

Assessment of the procedures record by professionals of Psychosocial Care Centers

Avaliação dos registros de procedimentos por profissionais de Centros de Atenção Psicossocial
Evaluación de los registros de procedimientos por profesionales de Centros de Atención Psicossocial

Nathália dos Santos Silva¹, Nayana Cristina Souza Camargo¹, Ana Lúcia Queiroz Bezerra¹

¹Universidade Federal de Goiás, Nursing School. Goiânia, Goiás, Brazil.

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ABSTRACT

Objective: To verify the use of procedures record tools as data source for monitoring and assessment of Psychosocial Care Centers (CAPS- *Centros de Atenção Psicossocial*). **Method:** A descriptive, exploratory qualitative study was carried out in seven CAPS in the state of Goiás. A total of 58 professionals participated, and the data collection was from April to May 2016 through focus groups. The data were submitted to the thematic analysis of content with the aid of the ATLAS.ti 6.2 software. **Results:** Three thematic categories emerged from the content analysis: *Understanding about the record of Psychosocial Care Centers procedures*; *Management of the record tools of Psychosocial Care Centers procedures*; and *Intervening factors for recording Psychosocial Care Centers procedures*. **Final considerations:** Investment in the Permanent Education of professionals will be necessary; focusing on the management of the records resulted from the actions developed in the CAPS to qualify the information and the work process of the professionals. **Descriptors:** Mental Health Services; Psychiatric Nursing; Health Services Research; Health Information Systems; Management Information Systems.

RESUMO

Objetivo: Verificar o uso dos instrumentos de registro de procedimentos como fonte de dados para monitoramento e avaliação de Centros de Atenção Psicossocial (CAPS). **Método:** Pesquisa descritiva, exploratória de natureza qualitativa, realizada em sete CAPS do estado de Goiás. Participaram 58 profissionais, e a coleta de dados foi no período de abril a maio de 2016 por meio de grupos focais. Os dados foram submetidos à análise temática de conteúdo com o auxílio do software ATLAS.ti 6.2. **Resultados:** Emergiram da análise de conteúdo três categorias temáticas: *Compreensão sobre o registro de procedimentos de CAPS*; *Manejo dos instrumentos de registros de procedimentos de CAPS*; e *Fatores intervenientes para registrar os procedimentos de CAPS*. **Considerações finais:** Será necessário o investimento na Educação Permanente dos profissionais, com foco no manejo dos registros gerados a partir das ações desenvolvidas nos CAPS para qualificação das informações e do processo de trabalho dos profissionais. **Descritores:** Serviços de Saúde Mental; Enfermagem Psiquiátrica; Avaliação em Saúde; Sistemas de Informação em Saúde; Indicadores de Qualidade em Assistência à Saúde.

RESUMEN

Objetivo: Verificar el uso de los instrumentos de registro de procedimientos como fuente de datos para monitoreo y evaluación de Centros de Atención Psicossocial (CAPS). **Método:** La investigación descriptiva, exploratoria de naturaleza cualitativa, realizada en siete CAPS del estado de Goiás. Participaron 58 profesionales, y la recolección de datos fue en el período de abril a mayo de 2016 por medio de grupos focales. Los datos se sometieron al análisis temático de contenido con la ayuda del software ATLAS.ti 6.2. **Resultados:** En el análisis de contenido se incluyeron tres categorías temáticas: *Comprensión sobre el registro de procedimientos de CAPS*; *Manejo de los instrumentos de registros de procedimientos de CAPS*; y *Factores intervinientes para registrar los procedimientos de CAPS*. **Consideraciones finales:** Será necesario la inversión en la Educación Permanente de los

profesionales, con foco en el manejo de los registros generados a partir de las acciones desarrolladas en los CAPS para calificación de las informaciones y del proceso de trabajo de los profesionales.

Descritores: Servicios de Salud Mental; Enfermería Psiquiátrica; Evaluación en Salud; Sistemas de Información en Salud; Indicadores de Calidad de la Atención de Salud.

CORRESPONDING AUTHOR

Nathália dos Santos Silva

E-mail: silvans09@gmail.com

INTRODUCTION

The implementation of *Centros de Atenção Psicossocial* (Psychosocial Care Centers- CAPS) emerged from the Brazilian Psychiatric Reform and required the development of a set of knowledge and psychosocial skills of the professionals in the area, and this service there is the complex task of articulating with other devices of a *Rede de Atenção Psicossocial* (Psychosocial Care Network- RAPS) to guarantee the integrality of care. Considering this premise, it will be important to assess how the psychosocial care in the *Sistema Único de Saúde* (Brazilian Unified Health System- SUS) has been conducted and how it has become necessary for the actions implemented in the CAPS to be monitored and evidenced to support the effectiveness and superiority of this care proposal⁽¹⁻⁵⁾.

For the monitoring and assessment of actions, the use of *Sistemas de Informação em Saúde* (Health Information Systems- SIS) is a reality in the context of health, and health information becomes a benefit for professionals and for society. SIS is a set of interrelated electronic components that process, store and distribute information to support the decision-making process and assist in the control of health organizations, aiming to achieve the improvement of individual or collective Health Care (depending on the efficiency and effectiveness in the record), retrieval and manipulation of health information by those involved⁽⁶⁾.

The assessment, based on SIS is not limited to the purpose of simply judging assertive or flawed actions, it has a rich process of support to a continuous production of indicators, information and knowledge of reality in search of improvement of decision-making by managers and others with interest⁽⁷⁻⁸⁾.

Considering the care model in mental health developed from the Brazilian Psychiatric Reform, it was also necessary a new view of the managers to formulate new tools of coverage and assessment measures. The indicators that were limited to bed/inhabitants and medical consultation/inhabitants began to define coverage in the community⁽³⁾ and currently focuses on procedures developed in the CAPS. However, the assessment will only be possible from the existence of data that can be transformed into information. The development of indicators in mental health is challenging because the tradition of indicators in this area is restricted when compared to other areas of health. The ethical and political character of the Brazilian Psychiatric Reform makes it difficult to establish assessment parameters⁽³⁾.

In the assessment studies of mental health services, more emphasis has been placed on the assessment process, with participatory elaboration of indicators for mental health assessment, particularly for assessment of CAPS, and less emphasis on assessment results⁽⁹⁻¹⁰⁾, despite the existing proposition of qualitative parameters related to satisfaction from the perspective

of users and their families⁽¹¹⁾. In addition, the implantation or improvement of information systems, essential for the processes of assessment in mental health, have been little studied⁽³⁾.

Thus, considering the need for standardized data on care actions for people with mental suffering or disorder, and health needs arising from the use of alcohol and other drugs developed in CAPS; and to qualify the information regarding the consultations performed in the CAPS, procedures were changed and included in the SUS table, which should be informed in the *Sistema de Informação Ambulatorial* (Ambulatory Information System- SIA/SUS)⁽¹²⁾.

These procedures are recorded in three systematized tools by the *Ministério da Saúde* (Ministry of Health): *Registro das Ações Ambulatoriais de Saúde* (Registry of Ambulatory Health Actions- RAAS), where procedures are recorded for direct care of the users of the service and/or their relatives inside or outside the unit, after joining the service; *Boletim de Produção Ambulatorial Individualizado* (freely translated as Individual Ambulatory Production Bulletin-BPA-I), where the initial reception by CAPS and *Boletim de Produção Ambulatorial Consolidado* (freely translated as Consolidated Ambulatory Production Bulletin-BPA-C) is recorded, where institutional actions and articulation and support of care networks are recorded⁽¹²⁾.

There is a large amount of information routinely recorded by the health services, which are not used for prioritization and reorientation of practices⁽¹³⁾. However, in CAPS, these practices have not been monitored and there is no evidence on the use of data by health managers in order to know the reality of the care offered.

OBJECTIVE

To verify the use of procedures record tools (RAAS, BPA-I and BPA-C) by CAPS professionals as a data source for monitoring and assessment of CAPS.

METHOD

Ethical aspects

The study was approved by the Research Ethics Committee of Clinics Hospital of the *Universidade Federal de Goiás - GO*. The research followed all the ethical precepts recommended by Resolution 466/12 of *CNS/MS* (NHC/MoH), which addresses aspects related to human research⁽¹⁴⁾. All participants signed the Informed Consent Form and, to ensure their anonymity, participants' reports were identified by the CAPS and participant professional.

Theoretical framework

This study is based on the model of psychosocial care model in mental health and assessment for management.

The psychosocial care model is guided by the presuppositions of the Brazilian Psychiatric Reform, which sustain the transformations in the theoretical and assistance fields that are related to the construction of the concept of existence-suffering as opposed to the disease-cure binomial; legal-political, which involves social control and legal apparatus that regulate the substitutive services and reorient the mental health care in the country; technical and assistance, which is evidenced by the construction of a network of articulated services as spaces of care, dialogue and dialogue and have a multiprofessional team whose practice should be based on the concept of integrality; in the sociocultural field, activities are related to transforming the collective imaginary about madness⁽⁴⁻⁵⁾.

The assessment for the management of health services is a process of judging the value or merit of something, to subsidize the decision-making in a timely manner, with reliability and comprehensiveness of information, and that is feasible within the available resources, even if for it is necessary to simplify processes⁽¹⁵⁾.

Type of study

This is a descriptive, exploratory research of qualitative nature.

Methodological procedures

Study setting

The research was carried out in seven CAPS of the state of Goiás, comprising types II, III, AD (Alcohol and Drugs), Child, and AD III. The CAPS were selected randomly among all the qualified ones, more than two years ago, through a lottery. The choice of services of different municipalities is due to the possibility of finding differentiated aspects, considering the characteristics of the population quantitative of the municipalities, the different activities performed in each of the types of CAPS and the regional characteristics.

Data source

58 professionals participated in the study and were linked to the CAPS, which performed some type of care in the respective services. The following inclusion criteria were considered: to compose the minimum CAPS team; having six months of work in the CAPS; and being in professional practice at the time of data collection, consequently excluding those who were officially removed from the service, such as vacations and leave; professionals who did not have the time available to participate in the workshops.

Collection and data organization

Data collection took place through the holding of focus groups in the period of April and May 2016. The researchers traveled to the municipalities on dates previously scheduled with the municipal coordination of mental health and the professionals of the CAPS. The group meeting was held in spaces that included the same in wheel format, to favor the visualization among all the participants. At the beginning of the group activity, an explanation was given about the context of the study, the objectives and ethical aspects of the research for the participants, followed by a focus group with the help of a guide with guiding questions about the understanding and the use of the tools used by professionals to record the procedures performed in the CAPS. Each group lasted 45 minutes, on average, and counted on the collaboration of an observer who recorded

information that they thought pertinent, in a field diary. In addition to the journal information, the data were also recorded through audio recording on digital recorders and were transcribed later.

Data analysis

The data were transcribed and submitted to the thematic content analysis, as proposed by Bardin⁽¹⁶⁾, with the help of ATLAS.ti 6.2 software. After categorization, due to common characteristics and the purpose of condensing the context units to favor understanding, the results were presented in tables containing the units of record that were words and phrases that had more frequency of citation and that could be grouped by similarities of meaning; and units of context that composed the communication, excerpt from speeches, a report whose frequency of appearance could present some meanings with the chosen analytical objective.

The thematic categories that emerged from the content analysis were: *Understanding about the record of Psychosocial Care Centers procedures*; *Management of the record tools of Psychosocial Care Centers procedures*; and *Intervening factors for recording Psychosocial Care Centers procedures*.

RESULTS

Understanding about the record of Psychosocial Care Centers procedures

The participants' understanding is that the record tools of the CAPS procedures are to record the actions developed in a CAPS, for the purposes of accounting for what is produced by the professionals, and associated to the financial transfer of the cost of the service.

The RAAS is a record that includes the production of the professional and the actions taken in the CAPS, the individual care and if it was effective. There is a code that corresponds to the production performed on that unit. (CAPS2 P7)

It is to record information, power the information system, fulfilling the role of the municipality accountability too, right!? Demonstrate the service being performed. (CAPS2 P2)

Even if the tool is understood as the possibility to record the production of professionals in the information systems, the benefit in the fulfillment perceived by the participants of this study is related to the improvements in the structure, either in the expansion of the service or in the acquisition of materials for carrying out the activities therapies.

Because if there is payment for the actions and if the record will facilitate the expansion of the service, because every service lives on cost of transfer. (CAPS4 P5)

This is necessary to prove and for us to be able to receive resources to acquire demands for the CAPS. This can benefit the user. If I need material for music, need material to work in the pool, or suddenly to enlarge a room ... I don't know how it works. (CAPS7 P11)

Also, the record of the procedures is understood as the possibility of monitoring the production of the professionals and, thus, giving visibility of the work that is developed in the CAPS.

So that there is not only an empirical thing, right? It serves to show that here at CAPS it is not just "offering tea". So, for statistical data it is important! And also to say that we worked and we did these and these actions, but it needs to be improved! Or replaced. (CAPS7 P8)

Even with the understanding of the tools for recording production, for financial transfer or for recording productivity of professionals, there is the perception that the RAAS does not contemplate the work process that is developed in the CAPS and attribute this to the distance from the management of what is developed in services.

There must have a tool that would meet our demand because ambulatory care is very different from our CAPS psychosocial care. It's like I have to fit in: "It's not from here, but let's fit in, let's find a way!" (CAPS5 P9)

To have an understanding of what we do, there must be immersion of the management in the service, the staff that requires it, to understand how it works, to be able to elaborate a more effective tool. [...] Even because who made this question of the RAAS doesn't know our reality of the CAPS, doesn't have that understanding. That's why you have these flaws, missing code (CAPS1 P2)

However, the participants mentioned only the use of the tool of RAAS, evidencing an ignorance of BPA-I and BPA-C, and made some misleading notes about the functionality of the records, such as the assessment of the effectiveness of the care dispensed and or evolution of the case.

Management of the record tools of Psychosocial Care Centers procedures

The participants reported on how they have operationalized the record of the procedures in the CAPS, related to the knowledge and the ability that they have to develop this assignment.

Among the activities recorded in the CAPS, the professionals listed the individual care, reception, care at home and groups. On the other hand, important actions that reflect the psychosocial care have not been recorded, being listed to the interventions in situations of crisis, matrixing, articulation of activities with other health services and intersectoral of the territory outside CAPS.

And talk like this: are we going to record all these calls? This is unreal, it doesn't happen! It cannot reach or measure the size of the work that is done. (CAPS2 P5)

The tool looks for activity done outside the CAPS, at first I thought it was the only production within the CAPS. (CAPS4 P3)

Many activities of daily living that we do and are not recorded. Interventions in case of crisis, personal intervention, family orientation. (CAPS2 P3)

Because RAAS made me think. When I joined CAPS, I realized that we made much more of what was on paper in the record of our production, our daily production, even what was being recorded. (CAPS1 P2)

In addition to the lack of record of several procedures, the professionals informed the record of certain actions in a wrong way, such as the record of routine procedures such as the verification of vital signs and telephone service recorded as individual care. Some of the participants questioned the lack of a procedure code that was related to the action of "Active Search" and even made a comparison with the home visit concluding that it is not the same thing.

A phone call [we sometimes get 10 minutes on the phone giving directions and talking]. And it's a call, right? So, none of this is recorded, so it shows that RAAS also doesn't meet the need for the service. (CAPS6 P9)

It seems like there isn't active search, but there is home visit! But it is not only at home that has active search, this code restricts a lot. (CAPS2 P5)

In all the services surveyed, it was possible to identify underreporting of records, whether related to the absence of record or incorrect record of procedures.

Intervening factors for recording Psychosocial Care Centers procedures

The intervening factors in the process are factors that have made it difficult for the professionals to record their actions properly. When questioning the reasons for the underreporting of the actions carried out by the professionals, it was evident the lack of knowledge about the procedures of the CAPS and the tools of record.

Another thing I have doubt: We visit the patient in the hospital to accompany that person. They record like what? Like active search? Like home visit? Like what? (CAPS1 P8)

That's the way we do it! We perform the action and is in doubt in which code to place the action, where it fits. I take it every Wednesday to the club, or go to the gym here in the county. I always put group service. We have doubts because it is an extra activity, right? (CAPS1 P5)

Many rehabilitation activities such as activities of daily living and practical life, which have no way you insert. Let's suppose a trip to the supermarket, which is daily living activity training, we do it in CAPS every day and I don't have a specific code. (CAPS6 P3)

This lack of knowledge was related by the participants to the lack of qualification, being a factor mentioned very frequently in all focus groups performed in the services. Moreover, many of them cannot interpret the definition of procedures established in the ordinance and correlate with the action developed, besides not differentiating between RAAS, BPA-C and BPA-I.

We all work by guessing. So, it gets a difficult service, no one really knows what to say which code corresponds to which action. (CAPS 3 P5)

At the time, it was so difficult for us to understand the tool. No one was trained, actually! We have been learning. We realize that a lot is being left behind. (CAPS2 P1)

The tools have been used only as a bureaucracy of accountability, with no other functionality. Therefore, they find it an annoying and unnecessary task. This perception is closely linked to the lack of feedback on the data, and the feedback from the managers, leaving the record by the record only. Thus, they blame the managers for the lack of access to the information produced, but also do not know that they can and how to consult the data that are already available in SAI-SUS.

If we had feedback, I believe it would be a way of growing through service assessment. We were going to see which one is demanding more and which is failing more. The downside is the issue of being bureaucratic and sometimes not having all the codes. (CAPS4 P8)

In addition, problems related to the structure of services were mentioned. As the data is not recorded online, the sending of the data can be frequently compromised by spoiled computers and poor maintenance, computer deviations with data, error in sending the reports and even theft of computers with the data reported.

The patient data is saved in the computer. You stole the computer and the data went together! The computer hit the wall! Done! Then, the service depends on the person repairing the computer. (CAPS6 P2)

Another very important intervening factor was the impossibility of record of the procedures by certain professionals working in the CAPS, due to the lack of inclusion of the *Cadastro Brasileiro de Ocupações* (freely translated as Brazilian Register of Occupations- CBO) of some of them, for example, the inclusion of the pharmacist, nutritionist, psychopedagogue or physical educator.

In CAPS everyone ends up doing the groups, then the time that will insert in RAAS cannot be inserted. The pharmacy here, for example, makes a group and has no way to insert. So, in the CAPS several professionals do the service and RAAS doesn't contemplate this. (CAPS2 P8)

Finally, they consider the time required to fill out the tools because they do not perceive return for the qualification of the work process, are many activities developed by the professionals daily, because the record is manual and paper, because system does not recover the data of identification and everything has to be recorded month by month.

We have to finish workshops and get all the medical records, which are not few, on average, 20 medical records up. Then you have to look for RAAS by RAAS and fill in one by one. [...] It's a lot of time and energy spent on something that we don't see the results so close, so palpable. It's complicated! (CAPS4 P10)

DISCUSSION

As in any other activity, in the health sector information should be understood as a reduction of uncertainties, an tool for understanding the reality, to identify priority issues, to make responsible planning and execution of actions coherent with

the health needs of population. Therefore, information is essential in the planning process, being able to become the basis for the implementation of new actions and decision-making, provided they are used so that those who record them have an understanding of their functionality, which still is something to be built as regards the record of CAPS procedures⁽⁶⁾.

The establishment of the RAAS, BPA-C and BPA-I tools establishes a differentiated logic of record of psychosocial care performed by the CAPS, by proposing procedures that are potentially more sensitive to the guidelines for the functioning of these services. The record will serve to qualify the information about the actions that the CAPS should carry out, and avoid the shrewdness as evidenced in the reports of the professionals, who do not know the definition of the procedures and cannot differentiate between RAAS, BPA-C and BPA-I.

The proper use of the tools can generate data as sources of monitoring and assessment indicators for modifications and affirmation of the CAPS care model. Only through this, it will be possible to verify its resolution considering that the assessment must follow in order to account for the quality and not only the quantity, other than the participants believe that the record is only to maintain and guarantee financial resources that in fact already are fixed .

The indicators are presented as potential tools to be used in assessment processes that aim to analyze in a more profound way the results of the practices developed by professionals⁽¹¹⁾. The effective use of the developed indicators can contribute to the development of the assessment culture as they can be confronted with different realities⁽¹⁰⁾.

However, several complex factors interfere with the incorporation of Information and Communications Technology (ICT) in health, such as: user interface quality, usability, resource functionality, data quality and integration with external systems⁽¹⁷⁾. The CAPS professionals' statements illustrate well the obstacles of the functionality of the resource when the users do not understand their functionalities and/or when they do not have the necessary equipment or efficient maintenance of the equipment to use.

The records made in CAPS are still made on paper. The advancement of the Electronic Health Record (EHR) is becoming more and more evident, and thus paper records, as a result of the globalization movement, tend to disappear. However, we have the deadlock that human resources sometimes do not keep up with the capabilities of electronic records. The lack of training entails a low demand in the use of these resources due to challenges such as ignorance of the real potential of EHR, poor data quality, and something that is very frequent in the reality of CAPS, reworking, characterized by typing after data collection in written forms⁽¹⁷⁻¹⁸⁾.

The assessment appears inseparably from the decision-making process and, for this, it will be essential that it be done in a timely manner and with the resources available⁽¹⁵⁾. Therefore, it is considered that the use of data available in SUS Information Systems (SIS) could allow the assessment process to be useful, timely, feasible, reliable, objective and directed to problem solving⁽¹⁵⁾. However, without the qualification of the record, decision-making may not produce the expected effects due to lack of data reliability.

Considering the diverse realities and the inefficiency of the information systems, as noted previously, it is necessary to qualify the record that is done by the CAPS in the SIA-SUS, as a standardized

data source of indicators, present in all CAPS enabled, for monitoring throughout the national territory and possible comparisons. This is because, at present, there is no national scope of assessment that can analyze mental health policy in its macrostructural scope. The assessments presented annually by the Technical Area of Mental Health make some cuts of the model related to the expansion and opening of services, reduction of beds and financed amount, without advancing in the analyzes⁽²⁾.

Therefore, the need for qualification is due to the fact that the professionals, when handling the tools, consider that there is a lack of correspondence between the record of actions and the work process developed in the CAPS related to the distancing of the different levels of SUS management from the work that is developed these services. Many SIS are developed following administrative norms, management of interests and health policies, often distant from the needs of health services and professionals⁽¹⁸⁾.

In addition, professionals mistakenly believe that the record of procedures is only to determine the financial pass-through cost that the CAPS receive. However, the perception of the participants is understandable, since traditionally in the SUS context, SIS are developed more by the needs of the use of information for management practices, monitoring of health situations, for the control of productivity and transfer of financial resources of actions and events when compared to their use in direct assistance to SUS users⁽¹⁸⁻¹⁹⁾.

Another perception that professionals have about the tools is that the record of procedures does not correspond to the reality of the work in the CAPS because many of the actions they develop are not recordable; considering the characteristic and the volume of soft technologies that are demands in the psychosocial care or because they understand that only the ambulatory characteristic procedures are recorded. Thus, related to the lack of knowledge of the professionals about the CAPS procedures and the record tools, several actions developed are not recorded or are done in the wrong way. They develop recordable activities, but they do not because they do not know which procedure is related.

The direct care actions of CAPS users and/or their relatives within or outside the unit as indicated by the professionals can be recorded in RAAS, such as: night reception, 3rd shift reception, day care in the CAPS, individual care, care in group, family care, home monitoring, corporal practices, expressive practices, attention to crisis situations, actions of psychosocial rehabilitation and promotion of contractuality⁽¹²⁾. Thus, the possibilities of record are broad and much more varied than the professionals know.

The name of the procedure described in the ordinance is not literal and therefore does not necessarily correspond to what was developed. The name reflects much more the therapeutic function of the action planned in the *Projeto Terapêutico Singular* (freely translated as Unique Therapeutic Project- PTS) of the user than necessarily the action. To exemplify this case, when one of the participants reports that the action of "going to the supermarket, which is activity of daily living training" cannot be recorded and has no specific code, it is misleading because it could be recorded in RAAS as promotion of contractuality.

It is worth mentioning that the PTS must systematize care for the users and their families in the CAPS from the identified needs. However, it is still possible to identify the lack of elaboration of the PTS, considering new possibilities of existence and

life, and not only to be seen as a grid or schedule of activities exposed to the user, pointing out the days and times of the week in which he should go to CAPS to do activities⁽²⁰⁾.

In this sense, it is emphasized again the need for a continuous process of assessment of the functioning of the CAPS and its alignment to the field of psychosocial attention as guiding the team's behaviors⁽²⁰⁾.

Considering the feasibility and timeliness of the assessment for the management and record possibilities, the orientation is that each municipality should make use of the data available in the SIA-SUS to generate information that reflects the practice and performance of the professionals, aiming to make decisions in order to qualify their mental health services, necessitating, for this, a greater dedication of the management as already pointed out by the participants of the study.

The recording of procedures is not only for internal control and/or for easy typing. However, professionals, by understanding the records only as a means to systematize the accountability of the financial resource that is passed on to the municipalities and or to evidence their production in the CAPS and not necessarily the actions developed with the users, disregard the possibility of expansion of the logic of action and validation of the actions and information of the services.

Also, actions developed by professionals within the network are not recorded and may show greater RAPS weaknesses than those already existing. The articulations with devices outside the health field, such as cultural and leisure spaces, should be further explored and valued to consolidate the psychosocial rehabilitation strategy axis⁽¹⁾. The articulation of networked institutions and professionals is a cornerstone of the reorientation of the mental health care model⁽⁴⁻⁵⁾, and it is necessary to record to show the effective work shared through the relationship between therapeutic projects conducted simultaneously by CAPS and other services health, or other sectors⁽¹⁰⁾.

It should be emphasized that the interpretation of the description of the procedures will direct in which tool to record, but the professionals did not differentiate between them and did not mention records of activities in GAP-C and BPA-I. The absence of record in BPA-C indicates a lack of network articulation and this weakens the interpretation of the intra and intersectorial work that is developed in the CAPS.

The indicators adopted for the purpose of monitoring by the Ministry of Health are the systematic screening actions performed by CAPS with Primary Care teams and the tool that powers the record of the procedure "Matrixing Primary Care Teams" is BPA-C. Considering the analysis of the professionals' reports, the analysis of this indicator can be compromised because it was evident that the professionals have not recorded the procedures in BPA-C, therefore, there is underreporting of the record.

The quality and relevance of health information may be compromised when tools with inadequate completion are verified. Incomplete data make assessment and use of information impossible in epidemiological studies and in decision-making⁽²¹⁾. Despite the relevance of informing the procedures, the SIS still present weaknesses in their organization and practice, which compromises the reliability of the data produced, not allowing reliable information on the reality of the health situation of the Brazilian population⁽¹⁹⁾.

Participants' perception of the tools as bureaucratic, with no other functionality is linked to the lack of feedback on the data, and by the managers, who also often pointed out the lack or the limitation of qualification to use SIS, leaving the record for record only, which are also intervening factors⁽²²⁾. The lack of assessment by managers directly implies the limitation of professionals and records failures.

The lack of a formal training process with professionals specialized in the area of mental health and SIS has a previous problem. Often, even the preparation for using the SIS was done informally, and the employees themselves passed on their learning regarding the use of the system, which triggers successive problems and gaps in the data generated^(8,23).

Another quite frequent aspect in the reports of professionals is the expenditure of time for the records of the data to the detriment of the service to the users. Although the record is still handwritten, this is done only by codes and quickly. The need for computerization of processes to improve the quality of records has been discussed, and the ease of use of information in the health professional's work practice has been discussed as a possibility to reduce the distance between recording data and using information. Handwriting requires time, but it is easy. On the other hand, more time is spent in the computerized record than the manual record, and that to be faster, training is needed and also adaptation strategies⁽¹⁸⁾.

Another issue that was mentioned by many participants was the "active search" that in some services was compared to the home visit because it can be complex and involve several people and services in the territory. It is clarified that, in case of "active search", if a home visit is performed; it should be recorded as Home Care. If the active search is made by phone call, the procedure should not be recorded but noted on the patient's chart.

The lack of inclusion of certain professional categories by means of the CBO is another aspect very questioned by some professionals because they do not feel recognized by the policy of the service. If the action is developed in the CAPS by pharmacist, nutritionist, physical educator, art therapist or psychopedagogue, it is not possible to record the procedure. Therefore, even if the need for record is to inform the SIA/SUS of the procedures resulting from actions in the CAPS, professionals in these categories do not feel included in the process. The work in the CAPS is multiprofessional and in team, and this aspect of the lack of the CBO weakens this care by negatively impacting on the work in team and the professional satisfaction.

Study limitations

The limitation of the study is related to the impossibility of generalizations about the results, given the regional delimitation of the research.

Contributions to the sectors of nursing, health or public policy

This study contributes to aggregate knowledge about CAPS assessment, considering the need for CAPS actions record tools, institutionalized throughout the national territory, to be adequate to the reality of the services, and either professionals are qualified to handle the tools and recording of data. Qualified data can be important sources of monitoring and assessment indicators for the management of the CAPS work process, especially for validating the quality of psychosocial assistance and for assisting in decision-making by managers, and the direction of the National Mental Health Policy.

FINAL CONSIDERATIONS

The record of procedures is essential for the monitoring and assessment of the CAPS work process. However, the bureaucratic, disinterested and incorrect form as they have been done by the professionals does not portray what the teams in the CAPS have developed and, therefore, the conclusion of any analysis of the data generated through them does not coincide with the reality of the services. Thus, management assessment can be compromised because despite the opportunity and feasibility, underreporting of data may compromise the reliability of information.

In order for monitoring and assessment through the analysis of the data available in the SIA-SUS to occur, it will be necessary to invest in Permanent Education of the professionals of the health team with a focus on the management of the records generated from the actions developed in the CAPS. This can be the way to be managed by managers to generate timely information and decision-making with the purpose of adapting the work process in the services, quality of results and consequently of the service to users in the context of regional and national mental health.

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