THE HEALTH WORK PROCESS IN A SURGICAL CENTER: The Record as a Noise

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ABSTRACT

The objective of this study was to identifying and discussing the implications of the records as constituent elements of the work / care process in the Surgical Center (CC). It is an evaluation research. As analysis tools, we used the "sentinel trajectory" and the "analyzer flowchart" for organization and analysis of data collected in documents that represented the written memory. The setting was the CC of a public institution of Rio de Janeiro. There were identified 30 noisy points, of which 13 noises are records with 230 occurrences. These may allow risks to the client, failing to control unnecessary spending on inputs and technological devices and to monitor drug therapy, mainly antibiotics causing adverse damage and events. The effects of records emerges as largest category of noises, resulting in communication between teams, on the continuity of care, as a source of data for researches and legal defense instrument for customer and institution.

Keywords: *Nursing Records; Nursing; Hospital Operating Room*

INTRODUCTION

This article is cut of the dissertation entitled "Health Working Process in the Surgical Center: implications for Nursing", which analyzes the records as interfering noise in the work process in the Surgical Center (CC) and its implications for nursing.

Health work is of a collective nature in which several categories share technical and scientific resources in the production of care. Its specificity is the fact that it is a relational work supported by communication between the teams, especially nursing records (MERHY, 2007).

Records and notes in the medical records are formal instruments of assistance, providing visibility and continuity of care, daily monitoring of clients' conditions, and serves also as a means of communication between the teams involved in care (ROQUE, MELO, TONINI, 2007).

These records are intended to transmit customer information related to nursing care provided in the course of practice and should pinpoint the needs and health situations defendants and interventions. Thus, the quality of nursing records influences in the work process in health institutions.

One can understand that the work process in health nurses is realized or legitimized through their care process, developing actions, attitudes and behaviors based on scientific knowledge, experience, insights and critical thoughts, made for and with the patient / client / to be careful.

Another of care is a scientific act that requires nursing diagnosis, intervention and review recorded, surpassing the simple implementation procedures and established routines. Caring involves understanding and undertaking specific nursing actions justified in the scope of acts directed also to organization, planning and therapeutic management of people in the health area (FRANCO, 2007)

Numerous situations may prevent or hinder the nursing care management in DC, configured as noisy points in the work process, namely: changes in surgical map for suspension of operations; blurring of surgical management and the flow of hospitalized patients for surgery, causing lack of beds available for post-operative; absence or failure of institutional routines and rules on pre-operative care and customer referrals to DC. In addition to these noisy points, there is a failure and / or weakness in nursing records as the highest voltage, causing damage to the Unit routine and client.

In this sense, emerges as research question: What are the implications of the constituent elements of the record in the care process in the Operating Room?

The aim of this study is to identify and discuss the implications of the records as constituent elements of the work process / care in the Surgical Center.

Research, discuss and stimulate discussion on this subject between the nurses involved in the daily care and manage is critical to improving direct customer support and communication between health professionals. The record makes visible the specific know-how of Nursing. When it documents the care provided, lights care inherent in Nursing through a written memory, creating possibilities to the scientific profession.

2 THEORETICAL FOUNDATIONS

Think the world of work health and relationships involved in this process involves creating "a way of looking at a health service, of any nature which would realize some situations and important characteristics about" making health "and which allows reflect on how is the work on a day-to-day services, which is its own, those who work and as it does, to what, why, who and how serves ... "(MERHY, 2007)

In health services, the notion of work does not follow the principle capitalist rules of consumption, and are based mainly the symbolic reference of life care and the other, with the central object the world of the needs of individual and collective users.

Thus, in the process of work, nurses organize the production of care, guided the conceptual guidelines established in the Unified Health System (SUS). One of the guidelines shall cover the completeness because it is a principle inherent in the continuous organization of the work process in health services, according to Mattos; Pine (2001).

Gomes and Pinheiro (2005) warn that integrity is a concept under construction, for now adopted as "a democratic way of acting, know-how integrated" in a care grounded in the principles of honesty, responsibility and trust between managers, professionals and users.

Nurses then should be strengthened to an increasingly collective work and greater interdependence among different professionals, so that meet the intense and continuous transformations and technological diversification of health work, especially in scenarios such as the Surgical Center.

A collective work should be an "action with purpose and intention of collective that produces and reproduces and only does so because it is permeated by power and symbolic constructions" (RAMOS, 1999 p.106).

However, if there is no worker's identification as a collective subject, there will be discontent and frustration and only the existence of a team working together as observed by Campos (1997, p.72) for workers in the public area.

For Malta and Merhy (2003), workers must feel as active subjects in the rehabilitation process on the other, being responsible for the ultimate goal of their intervention. Thus combine the opening of spaces for creative freedom and professional autonomy with the establishment of responsibility with users through a pact around a collective project, ensuring quality in health.

In addition, with the health work of a collective nature, its specificity is also in being a relational work, perform and produce against moments are professional-user or professional to professional; where everyone brings their expectations, their knowledge and their understanding of health needs. (MERHY, 2007a)

In workshops, professionals share their different knowledge, technologies and views / perceptions, bringing their own "toolbox" that for Franco; Merhy (2005) consists of a range of knowledge and skills to be applied in an attempt to meet the needs of users or even of other colleagues.

In order to be a relational work and be supported in wills, views, perceptions and knowledge of the subject, some authors, such as Franco (2005 and 2007); Onocko (2007); Malta (2003) and Merhy (2007) argue that health professionals establish a micro-work, understanding it as its own way, particularly to govern, to decide their attitudes, to relate, and do their job, in daily life the world of health. In this micro, people are individually and collectively fabricators and manufactured in ways of acting and relating.

When looking this micropolicy, Merhy (2007) says that the work takes place in acts in labor movements that can be alive or dead. As "work" is defined all work in action, which takes place at the time, when it is run, a creative work. For this, one can avail of "dead work" seen how the tools, raw materials, that is, a work performed previously by others.

All acts of health work expressed through knowledge mediated by technologies, sorted by Merhy as (op cit.): A - hard technologies (equipment manipulation, instruments), soft-hard B - (structured knowledge technical, protocols and working methods, routines and processes) and light C (related to the bond and relationship skills). Jointly are used by professionals, alternating the predominance of one over the other.

This predominance depends on the modes of action of each worker, since it establishes its own way of doing their job, providing a degree of autonomy, freedom or "self-government". From the level of "self-government", each worker stands in his own way of work establishing his territory, holding meetings with the other, called intersector times (Merhy, 2007), to produce health care.

In the process of conserving and challenging the order given in health institutions, being instituted and instituting, it builds up new working routes and lines of flight, sometimes silent processes that are characterized as noise, fighting, and conflict, interrogative truncated relations instituted way, opening up possibilities that may point different ways of walking.

3 METHODOLOGIES

It was an evaluative study, based on microdecision processes CC everyday identification noise (Franco, 2007). We used analysis tools like the trajectory sentinel and the flowchart analyzer due to the interrogator potential of processes and products, "since the questioning of the way and who produced such intervention to question the intentions of the subjects performing the actions and, the model that are serving "(JORGE, 2007)

The flowchart search "draw" a set of processes that link around a care supply chain, enabling industry stakeholders processes schemes, service or health facility, through the identification of existing noise. This analyzer tool is an instrument to interrogate workers in the care process, "as" working, "what" this way of working and is producing "so that" you are working (MERHY, 2007).

The setting was the CC a public hospital in Rio de Janeiro reference to urgent care and emergency in the city and metropolitan area. The delimitation of the field was made by an institutional clipping represented by the analysis of a case considered exemplary because of the required set of interventions and procedures during the hospitalization period of a given customer, acting as "trajectory sentinel" and enabling display the route trodden and customer needs.

For the case of election "sentinel", the inclusion criteria were: customers above 21 years old, with more than a mark or indication for surgery in the same hospital in the period from July 2008 to July 2009. This choice is due to the fact that multiple entries or indications to suggest CC mobilization extensive network of relationships or consumer product.

During data collection, we used the documentary book analysis of the CC surgeries record and surgical maps filed for case selection "sentinel" electing a hospitalized client for orthopedics, which was in an advanced stage of treatment and had required several admissions in the sector.

Then, we tried to detailed analysis of customer records with the case "sentinel" elected from admission in the emergency room until discharge from the orthopedics sector. This cut was necessary due to prolonged hospitalization in orthopedics concomitant to the numerous surgical interventions.

Data analysis demanded the chronological order of events, services and required care; tracking test results, nursing developments and medical opinions, since the institution customer records follows the traditional structure referred to as services and sectors.

Regarding the ethical aspects, this study was authorized by the Civilian Research Ethics Committee of the Municipal Health Department and Defense of Rio de Janeiro, under the number 126/09.

4 RESULTS AND DISCUSSION

The case study deals with the hospitalization of E.S.L., a client of 39 admitted with open fracture in his left leg and remained hospitalized for 107 days in the surgical clinic of orthopedics.

Through the trajectory sentinel analysis, there were identified 30 noisy points, 13 of which noises are records of 230 occurrences were found: absence of 26 records / nursing developments; 12 records initialed without stamp, 23 prescriptions for several days; absence of 32 records / medical developments; no check of 04 medications; 46 unsigned nursing records; absence of 04 blood products administration records; absence of 03 prescriptions for blood products; absence of 24 prescriptions; 05 medication checks and unrealized; absence of 02 records in transfusion record; non-registration of vital signs for 48 days; 01 incomplete filling in the form of anesthesia.

In addition, issues relating to the medical records and missing information in it for document archiving elsewhere. For example, the form for registering the surgical procedure referring to the start and end of anesthesia, surgery, the team members' name, description of the procedures performed and materials and medicines consumed in every anesthetic-surgical act. This information could serve as statistical data to feed the indicators of results and impacts of health care.

Sometimes, incipient information in medical records demanded the search for records books, old maps and surgical register on the RPA to elucidate obscure points.

Having the flowchart based on this trajectory and analyzing the marked noise, there is the absence / disability assistance of records is the main villain, can also affect data collection for this research. There is no possibility to determine whether the care was provided and how it was provided, if the records are inadequate.

For noise intra-teams identified, one can establish the division between nursing and medicine noise, encompassing questions regarding the registration. For nursing, lack of records and checking of medications are indicators of risk in the care provided, which can cause harmful results to the client's health and disastrous for the management of institutional work process. As for the noise of the medical team, are characterized as deficiencies records associated with therapy, identified by double prescription for the same client, prolonged use of antibiotics, prescription for several days, and absence of medical developments.

This reality has been confirmed by studies that indicate numerous deficiencies in the nursing records. One such study conducted in a university hospital, in order to analyze the notes / records made by the nursing staff, assessed 124 records and found that the notes / nursing records do not provide data needed to support the process of care and does not constitute an efficient tool for communication and evaluation of the quality of care (MATSUDA, et al, 2006).

So it seems that the acts and actions developed by professionals, especially nurses, demonstrate attributes of a practice of care in very poor health with changes in logical sequence of procedural steps or assumption of wayward ways, uncontrolled and unfocused of knowledge and do-specific exercing packed in DC and other institutional sectors.

Based on the teachings and writings of Florence Nightingale, a study says that hospital nurses must have "responsibility for ambience, by working conditions and everything else concerning the mechanisms and prevention of human error in the hospital work" and recognizes that the hospital nursing needs "to be seriously investigated and properly reconsidered" (Carvalho, 2009). Practicing these teachings implies mobilize professional knowledge to identify noise and make appropriate decisions for problems solutions, and require the understanding of the situation as a whole and therefore the parties at a specific time of the work process. However, if this process is not registered, the information will be lost. Only with an effective record, the care provided has scientific basis and becomes, therefore, quality.

Failure to written communication intra and inter-unit create tension and damage to relations between professionals; in the spaces of light technologies (welcoming, bonding, responsibility and autonomy); and writing memory, whose missing information cannot be taken as an object of evaluation in a management process to monitor quality indicators and cost-benefit or in a care process documenting the therapy implemented for the client that enables the management of cases and the effective systematization of individually nursing care.

The medical record is a legal document with information regarding customer history, their illness or problem and its treatment. The records must show the changes and demonstrate the evolution of the client during the entire period of service. The quality of nursing records in order and in the institution's database is a reflection of the quality of care offered.

In the case of this study, the absence of developments and medical prescriptions and nursing is very worrying for: enabling customer risks, fail to control unnecessary spending on technology inputs and apparatus; fail to accompany drug therapy, especially antibiotics causing adverse damage and events.

Find as many failures in the nursing record, as no record of procedures on blood transfusions, no nurses records during initial 107 days of hospitalization and even the absence of any nursing record for days in care, causes issues such as: will this team is unaware of the importance of documenting the assistance? There are some personal quantitative problem that prevents this record is done? Lack supervision of the activities of the team? Any training programs or continuing education will be needed? Or is this lack of "word" any sign or provocation?

It is essential to note that the studies pointed out some causes for this limitation in the registry such as the small number of professionals, lack of time to make records, excessive administrative and bureaucratic activities, the absence of a working organization of institutions, whichever yet, culture that nursing is a support service for the other categories (PIMPÃO, 2010).

If so nursing is presented, also fails to comply with the ethical and legal principles of the profession set by regulatory and oversight agencies such as the Federal Nursing Council (COFEN), that both the Code of Ethics, Chapter I, Article 25 establishes the responsibility and duty of the nurse, the record in the patient's inherent and indispensable information to the care process; as in Resolution COFEN 358/2009, in Article 1, decides that the nurse is up privately, among others, the evolution of nursing, defined as the registration by the nurse after the evaluation of the condition of the patient, must appear in this record the new problems identified, a brief summary of the results of prescribed and the problems to be addressed within 24 hours.

However, the nurse records were not targeted / implemented according to a method for the systematic professional work, especially the systematization of nursing care, with regard to diagnosis, intervention and client assessment and the environment.

Do not paying attention to the registration of shares offered to take care of - the evolution of customer conditions or actions to be implemented - the prescription of Nursing or Medical prescription, appears as a process of working out of regulatory standards and actions strategic inefficient to mobilize the theoretical and practical knowledge of each profession.

Mobilize professional knowledge includes knowing make appropriate decisions for troubleshooting or even to identify noise, and require the understanding of the situation as a whole and therefore the parties at a specific time of the work process.

Understand the situations of the whole to the parts requires recognizing that the work in healthcare has in intersectional moments and meetings to meet the needs of customers, professionals and institutions, producing intangible and immediate consumption goods - health care. To do this, one must have political notions

understood as the way in which each person involved acts, makes decisions, stands and reacts in the work process. That is, how it establishes and participates in a micro-politics of health work, regardless of the setting of care she and her clientele are (MERHY, 2007).

Reducing risks in healthcare requires concern for the safety of customers, whose acts and nurse's actions are based on the principle of quality of nursing care. This quality must be received by indicators to assess the care offered and improve professional practice. There are eleven basic indicators for a client in the CC: of laser injury, electricity injury, radiation injury, injury by foreign bodies, maintenance to normothermia, injury surgical positioning of chemical injury, falls in transfers, problems related to drugs, adequate filling of intraoperative records, and pain (DIB, 2008); identifying that the issue of registration is one of the indicators.

In practice, nursing professionals dedicate hours to ensure quality customer care, but there is no record of what they do. Care not registered; there is, is part of the hidden work of nursing does not receive due recognition (BLOOMER, 2011). The registry is a commitment and responsibility of nurses and expresses the technical and scientific competence and the rescue of their work (Ferreira et al, 2009). With the low quality of the record, which today are found in the records, there is little contribution to the preservation of the profession written memory. It seems that nursing walks for a "death foretold" (Machado, 2010).

5 CONCLUSIONS

Describing health work process in the CC allows the identification, analysis and discussion of the established network relationships among professionals and the interfering noise in this process, especially experienced by nurses.

Although the use of the analyzer flowchart has required time, patience and dedication to the data collection, it was instrumental in the organization of data, identification of the noise and the network of intra and extra-unities relations. This tool enabled the discrimination of events and the outcome, demonstrating the customer's movement and professionals in the work process.

Issues involving the absence and the precariousness of records documenting the customer support through the records were evidenced. It can be said that this situation represented / collaborated in difficulty to grasp this process work.

These absences point to a lack of commitment to the issues of continuity of care, information exchange in an interdisciplinary team, the lack of data to supplement future research, formulating new elements for managing the unit and the institution, beyond the written memory of professions.

Thus, it is understood that illuminating nursing care through memory writing is, above all, giving visibility to an accomplished work that cannot be perceived / seen by other professionals or family as it is an art of caring instant.

However, one should not think the error / failure under the requirement of punishment, but as a process failure. A "noise" that through "analysis tools" will alert to a given reality and rethink on activities and labor relations, favoring the responsibility and commitment to each other.

Thus, the unveiling of the existing records in the work process of the nurses, perhaps as higher purpose instrumentalize them or make them aware through this expanded focus of its reality, to see that they can change this situation. If put together the problems under discussion, seeking collective solutions, leaving the complaints and uncomfortable to face the problems, will certainly find solutions.

Nursing Records are keys to proving the application of a care based on scientific engineering principles, without which nursing would not be a science, from the simple care provided without any direction.

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