RESEARCH | PESQUISA

Patterns of knowledge used by nurses in caring for the patient in the first psychotic outbreak

Padrões de conhecimento utilizados por enfermeiros no cuidado ao paciente em primeiro surto psicótico

Estándares de conocimiento utilizados por enfermeros en el cuidado al paciente en primer brote psicótico

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Abstract

Objective: To know how the nurse provides care in the first psychotic outbreak of patients, and to identify the Barbara Carper patterns of knowing used for this action. **Methods:** A qualitative study using a phenomenological approach was performed in four Psychosocial Care Centers and in a psychiatric ward of a university hospital. Data collection was carried out with ten nurses participating in semi-structured interviews using the following guiding question: "Tell me your experience in caring for a patient in their first psychotic outbreak". **Results:** Carper's fundamental ways of knowing (empirical, aesthetic, ethical and personal) were identified in the caring of the patient in their first psychotic outbreak. **Conclusion and implications:** A fragmented practice is implied when patterns of knowledge are taken in isolation. This reflects on specific actions of nursing work, such as the nursing practice and its stages.

Keywords: Nursing care; Psychiatric nursing; Mental health; Psychotic Disorders.

Resumo

Objetivos: Conhecer como o enfermeiro realiza o cuidado de enfermagem ao paciente em primeiro surto psicótico e identificar os padrões de conhecimento de Bárbara Carper utilizados nessa ação. **Métodos:** Estudo qualitativo de abordagem fenomenográfica, realizado em quatro Centros de Atenção Psicossocial e em uma enfermaria de psiquiatria de um hospital universitário. A coleta de dados foi realizada com dez enfermeiros por meio de entrevistas semiestruturadas com a seguinte questão norteadora: "Conte-me sua experiência ao cuidar de um paciente em primeiro surto psicótico". **Resultados:** No cuidado de enfermagem ao paciente em primeiro surto psicótico identificaram-se os padrões de conhecimento em enfermagem (empírico, estético, ético e pessoal) de Bárbara Carper. **Conclusão e implicações:** Notou-se que quando os padrões de conhecimento são assumidos de forma isolada implicam numa prática fragmentada, refletindo em ações específicas do trabalho em enfermagem, como o Processo de Enfermagem e suas etapas.

Palavras-chave: Cuidados de enfermagem; Enfermagem psiquiátrica; Saúde mental; Transtornos psicóticos.

Resumen

Objetivos: Conocer cómo el enfermero realiza el cuidado de enfermería al paciente en primer brote psicótico e identificar los patrones de conocimiento de Bárbara Carper utilizados en esa acción. **Métodos:** Estudio cualitativo de enfoque fenomenográfico, realizado en cuatro Centros de Atención Psicosocial y en una enfermería de psiquiatría de un hospital universitario. La recolección de datos fue realizada con diez enfermeros a través de entrevistas semiestructuradas con la siguiente pregunta orientadora: "Cuéntame su experiencia al cuidar de un paciente en primer brote psicótico". **Resultados:** En el cuidado de enfermería al paciente en primer brote psicótico se identificaron los estándares de conocimiento en enfermería (empírico, estético, ético y personal) de Bárbara Carper. **Conclusión e implicaciones:** Se notó que cuando los patrones de conocimiento son asumidos de forma aislada, implican en una práctica fragmentada, reflejando en acciones específicas del trabajo en enfermería, como el Proceso de Enfermería y sus etapas.

Palabras clave: Cuidados de enfermería; Enfermería psiquiátrica; Salud mental; Trastornos psicóticos.

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INTRODUCTION

Until the 1980s, psychiatric patients were separated and isolated from the community, occupying asylum beds when they needed any type of hospitalization and, thus, nursing practice was marked by a controlling and repressor model.[1,2] Psychiatric Reform promotes the recognition of the condition of being a citizen that was denied to the mentally ill, modifying the clinical treatment of the disease and allowing the reorganization of care services, mainly with the creation of new modalities in this area, such as the Psychosocial Care Centers (CAPS).[1-3]

This reform also introduced, in the field of mental health, the Psychosocial Attention paradigm, which incorporates interdisciplinarity as a requirement of care, focusing on the person suffering from psychic suffering, with their life and frailties.[4] In this new model of health care, nurses should dispense with complementary theories of care that involve transcendent knowledge in the biomedical model, favoring the adoption of a practice based on the restoration of citizenship.[1,2,5,6]

Identifying Nursing knowledge allows the delimitation of its field of comprehension and an understanding of how this knowledge influences the practice of care.[7] In the 1970s, Barbara Carper understood that to contribute to nursing as a science, it was important to determine the type of knowledge specific to the area.[8] In her doctoral thesis, she describes four patterns of knowledge in nursing: empirical, understood as the science of nursing; aesthetic, seen as the art of nursing; personal knowledge, that makes authentic and genuine relationships with other human beings possible; and ethical, perceived as the moral component.[8] Even though they are separately described, these patterns should be used together because they are expressed concurrently and with connections, without which nursing care and interventions would not be holistically performed.[8,9]

In the context of the post-reform scenario, different treatment perspectives in caring for the person suffering from psychotic illness in their first psychotic outbreak also began to be studied and discussed with the psychoanalytic approach and interpersonal relationships being the nurse's means of taking a new stance. In this way, this professional takes on the role of therapeutic agent and considers relationship issues with the patient and family, leaving aside the position of custodian and repressor.[4,10-12]

Throughout the first psychotic outbreak, the nurses' performance has been described as fundamental to the prognosis of the patient, since this professional, as manager of the team, can perform biopsychosocial actions within the family and, in particular, related to communication therapy.[12,13]

However, it is perceived that although Psychiatric Reform has provided significant advances, the care of the person suffering their first psychotic outbreak is still permeated by reductionist practices and common sense knowledge, as articles have dealt with the first psychotic episode superficially, lacking guidance regarding the role of nursing during treatment.[6,10,12,14]

In view of the above and the need for more evidence on the role of mental health nurses in the treatment and care of these patients, the present study aims to understand how nurses provide care in the first psychotic outbreak, as well as to identify Carper's fundamental ways of knowing used in this action.[8] It should be noted that the relevance of this study lies in the discussion of the care given to the patient in question from the professionals' perspective, in order to recognize, through the patterns of knowledge, on what nursing in mental health is based.[8]

METHODS

This qualitative, phenomenological study aims to understand people's experience in the ways of conceiving and experiencing the world around them through a non-dualistic view.[15] This method shares its object of research with phenomenology, that is to reveal human experiences, but its peculiarity is to consider that phenomena are experienced qualitatively with different ways of seeing, experiencing and understanding.[15] Guided by the content of the findings, it is more interested in the collective sense than individual experience, and deals with cultural learning and the forms that each one evolved to relate with the world. It is possible to consider this type of research useful in the area of health and nursing, as it contributes with knowledge about how certain phenomena are experienced in care settings.[16]

This study was carried out in the psychiatric ward of a university hospital, and in the CAPS of the Municipality of Campinas, SP. Data collection was performed between January and March 2015 using semi-structured interviews, recorded and transcribed in full, with the following guiding question: Tell me your experience in caring for a patient in their first psychotic outbreak.

Ten nurses who worked in different shifts in the studied units were considered subjects of this research. Data collection was stopped when the answers were sufficient in the researcher's point of view.[17]

Data analysis followed the following steps: 1) transcription of interviews; 2) organization of the data from its reduction; 3) distinction and verification of different topics or phenomena; 4) separation of the different ways of experiencing or understanding the phenomenon by means of similarities or contrasts; 5) confrontation of the various declarations or conceptions; and 6) distinction of the critical attributes of each group as well as their differentiating characteristics.[15,16]

A re-reading of nursing knowledge patterns articulated as the ways of seeing, living and understanding by the study participants was used as a theoretical reference to support data analysis as a basis to the knowledge of the phenomenon.[8]

This study complies with all ethical aspects involved in human research as proposed by Resolution of the Brazilian National Health Council 466/12 and it was approved by the Research Ethics Committee of the School of Medical Sciences, State University of Campinas (No. 932,615).

RESULTS AND DISCUSSION

The patterns of knowledge identified in caring for the patient in their first psychotic outbreak were empirical, aesthetic, ethical and personal, all of which will be presented and discussed below.[8]

Patterns of knowledge used by nurses in caring for the patient in their first psychotic outbreak

The search for a body of specific knowledge that establishes it as a science, made nursing staff begin to worry about a clarification of their theoretical foundations.[18] The empirical pattern is related to science and knowledge based on facts; it is descriptive and focused on the development of theories. Because it is used with intense rationality and puts science as the only way to the theoretical world, it has opened space for an appreciation of qualitative aspects of the phenomena studied, which allows us to consider aspects that extend the focus of the biological body and pathologies.[8,18]

Although these changes are described, this has been the predominant knowledge pattern in society and also in nursing.[18] Thus, the care of the patient in their first psychotic outbreak, as evidenced in the interviews, is still strongly linked to the control of vital signs and symptoms of the disease:

> *It is a more intensive care in respect to the vital signs (N3).*
>
> *We perform basic care, vital signs, bathing, administration of medications (N9).*
>
> *You are simply studying the symptoms of the disease and doing it, understood? (N10)*

Because the body of knowledge of nursing is not static, its transformation takes on new modes of expression with theories being a way to rupture from the customary execution of tasks linked to the biomedical model. This allows for creative reflection and domination of the work process and allows nursing to develop actions in which the theoretical basis for their practice can be used to give visibility to the profession.[6,19]

Selecting the appropriate theory requires sufficient knowledge among all that is available as well as the variables that define the specific situation of the patient or group that will receive care, which is not always an easy task.[19] The lack of autonomy in nursing, the use of common sense as a theoretical basis and the predominance of the biomedical reference in the discourse of nurses are factors that can justify the disregard of scientific knowledge by professionals during the care of patients with psychic suffering.[6,14,20]

In the following discourses, it is possible to see some disregard on the part of the professionals, who report that the care of the patient in their first psychotic outbreak is characterized more by lived experiences than by theoretical sustenance. When a theory is used, they choose it because of its ease and not because of its applicability to care, and they even report that they combine several theories:

> *Look, nursing theory, even though I'm a nurse, our work has no theoretical foundation. (N4).*
>
> *We follow our experience, you know? We have experience, we know how to deal with the crisis, and that guides us (N6).*
>
> *So you're kind of targeting and you're doing a miscegenation yourself, of all the theories you have. (...) Vanda Horta, who I most identify myself with as a professional, as a person, for me is the easiest (N7).*

It is important that there is a symbiotic relationship between scientific and popular knowledge and that professionals understand the connection between science and common sense so that, from this articulation, one can construct knowledge in nursing.[20]

Theoretical non-appropriation is also related to erroneous concepts about the theoretical references available in mental health, a fact already discussed in a study that identified the use of psychoanalytic theory along with other theories in the work of nurses.[6] Psychoanalysis, on considering the subject as subjected to the unconscious, opposes any referential that does not propose to develop care that considers determining the unconscious, therefore, to indiscriminately articulate this referential to another implies a lack of knowledge of its foundation.[6] This finding is illustrated by the following discourse, in which nurses seek to use elements of psychoanalysis in the care of the patient in their first psychotic outbreak, but in an erroneous way, when they approach this referential from the behavioral perspective based on basic human needs:

> *It is an institution that uses psychoanalysis much more as a guide, you know? So, we sort of learn to care for this patient in a more psychoanalytic way [...]. Along with this, I go very much for the same human needs of Vanda Horta (N7).*

Opposite to the empirical pattern, one can cite the aesthetic pattern, which, in turn, is not adjusted in the repetition of formal instructions, but in experience involving the creation and/or appreciation of a singular, particular and subjective expression of possibilities for those who provide care. In other words, this is related to the art of nursing that is expressive, subjective and becomes visible in the act of caring.[8] This pattern has been diminished by some authors to little less than "know-how" techniques or procedures, however the aesthetics of care goes beyond the purely technical, since it integrates in its conception the world of values, feelings and ethical and cultural aspects.[21]

Still on this pattern, it is possible to cite, based on the interviews, the care evidenced by actions that involve community work and that seek to develop the autonomy of the patient in their first psychotic outbreak. For example, we can mention the Individual Therapeutic Project, which attempts to find possibilities

and alternatives for each person in different situations in their lives, demanding at all times, looking and listening to recognize subjectivities:[22]

> *From the question of doing several jobs in the community and doing the therapeutic follow-up, taking a bus, going downtown, going to the Timesaver Service[a], that it's not just because he needs it, it's because he's a citizen and because he can and is able to do so. We work for the autonomy of the other (N9).*

The aesthetic pattern is still closely linked to the concept of empathy which, in turn, is characterized by the ability to "put oneself in the shoes of the other", in order to see and feel the world as the patient.[8,23] Thus, empathy can be observed in the following statements, in which nurses report the approximation and creation of bonds in care that promote the protection of the patient, who sometimes feels fragile when entering the service:

> *Take care of the integrity and such like, so that this person feels, despite everything that is happening to her, protected [...]. So, we always try in this work to get close, that is through some bond (N6).*
>
> *When I speak of verbal management it is, in the sense, I need at that moment to try to build an initial bond with this patient (N1).*

However, empathy can only be valid when it is based on respect for the otherness of the other, with all the singularity and particularity.[24] Therapeutic listening emerges as a communication strategy that favors the understanding of the other, so that they develop adequately. Thus, it is important that professionals have the skills to provide emotional and practical support to the patient, allowing the patient to identify himself or herself and to trust those who care for them.[25]

Qualified listening and emotional support do not seem to be considered when the approach remains focused on the biomedical model, in which interventions are based solely on the prescription of medications, the normativity of behavior considered inadequate and the adoption of a pedagogical posture, as follows:[10,14]

> *We put limits, because there are other patients here [...]. Let's assume that the patient is a man, he is disoriented or has a deficit of attention as such and keeps going into the rooms of women, he cannot (N4).*
>
> *Setting limits is very important, you know? Propose activities that sometimes they do not accept (N2).*
>
> *Care goes a long way in highlighting, does it not? Really, you teach or not (N6).*

On the other hand, it is important for nurses to develop empathy-based care that recognizes that placing oneself in the other person's place should not offer a basis for judging the patient's choices as to what is good for him/her.

In this setting, the ethical pattern of knowledge that goes well beyond the code of professional ethics is discussed. This knowledge is related to the difficult choices to be made in the context of healthcare involving fundamental questions about right and wrong and requires an understanding of the different philosophical positions about what is good, what should be desired, and what is right.[8,9]

However, how do you infer what is good? The following section makes us reflect on the ethical pattern, in which the respondent says she uses affection and the word as strategies of care and, at the same time, uses shouts to facilitate the patient's understanding during care in their first outbreak, believing that it can calm the patient down. This is a kind of care that, on disregarding empirical knowledge, is defined by moral conditions:[8,26]

> *At that first moment, it was all by shouting, so, without much consideration of the consulting room, seated to be attended, it was by means of shouting until he understood that we were there to help him (N5).*
>
> *Often, this soothes the person in crisis, look eye-to-eye, often take the hand, give a hug. It calms the person in crisis. At least for me, that has always worked (N5).*

In making a decision, the nurse must first evaluate the ethical foundations of the Code of Professional Ethics with regard to responsibilities, rights and duties.[26] However, the Code of Professional Ethics hardly contemplates all situations or gives guidance about choices and the nurse is responsible for acting in a way that her principles and values respect the patient as someone who exists, who has a history, wishes, expectations and desires.[26] Thus, for the totality of care, deep knowledge is required about who is providing care, which requires interaction between the patterns of knowledge that are sometimes made unconsciously.[27]

One can observe this interaction of patterns when the professional describes her return to evaluate the patient after an intervention, based on her ethical commitment in which the complexity of moral judgments demand a correct understanding of what would be good and correct for the patient at that time. This fact is also associated with empirical knowledge related to the stages of the Nursing Process (NP), a methodological tool that guides professional care:[8,28]

> *We try to find out if we are going to need a conversation, mechanical restraint, a medication [...]. And we try to come back after a while, talking to him, seeing if he's*

getting better. But, always returning and observing the patient [...]. Explaining to him as to why he is being restrained [...]. As he improves, we decrease the restraints (N8).

Finally, the personal pattern, cited by Carper as the most difficult to master and teach, refers to knowledge of the self, that is, self-knowledge implies the way professionals view themselves and others, which is central to any relationship therapy. The realization that the professional, above all else, is also a human being and therefore presents physical, psychological and social feelings and barriers that make it impossible for anyone to understand and perform certain actions, must also be taken into account.[29] From the discourses, feelings related to insecurity, fear and even tranquility emerge while caring for the patient in their first psychotic outbreak:

The patient when he arrives in a psychotic outbreak, for the first time, we are always very cautious, because you do not know much, you usually know if he is an aggressive patient or not, then you become apprehensive (N10).

But it was really "trash" like that, some words like "I'm going to kill you", "to come after you with the machete" (N5).

My experience, I think, it was tranquil (N3).

The therapeutic relationship, because it is an instrument of interpersonal care, works not only with the psychosocial needs of the patient, but also with the needs of the nurse, allowing intrapersonal and interpersonal transformations to occur. In this way, professionals are advised to maintain a process of developing their self-knowledge and to work with their limitations, incompatibilities and potentialities so that they are able to re-establish the relationship of help with the patient.[30] Another example related to personal care are the questions of nurses about the quality of care provided, which demonstrates a search for an understanding of their potentialities and limitations, however, without questioning what happened:

What is the role of the nurse within CAPS? Why does the multi-team get mixed up a lot, you know [...]? What really matters in here? (N9)

I still think we can improve, the whole ward would improve a lot and we realize that there is a certain resistance (N3).

As noted, each pattern of knowing is necessary to achieve the domain of practice, but none should be considered sufficient, as they do not represent all forms of the knowledge used.[7] Nursing knowledge consists of empirical, aesthetic, ethical and personal components which in professional practice are used as a whole, although in a given situation one aspect or pattern is more easily recognized.[7,8] The interaction between the patterns is sometimes unconscious, however, through the analysis of the interviews, it was noticed that some nurses have approaches focused on certain patterns that leads to fragmented care and approaches against the precepts of the current perspective of mental health, which considers the subject as a whole and prioritizes the integrality of attention.[27,30]

By adopting fragmented knowledge, the professional takes responsibility for a fragmented job that reflects on the fundamental care of the patient in their first psychotic outbreak, such as the NP and its stages, and which includes nursing interventions using a biopsychosocial focus and care for the family.[13] NP, should be understood as a method that encompasses not only a judgment of the needs of the person, but also of the family or human collectivity, taking into account the results to be achieved and the nursing interventions, and that can be used as an alternative complementary to the Individual Therapeutic Project.[31-33]

The collection of data, the collection of information regarding the health status of the client, family and community that should contemplate the physical and mental state examinations, was done with the objective of filling in a printed form with dualistic characteristics, with a division between body and mind, as noted below:[31,34,35]

We have an anamnesis form. Then, the professional that is in the reception and receives the patient for the first time, has an organization protocol of data collection that after the identification data, the data are based on the examination of the mental state (N1).

Depending on the nurse or the service, we do a physical examination to rule out some kind of diagnostic hypothesis, or even detect something different (N7).

Today, even knowing that psychosis can appear abruptly and randomly, a period called prodromic, with nonspecific symptomatology precedes it. Symptoms include social isolation, behavioral changes, lack of initiative or interest in activities performed and others, which makes the family think about changes typical of age. This fact directly influences the demand for care, which is sometimes delayed.[12,13] Thus, when entering the service, both the patient and the family present numerous demands to be observed, with the NP and, in particular, the collection of data, being a means to favor the integral care of the subject and family in the context in which they live. Theories are also considered a means of providing qualified care.[5,31] Nursing diagnoses, elaborated after the collection of data, are later translated as the clinical judgment about the responses of the individual, family or community, and constitute the basis for the selection of prescriptions.[33] When a diagnosis is made, the nurse has an ethical and legal obligation to question what has occurred and provide a particular type of treatment or care.[36] According to the interviewees, many of the actions they use do not have a nursing diagnosis, but are developed through observations. At other times, a survey of diagnoses is prepared however there is no elaboration of a care plan:

> *While we are observing the patient, we are taking measures (N8).*
>
> *A patient diagnosed with social isolation. Socialization, encouragement to participate in occupational therapies, with all this you see the diagnosis, but you do not see the prescription. You do not see the care in prescribing to encourage this patient to be participating (N3).*

Failure to raise diagnoses interferes negatively with nursing prescription, which should individually organize the daily goals of each patient's care.[36] Of the discourses, reasons for not fulfilling the nursing prescription include not being valued by the members of the team or because it is an 'implicit' type of care that does not need to be documented. In this study, the following factors are highlighted as reasons for non-fulfillment of the nursing prescription: lack of credibility by the team, lack of time and lack of written documentation of what is done:[36,37]

> *The more you prescribe, the more you see the technical staff chuckling "why so much, why bother with it, why take the risk of aggression, the risk of suicide?" They check, check, check. In fact, they are implicit things, everyone does, but when they have to keep on reporting, writing, checking, it stops on the way (N3).*

It is noted that when a nursing prescription is not made, the team starts to concentrate their actions solely by the medical prescription, making the participation of the nurse in decision making unnecessary for the patient in question.[14,15,36] The non-planning of the actions seems to interfere in the nursing care cited in the literature as fundamental to the patient in their first outbreak. One aspect is the attention to the family, which when faced with what happened, feels helpless.[13] In this way, the reception becomes central, providing support to the demands found, since the conflicts generated in the family setting can negatively influence the patient's status.[1,13]

In this study, nurses consider the family responsible for referring the patient to the service or as an informant of the symptoms during the investigation of the history:

> *The patient, who arrives here for us in the first outbreak, is either referred by the family or comes from some health service (N7).*
>
> *I usually need a relative, you know? That he is accompanying, and then each professional works in a way that some talk to the patient alone and then call the family (N1).*

The literature has drawn attention to family burden, especially of families of psychiatric patients, and the negative impact of living with the mentally ill patient who, faced with family incomprehension or even rejection, has an increased chance of successive hospitalizations.[12,13] Thus, it is fundamental that services are structured in such a way as to enhance the family, professional and service relationships.[12,13]

Finally, through an evaluation of nursing, it is possible to know if the care provided by the team is providing benefits to the patient.[34] Regarding this stage, it was seen that the nurses performed it after the procedures, or as a parameter to evaluate the clinical picture, as reported below:

> *We try to come back after a while, talking to him, seeing if he is getting better, always helping him [...]. But always returning, observing the patient, as he improves, we decrease the restraints (N8).*
>
> *My responsibility is to make an evaluation of the patient, the evaluation of the patient in the bed is daily, if there was any improvement in the picture, if there was any worsening, if there is any change (N9).*

The evolution of nursing evaluates all the other stages of the NP and, in order to perform it, the nurse must consider whether its prescriptions have achieved the stipulated objectives. Thus, not only the evolution of the patient, as mentioned above, but also the results of the nursing care provided should be taken into account; this facilitates new decisions or the maintenance of previous prescriptions, thereby optimizing the care provided.[37]

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

In this study, it was possible to know how the nurse provides nursing care to the patient in their first psychotic outbreak, besides identifying the patterns of knowing used in the care process (empirical, aesthetic, ethical and personal), and how these relate to the development of NP.

It is argued that the knowledge linked to the empirical pattern allows a care based on theories, however, these were disregarded by the nurses in this study, who report developing actions based on common sense or have insufficient theoretical knowledge. As for aesthetic care, which makes creative work possible, it has been shown that nurses try to adopt some of their features, such as empathy and the creation of bonds, but the predominance of the biomedical model is unquestionable, and care is strictly focused on healing actions. The ethical standard, on the other hand, showed that nurses provide care coined on moral aspects, in which the feelings and experiences overshadow theoretical knowledge. The personal pattern demonstrated that nurses can do self-reflection of the care they provide, but this self-reflection is not perceived as a factor that alters the practice, and improvement is necessary.

It is noted that when the patterns of knowing are taken in isolation, a fragmented practice is implied, which reflects in specific actions of nursing work, such as on the NP and its stages. In this study, the nurses' understanding of NP is still strongly

linked to 'instrument-based data collection', which considers a separation between body and mind, favoring a dualistic view of who provides care. One cannot think of an efficient NP without all the phases being carried out, after all, they are interdependent. By ignoring these facts, the nurse fails to provide fundamental interventions to the patient, in particular, those related to the family, making relatives just mere informants, who can be characterized as another implication to the practice.

The limitation of this study lies in the difficulty of mapping the theoretical references that support the action of the nurse in mental health, which was evidenced by the supremacy of reports of experience without the significance of the importance of this practice. Thus, there is an opportunity of new study perspectives in which the research objective is the theoretical references used by the nurses in the care of the patient in their first psychotic outbreak, and not only their experience in caring.

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[a] Translator's note: The Timesaver Service (Poupa Tempo) is a governmental office that provides many services such as the renewal of driving licenses, housing services, inquiries about local government, etc.