NURSING CARE FOR PATIENTS AT THE END LIFE

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Received January 2023; Accepted February 2023; Published March 2023;

DOI: https://doi.org/10.31407/ijees13.214

ABSTRACT

Palliative medicine is one of the newest subspecialist branches of modern medicine. The main center of interest of palliative medicine is the care for patients with terminal diseases, ie patients in the final stage of the disease, where classical medicine, curative with its diagnostic-therapeutic approach and scientific-technological approach can no longer return the patient to health or lack of disease. Palliative medicine includes three areas: sedative symptoms, psychosocial support for residents and their caregivers, and ethical issues at the end of life. The research was conducted in the territory of the Republic of Kosovo (in the city of Gjakova): in the period July-August 2022.A total of 120 respondents were interviewed. Respondents were asked to list potential attitudes and attitudes, to the extent that they posed a barrier or not to palliative care, in their experience and practice.Descriptive analysis of the results identified attitudes towards palliative care. Alpha Cronbach's reliability test confirms that the data are reliable, and through the KolmogorovSmirnov and Shapiro Wilk normality test the data turned out to be parametric and non-parametric.For this reason, two tests were used, the Independent Sample T-test and the Mann Whitney U-test to confirm the hypothesis, and Pearson correlation analysis measured the correlation between palliative medicine factors. The results of the research showed that there are significant significant differences between the nurses of QKMF and those from Gjakova Hospital, respectively the nurses of QKMF are better prepared for the care of patients in the last stage of life, p value <0.05 %, while significant correlations were found between palliative medicine factors which are significant at 0.01% and 0.05% of the confidence level. The scientific contribution of this research lies in the fact that the nurses who work in QKMF are more prepared, compared to the nurses of Gjakova Hospital, which should be taken measures that the level of training is relatively the same, so that services be more qualitative in each Institution.

Keywords: Palliative medicine, Palliative care, Nurse, Patient and mobile palliative care.

INTRODUCTION

Brief summary. Palliative care is comprehensive active care for a patient whose disease does not respond to active treatment procedures. In palliative care, quality of life comes before longevity. To achieve this, it is necessary to

combine forms of physical, social, psychological and spiritual assistance. Death is inevitable for all living beings, and as health care providers nurses play a critical role in the care of dying individuals and their families. The vast manority of palliative care patients want to die at home. Hospitals are the most expensive place to provide palliative care while home palliative care has many benefits for the palliative patient and their family. Comprehensive care and coordination of the individual's health care, the family and the local community requires family physicians to work in a team and a multidisciplinary approach to the care of the Population that has chosen it. If necessary, the team is expanded to include palliative health professionals. The specialized mobile care palliative care team operating in the City of Gjakova contributes significantly to the provision of multidisciplinary, team and comprehensive palliative care. Quality palliative care at the primary level is essential because it improves the patient's quality of life and overall health care. The specialized mobile care palliative care team operating in the City of Gjakova contributes significantly to the provision of multidisciplinary, team and comprehensive palliative care. Quality palliative care at the primary level is essential because it improves the patient's quality of life and overall health care. The specialized mobile care palliative care team operating in the City of Gjakova contributes significantly to the provision of multidisciplinary, team and comprehensive palliative care. Quality palliative care at the primary level is essential because it improves the patient's quality of life and overall health care.

The paper deals with and researches the nurses in the primary health care MCMF as well as in the regional hospital of Gjakova as an integral, permanent and comprehensive part of the formal health care system throughout the country, that is understood as a means of balancing the two main goals of health care system - optimization and balance in the delivery of health services through quality health management.

For the purposes of writing, some selected methods have been used, which are adapted to the field of research related to the defined topic. A lot of theoretical knowledge based on numerous domestic and foreign, scientific and professional reports, as well as a large number of studies, strategies and reports, the subject of which is the research and analysis of primary (preventive) health care.

In addition to secondary sources of information, a primary study was conducted using the survey method, targeting dissatisfied users of health services and health institution workers at the primary level of heal.

Adequate mathematical and statistical data were used to process the data obtained through research through questionnaires.

In the statistical processing of the data collected from the survey, several different levels of statistical processing were used, as well as several different processing techniques. In the field of elementary statistics, data classification techniques, graphical representation of the frequency distribution of measures of central tendency, percentages and percentile ranks, and measures of variability were used.

Entry. The term palliative (lat. Palliativus) means hiding or temporary relief of the external signs of the disease in patients with complicated underlying diseases in which the cause of the disease as well as its progression cannot be prevented. It refers to the disease in the period from diagnosis to the death of the patient. Hospitality in Latin means welcome, hospitality given to a stranger, shelter, lodging. Since the Middle Ages, this name has meant a place where the sick, the sick and the poor can take shelter. Such institutions were created under the auspices of Christianity. Christianity brings a whole new attitude towards the weak, the elderly and the hungry. The founder of the hostpices-housing movement in Europe is Mrs. Dame Cicely Mary Saunders. Born in Hertfordshire, England in 1918. Even as a nurse she noticed the need for special care for patients in the final stage of the disease. Through further education, she became a doctor and was actively involved in promoting the need for palliative care for seriously ill patients. In that field, she lectured, wrote many articles and books on palliative medicine. She worked at St. Noseph, where she studied pain control in advanced maltreatment, with her hard work and maximum commitment, gave a strong impetus to the establishment of St. Noseph's Hospice Center. Christopher in London in 1967. which has become one of the largest centers of palliative care education. Mrs. Cicely Mary Saunders is rightly called the pioneer of palliative care in Europe. she became a doctor and was actively involved in promoting the need for palliative care for seriously ill patients. In that field, she lectured, wrote many articles and books on palliative medicine. She worked at St. Noseph, where she studied pain control in advanced maltreatment, with her hard work and maximum commitment, gave a strong impetus to the establishment of St. Noseph's Hospice Center. Christopher in London in 1967. which has become one of the largest centers of palliative care education. Mrs. Cicely Mary Saunders is rightly called the pioneer of palliative care in Europe. she became a doctor and was actively involved in promoting the need for palliative care for seriously ill patients. In that field, she lectured, wrote many articles and books on palliative medicine. She worked at St. Noseph, where she studied pain control in advanced maltreatment, with her hard work and maximum commitment, gave a strong impetus to the establishment of St. Noseph's Hospice Center. Christopher in London in 1967. which has become one of the largest centers of palliative care education. Mrs. Cicely Mary

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Palliative care is comprehensive active care for a patient whose disease does not respond to active treatment procedures. In palliative care, quality of life comes before longevity. To achieve this, it is necessary to combine forms of physical, social, psychological and spiritual assistance. Death is inevitable for all living beings, and as health care providers nurses play a critical role in the care of dying individuals and their families. The vast majority of palliative care patients want to die at home. Hospitals are the most expensive place to provide palliative care while home palliative care has many benefits for the palliative patient and their family. Comprehensive care and coordination of the individual's health care, the family and the local community requires family physicians to work in a team and a multidisciplinary approach to the care of the population that has chosen it. If necessary, the team is expanded to include palliative health professionals. The specialized mobile care palliative care team operating in the City of Gjakova contributes significantly to the provision of multidisciplinary, team and comprehensive palliative care. Quality palliative care at the primary level is essential because it improves the patient's quality of life and overall health care. The specialized mobile care palliative care team operating in the City of Gjakova contributes significantly to the provision of multidisciplinary, team and comprehensive palliative care. Quality palliative care at the primary level is essential because it improves the patient's quality of life and overall health care. The specialized mobile care palliative care team operating in the City of Gjakova contributes significantly to the provision of multidisciplinary, team and comprehensive palliative care. Quality palliative care at the primary level is essential because it improves the patient's quality of life and overall health care.

MATERIAL AND METHOD

Familiarity with the study

The paper deals with and researches the nurses in the primary health care (MCMF) as well as in the regional hospital of Gjakova as an integral, permanent and comprehensive part of the formal health care system throughout the country, that is understood as a means of balancing the two main goals of health care system - optimization and balance in the delivery of health services through quality health management.

For the purposes of writing, some selected methods have been used, which are adapted to the field of research related to the defined topic. A lot of theoretical knowledge based on numerous domestic and foreign, scientific and professional reports, as well as a large number of studies, strategies and reports, the subject of which is the research and analysis of primary (preventive) health care.

Pain is an unpleasant emotional and sensory experience associated with immediate or threatened tissue damage, or an experience described in the context of such damage is the official definition of pain of the International Association for the Study of Pain accepted by the World Organization of Health.

Pain is the most common problem that makes people visit a doctor, but also the most common symptom that indicates the onset or the disease itself. Along with fear, pain is the body's evolutionarily oldest response to any attack or destruction. Pain is a subjective feeling. Since no two people are the same, no two reactions to pain are equal and it is not easy to measure. The causes can be physical, mental, social and spiritual. It is difficult to compare biologically created pain with emotional, social or spiritual pain, but they all cause suffering. Pain is a prevalent public health problem in which pain in palliative care is of particular importance, and the role of the nurse is invaluable.

Man's basic human right is freedom from pain and suffering, because no one should suffer in silence or die in pain. Modern science and clinical practice have made it possible to significantly reduce the pain and suffering it brings, thus opening the doors to the modern foundations of the development of palliative care.

In the city of Gjakova, the Health Care Act 1993 introduced a hospital health care service and the MCMF, as a separate health care institution responsible for providing home medical care and rehabilitation of patients under the

guidance and supervision of a family physician. It belongs to primary health care and is not covered by health insurance, this is the basis that our.

State of Kosovo needs to improve the patient's health and prevent its deterioration with the help of a nurse/technician and family members as caregivers.

The number of health care personnel (nurses / technicians) in home health care is planned in accordance with the geographical distribution of residents, geographical characteristics and local conditions. Nurses / technicians provide health care in the principle of the primary model, ie they constantly care for a certain number of patients / wards. Since 2003, approximately 3,500 patients per year have been assigned to a nurse/technician. The implementation of health care includes the education of the patient as well as his family members. The health care service provided by nurses/technicians in hospital and at home is very complex. The responsibility is great regardless of the place and conditions, which requires additional knowledge, a high degree of independence in work,

Palliative care is specialized medical care for people suffering from serious illnesses. Its goal is to provide patients with relief from the symptoms, pain and stress of serious illness, regardless of diagnosis. This type of care focuses on providing relief to the patient from the symptoms, pain and stress caused by a serious illness. The goal is to improve the quality of life for both patients and their families.

Palliative medicine cannot cure a person, but it can care for him, relieve his pain and suffering, while preserving the person's dignity as a unique human being. In palliative medicine, there is not and should not be the sentence "nothing more can be done", because we always ask "what else can we do for the patient and his family". Here we test our ability to be a good doctor, communication skills, ability to work in a multidisciplinary team, but also humanity.

Modern medicine is divided into preventive, curative and palliative medicine. Palliative medicine is the total active care of a patient whose disease does not respond to curative treatment. Many aspects of palliative medicine are applicable earlier in the course of illness, so it is considered that palliative care should cover the period from the diagnosis of an incurable disease to the period of mourning after the patient's death.

Palliative care is provided by a team of doctors, nurses and other specialists who work with the patient's doctor to provide him or her with an extra level of support. Palliative care is appropriate at any age and can be provided at any stage of a serious illness alongside curative treatment of the illness.

Research in the city of Gjakova on this topic, especially on health care in the hospital and MCMF, is very underrepresented. However, the need to improve working conditions, the necessary training of nurses / technicians is increasing. Nurses/technicians are often faced with new situations and problems, in which they must know how to adapt and adequately solve the problem. However, there is also a lack of necessary and correct literature. While patient care is provided at home, nurses/technicians face a variety of behaviors from the patient's family, from full acceptance and receiving the necessary care of a sick family member to rejection and non-cooperation with the nurse/technician. Also, there is a Possibility of lack of necessary materials for work,

During development, community nursing was divided into two services:

- patronage service - focused on education and disease prevention and health maintenance;
- home health care service - focused on the physical care of patients.

The purpose of the work

The purpose of the paper is to highlight the problems, and recommend efficient ways, for nursing care for patients at the end of life, as well as to analyze the difference between primary health nurses (MCMF) compared to secondary care nurses. health.

Hypotheses:

Ho – Primary health care nurses (MCMF) are better prepared for the care of patients in the last stage of life, compared to secondary health care nurses.

H1 – Nursing care at the end of life does not differ between the two levels of care in relation to death education.

The study was conducted through anonymous questionnaires. The study aimed to examine the attitudes of nursing health professionals of the city of Gjakova, 120 of them were surveyed. The reason for its implementation (for the purpose of preparing a Master thesis). Below is the part of the survey that contains sociodemographic data on: age, gender, nationality, education, marital status, care unit, education of death, etc.

Objectives of the paper

- To describe and interpret the experiences of nurses, how their care affects the patient's life and what supports and services they use to manage the patient's illness.
- To identify the social needs perceived by palliative nursing care for patients at the end of life. To explore their needs, how they are perceived by medical and social services.
- To identify coping strategies and resources that patients and family members use to overcome the disease.

- To create modules during nursing education for the preparation of nurses to care for patients at the end of life
- Coordinate a harmonious relationship between the patient, the nurse and the patient's family members during palliative treatment.

Research questions

Research question - What effect can death education have on the attitudes of nurses working in primary health care and those working in secondary care, as well as the comparison between them? The questionnaire, which is intended for participants in palliative health care, aims to assess the situation in primary health care, show the benefits of prevention and the problem faced by the participants and finally provide guidelines for solving some problems within the management function.

The employees have been provided with answers to the questionnaires, which they will complete and thus give their answer to the question:

1. Not at all agree,
2. I do not agree,
3. I don't know,
4. I agree,
5. Completely agree.

The third phase of the research was the processing of the data collected from the survey and the presentation of the results using the SPSS method, conclusions and proPosals.

After the analysis of the questionnaires, the results are presented in tables and percentages through graphs.

Theoretical aspects of the research: Improving the quality of work of health care institutions, namely health care, as an integral part of care, is a continuous process aimed at achieving a higher level of efficiency and effectiveness at work, as well as satisfaction largest number of users.

Respondents

Respondents - The research was conducted in the territory of the Republic of Kosovo (in the city of Gjakova): in the period July-August 2022. A total of 120 nurses from the MCFM and the Gjakova Hospital were surveyed.

In the statistical processing of the data collected from the survey, several different levels of statistical processing were used, as well as several different processing techniques. In the field of elementary statistics, data classification techniques, graphical representation of the frequency distribution of measures of central tendency, percentages and percentile ranks, and measures of variability were used.

The paper will define palliative care through different theories, will show the importance of the existing forms of palliative care in Kosovo, in the city of Gjakova, the approach to the dying patient and his family. The purpose of the paper is mainly focused on the role of nursing on death education through specific nursing procedures that are oriented towards the recognition of nursing problems in the field of palliative care from which nursing diagnoses arise, goal planning, implementation of nursing interventions and evaluation of what has been done. In addition to all of the above, specific communication is also of great importance in working with the dying patient and his family.

Expected effects and research contribution

Expected effects and research contribution - The results of the research work present an empirical basis for the analysis of the current state of implementation of palliative health care in primary institutions, as a starting Point for improving its operation. In addition to the analysis of the current situation, the research process also contains a component of a qualitative approach which seeks to gain knowledge about the quality of health services provided by users and the satisfaction of employees of health care providers, which provides an opportunity to see problems of the level of education of nurses on the care of patients at the end of life.

The social importance of work is manifested through an analytical approach to the open question of the future way of functioning of the health care system and health services at the national level. The primary results of the empirical study on the level of functioning of the health system in the conditions of a severe general social and financial crisis and the formation of the current and future direction of development in the organization and provision of health services according to the principles of modern management, through redistribution and restructuring towards prevention, i.e. primary health care. The completion of the anonymous survey is voluntary and therefore the presumption of consent of the respondents is justified. This satisfies informed consent as a fundamental doctrine of clinical bioethics. Correlation analysis was carried out in order to measure the correlation of variables. The Pearson correlation was used, while the results show that a significant correlation was found in all cases.

Work methods

Work methods - In both surveys, respondents were randomly selected in order to collect data regarding the attitudes regarding the need of the Republic of Kosovo - in the city of Gjakova to organize a palliative care system and the need for care nursing in the last stage of life. The survey was conducted personally, in direct contact with the respondent with the help of two nursing students, and with the help of hospital staff, MCFM, health centers, clinics, home care staff. Respondents completed the surveys voluntarily and anonymously.

In addition to secondary sources of information, a primary study was conducted using the survey method, targeting dissatisfied users of health services and health institution workers at the primary level of health care.

Inductive-deductive method - a method used to explain the existence and discovery of new knowledge, but also to prove theses determined in order to connect the hypotheses of scientific research;

The method of analysis and synthesis - method that in the analytical sense first breaks down and simplifies the most complex phenomena, judgments and conclusions into their simple components and then studies each of these parts in order to understand in detail some views or concepts of certain. In contrast, with the method of synthesis, several parts and elements of knowledge are collected and merged into a thought- theoretical whole. By merging the collected, individual materials into a whole, a conclusion was reached regarding the state of preventive health care management, but also the prospects of its further development.

Statistical methods and modeling were used in the research. According to the data collected by the questionnaire and after the surveys, the statistical method was used to determine the test results in the form of parameters presented in graphs and tables in order to determine the characteristics, structures and priority models of the examined phenomena. During the processing of the data collected from the surveys, descriptive- statistical processing was used, which includes the methods of data collection, arrangement and presentation. Adequate mathematical and statistical data were used to process the data obtained through research through questionnaires.

The general conclusion of this research is that the palliative health care system of the city of Gjakova in such a difficult and turbulent time of the financial, Political and economic crisis successfully responds to the requirements, at least in the part that is primary in this research, which is primary health care.

After the analysis of the questionnaires, the results are presented in tables and percentages through graphs.

Theoretical aspects of the research: Improving the quality of work of health care institutions, namely health care, as an integral part of care, is a continuous process aimed at achieving a higher level of efficiency and effectiveness at work, as well as satisfaction largest number of users.

The results of the research showed that there are significant significant differences between the nurses of the MCFM and those from the Gjakova Hospital, namely the nurses of the MCFM are better prepared for the care of patients at the end of life, p value <0.05 %, while significant correlations were found between the factors of palliative medicine, which are significant at 0.01% and 0.05% of the reliability level.

Subjects and methods:

Subjects and methods - First, I received approval from the addressing you with a request for research to the institutions: Regional Hospital of Gjakovë, and the Main Center of Family Medicine in Gjakovë, after we were approved by these institutions, we continued with research "for this is what we have and the evidence we have attached to the paper"

The study was conducted through anonymous questionnaires. The study aimed to examine the attitudes of nursing health professionals of the city of Gjakova, 120 of them were surveyed. The reason for its implementation (for the purpose of preparing a Master thesis). Below is the part of the survey that contains sociodemographic data on: age, gender, nationality, education, marital status, care unit, education of death, etc.

Respondents express their views on each of the statements using the Likert Attitude Rating Scale, which consists of five levels:

1. Strongly agree,
2. I do not agree,
3. I don't know,
4. Agree,
5. Totally agree.

The data obtained were analyzed with appropriate SPSS statistical methods depending on the type of data.

The data obtained from this study are presented in absolute and relative frequencies. For the age variable, the median was used as a measure of central tendency. In order to determine the most appropriate test to determine the differences between variables, all variables were checked by the Kolmogorov-Smirnov test to check the normality of

the distribution of the results. The distribution of the variables was found to deviate from the normal distribution in some cases, and therefore two tests were used, the parametric Independent Sample T-test and the non-parametric Mann Whitney U-test. The level of significance was set at $P < 0.05$. All statistical analyzes were performed using the SPSS statistical package (version 25).

RESULTS

The results of the research work present an empirical basis for the analysis of the current state of implementation of palliative health care in primary institutions, as a starting Point for improving its functioning. In addition to the analysis of the current situation, the research process also contains a component of a qualitative approach which seeks to gain knowledge about the quality of health services provided by users and the satisfaction of employees of health care providers, which provides an opportunity to see problems of the level of education of nurses on the care of patients at the end of life. Descriptive results - Based on the following results, we see that the analyzes were performed in comparison with the groups of nurses, the group of nurses from the primary health care MCFM and the regional hospital of Gjakova.

Table 1. Demographics Results

Sex		**N**	**%**
Primary Health Care QKMF	Male	13	13%
	Female	47	47%
Regional Hospital of Gjakova	Male	26	26%
	Female	34	34%
Nationality		**N**	**%**
Primary Health Care QKMF	Albanian	52	86.7%
	Minorities	6	10.0%
	Other	2	3.3%
Regional Hospital of Gjakova	Albanian	54	90.0%
	Minorities	5	8.3%
	Other	1	1.7%
Marital status		**N**	**%**
Primary Health Care QKMF	Married	49	81.7%
	Not married	7	11.7%%
	Divorced	3	5.0%
Regional Hospital of Gjakova	Married	48	80.0%
	Not married	10	16.7%
	Divorced	2	3.3%
Level of education		N	%
Primary Health Care QKMF	High School of Medicine	50	83.3%
	Bachelor of Nursing	9	15.0%
	Professional Master	1	1.7%
Regional Hospital of Gjakova	High School of Medicine	43	71.7%
	Bachelor of Nursing	17	28.3%

The results show that 13 men and 47 women participated from the MCFM, while from the hospital there were 26 men and 34 women. From the MCFM there were 52 Albanians, 6 from minorities and 2 others, while from the hospital there were 54 Albanians, 5 minorities and 1 other. As for the marital status, from the MCFM we have 49 married nurses, 7 are unmarried and 3 others divorced, while from the hospital there are 48 married, 10 single and 2 divorced. There are 50 nurses with secondary medical qualification from the Medical Center, 43 nurses from the hospital, while 9 are with a bachelor's degree and 1 with a master's degree in the Medical Center, while in the hospital we have 17 with a bachelor's level.

Table 2. Education and the importance of service.

The unit where the nurse works		**N**	**%**
Primary Health Care QKMF	General Hospital - Gjakova	3	5.0%
	Main Center of Family Medicine - Gjakova	57	95.0%
Regional Hospital of Gjakova	General Hospital - Gjakova	57	95.0%
	Main Center of Family Medicine - Gjakova	2	3.3%
Continuing education		**N**	**%**
Primary Health Care QKMF	Basic training	35	58.3%
	Courses	14	23.3%
Regional Hospital of Gjakova	Basic training	19	31.7%
	Courses	34	56.7%
Religion ?		**N**	**%**
Primary Health Care QKMF	Muslim	40	66.7%
	Catholic	13	21.7%
	Bektashi	5	8.3%
	Others	2	3.3%
Regional Hospital of Gjakova	Muslim	37	61.7%
	Catholic	19	31.7%
	Bektashi	4	6.7%
Importance of religious services		**N**	**%**
Primary Health Care QKMF	Very important	13	21.7%
	Somewhat important	26	43.3%
	Not very important	16	26.7%
	Not important	5	8.3%
Regional Hospital of Gjakova	Very important	16	26.7%
	Somewhat important	20	33.3%
	Not very important	17	28.3%
	Not important	5	8.3%
	I don't answer	2	3.3%
Watch or listen to spiritual programs?		**N**	**%**
Primary Health Care QKMF	Yes	36	60.0%
	No	22	36.7%
Regional Hospital of Gjakova	Yes	36	60.0%
	No	23	38.3%
Religion		**N**	**%**
Primary Health Care QKMF	Yes	27	45.0%
	No	19	31.7%
Regional Hospital of Gjakova	Yes	29	48.3%
	No	31	51.7%
Attendance		**N**	**%**
Primary Health Care QKMF	Daily	5	8.3%
	Once a week	18	30.0%
	Once a month	8	13.3%
	A few times a year	15	25.0%
	Never	13	21.7%
	I don't answer	1	1.7%
Regional Hospital of Gjakova	**Daily**	**6**	**10.0%**
	Once a week	22	36.7%
	Once a month	14	23.3%
	A few times a year	14	23.3%
	Never	3	5.0%

Regarding the practice of the profession, we see that in the MCFM 3 nurses practice their profession in the general hospital, 57 in the main center, while 57 are in the general hospital and 2 in the main center. There are 35 nurses who complete basic training and 14 courses in continuing education at the MCFM, while 19 nurses from the hospital complete basic training and 34 courses. As for religious affiliation, we see that over 65% are Muslim, 21% are Catholic, 8.3% are Bektashi, while the rest have other religious affiliation, while the same participation is approximately the same in the hospital. Most of them do not see it as very important, while on the other hand 60% of them watch spiritual programs. Over 45% of nurses preach religion, while their participation is once a week to a few times a year.

Table 3. Testi I besushmeris- Alpha Cronbach"s.

Question groups	**Number of variables tested**	**Alpha Cronbach's**
Attitudes away from caring for the dead scale	30	0.867
The Dying Behavior Profile - Revised results from subscoring		
Fear of death	7	0.711
Avoiding death	5	0.777
Neutral acceptance	5	0.754
Escape from acceptance	5	0.662
Acceptance of access	10	0.746
Average reliability value	**62**	**0.752**

Reliability Test – Cronbach's Alpha- Reliability test was conducted to prove whether the data is reliable, while Cronbach's Alpha test was used. In all groups of questions, an acceptable level was found, precisely in Attitudes away from the care of the dead rate (AC=0.867), Fear of death (AC=0.711), Avoidance of death (AC= 0.777), Neutral acceptance (AC=0.754), Escape from acceptance (AC=0.662) and Acceptance of approach (AC=0.746), while the overall average value of reliability is 0.752.

Table 4. Tests of Normality

Tests of Normality						
	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Attitudes away from caring for the dead scale	0.066	120	0.200*	0.988	120	0.403
Fear of death	0.104	120	0.003	0.980	120	0.065
Avoiding death	0.096	120	0.009	0.979	120	0.056
Neutral acceptance	0.102	120	0.004	0.974	120	0.021
Escape from acceptance	0.064	120	0.200*	0.976	120	0.030
Acceptance of access	0.094	120	0.012	0.956	120	0.001
*. This is a lower bound of the true significance.						
a. Lilliefors Significance Correction						

Test of normality - distribution of data - The results of normal distribution were realized through the Kolmogorov smirnov and shapiro wilk test, while in most cases the data have normal distribution (p value >0.05%). For this reason, to prove the hypothesis, the parametric independent sample t-test was used, but to make the analysis more reliable, the non- parametric Mann Whitney U-test was also used.

Correlation analysis

Table 5. Correlations datas

Correlations							
		Attitudes away from caring for the dead scale	Fear of death	Avoiding death	Neutral acceptance	Escape from acceptance	Acceptance of access
Attitudes away from caring for the dead scale	Pearson Correlation	1	0.523**	0.458**	0.424**	0.481**	0.444**
	Sig. (2-tailed)		0.000	0.000	0.000	0.000	0.000
	N		120	120	120	120	120
Fear of death	Pearson Correlation		1	0.395**	0.233*	0.326**	0.229*
	Sig. (2-tailed)			0.000	0.010	0.000	0.012
	N			120	120	120	120
Avoiding death	Pearson Correlation			1	0.427**	0.227*	0.353**
	Sig. (2-tailed)				0.000	0.013	0.000
	N				120	120	120
Neutral acceptance	Pearson Correlation				1	0.187*	0.281**
	Sig. (2-tailed)					0.041	0.002
	N					120	120
Escape from acceptance	Pearson Correlation					1	0.275**
	Sig. (2-tailed)						0.002

	N						120
Acceptance of access	Pearson Correlation						1
	Sig. (2-tailed)						
	N						
**. Correlation is significant at the 0.01 level (2-tailed).							
*. Correlation is significant at the 0.05 level (2-tailed).							

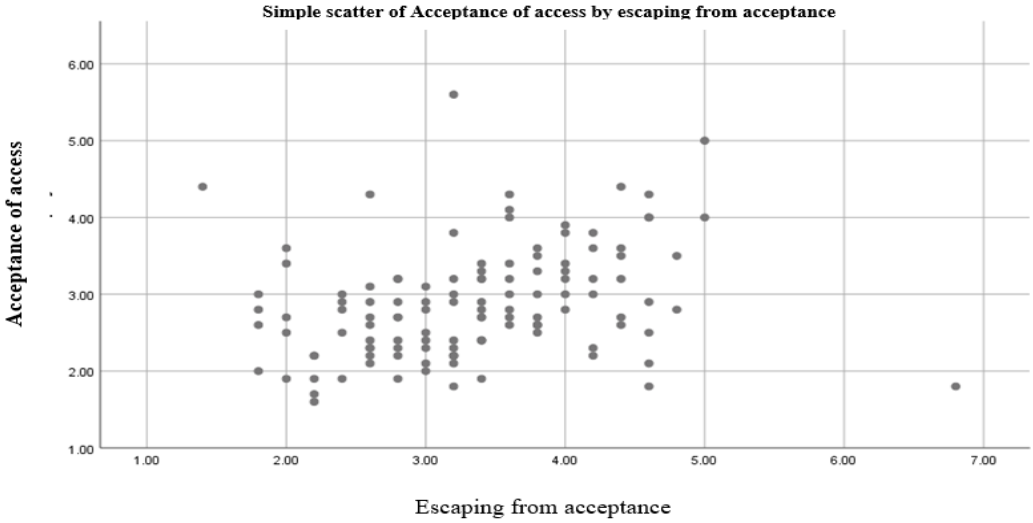

Figure 1. Correlation between escape from acceptance and acceptance of approach

Correlation analysis- Correlation analysis was carried out in order to measure the correlation of variables. The Pearson correlation was used, while the results show that a significant correlation was found in all cases.

According to the above results, we see that attitudes away from caring about the death rate have an impact on the increase in fear of death (rho = .523**, p value=.000), also affect the increase in avoidance of death (rho=. 458**, p value=.000), on the other hand there is an influence to accept (rho=.424**, p value=.000), the increase of escape from acceptance (rho=.481**, p value= .000) and acceptance of the approach (rho=.444**, p value =.000) which are significant at the 0.01% level of reliability.

Fear of death has an impact on the increase of death avoidance (rho=.395**, p value=.000), then it affects the neutral acceptance (rho=.233**, p value=.010), it affects the increase of the desire to escape from the acceptance (rho=.326**, p value=.000) and the acceptance of the approach (rho=.229*, p value=.012) which are significant at 0.01% and 0.05% of the level of reliability.

Avoiding death is influencing the increase in the desire for neutral acceptance (rho=.427**, p value=.000), in the increase in avoidance of acceptance (rho=.227*, p value=.013) and in the acceptance of approach (rho=.353**, p value=.000), which are significant at 0.01% and 0.05% of reliability.

The neutral acceptance influenced the avoidance of acceptance (rho=.187*, p value=.041) and the acceptance of approach (rho=.281**, p value=.002), which are significant at 0.01% and
0.05 % of reliability.

Escape from acceptance has influenced acceptance of approach (rho=.275**, p value=.002) which is significant at 0.01% of reliability.

Validation of the hypothesis-In order to validate the following hypothesis, the parametric Independent Sample T-test and the non-parametric Mann Whitney U-test were used. Both of these tests have the same purpose, to make a significant difference and validation of independent groups, in our case the comparison between the nurses of the MCMF and those of the Gjakova Hospital.

At first glance, we see that the differences are low between the nurses of the MCMF and those from the Hospital, where exactly in the attitudes away from the care of the death rate there is a mean of 3.711 among the nurses of the MCMF and a standard deviation of 0.338 , while the nurses of the Gjakova Hospital have an average of 3.06 and a standard deviation of 0.337. Regarding the fear of death, nurses from the MCMF have an average knowledge of 3.70, while hospital nurses have an average of 3.09. Avoidance of death has an average of 3.76 among nurses from the MCMF, while 3.02 among hospital nurses. In the neutral acceptance factor, we have an average of knowledge of

4.02 among the nurses of the MCMF, while 3.15 among the nurses of the Hospital. Also, there is an average of 4.02 in the absence from admission in the MCMF, while 3.15 in the nurses from the hospital

Table 6. Descriptive analysis of T-test

Group Statistics					
	Infermierët	N	Mean	Std. Deviation	Std. Error Mean
Attitudes away from caring for the dead scale	Primary Health Care QKMF	60	3.7111	0.33881	0.04374
	spitali regjional gjakoves	60	3.0633	0.33708	0.04352
Fear of death	Primary Health Care QKMF	60	3.7056	0.74874	0.09666
	spitali regjional gjakoves	60	3.0944	0.69594	0.08985
Avoiding death	Primary Health Care QKMF	60	3.7667	0.75659	0.09768
	spitali regjional gjakoves	60	3.0267	0.50552	0.06526
Neutral acceptance	Primary Health Care QKMF	60	4.0200	0.53196	0.06868
	spitali regjional gjakoves	60	3.1533	0.60098	0.07759
Escape from acceptance	Primary Health Care QKMF	60	3.5933	0.92496	0.11941
	spitali regjional gjakoves	60	3.0867	0.75767	0.09781
Acceptance of approach	Primary Health Care QKMF	60	3.2967	0.72742	0.09391
	spitali regjional gjakoves	60	2.4667	0.43126	0.05568

Table 7. Determination of statistical significance through Independent Sample T-test.

Independent Samples Test										
		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Attitudes away from care of the dead scale	Equal variances assumed	0.559	0.456	10.499	118	0.000	0.64778	0.06170	0.52560	0.76996
	Equal variances not assumed			10.499	117.997	**0.000**	0.64778	0.06170	0.52560	0.76996
Fear of death	Equal variances assumed	2.962	0.088	4.631	118	0.000	0.61111	0.13197	0.34978	0.87245
	Equal variances not assumed			4.631	117.375	**0.000**	0.61111	0.13197	0.34976	0.87246
Avoidance of death	Equal variances assumed	8.592	0.004	6.299	118	0.000	0.74000	0.11747	0.50737	0.97263
	Equal variances not assumed			6.299	102.924	**0.000**	0.74000	0.11747	0.50702	0.97298
Neutral acceptance	Equal variances assumed	0.530	0.468	8.364	118	0.000	0.86667	0.10361	0.66148	1.07185
	Equal variances not assumed			8.364	116.287	**0.000**	0.86667	0.10361	0.66145	1.07188
Avoidance of acceptance	Equal variances assumed	5.808	0.017	3.282	118	0.001	0.50667	0.15436	0.20099	0.81234
	Equal variances not assumed			3.282	113.596	**0.001**	0.50667	0.15436	0.20087	0.81246
Acceptance of approach	Equal variances assumed	11.191	0.001	7.603	118	0.000	0.83000	0.10917	0.61381	1.04619
	Equal variances not assumed			7.603	95.915	**0.000**	0.83000	0.10917	0.61329	1.04671

The following results prove that in all cases, the nurses of the MCMF have a higher average coefficient, compared to the nurses of the Gjakova Hospital. In the following table we see that p value=.000 is in all cases significant at 0.01% of confidence.

In this case, we accept the null hypothesis and say that it is statistically significant that primary health care nurses are better prepared for the care of patients at the end of life, compared to secondary health care nurses.

Table 8. Test Statistics[a]

Test Statistics[a]						
	Attitudes away from care of the dead scale	Fear of death	Avoidance of death	Neutral acceptance	Avoidance of acceptance	Acceptance of approach
Mann-Whitney U	308.000	967.500	705.500	480.000	1,095.000	562.000
Wilcoxon W	2,138.000	2,797.500	2,535.500	2,310.000	2,925.000	2,392.000
Z	-7.835	-4.381	-5.767	-6.956	-3.710	-6.506
Asymp. Sig. (2-tailed)	0.000	0.000	0.000	0.000	0.000	0.000
a. Grouping Variable: Nurses						

Since some of the factors turned out to be non-parametric, I also used the Mann Whitney U- test in order to meet the dilemmas of whether the results are relevant.

The results of the Mann Whitney U-test prove that there are significant differences in all cases, and in this case we accept the hyPothesis that primary health care nurses (MCMF) are better prepared for the care of patients at the end of life, in compared to secondary health care nurses.

Discussion

The development of the health care system attracts the social and professional attention of the public every day, through all elements of management and administration of this system and its elements. The previous traditional management of organizational systems, which was characterized by an analytical approach and interdisciplinary solution of its problems, has been replaced by the principles of modern management, which is characterized by a synthetic approach and interdisciplinary solution of its problems. The characteristic of the success of today's model is reflected in the totality of the approach to the realization of the tasks defined without the previous divisions in the sphere of medical and non-medical business in the business of the health institution. Of course, it is not possible to introduce such an approach overnight. It requires that the holders of disposal activities with health education, within Postgraduate studies, Possess the necessary knowledge in the field of management (palliative care) and vice versa, that the holders of disposal activities, with education in the field of management, Possess the necessary knowledge in the development, the creation and operation of health systems. Once this task is accomplished, there will be no need to distinguish between medical and non-medical health facility management.

The results of the study showed that sharing the first information about the patient's illness is very shocking and traumatic for the family. In the first moments of sharing information about the illness, the information can be complex and the family finds it difficult to understand it properly. Professionals seem to focus more on informing and sharing about the disease than on supporting and increasing safety and understanding about the disease. Other studies show that information is conceptualized as a form of cognitive control and that it has both an informative and a supportive element. The information that needs to be communicated during palliative care is complex and can be uncertain and emotionally charged, which can set the stage for misunderstandings.

According to our study, palliative patients in Gjakova have many problems in the last phase of their lives and the needs to address these problems are very great. Most of the nurses interviewed choose not to share information about the disease with the patient, as they find it difficult and think that this is the best way to protect them. Not sharing information causes some patients to develop their own thinking, according to the information they receive in different moments and environments. Another part of patients ask, as they want to be informed and understand what is happening with their health. Studies show that nurses are often a primary source of information and transmitters of information, between health care professionals and their patients and their worldview influences the patient's thinking about illness. According to Mack and Grier in order for information to become a resource it is important to ensure that the exchange of information between the patient, family and nurse will continue, while the shock from the initial diagnosis will be undone.

The diagnosis of terminal illness causes a loss of balance within families and is accompanied by many other difficulties besides emotional ones, increased uncertainty, inability to find medications, financial difficulties, diagnostic and treatment procedures that are traumatic for the patient, hospital conditions that are not appropriate, the lack of skills in the new role of palliative care for the patient, distance from other family members. Even according to studies, the family is a fundamental part of any palliative program: it is actively involved in the provision of care and has a great responsibility for the care of the patient, often having to make difficult decisions in the best interest of the patient and paying the social and economic price for incurable diseases; without proper support,

The very large burden that the family goes through with the patient in the hospital causes them to show various health, emotional and psychological problems. The physical, emotional, social and spiritual elements that burden the family make them not think about their own needs and devote themselves absolutely to the family. Parents (mainly mothers), who are employed, risk losing their Nobs since they have to stay in the hospital, accompany their family members during treatment, and this causes them to have occasional early breaks from work. According to Barakat, Marmer and Schwartz, family function is essential in the patient's quality of life while undergoing cancer treatment; it can promote Positive outcomes for them.

Core competencies in palliative care

- Apply the key components of palliative care to the environment in which patients and their families find themselves.
- Allow the patient to feel as comfortable as Possible throughout the illness.
- Meet the patient's psychological needs.
- Meet the patient's social needs.
- Meet the patient's spiritual needs.
- Respond to the needs of family caregivers regarding short-, medium-, and long-term patient care goals.
- Responding to challenges related to clinical and ethical decision making in palliative care.
- Implement comprehensive care coordination and interdisciplinary working across palliative care settings.
- Develop interpersonal and communication skills appropriate for palliative care.

To develop awareness and continuous professional development.

- Dying Person's Bill of Rights
- I have the right to be treated as a living person until I die.
- I have the right to hold on to hope, no matter how its focus changes.
- I have the right to care for those who can hold this hope.
- I have the right to express my feelings and emotions about impending death, in my own way.
- I have the right to participate in decisions about my care.
- I have the right to expect constant medical and nursing attention, although the goals of recovery have become goals of comfort.
- I have the right, above all, to be relieved of pain.
- I am entitled to an honest answer to my questions.
- I have the right to a loving, sensitive, educated person who will try to understand my needs and who will be happy to help me face death.
- I have the right to be informed about the truth.
- I have the right to assist my family in accepting death.
- I have the right to discuss and expand on my religious and/or spiritual experiences, whatever that means to others.
- I have the right to maintain my personality and not be condemned by the chorus of my decisions, which may be contrary to the views of others.
- I have the right to die in peace and dignity.
- I have the right not to die alone.
- I have the right to expect that after death the sanctity of my human body will be respected.

Recommendation

Organize a disease prevention handout/questionnaire that will monitor health indicators and health status at the local level, the Population it serves. The employees/nurses of this discipline would have the duty to deal exclusively with the prevention and not the cure of the disease. The education of the personnel selected to work in this institution would move only in the direction of preventing the appearance of pathological conditions, as well as monitoring hereditary chronic diseases in certain families and Potentially preventing their development.

Organize special clinics and medical institutions and nursing staff, which would treat the Population of pensioners, in the service of general medicine, from which the pensioners could choose the doctor of their choice. To make the examination more efficient, such an organization of the general medical service would be extremely useful. The fact

is that due to the physiological aging of the body, the Population of retirees has increased the needs for health services and more often to see a doctor, due to various health problems or simply to get a prescription for regular and mandatory therapy. When a service user who is employed needs to return to work after an examination or consultation with the selected doctor, they often spend hours in the waiting room, because pensioners, who mainly have less obligations, have already taken their turn since the early hours of the morning. Thus, separating doctors and clinics that treat employees and those that treat retirees would lead to a much greater effectiveness of palliative health care delivery.

Cancel an appointment with a nurse of your choice: Making an appointment with a nurse of your choice seems really Pointless and irresponsible. Even if a patient knew he was going to get sick, he wouldn't know when it would happen. Systematic preventive examinations would be planned and organized at the disease prevention dispensary, and after the examinations the results would be merged into the patient's card at the selected doctor, so that the selected nurse would take care of the patient's further treatment if necessary.

Open the patient's electronic card, and schedule all necessary additional examinations to be carried out by the chosen doctor, directly with the specialist service to which it refers: Opening the electronic card would significantly shorten the path of information about the individual's illness through all levels of the health system. with treatment. The anamnesis would be easily accessible to any doctor, specialist, when the patient would be referred for additional examinations, so the decision on the further treatment of the disease would be better and more reliable, they would not rely only on it data that the patient provides from memory.

Increasing the number of health workers employed in the palliative health care service (home visits), which would reduce the pressure on the cost of illness and the number of patients in hospital. In fact, all mild and acute conditions would be treated at home with increased supervision of doctors and health workers from the patronage service. Of course, a larger number of employed health workers can also be achieved through redeployment of staff from secondary and tertiary health care.

Obtain funds for the purchase of equipment, modern diagnostic equipment and technical equipment in the health center through cooperation with the local community: Organize and discuss with the local government the provision of additional health services, education, educational seminars, institutions, businesses and private companies. ways to get extra funds.

Apply for funding for projects committed to improving the functioning of the health system from the European Union, its professional staff and the necessary resources.

Establish a partnership with a local tourism organization to provide health tourism services and thus receive additional funding for the improvement of the health organization.

The creation of a special curriculum that deals with the implementation of new experiences by nurses to patients in the last stage of life, either through special trainings or through a special model from university educational institutions for nurses dealing with palliative care.

Recommendations for the city of Gjakova

Research on this topic is very little represented in the city of Gjakova. Namely, nurses take great responsibility in providing health services. It is necessary to have a high degree of independence, expertise, experience, to be ready for additional physical effort, to adapt to different conditions in the field (microclimatic conditions, family relations, etc.). At the same time, nurses must be satisfied with their work, creative and motivated, and they must focus all their attention on the patient. Also, in our case, there is a Possibility that the respondents are young nurses / medical technicians who have completed an internship in a hospital. The question of course arises: In these cases, is there a need for special education before going into the field relative to other nurses with work experience, and are there measures by which we can assess their knowledge? If we look at previous work experience and total work experience, according to work experience it is a heterogeneous group of nurses / technicians. However, most of the respondents had previously had 11-20 years of work experience. Rather, it is beneficial because younger and older nurses/technicians can learn from each other and must work together to achieve common goals. Of course, most nurses/technicians feel that they possess the necessary knowledge according to their experience. Does this mean that younger nurses/technicians need additional training before being employed in institutions because they are completely independent in this field in contact with the patient and his family? The attitude of patients in a hospital is that a nurse should have additional knowledge and experience. In their opinion, the younger nurse has too little experience to be able to react appropriately in complex situations. They certainly believe that experience is gained through practice. It would probably be best for novice nurses/technicians to first work under the supervision of mentors - senior colleagues or take a specialized pre-employment course, which would be designed at the level of all health institutions in Kosovo.

Support is provided for palliative care programs at all levels in the health care system and at home.
The importance of home care for patients with advanced disease and to ensure that hospitals are able to provide adequate back-up and support for home care.
Palliative care programs have been incorporated into existing health care systems. Health care workers are adequately trained in palliative care.
Availability of opioid and non-opioid analgesics and annual stock assessment.

Acknowledgment. The authors were thankful to Muhamet Kadrija for finished successful this Scientific Master in Nursing Science, University "Fehmi Agani" Gjakovë, Kosova; 2022 year.

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