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Case Report

Nursing care plan for people with heart failure in palliative care: case study

Plano de cuidados de enfermagem para pessoa com insuficiência cardíaca em cuidados paliativos: estudo de caso

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ABSTRACT

Introduction: Heart failure (HF) is significant due to its prevalence, hospitalization, and morbidity and mortality rates, and the impact the disease has on the lives of people, their families and the health system. Although advances in treatment have improved clinical conditions, people with HF can progress to the most severe stages, requiring palliative care.

Objective: To draw up a proposal for a nursing care plan based on the Basic Human Needs Theory for people with HF in palliative care.

Method: Case study, with a person with HF, using the instruments: nursing consultation, Barthel Index, Edmonton Symptom Scale, Diagnosis, Results and Nursing Interventions, analyzed and classified based on the references of the Basic Human Needs Theory and Total Pain.

Results: Based on clinical reasoning and the Outcome-Present State-Test model, eight diagnoses were prioritized to make up the nursing care plan.

Discussion: Clinical assessment based on theoretical references, scientific methods and standardized nursing classifications contributes to the best evidence, the development of clinical reasoning and the development of effective nursing care plan for people with HF.

Conclusion: Clinical, logical, critical, and analytical reasoning facilitated the development of a care plan aligned with the multidimensional demands presented by the patient.

Keywords: Heart Failure; Palliative Care; Nursing Care; Case Reports; Brazil.

RESUMO

Introdução: A Insuficiência Cardíaca (IC) assume relevância pelas suas taxas de prevalência, de internação, de morbimortalidade e os impactos da doença na vida das pessoas, de seus familiares e do sistema de saúde. Embora os avanços no tratamento tenham proporcionado melhoria das condições clínicas, pessoas com IC podem progredir para os estágios mais graves, necessitando de cuidados paliativos.

Objetivo: Elaborar uma proposta de plano de cuidados de enfermagem fundamentado na Teoria das Necessidades Humanas Básicas para pessoas com IC em cuidados paliativos.

Método: Estudo de caso, com uma pessoa com IC, por meio de instrumentos: consulta de enfermagem, Índice de Barthel, Escala de Sintomas de Edmonton, Diagnóstico, Intervenções e Resultados de Enfermagem, analisados e classificados com base nos referenciais da Teoria das Necessidades Humanas Básicas e da Dor Total.

Resultados: A partir do raciocínio clínico e do modelo Outcome-Present State-Test, priorizou-se oito diagnósticos para compor o plano de cuidados de enfermagem.

Discussão: A avaliação clínica fundamentada em referencial teórico, métodos científicos e classificações padronizadas de enfermagem contribui para as melhores evidências, para o desenvolvimento do raciocínio clínico, para a elaboração do plano de cuidados de enfermagem eficaz à pessoa com IC.

Conclusão: O raciocínio clínico, lógico, crítico e analítico permitiu a elaboração do plano de cuidados congruentes às demandas multidimensionais apresentadas pelo paciente.

Palavras-chave: Insuficiência Cardíaca; Cuidados Paliativos; Cuidados de Enfermagem; Estudo de Caso; Brasil.

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INTRODUCTION

In Brazil, studies have shown that the country is experiencing an epidemic of Chronic Non-Communicable Diseases (CNCDs) and that the impacts of this transition are enormous[1,2].

Among the CNCDs, special attention should be paid to Heart Failure (HF), which is characterized by being the final route of many cardiovascular diseases and is characterized by insufficient blood pumping, or adequate pumping at the expense of high filling pressures, resulting in hemodynamic changes such as reduced cardiac output and/or high filling pressure, at rest or on exertion[3].

It is a serious syndrome that affects more than 23 million people worldwide, and survival five years after diagnosis can be as low as 35%[3].

Although advances in treatment have improved clinical conditions, people with HF may progress to the most severe stages of the disease, thus requiring the work of a multi-professional team and the implementation of palliation actions[3–5].

Palliative care consists of an approach aimed at improving the quality of life of patients and their families in the face of a life-threatening illness and aims to prevent and relieve suffering through early identification, correct assessment and treatment of pain and other physical, social, psychological, and spiritual symptoms[6].

Thus, the palliative approach should focus on communication, shared decision-making, advance care planning, symptom control, psychological and spiritual care and providing a support system to help families and caregivers deal with the patient's entire journey[7].

From this perspective, Total Pain encompasses not only physical suffering, but also psychological, social, and spiritual aspects, and can be better diagnosed and treated using the biopsychosocial care model[8].

In view of the above, the Basic Human Needs Theory was adopted[9]. The proposed theoretical model is based on the laws of balance (homeostasis), adaptation and holism and focuses on the manifestations of Basic Human Needs, which are common to all human beings. The Theory used the following classification system: Psychobiological Needs; Psychosocial Needs; Psychospiritual Needs and these needs are interrelated.

The aim of the study was to draw up a proposal for a nursing care plan based on the Basic Human Needs Theory for people with heart failure in palliative care.

METHOD

A case study that aims to observe one or more individuals with the same illness or event, and, based on the analysis and description of these cases draw up a profile of their main characteristics. In this type of study, the conclusions cannot be generalized; however, due to the depth with which they are explored, they can be compared with similar situations[10].

The study was carried out in 2023, with a participant diagnosed with HF, living in a municipality in the south of Minas Gerais. The inclusion criteria were people aged 18 or older with a diagnosis of HF, registered with the Chronic Conditions: Innovative Care extension program. The aim of this program is to develop longitudinal care actions for people with chronic conditions. People eligible for palliative care according to the Supportive and Palliative Care Indicators Tool SPICT-BR™[11] since this tool helps to recognize the patient for palliative care and care planning. Non-inclusion criteria were people registered with the Extension Program who were hospitalized during data collection. Of the five possible participants with HF for the present study accompanied by the outreach program, four died, and one participant met all the inclusion criteria.

The data was collected by the authors, who have experience in data collection and clinical assessment, through four previously scheduled home visits between January and March 2023, lasting an average of 60 minutes, using interview techniques, participant observation, a field diary, and a physical examination. The following instruments were used: nursing consultation[12]; the Barthel Index[13], the result of which allows the assessment of the patient's performance in carrying out tasks independently, with some help or dependently; the Edmonton Symptom Assessment Scale[14], a tool used to identify common symptoms in palliative care patients. The taxonomy of the North American Nursing Diagnoses Association (NANDA-I)[15] was also used to define nursing diagnoses, the Nursing Intervention Classification (NIC) for interventions[16] and the Nursing Outcomes Classification (NOC)[17] for expected outcomes.

The study was carried out in the following stages: application of the nursing consultation tool; assessment of dependency using the Barthel Index and application of the Edmonton Symptom Assessment Scale; use of Risner's reasoning to draw up nursing diagnoses and the Outcome-Present State-Test (OPT) model to identify priority nursing diagnoses; drawing up and presentation of the care plan and presentation of the care plan to the sick person and their family members.

The study was approved by the Ethics Committee under CAAE nº 64730822.1.0000.5142 and Decision nº 5 812 054. To guarantee anonymity, the participant's name was replaced by the pseudonym Paulo.

RESULTS

Following the proposed objectives and methodological criteria, the result of the SPICT-BR™ was first presented, the

case, the compromised needs, the nursing diagnoses, and the nursing care plan.

Regarding the result of applying the SPICT-BR™ instrument, Paulo (pseudonym) experienced a decline in health with unscheduled hospital admissions, poor functional capacity, dependent on others for care, loss of body mass, persistent symptoms despite treatment and presence of the following associated comorbidities: heart failure, diabetes mellitus, systemic arterial hypertension and chronic renal failure and recent history of pleural effusion, according to the discharge summary.

Paulo, white-skinned, 54 years old, 170 cm tall, retired due to disability, is the third of five children, three men and two women, and lives with his wife and two children aged 12 and 14. They live in their own house, made of brick, with two bedrooms, a kitchen, and a bathroom, with an income of one minimum wage. He mentions many financial difficulties to support his family and his treatment. His wife doesn't work outside the home because she is his main carer and relies also on the children to look after him at home. His mother died 15 years ago, of an unknow cause, but he reports she had "a lot of shortness of breath". Paulo says he is the only one in the family who is ill. Prior to his illness, he had always been healthy, despite having high blood pressure since the age of 30, when he was diagnosed, but it didn't bother him to work as a bricklayer's assistant, he grew vegetables for consumption and occasionally worked in the fields during harvest periods. Currently, because of his illness, he no longer leaves the house except for treatment and hospitalizations and rarely receives visits from family members.

He appeared sad, uncommunicative, spoke quietly, answered only what he was asked, his voice was broken by fatigue and dyspnea, and during conversation he rubbed one hand against the other. His skin is discolored and slightly jaundiced, he has anasarca, a distended abdomen, and he is continuously using oxygen at 3 l/min via a goggles-type catheter. There were two flictomas on the backs of his lower limbs due to edema, and the one on the lower limbs was bulky and has ruptured over the days. He sits in a chair day and night and naps from time to time; he cannot rest in the prone position, even with the help of three pillows; he constantly complains of feeling unwell, nausea even when taking medication, which makes it difficult for him to eat, and has gastrointestinal discomfort, with a feeling of stuffiness. He cannot stand up, complains of dizziness, and has no balance. He moves around in a wheelchair and is dependent on care for basic activities of daily living. Three months ago, he fell from his own height when trying to get up to go to the toilet.

He reports that at the age of 40 he went to the health service complaining of feeling unwell and very weak, and that is when he discovered that he had diabetes mellitus. He was treated with oral hypoglycemic drugs, but he cannot remember the name, and after a year or so he had to start using insulin. At first, he applied it himself, but over time and because of his difficulties, his wife did it. After a while, he started to get very tired, reporting that he could not work anymore, and then he retired, and it only got worse. He was hospitalized because of the tiredness and shortness of breath. When he came out, he was better, without oxygen, but gradually he lost his strength, and he could not work anymore, and always had to be hospitalized. Towards the end of the year, he got worse, the shortness of breath came on and the swelling got worse, so they took him to hospital. He was hospitalized, and they ordered him to undergo treatment (renal replacement therapy), but it does not seem to be getting any better, he feels short of breath a lot, does not sleep, and gets very nauseous. He is undergoing hemodialysis treatment four times a week, refuses to eat due to nausea, and when he does eat, he reports a low intake of fruit and vegetables, and complains of constipation, 2-3 times a week, whereas before his bowel movements were daily. He drinks 500 ml of water and has oliguria. He has been hospitalized five times in the last four months due to dyspnea and fatigue. He is lucid and oriented in time, space, and person. He denies previous surgeries, alcohol consumption and is unaware of allergies. Claims to have had COVID 19 a year ago. Risk factors include being an ex-smoker for 10 years and non-practitioner of physical activity.

During the conversation, it was found that Paulo does not understand the disease, the complexity of the comorbidities and the purpose of the treatment, even because he does not notice any improvement.

Physical examination: serious general condition, conscious, lucid, oriented in time, space, and person, with no memory alteration. Physical mobility affected. Lower limbs with reduced strength and impaired gait, edema, loss of balance, unable to walk unaided, upper limbs with loss of strength. Dyspneic, using O_2 at 3 l/min for 24 h, although he feels very short of breath, pulmonary auscultation with physiological vesicular murmurs on the right and diminished on the left with the presence of crackling adventitious noises and a dry cough. Reduced visual acuity on the right and preserved hearing acuity. Jugular turgor ++/4+ at 45°, irregular and filiform carotid and pedicle pulse, capillary refill time > 2 sec, cold extremity, cardiac auscultation with hypophonetic arrhythmic sounds with systolic murmur, palpable ictus in the 6th intercostal space, abdomen globose, tense, ascitic, with hypoactive hydroaerial sounds, liver palpable three centimeters from the right costal margin. Mucous membranes dry and hypochromic. Non-integral skin with the presence of a large flictena on the back of the right lower limb at stage

2, with drainage of a small amount of serous exudate and a small flictena on the left lower limb.

The results of the laboratory tests for urea, creatinine, potassium, and troponin showed values above the reference parameters, while the values for platelets, hemoglobin and hematocrit, vitamins and iron were below the parameters, contributing to an understanding of the clinical picture and suggesting severe impairment of the renal and cardiac systems and which, combined with the patient's history and physical examination, demonstrate the need for a care plan appropriate to these demands.

Biopsychobiological needs: He needs help with elimination, hygiene, and dressing, but can eat by himself. He cannot self-apply insulin. He reports no sexual activity due to fatigue, reduced strength, and dyspnea. He is currently unable to move from one room to another and has felt no relief with the use of oxygen. He says that this condition affects his whole life because he depends on his family for care. He feels uncomfortable with his state of health and the conditions of his illness and sees no improvement in his condition.

Psychosocial needs: teenage children help with his care, he usually only leaves the house for appointments and hemodialysis, rarely receives visits from family members, has depressive symptoms, is poorly informed about his health problem and the purpose of his treatment, and is worried about his family, mainly because of their financial difficulties. He reports being discouraged with life, because everything has been very difficult, before the illness he worked and left the house.

Psycho-spiritual needs: He declares himself as Catholic, but because of his illness he feels discouraged with life, as he says, "it is very difficult". He refers to God as something sacred in his life.

According to the needs, the nursing diagnoses were drawn up using Risner's two stages of diagnostic reasoning, whereby in the first (analysis and synthesis), the data was mentally analyzed and in the second (labeling), the nursing diagnoses were established. In this phase, 27 nursing diagnoses were drawn up and the OPT model (Outcome-Present State-Test) was used to establish the priority diagnoses, resulting in eight nursing diagnoses, the respective interventions and the expected results, which will be presented below: (ineffective coping, sixteen interventions and eight expected outcomes); (impaired physical mobility, thirteen interventions and four expected outcomes); (fatigue, fifteen interventions and six expected outcomes); (decreased cardiac output, twenty-five interventions and ten expected outcomes); (impaired social interaction, four interventions and five expected results); (impaired religiosity, sixteen interventions and twelve expected results); (spiritual suffering, nineteen interventions and six expected results) and (impaired comfort, fifteen interventions and nine expected results) which supported the care plan, shown in Figure 1. It should be noted that some of the interventions in the care plan were carried out by the authors, while the others were carried out by members of the outreach program. Figure 2 presents the nursing diagnoses based on the theoretical references proposed by the Basic Human Needs Theory and Total Pain.

It was understood that the Basic Human Needs Theory encompasses the multidimensionality of the concept of Total Pain proposed by Cicely Saunders, covering not only physical symptoms, but spiritual suffering and the social context experienced by Paulo, allowing us to understand the suffering experience from of a holistic approach.

DISCUSSION

Drawing up a proposed care plan based on the Basic Human Needs Theory, using the nursing classification and Risner's reasoning for people with advanced heart failure in palliative care allowed us to identify psychobiological, psychosocial and psychospiritual needs to propose interventions that are more consistent with these needs.

The manifestations of dyspnea, fatigue, nausea, gastrointestinal discomfort, oxygenation deficit and edema included in the psychobiological needs are recurrent in people with HF and converge with the results found in the literature[18]. It should also be noted that a lack of knowledge about the disease is also an influencing factor in dependence on family members and in the difficulty of maintaining and controlling lifestyle habits[18,19]. These manifestations demand care because they greatly compromise basic activities of daily living.

Concern for the family, lack of financial resources and depressive symptoms are related to psychosocial needs, which are quite common in people with HF, especially in the more advanced stages of the disease Drawing up a proposed care plan based on the Basic Human Needs Theory, using the nursing classification and Risner's reasoning for people with advanced heart failure in palliative care allowed us to identify psychobiological, psychosocial and psychospiritual needs in order to propose interventions that are more consistent with these needs.

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Nursing Care Plan

ND: Impaired Physical Mobility (00085) related to decreased muscle strength and control and activity intolerance characterized by dyspnea on exertion, movement-induced tremor, loss of balance and falling.

Expected Results: 0208 Mobility: Improve balance, coordination, gait and transfer performance indicators.

Intervention: 0201 Exercise Promotion: Training for Strength

Help Paulo express his own beliefs, values, and goals regarding muscular fitness and health; to help him develop a strength training program compatible with the level of muscular capacity, musculoskeletal limitations, functional health goals, exercise equipment resources, personal preference and social support; specify the level of resistance, the number of repetitions, the number of sets and the frequency of "training" sessions according to the level of capacity; to advise him to recognize signs/symptoms of exercise tolerance/intolerance during and after sessions; to advise him to slowly extend the muscle/joint to the point of complete stretch (or reasonable discomfort), to hold for a specified time and to slowly release the stretched muscles; re-evaluate the exercise plan together with a physiotherapist if there are symptoms of low tolerance.

1800: Self-care assistance

– Help Paulo to accept his dependency needs; encouraging him to carry out some activities of daily living, according to his level of ability, creating routines and setting short- and long-term goals;

1805: Self-care assistance: Essential Activities of Daily Living

– Obtain tools to help with activities of daily living (ability to reach items in cupboards and bathrooms); guide Paulo and the caregiver on what to do if Paulo suffers a fall or other injury;

1806: Self-care assistance: transferring

– Determine Paulo's current ability to self-transfer (level of mobility, movement limitations, endurance, ability to cooperate, ability to understand instructions and select the appropriate transfer technique; prevent injuries during transfer; assess him at the end of the transfer for level of comfort.

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ND: Fatigue (00093) related to decreased cardiac output and lack of nutrients characterized by altered concentration, apathy, tiredness, insufficient energy, non-restorative sleep pattern and dyspnea.

Expected Results:0007 Fatigue Level: Improvement in indicators of exhaustion, decreased motivation, feeling unwell after exertion, activities of daily living, quality of rest and quality of sleep.

Intervention: 0180 Energy Control

– Encourage verbalization of feelings about limitations; use validated instruments to measure fatigue; correct deficiencies in the physiological condition such as anemia; select interventions to reduce fatigue using combinations of pharmacological and non-pharmacological categories; monitor nutritional intake to ensure adequate consumption of energy resources; monitor the cardiorespiratory response to activity (e.g., tachycardia, other arrhythmias, dyspnea, diaphoresis, pallor, respiratory rate); monitor/record sleep pattern and number of hours slept; help prioritize activities to accommodate energy levels; promote bed rest/activity limitation (e.g., increase the number of rest periods), taking into account the rest time chosen by him; offer auxiliary methods to promote sleep; monitor Paulo's response to oxygen, assessed through pulse rate, heart rate, and respiratory rate to self-care or nursing activities; help him to sit on the edge of the bed and swing his legs if he cannot walk or be moved; guide Paulo and his significant other on other self-care techniques that will minimize oxygen consumption; guide Paulo and his significant other on recognizing signs and symptoms of fatigue that require reducing activities; on stress and interventions to reduce fatigue and notify the nursing professional.

Figure 1. Nursing care plan for people with heart failure. Alfenas, MG, Brazil, 2023.

Nursing Care Plan

ND: Decreased Cardiac Output (00029) related to the heart's difficulty in maintaining output and ejection fraction characterized by decreased ejection fraction, jugular vein distension, edema, stuffiness, nausea, hypochromic mucous membranes, oliguria, fatigue and dyspnea.

Expected Results: 3106 Self-management of Heart Failure: Improvement of indicators participate in control decisions and accept the diagnosis; monitor respiratory rate, heart rhythm, dyspnea, blood pressure, edema and its complications; carry out the prescribed diet and therapeutic regimen; use energy conservation technique; balance activity and rest; use pulse oximetry monitor; get seasonal flu and pneumonia vaccine; use oxygen correctly at home; report depressive symptoms and get assistance; keep appointments with health professionals.

Intervention: 4046 Cardiac Care: Rehabilitation

– Encourage realistic expectations for Paulo and the family; guide Paulo and the family on wound care and precautions; coordinate referrals to nutrition, social and physiotherapy services; assess for anxiety and depression.

4062 Circulatory Care: Arterial Insufficiency

– Monitor the degree of discomfort with exercise, at night, or while resting; monitor fluid status, including intake and elimination due to CRF.

6680 Monitoring Vital Signs

– Monitor blood pressure, pulse, temperature, respiratory status, skin color and humidity; observe trends and wide swings in blood pressure; monitor heart rate and rhythm; monitor pulse oximetry.

3320 Oxygen therapy

Administer supplementary oxygen as prescribed; monitor oxygen flow; monitor the effectiveness of oxygen therapy; advise Paulo and his family on the use of oxygen at home.

1850 Sleep improvement

Encourage him to establish a bedtime routine to facilitate the transition from wakefulness to sleep; promote an increase in the number of hours of sleep, as necessary; provide naps during the day, if indicated, to meet sleep needs; seek positions that help improve discomfort; discuss techniques for improving sleep with Paulo and his family.

0840 Positioning

– Position in semi-fowler's position to relieve dyspnea or elevate the headboard with three pillows.

1100 Nutrition Control

– Determine food preferences; administer medication before eating (antiemetic); encourage consumption of favorite food; advise on dietary requirements for the disease state; offer nutritious snacks.

ND: Impaired Social Interaction (00052) related to housing restriction, little contact with family and friends characterized by depressive symptoms, impaired social function and dissatisfaction with social involvement.

Expected Results: 1504 Social support: Improved indicators of trusting relationships; people who can help as needed; social network of assistance; supportive social contacts; stable social network.

Intervention: 5480 Clarification of values

Consider the ethical and legal aspects of a free choice, given the specific situation, before starting the intervention; use appropriate questions to help Paulo reflect on the situations and on what is really important; support him during the communication of his own values to other people; encourage him to make a list of what is important and not important in life and the time spent on each of the activities listed.

Figure 1. Cont.

Nursing Care Plan

ND: Ineffective Coping (00069) related to the unpredictability of the disease and lack of results in treatment characterized by altered sleep patterns, altered concentration, fatigue, inability to meet basic needs and changes in communication patterns.

Expected Results: 1302 Coping: Improvement of the indicators identify effective coping patterns, verbalize acceptance of the situation, seek reliable information on diagnosis and treatment, adapt to life changes, use personal support system, verbalize need for assistance, report decreased negative thoughts and report increased psychological comfort.

Intervention: 5250 Decision-making support

– Help Paulo clarify values and expectations that can be useful in making important life choices; inform him about alternative points of view or solutions in a clear and supportive way;

5270 Emotional Support

– Discuss the emotional experience(s); explore with Paulo what triggered the feeling; encourage him to express his feelings of anxiety, anger, or sadness; listen to and encourage the expression of feelings and beliefs; facilitate the identification of Paulo's habitual response pattern when facing fear

5230 Improving Coping

– Assess Paulo's understanding of the disease process; evaluate and discuss alternative responses to the situation; use a calm, reassuring approach; provide an accepting environment; provide factual information about diagnosis, treatment and prognosis; give him realistic options about certain aspects of care; encourage an attitude of realistic hope as a way of coping with feelings of helplessness; assess decision-making capacity; encourage family participation as appropriate; encourage the family to verbalize feelings about Paulo.

ND: Impaired Religiosity (00169) related to anxiety, excessive suffering, depressive symptoms, spiritual suffering, lack of results in treatment and unpredictability of the disease, characterized by difficulty in reconnecting with the previous pattern of belief and questioning of religious habits.

Expected Results: 2011 State of Comfort: Psycho-spiritual: Improvement in indicators of psychological well-being, faith, hope, goal setting, meaning and purpose of life, spiritual satisfaction. Reduced stress, depressive symptoms, anxiety, fear, loss of faith and sense of spiritual abandonment.

Intervention: 5420 Spiritual Support

– Use therapeutic communications to establish trust and empathic care; use tools to monitor and evaluate spiritual well-being; encourage Paulo to review the past and focus on the events and relationships that have provided spiritual strength and support; treat him with dignity and respect; encourage his participation in interactions with family, friends, and others; encourage moments of privacy and quiet for spiritual activities; organize visits from the spiritual advisor; pray with him; provide spiritual music or radio and TV programs; be open to his expressions of loneliness and helplessness; encourage the presence of the chapel service, as desired; encourage the use of spiritual resources, as desired; provide the desired spiritual articles, according to individual preferences; refer him to the chosen spiritual advisor; be open to his feelings about illness and death; help him express and relieve anger, in an appropriate way.

Figure 1. Cont.

Nursing Care Plan

ND: Spiritual Suffering (00066) related to excessive suffering, depressive symptoms, unpredictability of the illness, characterized by anxiety, questioning the meaning of life and verbalization of suffering.

Expected Results: 1307 Ending Life with Dignity: Participates in decisions about hospitalization, maintains current wishes, maintains advance directives, discusses spiritual experiences and concepts, controls choices about treatment, food and drink intake and expresses preparedness for death.

Intervention: 5240 Counseling

Show empathy, warmth and authenticity; establish the duration of the counseling relationship; provide factual information as necessary and appropriate; encourage the expression of feelings; assist in identifying the problem or situation that is causing the distress; ask Paulo and significant others to identify what they can and cannot do about what is happening.

5260 Assistance in Dying

- Identify Paulo's care priorities; communicate the desire to discuss death; encourage Paulo and his family to share feelings about death; help them identify a shared meaning of death; seek to understand actions, feelings and attitudes; monitor anxiety, deterioration of physical and/or mental abilities; respect Paulo's and the family's specific requests for care; include the family in care decisions and activities, as desired; support them in the stages of grief; monitor pain; medicate by alternative means when there are swallowing problems; offer fluids and soft food frequently; facilitate obtaining spiritual support for Paulo and the family.

ND: Impaired Comfort (00214) related to the unpredictability of the disease, lack of results in treatment, dyspnea, fatigue, and spiritual suffering characterized by anxiety, discontent with the situation, regret, symptoms of suffering and altered sleep pattern.

Expected Results: 2109 Level of Discomfort: Improve indicators of fear, anxiety, dyspnea, and nausea, suffering, depressive symptoms, difficulty breathing, feelings of hopelessness and spiritual abandonment.

Intervention: 6482 Environmental Control: Comfort

- Determine Paulo's and his family's goal for environmental control and optimal comfort; avoid unnecessary interruptions and allow for rest periods; create a calm and welcoming environment; provide a clean and safe environment; provide, whenever possible, a choice of social activities and visits; determine the cause of discomfort; adjust the room temperature to the most comfortable, if possible; provide or remove blankets to promote thermal comfort; avoid unnecessary exposure to drafts, extreme heat; adjust lighting to meet his needs, avoiding direct light in his eyes; facilitate specific hygiene measures to keep him comfortable (e.g., wiping his forehead, applying skin creams, or cleaning their body, hair and oral cavity); position him to facilitate comfort (e.g., using the principles of body alignment, supporting the body with pillows, supporting the joints during movement, protecting the incision area and immobilizing the painful region); monitoring the skin for signs of pressure or irritation, especially on bony prominences; avoiding exposure of the skin or mucous membranes to irritants; providing relevant and useful educational resources regarding disease and wound management.

Figure 1. Cont.

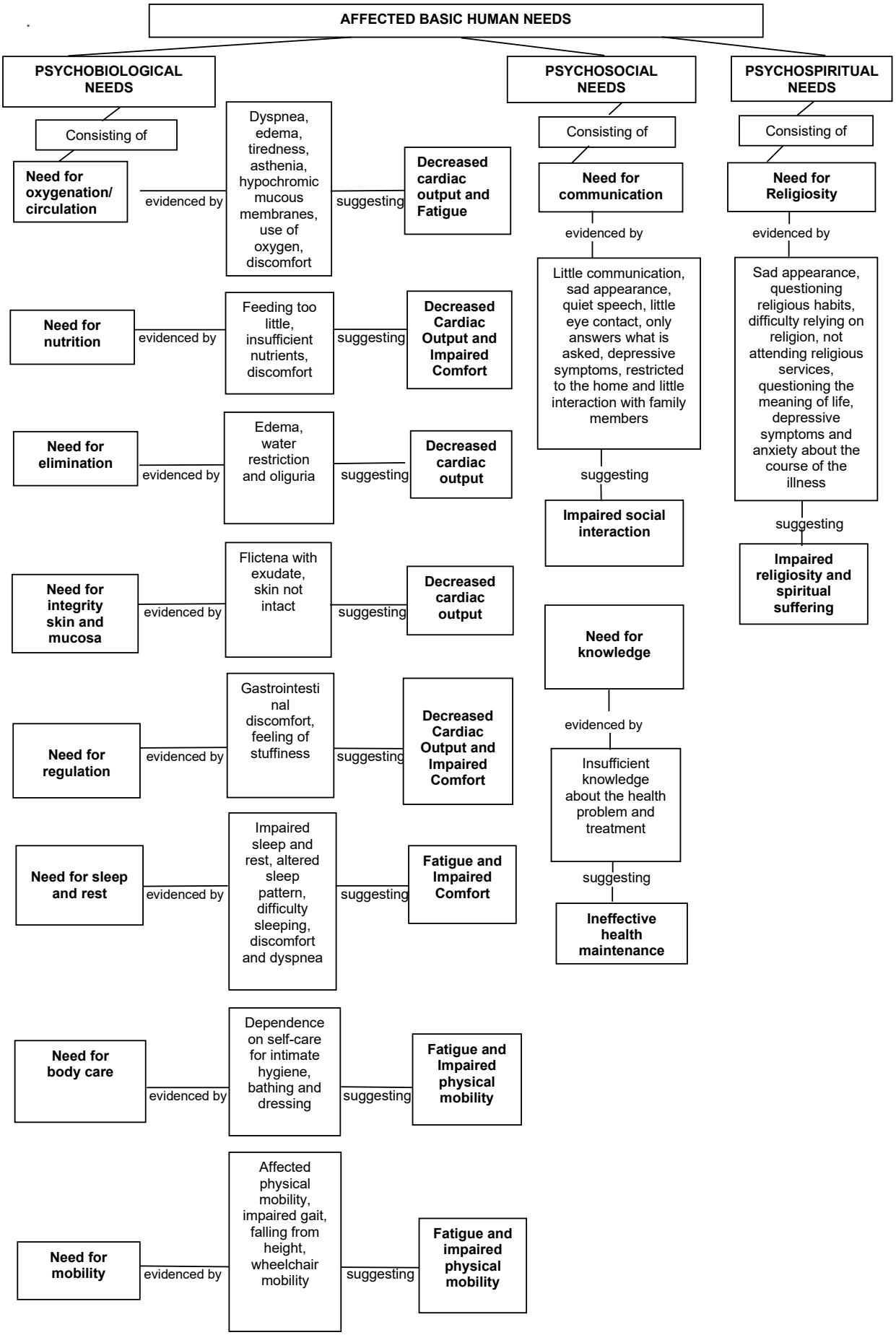

Figure 2. Affected Basic Human Needs, Total Pain, and Nursing Diagnoses for people with Heart Failure. Alfenas, MG, Brazil, 2023.

family members and in the difficulty of maintaining and controlling lifestyle habits[18,19]. These manifestations demand care because they greatly compromise basic activities of daily living.

Concern for the family, lack of financial resources and depressive symptoms are related to psychosocial needs, which are quite common in people with HF, especially in the more advanced stages of the disease[18, 20].

The limitations imposed by the change in lifestyle, the inability to carry out activities of daily living, frequent hospitalizations, the interruption of professional activities and the consequent reduction in income, are factors that provoke negative feelings, as also found in another study (21).

Although Paulo considers God to be sacred, he feels discouraged and unbelieving about life, evidencing that the psycho-spiritual need is a dimension that needs to be recognized and encouraged by health professionals because it contributes to reducing anxiety and better coping with the disease and treatment.

A study aimed at evaluating the connection between spirituality and the reduction of symptoms faced by patients in palliative care, such as spiritual distress, anxiety, depression, and pain, found that the palliative care environment was considered adequate to provide spiritual support, which is essential for patient care[22].

Authors corroborate this recommendation since people with irreversible and unpredictable conditions resulting from advanced HF and the high burden of physical symptoms combined with psychosocial and spiritual distress should be directed to palliative care[23, 24]. The aim of palliative care is to relieve the suffering of patients and their families, promoting comfort, control of psychological symptoms and satisfaction with care, reducing hospitalization rates and improving quality of life[23, 24]. Furthermore, they assist in advance care planning, patient preferences, and reduction of exacerbation of physical symptoms[21].

From this perspective, studies have concluded that palliative care interventions have benefited both patients with advanced heart failure and their caregivers in several important areas, such as improving general and disease-specific quality of life, controlling psychological symptoms, satisfaction with care, reducing hospitalization rates and caregiver burden[23, 24].

From an understanding of the complexity of the case and the aspects that directly impact the patient's quality of life, the multidimensional approach to pain becomes necessary to integrate needs in four contexts: physical, psycho-spiritual, social, and environmental[25, 26].

The multi-professional team plays an important role in implementing palliative care for people with advanced HF, as care focuses not only on relieving symptoms, but on improving quality of life, providing emotional and spiritual support, helping to plan care with the participation of the patient and their family, facilitating the transition to end-of-life care.

The nurse is responsible for the clinical assessment of the person as a way of identifying, through scientific methods, real and potential problems and drawing up an appropriate care plan with a view to promoting, maintaining, and recovering symptoms and improving quality of life. This method, when added to the standardized nursing classifications, helps to develop a nurse with critical thinking and diagnostic reasoning, favoring greater evidence and effective methods for the patient, contributing to evidence-based practice[27].

Nursing interventions provide the necessary support, adherence to treatment, prevent complications, control symptoms, increase comfort, and provide information about the state of health, enabling patients and their families to feel more secure and take ownership of care choices[28]. We reiterate the importance of a care approach that listens attentively and carefully analyzes the patient's complaints, allowing them to understand that pain goes beyond physical sensations, providing access to new dimensions of suffering and methods of comforting them [25, 26].

CONCLUSION

Clinical, logical, critical, and analytical reasoning in the identification of problems, based on the standardized nursing classification, Risner's reasoning and the OPT model, grounded in scientific knowledge, the Basic Human Needs Theory, and the Total Pain framework, allowed us to draw up a care plan that was congruent with the multidimensional demands presented by Paulo.

The complex problems faced by people with HF require interprofessional work to achieve the best results.

In this context, nurses, as innovative professionals who transform the care process, play a crucial role in the care of people with HF in palliative care, because they continuously monitor the patient's symptoms and state of health, offer support, educational information and create a dialogical space to listen to the fears, insecurities and concerns of patients and their families.

To this end, it requires professionals to have scientific knowledge and the sensitivity to perceive human beings as agents of their life story, with a view to providing care that is congruent with their needs and values, promoting comfort in all its dimensions.

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