

# The practice of records in Occupational Therapy: reflections on the technical-legal grounds of the resolution COFFITO-415

## A prática de registros em Terapia Ocupacional: reflexões sobre os fundamentos técnico-legais da resolução COFFITO-415

Tatiana Barbieri Bombarda<sup>1</sup>, Mauricio de Souza Moreira<sup>2</sup>,  
Daniel Ferreira Dahdah<sup>3</sup>, Taís Quevedo Marcolino<sup>4</sup>,  
Regina Helena Vitale Torkomian Joaquim<sup>5</sup>

<http://dx.doi.org/10.11606/issn.2238-6149.v29i1p85-91>

Bombarda TB, Moreira MS, Dahdah DF, Marcolino TQ, Joaquim RHVT. The practice of records in Occupational Therapy: reflections on the technical-legal grounds of the resolution COFFITO-415. Rev Ter Ocup Univ São Paulo. 2018 Jan.-Apr.;29(1):85-91.

**ABSTRACT:** This study tries to weave reflections from the technical-legal foundations of the resolution of the Federal Council of Physical Therapy and Occupational Therapy (COFFITO), number 415, sanctioned in 2012, which regulates the procedure of occupational therapy (OT) records. We present the state of the art of OT record in Brazil, the relationship between clinical/therapeutic reasoning and its record and the guidelines for the resolution COFFITO-415 in order to elucidate tensions, fragilities and give prominence to the powers of OT records. In addition, the article works on some practical aspects to expand the practice of OT record in the area.

**KEYWORDS:** Occupational therapy; Records as topic/legislation & jurisprudence; Therapeutic approaches/legislation & jurisprudence.

Bombarda TB, Moreira MS, Dahdah DF, Marcolino TQ, Joaquim RHVT. A prática de registros em Terapia Ocupacional: reflexões sobre os fundamentos técnico-legais da resolução COFFITO-415. Rev Ter Ocup Univ São Paulo. 2018 jan.-abr.;29(1):85-91.

**RESUMO:** Este artigo busca tecer reflexões a partir dos fundamentos técnico-legais da resolução do Conselho Federal de Fisioterapia e Terapia Ocupacional (COFFITO), número 415, sancionada em 2012, a qual regulamenta o procedimento do registro terapêutico ocupacional em prontuário. Apresentamos o estado da arte das pesquisas sobre registro em prontuário no Brasil, as relações entre o raciocínio clínico/terapêutico e seu registro e as diretrizes da resolução COFFITO-415 de modo a elucidar tensionamentos, fragilidades e dar destaque às potências do registro em prontuário. Além disso, o artigo busca trabalhar alguns aspectos práticos para ampliar a prática de registro em prontuário na área.

**DESCRIPTORES:** Terapia ocupacional; Registros como assunto/legislação & jurisprudência; Condutas terapêuticas/legislação & jurisprudência.

1. Universidade Federal de São Carlos – UFSCar, São Carlos, SP, Brazil. ORCID: <http://orcid.org/0000-0002-9478-7945>. E-mail: tatibb\_to@yahoo.com.br
2. Regional Council of Physical Therapy and Occupational Therapy of the 2nd Region (CREFITO-2). ORCID: <http://orcid.org/0000-0002-7402-5433>. E-mail: msm\_mb@hotmail.com
3. Universidade Federal de São Carlos – UFSCar, São Carlos, SP, Brazil. ORCID: <http://orcid.org/0000-0002-0777-2674>. E-mail: daniel\_dahdah@hotmail.com
4. Universidade Federal de São Carlos – UFSCar, São Carlos, SP, Brazil. ORCID: <http://orcid.org/0000-0002-9694-5118>. E-mail: taisquevedo@gmail.com
5. Universidade Federal de São Carlos – UFSCar, São Carlos, SP, Brazil. ORCID: <http://orcid.org/0000-0003-3700-397X>. E-mail: joaquimrhvt@gmail.com

**Corresponding address:** Tatiana Barbieri Bombarda. Department of Occupational Therapy – UFSCar, Rod. Washington Luís, km 235. São Carlos, SP, BR. Zip Code: 13565-905. E-mail: tatibb\_to@yahoo.com.br

## INTRODUCTION

The term record comes from Latin and corresponds to a unit of useful information related to a person<sup>1</sup>. In the health field, a patient record is a collective construction derived from multiple specialized records on care procedures carried out, aiming at improving the patient's quality of care<sup>2</sup>.

A record is an important tool not only for the health care context, by facilitating the medical staff communication and monitoring of procedures and results obtained, but also for administrative purposes by handling data on productivity, billing and quality of the service provided<sup>3</sup>. Nevertheless, a record has legal purpose, as it consists of a trustworthy resource to protect the professional and to legitimate its professional action<sup>4</sup>.

In addition, according to subsection II of article 3 in Ordinance GM 1.820 of the Ministry of Health, of August 13, 2009, the patient is entitled to "be informed about his/her health condition in a clear, objective, respectful and understandable manner"<sup>5</sup>. In this way, information from record belong to the patient, and the professionals and institutions are responsible for data safeguard and confidentiality<sup>6</sup>.

Thus, "register in record" should be understood as a occupational therapist's procedure of writing down information from the assessment process, intervention, complications, discharge process, referrals made and results obtained, in a chronological and systematized way. In Brazil, discussions and researches focused on the record are easily found in the medical and nursing field<sup>7,8</sup>, which is associated with the historical development of the medical record, which occurs in parallel to the medical science development<sup>9</sup>. However, in the occupational therapy context, Brazilian studies on this subject are scarce and show indications of certain weaknesses in this practice<sup>10,11,12</sup>.

Bombarda and Palhares<sup>13</sup> investigated this professional practice in the school context and found occupational therapists do not perform records of all the interventions made in this field. Moreover, some difficulties arise: (a) comprehension of the information recorded by professional colleagues in order to provide continued care; (b) not making time for record in the

structuring of the work routine; and (c) notes about unawareness on the resolution No. 415. These are factors that certainly interfere with the documentary quality.

A document analysis performed by Pelissari and Palhares<sup>12</sup> in 15 records of occupational therapy from a child and adolescent clinic identified that, despite the readability of the notes, the lack of professional identification and signature is frequent. In addition, information is lacking on the patients' prognosis, as well as explanation about the therapeutic conduct and the results obtained.

Other impasses concerning the record refer to a particular written narrative of occupational therapy, considering that the main objective is to foster meaningful professional experiences for patients so that they can be more active in their lives<sup>14</sup>. Some studies<sup>15,16</sup> discuss occupational therapists' difficulties in describing concisely their procedures in a narrative way, ending up giving a greater emphasis on descriptions of deficits<sup>17</sup>.

However, as the professional practice focuses on promoting occupational engagement and/or social insertion and participation, therapeutic procedures related to assessment, interventions, prognosis and discharge criteria gain greater visibility and facilitate the public discourse about actions in occupational therapy, such as records. This is one of the most visible aspects of the importance that the relationship between theory and professional practice have, because the practice takes more shape, have more purpose and gain more clarity as theoretical concepts are clearly expressed by professionals in a fruitful dialogue in both directions<sup>18</sup>. In this sense, Panzeri<sup>19</sup> argues that a greater investment in addressing the topic of documentary practice in the process of initial and continued training is necessary, regarding it as a potent factor for changes in the practice and professional perception regarding this theme.

It raises possibilities of reflections and investigations on technical-legal aspects and on the quality of records to understand the difficulties faced by the professionals when recording information, as well as to build strategies to overcome and solve existing problems. In this sense, through technical-legal aspects established by resolution No. 415/2012 of COFFITO, this article seeks to weave reflections fostering the record practice, as well as to improve its quality.

### The Resolution No. 415/2012

In Brazil, the document for guidance of occupational therapists on the act of registering in health records is the resolution No. 415/2012 of COFFITO. Such resolution gives guidance on the compulsory nature of the record practice; of safeguarding the record for five years from the last note; and of the duty of keeping the record in a place that ensures confidentiality and privacy; and provides guidelines that define the minimum content to be included in this document.

As listed in article 1, paragraph 1 of the resolution, the occupational therapy record should be composed of eight items. These items are presented in italics, followed by our considerations.

1. *Identification of the patient: full name, place of birth, marital status, gender, creed/religion, ethnicity, sexual orientation/usual name (optional), date of birth, profession, commercial and residential address.* Such information guide the process of opening a patient record. These data comprise the systematization of management and storage of information, as well as direct the initial knowledge about the patient and where to contact him/her.
2. *Clinical history: main complaint, life habits, current and previous history of the disease; personal and family background, treatments.* This item includes information related to the history of the health-disease process, in which medical-clinical diagnosis, treatments provided and engagement of the patient in these treatments, temporality of the clinical picture, complaints, factors of life context impacted by the effects of the illness and its experience, and expectations about the treatment to be started in the occupational therapy must be considered. The scope of such information requires, on the part of the occupational therapist, practice of empathic listening, observation of behaviors and adequate interpretation of the verbal and nonverbal language expressed. The record should be made based on what is explained by the subject and can include the comments of the occupational therapist.
3. *Clinical/educational/social examination: description of health status, quality of life and social participation,*

and occupational profile according to the occupational therapeutic semiology. This item consists of information from the assessment process, which seeks to make know data of the subject's daily life, recorded through notes that specify how his/her routine is, the activities he/she performs (assessed by performance areas, for example), his/her skills and difficulties, and the main micro and macro social contextual factors interfering with his/her health, quality of life and social participation. Depending on the theoretical-methodological framework, the professional can specify whether exists losses on components of the patients' occupational performance, level of importance and patients' satisfaction with their own occupations, among other things.

4. *Complementary examinations: description of the complementary examinations carried out previously and of those prescribed by the occupational therapist. It consists of a record of information from examinations made in the patient along his/her health-disease process that are considered important for constituting his/her situational diagnosis. According to resolution COFFITO No. 81/1997, article 3, the occupational therapist can resort to other professionals in the health team to request specialized technical reports accompanied by their respective results of complementary examinations, to expand the understanding of the patient's process of evolution.*
5. *Occupational therapeutic diagnosis and prognosis: description of the occupational therapeutic diagnosis considering the health status, quality of life and social participation of the patient, establishing the probable occupational therapeutic prognosis comprising the estimation of evolution of the case.* Through the assessment process, the occupational therapist identifies demands and, through them, he/she detects the occupational therapeutic diagnosis. The diagnosis should have the occupation as a basis, considering that the latter is the core of the professional performance.

It is observed that this item, in practice, is a great difficulty for the professionals, who must pay attention to evaluation elements related to needs of the patients' daily life contexts. Such stratified demands and their importance for the quality of life and social contribution of this individual are elements that facilitate the establishment of a diagnosis. Regarding prognosis, exploiting the strengths observed and analyzed by the occupational therapist is a possibility, preferably with the contribution of the patients. A suggestion of writing encompasses stratification of the needs identified and possible predictability to be achieved with interventions.

6. Occupational therapy plan: description of occupational therapy procedures proposed by reporting resources, methods and techniques to be used and therapeutic objective(s) to be achieved, as well as a probable number of appointments. These notes explain the professional planning, desirable goals, and resources and techniques employed. Indicating the number of appointments is recommended to reach these goals – although, in our conception, peculiarities of the fields of work should be considered.
7. *Evolution of health status, quality of life and social participation of the patient: description of the evolution of the health status, quality of life and social participation of the patient, as well as report of the treatment performed in each appointment and of possible complications.* The notes related to the evolution of the intervention should be made in the days of the appointments and, preferably, soon after the sessions, minimizing risks of losing information. This record should inform the procedures of each appointment, the patient's response to the interventions carried out, and whether a complication occurred. Information without context such as "conduct maintained" and "without complications" should be avoided.
8. *Identification of the professional who provided assistance: signature of the occupational therapist and stamp with his/her full name,*

*register number in the Regional Council Of Physical Therapy And Occupational Therapy (CREFITO), in accordance with the articles 54 and 119 of the resolution 08/1978 of COFFITO, and date of the procedures.* The identification of the professional at the end of each note validates the record and identifies the responsible for the intervention; thus, the document can be used for legal purposes in case of necessary clarification or defense on the part of the professional regarding his/her practice. Recording the date allows chronological view of the therapeutic pathway, which becomes easier to localize the information and favors the patient's perception of his/her own evolution.

#### **Main infraction notices issued through resolution No. 415/2012**

Aiming at expanding indicators of the scenario of record practice in the occupational therapy, we chose to consult the 16 departments of inspection (DEFIs) of the CREFITOs through a letter sent by email in April 2017. Half of them answered the request (CREFITOs 1, 3, 4, 5, 6, 8, 14 and 15) and another eight did not answer (CREFITOs 2, 7, 9, 10, 11, 12, 13 and 16). Information on infraction notices arising from the inspection process related to problems in occupational therapists records from January 2013 to July 2017 were organized in Chart 1.

The aforementioned infraction notices refer to the absence of record and daily record, which characterizes violation of resolution No. 415/2012 of COFFITO.

In addition to the resolution No. 415/2012, resolution No. 418/2012 of COFFITO (amended two years later by resolution No. 445/2014) should be highlighted, because it fixes and sets the parameters of care for occupational therapy. This resolution from item III of article 3 expresses that providing systematic record in record about the evolution of the patient and the therapeutic conduct of the professional is the responsibility of the latter. Chapter III, article 13, of the code of ethics of occupational therapy can be added to such regulation, expressing professional duty to ensure that the patient's record will be out of reach of strangers.



**Chart 1** – Information on infraction notices related to occupational therapists' records

Council	Information on infraction notices related to occupational therapists' records
<b>CREFITO 1</b>	Period: from 2013 to July 2017 Infraction notice: 30 infraction notices due to noncompliance of COFFITO Resolution No. 415.
<b>CREFITO 3</b>	Period: from 2013 to 2016 Infraction notice: 70 infraction notices due to noncompliance of Resolution COFFITO No. 415.
<b>CREFITO 4</b>	Period: from June 2014 to May 2017 Infraction notices: mean of 145 annual infraction notices/legal notices to professionals. Absence of record both from physical therapists and occupational therapists represents 82% of the total of infraction notices issued.
<b>CREFITO 5</b>	Period: from 2016 to June 2017 Infraction notice: 192 legal notices due to absence of record in 2016, and 124 in 2017 (until June). Data computed by professional category were not recorded.
<b>CREFITO 6 and 8</b>	These councils do not issue professional infraction notices related to irregularities in record and, therefore, they do not have information about it. Their inspection department usually guides professionals during visits to clinical institutions.
<b>CREFITO 14</b>	Period: from 2014 to 2017 Infraction notice: no records of infraction notices due to absence of record or daily records of care services provided by occupational therapists.
<b>CREFITO 15</b>	Period: from 2016 (year of beginning of this DEFI) to May 2017 Infraction notice: 13 infraction notices regarding the absence of record in 2016, and 5 until May 2017.

## DISCUSSION

The record expresses the clinical/therapeutic reasoning of the professional, showing the pathway of the processes of assessment (identification of needs and composition of occupational therapy diagnosis), intervention (objective of the appointment, conduct adopted, resources used, complications occurred, response of the patient to the interventions) and discharge (results obtained, goals reached, justification of the referrals). Considering the trajectory of the therapeutic process, record becomes an ally of the professional because it contains information that can be accessed for adjustments in the therapeutic project and prognostic understanding.

As the occupational therapy usually adopts a model of transmission and record of information related to the technique, the assumptions of its theories and the efficacy of its interventions are not shown, remaining as a fragile field in terms of scientific evidence<sup>20</sup>. One of the challenges for the 21<sup>st</sup> century is the identification of evidences on what can and should be considered in a conscious, explicit and careful way for making decisions in the patient's care<sup>21</sup>.

Although the most consistent evidences comes from researches that use systematic methods (systematic reviews, meta-analyses, randomized clinical trials)<sup>20</sup>,

Whiteford<sup>22</sup> discusses the need for constructing evidences in a continuous process that enhances researches on better practices and for different research problems that incorporate the complexity of the practice in occupational therapy.

More precise and complete records, with detailed information, readability, and structure of technical writing can provide variables qualifying the notes taken, compounding a new range of evidences for researches closer to the reality of the professional practice. In addition, considering the technical-legal aspects themselves, the appropriation of the professional class guidelines and of the minimum content to be included in the records contributes to the visibility of the clinical practice and of the role of the occupational therapist.

In relation to resolution No. 415/2012, it is based on the health sector – and therefore, it does not meet particularities of different fields of practice of the profession, which encourages reflections on the need for future amendments. It is understood that sanctioning this resolution is an advance for this professional class. However, as next steps, promoting dialogues to enhance such guidelines will probably encourage potential openings for writing records with the specificities demanded by the profession.

## CONCLUSION

We believe that the resolution No. 415/2012 of COFFITO represents an important advance for occupational therapy through the understanding of the need for systematization of the professional practice in the act of documenting the clinical practice, because of the potential visibility of the clinical practice and the public role of the occupational therapist – considering the record a channel for becoming the professional's public discourse<sup>17</sup> – and also for being material that, given the ethical assumptions of research with humans, support

the construction of evidences in a continuous process focused on the reality of the practice<sup>22</sup>.

However, this resolution provides general orientations for the practice of occupational therapists in their registers in records, being characterized as generalist, which denotes the need for deepening its guidelines.

Based on the aforementioned content, this article intends to trigger reflections on the subject on how to encourage improvements in the quality of the records, and possible improvements in the resolution itself, considering specificities of different fields of the profession.

**Authors' contribution:** All the authors have contributed in the different stages of construction of this article, that is, all participated in the conception, design, discussion and final draft of the manuscript.

---

## REFERENCES

1. Dicionário Houaiss de língua portuguesa. Prontuário. Rio de Janeiro: Objetiva; 2009. p.1561.
2. Mesquita AMO, Deslandes SF. A construção dos prontuários como expressão da prática dos profissionais de saúde. Saude Soc. 2010;19(3):664-73. <http://dx.doi.org/10.1590/S0104-12902010000300017>.
3. Possari JF. Prontuário do paciente. In: Possari JF. Prontuário do paciente e os registros de enfermagem. São Paulo: Látria; 2007. p.17-34.
4. Brasil. Resolução nº 415, de 19 de maio de 2012. Dispõe sobre a obrigatoriedade do registro em prontuário pelo terapeuta ocupacional, da guarda e do seu descarte e dá outras providências. Diário Oficial da União. 2012, maio 23; Seção 1.
5. Brasil. Ministério da Saúde. Portaria nº1820 de 13 de agosto de 2009. Dispõe sobre os direitos e deveres dos usuários da saúde. Diário Oficial da União, 2009, agosto 14; Seção 1. p.80.
6. Motta GHMB. Um modelo de autorização contextual para o controle de acesso ao prontuário eletrônico do paciente em ambientes abertos e distribuídos [tese]. São Paulo: Escola Politécnica da USP; 2003. doi: 10.11606/T.3.2004.tde-05042004-152226.
7. Alves MA, Szpilman ARM, Poton WL. Avaliação do registro médico nos prontuários de um ambulatório de ensino, Vila Velha, ES. Rev Bras Pesq Saúde. 2015;17(3):69-77. doi: <https://doi.org/10.21722/rbps.v17i3>.
8. Carneiro S.M, Dutra H.S, Costa FM, Mendes SE, Arreguy-Sena C. Uso de abreviaturas nos registros de enfermagem em um hospital de ensino. Rev Rene. 2016;17(2):208-16. doi: <http://dx.doi.org/10.15253/rev%20rene.v17i2.3001>.
9. Shortliffe EH, Barnett GO. Medical data: their acquisition, storage, and use. In: Shortliffe EH, Perreault, LM. An introduction to computers in medicine. New York: Addison Wesley; 1990. p.37-69.
10. Bombarda TB, Palhares MS. O registro de práticas interventivas da Terapia Ocupacional na Educação inclusiva. Cad Ter Ocup UFSCar. 2015;23(2):285-94. doi: <https://doi.org/10.4322/0104-4931.ctoAO0496>.
11. Panzeri CSB, Palhares MS. A documentação clínica em terapia ocupacional: revisão de literatura. Cad. Ter. Ocup. UFSCar. 2013;21(3):623-34. doi: <https://doi.org/10.4322/cto.2013.065>.
12. Pelissari DC, Palhares MS. O registro da intervenção no prontuário pelo terapeuta ocupacional em um ambulatório infanto-juvenil. Cad Ter Ocup UFSCar. 2015;23(4):711-22. doi: <https://doi.org/10.4322/0104-4931.ctoAO0497>.
13. Bombarda TB. A prática de registro dos terapeutas ocupacionais na educação inclusiva [dissertação]. São Carlos: Universidade Federal de São Carlos – UFSCar; 2014. Disponível em: <https://repositorio.ufscar.br/bitstream/handle/ufscar/6890/5865.pdf?sequence=1&isAllowed=y>.
14. Mattingly C, Fleming MH. Clinical reasoning: forms of inquiry in a therapeutic process. Philadelphia: F. A. Davis Company; 1994.

15. Parkinson S, Shenfield M, Reece K, Fisher J. Enhancing professional reasoning through the use of evidence-based assessment, robust case formulations and measurable goals. *British Journal of Occupational Therapy*. 2011;74(3):148-52. doi: 10.4276/030802211X12996065859364.
16. Kielhofner G, Hammel J, Finlayson M, Helfrich C, Taylor RR. Documenting outcomes of occupational therapy: the center of outcomes research and education. *Am J Occup Ther*. 2004;58:15-23. doi: 10.5014/ajot.58.1.15.
17. Marcolino TQ. O discurso público em Terapia Ocupacional: sentidos construídos em uma comunidade de prática. *Revisbrato*. 2017;1(2):149-62. Disponível em: <https://revistas.ufjf.br/index.php/ribto/article/view/4775/pdf>.
18. Towns E, Ashby S. The influence of practice educators on occupational therapy students' understanding of the practical applications of theoretical knowledge: A phenomenological study into student experiences of practice education. *Australian Occupational Therapy Journal*. 2014; 61(5):344-52.
19. Panzeri CSB. A prática da documentação clínica ambulatorial sob a ótica de terapeutas ocupacionais [dissertação]. São Carlos: Universidade Federal de São Carlos – UFSCar; 2012.
20. Sampaio, RF, Mancini, MC, Fonseca ST. Produção científica e atuação profissional: aspectos que limitam essa integração na fisioterapia e na terapia ocupacional. *Rev Bras Fisioter*. 2002;6(3):113-8.
21. Reagon C. Using occupational therapy theory within evidence-based practice. In: Boniface G, Seymour A. Using occupational therapy theory within evidence-based practice. USA: Wiley-Blackwell; 2012. p.155-64. Available from: <https://doi.org/10.1002/9781118709634.ch13>.
22. Whiteford G. Knowledge, power, evidence: a critical analysis of key issues in evidence based practice. In: Whiteford G, Clair VW. *Occupation and practice in context*. USA: Elsevier Health Scie; 2004. p.34-50.

Received: 11.01 2017

Accepted: 04.05 2018