Nursing Documentation in Occupational Health

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Abstract

Purpose: Traditionally, nursing documentation has been consistent with hospital standards and legal definitions of clinical nursing practice. Identify data and information nurses need to be recorded in order to maintain the continuity and quality of nursing care and the efficiency of nursing performance is a research question that is moving professionals around the world. This study objective is to describe the analysis of nursing documentation in the patient records. Methods: It is a retrospective study. The study was conducted in the ambulatory occupational health nursing; it was selected 111 patient records. Of these, in 106 we identified a total of 775 nursing records. The nursing records comprise the following dimension: identification, job history, health state, health and safety, psychological and socio-cultural, medical history, physical examination and nursing assessment. Results: In the data set elements found as documented in the subjective data and objective data, there was higher frequency of data elements related to the following nursing dimensions: health state, health and safety, physical examination and nursing assessment. The dimension of job history we found that 25% of the nursing records did not documented information about the current work status of the patient. In addition, the current job activity (20.77% of the records), working day (9.03% of the records), job process (8.13% of the records), worksite exposure (8.0% of the records), environmental works (6.19% of the records), occupation (5.81% of the records), job time (4.39% of the records), before job activity (4.13 % of the records), and work location (3.23% of the records) were not also documented. Conclusion: In conclusion, the present study was an attempt to highlight the importance of data to be documented and organized in the existing information systems in the specific area of occupational health care. The adequate data collected can provide the right information to improve nursing care in this care setting and enhance health population.

Keywords:
Documentation; Nursing Records; Occupational Health Nursing; Nursing Informatics

1. Introduction

The American Nurses Association –ANA [1] defines nursing as the diagnosis and treatment of human responses to actual or potential health problems. To support nursing care practice in different countries and settings, the nursing process methodology have been used as a useful instrument of record to answer the retrieval of data improving individualized patient care, and patient needs for decision making. The ability of the nursing professional to make a difference in patient outcomes must be demonstrated in practice and reflected in the records in the documentation [2] [3] [4].
Traditionally, nursing documentation has been consistent with hospital standards and legal definitions of clinical nursing practice. The records and reports of nursing care are also considered a legal documentation in the patient records [4]. The clinical record is the vehicle of communication of patient information among the multi-professional direct care health team members. It is through this record that nurses, physicians and other professionals involved with care are able to guarantee the performance and continuity of proper treatment, enabling the adequate delivery of care and safeguarding ethical and legal aspects involved in it. [5] However, some studies demonstrate that manual nursing records of patient information is frequently inaccurate and incomplete.

It is also important to emphasize the adequacy by which the information is presented in those records; information must be objective, clear, complete, so that all members of the health team understand its context and meaning [5].

In Brazil, the nursing practice on outpatient unit is named as nursing consultation. It is the encounter between nurses and patient, the mean nurse uses to provide care to the patient in the ambulatory unit. It is regulated and legitimated by Decree n. 94.496, dated June 8, 1987 of the Law of Professional Practice n. 7.498, dated June 25, 1986 [6]. The nursing consultation is also based on the nursing process that is a systematized and scientific methodology to identify real or potential health needs of the patient in order to provide an effective care.

In occupational health, nursing consultation practice and record must include what is related to the workplace and its influence on the health-sickness process, aiming at measures of promotion, protection, and rehabilitation. With the establishment of systematic records, we can obtain essential information to generate individual or collective work-health-sickness process and to identify characteristics of the social groups where this process takes place, allowing for a better understanding of real or potential life and work conditions [7].

In nursing occupational health care, the protocol for nursing interview can comprises questions related to health history (survey on chronic-degenerative damages1) and occupational history (survey on occupational damages2, occupational situation, work relations, work environment, ergonomic issues). Frequently, patient information is recorded based on: (a) Subjective data that comprises the data related to clients’ complaints; (b) Objective data which refers to physical and clinical exams; (c) Impression that is the documentation of all considerations that nurses had about clients, problems, diagnosis and treatment), and (d) Conduct that refers to the actions and interventions of the nursing staff in the resolution of problems identified.

With the adequate information obtained and identified, nurses can implement interventions at the individual level as to:

- Nutritional reeducation;
- The adequate use of protection or spacing equipment, in cases of exposure to harmful factors;
- Orientation as to physical safety rules, that is, the importance of respecting the vertebral axis, maintaining balance, using the strength of legs, nearing to loads to be lifted, among others;
- Prevention and control of damages produced by mental and psychical loads of work; all of these should not be neglected in interventions.

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1 Chronic-degenerative damages are understood as: systemic arterial hypertension, diabetes mellitus, cardiopathy, obesity, dislipidemias, etc.
2 Occupational damages are understood as: repeated effort lesions or osteomuscular diseases related to work, dermatoses, illnesses related to hearing, sight, the respiratory system, etc.
Considering the increasing volume of information and the greater complexity of data, the clinical records in its manual format, i.e., paper-based, is an inefficient records that can compromise the quality of nursing care [5]. Identify data and information nurses need to be recorded in order to maintain the continuity and quality of nursing care and the efficiency of nursing performance is a research question that is moving professionals around the world.

This study objective is to describe the analysis of nursing documentation in the patient records. The selected local is the nursing ambulatory of occupational health. It is our understanding that patient records are both a means of clinical documentation and a means of communication between providers involved in patients’ care.

**Background**

The study was conducted in the teaching hospital of Federal University of Porto Alegre, Rio Grande do Sul, situated on the south region of Brazil. Since 1997, the hospital implemented a computer-based application system for management and clinical documentation, including admission, transferring and discharge, diagnosis and therapeutics’ support service, surgery scheduling; drugs order, and patient management. In 2004, it was included the clinical documentation application. In such a system, nurses, physicians and professionals involved in the delivery of care, can record patient information. Nursing documentation is based on the nursing process. The institution staff designed the protocol for data collecting. The general format includes subjective data, objective data, impression and conduct.

**2. Materials and methods**

It is a retrospective study. The study was conducted in the ambulatory occupational health nursing of the teaching hospital of the Federal University of Porto Alegre, Brazil.

It was selected 111 patient records. Of these, in 106 we identified a total of 775 nursing records. The period of data collection was from August 1998 to August 2003.

The nursing records comprise the following dimension: identification, job history, health state, health and safety, psychological e socio-cultural, medical history, physical examination and nursing assessment. The data set elements selected are presented in the Table 1.

The analyses were done by SPSS (Statistical Package for the Social Sciences), according to the theoretical perspective of studies in nursing and informatics and its interrelations.

**3. Results and discussion**

Of the 111 patient records analyzed, 106 presented nursing information in occupational health. These records comprised several outpatient visits per patient in which we identified a total of 775 (N) nursing records.

The nursing record protocol is based on the phases of the nursing process that is recognized a method of obtaining patient information. It can combine data gathered from the history-talking interview, the physical examination, and data gathered from the results of laboratory/diagnostic studies.

In the data set elements found as documented in the subjective data and objective data, there was higher frequency of data elements related to the following nursing dimensions:

- Health state: food (93.03% of the records), hydration (89.42% of the records) and leisure activity (79.87% of the records);
Health and safety: symptoms of disease/illness (86.45% of the records), current complaints (85.94% of the records), treatment (63.23% of the records) and medication (52.90% of the records);

Physical examination: blood pressure (96.65% of the records), body weight (95.10% of the records) and behavioral (62.32% of the records);

Nursing assessment: adherence behavior nursing care (75.61% of the records).

Table 1 - Data set element of nursing records documentation

<table>
<thead>
<tr>
<th>Dimension Identification</th>
<th>Dimension Job History</th>
<th>Dimension Physical Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Job Activity (current)</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>Age</td>
<td>Job Activity (before)</td>
<td>Body Weight</td>
</tr>
<tr>
<td>Race</td>
<td>Job Process</td>
<td>Height</td>
</tr>
<tr>
<td>Sex</td>
<td>Job Time</td>
<td>Laboratory/diagnostic studies</td>
</tr>
<tr>
<td>Religion</td>
<td>Working Day</td>
<td>Pulse (palpation)</td>
</tr>
<tr>
<td>Hail from</td>
<td>Current Work Status</td>
<td>Glucometer</td>
</tr>
<tr>
<td>From</td>
<td>Worksite Exposure</td>
<td>Muscle Measures</td>
</tr>
<tr>
<td>Phone number</td>
<td>Work Location</td>
<td>Assessment Respiratory</td>
</tr>
<tr>
<td>Civil status</td>
<td>Environmental Works</td>
<td>Face</td>
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<tr>
<td>Occupation</td>
<td></td>
<td>Ears</td>
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<td></td>
<td></td>
<td>Eyes</td>
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<tr>
<td></td>
<td></td>
<td>Neck</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neuro/Muscular Assessment</td>
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<tr>
<td></td>
<td></td>
<td>Skin Integrity</td>
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<td></td>
<td></td>
<td>Mucous</td>
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<td></td>
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<td>Communication</td>
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<td>Behavioral</td>
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<td>Status Mental</td>
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<td>Status General</td>
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<td></td>
<td></td>
<td>Emotional State</td>
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<tr>
<td></td>
<td></td>
<td>Body Balance</td>
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<td></td>
<td></td>
<td>Mobility</td>
</tr>
</tbody>
</table>

The lower frequency of data elements related to physical examination was: height (29.94% of the records), laboratorial and other exams (28.77% of the records), emotional state (28.26% of the records), and neuro/muscular assessment (24.13% of the records).

The lack of data elements in the initial stage of the application of the nursing process in the records analyzed indicates an initial lack of information to support real and potential needs of patients. According to Marin, Rodrigues, Delaney, Nielsen and Yan [2] the subsequent stages of the process depend on the quality of the initial assessment and its respective documentation. In this study we verified that the initial stage of the process was not properly documented in the sample analyzed. For instance, related to the dimension of job history we found that 25%
of the nursing records did not documented information about the current work status of the patient. In addition, the current job activity (20.77% of the records), working day (9.03% of the records), job process (8.13% of the records), worksite exposure (8.0% of the records), environmental works (6.19% of the records), occupation (5.81% of the records), job time (4.39% of the records), before job activity (4.13% of the records), and work location (3.23% of the records) were not also documented.

It can be said that a smaller frequency of data elements collection does not mean that it have not been collected, since this data is implicit in the nursing impression and conduct, where nurses record their diagnostic impression as well as actions and interventions they provided. Another interesting finding was that in around 6.0 % of all records analyzed, subjective and objective data, impression and conduct were not always interrelated, or were not even consistent when conduct and data collected in the anamnesis and physical examination were compared.

Florence Nightingale, in *Notes on nursing: what it is, and what it is not*, stated that the purpose of documentation such observations was to collect, store, and retrieve data so that patient care could be managed intelligently [8]. Moreover, the documentation is the evidence that nurse’s legal and ethical responsibilities to the patient were met and that the patient received quality care [2][8][9].

Likewise, the documentation of phrases such as “there were no further alterations” (11.23% of the records), found in the subjective data, and “nothing further was observed” (21.42% of the records), found in objective data, are an ambiguous way of recording, for one cannot be sure whether elements were collected or not.

Marin states that it is impossible to give continuity to quality care if documentation is inadequate, absent, unreliable, and incapable of supporting clinical decisions; (...) the health environment increases the demand for professional growth and for the development of efficient documentation systems to be used simultaneously by many health professionals. [3]

### 4. Conclusion

Documented information is an essential element for the assessment of the quality of nursing care. Therefore, records must translate the application of the nursing process where action and delivery of care to the patients be assured and nursing ethical and legal aspects respected.

Developing a computer-based data collection to support nursing documentation is very important. Priority should be given to the design of interface and database. There is a real need of adequate methodological tools to provide not only the survey on health conditions and harmful occupational factors, but also the relation or association of elements that comprise the work-health-sickness process, taking into account both organizational and environmental aspects, as well as life conditions of workers.

Considering the scope of analyzed records, it is our understanding that:

a) Records must be kept in order to feed a database that guarantees the analysis of information to support and describe nursing practices in occupational health;

b) The terminology used must be adjusted in order to facilitate answers and avoid simple “yes” or “no” answers, making comprehension easier to achieve effective outcomes;

c) Question included on the patient interview protocols must be unambiguous in order to clarify its content in an accessible and pertinent way, facilitating the participation of providers.

In conclusion, the present study was an attempt to highlight the importance of data to be documented and organized in the existing information systems in the specific area of
occupational health care. The adequate data collected can provide the right information to improve nursing care in this care setting and enhance health population.

5. References


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