERMERÍA

Neuranides Santana[1]
Maiara da Silva Brandão Rodrigues[2]
Caren Lorena Menezes Freitas[2]
Rebeca Lopes Oliveira[2]
Danielle Silva dos Santos[2]
Luanda Karina Oliveira de Sousa Barbosa[2]

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Objective: to report the experience of Permanent Health Education for improving nursing records in medical charts. Method: qualitative, descriptive study, of the experience-report type, performed at a public hospital in Salvador, Bahia, between 14 June and 19 July 2018. The nursing records were observed at five inpatient units and presented in wheels of conversation. Results: the professionals acknowledged the deficiency of records and associated it with lack of attention, work overload due to the team sub-dimensioning, lack of legality, insufficient space to record interventions and shortage of time to meet the demands of the sector. Conclusion: the experience has confirmed that the Permanent Health Education, in addition to fostering meaningful learning, can transform health work processes, since it is a modality of support and supporting element to qualify the healthcare work, in this case, enhance nursing records in the charts.

Descriptors: Nursing Records. Education, Continuing. Nursing Care. Nursing Process. Patient Safety.

Objetivo: relatar experiência de Educação Permanente em Saúde para aprimoramento dos registros de enfermagem em prontuários. Método: estudo qualitativo, descritivo, do tipo relato de experiência, realizado em hospital público de Salvador, Bahia, entre 14 de junho e 19 de julho de 2018. Os registros de enfermagem foram observados em cinco unidades de internação e apresentados em rodas de conversa. Resultados: os profissionais reconheceram a deficiência dos registros e associaram à falta de atenção, sobrecarga de trabalho devido ao subdimensionamento de pessoal, desconhecimento da legalidade, insuficiência de espaço para registro de intervenções realizadas e à escassez de tempo para atender às demandas do setor. Conclusão: a experiência confirmou que a Educação Permanente em Saúde, além de favorecer aprendizagem significativa, pode transformar os processos de trabalho da saúde, por ser uma modalidade de suporte e elemento de apoio para qualificar o trabalho em saúde, neste caso, o aprimoramento dos registros de enfermagem em prontuários.

Descritores: Registro de Enfermagem. Educação Permanente. Cuidados de Enfermagem. Processo de Enfermagem. Segurança do Paciente.

[1] Nurse. PhD in Nursing. Professor at the Universidade Federal da Bahia. Salvador, Bahia, Brazil. https://orcid.org/ orcid.org/0000-0003-0553-264X
[2] Nursing student. Universidade Federal da Bahia. Salvador, Bahia, Brazil. caren3_lore5@hotmail.com. https://orcid.org/0000-0003-3269-1953; https://orcid.org/0000-0001-6678-8193; https://orcid.org/0000-0001-7850-1380; https://orcid.org/0000-0001-5718-1664; https://orcid.org/0000-0002-6200-8337.

Objetivo: presentar la experiencia de educación permanente en salud para la mejora de los registros de enfermería en los prontuarios. Método: estudio cualitativo, descriptivo del tipo relato de experiencia, realizado en un hospital público en Salvador, Bahia, entre el 14 de junio y 19 de julio de 2018. Los registros de enfermería fueron observados en cinco unidades de hospitalización y presentados en las ruedas de conversación. Resultados: los profesionales reconocieron la deficiencia de registros, asociándola con la falta de atención, la sobrecarga de trabajo debido a la falta de personal, la falta de legalidad, espacio insuficiente para grabar las intervenciones y la escasez de tiempo para satisfacer las demandas del sector. Conclusión: la experiencia confirmó que la educación permanente en salud, además de fomentar el aprendizaje significativo, puede transformar los procesos de trabajo de salud, al ser una modalidad de soporte y elemento de apoyo para calificar la labor en el cuidado de la salud, en este caso, la mejora de los registros de enfermería en los prontuarios.

Descriptores: Registros de Enfermería. Educación Continua. Atención de Enfermería. Proceso de Enfermería. Seguridad del Paciente.

Introduction

Health work is collective and segmented. For this reason, in order to give continuity to the care, an objective, concise and effective communication between the members of all health teams is necessary[1]. The communication is characterized as one of the pillars of quality in health services and articulates changes to their weaknesses to achieve the best performance standard[2].

Communication as a management tool related to healthcare quality enables the sharing of information between the members of the multiprofessional team, prevents errors, favors transmission of messages securely, besides promoting a more directed and qualified care[2-3]. The training programs to develop communication skills, practical simulations and propositions to present information for users are effective ways to overcome barriers of ineffective communication and, consequently, improve care processes, the quality of health services and patient safety[4].

The quality of health care is an indicator that has been incorporated by health institutions to improve the service provision. This indicator allows for identifying problems and intervening, seeking to solve them. Therefore, it constitutes as one of the strands that aims to ensure the safe, legal and ethical professional work, without prejudice to the assisted user[5].

In relation to the nursing team, the records represent an indispensable tool in the process of interlocution of interprofessional care. They establish the communication between professionals of the nursing team and other members of the health team, basing and guiding the planning, provision and evaluation of care, as well as any other action or decision concerning the user's health[6].

As a legal instrument, the nursing records must have the following characteristics: printout properly identified with user data, written with coherence and cohesion, reliable, with specific date and times, clear, objective, with the author's identification, in chronological order, with readable font, without erasures and containing all the information relating to the user's health care process, when in the health service, in both the primary as secondary and/or tertiary health care Any untruth, incompleteness or even lack of data and information, in addition to generating ethical and legal implications, jeopardize the user safety and the quality of care[7].

This set of health information belongs to the user, and professionals are responsible for the confidentiality of the information and, at the hospital, for the safe storage of the chart with these records. This guides all professionals in the development of the provided care, especially those that comprise the nursing team, who provide direct care; promotes the development of nursing diagnoses; serves as a routing for targets to be reached and interventions to be adopted, according to the care plan. Therefore, this communication instrument must present the

users' needs, the clinical procedures implemented and the indispensable elements for continuity and evaluation of this process[7-8].

The analysis of medical records favors the investigation, remediation and reassessment of the therapeutic plan, as well as collaborates to audit, teaching, research and extension in health. Thus, the records in medical charts are allies to support the practice of all professionals from the health team[9] and contribute to the patient safety.

Motivated by this perspective, inserted into the context of hospital practice of the curriculum component Management and Permanent Education in Health and Nursing, of the Nursing Course of a public university in Bahia, students and professor focused on this theme.

Based on the exposed theme, studies discussing the panorama of nursing records are relevant, because they contribute to the advancement of knowledge about the need and benefit of meeting at least the legal ethical norms that underlie records in medical charts. Moreover, reflecting on their impact for users, service and professionals involved in the healthcare network constitutes as one of the targets to be achieved for patient safety.

This article aims to report an experience of Permanent Health Education (PHE) for improving nursing records in the charts.

Method

This is a descriptive study of qualitative approach, of the experience-report type, about the action of PHE about nursing records performed at hospitalization units of a general public mid-sized teaching hospital, located in the city of Salvador, Bahia, Brazil. The study was developed in the period from 14 June to 19 July 2018, predominantly in the morning shift on Wednesdays and Thursdays.

Six undergraduate nursing students and a professor developed the action during the implementation of practices of the aforementioned curriculum component, whose one of the goals is to provide students "the ability to recognize and apply the Permanent Health Education as a management tool". During this practice, allocated at a ward under the direct monitoring of the nursing-coordinating nurse and supervision of the professor of the course, each student develops management activities. In the occasion, each student is responsible for identifying and intervening in emerging demands of her respective ward, provided its relationship with at least one of the goals of the curriculum component. The action can be individualized or intersectoral. It is important to highlight that the problem/demand should be primarily shared and consented with service managers, as far as feasible, and the students must dominate it.

As a strategy to identify potential problems in the management of hospital health units, seeking to correlate with the National Program for Patient Safety (PNSP), established by Ministerial Decree n. 529 of 1 April 2013, the students chose the goal number two of the PNSP, which proposes the improvement of communication between health professionals[10].

The clipping of the chosen goal to approach was directed to the written intra and interprofessional communication of the nursing team and other health team members.

Aiming to substantiate the problematic in that context and expand the relevance of the intervention, the coordinators of five hospitalization units were contacted, who ratified the need for and interest in the proposal.

After authorization, the students observed the records made by nursing professionals of those five units, during nine days, period between the last week of June and the first week of July 2018.

For this purpose, a guide developed and adapted from a quantitative study conducted in 2012[11] on nursing records was used, containing the following variables from the medical records: date, time, erasures, blank spaces, identification of the professional category, full name and registration in the Regional Nursing Council (Coren), continuity of information, misspelling, nursing note and evolution, non-inclusion of comments/criticism, illegible letter, generalized/ evasive words, non-standardized abbreviations and information not related to the user.

After observing 267 nursing records, the students described the variables that most drew the attention in the group and analyzed them in the light of the Code of Ethics of Nursing Professionals in force and the National Program for Patient Safety[10,12]. The reflections resulting from these experiences outlined the intervention with the group of nursing workers in three of the five hospitalization units. Two coordinators could not reconcile the schedules of the respective teams during the period of the practices of students and professor.

The interventions occurred as a Permanent Health Education strategy. The Decree n. 1996, of 20 August 2007, provides the guidelines for developing the PHE policy as a tool in health management, which seeks to promote changes in the institutional dynamics and is based on the concepts of problematizing teaching and meaningful learning[13].

In this sense, its premise is the real experience in daily work, and the teaching-learning occurs based on the reflection of that labor context. This understanding favors the worker to rethink ducts, seek new strategies and ways to overcome individual and collective difficulties, related to nursing records in the charts.

Thus, the intervention was made based on problems faced in reality, considering the worker's knowledge and experience, aiming at transforming professional practices and work organization itself, recognizing the records as an important part of this labor universe.

Four wheels of conversation, one with the nurses of the three units, and three with the technical-degree team; the latter was grouped by inpatient unit.

The participants were 24 nurses, 33 nursing technicians, 3 nursing assistants. The students and professor led the wheels of the four times, thus distributed: on 10 July 2018, 5 nurses and 11 nursing technicians attended. On 11 July 2018, the intervention counted with the presence of 1 nurse, 12 nursing technicians and 2 nursing assistants. On 13 July 2018, 10 nursing technicians and 1 nursing assistant attended. On 13 July 2018, 10 nursing technicians and 1 nursing assistant attended. Finally, on 17 July 2018, the wheel occurred with 18 nurses present.

Purposely, a number of nurses was gathered in distinct group. Among these, three were nursing coordinators and the others, nurses in direct care. Due to incompatibility of time, six nurses were present in the initial conversation wheels.

The choice to gather this category intended to broaden the discussion about the role of the nurse in relation to the supervision of the work of nursing technicians and assistants, including records in the charts.

As for the group of technicians and assistants by unit of admission, the intention was to present a result according to the ward, aiming to awaken the sense of responsibility for the records in medical charts and, thus, prevent the transfer to the collective of other units.

Each meeting lasted, on average, two hours, time considered sufficient for the students' considerations, discussion and reflection of workers about the aspects involved in the work process that affect nursing records.

Experience results

The quality of health care needs instruments to qualify and expand the safety of users of the health service, in order to pinpoint and fix procedures for the better development of assistance. The nursing records work under this perspective, as they are used to ensure the chronology of what happened when that user was under the care of a specific health service. Nursing professionals need to know the importance of adequate reporting on records, because, in addition to being permanent, they direct the subsequent chain of care. Therefore, they should express care with trustworthiness[14-15].

Thus, for quality notes that guarantee the integral care to subject, they must be organized, impartial, consistent, comprehensive, legitimate, appropriate to the context, current, without erasures, legible and shall contain the complete identification of the professional[15].

In this experience, the aspects that stood out in the notes of records relate to incomplete professional identification and inconsistency of information contained in the notes and nursing evolutions. Furthermore, the lack of time on the record, the high rate of erasures and the presence of blank spaces between the end of the record and the professional's signature also stood out.

However, the greater severity related to seven records of users admitted to one of the observed units, in which there was no nursing record. This unit had the largest set of non-compliance related to nursing records. As a positive point, there was no exchange of information related to the user records.

The art. 35 of Chapter II of the Code of Ethics of Nursing Professionals (CENP), records that the nursing professional is responsible for "Writing down the full and/or social name, both legible, number and category of registration in the Coren, signature or rubric on documents, in the professional work", with optional use of the stamp. Nonetheless, this experience revealed a predominance of incomplete identification, suggesting that nursing professionals need to enlarge the attention and knowledge about the ethical and legal responsibility[12].

Regarding the notes and nursing evolutions, the experience revealed fragmentation and little adherence to the recommendations of the Nursing Process, given the low or even inconsistency of information contained in the records.

The nursing history was found in most records, showing appreciation of the health-disease history as the initial stage of the care process by nurses. There were also changes and some plans of nursing discharge, but the steps of nursing diagnosis and prescription were not located.

This fragmentation does not contemplate the continuous and systematic aspects of the Nursing Process, which allow for identifying the needs and related interventions, as well as monitoring the clinical evolution and set of actions for achieving recovery, health stabilization or even the finiteness of the user. This irregular shape suggests that nurses prioritize daily actions at the expense of the Nursing Care Systematization (NCS).

The discontinuity of the contents in the nursing notes was a significant characteristic in most records, not allowing for revealing the users' clinical evolution, in the same way of the work done by the team.

Considering these records as indicators of quality of care, describing them incorrectly, without time and discontinuously are factors that compromise the establishment of indicators, evaluation and certification. It can even prevent form serving as legal protection for workers, for the service or for the user.

Records in medical charts, for both the nursing professionals as other health team members, constitute a legal requirement. In the case of nursing, the Law of Professional Exercise, n. 7.498/1986, brings, in its art. n. 14, the task of noting, in the patient's medical records, all activities from assistance; in the CENP, the art. 36 through 38 reinforce the duty of

> Recording, in the medical chart and other documents, the information inherent and essential to the care process clearly, objectively, chronologically, readable, complete and without erasures [...] Formally documenting the steps of the nursing process, according to its legal competence [...] Providing written and/or verbal, complete and reliable information, necessary for the care continuity and patient safety[12].

Therefore, the nursing records in the charts about the actions or activities with the user are part of the legal and ethical responsibility of nursing professionals.

These aspects were also found in a study conducted at two hospitals in Maceió (AL) that investigated, in the period from May to December 2012, through the analysis of the content of the nursing records in the charts of hospitalized patients, "[...] the contributions of the content of the records to the care practice based on the nursing process"[17:24]. The research results showed that the content of the records is deficient, does not portray the patient's reality, nor the nursing care provided, which, in turn, is a worrying symptom, repeated in other researches that involve the same thematic and exposes ethically and legally the nursing professionals[17].

Another study, conducted at a teaching hospital in Minas Gerais, between February and March 2015, described the importance of the nursing notes in the patient's medical records for the nursing team and discussed the professional and institutional implications of nursing records. The study showed that a large part of the team recognized the importance of nursing records, but was unaware of the law and the ethical-legal sanctions resulting from non-compliance[7].

The analysis of the manuscripts in medical records allowed for raising aspects that propitiated reflections about the implications of (in)correct nursing records in the quality of care and patient safety. It also favored detailed perceptions regarding the lack of information to ensure the integral and systematized care according to the NCS.

Although the note process is directed to the records of nursing professionals, inevitably there were some cases of absence of records of other categories of health team. This occurrence hinders, or even prevents, the interprofessional communication and consequently weakens the user safety.

Also in this perspective, there were, in the charts, accumulations of messy papers, which denotes the little appreciation of the information contained therein. This panorama sustains the justification for removing the "older" records, considered unnecessary for actions, preventing access to information relating to the near past, thus preventing the analysis of evolutions of the user's health condition.

Since the chart is a set of documents that shows the history of health visits of the user of the health service, the lack of access to the totality of information weakens the chain of interprofessional communication and increases the vulnerability to failures in the care process. The charts, in students' practical field, are not yet electronic and handwritten records are made on paper. These features increase the difficulty of handling, storage and conservation.

In all four wheels of conversation, the participants initially were surprised with the results presented. However, as a result, many acknowledged the deficiency in implementing the nursing records and associated with the lack of attention, work overload due to the team sub-dimensioning, lack of legality, insufficient space on the charts to record interventions and lack of time to meet the routine demands of the ward.

At the end of the wheels, it became clear to the authors that the professionals understood and acknowledged the risk of inconsistencies of nursing records. They were sensitized about the possibility of the records appreciate the work done, prove the productivity, the continuity and quality of care provided, directly affecting patient safety, with ethical and legal support, and in financial aspects of health.

Despite the difficulties related to implementing the correct records, initiatives are necessary to stimulate behavioral changes and critical reflection on how to improve the practice of records, as well as the supervision, monitoring and guidance of nurses in cases of non-compliance.

In the subsequent wheels of conversation, the coordination received folders with clarifications concerning the theme and the operational plan of the students for distribution among nursing professionals who had not attended the socialization. In this way, the contents could be accessed by the whole team. Another strategy was the elaboration of a banner with information about legal and ethical responsibilities involved in records in medical charts and the implications of (in)correct records for users, the professionals and the health service.

The experience confirmed that the PHE, also in the hospital context, provides significant learning and expands the possibility of implementing changes desired in the service[18]. Similar to another study, the PHE proved to be effective as a strategy for improving the quality of nursing records, stimulating critical and reflective thinking of professionals[19].

Dialogs with nursing professionals about completing the record in medical charts, according to the current legislation, is an important PHE tool that can be used at the hospital.

Conclusion

Regarding the importance of nursing records in the charts, free of non-compliance, it becomes relevant to reorganize the service, so that there is no work overload and undersized team, to ensure that the nursing professional is able to execute his/her function.

Nurses, as leaders, need to review and monitor periodically the records made in the medical charts, with the purpose of guiding, clarifying and strengthening the knowledge on aspects that are relevant to implement and ensure the safety of the user, team and even the recognition of the organization.

In the same perspective, nursing professionals should be routinely alerted about their legal and ethical responsibilities regarding their praxis, considering that such work processes focus on the life of human beings.

The experience confirmed that the PHE, in addition to fostering meaningful learning to the authors, could transform the health work processes, as a modality of support and supporting element to qualify it.

The reflection, together with the workers, on nursing records, reinforced the will to approach and produce experiences that encourage active and critical participation of the authors in the construction of their knowledge.

Collaborations:

1 – conception, design, analysis and interpretation of data: Neuranides Santana, Maiara da Silva Brandão Rodrigues, Caren Lorena Menezes Freitas, Rebeca Lopes Oliveira, Danielle Silva dos Santos and Luanda Karina Oliveira de Sousa Barbosa;

2 – writing of the article and relevant critical review of the intellectual content: Neuranides Santana, Maiara da Silva Brandão Rodrigues, Caren Lorena Menezes Freitas, Rebeca Lopes Oliveira, Danielle Silva dos Santos and Luanda Karina Oliveira de Sousa Barbosa;

3 – final approval of the version to be published: Neuranides Santana.

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