

# Methodology of Care Humanitude Implementation at an Integrated Continuing Care Unit: Benefits for the Individuals Receiving Care

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## Abstract

The increasing number of elderly people with behavioral changes, agitation, aggressiveness, and refusal to receive care imposes new challenges to caregivers, who need to take ownership of innovative care methodologies to better take care of this group of people. **Objective:** To evaluate the benefits of the Humanitude Care Methodology (HCM) in order to improve the health condition of people admitted in a Portuguese Integrated Continuing Care Unit (UCCI). **Methods:** An action research study was conducted between September and December 2016. The sample consisted of 33 people who were admitted in this UCCI for at least 90 days. Monthly data collection, during four periods, using the Braden Scale, Morse Scale, Barthel Index and Mini Mental State Examination. The data was processed using the Statistical Package for Social Science, version 17.0. **Results:** The following decreases were observed: in individuals with cognitive deficit (93.94 percent to 81.82 percent); in individuals considered totally dependent (60.61 percent to 30.30 percent); at risk developing pressure ulcers (PU) (84.85 percent to 51.52 percent); in individuals who had PU (24.24 percent to 15.15 percent); in people with high risk of fall (45.45 percent to 39.39 percent); in the number of individuals with two antipsychotic prescriptions (27.27 percent to 9.09 percent). **Conclusions:** These results allowed to understand the positive benefits, of implementing the HCM, on the people receiving care, specifically at cognitive level, dependency level in activities of daily living, and the avoidance of physical and mental deterioration.

## Keywords

Healthcare Quality, Humanization of Care, Patient-Centered Care, Elderly Care, Dementia

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## 1. Introduction

With the improvement of life conditions and the medical advancements, the human being is confronted with an increase of the life expectancy average. Associated with this aging phenomenon there is also an increasing prevalence of chronic diseases, in particular the number of people with Behavioral and Psychological Symptoms of Dementia (SCPD). In 1979, compelled to meet the needs of these individuals, Yves Gineste and Rosette Marescotti developed a methodology, named Methodology of Care Gineste-Marescotti® (MGM®) or Humanitude Care Methodology (HCM) [1] [2] [3]. Humanitude is defined by the set of particularities which make a person feel that he or she belongs to the human species, and with which he or she can recognize another human being as part of his or her kind [1] [2]. The authors have researched and developed this methodology that sustains a Structured Sequence of Humanitude Care Procedures (SEPCH) based on four pillars: the gaze, the speech, the touch, and the verticality, being the first three relational pillars and the last one an identity cornerstone. Following the HCM principles, the caregiver provides a comprehensive care, which with positive sensory stimulation allows the person to “live standing up” and to maintain all the abilities to live in interaction with others, with a meaningful connection with surroundings [1] [2]. HCM promotes relationship functionality through 5 consecutive and dynamic stages: pre-preliminaries, preliminaries, sensory circle, emotional consolidation and appointment.

In 2006, the Portuguese government established a National Network of Integrated Continuing Care (RNCCI) intended for people who were in a dependency situation and required long-term care and social support [1]. It was in this precise context that the training of RNCCI’s caregivers in the HCM arised. This training revealed to be particularly effective addressing the care of people with a high dependency level and/or a dementia syndrome. The training in Portugal consists of 51 hours, with both theoretical and practical components. The training program has a 4 stage design: 1) awareness, 2) dissemination, 3) consolidation, and 4) certification. The training involves all health professionals, including managers and clinical directors, and the institution’s formal and informal leaders.

The present study was carried out to evaluate the benefits of the HCM in the health condition of the people cared for in a UCCI in Portugal.

## 2. Methodology

In order to carry out this study, the HCM was implemented in a UCCI, and its

impact was evaluated. To evaluate the impact the following parameters were monitored: professionalization of the relationship between the caregiver and the person cared for, and a set of patient health outcomes such as risk of fall, risk of developing pressure ulcers, independency level, and cognitive functionality. The selection process of the participants was a convenience sampling, non-probabilistic, including 33 patients, who at the date of the beginning of the study, were admitted to the UCCI.

This UCCI was chosen for being at the planning stages of implementing the HCM, and consented to monitor the parameters aforementioned. The facility, where the study was conducted, is located at the central region of Portugal, in a mainly rural village, about 35 miles away from the nearest urban center. By providing care services, this UCCI's aim is to optimize health condition, or prevent health deterioration, as much as possible, during the hospitalization period of over 90 days. The people receiving care are mostly dependent and with cognitive deterioration. The study took place during a four-month period—between September and December of 2016. During this period, health professionals received training in the HCM.

That Humanitude training was provided and supervised by trainers from the Institute Gineste-Marescotti (IGM) Portugal, an accredited training structure responsible for the implementation of Humanitude in Portugal. The training included a total of 51 hours, with in-class theoretical component and care setting practical component. The care team went through 3 stages of the training program: 1) awareness—16 hours, for the entire multidisciplinary care team, during which the trainees were guided to reflect upon care practices, taught basic Humanitude techniques and presented to the importance of professionalizing the relationship and HCM results; 2) dissemination—35 hours, with the same team of professionals, taught to professionalize the pillars of Humanitude, Gaze, Speech, Touch and Verticality; 3) consolidation—7 hours for a group of 12 professionals who had completed the two previous training phases, selected for their leadership skills, who were trained to form a team with strategic and care management tools and leadership skills for an efficient implementation of Humanitude.

The UCCI inpatients health outcomes were monitored in a four-week interval.

The Morse Scale [4] was used to assess the risk of fall and the Braden Scale [5] was used to assess the risk of pressure ulcer development. Barthel Index [6] was used to assess the level of independency and the Mini Mental State Examination (MMSE) [7] was applied for the evaluation of the cognitive functions.

Data was also collected regarding skin breaks in forearms, arms, and legs. Physical restraint records were consulted, to identify the frequency and type of restraint used, the number of falls during the observation period and the resulting consequences. The number of people using wheelchairs, the intake of anxiolytics, sedatives, hypnotics, antidepressants, antipsychotics, and neuroleptics was also monitored during the four moments of data collection.

For data processing was used the Statistical Package for Social Science, version 17.0. The study was consented on July 14th 2016 by the Coordinator of the Office for Advance Studies of Coimbra's University, Faculty of Medicine and the Ethics Committee of Coimbra University Medical School (Reg. Nr. 056/2016). An authorization was also obtained from the institution administrative board members to conduct the study. All participants and caregivers signed the informed research consent, after being informed about the study's objectives, the voluntary participation assurance, and explicitly safeguarding that the acceptance or refusal would not carry any sort of harm to the individual.

### 3. Results

This study's sample included 33 participants with an average age of 78.42 years old. Hospitalization days in UCCI ranged between 90 to 779 days with an average length of stay of 290.21 days. A table with sociodemographic of the participants is presented bellow **Table 1**.

As shown in **Table 2**, for the risk of developing pressure ulcers (PU) was found that, at the first assessment phase, 28 out of the 33 participants in this study (84.85 percent) had a high risk of developing PU's. For the second assessment phase the number of people with high risk decreased to 24 (72.73 percent). This trend remained throughout the other assessments and at the third assessment the number of people cared for with high risk score was 20 (60.61 percent) and in the fourth assessment was 17 (51.52 percent). Overall there was a decrease in the risk of developing PU throughout all four assessment moments. Using the Friedman test (first phase: global average =  $14.48 \pm 2.79$ ; last phase:  $16.48 \pm 3.032$ ), the difference is statistically significant ( $X^2 = 40.507$ ;  $p < 0.005$ ), given that a higher value translates into a smaller compromise and, consequently, a lower risk exposure.

Regarding the presence of PUs during the study period (**Table 3**), for the 33 participants, was found that 25 (75.76 percent) of the people cared for did not have PUs on the first assessment. This number had a gradual increase over the assessment phases, reaching to 28 (84.85 percent) in the fourth assessment. In the first assessment 1 person (3.03 percent) had multi-skin tears, with two Stage III PU and one Stage II PU, and 1 other person (3.03 percent) had multi-skinned with three Stage III PU and two Stage II PU. By the third assessment, there were 0 (zero) individuals with two or more pressure ulcers.

In the first assessment, 1 person (3.03 percent) showed skin breaks on the forearm/arm, this same condition was not identified in the following assessments. In the first assessment, 1 person (3.03 percent) showed skin breaks on the legs, condition which was not identified in the fourth assessment. As for the risk of fall, as shown in **Table 4**, there was a reduction of the high risk of fall, from the second to the fourth assessment. Using Friedman Test, there was a decrease in the global average risk of fall (first assessment: global average =  $51.06 \pm 22.38$ ; last assessment:  $45.45 \pm 19.62$ ). However, the difference was not statistically significant ( $X^2 = 3.863$ ;  $p = 0.277$ ).

**Table 1.** Sociodemographic characterization of the participants.

Participants		Nr.	%
Genre	Male	8	24.24
	Female	25	75.6
Education	Completed primary education	22	66.67
	Illiterate	11	33.33
Provenance	Home/caregiver's home	23	69.70
	Hospital	10	30.30
Goal after discharge	Nursing home	25	75.76
	Return home	8	24.24
Main reason for admission	Dementia syndrome	28	84.85
	Cardiovascular disease	5	15.5

Abbreviations: Nr., Number.

**Table 2.** Percentage of people cared for according to the risk of developing PU, using the Braden Scale.

Risk of developing PU	1 <sup>st</sup>		2 <sup>nd</sup>		3 <sup>rd</sup>		4 <sup>th</sup>	
	Nr.	%	Nr.	%	Nr.	%	Nr.	%
High risk	28	84.85	24	72.73	20	60.61	17	51.52
Low Risk	5	15.15	9	27.27	13	39.39	16	48.48

Abbreviations: PU, Pressure Ulcer; Nr., Number; 1<sup>st</sup>, First assessment; 2<sup>nd</sup>, Second assessment; 3<sup>rd</sup>, Third assessment; 4<sup>th</sup>, Fourth assessment.**Table 3.** Percentage of people cared for with Pus.

Presence of pressure ulcers	1 <sup>st</sup>		2 <sup>nd</sup>		3 <sup>rd</sup>		4 <sup>th</sup>	
	Nr.	%	Nr.	%	Nr.	%	Nr.	%
Without pressure ulcers	25	75.76	25	75.76	26	78.79	28	84.85
Stage I PU	2	6.06	1	3.03	2	6.06	0	0.0
Stage II PU	1	3.03	1	3.03	2	6.06	2	6.06
Stage III PU	2	6.06	2	6.06	2	6.06	2	6.06
Stage IV Pressure Ulcer (PU)	1	3.03	2	6.06	1	3.03	1	3.03
2 PU II + 1 PU I	0	0.0	1	3.03	0	0.0	0	0.0
2 PU III + 1 PU II	1	3.03	1	3.03	0	0.0	0	0.0
3 PU III + 2 PU II	1	3.03	0	0.0	0	0.0	0	0.0

Abbreviations: PU, Pressure Ulcer; Nr., Number; 1<sup>st</sup>, First assessment; 2<sup>nd</sup>, Second assessment; 3<sup>rd</sup>, Third assessment; 4<sup>th</sup>, Fourth assessment.**Table 4.** Percentage of people cared for according to the risk of falls, using the Braden Scale.

Fall Risk	1 <sup>st</sup>		2 <sup>nd</sup>		3 <sup>rd</sup>		4 <sup>th</sup>	
	Nr.	%	Nr.	%	Nr.	%	Nr.	%
Low Risk	3	9.09	3	9.09	3	9.09	3	9.09
Medium Risk	15	45.45	13	39.39	15	45.45	17	51.52
High risk	15	45.45	17	51.52	15	45.45	13	39.39

Abbreviation: Nr., Number; 1<sup>st</sup>, First assessment; 2<sup>nd</sup>, Second assessment; 3<sup>rd</sup>, Third assessment; 4<sup>th</sup>, Fourth assessment.

During the assessment period, 6 participants (18.18 percent) had one fall and 3 participants (9.09 percent) had two falls; 24 people (72.73 percent) did not have a fall during this period. Of the 9 people cared for, who have had fall episodes, 8 (90 percent) had no sequels from the fall and 1 (10 percent) had abrasions and bruising as a consequence. Regarding the use of physical restraints, in the first assessment, we found that 9 participants (27.27 percent) had a physical restraint prescription while sitting on a chair. By the fourth assessment, this number reduced to 5 patients (15.15 percent). This meant that by the fourth assessment, 28 people (84.85 percent) didn't have a physical restraint. For those cases where participants required a physical restraint, there was a compensation plan, and the physical restraint was placed only when the person was sitting in the chair, unattended. There was no the use of physical restraints (0 percent) when lying in bed.

When evaluated the independency index, in the four moments of assessment (**Table 5**), there was a reduction in the number of total dependency patients. In the first phase assessment, 60.61 percent of the participants were totally dependent. Whereas at the last assessment this number decreased to 30.30 percent. The overall independency level increased, given that the Barthel Index overall average increased throughout all four assessment phases (first phase overall average =  $20.45 \pm 22.49$ ; last phase:  $35.45 \pm 27.79$ ), with a statistically significant difference ( $\chi^2 = 62.15$ ;  $p < 0.005$ ).

Regarding the activities assessed using the Barthel Index was found that along the four assessments there was a dependency decrease on feeding activities—from 48.49 percent on the first assessment to 21.21 percent in the fourth assessment. For this specific activity the percentage of independent patients increased from 3.03 percent, in the first phase assessment, to 15.15 percent in the fourth phase assessment. Regarding the bath activity, in the first assessment, 100 percent of the participants were categorized as dependent. By the fourth assessment, 93.94 percent were dependent for this activity. The dressing activity had a decrease of dependency going from 84.85 percent on the first phase assessment to 75.6 percent on the fourth phase assessment. During the first phase assessment there were no independent patients on this activity. However, on the fourth phase assessment was observed an increase of independent patients (12.12 percent). There was an increase of individuals doing their own personal hygiene independently, from 3.03 to 24.24 percent. There was an increase for bowel control activity in continent patients along the four assessment phases from 24.24 percent in the first assessment to 27.27 percent in the fourth assessment. The same has occurred for bladder control activity for continent patients registering an increase from 18.18 percent in the first phase assessment to 27.27 percent in the fourth assessment. Regarding the toilet use there was a decrease of patient dependency from 63.64 percent in the first assessment to 39.39 percent in the fourth assessment. The number of independent participants increased from 6.06 percent in the first assessment to 15.15 percent in fourth assessment. The chair-bed transfer activity registered a dependency decrease going from 36.36

**Table 5.** Percentage of individuals receiving care according to the degree of dependency applying Barthel Index.

Level of independency	1 <sup>st</sup>		2 <sup>nd</sup>		3 <sup>rd</sup>		4 <sup>th</sup>	
	Nr.	%	Nr.	%	Nr.	%	Nr.	%
Totally dependent	20	60.61	13	39.39	11	33.33	10	30.30
Severely dependent	7	21.21	8	24.24	10	30.30	9	27.27
Moderately dependent	4	12.12	9	27.27	7	21.21	9	27.27
Slightly dependent	2	6.06	3	9.09	4	12.12	3	9.09
Independent	0	0.0	0	0.0	1	3.03	2	6.06

Abbreviations: Nr, Number; 1<sup>st</sup>, First assessment; 2<sup>nd</sup>, Second assessment; 3<sup>rd</sup>, Third assessment; 4<sup>th</sup>, Fourth assessment.

percent, in the first phase assessment, to 6.6 percent, in the fourth phase assessment. The number of independent people in this activity increased from 6.6 percent in the first phase assessment to 18.18 percent in the fourth phase assessment. For the walking activity, the number of patients with dependency decreased during the four assessment phases, from 69.70 percent in the first assessment to 45.45 percent in the fourth assessment. The number of independent patients for walking activity increased from 6.6 percent in the first phase assessment to 18.18 percent in the fourth phase assessment. During the observation period, there was a reduction of the usage of wheelchairs for mobility. In the first moment of observation, 69.70 percent of the participants used a wheelchair to move around and by the final evaluation there was a decrease of 42.42 percent. The use of staircase activity also registered a dependency decrease going from 81.82 percent in the first phase assessment to 69.6 percent in the fourth phase assessment. The number of patients using the stairs independently increased from 3.03 percent (first assessment) to 6.06 percent (fourth assessment).

A significantly statistical difference was found ( $\chi^2 = 8.077$ ;  $p < 0.005$ ), using the Friedman test to evaluate the MMSE in all four phases. As shown in **Table 6**, the average values have increased, which translates into a decrease of the cognitive deficit. In the first assessment, 93.94 percent (31 participants) showed cognitive deficit, and this number reduced to 81.82 percent in the last assessment.

When assessing the medication and the group of drugs used (**Table 7**), the number of patients with prescribed sleeping pills, sedatives, antidepressants, antipsychotics, and hypnotics reduced along the four assessments. Also, the percentage of people receiving care, who had two drugs prescribed of the anxiolytic, sedative and hypnotic group, decreased from 30.30 to 3.03 percent. The use antidepressant drugs also had a decrease along all four assessments. The percentage of participants with prescription of two antipsychotics decreased from 27.27 percent to 9.09 percent, in all four assessments.

The percentage of patients with drug prescriptions, from the aforementioned pharmacological groups, decreased from 24.24 percent at the first assessment to 12.12 percent at the fourth assessment. The number of patients with a prescription for two drugs, from the aforementioned groups, also decreased from 45.45

**Table 6.** MMSE assessment mean and standard deviation in four assessment phases.

MMSE	Assessment Phase	Mean	Standard Deviation
MMSE	1 <sup>st</sup>	9.09	7.99
MMSE	2 <sup>nd</sup>	10.27	9.08
MMSE	3 <sup>rd</sup>	11.36	9.25
MMSE	4 <sup>th</sup>	12.00	9.19

Abbreviations: Nr., Number; 1<sup>st</sup>, First assessment; 2<sup>nd</sup>, Second assessment; 3<sup>rd</sup>, Third assessment; 4<sup>th</sup>, Fourth assessment.

**Table 7.** Percentage of individuals who received care according to drug prescriptions (N = 33).

Medication		1 <sup>st</sup> .		2 <sup>nd</sup> .		3 <sup>rd</sup> .		4 <sup>th</sup> .	
		Nr.	%	Nr.	%	Nr.	%	Nr.	%
Anxiolytics, sedatives, hypnotics	Not prescribed	5	15.15	4	12.12	7	21.21	8	24.24
	1 Prescribed	18	54.55	24	72.73	24	72.73	24	72.73
	2 Prescribed	10	30.30	5	15.15	2	6.06	1	3.03
Antidepressants	Not prescribed	14	42.42	18	54.55	21	63.64	22	66.67
	1 Prescribed	16	48.48	12	36.36	10	30.30	10	30.30
	2 Prescribed	3	9.09	3	9.09	2	6.06	1	3.03
Neuroleptics	Not prescribed	28	84.85	28	84.85	28	84.85	28	84.85
	1 Prescribed	4	12.12	5	15.15	5	15.15	5	15.15
	2 Prescribed	1	3.03	0	0	0	0	0	0
Antipsychotics	Not prescribed	17	51.52	18	54.55	17	51.52	18	54.55
	1 prescribed	7	21.21	9	27.27	13	39.39	12	36.36
	2 prescribed	9	27.27	6	18.18	3	9.09	3	9.09

Abbreviation: Nr., Number; 1<sup>st</sup>, First assessment; 2<sup>nd</sup>, Second assessment; 3<sup>rd</sup>, Third assessment; 4<sup>th</sup>, Fourth assessment.

to 39.39 percent. The percentage of patients who did not take any drugs, included in those pharmacological groups, increased from 6.06 to 9.09 percent.

#### 4. Discussion

The 33 participants in this study were mostly female, aged over 65 years, with a low level of literacy. This data overlaps the Health System Central Administration's (ACSS) [8] data report for the integrated continued care national network. More than half of the participants were admitted to UCCI for long term care meaning that the hospitalization period would be for minimum of 180 days. More than half of the participants in the study was referred to the long-term care network due to dependency on the Activities of Daily Living (ADL). Only a small percentage was referred due to cognitive deterioration. Although the main diagnosis on referral forms was cerebrovascular disease, the main diagnosis after the initial medical evaluation, at the admission assessment, was "degenerative



brain disease”, then followed by cerebrovascular disease. This is corroborated by another study [9], that also took place in Long Term Care and Maintenance Units, which found that the primary diagnosis on admission was “neurological damage”.

The number of people with dementia syndromes and cognitive deficits, admitted at the care unit, was higher than the number registered in referrals to the RNCCI, which suggests that these individuals may not have been properly identified and diagnosed. Identical results were obtained in another study [10], where it was claimed that dementia is still an underdiagnosed condition. In our study, through the MMSE, was found that more than half of the people receiving care had cognitive deficit, at the time of their first evaluation, and over time there was a slight deficit decrease, which meant a better cognitive function. This reduction of cognitive impairment may be related to the professionalization and intentionality of the interaction with the cared person; the promotion of independency and self-care, the multisensory stimulation during care (smell, touch, gaze, hearing and taste), leading to greater improvement of cognitive and psychomotor skills, through the reestablishment of brain connections [11].

According to the RNCCI [8] monitoring report, ADL dependency is the second most common reason for referral. Through the Barthel Index was found that more than half of the participants were totally dependent and there were no independent patients, in the first assessment. During the study, the level of independence has increased, which may be related with the upright intent (verticality), greater multisensorial stimulation, and continuing incentive for the remaining capacities. All these were possible due to the use of HCM and the healthcare professionals’ awareness to their rules of art, for example allowing the person to perform the care activity that is capable of. These results are aligned with other studies [12] [13].

With the Braden Scale was found that the number of patients with a high risk of developing PUs decreased, as well as the incidence number of PUs and their grade of severity. According to the RNCCI [8] monitoring report, the incidence of PUs in 2015 was higher than in the previous three years, which means that the tendency was to increase. In this report is claimed that the Long-term care units have the highest incidence of PUs, which in the central region corresponded to 9.2 percent of the people admitted. In 2015, the prevalence of PUs was 14.8 percent. In our study, the fact that patients had a reduction in the number and severity of PU’s, contradicts this data and reveals the greater results of this study. These results may be related to the intentionality of care and promotion of verticality and mobility; the decrease in the number of bedridden patients; personal hygiene done as vertical as possible; and the reduction of usage of wheelchairs during care, as recommended by Gineste and Pellissier [14]. This study was also found a reduction of skin breaks, which is consistent with other studies on the use of HCM. Due to Humanitude’s tender touch techniques, the reduction of agitation behaviors and refusal of care, there is a prevention of shear and skin bruising [15].

There also was a decrease in the number of people receiving care with a prescribed physical restraint. Physical restraint was only used after negotiating a consent with the person, and applied for short periods of time, when sitting in a chair unattended, to avoid slipping, and with a planned compensatory non-restrained time. These results are also aligned with those obtained by the authors of HCM, as well as with the proposed rules of art of Humanitude philosophy [14]. According to HCM the promotion of liberty and autonomy are to be privileged at all times. This is in line with the directives given by the Portuguese General Health Direction, on their normative guideline nr. 021/2011, which establishes that when applying restraint measures, all the preventive measures should be taken and, if possible, to obtain the patient's consent. This guideline sustains that restraints should be considered as a last resort intervention by health professionals, after having exhausted all alternative measures. In all circumstances, the principle of patient care with the lowest restraints possible prevails, given the negative impact of restraints on the patient's freedom, self-determination, and dignity (DGS 021/2011).

When providing care to patients with behavioral changes, it is of utmost relevance that the facility has human resources with specific skills to ensure the quality of care and to safely follow up the patient (DGS, 08/DSPSM/DSPCS; Date: 05/25/07). Thus, given the results obtained with the HCM in preventing agitation and patients defensive behaviors [13] [14] [16], it is essential to professionalize the relationship with patients and empower professionals with technical and relational procedures.

In this study, was found that the number of patients with a high risk of falls decreased over time, and most participants had no falls. Those who had a fall episode, only one person had sequels but not severe enough to change mobility. According to the ACSS RNCCI [8] monitoring report, the number of falls in Long Term Care (LTC) units increased between 2014 and 2015, and most falls had sequels (with or without change of mobility). Besides, a study [9] conducted in LTC units did not show significant improvement in reducing the risk of falls, using the Morse Scale. Results of our study may be related to intentionality in vertical care, which serves as an identity pillar, a functionality promoter, a blood circulation stimulator, a balance trainer and body schema rehabilitator [17]. Also, the Humanitude's relational handling techniques used during the mobilizations and transfers of patients, convey confidence, thus reducing agitation and increasing safety, autonomy and self-esteem.

In this study, the number of people cared for who had prescribed anxiolytic, sedative, hypnotic, antidepressant and antipsychotic drugs decreased over time. The number of neuroleptic drugs prescribed to patients decreased and polypharmacy also decreased with this type of drugs. These results may be related to the professionalization and intentionality while interacting with the person cared for, through the use of relational pillars (gaze, speech and touch) through which the person feels in charge of care, preventing anxiety and agitation [13] [16].

Polypharmacy in people with multiple chronic diseases is very common, increasing the risk of adverse effects due the interaction between the prescribed drugs [18]. So, whenever possible, in order to promote the well-being of these people, medication should be reduced and with it its side effects [2]. Hence, healthcare professionals should opt for the use of a non-pharmacological approach, such as methodologies of care that are relationship centered.

## 5. Limitations

We consider that this study has two main limitations. First, the reduced number of participants involved in the study, which conditions the extrapolation of the data obtained. Secondly, we consider that in order to accurately assess the evolution of participants, should be carried out a longitudinal study over a longer period of time.

## 6. Conclusions

During this study, there were effective health gains, in both health outcomes and health outputs. People receiving care during the implementation period of HCM, revealed a higher level of independency, with increased mobility and reduced use of wheelchairs; decreased risk of developing PU, reduction of the number and severity of PUs; decreased risk of falls, reduction of physical restraints, administration of anxiolytics, sedatives, hypnotics, antidepressants and antipsychotics. The positive results of implementing this methodology of care allowed us to reflect on the importance of HCM. Also, was inferred that the training of healthcare professionals in innovative care methods, evidence based, is key to promote professionalized and specialized care practices which are adequate to the personal needs of the patients. Therefore, conditions should be in place to allow the implementation and dissemination of HCM in nursing care practices. Moreover, professionals need to take ownership of this methodology of care so that the patient's dignity is safeguarded. It is paramount to reject care practices that place the patients' Humanity at risk, and impair their abilities, since this is unethical and unprofessional.

Challenges are posed to society, requiring innovative responses towards the relationship professionalization and the improvement of quality of care provided. Healthcare is under pressure to achieve health gains, improve patients' independency and prevent health complications such as pressure ulcers, risk of falls and the deterioration of cognitive functions. The HCM seems to be a response to all of the above, therefore healthcare professionals should be enablers to promote and protect the Humanity of the people cared for.

## Recommendations

Based on the results of this investigation, we consider relevant the development of future studies, with control groups, in units where this methodology of care was not implemented, for the same period of time, and in a longitudinal per-

spective, allowing a rigorous evaluation of the added value of the Humanity Care Methodology as an innovative care technology.

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### Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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