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NURSES' UNDERSTANDING OF PALLIATIVE CARE AT THE TERTIARY LEVEL OF HEALTH CARE

COMPREENSÃO DE ENFERMEIROS SOBRE CUIDADOS PALIATIVOS NO NÍVEL TERCIÁRIO DE ATENDIMENTO

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ABSTRACT: Diseases are increasing at an alarming rate and, when they reach advanced stages, they require continuous care. The objective of this study was to identify nurses' understanding of palliative care (PC) in public and private hospitals in the city of Joinville, Santa Catarina, Brazil. This was a descriptive and exploratory field study with a mixed qualitative–quantitative approach, conducted using a questionnaire. Data were collected in three public and two private hospitals between February and July 2022. Quantitative data were analyzed using frequency distribution, and qualitative data were examined through Bardin's content analysis (2016). A total of 99 nurses participated in the study, 66% from public hospitals. Most respondents reported that they had not learned about palliative care or had no formal exposure to the topic during their undergraduate education. In addition, 89% reported having already provided palliative care, 81% stated that they felt confident in delivering such care, and only 25% reported having received training in their institutions. It is concluded that although most nurses have had contact with palliative care in their professional practice, their knowledge on the subject remains limited.

KEYWORDS: Nursing Care. Palliative Care. Quality of Life. Tertiary Care.

RESUMO: As doenças crescem vertiginosamente e quando em estágios avançados, demandam cuidados contínuos. O objetivo foi identificar a compreensão sobre cuidados paliativos (CP) dos enfermeiros nos hospitais públicos e privados da cidade de Joinville/SC. Pesquisa de campo, descritiva e exploratória, com abordagem quali-quantitativa, por meio de um questionário. Realizada em 3 hospitais públicos e 2 privados, entre fevereiro e julho de 2022. Na análise quantitativa utilizou a frequência e nos dados qualitativos, empregou-se análise de conteúdo de Bardin (2016). Obteve-se 99 respondentes (66% de hospitais públicos). A maioria afirmou que não aprendeu ou que não teve nenhuma abordagem em sua graduação de CP, 89% relataram que já prestaram CP, 81% se sentem seguros para prestar a assistência e 25% mencionaram ter recebido capacitação em suas instituições. Conclui-se que a maioria dos enfermeiros tiveram contato com CP na sua vida profissional e que seu conhecimento é restrito sobre a temática.

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INTRODUCTION

Nowadays, about 70% of deaths worldwide are caused by non-communicable chronic diseases (NCDs), which directly impacts life expectancy and quality of life for patients and their families[1]. Although aging itself is not associated with diseases, it is related to the emergence of NCDs. However, chronic conditions such as diabetes, cardiovascular diseases, chronic obstructive pulmonary disease, and cancer are the main NCDs that, when in advanced stages, require continuous care and access to palliative care, despite being not limited to the extremes of age[2].

According to the World Health Organization (WHO)[3 4], Palliative Care (PC) is an "[...] approach that improves the quality of life of patients (adults and children) and their families, who face problems associated with life-threatening diseases." The field of PC focuses on identifying suffering, whether physical, psychosocial, or spiritual, for prevention and relief. Palliative care must be provided by an interprofessional team, due to the need to address the wholeness of the patient and the factors related to illness.

It is important to emphasize that palliative care is widely discussed worldwide, and numerous studies are being conducted, for better understand the perspectives of patients, their families, and the professionals involved. This is necessary, as it allows for the adaptation of care strategies aimed at improving quality of life and providing a more dignified dying process for patients and their families.

This understanding stems from studies conducted since the 1960s in the United States, where, based on pioneering work, researchers observed how healthcare professionals understood death and the dying process, revealing the experiences of patients themselves during the end-of-life trajectory in hospital settings[5]. Authors[6 7 8 9] in Portugal have been conducting studies on the subject, analyzing the specific challenges of the daily work routines faced by healthcare professionals when interacting with palliative care patients and their families. These studies suggest that hospital-based professionals tend to believe that the routine of care practices (procedures and intra-hospital routines) may affect patients' comfort during their terminal phase, causing uncertainty, distress, and often disagreement in opinions and decisions related to the care to be provided to these patients.

Authors state[10] that nurses play a crucial role in palliative care, as they are responsible for a holistic view of the patient and must be able to observe them in their entirety through knowledge and skills, whether in hospital, outpatient, or home settings. However, it is assumed that proper training and continuous health education are necessary for professionals providing palliative care, in a learning environment that is educational rather than punitive, so that the team can feel confident in the process of care and progression. A possible consequence of the team's lack of preparedness and improper management is the worsening of the existing condition and the possible development of new complications, which may accelerate the patient's death[11]. The fragility of academic training regarding end-of-life care, justified by a teaching approach focused on prevention, protection, and curative care, that is, education aimed at restoring health, leaving a gap when it comes to prognoses other than recovery, a situation for which professionals reported feeling unprepared[12].

The existence of health-related degree programs whose curricula do not include the subject of palliative care reveals not only the students' lack of theoretical preparation, but also their emotional and psychological vulnerability in the face of the negative feelings that arise in the practice of this kind of care. Given this reality, the need for research on the education of nursing professionals in palliative care becomes evident[13]

It can be understood that palliative care goes beyond symptom control and relief of suffering. The focus lies in valuing quality of life, even in the context of an illness with no possibility of cure. It is essential to promote comprehensive and individualized care for each patient and their family. To achieve this goal, it is fundamental that current and future healthcare professionals possess a deeper understanding of the subject. This approach enables more sensitive interventions, leading to dignified and personalized care throughout all stages of the illness process.

Due to the aforementioned facts, the objective that guided the research was to identify the understanding of palliative care (PC) of nurses in public and private hospitals in Joinville, Santa Catarina, Brazil.

METHODOLOGY

This was a field study, characterized as descriptive and exploratory with a mixed-methods approach. The research was conducted in three public and two private hospitals in a city in the southern region of the country: Hospital Municipal São José (HMSJ), Hospital Regional Hans Dieter Schmidt (HRHDS), Hospital Bethesda, Centro Hospitalar Unimed (CHU) and Hospital Dona Helena (HDH). Data collection took place from February to July 2022.

The research participants consisted of 99 clinical nurses from adult inpatient units. The inclusion criteria for the study were clinical nurses working in sectors with adult patients who agreed to participate in the research by signing the Informed Consent Form (ICF). The exclusion criteria included professionals who declined to participate in the study, those professionals on leave, medical leave, or retired, as well as nurses working in administrative areas, management, the Hospital Infection Control Committee (HICC), the Central Sterile Supply Department (CSSD), the Surgical Center (SC), and those working in pediatric and obstetric units.

The research used the following variables: nurses' opinions on the topic studied, their academic qualifications, and their experience in caring for palliative patients. Data collection was carried out via a questionnaire created by the authors, allowing qualitative and quantitative data to be obtained. The instrument was initially applied online, however, due to low participation, data collection was shifted to an in-person format.

For the analysis of qualitative data, the content analysis method with a thematic technique, proposed by Bardin[14] was used, structured in three stages: pre-analysis, which corresponds to the planning phase of initial ideas, involving floating reading and organizing the textual corpus. The exploration of the material, which involved referencing, coding, and categorizing the selected corpus. And the treatment of results and interpretation, which consists of critical and reflective analysis through inferential interpretations.

For the processing and analysis of quantitative data, the information was initially tabulated. The study participants were characterized using descriptive statistics: absolute and relative frequencies (for non-parametric data). All variables were subjected to the Shapiro-Wilk normality test, which indicated that the data were non-parametric. Data analysis was performed using the Jamovi software, with a significance level of 5%.

Through the questionnaire applied during data collection, it was possible to identify the number of participants per institution. Each institution was assigned a number for referencing the analysis documents (H No.), and the nurses from each institution were also assigned a number alongside the institution's reference (E No.). Example: Nurse No. 1 from Institution No. 1: (E1H1).

The project was submitted to the Research Ethics Committee (REC) of the University of the Joinville Region (Univille), Dona Helena Hospital and Hans Dieter Schmidt Regional Hospital / SES/SC and was approved under CAAE No. 53606721.2.0000.5366, CAAE No. 56666922.4.3001.8062 and CAAE No. 56666922.4.0000.5363 and only after the approvals were granted, field activities began.

In compliance with Resolution 466/12[15], which addresses the Ethical Guidelines for Research Involving Human Beings, all participants were properly informed about the objectives of the study and were provided with clarification before and throughout its course regarding the methodology and the use of the collected information, as well as the assurance of confidentiality to protect the privacy of the subjects concerning the confidential data involved in this research.

RESULTS

The study was conducted in five hospitals, three public and two private, in a city in the southern region of Brazil, and included a sample of 99 participants who met the inclusion criteria, with a predominance of nurses from public hospitals (66.67%), while 33.33% of respondents were from private hospitals.

The questionnaire applied included 5 objective questions on palliative care, allowing for the collection of the study's quantitative data. Table 1 shows the absolute frequency of the objective responses related to the nurses' understanding and relationship with palliative care.

Table 1. Nurses' understanding of palliative care, and relationship of the topic with their professional practice, in the period from Feb-Jul/2022 (n=99). Joinville/SC, 2022.

Questions	N	%
Do you believe you learned about palliative care during your education?		
Yes	36	36.3
No	63	63.6
Did you learn during your undergraduate studies how to handle a palliative care patient?		
Yes	28	28.2
No	70	70.7
Not applicable*	1	1.1
Have you ever provided care to a patient in palliative care?		
Yes	89	89.9
No	9	9.0
Not applicable*	1	1.1
Do you feel confident providing care to patients in palliative care?		
Yes	81	81.8
No	17	17.1
Not applicable*	1	1.1
Have you ever received any training or professional development related to palliative care?		
Yes	25	25.2
No	73	73.7
Not applicable*	1	1.1

*1 questionnaire was submitted incomplete. Source: research data (2022).

Regarding the responses to the descriptive questions, these were categorized and analyzed according to Bardin's content analysis, in the thematic technique. To facilitate understanding and visualization of the qualitative data, tables were created showing the simple frequency of each category based on the number of citations of the identified recording units.

Table 2 presents the grouping of responses to the question "What does palliative care mean to you?" A total of 95 responses were analyzed that fit the question, with 116 recording units identified and distributed across 7 categories related to the topic. 3 irrelevant responses and 1 blank response were excluded. As shown in the table below, the category "comfort and relief of physical symptoms" was the most frequent, representing 62.93% of the themes analyzed.

Also in the same table, the second question addressed the categories created based on the responses about the role that nurses play in palliative care. A total of 86 responses were analyzed, with 87 recording units identified and distributed across 3 categories, 8 responses were excluded for lacking relevance to the question, and 5 were left blank. "Comfort and quality care" were the most frequent themes in this analysis, corresponding to 65.52% of the responses. Next, "team management and assistance" were identified in 33.33% of the responses. One participant reported not knowing how to respond, accounting for 1.15% of the responses.

Table 2. Meaning of Palliative Care and nurses' role in this field of care, from Feb-Jul/2022 (n=99). Joinville/SC, 2022.

Questions	N (%)	Example of Recording Unit
What does PC mean to you?		
Comfort and relief of physical symptoms	73 (62.9)	*"Comfort care for a patient who is in the terminal stage of life"* E13H1
Quality of life	18 (15.5)	*"Promote quality of life for patients who have no projection of cure* [...]" E2H1
End-of-life care	8 (6.9)	*"Care for the patient before death"* E4H1
Multidisciplinary care	6 (5.1)	*"Care provided by a multidisciplinary team* [...]" E3H5
Therapeutic limitation	5 (4.3)	*"They are non-invasive care as a way to provide comfort to the patient without measures"* E2H5
Psychological care	4 (3.4)	*"Provide comfort* [...] *psychological to the patient"* E6H4
Spiritual care	2 (1.7)	"[...] *support* [...] *spiritual"* E5H1
What is the nurse's role in palliative care?		
Comfort and quality care	57 (65.5)	*"My job as a nurse with palliative patients is to bring comfort to the patient and to the family, as well as to provide quality care to them"* E16H2
Team and care management	29 (33.3)	*"To develop an excellent care plan for the team to carry out in the best way and with the best quality"* E27H4
Did not know how to respond	1 (1.1)	

Source: research data (2022).

Subsequently, table 3 presents how palliative care was introduced to the nurses: 4 categories were obtained, with 95 responses that adequately answered the question, 3 responses were excluded for lack of relevance, and 1 response was left blank. It was identified that 52.63% of participants became familiar with palliative care only through professional practice, while 41.05% reported having learned about it during their undergraduate studies. Also in the same table, it is possible to identify the training and professional development in palliative care reported by the nurses, 25 participants stated that they have some type of training or qualification and described where it took place. 3 categories were created based on 21 responses, with 24 recording units, 3 responses were disregarded due to lack of context, and one was left blank. Based on the data analyzed, it is remarkable that the training in the workplace was the most commonly reported (58.33%), followed by specialization programs (25%) and short courses (16.76%).

According to Table 4, it is possible to identify the situations in which nurses believe PC applies. A total of 91 responses were analyzed and distributed into 4 categories, with 7 excluded for lack of relevance and 1 left blank. It was observed that 69.23% of the recording units indicated that CP applies in cases of therapeutic limitation and end-of-life. The provision of care starting from the diagnosis of a life-threatening illness appeared in 20.88% of the responses. Another 7.69% described it as a doctor/patient decision. And 2.20% did not know how to respond.

Table 3. Moments in which Palliative Care was introduced to the nurses and updates on the topic, (n=99). Joinville/SC, 2022.

Questions	N (%)	Example of Recording Unit
When were you introduced to PC?		
Professional practice	50 (52.6)	*"While working as a nurse"* E6H2
Graduation	39 (41.0)	*"In college, during theoretical classes"* E6H1
Specialization	4 (4.2)	*"10 years ago, during my specialization training"* E2H1
Research	2 (2.1)	*"In books that talk about the subject, because I'm interested in it"* E7H1
Training and professional development in PC		
Training in the institution	14 (58.3)	*"At a hospital where I worked in 2018"* E14H5
Specialization	6 (25.0)	*"In a postgraduate program in palliative care* [...]*"* E1H1
Short Courses	4 (16.6)	*"Course on Palliative Care Patient Managing through the UnaSUS platform"* E9H4

Source: research data (2022).

Table 4. Indication of palliative care according to nurses and essential care provided to patients, from Feb-Jul/2022 (n=99). Joinville/SC 2022.

Questions	N (%)	Example of Recording Unit
Indication of PC		
Therapeutic limitation or end-of-life	63 (69.2)	*"Situations in which there is nothing else that can be done for the patient."* E4H1
Diagnosis of a life-threatening condition	19 (20.8)	*"In the face of any life-threatening."* E1H4
Doctor/patient decision	7 (7.6)	*"In that situation where the palliative care doctor evaluates the patient and has a multidisciplinary conversation with the family, and everyone understands/accepts to provide palliative care to the patient"* E9H1
Did not know how to respond	2 (2.2)	*"I don't know"* E30H2
Essential care for PC patients		
Comfort and relief of physical symptoms	86 (57.3)	*"Keep the patient pain-free and comfortable."* E21H2
Care for the family/caregiver	25 (16.6)	*"Managing family members, encouraging interaction within the family unit* [...]*"* E26H4
Nursing care	18 (12)	*"Hygiene, comfort, nutrition, medication."* E32H2
Psychological care	15 (10)	"[...] *psychological support in coping* [...]" E12H1
Spiritual care	6 (4)	"[...] *spiritual support* [...]" E5H4

Source: Research Data (2022).

In the same table, the essential care measures for palliative care patients, as reported by the nurses, are presented. A total of 89 responses were analyzed, resulting in 150 recording units, organized into five categories. Seven responses were excluded due to lack of relevance, and four were left blank. The category "comfort and relief of physical symptoms" accounted for 57.33% of the care measures mentioned, followed by "care for the family and caregiver," which appeared in 16.67%. Nursing care actions such as hygiene, comfort, diet, and medication were grouped into one category, with a frequency of 12%. Psychological care represented 10% of this analysis, and spiritual care accounted for 4%.

DISCUSSION

In light of the research findings, it is possible to identify a distorted understanding of palliative care among nurses, as evidenced by the predominance of the category "comfort and relief of physical symptoms." Furthermore, many of the responses also include a context of end-of-life care, as illustrated by the following examples:

> *All possible comfort to the patient so they can have a peaceful death, avoiding greater harm to the patient* E10H2
>
> *Comfort care for a patient who is in the terminal phase of life* E13H1.

In a study[16] that aimed to identify the nursing team's understanding of pediatric palliative care, it was highlighted that 46.7% of the respondents had limited knowledge regarding the objectives and philosophy of PC. The authors also noted that palliative care began in Brazil in the 80s decade in the state of Rio Grande do Sul, which could be one of the factors contributing to the delayed inclusion of this knowledge in the participants' education. It is worth noting that this limited view of PC may reflect academic training, since death is often portrayed as something to be fought at all costs[17]. It is of fundamental importance that institutions responsible for training healthcare professionals across all levels of education improve the discussion of this subject in the formation of future professionals.

Limited understanding was also observed in the possible indications for palliative care. It was noted that 69.23% of the entries in Table 4 describe the applicability of palliative care in cases of therapeutic limitation or end-of-life, restricting the professionals and patients from accessing this practice from the moment of diagnosis as highlighted in the literature. Despite this, 20.88% of the entries mentioned offering palliative care from the diagnosis of a life-threatening illness, 7.69% believe it to be a decision shared between doctor/patient/family, and 2.20% did not know how to respond.

A deficit[18] in nurses' understanding of palliative care is also identified, mainly referencing the subject as care provided at the end of life, that is, a mistaken understanding of the objectives and palliative practice. This observed restriction impacts the nurses' care practice, since palliative care, when offered from the diagnosis of a life-threatening condition, enables a broad use of variable resources, according to the recognition of the patient's and family's needs, through support, bonding, and listening throughout the course of the illness.

In this context, the early offer of palliative care enables higher-quality care. With this in mind, the nurse's actions will be focused on the assessment and management of the signs and symptoms throughout the course of the illness, as well as on the individual evaluation of the patient's needs and a major pillar of communication, both within the multidisciplinary team and with the family or caregivers, acting as a disseminator of guidance, information, or health education in the pursuit of therapeutic effectiveness[19].

Researchers[20] identified that one of the difficulties faced by an oncology PC team is the late offer of palliative care, which results in challenges in providing qualified care and in patient/family acceptance. The authors also mention the difficulties in accessing specialized public services and failures in public policies as major barriers to qualified care.

In the 2019 Palliative Care Atlas in Brazil[21], the indication for palliative care is clarified: "[...] any person affected by a life-threatening condition, whether acute or chronic, is eligible for palliative care from the moment of diagnosis."

It is observed that some pillars are forgotten or unknown by nurses, since psychological and spiritual care appear in only a few entries as previously shown in Table 4. According to the definition of the World Health Organization, the pillars of the quality-of-life dimension for palliative care patients are: physical, spiritual, and psychological.

When faced with life-threatening illnesses, human beings tend to seek spirituality more intensely, and studies show that this influences the course of the disease. Therefore, healthcare professionals must be prepared to meet this demand. Spiritual practice in palliative care is considered a promoter of quality of life, being effective in reducing levels of anxiety and depression, and in improving physical symptoms[22]. In this sense, it is the nurse's responsibility to be attentive to the patient's needs and to build a bridge between the patient and the appropriate care, whether it be psychological, occupational, spiritual, or family support.

Despite the need for palliative care to be increasingly present, evidenced by the fact that 89.90% of participants had already provided care to patients in PC, it remains a new topic and one with many stigmas. Still in the attempt to identify nurses' understanding of the subject, it was observed in the responses that 50 participants were introduced to PC only during professional practice. In this sense, 17.17% of participants reported not feeling confident in providing care to patients in PC, which raises the question about the academic training of these professionals.

As shown in Table 1, 63.64% of the participating nurses believe they did not learn about palliative care during their undergraduate education and 70.71% did not learn how to manage this type of patient. Nevertheless, 89.90% of the professionals reported having already provided such care. Furthermore, reflections on how to manage a palliative care patient range from doctor/patient decisions to complete lack of knowledge (Table 4), however, quality care requires theoretical and practical knowledge about the care to be provided. It is essential to emphasize that palliative care is not about taking action only when there is nothing else to be done for the patient; with deeper understanding of the subject, it becomes clear that this type of patient has a high demand for care and that there is still much to be done.

In Brazil[23], when evaluating the curricula of medical, nursing, psychology, and social work programs, only 20.9% of medical degrees include an independent palliative care subject in their curriculum. The other programs mentioned do not have a specific subject on PC. From this, it is possible to identify that the training of healthcare professionals today still does not provide contact with the topic, which impacts their understanding and professional practice.

In seeking to identify education and training in palliative care, it was observed that only 21 out of the 99 participants had some form of training in PC, with workplace training being the most prevalent. Considering that the nurse is the member of the multidisciplinary team most present in bedside care, the lack of preparation among these professionals is concerning, especially in relation to a type of care that is so significant for the patient and delicate for the family. In addition to the importance of including palliative care in undergraduate academic curricula, it is also necessary to take into account the large number of professionals already in the workforce, therefore, one solution would be to provide training for these professionals within hospital institutions.

Permanent health education is already a practice adopted in most of the hospitals included in this research. This sector aims at refresher projects, guidance, and training in a non-punitive way regarding healthcare assistance, representing a pertinent opportunity for addressing professionals who are already graduated and working in the field for a generalist knowledge concerning palliative care.

In this context, the National Policy on Permanent Health Education (PNEPS) is highlighted[24], which can be defined as a political-pedagogical strategy that articulates professional practices with continuous training, aiming at the improvement of work processes[25]. In a document published in 2018 by the Ministry of Health, some difficulties related to the implementation of this policy are pointed out, such as the lack of understanding by public bodies regarding the very concept of PNEPS and its importance in the development and formulation of local policies.

The provision of this care requires, first of all, a theoretical foundation so that the professional understands what palliative care is about in order to avoid a mistaken understanding or an ethical conflict regarding the boundaries of PC, which may even involve topics such as euthanasia and dysthanasia. This makes it essential to understand this type of care and what other forms of care may be offered alongside PC, such as orthothanasia, for example. A study conducted in Primary Care in Cascavel/PR[26], through interviews with primary healthcare professionals, highlighted their perceptions regarding the topic and reaffirms what was observed in the present study, in which continuous education of the team and the increasing inclusion of this subject in healthcare service spaces are indispensable.

When analyzing Table 4, the main types of care mentioned by nurses for patients in PC are identified; once again, comfort and relief of physical symptoms appear in most of the responses, accounting for 57.33%.

> *Keep the patient free of pain and comfortable.* E21H2

With this analysis, it is possible to see that one of the main types of care provided by the participating nurses is the management of comfort and physical symptoms. However, it is known that the patient's suffering is not limited to this aspect; it may also manifest as spiritual or psychological. With that in mind, psychological care represents 10% of the responses. Spiritual care appears in 4% of all the care described by the nurses. Although the nurse is not the main professional responsible for psychological and spiritual care, it is necessary that they understand the importance of implementing such care for the patient, aiming to offer comprehensive care, as referenced in the literature mentioned above.

In another study[27], conducted with a team of nurses and physicians, totaling 160 professionals, it was observed that only 62 (38.75%) of the professionals stated that they recommend referring patients for social, spiritual, and psychological follow-up. The authors affirm through their research that, although such referrals are made for a minority of patients, this aspect of treatment is important and fundamental for improving the patient's quality of life.

Care for the family and caregivers appears in 16.67% of the responses, which highlights the need to consider the importance of the patient's social support network, given the disease context that may cause physical and emotional strain on the family member or caregiver. The professionals pointed out the participation of family members and the skills acquired through lived experience as fundamental. This is justified because the family is a component of the basic unit of care and, just like the patient, presents social, spiritual, physical, and psychological needs. Throughout the process, the family comes to play a fundamental role. In this regard, the World Health Organization (WHO) recommends that the multidisciplinary team understand and develop actions directed toward the family[28].

Understanding the importance of the nurse within palliative care assistance, it was identified that the participants mentioned their role in PC in two categories, as shown in Table 2, where 65.52% of the entries refer to comfort and quality care.

> *My work as a nurse with palliative patients is to bring comfort to the patient and to the family, as well as to provide quality care to them.* E16H2

> *To support, welcome, and be a humane nurse when providing care, when talking to the patient and their family. To be willing to help face their fears and insecurities, solve problems, and be a spokesperson when requesting other professionals to assess this patient in need.* E4H3

The entries show concern for the patient in suffering and the assurance of qualified care. Despite the limited knowledge about PC, it is known that nursing, in its entire professional logic, holds principles that align with palliative care and contribute to the patient's quality of life. In this regard, 33.33% of the statements refer to team and care management:

> *Do everything possible to ensure the person has a dignified outcome, without suffer.* E18H2
>
> *Ensure that all care is provided in a way that offers comfort and relief of symptoms.* E10H5

It is understood, through the statements of the interviewees, that nursing recognizes a holistic and humanized approach as essential in the care of palliative care patients. From humanized care to symptom relief, these are appropriate practices that reflect concern for the human being, thus contributing to the improvement of quality of life in critically ill patients.

After analyzing the transcribed interviews, it became evident that nurses working in the field have gaps in their understanding of the subject. This is evident in terms of early intervention, interdisciplinary management, and the recognition of the psychosocial and spiritual aspects of care. Therefore, these limitations highlight the need for permanent and continuing education. Educational strategies should promote critical reflection and strengthen the competencies necessary for practicing in Palliative Care.

With the data collected and discussed in this research, the importance of incorporating care protocols that address palliative care at different levels of healthcare is reinforced. Fostering work environments that promote discussion on the topic is essential for better understanding and applicability of the subject. Thus, this study contributes not only to the advancement of scientific knowledge, but also to the qualification of care practices, promoting more ethical, sensitive care aligned with the real needs of patients and their families.

CONCLUSION

In light of the above, it becomes evident that PC still has a limited understanding in terms of its definition and objectives among nurses, when compared to recognized literature. In this study, an understanding of PC as comfort and relief of physical symptoms applied in cases of terminality and therapeutic limitation is evident. This fact may be related to a lack of emphasis on the subject during undergraduate nursing education and to the low level of training and qualification of these professionals in clinical practice. Given this, we reinforce the current scenario regarding nurses' understanding of PC and suggest future research to outline the training and educational profile of nurses or other healthcare professionals.

The findings are in line with the results of other studies with similar objectives, highlighting the need to reformulate the curricular structures of nursing undergraduate programs, enabling broader knowledge on the subject. It is also suggested that attention be given to permanent education within healthcare institutions, since it was identified that most nurses have already provided care to patients in PC, making it necessary for professionals to have an adequate understanding in order to provide increasingly better care.

Thus, we emphasize the vital role of nurses in interdisciplinary palliative care, with broad potential to promote quality of life for the patient, and the need for nurses to be properly trained to act according to what this practice proposes. In addition, we suggest the creation of a Nursing Care Systematization (SAE) specifically for Palliative Care, given that its needs are specific to this type of care.

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