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RESEARCH

# The process of dying/death: intervening conditions to the nursing care management

*Processo de morte/morrer: condições intervenientes para o gerenciamento do cuidado de enfermagem*

*Proceso de muerte/morir: condiciones intervinientes para el manejo del cuidado de enfermería*

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**ABSTRACT**

**Objective:** To exhibit the factors that influence the Nursing care management in the face of death and the process of dying/death of hospitalized adults in the medical-surgical units for hospitalization. **Method:** The Grounded Theory was applied with the theorical support of the Complex Thinking Theory. Data have been collected through semi-structured interviews from May, 2015 to January, 2016 with three sample groups totaling 41 participants: nurses, assistant nurses and members of multidisciplinary group. Data analysis followed the steps of open coding, axial coding and selective coding. **Results**: The category "Pointing out the interfaces of care management to patients in process of death/dying and their families" and its respective subcategories show the complex interactions established by the nurse due to the Nursing care management. **Final considerations:** Subjective, educational, sociocultural and institutional conditions influence the nurse interactions, causing order/disorder on care management.

**Descriptors:** Nursing; Sciences; Health Management; Death; Attitude in the Face of Death.

**RESUMO**

**Objetivo:** Desvelar os fatores que influenciam o gerenciamento do cuidado de enfermagem diante da morte e do morrer de adultos hospitalizados em unidades de internação médico-cirúrgicas **Método:** Adotou-se a *Grounded Theory*, com o aporte teórico do Pensamento Complexo. Os dados foram coletados por meio de entrevistas semiestruturadas, no período de maio de 2015 a janeiro de 2016, com três grupos amostrais, totalizando 41 participantes: enfermeiros, técnicos de enfermagem e membros da equipe multidisciplinar. A análise dos dados seguiu as etapas de codificação aberta, axial e seletiva. **Resultados**: A categoria "Apontando interfaces do gerenciamento do cuidado aos pacientes em processo de morte/morrer e às suas famílias" e suas respectivas subcategorias apresentam as complexas inter-ações estabelecidas pelo enfermeiro frente o gerenciamento do cuidado de enfermagem. **Considerações finais:** Condições de âmbito subjetivo, educacional, sociocultural e institucional influenciam as interações do enfermeiro, gerando ordem/desordem no gerenciamento do cuidado.

**Descritores:** Enfermagem; Ciência; Gerência em Saúde; Morte; Atitude Frente à Morte.

**RESUMEN**

**Objetivo:** Desvelar los factores que influyen en el manejo del cuidado de enfermería ante la muerte y el morir de adultos hospitalizados en unidades de internación médico-quirúrgico. **Método:** Se adoptó la *Grounded Theory*, con el aporte teórico del Pensamiento Complejo. Los datos fueron recolectados por medio de entrevistas semi-estructuradas, en el período de mayo de 2015 a enero de 2016, con tres grupos de muestra, totalizando 41 participantes: enfermeros, técnicos en enfermería y miembros del equipo multidisciplinario. El análisis de los datos siguió las etapas de codificación abierta, axial y selectiva. **Resultados:** La categoría "Apuntando interfaces del manejo del cuidado a los pacientes en proceso de muerte/morir y a sus familias" y sus respectivas subcategorías presentan las complejas interacciones establecidas por el enfermero frente al manejo del cuidado de

enfermería. **Consideraciones Finales:** Las condiciones de ámbito subjetivo, educativo, sociocultural e institucional influyen en las interacciones del enfermero, generando orden/desorden en el manejo del cuidado.
**Descriptores:** Enfermería; Ciencia; Gerencia en Salud; Muerte; Actitud Frente la Muerte.

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## INTRODUCTION

Care, be it health or nursing, is complex, since it is dynamic and multifaceted, comprising different people (professionals, patients, family/community) that establish interaction and retroaction. It occurs among and with people in different health situations, scenarios and distinct contexts, with subjects that have different representations. Human-centered health care practices generate services through care. They also show themselves both as a process and as a product of work, in which the relationships and associations between subjects and objects of care are continually recognized and thought of in their complexity[1].

Complex thinking proposes to reconnect the dimensions of man and life, seeking to recognize the micro and macro issues involved in this relationship. Looking at the understanding of care management, according to the conceptions of complexity, the focus turns to the perspective of historical and socially constructed health practices, recognizing the uncertainties, disorders, contradictions and tensions in the context of life and work[2-3].

Human life is complex, and dealing with its terminality is also complex. In western cultures, highlighting the Brazilian reality, the meaning of death has undergone several transformations. Each society presents its own culture, with beliefs, rites and habits that give people different meanings for terminality and death, as well as mechanisms for coping with it[4-5]. DATASUS/MS, the country's official database registered in 2014 a total of 823,827 deaths in hospitals[5].

In view of this, the need to re-signify care in the hospital context, in the face of death and dying, is based on the reorientation of practices to the needs of the individuals involved, through management, care and educational actions that appreciate the act of thinking and acting of health professionals in this process. Among these, we highlight the nurses who deal with the management of nursing care in the different hospital units.

The management of care in adult medical-surgical hospitalization units is a challenge for the nurse, as it requires working with a team, in which each one has a focus, with a different way of thinking and doing. In these units, people with different pathologies are hospitalized, with various care needs, which demand different types of technologies and require each professional to be prepared to deal with the unforeseen, with the contradictions and uncertainties during their care practice. These characteristics make these care units, by nature, complex; allowing us, therefore, to understand the factors that influence the management of nursing care in the face of death and dying that occur in them, through the complexity theory.

Once defending his mindset about complexity, Morin pointed out that degradation and order are part of life, as well as death, cooperating in a way to maintain the organization of the universe. Life works with disorder, developing tolerance, combat and gain, in a relationship that is simultaneously antagonistic, competitive and complementary[2,6]. The relation between individual, society and species is dialogic, so that the complement can become antagonistic. These terms are means and aims of each other, thus explaining that the understanding of the other involves the need to grasp at the same time its identity and its difference from ourselves[6-7].

According to this thinking, the management of nursing care in the face of death and dying can be understood as a process that continually involves order, disorder and organization, in an antagonistic and complementary dynamic, as mistakes, unpredictability and uncertainties contribute to the reorganization[8].

In this sense, it is questioned: what are the intervening conditions for the management of nursing care with hospitalized adults in medical-surgical units experiencing the process of dying/death? How do these conditions influence nurses' interactions in the caring process? It is assumed that the answers to such questions do not have a linear relation of cause and effect, since it involves complex phenomena[8].

## OBJECTIVE

To understand, from the perspective of complexity, the factors involved in the management of nursing care along with adults in the process of dying/death during a hospitalization in medical-surgical units.

## METHOD

### Ethical aspects

The research was approved by the Research Ethics Committee of Escola de Enfermagem Anna Nery, Universidade Federal do Rio de Janeiro[9] on April 29, 2015. In order to guarantee anonymity, the names were replaced by the initials of the profession, followed of the respective interview number: N (nurse), NT (nursing technician), P (psychologist), SW (social worker) and P (physician).

### Design, place of study and period

This exploratory and qualitative research has as theoretical reference the Complexity Theory, from the perspective of Edgar Morin, and as a methodological reference to Grounded Theory, which in Brazil is translated as *Teoria Fundamentada nos Dados* (TFD). It is a method developed from a set of analytical resources that, systematically conducted, can generate a theoretical matrix explaining the phenomenon investigated[8,10-11].

The institution, the setting for this research, is a general public hospital, located in *Zona da Mata Mineira*, which performs ambulatory care, physical rehabilitation, hospitalization and surgery in various specialties. It is a reference institution in the southeastern macro-region of Minas Gerais state that develops assistance, research and teaching activities.

**Data collection and organization**

We adopted the semi-structured interview as a technique for data collection in all groups. The interviews were conducted in rooms chosen by the participants, in the study scenario, between May 2015 and January 2016, and recorded in digital media.

**Population or sample, inclusion and exclusion criteria**

A total of 41 participants were selected from the study, which formed three sample groups. The first consisted of 18 nursing assistants, the second by 12 nursing technicians and the third by 11 members of the multidisciplinary team, consisting of three psychologists, three social workers and five assistant physicians.

It should be pointed out that, according to the Grounded Theory, the delimitation of these groups occurred during the collection and analysis of the data, concomitantly carried out, thus signaling which other social players would be necessary for the investigation, forming new groups for the explanation of the phenomenon. Through theoretical memos, throughout the research, it was possible to raise hypotheses that revealed which other contexts (spatial or participant) the death and dying phenomenon was rooted/grounded, as proposed by the method[4].

In this sense, the delimitation of the first group was based on the understanding that the nurse is responsible for the management of nursing care. Nurses were selected to develop health care in the hospital context in the medical-surgical hospitalization of adults. Considering the specificities of care settings, a transversal perspective was sought to observe the different experiences of the process of dying/death that could influence the field of meanings of the research participants.

With the help of the memos, during the investigative process, the data raised the hypothesis that to understand the issues would be necessary to understand the multidimensionality imbued in it. This implied the need to consolidate the data from the perspective of other players that directly influenced nursing care management in the process of dying/death.

The collection was finished when reached the theoretical saturation, namely: when the categories presented explanatory density capable of answering the research questions. We included professionals working in the institution's medical and surgical hospitalization units who had two years of experience or more. Those who were separated from the service, and who did not play in the direct assistance were excluded for any reason.

**Data analysis**

The steps followed of data analysis proposed by the Grounded Theory were the open, axial and selective coding. In open coding, known as microanalysis, the data were analyzed line by line, defining the preliminary codes. They were then brought together, by similarities and differences, from the elaboration of conceptual codes. In axial coding, the data were regrouped in order to obtain a clearer explanation on the issues, to relate the subcategories to their categories, as well as to develop the properties and dimensions of the categories[8]. In the selective coding, the subcategories and categories found were continuously contrasted and analyzed with the purpose of integrating and refining them, in order to identify the central category.

The paradigmatic model was adopted to connect the categories, obtaining the understanding on the phenomenon investigated. This scheme allows an explanatory coherence between the dimensions that support the phenomenon researched. Its structure is based on the following components: phenomenon, causal conditions, intervening conditions, context, action/interaction strategies and consequences[8].

**RESULTS**

The conditions that intervene in the management of nursing care, in the face of the process of dying/death are understood from the perspective of the following theoretical model: "Looking at the management of nursing care before the process of dying/death". The observation takes place through two categories: "Aiming care management interfaces to patients in the process of dying/death and their families" and "Highlighting the aspects of the communicational process before the process of dying/death".

These are intervening conditions in the Grounded Theory that mitigate or alter the impact of causal conditions on the phenomena[10]. Both the management interfaces and the aspects related to communication reveal the multiple interfaces before the death and death of hospitalized people who have influence on the nursing care management.

This article presents the category "Aiming care management interfaces for patients in the process of dying/death and their families", which consisted of six subcategories. In the first subcategory, "Finding Facilities and Difficulties for the Management of Nursing Care to the Patient in the Process of Dying/Death", the critical judgment of the nurses was analyzed, with emphasis on the facilities and difficulties found in the course of care management.

Among the first difficulties reported for the management of care were identified the failures in communication between doctors, patients and family members, as well as the presence in the ward of other patients hospitalized in beds close to those in terminality.

> *I think it creates a great deal of stress in this, when the family is not oriented or has no opinion as to what they are going to do when the time comes.* (EA 9)

They added to these failures, such as negative interferences to the context of care management, the workload of the nursing team and the lack of integration of the multidisciplinary team.

> [...] *nursing, it is very overworked. So it is difficult for them, at times, to approach the patient or the family about death.* (MA 2)

In addition to these factors, the constant change in the professional staff of the nursing team, expressed by the participants as "turnover", was also mentioned both in relation to nursing technicians and nurses, with impacts on care.

> *And another thing that I think management is very precarious is how much the employee is not fixed in the industry. This turnover is very bad and employees are also very lost. They ask us 'Are you staying here today?' Like a 'pinch hitter'* [...] *because the place here belongs to someone else.* (EA 15)

In the scope of the facilities, the records of information in the medical records on the prognosis of the patients, the care that

should be taken or not, the conversation that the MA had with the relatives and with the patient who lived the terminality of life stood out. The possibilities of dialogue in the team, especially between the nurse and the attending physician who assisted the patient were widened, although they did not always occur.

> *Few doctors report. When they report is much easier. The on duty physician arrives to evaluate and we already have it in the medical record and it is easier to talk. They have already understood and will act just as the attending physician has already pointed out in the chart. If he talks only by word of mouth, what happens a lot, we have to try to talk with the doctor on call and there varies greatly their assistance, the conduct in these cases.* (EA 14)

The possibility of the nurse requesting the specific opinion of professionals who make up the multidisciplinary team of the institution has potentiated the management of patient care in the process of dying/death.

> *But I will not say that there is no such management, but it is more intensive when the request exists through an opinion. And the opinion is usually requested by the physician, by the medical professional, with the nursing staff being free to make the request.* (EA 16)

Therefore, the nursing care management process is related to the medical criteria for diagnosis and prognosis and communication with the families of the patients. Thus, records, or lack in the records interfered and modified the care management process.

> *In fact, it depends on the medical evaluation and the medical criteria for prognosis. So, usually we already know that the patient is in a terminal phase, but he waits for the doctor to write, to register for us to know how to deal with this patient.* (EA 14)

On the other hand, the participants identified that an obstacle for the professionals to make the records related to direct care is the "existence of a lot of bureaucracy" in the institution. The high number of technical protocols demanded by the institution took up time and removed the nurse from direct care to patients and their families.

> *I think there's protocol here, there's paper for too many things.* (EA 14)

In the subcategory "Coexisting order and disorder in the management of nursing care to the patient in the process of dying/death", are exposed aspects that were perceived by the participants as improvements achieved or management weaknesses.

**Chart 1 –** Facilities for managing nursing care in the face of the process of dying/death

| Facilities |
|---|
| » when there is effective communication between physicians, patients and their families;<br>» when doctors record the (inter) actions they had with patients and their families in the medical records;<br>» feasibility of requesting an opinion from the multidisciplinary team in the institution. |

**Chart 2 –** Difficulties in the management of nursing care in the process of dying/death

| Difficulties |
|---|
| » failure of physicians to communicate with patients and their families, especially in diagnosis, prognosis and behavioral communication;<br>» visiting relatives who do not know the patient's situation;<br>» presence of other patients close to patients in terminal care in the ward, especially if they are lucid;<br>» overloaded work of the nursing team;<br>» lack of integration of the multidisciplinary team;<br>» excessive bureaucratic activities for nurses;<br>» nursing professionals turnover in some wards. |

The improvements pointed out by the participants were not mentioned in the interviews. It was also mentioned the existence of an institutional movement for the creation of an assistance protocol for patients with indication of palliative care.

> *I believe the institution is looking to see this* [palliative care implementation]*, but I think the process is very complicated.* (EA 8)

In the subcategory "Finding difficulties to perform palliative care", the participants presented intervening factors in the implementation of palliative care (PC), listing some difficulties encountered by professionals.

> *It has improved, but I think it can still improve a lot, especially for the palliative patient* [...] *both the medical staff and the nursing staff kind of neglect the care of this patient 'who has nothing to do'* [...]. (EA3)

One of the main difficulties associated with the implementation of PC was related to physicians.

> *And another thing we have more difficulty with is the question of the physician, of talking with the physician. They have this thing of them making decisions or else involving the team, but charging something that is not our role, not listening much what we have to say.* (P 1)

The (inter) action with the patient's family was listed as one of the intervening factors in the PC. The family's lack of understanding and/or acceptance of the terminality experienced by the person who is significant to them may create barriers to the implementation of such care, so that family members need to be prepared to deal with such issues. When it is identified the difficulty of the family to understand a diagnosis of terminality and indication of PC, it is fundamental that care should also be turned to it, not focusing attention and care only on the patient who is in the process of dying/death.

> *I think that this should have a family training. Not only by psychology, but nursing also by explaining regarding symptoms, signs and symptoms that this patient may come.* (TE 5)

The lack of an institutional protocol that guided professionals to make decisions about care to be or not performed was an intervening factor in the management of care. The participants

acted in an unsystematic way, but believed that through their actions they would have support for the necessary approaches, considering the technical-scientific, ethical and legal implications involved in the care process of patients experiencing terminality.

> *No, we do not have, the institution does not have a protocol, and they have nothing defined for palliative care here where I work. This will change from shift to shift.* (EA 8)

In the subcategory "Listing social, ethical and legal aspects involved in the process of dying/death", different interfaces of the process of dying/death are presented as aspects related to organ/tissue donation for transplants. The need to report the deaths that occurred to the Eye Bank or Centers of Notification, Procurement and Distribution of Organs, as well as the feasibility of discussing the possibility of donating corneas for the purpose of transplantation with the family were pointed out.

> *Notify the Eye Bank for a possible transplant.* (EA 6)

Participants recognized the need to understand legal aspects and their impacts on patient and family care, the performance of workers' activities, the institution and even referral of the patient's body after death.

> *We have to understand this other flow, which is the legal flow of the thing, the situation. Because it is extremely necessary for the institution, the patient, and the family to move from there forward.* (EA 6)

In addition, it was considered that setting up a group in the institution to deal with issues of the process of dying/death should be endorsed by law/legal and ethical issues, by the ethical issue of Councils of the profession.

> *It would be interesting to evaluate this patient together with the attending physician, along with the professional who accompanies the case and the family and everything else. This is all endorsed by the law/legal question, by the ethical issue of professional advice. Just like we have the Regional Medical Council* [CRM]*, the Regional Nursing Council* [COREN]*, the profession boards. What is within the ethical limit or not.* (MA 4)

Respect for patient autonomy should be observed in the decision about treatment, so that the team who attended would maintain open communication and respect their wishes, certainly considering the legal aspects involved.

> *And we always respect a lot who gives up operating or who arrives at the hospital, does a surgical diagnosis and does not want to undergo surgery. Because the patient is the boss. So, it is up to the patient the decision of not having the treatment when he exposes this well done situation.* (MA 4)

There is a specific routine related to the death certificate (DO), which must be completed by the doctor. However, the nurse manages this process, involving information and communication resources. The nursing guides and directs the relatives of the patients to the hospital admission service so that they show a photo document that identifies the patient, so that the DO is provided. They recognized that this statement is a free document of relevant legal representativeness, needing to be filled out correctly, without inaccuracies, errors or erasures, and that access to these forms should be controlled.

> *Because these are control documents.* (EA 16)

It may happen that the hospitalized patient does not have a family reference, this being an issue pointed out by the HA, in addition to mentioning the procedures required in this situation. After exhausting the possibilities of locating a family reference of the patient, the HA informed the hospital direction that it talked with the city hall, police station and Medico-Legal Institute (MLI) to enable the burial of this patient, respecting the terms described in the law.

When identifying that the family could not afford the funeral expenses, the professional of the Social Service used to send it to obtain the benefit of public aid of social assistance. However, the participants considered that it was not common for the families of the patients who died at the institution to request assistance, as well as the demand for many bureaucratic procedures in the process, which discouraged relatives.

> *Very few families come to us or the staff asks us* [...] *But they have the income criterion and the income criterion is very low, it's that miserable family of the miserable, you understand? So, this family has the right, but it is extremely bureaucratic.* (AT 3)

The sub-category "Presenting issues related to culture, religion/spirituality and vocational training" presents other points of interest in the process of dying/death. The search for interfaces with religion and/or spirituality comforts people, and this is pointed out in some lines.

> *Suddenly, listening to a patient's need that is spiritual, that is* [...]. (TE 3)

> *We go more for spiritual experience outside, outside professional. But guidance, this matter of a psychologist talks or in the religious part, we do not have. It should! I think it's very important* [...]. (TE 12)

The influence of culture on the (re) action of people to the process of dying/death was a constant subject. Participants believed that culture gives a direction on the way people deal with terminality and death and mentions the differences seen between the cultures.

> *Because, culturally, we are not ready for death. Just like in the East they are ready. They have people celebrating death. We do not, we celebrate life alone. Death to us is such a far thing.* (EA 7)

Caregiving practices and the way we deal with terminality and death have undergone changes throughout the ages. It has been mentioned that a difficulty has been built in society in dealing with the process of dying/death.

> *A society that denies death and suffering. This was built from a postmodern age and a postmodern age, too, where finitude is denied at all times ... Earlier societies in the Middle Ages, for example, experienced death as a very natural thing, it was part of the context there.* (P 3)

The biomedical and hospital-centered model that guided care practices still persists. The participants reported that the institution in which the process of care management is under the influence of this model in which the doctor, the hospital and the healing actions are located in the care center.

> *And, the people in the hospital also have the closure, a biomedical model very ingrained with us, where the physician makes the diagnosis and is closed. Sometimes there is not even openness for you to work on the subject.* (EA 17)

One note concerns the training of health professionals to deal with the process of dying/death. It was identified that the nursing team lacked the knowledge to deal with the process of dying/death, especially in matters that were not related to techniques and procedures.

> *I think it lacks preparation too. That we are not, even in college, nor in school, nor in life prepared for these things.* (EA 14)

Another point has to do with social and economic issues associated with the existence of the patient.

> *So there is a cultural question, there is a social question. Sometimes that person is more profitable alive than dead, because unfortunately it has.* (EA 18)

> *It has already happened a case where the patient spoke to me that he was already thinking to whom he was going to leave what, that he realizes he was not well.* (P 1)

Affective issues were also cited as intervening in the process of dying/death. The termination of life and death usually carry many emotions and this impacts on the (re) actions of the people involved. At times, there were even conflicts between family members.

> *So I think this generates a lot, fantasy, affective issue for this team.* (P 1)

> *And when does the family have conflicts within it? What do we do? Because it is an other case, too.* (MA 4)

In the process of dealing of nursing routine that manages this process, a raised question was that, possibly, the patient wanted to review somebody when he was hospitalized and, thus, solve some pending issues before dying.

> *Suddenly, I do not know, he would like to see a relative, someone who has not seen him in a while. It's more of an issue, like what do I say? As if it was personal.* (TE 3)

The subcategory "Pointing institutional elements that influence the actions of professionals before the process of dying/death" considers the influence of the management of the institution on the assistance offered to patients and their families. Institutional failures that the participants pointed out as influencers of the professionals' actions in the face of the process of dying/death and as a tendency of the institution to value highly the technical aspect of the assistance.

> *I think it depends a lot on the people to be protected, to be subscribed and directed. I think that management, the direction, the profile of the direction interferes, yes, in the way people go to work.* (P 2)

> *I think there is a tendency for the institution, in these accreditation processes and such, to greatly value the technical aspect of the assistance.* (P 2)

It was considered that the management of the institution can facilitate the improvements desired by professionals in the care given to patients and their families.

> *I realize that there is a desire on the part of non-medical categories to share decisions, share assessments. In this current management I realize that there is an appreciation of this, too.* (P 2)

Some participants believed that the work scale of certain professionals did not meet the demands of the hospital.

> *We have the flaw of not having a social worker and psychologist on weekends and their schedule is also reduced through our nursing scale.* (EA 16)

The lack of material resources for care, as well as the physical structure of the hospital unit and the need to define assistance protocols related to the process of dying/death, including guidelines that pointed out as interventions in the management of nursing care before the process of dying/death.

> *Because we do not always have the right material. So, sometimes there is a lack of material in the industry.* (TE 11)

> *Not always this patient has appropriate psychologist care, with privacy as well. We have wards together.* (EA 14)

> *I think the big problem is knowing how to name the situation: 'this is the patient who has no more to invest because he no longer has a reversible situation and he is already in the process of death that is natural of his illness.* (MA 4)

The following chart summarizes the barriers to adequate care management in the process of dying/death that were cited in the interviews by nurses and nursing technicians.

**Chart 3 –** Obstacles to adequate care management in the process of dying/death

| |
|---|
| » work scale of some professional categories does not meet hospital demand, especially at night, weekends and holidays; |
| » lack, at times, of a declaration of death in the institution; |
| » workload of professionals, especially nursing; |
| » prioritization of bureaucratic procedures to the detriment of care; |
| » failures in the reception of patients and their families, including in the preparation of the body; |
| » lack of material resources for assistance; |
| » inadequate physical structure; |
| » inadequate use of physical space; |
| » gaps in communicating difficult news; |
| » lack of definition of multidisciplinary care protocols. |

## DISCUSSION

Participants reported finding facilities and difficulties for the management of nursing care to the patient in the process of dying/death. In this sense, it is perceived that there is an interdependence of professionals facing the death and process of dying/death and their (inter) actions can facilitate or hinder the management of nursing care, as in any other context of care[12].

Facilities are perceived when there is effective communication between physicians and patients and their families, when physicians record (inter) actions they had with patients and their families in the medical records and the feasibility of requesting a written opinion by the nurse to the multidisciplinary team in the institution. On the other hand, the cited difficulties were more expressive and are related to the failures in the interaction of physicians with patients and their families, especially in some cases: diagnosis, prognosis and behavioral communication; visits by family members who do not know the patient's situation; in the presence of other patients near the patients in terminality in the ward, especially if they are lucid; in the workload of the nursing team; in the lack of integration of the multidisciplinary team; in the excess of bureaucratic activities for nurses; and in the turnover of nursing professionals in some wards[12-13].

Order and disorder coexist in the management of nursing care to the patient in the process of dying/death, being mentioned perceived fragilities. As an improvement, it was pointed out an institutional movement to create a care protocol for patients with PC indication. Regarding the deficiencies, the lack of visibility of the interface of nursing care management before the process of dying/death and the need for reorganization of the nursing service, with redefinition of the nurses' attributions, were highlighted.

It was pointed out that the lack of understanding and/or acceptance of the termination of the loved one by the family generates obstacles to the implementation of PC. In addition, it was emphasized that the physician's communication with the family and patients about diagnosis and prognosis may stimulate or hinder their implementation. The lack of an institutional protocol that directs the professionals in the implementation of PC, the deficiency in the integration of the professionals of the team and persistence of the centralization of the decision-making in the doctors also make this implementation difficult. In addition, it is believed that the denial of terminality and death by professionals makes it difficult to recognize the indication of PC in certain patients[14-15].

Social, ethical and legal aspects involved in the process of dying/death involving the need for communication of death to Centers of Notification, Procurement and Distribution of Organs (CNCDO) or Eye Bank, the evaluation of the possibility of approaching family to talk about donation of corneas, can generate impacts on the care of patients and their families in the performance of workers' activities, in the institution and even in the referral of the body after death[14].

In addition, it was highlighted the need for the professionals' records about the assistance performed (especially in the patient's chart and the shift instrument) and records in the death certificate. It was stated that care practices must respect ethical and legal precepts, as well as the indispensability of respect for patients' autonomy. In addition, social, economic and affective issues interfere in the (re) actions of the patients and their relatives before the process of dying/death.

Questions that interfere in the phenomenon studied are related to culture, religion/spirituality and professional training. It was pointed out that the search for interfaces with religion/spirituality comforts people in the face of the death and process of dying/death and that professionals must seek to identify the needs and desires of patients and relatives, respect and support them[15-17]. Cultures direct the way people perceive terminality and death, a taboo in our society[2,6]. It is recognized that the biomedical and hospital-centric model persists dictating care practices, but there are movements of change, such as the palliative philosophy. In addition, the training of professionals is interfered with by culture and perpetuates it, inhibiting the consolidation of new practices[15,18-19].

A path to the institution of new care practices involves interdisciplinarity and cultural change, in which care is a priority, not cure, and that each being is recognized as unique, having their (re) known and respected needs[13].

Institutional elements that influence the actions of professionals before the process of dying/death were pointed out: they feel supported and directed by the management of the institution; tendency to value highly the technical aspect of care, especially with hospital accreditation processes; and the need for management to invest in permanent education of workers and in the creation of a protocol to direct the implementation of PC[20].

In view of this, it is argued that the reductionist, simplifying and fragmentary thought that was initiated with Descartes, although widely used, no longer corresponds to the demands presented. Complex thinking seeks to contextualize, globalize, without leaving aside the singular, seeing that the parts are in the whole and that, also, the whole is in the parts, that man is part of the world and that man is part of man. This thought considers the interfaces of phenomena, uncertainty, contradiction, seeking to understand the dialogical relationship existing between forces that are antagonistic and, at the same time, concurrent and complementary. Organizational recursion denies simplification and uniqueness, breaking with the linear idea of cause and effect, in which products and effects are at the same time products and producers of what produces them[2,8,13].

### Study limitations

One limit of this study may be pointed out by the fact that it was carried out in only one place, at a time and in a historically dated setting, in a particular cultural context. In addition, he specifically focused on managing care in the adult process of dying/death. In this way, more research is needed in the area, in different scenarios and with a focus on the death of children and adolescents, for example. The relationship between religiosity/spirituality and the process of dying/death is also a phenomenon to be understood in the context of nursing care management.

### Contributions to the area of nursing, health or public policy

It is proposed that nurses know and understand the subjective, educational, sociocultural and institutional conditions

that influence their interactions. Thus, it can be a reflexive and critical subject before its performance that manages the nursing care with a thought and reintegrative look of the whole, with a view to the singularity of the parts and the interaction between them, thinking about the process as living, dynamic, with uncertainties and contradictions.

## FINAL CONSIDERATIONS

The results of the investigation reaffirm that the interactions before the process of dying/death and between professionals-family-patients are permeated by orders and disorders. The management of care in adult medical-surgical units is a challenge for nurses, since it involves working with a multiprofessional team, in which each one has a different look and feel. In these units, patients with multiple pathologies and multiple care needs are cared for, so that professionals deal with unforeseen circumstances, contradictions and uncertainties regarding the provision of care. Therefore, management involves inter and retro actions between complex human beings and who experience a complex care before the constitution that they have from their formations and developed relations.

Some factors alter the impact of causal conditions on the phenomenon. It was identified in this study that the nurses find facilities and difficulties for the management of nursing care to the patient in the death and process of dying/death that order and disorder coexist in this management. In addition, professionals find it difficult to implement PC. Participants mentioned some aspects involved in the process of dying/death, such as: social, ethical and legal; issues related to culture, religion/spirituality; and vocational training. In addition, they pointed out institutional elements that influence the actions of professionals before this process.

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