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Implementation of the nursing process in Portuguese hospitals

Aplicação do processo de enfermagem em hospitais portugueses

Aplicación del proceso de enfermería en los hospitales portugueses

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ABSTRACT

Objective: To obtain a description of the implementation of the nursing process by nurses who work in hospitals.

Methods: Qualitative, descriptive study that was carried out in 19 hospitals in Continental Portugal with 56 nurses. Data were collected through a semi-structured interview.

Results: Content analysis originated the categories nursing process, initial evaluation, diagnosis, planning, implementation, and final evaluation. Although there has been a progressive appropriation of the nursing process in the past years, the description of nurses' practices evinces some weaknesses.

Conclusion: The results of this study show that the application of the nursing process requires more clarification and comprehensiveness of the contents included in its stages.

Keywords: Nursing. Nursing process. Hospitals.

RESUMO

Objetivo: Obter uma descrição da aplicação do processo de enfermagem feita pelos enfermeiros que exercem funções em instituições hospitalares.

Métodos: Trata-se de um estudo descritivo com abordagem qualitativa, realizado em 19 Centros Hospitalares de Portugal Continental, no qual participaram 56 enfermeiros. Os dados foram coletados através de entrevista semiestruturada.

Resultados: Da análise de conteúdo emergiram as categorias processo de enfermagem, avaliação inicial, diagnóstico, planejamento, implementação e avaliação final. Apesar de nos últimos anos ter ocorrido uma progressiva apropriação do processo de enfermagem, a descrição das práticas dos enfermeiros torna evidentes algumas fragilidades.

Conclusão: Os resultados do estudo evidenciam que a aplicação do processo de enfermagem requer maior esclarecimento e completude dos conteúdos incluídos nas etapas que o constituem.

Palavras-chave: Enfermagem. Processo de enfermagem. Hospitais.

RESUMEN

Objetivo: Obtener una descripción de la aplicación del proceso de enfermería echa por los enfermeros que ejercen funciones en instituciones hospitalarias.

Métodos: Se trata de un estudio descriptivo con enfoque cualitativo, que se realizó en 19 centros hospitalarios en Portugal Continental, y en el que participaron 56 enfermeros. Los datos se recolectaron a través de entrevista semiestructurada.

Resultados: Del análisis de contenido surgieron las siguientes categorías: proceso de enfermería, evaluación inicial, diagnóstico, planificación, implementación y evaluación final. Aunque en los últimos años se haya producido una apropiación progresiva del proceso de enfermería, la descripción de las prácticas de los enfermeros hace evidente algunas debilidades.

Conclusión: Los resultados del estudio sugieren que la aplicación del proceso de enfermería requiere una mayor clarificación y la integridad de los contenidos incluidos en los pasos que lo constituyen.

Palabras claves: Enfermería. Proceso de enfermería. Hospitales.

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INTRODUCTION

The nursing process was formulated between 1950 and 1960 in the United States and Canada, and in its first years, it was developed essentially in the teaching area. In the 1970s, its use was extended to the clinical practice[1]. It is undeniable that the nursing process has been valued throughout the evolution of the profession[2-3]. In Portugal, in accordance with the regulation for the professional practice of nursing, response to care needs of clients implies a systematic and intentional approach, which can be achieved only through a scientific method, that is, the application of the nursing process[4]. When used this way, the nursing process allows the needs of the clients to be met specifically and safely, which may increase the quality of care and the visibility, valorization, and recognition of the profession[5-6]. In addition to driving nursing work organization according to its specific attributions, implementation of the nursing process provides a higher personal and professional satisfaction for nurses[6-7]. Nevertheless, despite the evidence regarding the advantages of implementing the nursing process in health institutions, notably hospital facilities, adherence to this methodological instrument remains a challenge[7-8], whose realization entails to explore conceptions and perceptions of nursing professionals regarding its use[6]. In Portugal, during the past ten years, a nursing information system currently called SClínico® has been integrating the International Classification for Nursing Practice (ICNP®) and incorporating items which translate the nursing process, thus contributing to its incorporation in professional practice significantly. The requirement to include data relevant to nursing-related decisions in the initial evaluation field of SClínico® and, in a posterior step, identify nursing diagnoses electronically and plan interventions has facilitated the appropriation of the nursing process. Although the evolution in documentation has been remarkable, the thinking process of some nurses evinces the existence of weaknesses that, despite being common, have not been examined. The present study is part of a more comprehensive research project carried out in Portugal, entitled "Contexts of hospital practice and nursing conceptions", and aimed to answer the following question: "How do nurses who work in hospital institutions in Continental Portugal express the application of the nursing process?" The objective of the investigation was defined as the description of the application of the nursing process by nurses who work in hospital institutions in Continental Portugal.

METHODS

This descriptive and qualitative study was carried out in 19 hospital centers of Continental Portugal. Purposive sampling was used to choose participants. To reproduce the three functions that nursing professionals practice and ensure a better understanding of the phenomenon, each hospital institution was represented by a nurse manager, a specialist nurse, and a nurse caregiver. As a consequence of sampling bias, the three participants from each institution were indicated by the chief nurse of the respective facility. The inclusion criterion that guided the choice for participants was to perform professional practice in the studied hospital institution for at least six months, in the departments of clinical medicine, surgery or intensive medicine and urgency. Once the professionals were indicated as potential participants, they were asked to confirm the decision to join the study. One nurse manager declined the invitation, which caused the final sample to have 56 nurses. All the participants were requested to sign an informed consent form declaring they accepted to be included in the investigation and authorized the recording of the interview. The study was approved by research ethics committees and administrative councils of the 19 hospital institutions involved in the project and guaranteed anonymity and confidentiality for the interviewees. Data collection was performed through the application of a semi-structured face-to-face interview. The meeting with the participants was scheduled previously through a phone call, considering their availability. Interviews were conducted from August 2015 to February 2016 with an average duration of 60 minutes. The shortest and longest meetings took 28 and 110 minutes, respectively. To assure data reliability, the interviews had their audio recorded. All the conversations were fully transcribed and sent to the respective interviewee by email so the contents could be validated. It is noteworthy that a single researcher was responsible for conducting, transcribing, and analyzing the interviews. To ensure anonymity, all the accounts were encoded: the identification consisted of the first letter of the words caregiver, specialist or manager, followed by a number. Interviews labeled C1 to C19 involved caregiver nurses, accounts entitled S1 to S19 referred to the specialist nurses group and conversations named M1 to M18 pertained to nurse managers. Content analysis was made from the perspective of Bardin's framework[9], using the *Atlas.ti*® software. The examination of the testimonials of the participants had three stages: pre-analysis, exploration of the material, and inference and interpretation[9]. Throughout this route, the authors focused their attention on the accounts which addressed the subject under investigation, interpreted their meaning and considered how they could be a contribution to the phenomenon under study. From this point, they identified the represented topics and prin-

ciples. Following the sequence of use of the *Atlas.ti*© software, identification codes (*codes*, in the software language) were assigned to register units (*quotations*). Subsequently, the data were organized into categories (*families*).

RESULTS AND DISCUSSION

The analysis revealed that most professionals were women (73.2%) and the prevalent ages were from 30 to 35 years old and between 50 and 55 years old. The most common marital status was married or living in a consensual union (73.2%). The distribution of functions was identical, given the purposive nature of the sampling: there were 19 nurses (33.9%), 19 specialist nurses (33.9%) and 18 nurse managers (32.1%).

Regarding content analysis results, in the context of the thematic unit entitled care delivery scientific methodology (Chart 1), elements inherent to professional practice, which qualified to fit in the steps of the nursing process, emerged in the accounts[10].

Thematic Unit	Categories
Care delivery scientific methodology	Nursing process
	Initial evaluation
	Diagnosis
	Planning
	Implementation
	Final evaluation

Chart 1 - Care delivery scientific methodology
Source:[10].

Similarly to what has been observed in other countries[11], in Portugal, especially in the hospital institutions where the investigation was carried out, the use of the nursing process seemed to be transversal:

In terms of evolution, I believe that maybe the teams have been more directed these past years (…) to the question of the nursing process (S19). We use a scientific method which is the nursing process and consequently (…) I think that we use the best method to organize care (C14).

Although the application of the nursing process is one of the competences of primary care nurses[4], regarding its incorporation into the practice, different realities seem to exist. Despite the fact that the use of this scientific methodology was noticed in some contexts, there are situations in which it is necessary to invest in the integration of the nursing process, which will contribute to develop the autonomy of the profession:

I think that they are already more concerned with users, their difficulties, and focuses… and with the interventions, they have to develop later to see if they had results or not, and how they can remedy the situation and reach their goal if the outcomes are not positive (S9). If the nursing process were followed and integrated into the spirit of people and their way to work, for people to realize why it exists and how it works, this area would be much more developed (S14).

In addition to the complexity intrinsic to the nursing process itself, there may exist problems in its systematic and effective implementation in the professional practice, whose examples are lack of professional training, specificities of work methodologies and organizational characteristics[5-6]. Among the weaknesses cited by the participants, the difficulty that nurses show to integrate the essence of the nursing process stood out:

They resort to the nursing process necessarily to fulfill obligations, I mean, they use it in an operational, not in a coordinated way, in the way they work, in the work spirit that nursing really is (S14).

In this context, there is the risk to make the nursing process a mere routine execution, which deprives it of its scientific method nature[3]. This finding corroborates the results in the literature, according to which the nursing process is perceived more as a bureaucratic task to accomplish[6]. The following excerpt shows that the need for standard nursing procedures raises doubts about the effectiveness of the integration of the nursing process:

Over the years, we had standard records to guarantee that (...) they conform to the reality… (M7). These days we know that the nursing processes are standardized in each service (…) with interventions in each service and it reveals precisely that we are not taking into consideration the people and personalized practice… So, I think it is a huge step we have to take in that direction (C10).

From the accounts of the participants, it is possible to identify the need to think over the value of the nursing process and the steps that make it up in the context of professional practice. The first stage, initial evaluation or appreciation, as presented in the information system currently in use, is oriented to collect data which allow to infer nursing diagnosis and may affect the way nurses plan and implement interventions. The relevance of the initial evaluation was cited by the interviewees, and the way it presents itself depends on the professional who describes it:

Another thing that we work on, and I believe that the team is doing very well with it, is the reception of sick people with an initial evaluation (…) there is always a concern to do (…) a very complete initial evaluation (M11). We have an initial evaluation that addresses many aspects and that may be fulfilled more rigorously, with more judgment, depending on the sensitivity (…) and the availability of the nurse (S7).

Despite the importance attributed to the initial evaluation and the need to develop it, there are difficulties in its appropriation:

They know (...) that they have to do an initial evaluation, because they think of the form they have to fill in and these are conditions that have to be secured, but they do not understand very well why they have to do this initial evaluation, because sometimes they say: patients come here to undergo a surgery to treat this… why do I need to know their habits (…) and, consequently, they are not imbued with this culture (S14).

During the initial evaluation, information is usually transmitted by patients themselves, but in some situations, even when their health condition allows them to contribute to data collection, family participation is more important:

In the institution, we have many bedridden patients whose level of cognition is low… during the meeting with the family, I always try to notice what we want for that patient (S15). The relative (...) knows the patient better than we do and (...) sometimes, what we identify as a need may not be one. And it is possible that, before being admitted to the hospital, the patient no longer had the capacity we want him/her to have, so this is important (M5).

The data relevant to nursing decision making may also be available in the clinical process and conveyed by the multidisciplinary team:

I try to gather as much information as possible (...) both from what is already known in the clinical process and from what is conveyed by colleagues (S13). Therefore information about the patient comes to us in several ways. We have the medical team, which talks to us (…) Then we have the social team, which is always here (…) And then we talk to other colleagues (…) who even know that patient already (C18).

As for the data related to patients, gathered during the initial evaluation, the factors identified by the participants were level of education and learning skills, beliefs and values, level of dependence for self-care, awareness of the disease, knowledge and potential to recover and readapt:

We have been taking into consideration (…) the level of education and the learning skills of the user (C19). In my opinion, the most important thing is (...) what people have internalized, the beliefs, the values (C5). (…) to know how the patient was at home regarding self-care, that is, if he/she was dependent or independent, is fundamental (C4). Here we always make that initial evaluation of the patient, what he/she knows, does not know, their level of awareness and knowledge of the disease. There are many patients (…) that do not even know the name of the disease (S15). (…) the knowledge patients have (…) is also very important (…) the potential they have to recover, to readapt to a new situation, makes the difference, regardless of the situation and its severity (C5).

Data referring to social status and family support were also emphasized:

We are increasingly receiving people who live alone, or live with elderly relatives and our first concern is to know the social situation of the person (M2).

The identification of caregivers and collection of data about their potential to look after patients were also mentioned by the participants:

I have to be able to describe the potential caregiver who is going to be responsible for the patient after discharge and immediately start to plan it… (M2). (…) we approach all the aspects related to the significant person (…) if they have enough knowledge to look after this relative at home; from this point, we can plan the discharge, realize if the relatives are ready to receive the patient in this situation… (M7).

After the initial evaluation, the second phase of the nursing process corresponds to the diagnosis. In the ICNP® Beta 2 version, which supported the first version of the information system currently in use, the areas of attention were split into two domains: function and person. The relevance of diagnoses in the first domain was evident in the accounts of the interviewees:

The diagnoses that they formulate, identify, are essentially in the function area and then they have no doubts (…) if they identified diagnoses in the person scope, aspects more related to the process of adaptation, (…) playing the

role of caregivers, we would discuss more (…) by the way, the few situations in which we talk about nursing diagnoses have to do with these aspects (S2).

The transcribed excerpts show that the identification of nursing diagnoses in areas of the subject core promotes reflection and discussion about the nature of the profession. An investigation carried out in a hospital setting in 2013 reported that the function domain had a significant representation in the global documentation of nursing care needs[12]. The analysis of the reports of the nurses in the present study corroborated this finding:

A large part (…) of what we do (…) is centered at function (C14). No doubt that these days nurses document more and better. There has been this effort (…) but this improvement in documentation does not change the focus from function (S2).

The participants manifested difficulty to identify diagnoses in the domain of emotions experienced by clients:

In our daily routine, our strongest tendency is (...) the patient has a wound, is uneasy (…) The emotional aspects, I believe that somehow all of us ignored them (…) if we check our records, we will see that few examples in this area are found (S9).

In the sphere of ill people, self-care is the area of attention to which nurses resort more often to describe nursing care delivered to patients. In addition, dependence is frequently associated with self-care in the sense of translating the patients' needs in this domain:

Many of the identified problems are related to the different self-care practices (…) the level of dependence is evaluated regarding all these practices (C4). For every admitted patient, we have to check the level of dependence that they present (S16).

The statement is in agreement with the results described in other studies, an evidence of the influence of the needs school in the practice of Portuguese nurses[12-14]. The focuses of attention in the function domain cited by the participants were pain, swallowing, and dyspnea:

Here we see many cases of acute pain (…) but also of chronic pain (M3). (…) We are always alert to the possibility of existing swallowing alterations (…) Sometimes our intervention is influenced by dyspnea, which is really common here (C4).

Awareness, knowledge, capacity, and management of the therapy are areas of attention that nurses have been gradually valuing. Although they were mentioned fewer times in the accounts, it is worth stressing them, given that they show nurses' efforts to identify attention focuses on the scope of the nursing subject core:

Awareness of their new health condition (S2). Knowledge of the disease (C4). The capacity to do it by themselves, without the nurse's help (M1). (…) in a certain patient, with whom we were working on the management of the therapeutic plan (C5).

As for the focuses on the family, nurses evinced difficulty to coordinate them, and their attention was often oriented to a single member of the family, the one appointed as the family caregiver, and who has recently been named so by the International Council of Nurses[15]. Some authors have found that, despite the theoretical development and the opening of hospitals to families, nursing care is still centered at the individual and not the family[16], which was also observed in the present study. Regarding the emphasis on caregivers, knowledge, and capacity to look after ill people emerged in the interviews:

Our role is crucial in these first steps (…) of the role of the caregiver (S2). In addition to having knowledge, it is important that they have ability to learn and do (C4).

Although the approach to caregivers as clients and not as a resource to secure care has been mentioned few times by the participants, it is important to consider it in the context of an approximation to the exposed models:

The truth is that we know that there are several studies showing that we have to pay attention to caregivers (…) as clients and not as a resource. In terms of form, we even see them as clients, but when it comes to substance we treat them as a resource (C14).

In this excerpt, the participant's comment illustrates the frequency with which nurses approach caregivers as clients and targets of care, evincing the existence of a dichotomy in the models presented in theories and the ideas applied in hospital facilities[16]:

A caregiver who had never been approached that way and whose stress dimension became my focus (…) and because I treated him as a client, he was very surprised because (…) "did not know that nurses did that"… (C14).

The focuses of attention with which nurses have been associating a probability judgment relate to falls, pressure ulcers, aspiration, maceration, and infection. This attitude is a consequence of a practice oriented to preventing complications. Similarly to what was described in another Portuguese study[12], the identified risk diagnoses were:

Fall risk (M10), pressure ulcer risk (S6), aspiration risk (S2), maceration risk (C3) and infection risk (C9).

In the scope of nurses' competences, the care plan must be formulated after the appreciation of data relevant to care design[4]. The interviews reveal the intention of nurses to achieve this goal in the third step of the nursing process, entitled planning:

We have a care plan (S19). (…) I think that we are in a good direction and that our care plans are excluding what is superfluous and unnecessary and we are focusing on essential aspects (S7).

In the formulation of the care plan, despite the focus on clients, the conception of care centered at disease processes still remains, although it is not advocated:

The care plan is oriented to that patient (M14). There is always the reception of the patient (…) and from that point we formulate (…) the care plan depending on the pathology that the patient has and concomitant pathologies (C11).

The concern with the definition of feasible objectives was mentioned by participants as an important aspect:

The idea I have in mind is (…) to set a real, viable goal (…) if we have something too utopian, first there will be frustration because we could not get there, we get frustrated, the user and the family too, because they also expected more (S9).

According to the regulation, whenever possible, the formulation of the care plan must include the collaboration of clients, patients or caregivers[4]. The importance of the engagement of clients in the planning process was stressed:

What is the point of me including in the care plan something that was not negotiated with the patient? (…) we have to encourage the person (…) in the decision making about the care (M3). In medicine services, it is necessary to include the caregiver in the whole planning process, from admission to discharge (…) and when things go well both the caregiver and the client get satisfied (S1).

This extract shows that nurses have been adopting practices considered appropriate according to scientific evidence. The Portuguese Plan for Patient Safety[17] advises that patients must be actively involved in the care process, given that it is the only way to assure that they can be held responsible for their health or the control of evolution of the disease. Despite the relevance of clients' participation, its realization is not always easy:

It is important (...) to negotiate with the person exactly what (...) we are going to plan in terms of interventions, because many times we are an external agent that comes up determining a care plan (…) that only gives indications (C10). The workload is higher and higher and we have to do more things at the same time; sometimes, this part, related to questioning the person, validating these points with the person, is overlooked (S4).

The most materialized interventions emerged in the implementation scope, considered the fourth phase of the nursing process. Among the interventions directed to patients, the following must be emphasized: assisting self-care, teaching adaptation strategies for self-care, encouraging self-care, teaching about the therapeutic plan, teaching about respiratory exercises, teaching about ostomies, and teaching and raising awareness about the disease. In this perspective, it is evident that nurses steer their actions to promote self-care, provide knowledge about the disease and its management and practice abilities to deal with alterations resulting from the disease process and the treatment itself, to help patients to adapt to their new health situation. As for the interventions in the self-care domain, it was possible to identify different perspectives. One is a derivation of replacing the patient as a consequence of an acute episode of a disease:

Mainly in the scope of replacing the patient, or the care to him/her in that self-care, many times still centered on what he/she cannot do (...) And then, as the disease evolves, and when we are helping them with the care (…) we help people to realize that they are getting better (C3).

An evolution is observed from an approach centered on the client's replacement, based on Dorothea Orem's theoretical framework and ranging from a partially to a totally compensatory system[18] that is important in the management of the disease signs and symptoms, to a stage of awareness of the favorable evolution of the pathological process and, consequently, of self-care promotion. By coming across self-care activities that they can and cannot

perform, patients become aware of their evolution[13]. Another perspective, grounded on clients' knowledge and capacities, could be spotted in the narratives:

In the service (…) we worked on adaptation strategies, worked on potentializing patients to improve their self-care (C5). To teach and train adaptation strategies to promote patients' self-care capacity, this is our routine (C4).

It often means to offer professional help to patients when they take a shower:

They are the patients that need most our help in the bathroom to help them in the activities, in all the self-care (S15). It is in this moment that we teach more strategies (C4).

It is noteworthy that learning new self-care skills can occur in two ways, through trial and error or resorting to professional help. The first option happens when the second is not available in time[13]. It is also necessary to take into consideration that professional help makes self-care activities faster and safer. In the situations in which the realization of self-care procedures was temporarily compromised, a greater relevance was given to the intervention of encouraging self-care:

The day after the surgery these patients are stimulated to try to get up, sit on the chair, so on day two they are able to do self-care tasks (…) they are encouraged to get up a short time after the surgery (…) to be able to execute the self-care routine (M13).

In the therapy management domain, interventions are essentially to teach and educate. It is worth stressing the importance given by nurses to the technique executed by clients during the treatment:

In our service we have patients with respiratory pathologies; many times, they have to use an inhaler at home and we teach them (…) If it is a patient who already uses it at home, what happens sometimes is that they have a poor technique. The family is asked to bring the inhaler, and together with the patient we supervise, explain how they have to do it (C15).

To train clients to deal with changes resulting from the disease process or the treatment itself, nurses implement teaching interventions:

We teach certain respiratory exercises, it is a way to keep the patient healthy much longer (S9). There are things that we teach every day (…) to colostomized patients (C8).

In the sphere of pathology processes, the goal of promoting awareness and knowledge of the disease was valued:

To raise awareness about the fact that they have that disease (S15). Inform and teach about the disease (C4).

Regarding interventions oriented to families, there was a noticeable concern about the preparation of the relatives to receive the patient at home:

The preparation of the family is crucial (C4). (…) we prepare the family so it realizes it is ready to accommodate that person (S2).

As a consequence of recognizing the importance of professional support to the families, the accounts demonstrate an interest in the family structure itself:

Sometimes we have to optimize family structures… the family structure is not ready to receive the patient in the conditions he/she is discharged (…) and sometimes the family is not able to coordinate itself without our help (S18).

The participation of different family members is usually construed as positive, because in addition to assuring a better support, it may be a possibility of dividing tasks[13]. The analysis of the interviews uncovers episodes that illustrate the nurses' intention to engage families, sometimes to teach them about the disease, but also to prevent complications:

Every time there are relatives with a minimum willingness to help, I always ask their help to position the patients (…) to explain to them either the way to position them, or the way to pull them, because quite often people grab the patients' arm and pull it back to put them on the bed and (…) one day they will have their arm broken (C16).

The concern of nurses to endue the members of families with knowledge, skills, and resources which allow them to help the dependent relative to master self-care or avoid complications contributes to a personalized and high-quality transition and is important to patients[19]. As previously mentioned, the approach of families as clients is rare, and some authors[16] claim that the interventions oriented to families in hospital facilities assume that the relatives are a tool in the discharge process, a fact that was also observed in the present study. However, given the importance of families in the continuity of care to patients, some excerpts showed the concern to prepare specifically the relatives who take over the responsibility of caregiver, usually named so by the interviewees in the reports:

We require them to come here with the future caregiver, with the person who is going to look after them (S8). Somehow we try to supply their needs and foresee what will be a problem for them at home, so we can teach them something (S9).

There has been an effective evolution from an almost exclusive emphasis on clients' needs to meeting the demands of people who will take on the function of caregiver[12]:

We have to look after not only the patients, but also the people close to them, or who will be with them at home and have to continue our care after discharge (S9).

The relevance attached to nurses' actions was evident in the nursing interventions of teaching and training. It can be considered a consequence of the clinical judgment regarding the knowledge and skills of the relative that acts as a caregiver:

What we do the most is teach and train caregivers to wash, position, move and feed using a nasogastric tube (C4).

The interventions directed to caregivers are essentially focused on their training for the process of taking care. The present investigation demonstrates, in agreement with other studies, that the preparation of caregivers, when it exists, is oriented to complement what patients cannot do, and does not aim to recover the autonomy of patients. The current conduct falls short of expectations regarding the process of facilitating the transition for the role of caregiver, which starts in the hospital[13,19].

As a consequence of a policy that advocates increasingly shorter hospital admissions, the role of caregiver has been played by a member of patients' families[19-20]. However, demographic and family structure changes have been causing a reduction in the availability of relatives to deliver care. In hospital settings, the confirmation of this reality involves communicating the situation to the discharge management team or the social worker. As for the intervention notifying problematic situations to the discharge management team, the participants recognize the need to act as quickly as possible:

During the first days of admission, it is necessary to check whether patients met the criteria to be mentioned or not (C4). We resort to the discharge management team, because many patients need referral for continued care units (…) it is a coordination that we do every day when faced with problematic situations (M17).

The intervention to notify problematic situations to the social worker was stressed by the participants in the cases in which clients live by themselves or in unsafe circumstances:

The client walked in and I realized that he/she lived alone… we talk to the social worker and she comes here (C12). If the patient lives in situations of unsafety or frailty, we immediately communicate it to the social service to prepare for the post-discharge period, namely we look for resources in the community (M2).

Episodes of negligence and/or abuse are also commonly reported to the social worker and, whenever possible, hospital discharge is delayed until the necessary social conditions are secured:

Situations of marked negligence by relatives, or abuse, (...) even if the doctor says that the patient can be discharged the next day, I say that I do not know, while this problem is not under control (M2).

Despite the difficulties inherent to the coordination with other institutions, the accounts revealed the need to establish a cooperation effort with community health services in some situations:

When I get worried about the continuity of a certain care, I end up calling the health center (C4).

Although the development of self-care or therapy management competences should start in the hospital, the confrontation with real needs takes place when patients come back home[13]. Considering that currently it is not viable to provide home care by the professionals who assisted a patient in a hospital, one of the strategies is to resort to workers from community health services, so these can fulfill the gaps that may exist in care continuity. This alternative has not been fully successful, though. This problem points to the necessity to consider creating a direct communication channel with services to facilitate patients' return to home and avoid the need to go back to health institutions[13]. The interviewees emphasized the importance to develop a coordinated work with social support organizations:

When the patients go home, there are homes that are not ready for certain interventions... we contact the colleagues… to tell them about the situation of the patient… and what type of care is needed… (M11).

Last, in the context of the final evaluation, it is evident that evaluating the results of nursing interventions should be more notorious, according to the participants:

There is not the type of feedback that I like… the patient starts to do something (…) and is already good to go home (…) I think that it could make (…) a difference in our practice (M7). As a general rule, nurses have no sensitivity to evaluate and document the interventions they execute (…) (C4).

According to the description of nurses' competences[4], it is crucial to review and reformulate the care plan regularly, a necessity that stood out in the interviews:

Once new data are available, it is necessary to reevaluate the care plan (C2); it is possible that we have to change the intervention to get good results. We may have to do a new evaluation, swap interventions, to reach the goal (S9).

Although nurses value the update of care plans, they do not always do it, because of the requirement to do it in the information system currently in use, SClínico®:

Sometimes the interventions are not suitable for the diagnoses, or the diagnoses are not updated (C4). I think that there is this concern in some patients (…) patients who really have potential, capacity to learn, we are much more alert for the evaluation and update. But when the patients arrive here already dependent, remain dependent, whose caregiver has been looking after them for ten years, this gets a bit overlooked (S1).

From the perspective of the participants, in addition to the lack of sensitivity of professionals, the patients' health conditions influence the care plan update, which has been reported by other authors[5].

CONCLUSION

During the past decade in Portugal, the use of an information system whose conceptual matrix incorporates items which translate the nursing thinking explicitly has been a factor that facilitates the application of the nursing process. Despite a progressive appropriation of the nursing process in the past years, some weaknesses in its use are still evident, which results in a limited, partial and superficial application of this scientific methodology. Nurses recognized the value of the nursing process to achieve a systematized and deliberate practice, but revealed to remain focused on a care conception centered at the management of signs and symptoms of diseases, with more attention to the function domain in detriment of the real needs shown by patients. In addition, in contexts in which the partial and poorly grounded use of the nursing process is noticeable, nurses' practices are usually directed to reproduce routine procedures and rooted traditions. Even considering the limitations of a purposive sampling, the findings reveal that it is necessary to achieve a better understanding and the completeness of the contents included in the nursing process, as a methodology which can guide professional practice and make it more scientific. In the teaching sphere, it is important to adopt teaching-learning strategies to boost the appropriation of the nursing process. Regarding the nursing practice, the findings reveal the need to reinforce the adoption of systematized procedures in the care context. Inclusion of the nursing process and case studies in the training of nurses and the adoption of periodic evaluations of the practices with all the nurses from the team are possible strategies. As for the research domain, it would be useful to design studies based on observation of real settings with the goal of checking the agreement between the elements mentioned by nurses and the reality of professional practice. Also, investigations dedicated to address the factors that enable or impair a practice in consonance with the nursing process would be a contribution to the field.

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