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RESEARCH

DEVELOPMENT OF A COLLECTIVE KNOWLEDGE FOR IMPLEMENTATION OF THE NURSING PROCESS IN A SPECIALIZED PSYCHIATRIC HOSPITAL

CONSTRUÇÃO DE UM SABER COLETIVO PARA IMPLANTAÇÃO DO PROCESSO DE ENFERMAGEM EM UM HOSPITAL PSIQUIÁTRICO ESPECIALIZADO

CONSTRUCCIÓN DE CONOCIMIENTO COLECTIVO PARA LA APLICACIÓN DEL PROCESO DE ENFERMERÍA EN UN HOSPITAL PSIQUIÁTRICO ESPECIALIZADO

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ABSTRACT

Objective: to develop a collective knowledge for the implementation of the Nursing process in a specialized psychiatric hospital. **Method:** qualitative research in the action research modality, developed in a referral specialized psychiatric hospital in Santa Catarina, Brazil, with the participation of 18 nurses. Data collection was performed in June 2014 through a semi-structured questionnaire and workshops. **Results:** were elaborated and implanted in the patient's electronic medical record: history, diagnoses, interventions and Nursing evaluation, based on Resolution Nº 358/2009 of the Conselho Federal de Enfermagem, having as theoretical support the theory of person-person relationship of Joyce Travelbee. **Conclusion:** the scientific rigor allied to the nurses' care practice enabled the collective elaboration and implementation of the Nursing process in the patient's electronic medical record. It highlights the innovative role of nurses for the implementation of this assistive technology in the institution in favor of safe and qualified care, supported by the ethical, technical and legal aspects of the profession.

Keywords: Nursing Process; Nursing Care; Mental Health; Psychiatric Nursing.

RESUMO

Objetivo: *construir um saber coletivo para implantação do processo de Enfermagem em um hospital psiquiátrico especializado.* ***Método:*** *pesquisa qualitativa na modalidade pesquisa-ação, desenvolvida em um hospital psiquiátrico especializado de referência em Santa Catarina, Brasil, com a participação de 18 enfermeiros. A coleta de dados foi realizada em junho de 2014, por meio de um questionário semiestruturado e oficinas.* ***Resultados:*** *foram construídos e implantados em prontuário eletrônico do paciente: histórico, diagnósticos, intervenções e avaliação de Enfermagem, pautados na Resolução nº 358/2009 do Conselho Federal de Enfermagem, tendo como suporte teórico a teoria da relação pessoa-pessoa de Joyce Travelbee.* ***Conclusão:*** *o rigor científico aliado à prática assistencial dos enfermeiros viabilizou a construção coletiva e implantação do processo de Enfermagem no prontuário eletrônico do paciente. Destaca-se o papel transformador dos enfermeiros para a implementação dessa tecnologia assistencial na instituição em prol de uma assistência segura e qualificada, apoiada pelos aspectos éticos, técnicos e legais da profissão.*

Palavras-chave: *Processo de Enfermagem; Cuidado de Enfermagem; Saúde Mental; Enfermagem Psiquiátrica.*

RESUMEN

Objetivo: *construir conocimiento colectivo para la implementación del proceso de enfermería en un hospital psiquiátrico especializado.* ***Método:*** *investigación cualitativa en la modalidad de investigación de acción, desarrollada en un hospital psiquiátrico especializado de referencia de Santa Catarina, Brasil, con la participación de 18 enfermeros. La recogida de datos se realizó en junio de 2014 a través de un cuestionario semiestructurado y de talleres.* ***Resultados:*** *fueron construidos y colocados en la historia clínica electrónica del paciente: historial, diagnósticos, intervenciones y evaluación de*

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enfermería, en base a la Resolución No. 358/2009 del Consejo Federal de Enfermería, teniendo como soporte teórico la teoría de la relación persona-persona de Joyce Travelbee. ***Conclusión:*** *el rigor científico aunado a la práctica de atención de enfermería permitió la construcción e implementación colectiva del proceso de enfermería en la historia clínica electrónica del paciente. Destacamos el papel transformador de los enfermeros para la implementación de esta tecnología asistencial en la institución a favor de una atención segura y calificada, respaldada por los aspectos éticos, técnicos y legales de la profesión.*

Palabras clave*: Proceso de Enfermería; Atención de Enfermería; Salud Mental; Enfermería Psiquiátrica.*

INTRODUCTION

The Nursing process (NP) can be represented as the central element of Nursing Care Systematization (NCS), being described by the *Conselho Federal de Enfermagem* (COFEN) as a methodological tool that organizes Nursing care, enhancing the expression of Nursing records.[1] In this sense, the organization and direction of the Nursing work process, provided by the implementation of this assistive technology, becomes essential for safe, organized and qualified assistance.[2]

From this perspective, the NP presents itself as a methodology that guides the nurse's activities for care management, enabling integral assistance to the individual and collective human being, based on technical, ethical, legal and scientific bases.

It is important to highlight that the notions that underlie the NP occur since the period of Florence Nightingale, when Nursing began the development of its activities supported by scientific criteria. In this respect, "Nursing techniques" have characterized the first movement for a "systematized knowledge" of the profession, particularly supported by scientific methods and Nursing theories and, more recently, by "diagnostic classifications".[3: 37]

In the American literature, the NP was developed between 1950 and 1960, arising from the need to guide Nursing actions based on the scientific method.[4] In this sense, the global diligence to ensure more qualified Nursing care fostered the development of the NP in the Brazilian scenario, initially represented by Wanda de Aguiar Horta, in 1970. Horta described the NP as the systematization of dynamic and articulated stages, structured in six moments: Nursing record, Nursing diagnosis, care plan, Nursing prescription, Nursing evolution and Nursing prognosis.[5]

In order to technically, ethically and legally support Nursing care from a scientific perspective, the Resolution Nº. 358/20091 by COFEN was published, which provides for the implementation of the NCS in public or private environments. This Resolution also reinforces the need for the NP to be based on a theoretical support that guides its realization.

In order to give the profession a technical and scientific back up, which represents more visibility and understanding of the NP among Brazilian nurses, it is considerable to describe it as a representative resource of Nursing scientific method and a core element of the NCS, which enables a careful work of the profession,[6] allowing patients' needs to be met in a particular way, which can enhance the quality of care as well as improve visibility, appreciation and professional recognition.[4]

When discussing Nursing care for people with mental disorders over time, it is considered to highlight the disjointed way it was performed, thus raising significant reflections on these current practices. The health care of these people was developed exclusively in the hospital-centered model, which became places of repression and social isolation. From this reality, it was necessary to reflect on new political propositions of mental health care, with new spaces and humanized care models, so that people with mental disorders could exercise their status as citizens.[7]

The 1970s are the historical milestone of the movements that questioned mental health care in the Brazilian scenario, indicating the need for discussions on the urgency of public policies regarding this field in Brazil. Such movements emerged from denunciations about neglect and violence to people with mental disorders, gaining more strength when they made sure to perform disarticulated care in psychiatric hospitals, institutionalizing this population. This care model promoted considerable criticism of the psychiatric knowledge instituted at the time, which in turn provided a scenario of changes to the current model.[7]

The Brazilian Psychiatric Reform movement had its origin from the *VIII Conferência Nacional de Saúde*, where the elements for the elaboration of the *Sistema Único de Saúde* (SUS) were discussed, making possible the *Conferência Nacional sobre Saúde Mental* (CNSM) in 1987. In 1991, the National Mental Health Policy (Ordinances Nº 189/91 and 224/92) was standardized and on August 7, 1992, in the state of *Rio Grande do Sul*, Law 9.716 was approved, which outlined the urgency of comprehensive care for people with mental disorders.[8]

Parallel to the aforementioned movement, the state of *Santa Catarina* followed the transition process of psychiatric care, and in 1996 a specialized psychiatric hospital and a social center were created, after the closure of the former *Hospital Colônia Santana*. In this context, the Nursing practice of this specialized psychiatric hospital has been polished over the years, so that professionals employ scientific methods and technologies in their care practice, ensuring a safe and qualified care to people with mental disorders, thus promoting profound changes in their care paradigms.[9]

Another landmark in the context of mental health in Brazil was the approval of Federal Law Nº 10.216, which established the responsibility of the federal government to elaborate public policies in defense of the autonomy and rights of

people with mental disorders.[8] In this evolutionary movement of psychiatric care, the *Rede de Atenção Psicossocial* (RAPS) was created by Ordinance No. 3.088 of December 23, 2011,[10] as part of the health care network of the *Sistema Único de Saúde* (SUS), aiming to build, expand and articulate all points of network attention to people with mental disorders and those with consequent needs to use psychoactive substances.

In 2017, a new arrangement of RAPS was proposed by Resolution No. 32 of December 14, 2017[11] and Ordinance Nº 3.588 of December 21, 2017,[12] being that, the network currently includes primary care, street offices, health centers living, care units (adult and juvenile child), residential therapeutic services (RTS) I and II, day hospital, referral units specialized in general hospitals, psychosocial care centers (CAPS) in their different modalities (CAPS I, II and III, CAPSi, CAPSad, CAPSad III and IV), specialized psychiatric hospitals and mental health outpatient clinics.

Facing the transformation of Nursing care in the institution studied in favor of new knowledge, nurses seek to combine scientific methods with their care practice, appropriating a power arising from knowledge, discussing the NP as a new existing truth. In this context, the present study supported its discussions from the perspective of knowledge/power and truth proposed by the French philosopher Michel Foucault,[13] who epistemologically developed the understanding that power relations determine the production of knowledge and truths.

Based on the historicity of Nursing care developed in the institution studied, it is considered that nurses are gradually seeking to develop a scientific arsenal to produce knowledge about safe and qualified care for people with mental disorders. However, there is no systematic methodology for the care practice of these professionals. In addition, it is noteworthy that in the literature there is a knowledge gap about the implementation of the NP to people with mental disorders, thus justifying this study.

Alluding to the aforementioned reference, the guiding question of the study is presented: how to build a collective knowledge for the implementation of the NP in a specialized psychiatric hospital?

Thus, it is emphasized that the objective of the study was to build a collective knowledge for the implementation of the Nursing process in a specialized psychiatric hospital, intending to qualify Nursing care for people with mental disorders, besides being supported from an ethical perspective, technical and legal by COFEN.

METHOD

This is a study with a qualitative approach in the action research modality, which is a "type of empirical based social research", structured, developed and related to the "resolution of a collective problem", in which the "researchers and participants of the situation" are inserted "collaboratively". Action research aims to enable those involved in research to be able to respond more effectively to the problems they experience, envisaging a transformative action.[14: 16-17]

The study was designed as a master's thesis of the postgraduate Nursing course of the Professional Master's Degree in Nursing Care Management at the *Universidade Federal de Santa Catarina* (PEN/UFSC),[15] being developed in a referral specialized psychiatric hospital in *Santa Catarina*, oriented to teaching, research and extension, administered by the *Secretaria do Estado da Saúde* (SES-SC). This institution has a screening and admission unit, four 40-bed psychiatric inpatient units and a medical clinic unit for hospitalized people in need of clinical support. In addition, the hospital comprises a community center that accommodates people with mental disorders, remnants of the former *Hospital Colônia Santana*, and which retains the same physical layout as its former building.

Eighteen intentionally selected nurses participated in this research, being used as inclusion criteria: to be a nurse of the psychiatric hospital specialized in the study, regardless of the time of training. As an exclusion criterion, it was established: being on vacation or on leave during the data collection period. Of the participants, 16 were female and two male; 10 of the participants have been working in the hospital for more than 20 years, six work between one and five years old and two work between five and 10 years old; and 15 have specialization and three have a Master's degree.

The research project was approved by the Ethics Committee of the *Universidade Federal de Santa Catarina* under the registration CAAE: 26221014.6.0000.0121, by the Consubstantiated Opinion Report Nº 538.888, in addition to the formal consent of the participating institution for data collection. Prior to data collection, participants were informed about the purpose of the study, as well as about the collection techniques adopted by signing the Informed Consent Form. To ensure anonymity, participants' names were replaced by pseudonyms formed by the letter "E", followed by the number corresponding to the sequence of questionnaires answered by them.

Data collection was performed in June 2014 and took place in two stages: the first was the application of a semi-structured questionnaire and the second contemplated the development of four workshops with nurses, which were planned from the emerging themes extracted from the questionnaires, which highlighted the NCS and NP themes. During the workshops, Joyce Travelbee's theory of the person-person relationship[16] was defined as the theoretical support of the NP, due to its adherence to the philosophy of care for people with mental disorders, which is built and strengthened based on the relationship between nurse and patient. In the workshops, the following instruments were also elaborated: history, diagnoses and Nursing

interventions. Data originating from these workshops were recorded in a field diary by the researcher.

For data analysis, we used the content analysis proposed by Bardin[17], which defines this technique as a method to describe and interpret the emerging messages of data collection instruments, reaching the understanding of their meanings and allowing the inference of knowledge. Data were categorized based on Michel Foucault[13] approaches to knowledge/power and truth, establishing the power relations of nurses to construct new collective knowledge related to NP.

RESULTS

The knowledge built collectively by the study participants to implement the NP in the institution followed the ethical, technical and legal prerogatives advocated by Resolution Nº 358/09 of COFEN[1], which was presented by the researcher in the first workshop.

In the first workshop, participants also discussed assumptions of Travelbee's person-person relationship theory, highlighting its adherence to the philosophical perspective of Nursing care for people with mental disorders, considering the author's experience in Psychiatric Nursing. Among the assumptions raised, stood out the person-person relationship, whose focus is crucial to the development of professional Nursing care. Elements such as the nature of mental disorders, the uniqueness of people, and human experiences in the subjectivity of mental sufferings were also mentioned.

Based on the person-person relationship to promote the bond between nurse and patient, a central element of Travelbee's theory, widespread in the field of mental health, the study participants recognize that this theoretical support constitutes the medullary axis to support the implementation of PE in the institution, as follows:

> *The sustainability of the Nursing process through a theory helps to guide patient care, aiming at holistic care* […] (E3).

> *It offers Nursing structure and organization to knowledge, providing a systematic means of data collection. It works as a structural foundation that makes it coherent* […] (E5).

> *The theoretical basis supports the practice, guides the care. Scientifically proven, argued work gives more credibility and strength in execution* […] (E7).

During the first workshop, which was planned and oriented from the emerging themes of the questionnaires, the participants emphasized the NP stages already developed in their professional training and care practice, without mentioning the theoretical support adopted (Table 1).

Table 1 - NP steps developed by participants in their care practice, *Florianópolis, Santa Catarina*, Brazil, 2015

	n	%
Nursing Record		
Yes	17	94.5
No	1	5.5
Total	18	100
Nursing Diagnosis		
Yes	15	83.3
No	3	16.7
Total	18	100
Nursing Planning		
Yes	16	88.9
No	2	11.1
Total	18	100
Implementation		
Yes	13	72.2
No	5	27.8
Total	18	100
Evaluation		
Yes	15	83.3
No	3	16.7
Total	18	100

Source: Bruggmann, 2015.[15]

According to the contents obtained from the questionnaires, the participants characterized the NP as a technical, scientific and systematized method used by nurses to plan Nursing care and evaluate the expected results, according to the following reports:

> *It is a scientific method that raises the quality of Nursing care* (E1).

> *The Nursing process is a method or way of doing related to the technical-scientific knowledge* […] (E3).

> *Set of actions that are performed through a certain way of doing and suggesting a certain way of thinking, in view of the need of the person or human collectivity at a given moment of the health and disease process* […] (E6).

> *In the Nursing process the professional sees the individual as a whole. It considers their physical, mental, psychological and social needs, which allows an evaluation* […] (E12).

In the second workshop was collectively elaborated by nurses, a data collection instrument, which was configured in the Nursing record. This tool was widely discussed by professionals and considered elements of Travelbee's theory of person-person relationship, mental state examination and physical examination, in order to enable nurses to have an integral view of the human being. Table 2 shows the Nursing record prepared by the study participants.

After the collective elaboration of the first stage of the NP, the nurses signaled the need to develop a prototype for the selection of Nursing diagnoses, considering its relevance to the elaboration and selection of interventions, aiming to achieve the expected results of the NP.

In the third workshop, aspects related to the diagnostic components were discussed by the participants, to rescue this knowledge already experienced by nurses in their care practice. The Nursing diagnoses of this study followed the North American Nursing Diagnosis Association International's diagnostic classification[18] because of the greater approximation of nurses to this classification. It is noteworthy that the elaboration of the prototype for Nursing diagnoses was based on the above classification, because it represents the bibliography updated at the time.

Table 3 shows the instruments that contemplates Nursing diagnosis, as well as related factors and defining characteristics selected by the participants.

In the fourth workshop, the Nursing planning, intervention and evaluation stage was discussed. For the planning stage, it was highlighted by the participants of the study the relevance of nurses broadly knowing the subjective and objective aspects collected in the record and the diagnostic definition of Nursing.

It is worth mentioning that the participants elaborated a Nursing prescription with standard interventions, but flexible and subject to change, according to the nurse's assessment. Table 4 shows the Nursing interventions raised by the participants of the study.

Table 2 - Nursing Record. *Florianópolis, Santa Catarina*, Brazil, 2015

NURSING RECORD
Date: ____/____/____ Unity: _____
Name: _____ Age: _____
( ) 1st admission ( ) Re-admission ( ) Voluntary admission ( ) Involuntary admission ( ) Compulsory Admission
Reason for the admission: _____
No conditions for the interview: _____
General appearance/Personal hygiene
( ) Good ( ) Regular ( ) Poor
PSYCHIC FUNCTIONS
1. Consciousness
( ) Alert ( ) Obnubilation ( ) Confusion ( ) Stupor
2. Awareness
( ) Normopresecious ( ) Hyperpresecious ( ) Hypopresecious ( ) Normovigil ( ) Hypervigil ( ) Hypovigil
3. Orientation
( ) Oriented ( ) Parcial oriented ( ) Desorientado
4. Memory
( ) Preserved ( ) Hypermnesia ( ) Hypomnesia ( ) Amnesia
5. Thoughts/Reality judgment
( ) Logic ( ) Organized ( ) Lentified ( ) Blockade ( ) Accelerated ( ) Illusionist ( ) Dissociated ( ) Disaggregated ( ) Escape of ideas ( )Persecutory ( ) Depreciatory ( ) Mystic ( ) Sexuals ( ) Euphoric ideas/ greatness /power ( ) Ideas of ruination
6. Language/Speech
( ) Logical/receptive ( ) Aphasia ( ) Mutism ( ) Bradiphasia ( ) Dyslalia ( ) Dysarthria ( ) Echolalia ( ) Logorrhea ( ) Prolixity ( ) Neologism ( ) Dysphemia ( ) Coprolalia
7. Senseperception
( ) Hyperesthesia ( ) Hypoesthesia ( ) Paraesthesia ( ) Anesthesia ( ) Auditory hallucination ( ) Visual hallucination ( ) Tactile hallucination ( ) Olfactory hallucination ( ) Taste hallucination ( ) Kinesthetic hallucination ( ) Cenesthetic hallucination

Continue...

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Table 2 - Nursing Record. *Florianópolis, Santa Catarina*, Brazil, 2015

NURSING RECORD
8. Humor/Affection
( ) Euthymic ( ) Hyperthymic ( ) Hypothymic ( ) Irritable ( ) Puerile ( ) Anxious ( ) Phobic ( ) Dull ( ) Labile ( ) Anhedonia ( ) Panic ( ) Affective ambivalence
9. Desire to eat
( ) Normobulia ( ) Abulia ( ) Hypobulia ( ) Hyperbulia
10. Psychomotricity
( ) Agitated ( ) Lentified ( ) Tics ( ) Conversion ( ) Mannerism ( ) Stereotypes ( ) Akathisia ( ) Dystonia
Sleep pattern
( ) Adequate ( ) Insomnia
Use of psychoactive substances
( ) Yes ( ) No ( ) Cannabis ( ) Cocaine ( ) Crack ( ) Alcoohol ( ) Tobacco ( ) LSD ( ) Ecstasy ( ) Others
Risks
( ) Suicide ( ) Fuga ( ) Heteroaggression ( ) Autoaggression
PHYSICAL EXAMINATION
1. Vital signs
Blood Pressure: _____ Temperature: _____ HR: _____ RR: _____ BGT: _____
2. Alergy
( ) Yes ( ) No
3. Medication in use
4. Clinical commorbidity
5. Neural system
6. Cardiovascular system
7. Respiratory system
8. Gastrointestinal system
9 Genitourinary system
10. Skin and mucous membranes
11. Nutritional status
12. Hydration
13. General observations
Signature: _____

Source: Bruggmann, 2015.[15]

Table 3 - Nursing diagnosis. *Florianópolis, Santa Catarina*, Brazil, 2015

NURSING DIAGNOSIS	
Date: ____/____/____	Unity: _____
Name: _____	Age: _____
( )	**Acute confusion** related to: ( ) substance abuse, ( ) delirium, evidenced by: ( ) increased agitation, ( ) fluctuation in cognition
( )	**Ineffective maintenance of health** related to: cognitive impairment, evidenced by: demonstrated lack of knowledge regarding basic health practices
( )	**Impaired verbal communication** related to: ( ) low situational self-esteem, ( ) treatment-related side effects, evidenced by: ( ) stubborn refusal to speak, ( ) verbalizing with difficulty
( )	**Self-neglect** related to: ( ) cognitive impairment, ( ) drug abuse, evidenced by: inadequate personal hygiene
( )	**Self-care deficit for food** related to: ( ) cognitive impairment, ( ) severe anxiety, evidenced by: inability to eat enough food
( )	**Impaired sensory perception** related to: ( ) impaired sensory interaction, ( ) psychological stress, evidenced by: ( ) hallucinations, ( ) change in behavioral pattern
( )	**Risk of personal identity disorder** related to: psychiatric disorders
( )	**Control of ineffective impulses** related to: ( ) mood disorder, ( ) drug abuse, ( ) delusional ideas, evidenced by: ( ) irritability, ( ) violence
( )	**Risk of violence directed at others**, related to: ( ) psychotic symptomatology, ( ) history of violent antisocial behavior
( )	**Impaired social interaction** related to: ( ) self-concept disorder, ( ) disturbed thinking process, evidenced by: dysfunctional interaction with other people
( )	**Dysfunctional family processes** related to: ( ) personality predisposing to addiction, ( ) family history of resistance to treatment, evidenced by: ( ) inability to deal with conflicts, ( ) drug abuse
( )	**Low situational self-esteem** related to: ( ) failures, ( ) loss, evidenced by: autonegative verbalizations
( )	**Hopelessness** related to: ( ) social isolation, ( ) prolonged stress, evidenced by: diminished affection
( )	**Insomnia** related to: ( ) anxiety, ( ) interrupted sleep, ( ) environmental factors, ( ) depression, ( ) fear, evidenced by: report of dissatisfaction with sleep (current)
( )	**Anxiety** related to: ( ) situational crisis, ( ) substance abuse, evidenced by: ( ) concern, ( ) nervousness, ( ) fear of nonspecific consequences
( )	**Fear** related to: phobic stimulus, evidenced by: report of apprehension
( )	**Risk of self-harm** related to: ( ) psychotic state, ( ) low self-esteem, ( ) drug abuse
( )	**Suicide risk** related to: psychiatric disorders
( )	**Impaired gas exchange** related to: dyspnea, evidenced by: imbalance in the ventilation-perfusion relationship.
( )	**Aspiration hazard** related to: ( ) reduced level of consciousness, ( ) tube feeding, ( ) impaired dentition
( )	**Acute pain** related to: injurious agents (biological, chemical, physical, psychological) evidenced by: verbal report of pain
( )	**Risk of infection** related to: ( ) traumatized tissue, ( ) poor knowledge to prevent exposure to pathogens
( )	**Risk of injury** related to: sensory dysfunction
( )	**Impaired skin integrity** related to: ( ) mechanical factors, ( ) age extremes, evidenced by: disruption of skin structures.
( )	**Deficient fluid volume** related to: ( ) failure of regulatory mechanisms, ( ) active loss of fluid volume, evidenced by: ( ) decreased skin turgor, ( ) dry mucous membranes
( )	**Impaired urinary elimination** related to: ( ) urinary tract infection, ( ) multiple causes, evidenced by: ( ) dysuria, ( ) incontinence
( )	**Diarrhea** related to: ( ) anxiety, ( ) adverse drug effects, ( ) malabsorption, ( ) contamination, evidenced by: ( ) abdominal pain, ( ) urgency to evacuate
( )	**Constipation** related to: ( ) change in dietary patterns, ( ) medication use, evidenced by: decreased stool volume
( )	**Risk of falls** related to: ( ) decreased mental state, ( ) anxiolytic agents, ( ) impaired physical mobility
Signature: _____	

Source: Bruggmann, 2015.[15]

At the last moment of this workshop, it was established by nurses that, at the Nursing evaluation stage, the patient's medical records would be grouped, and their data organized into four aspects: subjective, objective, evaluation and care plan. This method of data recording was deliberated by the participants, for its closer approach to the model, thus promoting more organized and systematized records.

The result of this study reached the elaboration of a collective knowledge based on the knowledge/power and truth of nurses, which was the development of instruments related to the stages of the NP. This methodology was implemented in its entirety in the institution studied, based on electronic patient record software adopted by the *Secretaria do Estado da Saúde*, meeting the objectives of the study.

Table 4 - Nursing interventions elaborated by the participants of the study. *Florianópolis, Santa Catarina*, Brazil, 2015

NURSING INTERVENTIONS
Communicate level of consciousness lowering
Check vital signs ( ) times/day
Stimulate/Assist/Supervise food and water intake
Record diet acceptance
Watch out for risk of bronchoaspiration
Communicate/Record/Supervise medication intake
Report/Record signs and symptoms of drug intoxication
Watch out/Record Fall Risks
Guide/Supervise/Assist/Perform ( ) sprinkler bath Perform bed ( ) bath
Guide/Supervise/Assist/Perform oral hygiene 5 times/day
Report/Record behavior pattern changes
Report changes in thinking, mood, and/or perception
Watch out to the risk of heteroaggression
Communicate/Register suicidal ideation
Step up surveillance for suicide risk
Report/Record signs of psychomotor agitation
Communicate/Record signs, symptoms and degree of anxiety
Report/Record sleep pattern
Report/Record complaints of pain or discomfort
Maintain caution with mechanical containment
Report/Register changes in skin and mucous membranes
Register characteristics of bladder and bowel eliminations
Perform rotation for intramuscular injection according to table
Perform comfort massage/change of position according to table
Encourage participation in therapeutic and operative groups

Source: Bruggmann, 2015.[15]

DISCUSSION

A significant moment during the NP elaboration and implementation itinerary is the definition of a theoretical support that has adherence to the institutional philosophy and the profile of the population served. In the present study, Joyce Travelbee's theory of the person-to-person relationship[16] was defined by nurses to support the NP in the institution, considering the issues described above and considering the relationship between professional and patient. Thus, it is noteworthy that the deliberation of the aforementioned theoretical support structured the basis for the elaboration of this collective knowledge and implementation of the NP in the institution.

In his career, Travelbee developed her activities as a psychiatrist nurse signaling central and fruitful elements to promote the bond between the nurse and the person assisted by the nurse. Among the potentiating elements to the therapeutic relationship discussed by Travelbee, are the ability to love, to face reality and to find meaning in life, which should be substantially addressed by the mental health nurse.[16] In this dimension, it is justified to choose this theoretical support, considering the subjectivity of the mental state examination evaluation described in the data collection stage and its impacts on Nursing care planning.

In order to corroborate the conception described herein, the fact that COFEN Resolution Nº 358/09[1] determines in its Article Nº 3, that the NP must be supported by a theoretical support that guides the data collection and other steps of this methodology.

Referring to the NP as a scientific method, recognized by the participants, it is emphasized that this assistance technology can be represented as the work process of nurses regarding care management, as it is supported by interrelated stages and a theoretical support.[6] Alluding to the NP as a systematized work process of nurses, it is worth noting that it can elicit intellectual, critical and reflective activities of the nurse who develops it. Thus, these professionals will be able to question their own attitudes and work to build assistance based on scientific knowledge.[19]

According to the knowledge collectively developed by nurses in the Nursing record presented in Table 1, it is noteworthy that it broadly lists objective and subjective information on the patient's health status, from the physical examination and mental state examination. According to COFEN Resolution Nº 358/09[1:1], the Nursing record is a "deliberate, systematic and continuous process", performed by nurses with the help of techniques, aiming at obtaining information about the "human person, family or community". and their responses in the health and disease process.

The completeness of the investigative process carried out in the Nursing record is an expressive point for the development of the other stages of the process, as nurses now collect and process the information in a systematic way, organizing it into specific categories of knowledge. In this sense, it is emphasized that data collection is an intellectual action of the professional and an opportunity for nurses to establish a therapeutic relationship with the patient.[20]

Nursing diagnoses are described by COFEN as a strategy for interpretation and grouping of data collected in the history, representing the responses of the person, family or human community in the health and disease process.[1]

Regarding the Nursing diagnostic formulation, it is considered that the scientific knowledge of this construction gives nurses the necessary autonomy to plan qualified care through integral approaches.[21] The use of standardized languages to name and classify Nursing diagnoses. Nursing is characterized as a method that seeks the unification, communication and information of nurses' judgments about human responses to health problems. For this language to

follow a standardized pattern, the North American Nursing Diagnosis Association International (NANDA-I)[18] suggests a widespread and internationally recognized classification as a source of terminology for Nursing diagnoses.

NANDA-I's terminology of Nursing diagnoses includes diagnostic titles to "describe clinical judgments made by nurses". Thus, its taxonomy can be characterized by "a systematic ordering of clinical phenomena/judgments, which defines the knowledge of the Nursing discipline". NANDA-I further classifies Nursing diagnoses into three categories: problem-focused, health-promoting, and risk-focused. However, in the problem and risk-focused categories, the use of syndromes can also be found.[20:138]

During the explanation about Nursing diagnoses in the workshops, it was identified that most nurses knew the diagnostic classification of NANDA-I, although not fully mastering the topic. Most Nursing diagnoses raised by participants are associated with the mental health field, articulated with the subjectivity of the mental state examination and the essential premises of the person-person relationship. However, some diagnoses mention the physical examination, considering the potential risks of clinical complications, thus conferring a full assessment of the patient.

The planning of Nursing actions is presented by COFEN[1] as the opportunity for the definition of expected results and implementation of interventions performed in response to the human response in the health and disease process. From this point on, Nursing interventions were built in articulation with the previous stages of NP, also focused on a global perspective of patient needs.

Nursing interventions in mental health are oriented to a line of care and developed on the bond established between the nurse and the patient. The interventions addressed in Table 3 reflect the basis of Nursing care planning for people with mental disorders, in order to cover all physical and mental aspects.

The implementation stage is established by COFEN[1] as the implementation of the interventions determined in the planning stage, consisting essentially in applying the interventions that were elaborated in the Nursing prescription.

Nursing evaluation is based on a "deliberate, systematic and continuous process of verification of changes in the responses of the person, family or human community" at the determined moment of the health-disease process. Briefly, at this stage the consequences of Nursing interventions will be investigated, considering the expected and achieved results. At this point the "need for changes or adaptations in the NP stages" is also assessed.[1:3]

The method of recording data in electronic patient records, in turn, originated from the knowledge of nurses about the security, confidentiality, quality and organization of information, being directly related to the evolution of the patient's physical and mental condition. Nurses make evolution and Nursing annotation, while technicians make only the latter, as established by COFEN.[1]

Throughout the process of developing a collective knowledge of nurses to implement NP in the institution, Foucaultian relations of knowledge/power and truth were particularly related to the participants' speech. Thus, it is emphasized that the power of nurses modified Nursing care, deconstructed paradigms and validated new knowledge and truths that emerged from the professionals involved in the study. It is also considerable to point out that the knowledge expressed by nurses remained centered on a conception that values the right of the person to safe, ethical and committed Nursing care.[13]

Even realizing that the new knowledge can bring with it some form of resistance, it is expressive to highlight that, to deconstruct a current paradigm, the protagonists of this change must be empowered with knowledge/power and truth.[13] The power of nurses conceived, in this case, a new truth in force, represented by the collective development and implementation of the NP in the institution. It is also noteworthy that the previously presented instruments were implanted in the patient's electronic medical record, providing greater security of records, as well as serving as a more accessible source for further research.

As limitations of the research, we highlight the lack of studies on the implementation of NP in mental health services. However, developing, implementing and evaluating instruments on the stages of NP in this field is a pressing need, which will enable more adherence between Nursing care theory and practice.

The contributions of the study are centered on different aspects, highlighting the promotion of qualified Nursing care, safe and supported by ethical, technical and legal precepts of the profession; appreciation and professional recognition of nurses as protagonists of their actions; presentation of a NP model in a mental health service; expansion of knowledge in Nursing and mental health.

FINAL CONSIDERATIONS

This research showed that the scientific knowledge of nurses associated with their care practice in a specialized psychiatric hospital allowed the construction of a collective knowledge and implementation of NP in the institution, responding to the objective of the study.

It is considered to emphasize that the nurses' perception about the implantation of the NP in the institution, supported by the prerogatives of COFEN Resolution Nº 358/2009, was established as a moment for the production of knowledge that qualifies the assistance and gives visibility to these professionals in the institution. scientific and social scenario.

Regarding the theoretical support of the person-person relationship that supports the NP implanted in the institution, it is significant to emphasize that it articulates the concept of bond between professional and patient, strengthening the foundations for the integral implementation of care. Given this concept, the unfolding of the stages of the NP extend profitably and ensure better grounded assistance to the person with mental disorder.

It is worth mentioning that the interlocution of nurses' knowledge favored the construction and implementation of NP as a new truth in force at the institution, reflecting on the possibility of further studies to further qualify their doing.

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