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Knowledge and practices of the nursing team regarding palliative care provided to older adults

Saberes e práticas da equipe de enfermagem sobre cuidados paliativos prestados à pessoa idosa

Saberes y prácticas del equipo de enfermería sobre cuidados paliativos prestados al anciano

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ABSTRACT

Objective: to assess the knowledge and practices of the nursing team regarding palliative care provided to older adults. **Method:** qualitative study based on the Peaceful End of Life Theory, with 18 nurses and 28 nursing technicians. Data collection took place through semi-structured interviews between May and June 2024, in a public hospital in Fortaleza, Ceará, Brazil, with thematic-categorical content analysis. **Results:** the analysis resulted in three categories: 1) Emphasis on comfort and the physical dimension of care; 2) Integration of emotional, spiritual and social dimensions; 3) Eligibility criteria and ethical care. **Final considerations:** the participants understand palliative care as an integrated approach which involves physical, emotional, social and spiritual aspects, with an emphasis on effective communication and respect for autonomy. However, this understanding is restricted to the final phase of life, resulting in practices more focused on technical aspects of care.

Descriptors: Nursing; Palliative Care; Aged; Practice Patterns, Nurses'.

RESUMO

Objetivo: avaliar os saberes e as práticas da equipe de enfermagem sobre cuidados paliativos prestados à pessoa idosa. **Método:** estudo qualitativo, fundamentado na Teoria do Final de Vida Pacífico, com 18 enfermeiros e 28 técnicos de enfermagem. A coleta de dados ocorreu por entrevistas semiestruturadas entre maio e junho de 2024, em um hospital público de Fortaleza, Ceará, Brasil, com análise de conteúdo temático-categorial. **Resultados:** a análise resultou em três categorias: 1) Ênfase no conforto e na dimensão física do cuidado; 2) Integração das dimensões emocional, espiritual e social; 3) Critérios de elegibilidade e cuidado ético. **Considerações finais:** os participantes compreendem os cuidados paliativos como uma abordagem integrada, que envolve aspectos físicos, emocionais, sociais e espirituais, com ênfase na comunicação eficaz e no respeito à autonomia. No entanto, essa compreensão está restrita à fase final da vida, resultando em práticas mais centradas nos aspectos técnicos do cuidado.

Descritores: Enfermagem; Cuidados Paliativos; Pessoa Idosa; Padrões de Prática de Enfermagem.

RESUMEN

Objetivo: evaluar los saberes y las prácticas del equipo de enfermería sobre cuidados paliativos prestados al anciano. **Método:** estudio cualitativo, fundamentado en la Teoria del Final de Vida Pacífico, con 18 enfermeros y 28 técnicos de enfermería. La recolección de datos se llevó a cabo por medio de entrevistas semiestructuradas entre mayo y junio de 2024, en un hospital público de Fortaleza, Ceará, Brasil, con análisis de contenido temático-categorial. **Resultados:** el análisis dio lugar a la identificación de tres categorías: 1) Énfasis en el confort y en la dimensión física del cuidado; 2) Integración de las dimensiones emocional, espiritual y social; 3) Criterios de elegibilidad y cuidado ético. **Consideraciones finales:** los participantes comprenden los cuidados paliativos como um enfoque integrado, que involucra aspectos físicos, emocionales, sociales y espirituales, con énfasis en la comunicación eficaz y en el respeto a la autonomía. Sin embargo, esa comprensión se restringe a la fase final de la vida, resultando en prácticas más centradas en los aspectos técnicos del cuidado.

Descriptores: Enfermería; Cuidados paliativos; Anciano; Pautas de la Práctica en Enfermería.

INTRODUCTION

Increased life expectancy has led to significant demographic changes which pose major public health challenges. There is an increase in the prevalence of chronic non-communicable diseases as the population ages, which cause progressive changes in health and lead to functional dependence. This scenario, combined with declining health status, often results in the need for palliative care (PC)[1].

For many years, PC was seen as an exclusive approach for patients at the end of life. However, this vision was expanded over time, and came to be understood as a continuous and integrated strategy aimed at alleviating suffering and improving quality of life from the diagnosis of serious illnesses, regardless of the illness stage. This expanded model

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not only seeks physical comfort, but also emotional, social and spiritual support for both patients and their families throughout the entire disease process.

Palliative care should not be limited to the end of life, but should be introduced as early as possible with the aim of alleviating suffering and improving quality of life on an ongoing basis. This paradigm shift reflects a movement towards a more inclusive and proactive approach which aims at comprehensive patient care and disease management at all stages.

In this context, the initial definition of Palliative Care established by the World Health Organization (WHO) in 1990 and revised in 2002 was fundamental in outlining this approach, focusing on improving the quality of life of patients and their families facing life-threatening illnesses. The definition included suffering prevention and relief, as well as early identification, assessment and treatment of physical, psychosocial and spiritual symptoms[3].

The International Association for Hospice and Palliative Care (IAHPC), a non-governmental organization (NGO), expanded the PC definition in 2017 through discussions with experts in the field to a holistic and active approach for individuals of all ages facing suffering related to serious illnesses, with a special focus on those near the end of life. The central objective of this approach is to improve the quality of life of patients, families and caregivers, something that was widely accepted by the WHO[4].

The WHO subsequently updated its concept and redefined PC as an approach aimed at improving the quality of life of patients of all ages, their families and caregivers facing life-threatening illnesses, with a focus on preventing and alleviating suffering through early identification, assessment and appropriate treatment of pain and physical, psychosocial and spiritual problems[3].

Therefore, the support of a qualified and confident multidisciplinary team is essential in order to assertively and effectively develop PC, since the care demands include several specializations and all professionals are important for monitoring the patient's trajectory[5].

Nursing professionals stand out among the members of the multidisciplinary team for their continuous and uninterrupted presence in care provision. In this context, they experience the anguish and suffering inherent in the dying process of patients, which enables them to offer care based on the nursing process. Health education, emotional and social support, assessment, identification of problems and nursing diagnosis are considered fundamental actions. These actions adopt a biopsychosocial and educational approach, aiming to meet the needs of patients and their families throughout the care process[5].

Despite the importance of the nursing team in providing palliative care, the literature points to a significant gap in understanding this care approach. Studies[6,7] highlight the insufficiency of continuing education programs, the lack of formal training, limited knowledge about symptom management, difficulties in communicating effectively with patients and family members about the dying process, as well as an incomplete understanding of the concept and principles that underpin palliative care.

The aforementioned knowledge gaps negatively impact the care quality, as the nursing team may not be sufficiently prepared to adequately manage patient symptoms and effectively communicate with them and their families. This limitation results in insufficient care, which intensifies patient suffering and leads to family dissatisfaction with the care provided[6-8].

In view of the above, the objective of this study was to evaluate the knowledge and practices of the nursing team regarding palliative care provided to older adults.

THEORETICAL FRAMEWORK

The Peaceful End of Life Theory (PELT)[9] was adopted for this study, which not only focuses on the final instance of death itself, but also on promoting a peaceful and meaningful life during the patients' remaining time. From this perspective, the individual contexts of each patient and what is most relevant to them are considered.

The theory aims to "improve the quality of life and provide a peaceful end of life for patients with advanced diseases", focusing on nursing interventions and specific outcomes for this group. It is based on concepts that highlight the importance of not being in pain; of having comfort, dignity and respect; of being at peace; in addition to being close to important people who show concern[9].

METHOD

This is a descriptive qualitative study based on the Peaceful End of Life Theory, designed according to the Consolidate Criteria for Reporting Qualitive Research (COREQ) instrument developed to guide researchers regarding the quality and transparency of the information collected[10].

The data were collected between May and June 2024, exclusively conducted by the lead researcher through individual interviews lasting an average of 20 minutes, which were recorded after obtaining prior authorization and later transcribed for analysis. A semi-structured form prepared by the researcher was used, which contained questions designed to characterize the sociodemographic profile of the participants, such as: age, gender, occupation/profession, time of technical or higher education, working time in the institution and previous courses on palliative care. Additionally, open-ended questions related to the knowledge and practices of the nursing team regarding palliative care provided to older adults were included, namely: *How do you conceptualize and understand the practice of palliative care? How does this understanding influence your approach and performance in caring for older adults? What strategies and interventions do you use when providing care to older adults in a palliative setting?*

The study was conducted in a public hospital of secondary complexity located in the city of Fortaleza, Ceará, Brazil. This institution was chosen due to the presence of a palliative care and rehabilitation unit with an active multidisciplinary team. Most of the patients treated at this unit are older adults receiving palliative care, which allows for a comprehensive analysis of the nursing team's performance in caring for this group taking into account the multidimensional complexity involved.

A total of 46 nursing professionals participated in the study, including 18 nurses and 28 nursing technicians. The inclusion criteria adopted were that participants should be nurses and/or nursing technicians with a formal employment relationship at the hospital and experience in caring for at least one person receiving palliative care. Nursing professionals on vacation or sick leave during data collection, as well as those who were not active in the unit during this period, were excluded from the sample.

After receiving information about the objectives and purposes of the research, the participants voluntarily consented and signed an Informed Consent Form (ICF). Nurses were identified with the abbreviation "N" and nursing technicians with "Tec" to ensure anonymity and preserve their identities.

The data were initially digitized into a document using Microsoft Word software. They were then transferred to Notepad and organized appropriately for processing by the IRaMuTeQ (Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires) version 0.7 alpha 2 2020 software. IRaMuTeQ[11] is a free software specialized in analyzing textual content and organizing significant elements.

The analysis for the purposes of this study was performed using Descending Hierarchical Classification (DHC). In this method, textual segments, or elementary context units, were classified based on the highest words and chi-squared values. The words were organized in a dendrogram, and those selected to form the classes presented a p-value <0.001, indicating a statistically significant association.

The lexical content analysis performed by the Iramuteq® software presented a *corpus* of 202 text segments (TS), with 7,089 occurrences and a utilization rate of 86.63%. It is worth noting that at least 75% of the text segments must be classified or utilized for this type of analysis to be effective in classifying any textual material. Therefore, the utilization rate observed demonstrates the robustness and validity of the analyzed *corpus*, ensuring the quality and relevance of the results obtained in the research.

The research protocol was approved by the Research Ethics Committee and complied with the guidelines and regulatory standards established by Resolution No. 466/2012 of the National Health Council, which guides research involving human beings.

RESULTS AND DISCUSSION

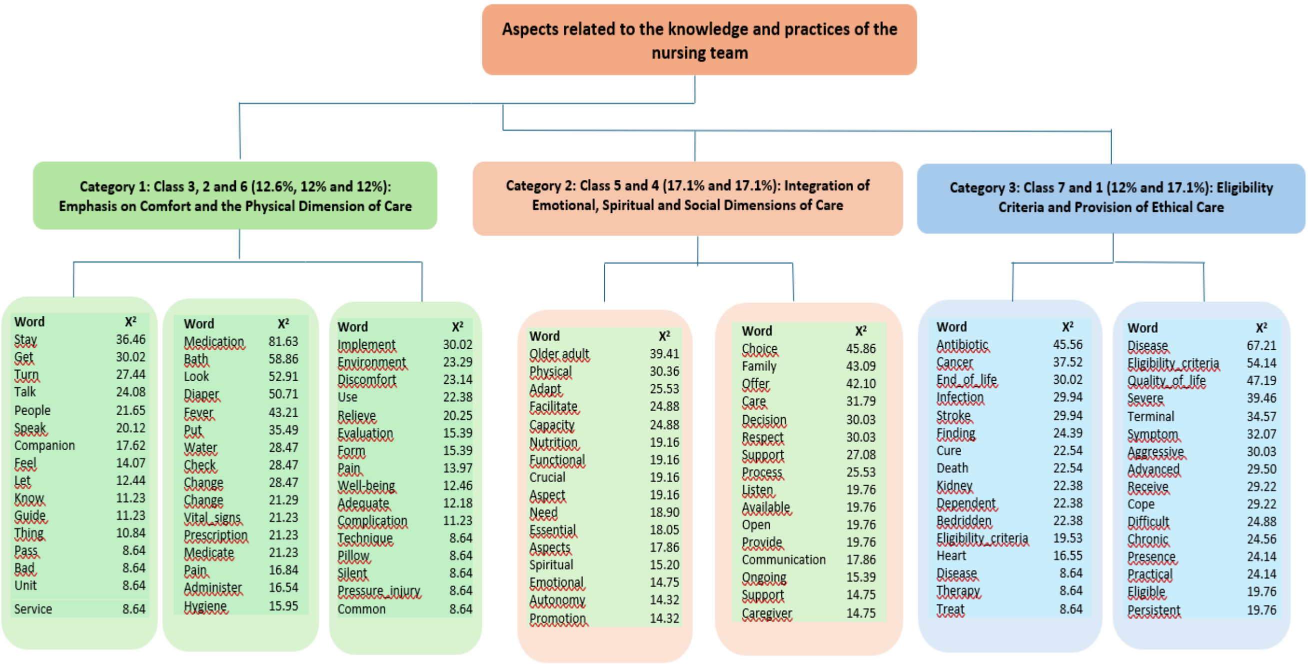
A predominance of women was observed (68.7%) in the analysis of the participants' characteristics. The average age was 34 years. The length of service in the unit was three years, with professionals having an average of 10 years of experience in the health area, specifically in the hospital context.

The sociodemographic data of the interviewees correspond to the profile identified in another study[12]. Nursing has historically had a predominance of women. However, there has been an increase in the presence of men in the profession in recent years, although the numerical superiority of women has remained.

All of the 18 nurses interviewed reported having basic PC knowledge; however, none had any type of training in a specialization or improvement course in the PC area, and 11 reported having taken a short course of less than 10 hours on the subject. This number for the nursing technicians was even more discrepant, where 83.3% (n=15) had never taken any training on PC.

Including disciplines and clinical internships focused on theoretical and practical teaching of palliative care has been widely discussed, since the lack of specific teaching on this topic in higher education and technical courses compromises training qualified professionals. This gap results in a shortage of specialists and negatively affects care quality for a pent-up demand. Recent studies[6-8,13] corroborate this finding, highlighting the urgent need to integrate palliative care into academic curricula to improve professional training.

Next, the textual domains in the qualitative analysis based on the DHC were analyzed and interpreted to give meaning to the classes. The segments used were divided into seven classes, later organized in a dendrogram. It is worth noting that the authors considered the classes to organize the thematic axes in this order (3, 2, 6, 5, 4, 7 and 1) from the *corpus* processing by IRaMuTeQ, which generated this partition logic as illustrated in Figure 1.



Word	X^2
Stay	36.46
Get	30.02
Turn	27.44
Talk	24.08
People	21.65
Speak	20.12
Companion	17.62
Feel	14.07
Let	12.44
Know	11.23
Guide	11.23
Thing	10.84
Pass	8.64
Bad	8.64
Unit	8.64
Service	8.64

Word	X^2
Medication	81.63
Bath	58.86
Look	52.91
Diaper	50.71
Fever	43.21
Put	35.49
Water	28.47
Check	28.47
Change	28.47
Change	21.29
Vital_signs	21.23
Prescription	21.23
Medicate	21.23
Pain	16.84
Administer	16.54
Hygiene	15.95

Word	X^2
Implement	30.02
Environment	23.29
Discomfort	23.14
Use	22.38
Relieve	20.25
Evaluation	15.39
Form	15.39
Pain	13.97
Well-being	12.46
Adequate	12.18
Complication	11.23
Technique	8.64
Pillow	8.64
Silent	8.64
Pressure_injury	8.64
Common	8.64

Word	X^2
Older adult	39.41
Physical	30.36
Adapt	25.53
Facilitate	24.88
Capacity	24.88
Nutrition	19.16
Functional	19.16
Crucial	19.16
Aspect	19.16
Need	18.90
Essential	18.05
Aspects	17.86
Spiritual	15.20
Emotional	14.75
Autonomy	14.32
Promotion	14.32

Word	X^2
Choice	45.86
Family	43.09
Offer	42.10
Care	31.79
Decision	30.03
Respect	30.03
Support	27.08
Process	25.53
Listen	19.76
Available	19.76
Open	19.76
Provide	19.76
Communication	17.86
Ongoing	15.39
Support	14.75
Caregiver	14.75

Word	X^2
Antibiotic	45.56
Cancer	37.52
End_of_life	30.02
Infection	29.94
Stroke	29.94
Finding	24.39
Cure	22.54
Death	22.54
Kidney	22.38
Dependent	22.38
Bedridden	22.38
Eligibility_criteria	19.53
Heart	16.55
Disease	8.64
Therapy	8.64
Treat	8.64

Word	X^2
Disease	67.21
Eligibility_criteria	54.14
Quality_of_life	47.19
Severe	39.46
Terminal	34.57
Symptom	32.07
Aggressive	30.03
Advanced	29.50
Receive	29.22
Cope	29.22
Difficult	24.88
Chronic	24.56
Presence	24.14
Practical	24.14
Eligible	19.76
Persistent	19.76

Figure 1: Dendrogram of the Descending Hierarchical Classification of the *corpus* "Aspects related to the knowledge and practices of the nursing team". Fortaleza, Ceará, Brazil, 2024.

Emphasis on comfort and the physical dimension of care

This category emerged from the lexicons from classes 3, 2 and 6, which together reveal the participants' understanding of palliative care, particularly in the dimension of physical comfort. The participants showed an understanding that palliative care is directly linked to practices which aim to alleviate symptoms and promote physical well-being for patients, which highlights the centrality of physical care in palliative management. The following TSs illustrate these aspects:

> *(...) We prioritize the assessment and appropriate management of pain and other symptoms such as dyspnea, nausea, and fatigue. We use symptom management scales to ensure maximum comfort. (**** *N_01)*
>
> *(...) We value quality over quantity. Our focus is on relieving pain and promoting emotional well-being by providing a loving, non-judgmental environment of care (...) We implement skin care protocols to prevent pressure injuries and other complications related to immobility ensuring skin integrity is essential for patient comfort and well-being. (**** *N_02)*
>
> *(...) Adaptations to the care plan must be made to meet the specific needs of this age group (...) we implement comfort measures such as adjusting the room temperature, using pillows and blankets to promote the well-being of elderly patients in palliative care. (**** *Tec_03)*
>
> *(...) for this care to be of high quality, the patient must be made as comfortable as possible, pain must be controlled, the morphine pump must be placed, the patient must not be fed when the abdomen is distended and dieting must be avoided, the patient must be sedated more because it causes immense suffering (...) hygiene, medication, diaper changes, attention must be paid to pain, dyspnea, fever, talking to the companion and the patient, explaining things because they always have many questions, and if they do not have a companion, they must speak to social services. (**** *Tec_22)*

The interviewees understand palliative care as relief from physical pain, as they understand it as something that causes intense suffering and emphasize that it should always be assessed. However, most of them are unaware of pain scales and use the increase in heart rate to analyze the intensity of this symptom. After verifying that pain is present, the interviewees mentioned the importance of using pharmacological methods (administration of medications) and non-pharmacological methods (relaxing massage) to manage the symptom.

Administration of analgesics and opioids, including continuous infusions and management progression to palliative sedation in cases where symptom control becomes unfeasible, is widely documented in the literature[5,14-15]. However, a highlight of the study was that the majority of the interviewees stated that they did not use formal scales to assess pain, predominantly relying on observation of patients' facial expressions.

This lack of knowledge and practice contributes to underestimating pain, which results in a recurring problem and often leads to inadequate treatments[15]. A comprehensive investigation showed that professionals tend to underestimate pain intensity compared to assessments made by patients themselves, especially in cases of severe pain. This discrepancy significantly contributes to undertreating pain, which is a complex challenge in the context of palliative care[14].

Thus, despite the prominent role that pain plays among the professionals interviewed and analyzing it from the perspective of the "absence of pain" and "promotion of comfort" concepts originating from the PELT[9], which emphasizes the importance of not having pain so that the patient can experience the end of life with dignity and serenity, there is still a large gap in understanding the full importance of the pain phenomenon, its nuances and consequences if it is not assessed and treated quickly and assertively. The theory also highlights pain as a fundamental aspect to be monitored and treated in this profile of patients, defining it as the experience of not reporting pain, achieved through comprehensive and proactive care.

Other symptoms in addition to physical pain were identified, including nausea and dyspnea. Practical aspects were mentioned, such as care with nutrition, hygiene, changing positions, and preventing and treating skin lesions. These data were corroborated in another study[16], in which nursing professionals emphasized the importance of these care measures to promote comfort for patients in palliative care, especially at the end of life, and were considered priorities until the final moments.

A prominent aspect in category 1 was the concern with comfort not only related to physical aspects (controlling pain and other symptoms, preventing and treating pressure injuries to the skin, hygiene, bathing, clean bedding, among others), but also the environmental structure, highlighting the importance of a calm, quiet, clean environment with a pleasant temperature. This finding was also found in another study[17] that discussed the importance of caring for the physical environment and highlighted the difficulties in providing dignified and assertive care when there are difficult working conditions, limited material and human resources, and care discontinuity.

Thus, the importance of a comprehensive approach to providing care to older adult patients in palliative care which goes beyond the control of physical symptoms is highlighted, and also includes attention to environmental comfort and the quality of the care structure provided. Recognition of the need for a calm, clean and adequately air-conditioned environment, combined with care for nutrition, hygiene and prevention of skin lesions demonstrates the centrality of the quality of life of the patient in palliative care.

Success of this care form not only depends on the technical skills of the nursing team, but also on working conditions, which include resource availability and care continuity. Therefore, it is essential that health professionals, particularly nurses, are trained and have access to infrastructure which enables them to provide dignified, effective and humanized care.

In this context, the first mention made by the interviewees when questioning them about their understanding and practice of palliative care was about the physical aspects of care. Even among nurses who participated in short courses on the subject, their understanding was similar to that of those who did not receive this specific training, being largely limited to the physical handling of patients.

The first reference made among nursing technicians to deal with palliative care was related to physical actions with a focus on bedside care. This predominantly technical approach reflects the training received, which often does not include specific content on palliative care in the curricula of technical courses. This limitation contributes to a restricted care view which fails to encompass emotional, social and spiritual dimensions, which are essential for comprehensive and humanized care. These results highlight the need to rethink technical training, integrating palliative care teaching as a fundamental part of the training of these professionals.

Integration of the emotional, spiritual and social dimensions of care

Classes 5 and 4 elucidate participants' understanding of the ideas that highlight the other care dimensions for older adult patients in palliative care, highlighting the importance of integrating emotional, spiritual and social aspects. The interviewees highlighted themes related to emotional and spiritual aspects as a means of promoting dignity and respect for the older person in palliative care.

> *(...) We are attentive to mental health, offering support to deal with anxiety, fear and concerns related to the terminal phase of life (...) we offer emotional and spiritual support to the older adult patient and their family, helping to resolve conflicts, search for meaning and prepare for the end-of-life process (...) we facilitate access to additional resources such as counseling and religious assistance as needed. (**** *N_07)*
>
> *Our role as nurses goes beyond the clinical aspect; we seek to understand the unique desires and values of each patient, adapting care to meet their physical, emotional and spiritual needs (...) in addition to taking care of the physical and emotional aspects, we also pay attention to the spirituality of older adult patients in palliative care, offering support for existential and spiritual issues if so desired by the patient and their family. (**** *N_09)*
>
> *(...) we are always available to listen to the patient and their family, offering support, we try to ensure that they feel cared for and understood throughout the palliative care process. (**** *Tec_12)*

The statements focused on emotional support through listening and conversation, both free from judgment, and emphasized the importance of considering and providing opportunities for spiritual experience, which is only possible if the physical environment is cohesively prepared, which aims to promote care based on dignity and respect.

These findings were corroborated by another study[18], in which the majority of interviewees expressed concern about ensuring patient comfort through actions to humanize care, which in this context go beyond technical aspects and involve the patient's emotional, affective and spiritual needs, in addition to providing physical comfort.

Such psychological suffering should be taken into consideration based on strategies that use psychosocial diagnosis, as it is clinically important for the practical exercise of ethical aspects, which implies the relevance of looking at psychological aspects in coping with life-threatening diseases. The study also highlights Dignity Therapy (DT) as an individualized and brief intervention, effective in reducing psychological suffering and persistent sadness[18].

Improvement in physical and emotional symptoms is associated with spiritual well-being, recognizing spirituality and religiosity as sources of support, as evidenced by several authors[19-21], who indicate that this relationship contributes to a better quality of life and reduced intensity of symptoms.

Spiritual well-being refers to an individual's subjective perception of their understanding and vision of life and the world, in which the imminence of death leads the individual to seek meaning in their surroundings. In this context, patients and their families often find religious beliefs to be an important strategy for coping with and optimizing the challenges imposed by the disease and treatment, especially in matters related to the meaning of life, in addition to experiencing death with dignity[19-21]. The spiritual dimension allows patients to develop hope, attribute meaning to the illness and find purpose and meaning in life in situations in which diseases are incurable. This process contributes to personal maturity, promoting preservation of integrity and expanding the ability to deal with the situations faced.

Spirituality and religiosity play a significant role in daily life in older patients with life-threatening illnesses, being used as resources to face the challenges, suffering and uncertainties of the illness process[22]. The search for the sacred is a daily practice which helps to fill the existential void that may arise. In this context, the spiritual dimension provides patients with the possibility of developing hope, attributing meaning to the illness, and finding purpose and meaning in life[23].

Nurses highlighted qualified listening, strengthening the patient-team relationship, life experience and professional experience as essential strategies to ensure comprehensive and humanized care in the emotional and spiritual dimensions. Although they recognize the importance of emotional and spiritual aspects for more complete care, lack of time was repeatedly mentioned as a significant obstacle in daily practice. Studies[24,25] state that emotional and spiritual care often end up being left on the back burner or are limited to short and specific moments due to high numbers of patients and urgent clinical demands in the hospital environment with accelerated routines.

However, the lack of time does not mean that care for these dimensions should be neglected. On the contrary, an attentive and empathetic look, even if brief, can have a profound impact on the patient's experience and on building a relationship of trust. For example, active listening does not necessarily require long periods, but rather the availability of full attention in the present moment[24-26].

References to communication practices predominantly focused on interaction with caregivers, while direct communication with patients was rarely mentioned among nursing technicians. When asked about situations in which patients sought information about their health condition, technicians reported frequently directing these questions to the doctor or nurse in charge, avoiding directly addressing the patient's questions.

This attitude may reflect the perception of limitations in the scope of their duties or a lack of preparation to deal with communication in complex contexts, such as palliative care. The lack of direct dialogue with patients compromises the therapeutic relationship and the construction of person-centered care, in addition to limiting the possibility of meeting patients' emotional and informational demands.

Therefore, it is necessary to rethink work organization and the ongoing training of the nursing team so that emotional and spiritual care is not sacrificed even under time pressure, making communication an important link in this context. This may include practices such as team meetings to discuss cases, the use of tools that facilitate communication between professionals and patients, or even integrating other professionals, such as psychologists and chaplains, who can contribute to this care dimension more specifically[25-27].

This category also highlighted the importance of looking at the social aspect which was revealed in the statements of the participants, as they understand the importance of family members and significant others as a support network in order to provide opportunities for the fulfillment of desires or rituals:

> *(...) We maintain an open dialogue with the patient and family to ensure that their wishes are respected at all times (...) We offer emotional and practical support to family caregivers of older adult patients, providing guidance on care, medication administration and symptom management, empowering family members to feel more prepared and supported during this challenging time. (**** *N_10)*
>
> *(...) The goal is to not only alleviate suffering and provide support to the patient, but also to their family. We believe in the importance of true communication and respect for the patient's choices, promoting dignity until the end of life (...) Maintaining open communication with the patient and family, discussing expectations, wishes and care decisions is essential to ensure that everyone involved is informed and comfortable with the care plan. (**** *Tec_04)*

This category highlighted the importance of considering the patient's family and significant others, emphasizing empathic communication as a form of dignified care during this challenging phase of life.

The disease not only affects the individual, but everyone around them, especially when it limits continuity of life. Therefore, adequate emotional support and assertive communication should be provided to families[28] as they face a significant burden in providing ongoing care and require appropriate assistance and guidance. Their main concern is to ensure that the patient is comfortable and free from suffering. In addition, they need detailed information about the disease progression and how to provide the necessary care effectively[29].

This topic has been widely discussed in the literature[28-30], which shows that the patient, their family, and their caregivers constitute the central unit of care in the context of palliative care philosophy. These studies highlight that the family plays a fundamental role, being recognized as the first and most relevant support network, responsible for the initial transmission of cultural values and practices. Although the family nucleus is a source of positive feelings, such as love, satisfaction, well-being and support, it can also be associated with experiences of anguish and fear, particularly in situations of illness and death. This duality highlights the importance of a careful and sensitive approach that integrates the emotional and social dimensions in palliative care planning.

PELT[9] underpins care by highlighting the importance of the support network in assisting the sick person in one of its concepts, with the aim of enabling fulfillment of their wishes and strengthening emotional support. The theory also emphasizes that the experience of dignity and respect for the patient depends on active participation by the patient, their family members and their support network in decisions related to care, ensuring that they are treated with dignity and respect, recognizing them in their full condition as human beings.

Guiding and involving the family in care is essential in PC, but at the same time a major challenge. There is a noticeable gap in the hospital space to accommodate them; after all, communication, listening and support in moments of fragility end up being put on the back burner or carried out with limitations due to the structural restrictions of the institution[17,30].

In addition to the structural limitations of institutions, lack of adequate preparation of health professionals in communication and emotional support leads to silence, false hopes of a cure, or abrupt announcements of adverse prognoses, which can negatively impact the therapeutic relationship. Such ineffective communication can cause doubts about the therapeutic plan[29,30], as evidenced by the uncertainties of nursing professionals regarding what was discussed with families and the execution of procedures. Despite the importance of communication, its inclusion in higher education in health and in continuing education programs is still insufficient[31].

The difficulty in informing patients and their families about the need for PC, as well as providing news related to the diagnosis and prognosis, has been widely discussed by nursing professionals in other national[32,33] and international[34,35] studies, which reinforces that nursing professionals feel unprepared to establish adequate communication with PC patients, their families and among the health team itself.

Communication should be highly valued, as it promotes quality care and comfort for patients. Thus, it enables clear understanding of their health status, prognosis and therapeutic alternatives. It should be initiated early in the course of the disease in order to provide time for patients and their families to fully understand the situation and participate in an informed and collaborative manner in clinical decisions[32-35].

In turn, it is clear that learning about communication represents a major gap in the education and training of the nursing team, despite being essential for care.

Eligibility criteria and provision of ethical care

This category was extracted from the lexicons of classes 7 and 1, and contains context units which reflect the interviewees' views on the eligibility criteria for a patient to receive palliative care, as well as the importance of providing individualized care based on ethics. These issues were expressed in the statements below:

> *(...) Patients with serious or terminal illnesses benefit from palliative care, and it is necessary to prioritize the patient's comfort, autonomy and quality of life, managing physical, emotional and spiritual symptoms. (**** *N_05)*
>
> *(...) these patients usually have an irreversible disease trajectory with a severe impact on functionality and quality of life, and so we nurses are committed to offering comprehensive support to help these patients live with dignity and comfort, so that they will be at peace. (**** *N_09)*
>
> *(...) it is important to consider ethical and legal issues such as advanced care guidelines and treatment decisions. (**** *N_10)*
>
> *(..) we not only assess the severity of the clinical condition, but also the need to manage complex symptoms and the impact of the disease on the patient's quality of life, and we seek to ensure personalized care for each individual we care for, so that they can be much more at ease, as can family members (...) we try to focus on the patient's autonomy, so that everyone is at peace. (**** *N_12)*
>
> *Palliative care is a type of care focused on providing comfort and quality of life for those facing serious and advanced illnesses. If we can achieve this, these patients will be at peace (...) we try to implement an individualized approach for each one. (**** *Tec_04)*

The profile of patients who met the criteria for palliative care was remembered in this category, highlighting oncological diseases, neurodegenerative diseases, patients with disease progression and with treatment failure. These criteria were highlighted to emphasize that several patients can benefit from palliative care and that as long as the team understands the eligibility criteria, it is able to offer individualized and more assertive care.

It is worth noting that none of the 46 participants presented a vision of palliative care early from the diagnosis of the disease. Unanimity was for at an advanced stage of serious and incurable disease, whose focus is to offer comfort and avoid additional suffering. This reflects aspects of academic and technical training, since the subject of palliative care is not mandatory in the curriculum of most health courses in Brazil, including nursing[22,36,37].

Respect for the autonomy of the subject was strongly emphasized by nurses in this category, who highlighted that since the objective of PC is to promote comfort in multiple dimensions, consideration of individual choices, especially of patients in advanced stages of illness, allows the team to provide a sense of peace and dignity to the patient.

On the other hand, nursing technicians rarely addressed ethical issues related to care, rarely mentioning aspects such as autonomy, respect for patients' decisions or issues involving ethical dilemmas in practice. This absence may be associated with technical training, which often emphasizes practical skills, but offers a limited approach to ethical and humanistic principles that guide PC.

Adopting a subject-centered approach, especially in the context of care for older adults, expands the possibilities of more ethical and assertive practices, as pointed out by the participants. From this perspective, older adults occupy the center of care, which makes it essential to promote discussions about the various possibilities of care, considering the wishes and choices of both patients and their family members and caregivers[38].

This reflection process contributes to better understanding of the decisions involved and to clarify treatment goals, which favors more personalized care aligned with the needs and preferences of the individual. Furthermore, it is essential that these discussions are documented in the patient's medical record, serving as a reference for the multidisciplinary team[38].

Consideration for the subject's autonomy is seen as a way to ensure care that respects their dignity, values, and preferences, providing them with a care experience that fosters a sense of peace and control over the illness process. This approach reflects the fundamental ethical principles of palliative care, aligned with promoting patient-centered care which not only integrates their clinical needs, but also their personal desires and priorities[3].

These findings reinforce the importance of strengthening practices that promote dialogue between staff, patients, and family members, ensuring shared decisions and truly humanized care[32-35]. These conversations with older adults and their families should address risks that are worth taking and avoiding, and explore what outcomes and risks they and their families are willing to seek or want to avoid, since the patient's wishes, desires, and autonomy are not taken into account in most situations[35,38].

In turn, the study gathers subsidies which reflect on the meaning of acting with respect towards the patient's autonomy, taking into account their desires, beliefs and wishes beyond the impeccable control of physical, emotional and spiritual symptoms, which streamlines professional practice and enhances dignified and valuable attitudes towards patients.

The results of the study are supported by PELT[9], which emphasizes the importance of offering assertive, individualized care that respects the patient's autonomy. Therefore, it helps the patient to reach a state of peace, and it is essential that they and their family receive adequate support to clarify practical and economic issues related to the process of human finitude.

Study limitations

The main limitation of this study is that it was conducted in a single health unit located in the city of Fortaleza, Ceará, Brazil, which restricts the analysis to a segmented population group and a specific context, to the detriment of the diversity that exists at a national level, which may reduce generalizability of the results. The palliative care topic investigated is permeated by stigmas, prejudices and lack of knowledge, constituting aspects which may influence the results. In addition, the qualitative methodological approach and adherence to the theoretical proposal of analysis introduce additional limitations.

FINAL CONSIDERATIONS

The study revealed that the nursing team's knowledge about palliative care provided to older adults emphasizes the importance of attention to physical aspects, such as pain control, dyspnea, and nausea, and to the structural conditions of the environment. In addition to physical and environmental comfort, professionals highlighted the relevance of emotional, spiritual, and social dimensions, reinforcing a commitment to humanized care that values the individual's uniqueness, beliefs, traditions, and support network.

The presence and relevance of family members and significant others were frequently mentioned, showing that effective communication between the team and the family is essential. Respect for the patient's autonomy was highlighted as a central principle to ensure dignified and ethical care.

A focus in care practices was observed on actions that promote physical comfort, including strict control of symptoms through pharmacological measures, such as administration of analgesics and opioids, and non-pharmacological interventions, such as adequate hygiene, dressing changes, comfort massages, diet, and other measures that ensure the patient's dignity and well-being. Communication with patients, family members and caregivers was highlighted by participants as a fundamental practice, with emphasis on empathetic listening, underlining that nursing work is still significantly seen in its technical aspect.

One gap identified in the study was the understanding that participants still mainly relate palliative care to the process of death, without considering the scope of care from the moment of diagnosis. In addition, difficulties in carrying out effective and assertive communication were highlighted.

The results of this study indicate the need to strengthen actions which discuss and provide training in palliative care in order to contribute to a more patient-centered practice. Adequate support for professionals, especially those in training, is essential, since a lack of knowledge and mistaken perception about the subject deeply affect their actions.

Therefore, it is recommended that new studies be conducted to investigate the relationship between palliative care and nursing practice in different regions of the country, aiming to broaden understanding and improve practice in this fundamental health area.

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