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## CARE PLAN SHARED WITH OSTOMIZED CLIENTS: FREIRE'S PEDAGOGY AND ITS CONTRIBUTIONS TO NURSING EDUCATION PRACTICE<sup>1</sup>

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**ABSTRACT:** The aim of this qualitative research was to get to know the sharing of knowledge and practices with ostomized clients on intestinal and urinary elimination stoma maintenance in the outpatient context, and to discuss its possible repercussions in the home context. The subjects were 17 adult and elderly ostomized clients under outpatient follow-up in Campos dos Goytacazes - Rio de Janeiro. The Convergent Care Research method and thematic content analysis were applied. The confection of the care plan was the product obtained through experience and knowledge exchange at the clinic. During the education process, the problematizing pedagogy facilitated the ostomized clients' learning. When the clients returned to the clinic, the success deriving from the adopted pedagogy could be observed. Their critical and reflexive conditions were sharpened, practicing stoma maintenance care with more security and autonomy, at the same time as they assessed and modified habits and transformed reality.

**DESCRIPTORS:** Nursing. Nursing care. Health education. Ostomy.

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## PLANO DE CUIDADOS COMPARTILHADO JUNTO A CLIENTES ESTOMIZADOS: A PEDAGOGIA FREIREANA E SUAS CONTRIBUIÇÕES À PRÁTICA EDUCATIVA DA ENFERMAGEM

**RESUMO:** Pesquisa qualitativa, objetivando conhecer o compartilhamento de saberes e práticas de clientes estomizados sobre a manutenção da estomia de eliminação intestinal e urinária no contexto ambulatorial, e discutir suas possíveis repercussões no contexto domiciliar. Os sujeitos foram 17 clientes adultos e idosos estomizados em acompanhamento ambulatorial no município de Campos dos Goytacazes-RJ. Aplicou-se a abordagem metodológica Pesquisa Convergente-Assistencial e a análise de conteúdo temática. A confecção do plano de cuidados foi o produto instituído mediante a troca de experiências e saberes no ambulatório, tendo sido a pedagogia problematizadora instrumento facilitador na aprendizagem de clientes estomizados, durante o processo educativo. Com o retorno dos clientes no ambulatório, foi possível denotar os sucessos derivados da pedagogia utilizada. Sua condição de crítica e reflexão tornou-se aguçada, exercendo com maior segurança e autonomia os cuidados relacionados à manutenção de sua estomia, avaliando, modificando hábitos e transformando a realidade.

**DESCRIPTORES:** Enfermagem. Cuidados de enfermagem. Educação em saúde. Estomia.

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## PLAN DE CUIDADOS COMPARTIDOS JUNTO A LOS CLIENTES OSTOMIZADOS: PEDAGOGÍA FREIREANA Y SUS CONTRIBUCIONES A LA ENFERMERÍA PRÁCTICA EDUCATIVA

**RESUMEN:** Investigación cualitativa, objetivando conocer el intercambio de conocimientos y prácticas de clientes ostomizados sobre el manejo de la ostomía y la eliminación intestinal y urinaria en el contexto ambulatorio, y discutir las posibles repercusiones en el contexto domiciliar. Los sujetos fueron 17 clientes adultos y ancianos ostomizados bajo seguimiento ambulatorio en el municipio de Campos dos Goytacazes-RJ. Se utilizó un abordaje metodológico de pesquisa convergente-asistencial y un análisis del contenido temático. La realización del plan de atención fue producto del intercambio de experiencias y conocimientos en la clínica, siendo el facilitador en la solución de problemas de aprendizaje, el cliente ostomizado. Con el regreso de los clientes en el ambulatorio se pudo denotar los éxitos derivados de la pedagogía utilizada en el proceso educativo. Su pensamiento crítico y reflexivo se agudizó; ejerciendo con mayor seguridad y autonomía los cuidados relacionados al manejo de su ostomía, evaluando, modificando hábitos y transformando la realidad.

**DESCRIPTORES:** Enfermería. Atención de enfermería. Educación en salud. Estomía.

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## INTRODUCTION

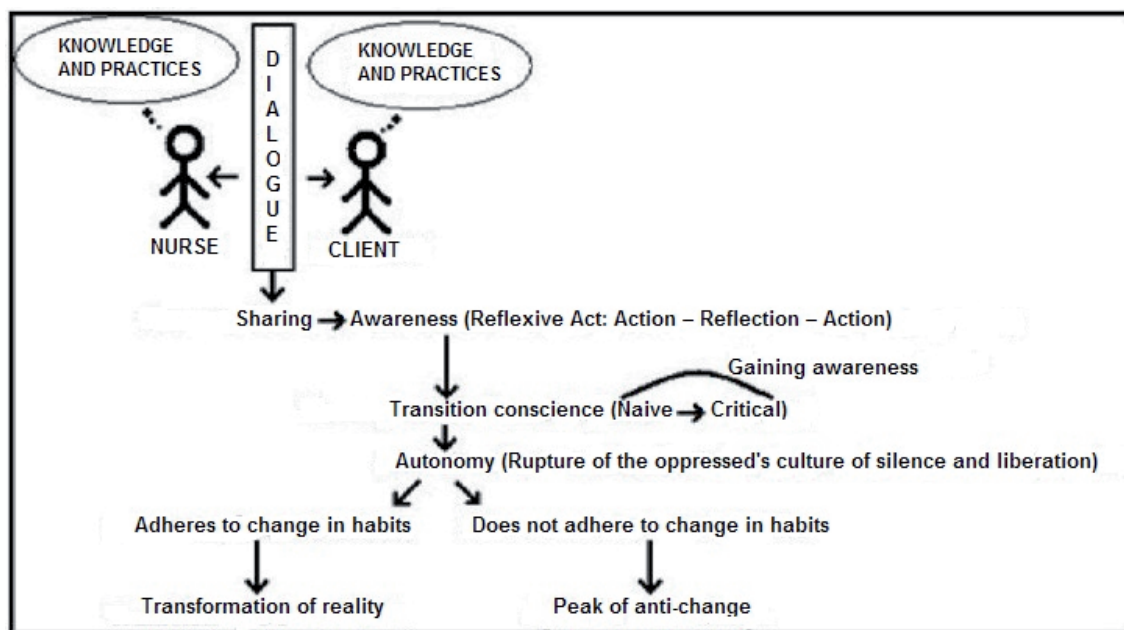
At the outpatient clinic where we had the opportunity to deliver care to ostomized clients, we observed that, when nursing performed health education, this almost always happened in the vertical and one-way sense, characterized by the traditional depository education model, which comprises actions oriented towards the client and not "with" the client, resulting in dominant care, which imposes practices that are officially established through scientific culture.<sup>1</sup>

A study developed in São Paulo State, aimed at identifying colostomized clients' knowledge level about their care, with a view to preventing possible complications, showed that 100% of participating clients did not know what a colostomy was and agreed with the importance of self-care training.<sup>2</sup>

As health educators, nurses need to get to know the reality the clients are part of and should

rescue these subjects are citizens who participate in their care process through dialogue, thus permitting the transition from naïve awareness, characterized by a passive attitude, to critical and reflexive conscience, capable of putting them in an inquiring, participatory and active position. This means that clients should take the position of subjects instead of objects of professional action. In this sense, they can choose to adhere to the change in habits, attitudes and ways of thinking life and health or not. Thus, together with the clients, nurses construct possible routes. Clients can either choose change towards man's true humanizations, or decide to continue, reaching the summit of anti-change.<sup>3</sup>

The scheme displayed in figure 1 expresses Paulo Freire's ideas applied to Nursing educative practice, broaching Freire's pedagogical focus in this research.<sup>1,3</sup>



**Figure 1 - Articulation between Freire's ideas (mainly taken from his works "Pedagogy of the Oppressed" and "Education and Change") and Nursing education practice**

This study underlines the possibilities of sharing between popular knowledge and practices, especially of ostomized clients, and professional knowledge and practices, represented here by nurses working in care delivery to these clients in the outpatient context. The idea of shared care is based on the premises of social constructionism, that is, knowledge construction will be based on the subject's experience in a signification process. "In that sense, when we consider that the product

of the care action (care) can be shared, this necessary reveals a dialogical process permeating this construction in the encounter of knowledge - from common sense and reified knowledge - which in turn comprises the encounter between knowledge cultures and practice".<sup>4:758</sup>

This demands access to ostomized clients' knowledge and practices on intestinal and urinary elimination stoma maintenance, which is the problem in this study. That is so because, in this

proposal, the client is understood as potentially active, socioculturally inserted in a singular reality, whose experiences accumulate, re-elaborated and modified throughout their existential trajectory.<sup>5</sup>

In view of these considerations, the aims of this research are to: get to know the sharing of knowledge and practices with ostomized clients on intestinal and urinary elimination stoma maintenance in the outpatient context, and to discuss its possible repercussions in the home context.

## METHOD

The qualitative methodological approach was chosen. The research method was Convergent Care Research (CCR)<sup>6</sup>. The research was developed at a public outpatient clinic in Campos dos Goytacazes-RJ. Subjects were 17 adult and elderly ostomized clients under outpatient follow-up and who had some kind of permanent or temporary intestinal and urinary stoma (ileo/colo/urostomy).

Approval for the project was obtained from the Research Ethics Committee at Anna Nery School of Nursing/ São Francisco de Assis Teaching Hospital, *Universidade Federal do Rio de Janeiro*, under Protocol number 052/2009, in compliance with Resolution 196/96. Subjects signed the Informed Consent Term.

The development of the study involved six phases, which took place between April 2009 and January 2010, on alternating days and times, according to the researcher and ostomized clients' availability, following a program that was previously established with the client or not, in which case (s)he was randomly recruited upon the first contact. The phases complied with the methodological proposal of CCR, described as follows:

Phase 1 - Initial contact with the nurse and nursing auxiliaries working at the outpatient clinic, with a view to further immersion in the unit. This initial contact took about three months, more precisely in April, May and June 2009.

Between September 2009 and January 2010, phases 2, 3, 4, 5 and 6 were accomplished individually. It should be mentioned that phases 2, 3 and 4 took place during a single meeting. Then, at an interval of between two and three months, with a view to putting in practice the shared care plan, the client returned to the clinic for phases 5 and 6, which terminated the process.

Phase 2 - Insertion of the researcher into care, followed by the subjects' characterization with the

help of a form to identify the ostomized patient, which was completed individually.

Phase 3 - Warm-up and reflection about the theme, using support material the nurse researcher had previously elaborated, including figures and text about "elimination stoma maintenance and its late complications". Next, experiences were exchanged with the subjects about the maintenance of their elimination stoma, using a semistructured interview script as a guide.

Phase 4 - Elaboration of the shared care plan, in the light of previously discussed aspects, done simultaneously with the previous phase. This provided the subjects with their individual care plan to perform stoma maintenance care at home and common spaces of life.

Phase 5 - Participant observation at the follow-up consultation room, focusing on the results of the previous phase, including data on stoma evolution throughout the meetings, besides records on the client's position during the nursing care process with the researcher.

Phase 6 - Finally, the subject was contacted to validate the applied method. Considerations on the entire process were made and a script with pre-established key questions was used to guide the discussion, which were digitally recorded like in the third phase.

Individual meetings to produce the data with the 17 subjects were fully transcribed. Clients were identified using alphanumeric codes: the letter C for clients and R for the researcher. Each letter C in the text was followed by sequential Arabic numerals, according to the order in which the data were produced.

Data were analyzed and interpreted based on the triangulation of the findings that emerged from the previously appointed data production techniques, relating the ostomized subjects' characteristics with the knowledge and practices shared and their repercussions, in combination with the participant observations. Thus, the categorization process started based on thematic content analysis.<sup>7</sup> The following category emerged from this thematic categorization process: "The sharing between knowledge and practices in the professional and popular systems about elimination stoma maintenance", and the sub-categories: "From the confection to the execution of the shared care plan"; and "Repercussions of shared care in the home context".

## RESULTS AND DISCUSSION

### The sharing between knowledge and practices in the professional and popular systems about elimination stoma maintenance

Knowledge in the professional system is almost always established as the most correct and impassable. This knowledge, however, cannot always account for each subject's individuality, as it is elaborated based on scientific proof, for a specific group of clients with the same physical and/or mental situations. In practice, they do not always account for the anxieties each subject presents, imbued with his/her social, political and cultural context. Although they do not cover subjects holistically, health professionals generally continue imposing their knowledge, in a monologic and prescriptive relation with the clients, demanding a changed perspective in nurses' thinking and practice in popular health education.<sup>5</sup>

The starting point for popular education is students' previous knowledge, constructed along their life trajectories; a pedagogical bet that permits the inclusion of new actors in the health area, strengthening popular organization and broadening health teams' practices, based on the dialogue with popular knowledge. Thus, the intent is to undertake a relation of knowledge exchange between popular and scientific knowledge, in which both have reciprocal contributions to offer.<sup>8</sup>

A reorientation of nurses' health education practices is proposed, so that this activity becomes a joint construction with the users, emphasizing popular participation in their daily reality. The dialogic relation with a view to knowledge exchange would permit the emergence of a third knowledge, resulting from the interaction between health professionals' and the population's knowledge.<sup>8</sup>

In that sense, based on clients' stoma maintenance experiences revealed during the meeting with the nurse, an individual care plan was elaborated, in line with the needs and desires of the clients who participated in the convergent care research moments. In this involving exchange, practices and knowledge emerged about the replacement of the (drainable and closed) collector pouch; daily maintenance of the drainable collector pouch (one and two openings); maintenance of the closed collector pouch; daily maintenance of the drainable collector pouch for urostomy; self-irrigation; use of adjuvants (protective skin barrier in paste and powder, and deodorizing lu-

bricant); late complications (dermatitis, prolapse and hernia); use of accessories (belt and adhesive tape); sunbathing (lack of privacy for sunbathing and lack of time for sunbathing); equipment protection during common bathing; social, family and professional life; religiosity and spirituality; sexuality; exercises and sports; leisure; rights and duties; clothing and diet.

Based on the process that revealed this knowledge and practice and the joint analysis about the pertinence of their use for criticism and reflection, efforts were made to appoint fundamental care for intestinal and urinary elimination stoma maintenance, in the light of what was discussed, with a view to its implementation at home, in order to bring satisfactory results to the outpatient unit concerning nursing care effectiveness. Therefore, knowledge on the clients' care demands was due, as well as on the care elements resulting from common knowledge and those incorporated from scientific knowledge and reproduced at home.

### *From the confection to the execution of the shared care plan*

The confection of the care plan was the product obtained through experience and knowledge exchange at the clinic. During the education process, the problematizing pedagogy facilitated the ostomized clients' learning.

"When we introduce Freire's ideas into nurses' daily education (care) practice, through criticism and reflection, we can witness the transformation or reconstruction of knowledge in a group without academic-scientific knowledge, at the same time as we also get to know the knowledge deriving from the common universe. In this perspective, the person has the opportunity to appoint and reflect on health education vehicles themselves"<sup>5:316-7</sup>

The use of Freire's pedagogy in nursing education permits further knowledge absorption, like: [...] *we absorb more from what we are in doubt about, you see?* (C1). A pedagogy that revitalizes and cares about the subject's reality. When problematizing the different situations that appear, clients sharpen their reflexive capacity and start to question what they think, how they act and the consequences of their action, which can result in greater safety to imprint the changes needed for their health and wellbeing.

When based on the critical-reflexive approach, the educative process uses dialogue as a

loving commitment, with a view to accessing the universe of the clients' conceptions, knowledge and practices, considering them as active subjects in this process. "[...] true dialogue presupposes true thinking, thinking that perceives reality as a process".<sup>9:119</sup> Therefore, a horizontal dialogic relation needs to be established with the client, nourished by love, humility, hope, faith and confidence. Empathy is established between both to issue criticism, with communication.<sup>10</sup> This attempt allows nurses to penetrate into the cultural universe of ostomized patients, exchanging experiences and, at the same time, makes them receptive to eventual changes. In this interim, the adaptation of language to subjects' reality needs to be highlighted, in view of their sociocultural insertion.

Co-participation in the educative process takes form through the intertwining between information resulting from sharing between nurses and clients, one helping the other, in which the nurse and the client's tips stand out, constantly seeking a consensus on what care should be established: [...] *you gave some tips to put in practice and that was positive for me [...]* (C2). After all, health education is constructed "with" the other and not "for" the other, which implies a horizontal and reciprocal relation, in which both gain benefits, as they are interested in joint learning and the co-construction of care. In that sense, education, understood as a collective act, cannot be imposed, exactly because it presupposes an exchange among people. Hence, there will always be parts of both. Likewise, thinking of shared compact implies opening to debate, being receptive to other possibilities to take care of the other and oneself. The search to take care of one's own body is gratifying, but demands time and requires dedication.

In that perspective, nursing is responsible for valuing ostomized clients' subjectivity, based on the acknowledgement that this human being is the only person who knows the situation experienced. To further self-care, nurses should help them, respecting their experience in health care, with a better quality of life as the target.<sup>11</sup>

C7 highlights how good it is to have a person to share care and that the experience of our meetings in the convergent care research was fundamental for her learning and self-confidence: [...] *with your experience, I think I've learned a lot. It was really good for me, oh dear! We talked with an experienced person. We gain more confidence!*

Dialogue as a facilitator of the educative process revealed its fundamental importance

in the achievement of shared care: [...] *and you gave me some more tips [...]* (C2). Associated with dialogic practice, other learning resources were incorporated into this process, like the placement of self-care materials on the table.

Health education based on the principles of problemization is opposed to traditional, hierarchized pedagogy, which is almost always prescriptive and monologic. The achievement of criticism-reflection about care now permits full autonomy instead of the execution of fragmented practices, by who follows what professionals have prescribed, without critically reflecting on the use of a given practice:

[...] *it also helped with small details, we start to pay more attention to our daily actions* (C1).

[...] *I liked it because I gained abilities [...]* (C9).

[...] *I did it because it was daily reality, it's that daily custom, I did it that way because it was the day we had like, we had already learned it that way and did it that way, but without experience, without innovation, that is, we got another opportunity for how it must be done now as well [...]* (C10).

[...] *I did start to reflect better, think about the most adequate treatment* (C12).

Learning demands were extracted from the criticism and reflection the problematizing dialogue permitting during care research meetings. These demands emerged from the sharing of knowledge and practices in the popular and professional systems between myself, the nurse and the ostomized clients. Criticizing their own care practice, resulting from existential praxis, these clients experienced new ways of acting towards their stoma, reflecting and performing care that is fundamental for its maintenance. Gradually, as their condition of criticism and reflection advanced, the clients sharpen their ability not only to perform, but also to assess the care delivered in a singular way, which makes their action more autonomous. "[...] when the educator acknowledges the historical, temporal, creative and cultural subject-being's ontologic vocation, (s)he uses education for the student's transformation and autonomy, that is, to be more".<sup>12:635</sup>

When considering the achievement of these clients' autonomy, which transformative dialogue made possible, the culture of silence is ruptured, releasing the oppressed, which professional action had "reified" until then. It should be reminded that "man should be the subject of his own education. He cannot be the object. Therefore, nobody edu-

cates nobody".<sup>3,28</sup> As a cognizant subject, immersed in the world and with the world, he should be acknowledged and heard through an education process that is established in a horizontal and reciprocal relation, through the dialogue he communicates. Based on this participatory, dialogic and active method, which permits communication, both are educated jointly, mediated by the world. This permits transforming reality, to the extent that it facilitates learning, in this case ostomized clients' learning in the outpatient care context:

[...] *after I talked to you, you instructed me and thanks God everything worked out!* (C6).

Thus, instead of passive, clients become active and co-participate in their own care, assessing the use or not of practices related to their stoma: [...] *that's very good [...] even more for a closed person like me, I got in here and left saying everything [...]*. (C9). The educative practice that was implemented made a difference, based on the problematization principles, resulting in the research participants' positive assessment.

Nurses' listening skills were also related with the use of the problematizing pedagogy. Observations of nurses' sensitive listening is important, as it cooperates in the expression of the clients' feelings about issues involved in living with the stoma. Listening to the other demands personal willingness, attention to his/her feelings and the way in which clients expect to receive care. When expressive qualities are imprinted in care, nurses no longer implement procedures in someone, but reflects together and performs integrated actions, including involvement and accountability; this enhances the growth of both stakeholders in the care relation.<sup>13</sup> The basic premise of those who put the educative process in practice is to enhance the personal strengthening of the human beings they interact with, to help them help themselves, turning them into agents of their transformation.<sup>3</sup> Thus, through the educative process, favorable results could be achieved:

[...] *I didn't experience any difficulty, I learned it quickly, I learned it well, I didn't feel any difficulty and I even practiced faster* (C12).

[...] *that's good, because every place that does that [health education centered on dialogue] reports evolutions, better evolution for us* (C14).

A pedagogy that goes beyond the facilitation of learning improves clients' confidence regarding care and is fundamental for care quality: [...] *because I learned more, I learned more, I got like, I believed in myself more! That's what I think was the most*

*important, that I believe in me! I really didn't know how to do that! It made a huge difference to me!* (C7). Enhancing a relation of participation and reciprocity increases the possibilities of establishing bonds in view of the limits that appeared, and this becomes feasible through a dialogic and horizontally processed relation. If not, in view of an anti-dialogue, in a vertical relation, people become insecure and incapable of making decisions.<sup>14</sup>

Thus, the shared care plan resulted from the problematizing dialogue that made each client revisit his/her knowledge and practices about stoma maintenance and open up to new forms of self-care.

### ***Repercussions of shared care in the home context***

Information sharing between nurse and client in the outpatient context, based on the problematizing pedagogy, showed its pertinence, to the extent that it facilitated ostomized clients' learning about elimination stoma maintenance. Consequently, it contributed to nursing care in the outpatient context, resulting in greater effectiveness:

[...] *yes, it was very important, right, because we think that we're acting correctly and a professional's help is very gratifying, right, because there's observation, you start to observe more, right? Having that care, but care is doubled because there are details we do not even perceive and a professional conversation we evaluate more [...]. More carefully, right, more attentively, with more attention in that process. It was very good, I liked it* (C1).

The client starts to reflect and pay attention to essential stoma maintenance care, like hygiene. In addition, what the client or the nurse *a priori* presented as a problem during the outpatient health education process, after the implementation of practices that had been established in the jointly constructed care plan in the home care context, the positive transformations resulting from shared care could be unveiled, mainly upon the client's outpatient return.

One example is the improvement of dermatitis, in which the client is also keeping the collector pouch longer as a result. During the established knowledge exchange, the nurse researcher asks about the details of care established at home and that is exactly when possibilities to change habits are revealed, in view of the difficulties and problems faced. That is the case because, aware of their

condition and the necessary stoma maintenance care, clients joint better possibilities for self-care at home. For the nurses, this event entails a positive assessment of the care implement and the instruments used for its implementation, which was the case of shared care with the help of problematizing pedagogy:

*[...] everything I learned here, I can say that I feel more professional concerning my stoma (C4).*

*[...] yes, I got it. More autonomously, let's say, regarding the care. He can assess it, right?! (R).*

*[...] more maturity, right?! (C4).*

Dialogic practice brings the client's critical-reflexive condition into the care context, which in turn permits greater awareness of the problem and the possibility to act on it and transform it.<sup>5</sup> Once aware, clients become more active and participate in care; they feel more secure to practice their autonomy in this process, which enables them to assess the care delivered at home.

The security felt in view of a positive result contributed to the social reinsertion of C5: *[...] because, before, I used to install the pouch and rapidly felt that the pouch, that the adhesive heated. So, that is, that happened and I didn't have the courage to go out [...]. Not now, even to travel, somebody invites me to go to Rio, to the house of a relative, I go! Because I'll feel secure! Because, before, to go to a distant place or get into a car, my pouch could get loose at any time. It started to leak and I didn't even perceive it and, when I noticed, everything was wet! (C5).*

Another client who was unable to change the collector pouch, whose sister-in-law performed the procedure, is doing all maintenance care after the shared care plan, including fixing the pouch, without depending on any other person. The client said that, as a result of our "conversation", she gained courage, gained courage..., And expressed: *[...] a relief! (C7)* As a result of independence, the client is again inserted in society and feels more secure when using the adhesive tape.

C5 also started to use soap for washing when changing the collector pouch, and C6 stopped removing the adhesive harshly when detaching the pouch, and also started to measure always before cutting out the wafer.

Also regarding the cut for the pouch, C7 transformed his reality, always measuring before cutting and fixing, causing a cut close to the stoma. Also, when learning about this care, the patient attempted to advise the companion, who until then was the main responsible for care delivery to the

client's stoma. It is highlighted that this relation of dependence also changed.

In addition, the indication of the stomahesive powder and its appropriate use helped to heal the dermatitis and, also, to achieve independence to change the pouch:

*[...] helped me with the cut, helped me to put on this powder that helped with the healing, right! [...] I think it was really worth it! (C7).*

C5 started to remove excess stomahesive powder, which caused non-adherence of the collector pouch to the skin. When the patient got to know deodorizing lubricant, C14 considered use at home and, therefore, took it for testing:

*[...] after using that product there, the solution, it got better, at least that, besides what we [...]. It wasn't repeated and, sometimes, we thought that the pouch was clean and it wasn't, sometimes, the feces got stuck here at the side and it was bad to get off; not with that, you just shake it a bit and, when you check, the water is really clean [...] (C14).*

This shows that nurses at the outpatient clinic should stimulate knowledge of what is new, taking into account the pertinence of each case applied to reality though. C4 started to take better care and, now, no longer uses the ether the patient had been using for year to remove the collector pouch easily:

*[...] look, it contributed because I didn't take really good care of that, I started to take better care, right. Like: I said the other time that I used to use ether to remove the adhesive better and you informed me that that is harmful, is not good for the skin... and I stopped using it and I'm feeling that that's really it... ether really was not made for that... 'cause that's a mistake of ours, that we sometimes want something faster, but which is harmful (C4).*

According to C5, then, the shared care experience improved self-esteem and social reinsertion:

*[...] my self-esteem also got better because I'm even going out [...] even to my self-esteem it contributed. It contributed a lot, improved a lot. I didn't have that before, I got out of here and my thing was to stay at home, stuck. I didn't even go out to the gate. I felt worse than a prisoner, because prisoners at least sunbathe [...] (C5).*

The increased quality of life as a result of correct stoma maintenance at home was also highlighted:

*[...] I liked it. It was very good because I stopped to reflect on some things I was doing. Because sometimes we think that we are doing it correctly because of our*

*practice, and then it's not. And, to have a better quality of life, it's better for us to do it correctly (C8).*

Health education revealed its key role for clients' successful life with the stoma. This client, aware of his limits and possibilities for elimination stoma maintenance care, turns into an ally in the care relation. It is ascertained that the alterations the establishment of the stoma causes affect the physical, mental and socioeconomic dimensions of ostomized patients' lives. They need to deal with their new health condition optimistically though, which demands multidisciplinary cooperation to promote their rehabilitation and improve their quality of life.<sup>15</sup>

In the reported examples, one can perceive that the repercussion of care in the home context was highly relevant, to the extent that it permitted noteworthy contributions to care and to the evolution of the stoma itself. The achievement of the planned autonomy became reality and, thus, facilitated the different care actions ostomized clients performed in the home context. The educative proposal could "[...] be understood as a way to understand the world, reflect on it, transforming reality based on conscious action".<sup>12:634</sup>

The elaboration of the shared care plan was terminated in the intent to promote changes or minimize problems, which was verified in the liberation of the oppressed clients, evidencing commitment to the direct improvement of the social context under analysis.

## CONCLUSIONS

In this research, Freire's pedagogy showed to be an instrument that facilitated ostomized clients' learning in the context of a nursing care education proposal in the outpatient context. By problematizing the different situations they are confronted with in life with the elimination stoma, the clients were stimulated to reflect on their reality through the dialogic practice that was implemented in the convergence between research and care.

When the clients' returned to the outpatient clinic after shared care had been put in practice, the successes resulting from the pedagogy used in the educative process could be noted. Their critical and reflexive condition is sharpened; practicing stoma maintenance care more secure and autonomously, assessing, changing habits and transforming reality.

As for the study's repercussions for the unit, we faced limits to put this principle to work, as

operational difficulties emerged, regarding the researchers' lack of bond with the research scenario, despite their immersion in care during the data production period, besides the nurse's absence from weekly activities, which hampered her participation and communication with the nurse researcher. The research has demonstrated, however, that subjects can be transformed when the nursing care education proposal is used in the outpatient context.

The debate about a nursing care education proposal in the outpatient context is evidenced in the research, revealing a guideline as to nurses can actually put this specific activity in practice for ostomized clients. Further studies are still lacking, however, which express a health education process technology applied to different contexts and social groups.

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