MEANINGS OF THE NURSING DIAGNOSIS IMPLEMENTATION PROCESS FOR NURSES AT A UNIVERSITY HOSPITAL[1]

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This qualitative study aims to understand the meanings nurses at a university hospital attribute to the implementation process of the Nursing Diagnosis Classification System (DEn) as a phase in the Nursing Care System (NCS). Data were collected through interviews with eight nurses from the Medical Clinical Unit, who participated in the creation of an instrument to implement the DEn in the NCS. In their reports, the respondents expressed a positive change in their feelings, from initial discomfort and adverse perception of the change proposal. The stepwise appropriation of the process stages allowed them, besides the sharing of feelings, decisions and responsibilities for the results, to develop the belief that they would able to overcome the difficulties.

DESCRIPTORS: nursing diagnosis; organizational innovation; resources management

SIGNIFICADOS DEL PROCESO DE IMPLEMENTACIÓN DEL DIAGNÓSTICO DE ENFERMERIA PARA ENFERMERAS DE UN HOSPITAL UNIVERSITARIO

Este estudio cualitativo busca comprender los significados atribuidos por enfermeras de un hospital universitario al proceso de implementación del diagnóstico de enfermería (DEn) como etapa del Sistema de Atención de Enfermería (NCS). La recolecta de datos fue realizada por medio de entrevistas con ocho enfermeras de la unidad de Clínica Médica, que participaron de la construcción de un instrumento para la implementación del DEn en la NCS. Durante las narraciones, las colaboradoras explicitaron una transformación positiva de sus sentimientos, a partir del desconforto inicial y de la percepción desfavorable con relación a la propuesta de mudanza. En virtud de la apropiación gradual de las etapas del proceso por la cual pasaron, permitieron además de compartir sentimientos, decisiones, responsabilidades por los resultados, fundamentalmente alcanzaron el desarrollo de la creencia de que serian capaces de superar las dificultades.

DESCRIPTORES: diagnóstico de enfermería; innovación organizacional; gestión de recursos

SIGNIFICADOS DO PROCESSO DE IMPLEMENTAÇÃO DO DIAGNÓSTICO DE ENFERMAGEM PARA ENFERMEIRAS DE UM HOSPITAL UNIVERSITÁRIO

Este estudo qualitativo busca compreender os significados atribuídos por enfermeiras, de um hospital universitário, ao processo de implementação do sistema de classificação de diagnósticos de enfermagem (DEn) como etapa do Sistema de Assistência de Enfermagem (NCS). A coleta de dados foi realizada por meio de entrevistas com oito enfermeiras da unidade de Clínica Médica, que participaram da construção de um instrumento para a implementação do DEn no NCS. Nos seus relatos, as colaboradoras explicitaram uma transformação positiva em seus sentimentos, a partir do desconforto inicial e da percepção desfavorável em relação à proposta de mudança, em virtude da apropriação gradativa das etapas do processo que lhes permitiu, além do compartilhamento dos sentimentos, das decisões e das responsabilidades pelos resultados, o desenvolvimento da crença de que seriam capazes de superar as dificuldades.

DESCRITORES: diagnóstico de enfermagem; inovação organizacional; gestão de recursos

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INTRODUCTION

Since 1981, the Nursing Department (ND) at the University Hospital of the University of São Paulo (HU-USP) has been implementing the Nursing Process, later called Nursing Care System (NCS), which consists of three phases: History, Evolution and Nursing Prescription. Since that time, nurses have been developing the system as an important instrument to guide care, teaching and research.

Nurses from the ND believe that the NCS not only favors health promotion, maintenance and recovery, but also stimulates self-care and allows for the integration of teaching-care actions, as a learning strategy for undergraduate and graduate students and the nursing team[1].

Across the years, the nurses from the HU-USP have proved the success and efficacy of the NCS[2]. However, they have also indicated the difficulties they are confronted with to develop the system, as well as the need for changes towards greater agility, increasingly improving the quality of care and educational actions. Hence, in December 2001, ND management started the Nursing Diagnosis implementation process, as the second phase of the NCS, also aiming for its computerization.

Implementing a new methodology to guide nursing care delivery implies facing a series of challenges, which requires the a priori acknowledgement of the institution's and the nursing team's possibilities and limits[3]. Thus, in March 2002, the Facilitator Group for Nursing Diagnosis Implementation (GFIDE) was constituted, to support the guidance of the planned change process, using the nursing diagnosis classification system proposed by the North American Nursing Diagnosis Association - NANDA[4] as a theoretical reference framework.

Between June and December 2002, two courses were held about nursing diagnosis, with the participation of 157 (97%) nurses active in the HU-USP, including practical exercises to apply the nursing diagnosis classification in the different units' care reality, as well as scientific meetings with nursing technicians and auxiliaries, during which professionals shared their perspectives and expectations about the new work proposal. It should be highlighted that, during the courses, most nurses did not possess previous knowledge about the addressed contents and indicated their concern about the changes needed to implement the nursing diagnosis as a phase of the NCS; some nurses demonstrated their interest and excitement about the new work proposal, while others manifested their resistance to the new proposal, stating that this would entail a work overload for the nurses.

A large part of resistance to change originates in individual perceptions related to imagination about the future, to past experiences and to the burden inherent to the change process itself[5]. Therefore, at the same time as the developed activities, workshops were held, with the presence of guest specialists in the nursing diagnostic process, and some ND nurses got the chance to participate in international scientific events about the theme. Furthermore, visits were organized to other institutions that had already implemented the nursing diagnosis, to get to know its functioning and share other nurses' experiences in this process.

In January 2003, with a view to the creation of an instrument to put the nursing diagnosis in practice in the NCS, which would be appropriate for the ND's philosophy and for nursing reality at the HU-USP, a 30-day survey was carried out of the nursing diagnoses observed in patients at the different units. At the end of the established period, the identified diagnoses were inserted in a database to calculate the frequencies of diagnostic categories. The need for the instrument to consider the particularities of each unit revealed the importance of a preliminary study at a unit where the nursing diagnoses, elaborated by the nurses, had already been inserted into the database. This research was carried out at the Medical Clinical unit (MC), which attended to this condition and, as it hospitalizes adult patients, its results could be replicated in other units of the institution.

THE EXPERIENCE

Initially, the nurses from the MC received a list of all nursing diagnoses contained in the database, distributed according to the domains established by NANDA's[4] Taxonomy II, together with a letter that asked them to individually choose the diagnoses they found most significant, i.e. that represented the clients they attended, and informing that they could add other diagnoses they considered necessary. The same letter contained an invitation for them to participate in a meeting, at the MC, to be held a few days after the material had been handed in, when the obtained results would be presented and discussed.

The ND management emphasized to the persons responsible for holding the meeting and conducting the preliminary study, that they should favor reflections about the evidenced themes, respecting and welcoming the group's choices. Thus, the meeting took place in May 2003. It presented the result of the above described analysis, after which the MC nurses were informed about the intention to involve them in workshops, aimed at creating an instrument they would consider adequate to the demands of the patients they attended, and were invited to participate in the proposed project. It was explained that, to carry out this activity, some meetings would be required, and the importance of spontaneous participation was emphasized. Participation is considered to be a shared process in which people get emotionally involved, in group situations, which encourage them to contribute to the group's objectives and to assume responsibility for achieving them. Hence, decisions should be made through group consensus, with the participants' maximum involvement and commitment[6].

Next, seven two-hour workshops were held, on days and times chosen by the participants, during which they thoroughly discussed the 14 selected nursing diagnoses, based on NANDA's[4] theoretical reference framework. Then, the main corresponding nursing interventions were chosen, based on the knowledge that guides nursing care practice and on protocols that existed at the institution. The constructed instrument contained the diagnoses and respective interventions in print, as well as room to record the nursing evolution, and was therefore called Nursing Diagnosis-Evolution-Prescription.

Later, the nurses held meetings with nursing technicians and auxiliaries at the MC to share the changes in the NCS and to emphasize the importance of their participation for the success and concretization of this new work proposal. During these meetings, the nursing technicians and auxiliaries assessed the new instrument and suggested changes that were later incorporated. These professionals indicated they felt valued and respected because they could give their opinion and decide about the contents of the new instrument and manifested their eagerness to start using it.

Despite the doubts and uncertainties that emerged during the workshops, the nurses constantly demonstrated their motivation to participate in a preliminary study that could be a landmark for the implementation of the nursing diagnosis as a phase of the NCS. We decided to carry out this study to understand the meanings the MC nurses attributed to this process of implementing the nursing diagnosis classification system at the NCS of the HU-USP.

THE METHODOLOGICAL TRAJECTORY

We used the qualitative case study as a methodological reference framework. The case study is a qualitative methodological approach that represents a research moment, guided by an interpretative epistemology, where the subject, considered as the study object, is conceived as an individual and concrete being, unique in his/her existence, develops his/her activities creatively, in a determined space and time, within a structured sociocultural system[7].

Initially, the research project was submitted to the Teaching and Research Commission and the Ethics Committee of the HU-USP. After their approval, data collection started. Then, we invited the MC nurses who had participated in the nursing diagnosis course, carried out the case studies by formulating nursing diagnoses and participated in the preliminary study for the construction of the instrument, to participate in this research by granting an interview, which would be recorded. Among the ten nurses who worked at the unit, eight attended to the adopted selection criteria and were invited. None of them refused to participate.

Three guiding questions were formulated for the interviews: "How do you perceive the NCS of the HU-USP before the nursing diagnosis implementation process?", "How do you perceive the nursing diagnosis implementation process in the NCS of the HU-USP?" and "How do you perceive the concretization of the nursing diagnosis implementation process and your insertion in this process from this moment onwards?". After each interview, the transcription (rigorous transference of the recorded oral report to written language), textualization (reorganization of the text, where the questions asked are eliminated and added to the interviewee's answers) and transcreation (inversion of paragraph order, addition or removal of words, based on agreements with the interviewee) phases were realized. It should be highlighted that, due to their significant roles in the entire process, the interviewees are called collaborators[8].

The transcreated texts were returned to the collaborators, so that they could authenticate them and authorize their publication. To maintain anonymity, we decided, with the collaborators' agreement, to use the names of Egyptian queens. In the Egypt of the pharaohs, a woman could occupy different social positions, whether as a queen-pharaoh, high royal wife, housewife, worker, initiated in a religious cult or priestess. Women were considered equal to men in the material as well as spiritual domain, having autonomy to organize her life and form of living[9].

The collaborators' ages ranged from 25 to 40 years, and they had graduated between one and a half years and 16 years. Two collaborators had worked at the MC for less than three years, four had worked between five and ten years and two more than ten years. Four collaborators were taking a specialization course in Gerontology Nursing; one was taking a Master's course in Adult Health; one was a specialist in Hospital Administration and had a Master's degree in Nursing Administration, while two were not taking any graduate course.

INTERPRETATIVE DATA ANALYSIS

The interpretative analysis of the narratives allowed us to construct three categories: Perception of the NCS before the nursing diagnosis implementation; perception about the NCS in the nursing diagnosis implementation and perception of new roads for the NCS.

Perception about the NCS before the nursing diagnosis implementation

This first category presents the collaborators' perceptions about the NCS before the nursing diagnosis implementation proposal, considering the information received according to their experiences in different contexts. According to the discourse of the collaborator presented below, the theoretical or theoretical-practical information received during her undergraduate course, as well as her experiences at the HU-USP itself and in other institutional realities, influenced her perception about the NCS: *I started working at the Medical Clinical unit 12 years ago. I did not have any experience with the NCS, this theme had been treated very theoretically in college, without any practice. It was a very good experience, I learned how to use the NCS to guide my actions and plan nursing care. I had the opportunity to work at another hospital that did not use the NCS and I observed how difficult it was to plan care... I was lost because I did not manage to direct the actions I intended to deliver to each patient... (Meresankh)*

The other collaborators' statements evidenced that, in general, the nursing process had been addressed only superficially during their undergraduate course, merely focusing on the theoretical dimension. It was only after they started working at the HU-USP and lived the NCS, in theory as well as in practice, that they could perceive the importance of this care model as an element to guide nursing care.

The analysis of discourse about this first category allowed us to construct the following subcategory:

- Aspects related to putting the NCS in practice

The collaborators explained that their daily NCS experience allowed them not only to reflect about its practice, but also to compare it with other institutional scenarios, highlighting facilitators and aspects that turn care delivery more difficult. In the following statement, the simultaneous presence of the positive and negative poles is remarkable: *I believe the NCS grants the nurse a global view of the patient, allowing her to identify care needs and facilitating the daily distribution of nursing team activities. The NCS helps us a lot, we are a reference for the patient, we attempt to clarify his doubts during our daily visit, we give orientations, in short, we are always following him in one way or another. What used to make some of our actions more difficult was that we wrote a lot... registering unnecessary information, not always the most adequate contents. This used to take a large part of our time (Cleopatra)*

In their discourse, the nurses emphasized that they associate the NCS with positive aspects, such as: providing safety in nursing action planning, execution and assessment, thus allowing for the individualization of care and, as it clearly sets the limits of nursing professionals' action sphere, it guarantees visibility and autonomy to the nurse. This is because the Nursing Care System allows nurses to manage their own work, and also favors the development of the nursing profession's economic aspect, as the system makes it possible to fix a price for its product - care - and to carry out research about the cost/benefit of nursing activities delivered to clients, families or communities in different scenarios[10]. However, the collaborators also

associated the NCS with negative aspects, mainly related to the registration of NCS documentation, which requires a lot of time and distances them from care and supervision. Sometimes, the collaborators' conception of NCS as a bureaucratic activity points towards the need to reflect about how they have been conducting the system, with a view to a conscious and critical practice, based on clinical reasoning, to achieve results the nurses and the entire nursing team are responsible for.

Perception about the NCS in the nursing diagnosis implementation

Two subcategories were extracted from this second category, one of which addresses the technical dimension in the nursing diagnosis implementation process, and the other the feelings experienced at different times during this process.

- The technical dimension in the nursing diagnosis implementation process

ND management believed that the success of the planned changed process presupposed training for the persons involved and, thus, was constantly concerned about granting the nurses the necessary conditions for training: *Through the studies, we obtained a clearer understanding of the diagnostic process and also observed the singularity of the Medical Clinic in relation to other units. When we started to survey the most frequent diagnoses, we were already more accustomed to elaborate them... Of course we had to continue studying a lot, consulting books... We wanted to make the nursing diagnosis happen, we wanted it to work. (Nefertari)*

In view of recommendations for the execution of the nursing diagnosis implementation to focus initially on knowledge, then on attitudes, individual behavior and, finally, on organizational change, i.e. four change levels[11], various individual and groups strategies were used for training the nurses, such as case studies, meetings and scientific discussions, within and outside the HU-USP, with favorable repercussions on the collaborators' conception.

- The feelings experienced in the nursing diagnosis implementation process

The feelings the collaborators disclosed showed how each of them reacted to the changes deriving from the new work proposal. The following discourse pictures one collaborator's feelings in the initial stage of the nursing diagnosis implementation: *At first, I felt the nursing diagnosis implementation was being imposed by the Nursing Department... The nurses I had contact with said they felt the same too... I was one of those persons who could not even hear the words nursing diagnosis, I pretended that it did not exist as long as I could... I thought it was yet another task, among so many others I had to deal with... And then they were inventing this new hype... (Neith)*

This evidences that, for many nurses, the contact with the ND's new work proposal caused feelings of discomfort, such as fear, insecurity, fragility, despair, difficulty to accept the new and perceive the proposal as an imposition by the heads. These jointly perceived and expressed feelings gave rise to reactions like flight, discredit and, consequently, resistance to the proposal, which is considered a factor that makes work more difficult.

In order to understand behaviors of resistance to change, it is not only necessary to examine individual attitudes towards the novelty, but also to analyze behaviors, which can range from indifference and subtle forms of impediment to radical opposition actions. In this sense, the change leaders need to develop tolerance, as people are different; comprehension, because administrative behaviors have a cause; caution, because new people and knowledge threatens what already exists and the acknowledgement of employees' capacity, because creative and innovative resources exist within the organization itself[5].

As mentioned above, the methodology adopted to implement the nursing diagnosis process in the NCS sought to privilege the nurses' actual participation, which required their gradual training. The collaborators expressed their perceptions and feelings when going through the different phases of this process, as follows: *When we started to elaborate the diagnoses, we faced many difficulties and we had no one to turn to, it was all new to everybody. So it was difficult because we did not have a more experienced person to help us with our doubts... Even the heads were participating in the process and learning together with us. (Nitocris)*

Some collaborators evidenced how their feelings transformed from initial discomfort, both individually and collectively, to other more favorable feelings and, thus, how their conception of this experience changed. According to their discourse, the foundation for each of the phases in the nursing

diagnosis implementation process and the fact that they could actually participate played a paramount role in this positive transformation: *We perceived that the diagnosis was not something invincible, that, in a way, it would help us, mainly by decreasing the time spent to put the NCS in practice... We gradually recovered from the initial shock and actually got into the thing, we incorporated the process and, nowadays, we believe it really came to improve a lot of things... (Isis)*

For the MC nurses, the joint construction of an instrument to put the nursing diagnosis into their daily practice, as well as the possibility that their needs and proposals would be taken into account, created feelings of appropriation and co-responsibility for the concretization of this phase of the nursing diagnosis implementation process in the NCS: *The construction of this instrument was very valuable because it was accomplished by our group, which lives the reality of the Medical Clinic, including our division director and a representative from permanent education. We all conquered this, together. Since I have started working here, I have never heard of an instrument constructed by nurses. All instruments had been implemented many years ago and no change had been proposed in the NCS... When we participate, we are more involved, we give more, our effort is bigger because we want to facilitate our work. (Nefertite)*

It is important to listen to employees in order to understand their motives to be satisfied or dissatisfied. Management should transmit information about important facts and decisions related to the company's objectives, the problems it is facing, the responsibilities and attributions to be complied with, the future and programmed events that will affect the staff[12].

The nurses explained that, during the meetings to construct the instrument, when they could share their feelings and experiences, they perceived similarities between the situations they experienced, no matter what shift they worked. The view of the whole made them create awareness about the dimension of this moment, as well as solidarity, considering that they were facing common problems, and that they should seek the answers together. It is noticeable that they assumed responsibility, individually and collectively, for the activities developed during the workshops, when they started to consider the proposal no longer as a perspective imposed by the ND, but as something shared by the entire group. This started to express their belief in the process.

As soon as the collaborators started to incorporate the change process, seeking the knowledge needed for their training and turning into active participants, they started to reflect about the new reality and about the events they experienced, facing them differently: *When I think about things today, I don't see how this could have been implemented differently, because we needed to live the difficulty of the process to value it and to manage to understand it... To feel that this process was made possible based on our reality, that it was not imposed, we constructed it by living it each day. Today, I feel quite at ease in this process, because I like it a lot when I have the opportunity to learn new things. (Nitocris)*

When their participation became more intense, gradually starting through the case studies and followed by the workshops at the MC, the collaborators' discourse expressed that the change started to be seen as a positive event, which moved into the future. In this sense, the nurses started to share the commitments and responsibilities and created awareness of their potential, as demonstrated below: *My motivation to participate in the meetings was the search for knowledge, the fact that we thoroughly study the interventions, to turn them actually viable in our practice... Our conducts gradually became more uniform, less individual and more representative of our work at the Medical Clinic. We met, talked and chose the interventions that were most coherent with our professional practice, respecting our colleagues, seeking a consensus... The implementation of the diagnosis is a new thing and, as we are a reference at the NCS, our experience will also be useful to other institutions. (Neith)*

As mentioned before, the gradual appropriation of this phase in the nursing diagnosis implementation allowed the collaborators to transform the feelings of discomfort into positive feelings, such as personal and professional realization. This transformation did not only occur through the construction of the instrument, but mainly because they could jointly assume the responsibilities and visualize the perspectives related to the conduction and assessment of the process. Despite the uncertainties they revealed, the nurses showed the transformations that occurred not only in their way of feeling, but also in their ways of thinking and reacting, referring to their preparation to cope with future challenges: *I feel encouraged to participate in this process, I know I need to study more, to act better... I intend to do the best I can, to discuss the diagnosis with the entire nursing team, to stimulate them to participate... After all, this is a great opportunity for all of us to participate in something that is still being constructed. Despite the difficulties and challenges we will face, I believe it is going to work, and I believe my colleagues think so too. (Cleopatra)*

The planned change process is still a challenge for the collaborators. However, the challenge is already faced with optimism, in spite of doubts, fears and uncertainties about the concretization of the preliminary study and its developments. The presence of these feelings no longer represents a threat, but a sign of alert and challenge to maintain attention and commitment in the conduction of this process, legitimated by the collaborators.

Perception of new roads for the NCS

This third category recovers the nurses' perceptions about new roads for the NCS through the integration of the nursing diagnosis phase, with two subcategories. The first considers the conduction of the nursing team, while the second deals with the proposal to computerize the NCS.

- In the conduction of the nursing team

By taking hold of the nursing diagnosis implementation process, the collaborators showed that difficulties can be overcome and that individual differences can be decreased through the complementariness of their actions. They indicated possible roads to continue and improve the change process: *When the nursing diagnosis is implemented, we will be able to spend more time with the employees and plan care together, with the new instrument, they will be able to understand better why we are proposing a certain intervention... And that is very important: that the team stays together, and that it's not just the nurse sitting there and prescribing, while they only execute the prescription. (Meresankh)*

To nurses, the Nursing Diagnosis-Evolution-Prescription instrument represents the expectation of decreased time spent on documentation for the NCS and, consequently, that they will be able to get closer to patients and the nursing team. Thus, they consider that they will be able to participate more frequently in care delivery, diagnose needs for professional nursing training and development and act, together with the Educational Support Service (ESS), to conduct strategies that favor these professionals' qualification and, consequently, improve nursing care and teaching.

The collaborators evidenced their awareness about the need for continuous improvement, indicating strategies they consider relevant for the adequate maintenance and concretization of the nursing diagnosis implementation process in the NCS: *To concretize the nursing diagnosis in the NCS, we will have to keep on studying a lot, our patient profile is very complex... We will have to continue our involvement and maintain our availability... Accepting that we can make mistakes and being flexible to change what is needed. I am sure that we will have to make changes in the instrument, and also that it's going to work. This will all be very good to keep the group together, after all, we perceived the importance of sticking together always, discussing our reality. Of course disagreements will always exist, but that is what makes us grow. (Nefertari)*

The nurses believed it is important to maintain a participatory process that favors spaces, within and outside the HU-USP, to exchange knowledge, feelings, experiences and commitments. Participatory administration can be considered as a lever for an institution to progress, base don the people directly involved in its management. This form of administration is an evolution of the democratic process, as what prevails is the result of negotiations among all sides, including the minority's will[8].

- In the NCS computerization proposal

One of the ND's goals in proposing the use of the nursing diagnosis as a standardized language system is to favor conditions to computerize the NCS. The Nursing Diagnosis-Evolution-Prescription instrument, constructed by the nurses, concretizes an intermediary phase between the previously developed NCS and the proposed goal of a computerized NCS: *I still cannot imagine how the computerization of the NCS will be put in practice... From our discussions, it seems that it will be something good, that it will facilitate our work. However, the fact of moving from one extremity to the other, that we will not write anything anymore, it scares me, it seems that something will be missing... That is why we need to develop and achieve more security in the diagnostic process, believing that it will be very useful to make computerization viable as well. Any change creates doubts and discomfort in people... We will have to be flexible to experience this new reality and assess its repercussions for our work process. (Cleopatra)*

The nurses expressed they see computerization as a new challenge and, as it represents yet another change, it produces feelings of alert and concern about the need to adapt human and material resources. However, these feelings do not cause paralysis and resistance, as the collaborators demonstrated their willingness to assume a pro-active attitude, as well as the belief that they will be capable

to overcome difficulties when new events come about. The process they have experienced makes sense to the collaborators and is valued, because they feel that they are a part of it, that they are partners in its conduction and are responsible to assess the process and achieve results.

FINAL CONSIDERATIONS

According to the collaborators, the nursing diagnosis implementation was conceived as an imposition, as they had not chosen the ND's change proposal, producing resistance and feelings of discomfort.

Throughout the process, with the gradual increase of theoretical-practical training and participation, the collaborators became agents of change, disclosing a positive transformation in their feelings, after their initial discomfort and unfavorable perception about the implementation of the nursing diagnosis in the NCS.

During the realization of the preliminary study at the MC, the feelings the nurses shared started to be treated more easily, as they started to assume a pro-active attitude towards them, confident that they could cope with these feelings and overcome difficulties together. Innovative thinking-acting in health care requires a permanent attitude of reflection and ethical investments from professionals, about the construction of a new care quality, in accordance with institutional possibilities and potentials[13].

The experience showed that the result turned into individual growth and, consequently, into an actual collective product. When the nurses appropriated themselves of the process, this not only enabled them to share decisions, but also to assume responsibility for the results. A participatory culture only emerges and develops in organizations when their leaders consider that the human being is reliable and likes to assume responsibilities[6].

Finally, it should be emphasized that the work methodology we described in this study was successfully reproduced at the other ND units and has shown that technical-scientific training, in combination with the creation of spaces that value participation, favor professionals' emotional dimension towards changes.

REFERENCES

1. Melleiro MM, Fugulin FMT, Rogenski NMB, Gonçalves VLM, Tronchin DMR. A evolução do Sistema de Assistência de Enfermagem no Hospital Universitário da Universidade de São Paulo: uma história de 20 anos. In: Cianciarullo TI, Gualda DMR, Melleiro MM, Anabuki, MH. Sistema de Assistência de Enfermagem: evolução e tendências. São Paulo (SP): Ícone; 2001. p. 109-30.
2. Cianciarullo TI, Gualda DMR, Melleiro MM, Anabuki, MH. Sistema de Assistência de Enfermagem: evolução e tendências. São Paulo (SP): Ícone; 2001.
3. Barros ALB de, Gutiérrez MGR. Sistematização da Assistência de Enfermagem sob o referencial do cuidar. In: Programa final e anais do 7º Simpósio Nacional de Diagnósticos de Enfermagem; 2004; Belo Horizonte (MG). Belo Horizonte: ABEn; 2004. p. 45-52.
4. North American Nursing Diagnosis Association. Nursing diagnoses: definitions & classification 2001-2002. Philadelphia: NANDA; 2002.
5. Motta PR. Transformação organizacional: a teoria e a prática de inovar. Rio de Janeiro (RJ): Qualitymark; 1998.
6. Chiavenato I. Gerenciando pessoas: como transformar os gerentes em gestores de pessoas. 4ª ed. São Paulo (SP): Prentice Hall; 2002. p. 47- 73.
7. Blasco JS.Estudio de casos. In: Aguirre Baztán A. Etnografia: metodología cualitativa em la investigación soiciocultural. Barcelona (ES): Marcombo; 1995. p. 203- 8.
8. Meihy JCSB. Canto de morte Kaiwá: história oral de vida. São Paulo (SP): Loyola; 1991.
9. Jacq C. As egípcias: retratos de mulheres do Egito faraônico. 5ª ed. Rio de Janeiro: Bertrand Brasil; 2002.
10. Cruz ICF da. A Sistematização da Assistência de Enfermagem (SAE) e o Sistema Único de Saúde (SUS): breves considerações. In: Programa final e anais do 7º Simpósio Nacional de Diagnósticos de Enfermagem; 2004; Belo Horizonte (MG). Belo Horizonte: ABEn; 2004. p. 24-30.
11. Miller E. Implementation issues: an overview. In: Miller E, editor. How to make nursing diagnosis work: administration and clinical strategies. Norwalk: Applenton Lange; 1989. p.73-117.
12. Maximiano ACA. Teoria geral da administração: da escola científica à competitividade na economia globalizada. 2ª ed. São Paulo (SP): Atlas; 2002. p. 457-78.
13. Mandú ENT. Intersubjetividade na qualificação do cuidado em saúde. Rev Latino-am Enfermagem 2004 julho-agosto; 12(4):665-75.

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