Validation of a nursing care protocol for patients undergoing palliative care

Validação de protocolo assistencial de enfermagem para pacientes em cuidados paliativos

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Keywords

Nursing assessment; Palliative care; Hospice and palliative care nursing; Ethics, nursing; Nursing care

Descritores

Avaliação em enfermagem; Cuidados paliativos; Enfermagem de cuidados paliativos na terminalidade da vida; Ética em enfermagem; Cuidados de enfermagem

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Abstract

Objective: To describe the validation process of the content of a nursing care protocol for patients undergoing palliative care and hospitalized in intensive care units.

Methods: This was a cross-sectional, descriptive, methodological study, resulting from the judgment by 11 experts involved in teaching and/or care. The operationalization occurred through the consistency among the answers of the experts obtained by the Content Validity Index in a round.

Results: Fifteen items were assessed: nine corresponding to the nursing history and six related to nursing interventions, presenting a content validity index of 0.9 to 1.0. Of the 165 answers, 67.27% were considered appropriate, 30.91% were appropriate with alterations, and only 1.82% were deemed inappropriate. Such results confirm the validity of content according to the assessment by the experts.

Conclusion: The nursing care protocol for patients undergoing palliative care, hospitalized in intensive care units, proved to be valid and applicable in the clinical practice.

Resumo

Objetivo: Descrever o processo de validação de conteúdo de protocolo assistencial de enfermagem para pacientes em cuidados paliativos internados em Unidades de Terapia Intensiva.

Métodos: Trata-se de um estudo transversal, descritivo, do tipo metodológico. Resultado do julgamento de 11 *experts* envolvidos na assistência e/ou docência. A operacionalização ocorreu por meio da concordância entre as respostas dos juízes obtidas pelo Índice de Validade de Conteúdo em uma rodada.

Resultados: Foram avaliados 15 itens, nove correspondentes ao histórico de enfermagem e seis referentes às intervenções de enfermagem, os quais apresentaram índice de validade de conteúdo de 0,9 a 1,0. Das 165 respostas, 67,27% mostraram-se adequados; 30,91% adequados com alterações e somente 1,82% foram considerados inadequados, resultados que atestam a validade de conteúdo segundo a avaliação dos juízes.

Conclusão: O protocolo assistencial de enfermagem para pacientes em cuidados paliativos internados em Unidades de Terapia Intensiva se mostrou válido e aplicável na prática clínica.

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Introduction

Death and the process of dying permeates human life, especially the lives of care nurses working in intensive care units facing situations of coping with death in their professional practice routine.

Although everyone is aware of its inevitability, the concept of death is a theme that is usually avoided, as it is not easily discussed in modern society. The awareness of their own finitude is experienced with affliction by those who work with the terminally ill. However, the theme has not always been seen that way; in the Middle Ages it was approached within the family sphere without any drama or eloquence. With therapeutic advances and the incorporation of healthcare technologies, death began to be seen as a taboo, favoring a detachment from the family environment in favor of the hospital environment.⁽¹⁾

Increased survival has also generated a significant number of patients hospitalized in ICUs and, as a result, a higher experience of nursing professionals in the terminality process. Thus, palliative care, which uses advanced communication skills in order to ease the pain and the psychic and spiritual suffering, are implemented in order to individualize the provided care and organize the care in high complexity environments.⁽²⁾

From the need to establish criteria to guide the nursing care during the death and dying processes, the elaboration and validation of a nursing care protocol have been carried out to deal with patients undergoing palliative care.

The use of care protocols for patients in the final stage of life is of paramount importance, as these protocols systematize nursing care.⁽³⁾ Thus this study approaches the development of an instrument that is capable of systematizing this care in order to get more effective results, with a view to the consistency of the actions at the final stage of life so that a more human, high quality care is provided. Furthermore, the scarcity of these valid protocols leads to a need for validation before implementation in order to imply the reliability of the items of the instrument, which

become valuable resources for further studies on the theme.

Therefore, this study's goal was to describe the validation process of nursing care protocol content for patients undergoing palliative care who were hospitalized in ICUs.

Methods

This was a cross-sectional, descriptive, methodological study with a quantitative approach to validate nursing care protocol content in order to optimize the nursing care to patients undergoing palliative care who were hospitalized in ICUs.

Content validation is a process consisting of two stages.⁽⁴⁾ In the present study, the first stage consisted of the elaboration of the care protocol considering a nursing history and the interventions listed according to the human dimensions guided by the Nursing Interventions Classification (NIC) in order to standardize the terminology of the actions from the integrative review. The second stage is content validation, which was conducted through the protocol assessment by experts.

The items included in the nursing history were: identification; level of consciousness; ventilation and hydration; bladder elimination; hydrous balance; intestinal elimination; body hygiene; and dressings. In Nursing Interventions they are divided into the following dimensions: biological (control of pain and respiratory symptoms, nausea and vomiting, diarrhea and constipation, delirium, and dementia); psychological (identification of the Kübler-Ross stages and psychological care); social (support to patient and family members); and spiritual (spiritual support); as well as the interventions for terminal illnesses and postmortem care.

Expert assisting nurses from the ICUs of hospitals in the city of Natal-RN and professors from major Brazilian universities were selected. The identification of these experts occurred through the websites of the higher education institutions and the *Plataforma Lattes* of the *Conselho Nacional de Desenvolvimento Científico e Tecnológico* (CNPq).

The sampling was chosen by intentional method in accordance with the following adapted criteria based on the scoring system proposed by Fehring, namely: title of master of science in nursing; master's thesis involving the terminality process; works published; and participation in groups and/or research projects involving the theme scoring 1 point. Also, the title of doctor of nursing practice; a doctoral dissertation; professor of the nursing course in the areas of bioethics and terminality; professional experience scoring 2 points; and nurses presenting scores equal to or higher than 5 points were considered to make up the sample.^(5,6)

After the selection, the experts were approached via e-mail. An invitation letter was sent, with emphasis on the justification and aim of the study, the legal opinions of a research ethics committee, and the free and informed consent form to be signed in case of acceptance. Upon delivery of the duly signed consent form, the care protocol and the protocol analysis instrument were also sent via e-mail. Twenty-eight expert nurses were located, including masters and doctors; 11 returned the protocol fully analyzed and assessed. The others were removed from the process of validation for not returning the instrument analyzed within the time limit (30 days) or due to incomplete analysis.

All 11 nurses assessed all of the items corresponding to the nursing history and nursing interventions. The experts analyzed the care protocol within the period from September to October 2014 considering relevance, consistency, clarity, objectivity, simplicity, practicality, modernity, and using an accurate vocabulary that prevents ambiguities.

The instrument was reformulated based on the following criteria: suggestions with more than 50% of the experts in the blocks Nursing History and Nursing Interventions; and corroboration with the literature through evidence from the integrative review.

Consistency between the answers of the experts was obtained through the Content Validity Index (IVC), which enables every item of the instrument to be assessed for a subsequent assessment of the entirety. As a widely used method in the area of health, the IVC points out that the main focus of

the content validation is to determine whether the items listed in the protocol present adequacy of the content. A minimum of six experts is recommended for this calculation, as well as a concordance rate of not less than 0.78.⁽⁴⁾ The assessment by each expert was compared to the assessment by the others, calculating the IVC for each pair of experts (Expert 1 x Expert 2; Expert 1 x Expert 3; Expert 2 x Expert 3, and so on).⁽⁷⁾

A database in .xlsx format was developed to statistically process the data, and Excel 2010 and the statistical software SPSS (Statistical Package for Social Science) version 20.0 were used to develop the tables and charts. In relation to the analysis of each eligible item to make up the care protocol throughout the study, it was possible to remove and/or change some items according to the adaptations suggested by the evaluators; therefore, a criterion of 50% of the observations among them was established in addition to the findings of the review.

The development of the study met the national and international standards for ethics in research involving human beings, and was approved by the *Certificado de Apresentação e Apreciação Ética* (CAAE): 33913514.9.0000.5537.

Results

Eleven nurses participated as experts. Most (81.82%) were female, with a mean age of 36.64 years (standard deviation of 8.51). In their variable training, most of them presented a maximum degree of expert (45.46%), a minimum working time of two years and a maximum of 35 years (mean of 11.91 and standard deviation of 8.95).

Of the 15 assessed items, table 1 shows the values obtained through the calculation of the IVC. The 11 experts are represented by numbers (1 to 11); the intersection of the abscissa with the ordered lines exposes the value corresponding to the index of agreement between them, in which a favorable correlation with the content validity is evidenced. Only Experts 1, 3, and 9 presented adverse answers to the validation of the item "state of consciousness."

Tabela 1. Content validity analysis of the items of the care protocol proposed by the study

IVC	Expert 1	Expert 2	Expert 3	Expert 4	Expert 5	Expert 6	Expert 7	Expert 8	Expert 9	Expert 10	Expert 11
Expert 1	-	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Expert 2		-	0.9	1	1	1	1	1	0.9	1	1
Expert 3			-	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Expert 4				-	1	1	1	1	0.9	1	1
Expert 5					-	1	1	1	0.9	1	1
Expert 6						-	1	1	0.9	1	1
Expert 7							-	1	0.9	1	1
Expert 8								-	0.9	1	1
Expert 9									-	0.9	0.9
Expert 10										-	1
Expert 11											-

IVC - Content Validity Index

By applying the aforementioned IVC formula, the estimated value of 0.9 was obtained for this study.

Table 2 shows the percentage of agreement between the experts in relation to the classification and their respective absolute frequencies. Illustratively, the above table shows the percentage of answers provided by the experts. There were a total of 165 answers, of which 67.27% of the assessed items were deemed appropriate, and only 1.82% were assessed as inappropriate; the item “state of consciousness” was removed from the instrument.

Table 2. Classification in relation to the level of agreement between the experts in the study

Classification	n(%)
Appropriate	111(67.27)
Appropriate with change	51(30.91)
Inappropriate	3(1.82)
Total	165(100)

The content validity is represented by table 3 in order to view the classification of the protocol with its respective absolute frequencies in the nursing history and interventions.

In relation to the aspect of the nursing history, table 3 shows that the highest value of agreement was observed in the items level of consciousness, ventilation, feeding, and hydration, with a percentage of 81.82%. Despite a variation between the

assessed items, it was observed that the minimum value was 54.55% for adequacy of the protocol, revealing the relevance of the material.

Table 3. Items of the care protocol assessed by the experts of the study

Items	Appropriate n(%)	Appropriate with change n(%)	Inappropriate n(%)
Level of consciousness	9(81.82)	2(18.18)	-
State of consciousness	7(63.64)	1(9.09)	3(27.27)
Ventilation	9(81.82)	2(18.18)	-
Venous access	7(63.64)	4(36.36)	-
Feeding and hydration	9(81.82)	2(18.18)	-
Bladder elimination and hydrous balance	6(54.55)	5(45.45)	-
Bowel elimination	8(72.73)	3(27.27)	-
Body hygiene	7(63.64)	4(36.36)	-
Dressings	6(54.55)	5(45.45)	-
Biological dimension	7(63.64)	4(36.36)	-
Psychological dimension	8(72.73)	3(27.27)	-
Social dimension	7(63.64)	4(36.36)	-
Spiritual dimension	7(63.64)	4(36.36)	-
Intervention in the terminality act	7(63.64)	4(36.36)	-
Postmortem intervention	7(63.64)	4(36.36)	-

During the reading of the protocol the nurses were instructed to record in their own material the corrections and recommendations they found necessary. From this instruction, the suggestions deemed pertinent were accepted with a view toward improving the proposed protocol. The main suggestions were related to the clarity of the items that could lead to confusion in their implementation by the nursing professional.

State of consciousness was deemed inappropriate by 27.27% of the experts. In terms of changes, this item was added to the item level of consciousness and added to the Palliative Performance Scale (PPS) widely used in palliative care, combined with the Glasgow Coma Scale and the Ramsay Sedation Scale. The other changes involved hydration and administration of drugs in patients in ICUs in the context of palliative care combined with the hypodermoclysis technique. In relation to bladder elimination, the addition of urinary derivations of the types “ureterostomy”, “Bricker”, “urostomy”, and “wet colostomy” were conducted.

In the items corresponding to intestinal elimination, the terms “absent” and “jejunostomy” were added. Following the analysis of observations, the item body hygiene was complemented with “assisted affusion bath”, “non-assisted affusion bath,” and “oral and intimate hygiene.”

Among the variables corresponding to the nursing history, the item “sleep and rest” was added as suggested by an expert based on the fact that this consists of one of the essential needs of patients under palliative care. In this item, characteristics such as “preserved” and “endangered” were added.

It is important to mention that in the aspect of the nursing interventions seven experts (corresponding to 63.64%) agreed that the protocol was appropriate to the biological, social, and spiritual dimensions, as well as the interventions in the terminality act and postmortem care. The psychological dimension presented 72.73% of agreement for adequacy of the instrument among eight experts.

Suggested changes include the need for a higher level of clarity and the exclusion of repeated activities and activities that had no relevance to the protocol. In interventions for pain control, the following items were excluded: “Observing the occurrence of non-verbal indicators of discomfort,” as it had already been covered in the previous number, and “Using measures for control before aggravation,” useless for the protocol.

In relation to the intervention “control of respiratory symptoms,” the need for further clarification in Item 9 was observed as it points out a measure to relieve cough. Similarly, more details in relation to

the explanation of the non-pharmacological measure expressed in Item 10 was necessary in the intervention “control of nausea and vomiting.”

For the intervention “fatigue,” the types of activities that may be performed to minimize this discomfort, as well as the use of songs and stimulating massages expressed in Item 9, were added.

In relation to the psychological dimension in psychological care, the present study aimed to adjust the identification of the stages of Kübler-Ross in “signs of denial, anger, bargaining, depression, and acceptance,” registered within 24 hours instead of per shift as in the initial proposal.

In the same intervention the item “actively listening to the patient and requesting the psychological service” was removed from the stages of Kübler-Ross as it is not a component of this stage. Therefore, this item is now part of the first one of the sequences of this intervention.

In the spiritual dimension, there is a detailing of the spiritual resources listed in Item 7, such as “Eucharist”, “anointing of the sick”, “holy water”, “recitation of the rosary”, “prayer”, “anointing oil,” and “fluidic water.”

During the act of terminality only the terms “care with windows”, “surround sound”, and temperature” were added to Item 2. Regarding the intervention “postmortem care,” the inclusion of time of death was necessary, as death is a timely event. One nurse suggested to change Item 7 to “provide support and listening to family members during the period of hospitalization and after burial by means of telephone contact,” and finally an adjustment in the last item (“record the adopted measures in the medical records”) of this intervention proposed by the care protocol (Appendix 1).

Discussion

The results of the content validity analysis obtained through the calculation of the IVC were found to be valid for 67% of the answers analyzed by the experts, as the value of the level of agreement between them was of at least 0.9. This finding corroborates the rate of agreement of not less than 0.78.⁽⁴⁾ Thus,

it is observed that the cutting point was achieved through the verified value.

In relation to the interventions proposed to the protocol, there was a significant level of agreement in the biological, social, and spiritual dimensions, as well as the care in the terminality act and post-mortem care, completing the assessment of seven experts of the adequacy of the instrument.

The Palliative Performance Scale (PPS) was added for the adequacy of the care protocol in relation to the assessment of level of consciousness, as it is commonly used in palliative care. In addition to being an excellent instrument of communication between the multidisciplinary team and the patient, the scores of this scale enable the continuous assessment of the functional status of the patient.⁽⁸⁾

In relation to hydration and administration of drugs in patients hospitalized in ICUs in the context of palliative care, hypodermoclysis represents an alternative by subcutaneous means; it is safe, effective, and particularly comfortable.⁽⁹⁾ This technique consists in the infusion of liquids into the hypodermis with a scalp or Jelco catheter of varied diameters ranging between 18G and 27G according to assessment and quantity of subcutaneous tissue in the following regions: scapular, outer thighs, anterolateral abdominal, anterior chest, and anterior arms. It is important to ensure that the volume of liquids does not exceed 3000 ml within the hours and that the solutions are isotonic. Catheter maintenance occurs every four hours, and it may remain in situ for up to 72 hours.^(9,10)

The item “sleep and rest” represents an important aspect to be considered before the patient’s terminality, as the change in the sleep-wake pattern directly interferes in the quality of life and comfort of the patient; it is verified through a number of factors, such as environmental factors, that sleep interruptions for examination collections, anxiety, and use of sedatives and painkillers are disruptive. It was also observed that sleep maintenance must be highly stimulated in order to promote quality at the final stage of life, also minimizing stressing events.⁽¹¹⁾

In relation to bladder elimination combined with urinary derivations of the types “ureterosto-

my”, “Bricker”, “urostomy,” and “wet colostomy” in the protocol, it is observed that the use of such ostomies is common, as their use improves the quality of life of patients undergoing palliative care. Wet colostomy, also known as ureterosigmoidostomy, enables the output of urine and feces in the same stoma. Ureteroileostomy or a derivation of Bricker consists in the implementation of ureters in an isolated terminal ileal segment.⁽¹²⁾

The presence of integrative and complementary therapies in palliative care is also common. These actions are corroborated by the modalities of acupressure, electroacupuncture, shiatsu, reflexology, aromatherapy, meditation, art therapy, flower therapy, reiki, and therapeutic touch.⁽¹³⁾ These actions are non-invasive palliative actions that are accepted by patients during this process. A palliative care unit must rely on resources such as psychotherapy, acupuncture, massages, and body relaxation techniques, as well as music therapy.⁽¹⁰⁾

In this context the nurse as the professional that is closer to the patients must reflect on the possibilities of care and be able to identify alternatives to provide the best quality of life possible to terminal patients, aiming to improve the physical, mental, and emotional balance of the patient, as well as their well-being.⁽¹¹⁾

Limitations of the study include the absence of answers and the devolution of incompletely filled and/or assessed protocols by some experts, as they lead to a reduction in the size of the sample (which was already limited due to the number of professionals who work in the area of palliative care). Furthermore, the short data collection period resulted in the impossibility of conducting other rounds in the validation process, also consisting in a limiting factor of the method.

Despite such difficulties, the importance of this protocol for palliative care nursing is highlighted. In this sense, further studies are necessary to continue the validation process of the instrument in the practice, such as the implementation of the Delphi technique and the clinical validation with the use of the instrument in the intended population.

Conclusion

The nursing care protocol for patients undergoing palliative care who are hospitalized in intensive care units was found to be valid in its content, with potential applicability in clinical practice after the conclusion of other validation studies in order to ensure a more human and high quality care.

Collaborations

Santos EC, Oliveira ICM and Feijão AR declare that they have collaborated in the conception of the project and data interpretation, wording of the article, relevant critical review of its intellectual content, and final approval of the version to be published.

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Part II. Nursing interventions during terminality

Biological dimension																																											
Intervention-pain control										Morning	Afternoon	Night																															
1. Assess pain intensity.																																											
<table border="1"> <thead> <tr> <th colspan="3">MILD</th> <th colspan="5">MODERATE</th> <th colspan="2">INTENSE</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>6</td> <td>7</td> <td>8</td> <td>9</td> <td>10</td> </tr> <tr> <td colspan="3">😊</td> <td colspan="5">😐</td> <td colspan="2">😞</td> </tr> </tbody> </table>										MILD			MODERATE					INTENSE		0	1	2	3	4	5	6	7	8	9	10	😊			😐					😞		Score _____	Score _____	Score _____
MILD			MODERATE					INTENSE																																			
0	1	2	3	4	5	6	7	8	9	10																																	
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VAS - VISUAL ANALOG SCALE																																											
2. Ensure that patient receives accurate analgesia care as prescribed.																																											
3. Investigate the knowledge of the patient on the pain according to their belief.																																											
4. Promote measures that enable the reduction or elimination of factors that trigger pain (fear, fatigue, lack of information).																																											
5. Choose non-pharmacological strategies (massage, music) to relieve pain. Specify																																											
6. Encourage the patient to talk about their pain experience.																																											
7. Use multidisciplinary approach for pain control.																																											
Intervention-control of respiratory symptoms										Morning	Afternoon	Night																															
1. Assess the intensity of dyspnea and cough.																																											
2. Assess triggering factors of dyspnea.																																											
3. Assess the need of aspiration.																																											
4. Maintain airways patency.																																											
5. Viabilize a comfortable positioning in bed in semi Fowler.																																											
6. Promote serenity.																																											
7. Offer SN supplemental oxygen as prescribed.																																											
8. Monitor the flow of oxygen according to the used device.																																											
9. In case of cough: compress patient's abdomen below the xiphoid process with flattened hands while helping them to bend forward while coughing.																																											
Intervention-control of nausea and vomiting										Morning	Afternoon	Night																															
1. Identify triggering factors of nausea and vomiting.																																											
2. Control environmental factors that may trigger nausea and vomiting.																																											
3. Reduce personal factors that precipitate nausea and vomiting (anxiety, fear, lack of knowledge).																																											
4. Position for prevention of bronchoaspiration.																																											
5. Keep airways penetrable.																																											
6. Hygiene process of oral cavity with chlorhexidine 2%.																																											
7. Offer ice 40 minutes before meals in order to minimize the symptoms.																																											
8. Monitor hydroelectrolytic balance.																																											
9. Stimulate rest.																																											
10. Teach non-pharmacological measures to control nausea and vomiting as follows: Measure three fingers from the wrist flexion crease and press between the tendons of the palmaris longus muscle and flexor carpi radialis muscle for two minutes. Measure four fingers below the patella and lateral to the tibial tuberosity pressing for two minutes.																																											
11. Offer liquids as appropriate.																																											
12. Perform gastric catheterization for relief in case of fecal vomiting.																																											
Intervention-control of diarrhea and constipation										Morning	Afternoon	Night																															
1. Assess the episodes of diarrhea in relation to color, volume, frequency, and stool consistency.																																											
2. Assess the absence of bowel elimination on a daily basis.																																											
3. Assess triggering factors of constipation (opiates, diet).																																											
4. Monitor bowel sounds.																																											
5. Nutritional assessment for adequacy of diet.																																											
6. Offer isotonic liquids.																																											
7. Offer meals 6-8 times every day according to nutritional prescriptions.																																											
8. Conduct positional change every two hours for diarrhea control according to response of comfort by patient.																																											
9. Promote body hygiene and comfort after diarrheal episodes.																																											
10. Keep water control.																																											

continue

continuation

Intervention-fatigue control	Morning	Afternoon	Night
1.Encourage expression of feelings about the limitations.			
2.Monitor nutritional intake in order to ensure an appropriate energy intake.			
3.Select the interventions (aerobic exercise, manual activities) to reduce fatigue.			
4.Practice exercises as appropriate.			
5.Use of massage with essential oils as necessary.			
6.Help the patient to identify their preferences in relation to the activities.			
7.Limit environmental stimuli (noises and lights) in order to promote relaxation.			
8.Encourage alternate periods of rest and activities.			
9.Offer complementary resources (music).			
Intervention-control of delirium and dementia	Morning	Afternoon	Night
1.Continuously monitor the neurological status.			
2.Allow patient to maintain their rituals to limit anxiety.			
3.Encourage visits of people that are important to the patient.			
4.Guide the patient in relation to the person, place, and time if necessary.			
5.Use environmental indicators (photos, colors, objects) that stimulate memory.			
6.When approaching a patient, come closer slowly and preferably from ahead.			
7.Provide appropriate lighting (not excessive).			
8.Express verbal and non-verbal interest for the patient.			
9.Avoid questions that the patient is unable to answer.			
Psychological dimension			
Identification of the stages of Kübler-Ross	Within the 24 hours		
1. Signs of denial			
2. Signs of anger			
3. Signs of bargaining			
4. Signs of depression			
5. Signs of acceptance			
Intervention-psychological care	Morning	Afternoon	Night
1.Actively listen to the patient and request psychological service.			
2.Promote family involvement.			
3.Allow the patient to actively express their feelings and wishes			
4.Keep an effective communication between the team and the patient.			
5.Promote a relationship of trust with the family.			
Social dimension			
Intervention-support to patient and family members	Morning	Afternoon	Night
1.Assess the emotional reaction of the family to the condition of the patient.			
2.Listen to the concerns, feelings, and doubts of family members.			
3.Facilitate communication between family members.			
4.Accept the values of the patient and family with no judgments.			
5.Answer all the questions made by family members and patient jointly with the multidisciplinary team.			
6.Help the family the solve value conflicts.			
7.Teach the care plans to the family.			
8.Provide the necessary knowledge to family members who will participate in the decision making.			
9.Create opportunities for visits of people desired by the patient.			
10.Guide the patient and their families in relation to the advance directives of will.			
11.Promote attitudes aiming at protecting the rights of the patient.			
12.Avoid procedures that prolong their suffering.			

continue

continuation

Spiritual dimension			
Intervention-spiritual support	Morning	Afternoon	Night
1. Use effective communication to establish trust and care with empathy.			
2. Treat the patient with dignity and respect.			
3. Encourage the participation in interactions with family and friends.			
4. Offer privacy for spiritual activities.			
5. Facilitate the process of forgiveness within the family and social circle.			
6. Organize visits of spiritual advisor.			
7. Encourage the use of spiritual resources, when desired (Eucharist, anointing of the sick, holy water, recitation of the rosary, prayers, anointing oil, and fluidic water). Specify: _____			
8. Provide spiritual music, literature, or TV/radio shows to the patient.			
9. Being with the patient regarding their religious rituals.			
Interventions in the act of terminality	Morning	Afternoon	Night
1. Remain physically close to the patient when they are scared.			
2. Make changes in the environment based on the needs and desires of the patient (care with windows, ambient sounds, temperature).			
3. Respect specific requests of care made by the patient and their family members.			
4. Support the family efforts to stay with the patient.			
5. Include family members in the decision making and care activities, if desired by them.			
Intervention-postmortem care	Time: _____		
1. Remove all drains, probes, and accesses.			
2. Clean the body, if necessary.			
3. Put in dentures, if possible.			
4. Close the eyes of the patient.			
5. Cover any puncture marks with cotton and a spatula, completely hiding them.			
6. Keep the correct body alignment.			
7. Offer support and listen to family members during the length of stay and after burial through telephone contact.			
8. Identify the patient with a two-copy label containing name, age, date of death, time of death, and ward) to be placed on the chest of the patient e on the external human remains pouch (HRP).			
9. Organize, protocol, and deliver the belongings of the patient to the family.			
10. Guide the family in relation to the death certificate provided and filled by the attending physician (deliver the yellow copy and instruct them to go to a notary's office within 15 days).			
11. Transfer the patient to the morgue.			
12. Record the adopted measures in the patient's record.			