ISSN-e [2675-5602]

Global Academic Nursing Journal

REVIEW ARTICLE

Caring when there is no longer a cure: the role of nurses in terminally ill patients

Cuidar cuando ya no hay cura: el papel de la enfermera en el paciente terminal

Cuidar quando não há mais cura: a atuação do enfermeiro na terminalidade

Erika Diniz de Oliveira Sousa[1*]
ORCID: 0009-0004-9292-5533
Elias de Oliveira Silva[1]
ORCID: 0000-0003-2407-5157
Luiz Otávio Lessa[1]
ORCID: 0009-0009-0815-0656
Lilian Bezerra do Nascimento[2]
ORCID: 0009-0007-5558-1657
Fernanda Araujo Lemos[2]
ORCID: 0009-0008-3345-0645

[1]Universidade Federal do Estado do Rio de Janeiro. Rio de Janeiro, Brazil.
[2]Fundação Oswaldo Cruz. Rio de Janeiro, Brazil.

How to cite this article:
Sousa EDO, Silva EO, Lessa LO, Nascimento LB, Lemos FA. Caring when there is no longer a cure: the role of nurses in terminally ill patients. Glob Acad Nurs. 2026;7(4):e551. https://dx.doi.org/10.5935/2675-5602.20200551

***Corresponding author:**
enf.erikadiniz.os@gmail.com

Submission: 03-24-2026
Approval: 06-10-2026

Abstract

Palliative care is an assistance that may be offered to individuals of all ages, at any stage of serious, incurable, or life-threatening illness, seeking to promote quality of life in the face of human finitude. From this perspective, the role of the nurse is essential to ensure comprehensive, humanized care grounded in ethical principles. The objective was to critically analyze the nurse's role in palliative care during the terminal phase of life. An integrative literature review was conducted from June to October 2025, with 12 articles selected for analysis. It was evidenced that the nurse's role is essential in welcoming patients and families, alleviating physical and emotional suffering at the end of life. However, gaps were identified regarding professional training and challenges in the applicability of good practices in palliative care, especially in the face of the need for important decision-making, such as the use of palliative sedation. It was noted that investment in training is necessary to provide specialized care that ensures qualified and ethical assistance to patients in palliative care and their support network.

Descriptors: Palliative Care; Palliative Care at the End of Life; Nursing; Quality of Life; Nurses.

Resumén

Los cuidados paliativos son una forma de asistencia que puede ofrecerse a personas de todas las edades, en cualquier etapa de una enfermedad grave, incurable o que amenaza la vida, con el fin de promover la calidad de vida ante la finitud humana. Desde esta perspectiva, el papel de la enfermería es fundamental para garantizar una atención integral y humanizada, fundamentada en principios éticos. El objetivo fue analizar críticamente el rol de la enfermería en los cuidados paliativos durante la fase terminal de la vida. Se realizó una revisión integradora de la literatura entre junio y octubre de 2025, seleccionándose 12 artículos para su análisis. Se evidenció que la labor de enfermería es esencial para acoger a los pacientes y a sus familias, así como para aliviar el sufrimiento físico y emocional al final de la vida. No obstante, se identificaron carencias en la formación profesional y desafíos en la aplicación de buenas prácticas en cuidados paliativos, especialmente ante la necesidad de tomar decisiones importantes, como el uso de la sedación paliativa. Se concluyó que es necesaria una inversión en capacitación para brindar una atención especializada que asegure una asistencia cualificada y ética a los pacientes en cuidados paliativos y a su red de apoyo.

Descriptores: Cuidados Paliativos; Cuidados Paliativos en la Fase Terminal de la Vida; Enfermería; Calidadde Vida; Enfermeros.

Resumo

O cuidado paliativo é uma assistência que pode ser ofertada a indivíduos de todas as idades, em qualquer fase de doença grave, incurável ou que ameace a continuidade da vida, buscando promover qualidade de vida diante da finitude humana. Nessa perspectiva, a atuação do enfermeiro é fundamental para assegurar um cuidado integral, humanizado e pautado nos princípios éticos. Objetivou-se analisar de forma crítica a atuação do enfermeiro nos cuidados paliativos durante a terminalidade da vida. Realizou-se revisão bibliográfica integrativa, no período de junho a outubro de 2025, sendo selecionados 12 artigos para análise. Evidenciou-se que a atuação do enfermeiro é essencial para acolher pacientes e familiares, atenuando o sofrimento físico e emocional no fim da vida. No entanto, foram identificadas lacunas no que se refere à formação profissional e desafios na aplicabilidade das boas práticas em cuidados paliativos, sobretudo, diante da necessidade de tomadas de decisão importantes como o uso da sedação paliativa. Notou-se que é necessário investir em formação para ofertar um cuidado especializado, que assegure uma assistência qualificada e ética, ao paciente em cuidados paliativos e à sua rede de apoio.

Descritores: Cuidados Paliativos; Cuidados Paliativos na Terminalidade da Vida; Enfermagem; Qualidade de Vida; Enfermeiro.

Introduction

Health care is configured as an essential practice that transcends the technical dimension, encompassing human and ethical-relational values. Its purpose is not restricted to cure, but also to the promotion of comfort, well-being, and dignity of the patient, especially in situations of serious illness. In this sense, the act of caring generates a relationship of responsibility and commitment between the health professional, particularly the nurse, and the individual receiving care, considering their needs in different situations.

In situations where the disease is incurable and progressive, it becomes necessary to redirect care, prioritizing the relief of suffering and avoiding unnecessary therapeutic interventions. Scientific evidence indicates that, in the face of the irreversibility of the clinical condition, the maintenance of unnecessary treatments may contribute to increased suffering, reinforcing the importance of more humanized and individualized care[1].

In this context, palliative care stands out as a fundamental strategy for care aimed at promoting the quality of life of patients with life-threatening illnesses. This assistance involves early identification, assessment, and appropriate management of pain and other symptoms, in addition to psychological, social, and spiritual aspects, respecting the patient's dignity and autonomy throughout this process. During this scenario, the fundamental role of the nurse in providing comprehensive and humanized care is highlighted, working directly in symptom control, communication with the patient and their family members, as well as in care coordination, assisting in the promotion of comfort and dignity throughout the illness trajectory[1,2].

In the care context, especially in situations involving patients with incurable or advanced-stage diseases, care must be guided by attention to individual needs and limitations, considering the irreversible nature of the dying process and the temporal limitation of life, often restricted to days, weeks, or months.

The historical development of Palliative Care (PC) began in the 5th century, with the sheltering and care of travelers and the sick in hospices (hostels), giving rise to the hospice movement, which in the 19th century began to take on characteristics of hospitals. Over the years and with the expansion of PC, the World Health Organization (WHO), in 1990, defined PC as active and total care for patients whose disease is not responsive to curative treatment. Pain control, control of other symptoms, and of psychosocial and spiritual problems are paramount. Evolving the concept review, in 2018, the Lancet Commission, together with the WHO and the International Association for Hospice and Palliative Care (IAHPC), evidenced the need to reassess and update the definition of Palliative Care.

> *"Palliative Care (PC) is the active holistic care of individuals of all ages with health-related suffering (HRS) due to serious illness (serious illness is a condition that carries a high risk of mortality, negatively impacts quality of life and daily functioning, and/or is burdensome in terms of symptoms, treatments, or caregiver stress) and, especially, of those nearing the end of life. Its goal is to improve the quality of life of patients, their families, and their caregivers, including prevention, early identification, comprehensive assessment, and management of physical problems, including pain and other distressing symptoms, psychological distress, spiritual distress, and social needs"*[3:761].

According to Hermes[4:2578], "[...] the etymology of the term palliative derives from the verb to palliate, from the Latin palliare and palliatus, meaning cloak, protection, and temporary relief from suffering, evidencing this philosophy in the sense of alleviating moments of suffering and pain", which reinforces the idea that palliative care seeks to offer support and dignity until the end of life.

In Brazil, the focus on palliative care was expanded with the publication of Resolution No. 41, of October 31, 2018, which provides guidelines for the organization of palliative care, considering integrated continuing care, within the scope of the Unified Health System (SUS)[5]. More recently, the National Palliative Care Policy (PNCP)[6], established by Ordinance GM/MS No. 3,681, of May 7, 2024, reinforced the importance of team qualification and the incorporation of health services as a primordial part of comprehensive care.

According to the Ministry of Health, in the Palliative Care Guidelines within the scope of the SUS, Article 1 established that: "[...] palliative care consists of assistance provided by a multidisciplinary team, aimed at improving the quality of life of patients and their families in the face of a life-threatening illness"[5]. The main diseases requiring palliative care, according to global WHO estimates, are cardiovascular diseases (38%), neoplasms (34%), COPD (10%), AIDS (10%), and others (8%)[7].

In 2021, Brazil ranked 79th among 81 countries in terms of quality and availability of palliative care, reflecting both regional inequalities and structural and cultural shortcomings[8]. Furthermore, it is estimated that the need for or inadequacy of palliative care accounts for a portion of deaths in Brazil annually[9]. The WHO indicated that 40% to 60% of deaths worldwide resulted from people who required this type of care, yet only about 14% of patients receive it, especially in underdeveloped countries[10]. From the perspective of Valentino[11], patients who received such care experienced a reduction in hospitalizations and fewer in-hospital deaths occurred.

Even with all normative advances, challenges to access to palliative care persist, associated with the urgent need for professional qualification, especially in low- and middle-income countries, where most patients require such care but do not receive it adequately[10]. These findings strengthen the need for the expansion of public policies and for the training of qualified professionals.

The provision of palliative care throughout the life cycle, without distinction, for people suffering from any clinical condition that threatens the continuity of life, initiated as early as possible and in association with treatment, is considered a principle of the PNCP[6]. However, this study shed light on the terminal phase of life.

As reported by Charruf[12], there is no consensus in the literature regarding the terms used to define 'terminality,' 'end-of-life phase,' and 'active dying process.' Nevertheless, the author proposes the standardization of these definitions to unify the language. In this vein,

terminality refers to the moment when it is no longer possible to recover the previous health condition, with an estimated prognosis of between six months and one year. The end-of-life phase corresponds to the period in which the patient presents a Palliative Performance Scale (PPS) below 50%, with a life expectancy limited to months or weeks. The active dying process, in turn, is characterized by the presence of signs of organic failure, indicating a prognosis of hours to a few days of life.

The terminal phase of life, therefore, is an extremely delicate and highly complex stage for patients, family members, and healthcare professionals alike. At this moment, care transitions to a stage in which providing comfort, dignity, and respect for patient autonomy is fundamental. Palliative care should be offered through assistance grounded in comprehensiveness, considering not only physical symptoms but also the emotional, social, and spiritual aspects, both for the patient and for their family members throughout this process.

In this panorama, Nursing holds a prominent position, as it acts directly and continuously in the care of the patient and family, being essential in symptom support, effective communication with the multidisciplinary team, and even in emotional support, promoting dignified and respectful care.

In view of this reality, it becomes important to critically analyze the role of nurses in palliative care during the terminal phase of life, considering their leading role in care provision and their responsibility in promoting humanized, qualified, and evidence-based practice-aligned care. In this context, the present study is based on the identification and analysis of the current scientific production that addresses the importance of the nurse's role in palliative care during the terminal phase of life.

Methodology

This study is characterized as an integrative literature review, through bibliographic research, described by Soares[13] as a rigorous and comprehensive method that allows for the inclusion of different types of publications, considering quantitative, qualitative, and theoretical studies, enabling a broad yet in-depth comparison. In the methodological pathway, the recommendations of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart were followed in an adapted manner, as, according to Galvão *et al.*[14], they ensure rigor and transparency in data collection.

The guiding question "What is the importance of the nurse's role in palliative care during the terminal phase of life?", developed based on the PICo strategy, considering Population (P), Interest (I), and Context (Co) (Chart 1), sought to understand the contributions and challenges faced by this professional in this highly delicate contexto".

Chart 1. PICo strategy of the study. Rio de Janeiro, RJ, Brazil, 2025

Population (P)	Interest (I)	Context (C)
Patients in palliative care at the end of life	Role of nurses in palliative care assistance	Care at the end of life, especially in the hospital setting

Searches were conducted using descriptors, combined with Boolean operators (AND/OR), between June and October 2025, as described in Portuguese and English. The terms and interterms for each PICo branch were defined based on consultations, through the permuted index, in DeCS, the basis for extracting descriptors in Portuguese and their respective MeSH terms. Portuguese search: ("Cuidados Paliativos" OR "Cuidados paliativos na terminalidade de vida") AND ("Enfermagem" OR "Enfermeiros"). English search: ("Palliative Care" OR "Palliative care at the end of life") AND ("Nursing" OR "Nurses").

The data were retrieved from the following databases and portals: the Regional Portal of the Virtual Health Library (VHL), which encompasses the scientific databases SciELO; Latin American and Caribbean Health Sciences Literature (LILACS); Spanish Bibliographic Index in Health Sciences (IBECS); the Nursing Database (BDENF); and the National Library of Medicine (PubMed). The strategies were adapted according to the specificities of each database.

For the selection of studies, certain criteria were defined, with inclusion criteria being: all types of studies focused on adult patients (over 18 years of age), published in the last 10 years, in Portuguese, English, or Spanish, available in full text and exclusively. The choice of the time frame is justified by the fact that, among the selected studies, according to the established criteria, there are no articles restricted exclusively to the last five years. Exclusion criteria involved studies that did not have an exclusive focus on adult patients under palliative care, such as those addressing the elderly population or pediatrics.

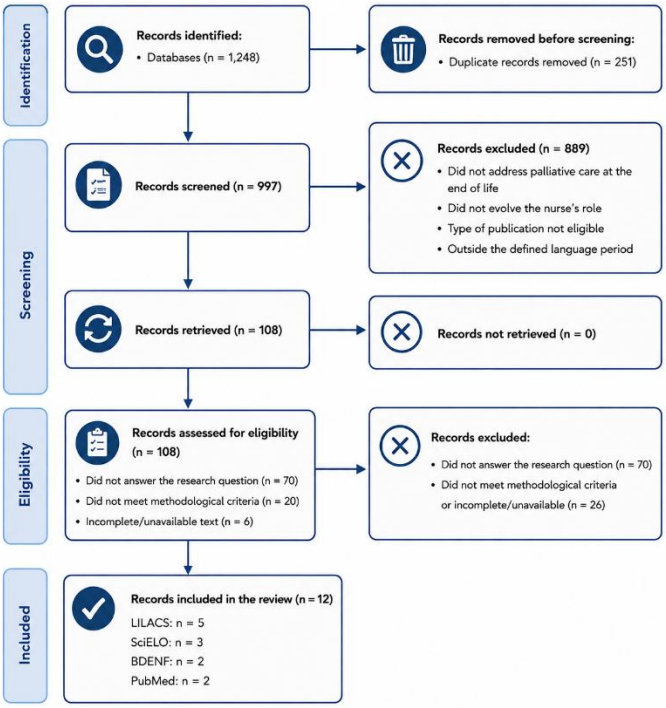
Despite the existence of different methods for evaluating and classifying evidence in the literature, it was decided to base this study on the classification by Melnyk and Fineout-Overholt, apud Brunt[15], Level I – Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs) or evidence-based clinical practice guidelines grounded in a systematic review of RCTs or three (3) or more RCTs of reasonable quality with comparable results. Level II – Evidence obtained from at least one (1) well-designed RCT. Level III – Evidence obtained from well-designed controlled trials without randomization. Level IV – Evidence from well-designed case-control or cohort studies. Level V – Evidence from a systematic review of descriptive and qualitative studies (meta-syntheses). Level VI – Evidence from a single descriptive or qualitative study. Level VII – Evidence from the opinion of authorities or reports from expert committees.

After the article collection, the studies were selected in two stages. In the first stage, title and abstract screening were performed to verify whether the articles met the pre-established inclusion criteria. Subsequently, a full-text reading of the eligible articles was conducted, and those that corresponded to the study objectives were included in the review.

The synthesis of the articles was performed using a previously developed instrument, containing information such as author, year of publication, country of origin, study objective, research type, main results, and conclusions. Finally, the data were presented descriptively for the

analysis of the studies to contribute to the understanding of the nurse's role in palliative care at the end of life. The process of identification, screening, eligibility, and inclusion of studies followed the recommendations of the PRISMA 2020 guidelines, as adapted by Page et al.[16], as presented in Figure 1.

Figure 1. Stages of search, selection, and inclusion of studies. Rio de Janeiro, RJ, Brazil, 2025



Results

After the execution of the searches (data collection), a total of 1,248 records were identified. Subsequently, 251 duplicate studies were removed, resulting in 997 studies for the screening stage. In the first stage, title and abstract screening were performed, with 889 studies excluded for not meeting the inclusion criteria. A total of 108 articles remained for full-text reading. In the second stage, after full reading, 96 studies were excluded for not addressing the research question or not meeting the established methodological criteria. In the end, 12 studies comprised the review.

Chart 2. List of selected studies. Rio de Janeiro, RJ, Brazil, 2025

Author/year	Methodology	Level of evidence	Limitations
Diaz *et al.*[17]	Retrospective observational study.	IV	Single-center study, sampling method, subjectivity in analysis, and degree of study relevance.
Gomes *et al.*[18]	Integrative review.	IV	Small number of articles due to the time frame.
Cândido *et al.*[19]	Qualitative, exploratory, and descriptive study with a cross-sectional design (interviews with 16 nurses).	V	Scarcity of studies on palliative sedation and on nurses' practice and knowledge regarding this process and death.
Júnior *et al.*[20]	Qualitative study.	V	Small number of participants, study conducted at a single health service, specific pandemic context.
Huppes *et al.*[21]	Scoping review.	V	Methodological diversity, low level of evidence in the studies.
Torquato *et al.*[22]	Observational, cross-sectional, and retrospective study.	V	Study conducted during the COVID-19 pandemic and in only one emergency care unit.
Rocha *et al.*[23]	Scoping review.	V	Need for scientific rigor in publications.
Bacigalupo[24]	Quasi-experimental, quantitative, longitudinal study with pre- and post-tests.	IV	The study presented no limitations.
Alves and Oliveira[25]	Exploratory qualitative study (23 interviewees).	V	The study presented no limitations.
Cordeiro *et al.*[26]	Quantitative, descriptive, retrospective study.	V	Small number of participants, incomplete information, patient frailty, and varying assessments performed by students.
Perão *et al.*[27]	Descriptive study with a qualitative approach.	V	Conducted with family members of patients receiving palliative care in a single ICU (only one setting studied).
Tripodoro *et al.*[28]	Observational pre- and post-intervention study with quantitative (clinical record audit) and qualitative (professional perceptions) components.	IV	No external control group, potential selection and recording bias; subjective quantitative analysis; limited generalizability.

Chart 3. Síntese com objeto e/ou questão e/ou objetivos dos estudos e principais resultados encontrados nos artigos analisados. Rio de Janeiro, RJ, Brasil, 2025

Author/year	Study objectives	Main results
Diaz *et al.*[17]	Estimates the number of cancer deaths, reports the frequency of chemotherapy (CT) use during the last three months of life, and describes the clinical and epidemiological characteristics of these patients.	There is a concerning frequency of chemotherapy use at the end of life, and deaths continue to occur primarily in hospitals.
Gomes *et al.*[18]	Identifies self-care actions performed by adults receiving palliative care.	Self-care actions were identified across all dimensions (physical, psychological, social, and spiritual).
Cândido *et al.*[19]	Explores nurses' knowledge and perceptions regarding palliative sedation in oncology.	Feelings of insecurity and uncertainty were identified, highlighting the need for nurse training.
Júnior *et al.*[20]	Analyzes palliative nursing care within the context of the pandemic, based on the Peaceful End-of-Life Theory.	The pandemic intensified challenges in palliative care, requiring adaptations in nursing practices to ensure comfort and dignity for patients at the end of life.
Huppes *et al.*[21]	Investigates, through a scoping review, the practice of continuing or withholding nutrition during the final phase of life.	There is no consensus on the subject; decisions must be individualized, considering ethical and clinical aspects as well as the wishes of patients and their families.
Torquato *et al.*[22]	Describes the clinical-epidemiological profile of palliative care patients treated in a general emergency service.	Most patients had advanced chronic diseases requiring continuous care, with urgent issues related to pain and physical symptoms.
Rocha *et al.*[23]	Conducts a scoping review on palliative care, end-of-life care, and COVID-19.	The pandemic impacted palliative care, hindering access to services, family presence, and symptom control at the end of life.
Bacigalupo, Vega and Rodriguez[24]	Explores family experiences regarding caregiving within a palliative care context.	Families reported feelings of suffering but also of finding new meaning, underscoring the importance of emotional support and active listening provided by nursing staff.
Alves and Oliveira[25]	Identifies the advances made and the challenges faced.	Difficulties such as a lack of specialized training and a shortage of resources were identified.
Cordeiro *et al.*[26]	Describes the clinical and sociodemographic profile of hospitalized adults receiving palliative care.	The prevalence of adult patients with advanced non-communicable chronic diseases requiring palliative care was observed.
Perão *et al.*[27]	Explores the social representations of comfort held by family members of palliative care patients in the intensive care unit.	Comfort was linked to physical, emotional, and spiritual aspects, highlighting the nursing role in providing a welcoming environment and support to families.
Tripodoro *et al.*[28]	Analyzes the outcomes of a palliative care quality program for the final days of life, following a decade of implementation.	The program contributed to better quality end-of-life care, emphasizing the relief of suffering, respect, and humanization.

In Charts 2 and 3, studies were selected that evidence the importance of palliative care in the end-of-life process, highlighting emotional preparation, family support, and the qualified performance of healthcare teams. The main topics identified were ethical issues identified, including oncological patients, ethical and nutritional issues, as well as challenges related to training, intensification of care, and the need for adaptation and humanization. In response, the study showed the relevance of promoting quality and strengthening support for families.

Discussion

Professional training, feeding management, family assistance, and the use of sedatives in patients under palliative care

From the reading and analysis of the selected studies, it was possible to identify common points among the articles, which allowed the results to be organized into thematic categories, highlighting professional training, feeding management, family assistance, and the use of sedatives in patients under palliative care. This organization enabled a better understanding of the main aspects related to the nurse's role at the end of life, contributing to a clearer discussion of the challenges and practices involved in this context.

Based on the authors, the prevalence of complexity and the relevance of palliative care were analyzed, especially in the end-of-life context, as well as the precision with which this theme is addressed, particularly by nurses, family members, and society in general. As stated by Sanhueza *et al.*[29], the involvement of family members and healthcare professionals in the care of individuals under palliative care firmly contributes to a humanized farewell process, which is fundamental not only for the patient but for everyone around them.

This finding corroborates Bacigalupo, Vega and Rodriguez[24] when analyzing how family experiences in the palliative care process can be resignified when support, welcoming, and effective and humanized communication are present, which reduces emotional suffering and enables the end of life to be experienced in a more dignified manner.

In this sense, Perão *et al.*[27] highlighted that the provision of comfort cannot be understood solely as the absence of physical pain, but in a broader sense, it must encompass the emotional, psychological, and spiritual well-being of both patients and their family members. This perception reinforces what Candido *et al.*[19] addressed regarding palliative sedation, which is a therapeutic intervention indicated for cancer patients in the advanced stage of the disease, especially in the presence of refractory symptoms, that is, those that do not respond to conventional measures. Among the main symptoms that may justify its indication are intense pain, dyspnea, and decreased level of consciousness, which significantly impact the quality of life of these patients. Since the end of the 20th century, palliative sedation has been the subject of debate,

particularly regarding its ethical aspects, clinical indications, and application in clinical practice. Despite advances, knowledge gaps and divergent interpretations among professionals are still observed. Candido *et al.*[19] further emphasize that palliative sedation is a medical procedure; however, when it comes to PC, the participation of the multidisciplinary team is of fundamental importance, especially the nurse in the decision-making process. This professional is present daily at the bedside, providing care, listening to anxieties and wishes, and must also be attentive to identifying signs and symptoms of suffering, as well as responses to treatments. Thus, they contribute to the development of conduct that respects the particularities of each patient and offers a dignified end of life, even amidst uncertainty or doubts about the most appropriate time to initiate such care.

Furthermore, Diaz *et al.*[17] addressed an essential point of reflection when discussing the theme focused on oncology patients: the possibility that chemotherapy treatment, even without chances of reversal, may be compatible with the concept of dignified death, provided it is evaluated on a case-by-case basis and is in harmony with the principles of palliative care. This demonstrates how necessary it is that care be individualized and initiated early, from the diagnosis of chronic (incurable) diseases, considering not only the clinical aspect (pain relief and symptom burden) but also spiritual, social, human resource, financial, and physical aspects, offering a more dignified and better quality of life, respecting the wishes of the patient and family members.

The studies by Júnior *et al.*[20] and Rocha *et al.*[23] raised a current and necessary discussion about the challenges for palliative care during the COVID-19 pandemic. It was observed that social isolation, overload, and access difficulties compromised the humanization of care, requiring adaptations from both teams and families. This perspective brings reflection on how the pandemic exacerbated the fragilities in health services and care. Therefore, it is important to be prepared to act in scenarios of public calamity without losing sight of respect, dignity, and welcoming.

Another important point were the studies by Torquato *et al.*[22] and Cordeiro *et al*.[26], which showed that a large portion of patients receiving palliative care have advanced chronic diseases. This finding brings an alert to the need for comprehensive care for this population, who live under intense physical suffering and therefore require emotional support and welcoming.

Finally, the study by[25] showed that even in the face of advances in the recognition of palliative care as an essential part of care, difficulties persist, especially regarding the lack of continuing education and the scarcity of resources. Tripodoro *et al*.[28] complement this view by reporting how investing in quality and structure can transform palliative care, providing relief from suffering, respect for patient autonomy, and welcoming of family members. In this context, it is possible to understand that palliative care is not limited solely to the control of physical pain, but involves comprehensive (spiritual, emotional, and social), interdisciplinary, and humanized care, through technical practice, dialogue, welcoming, and respect for the needs of each patient and their family members. The urgency of professional training and preparation to deal with complexities and challenges is evident, with the aim of always seeking to ensure comfort, dignity, and respect.

Thus, upon analyzing the presented studies, the role of the nurse in palliative care assistance becomes evident, especially in the end-of-life process. Sanhueza *et al.*[29] and Bacigalupo, Vega and Rodriguez[24] addressed emotional support, welcoming, and family preparation. For this, preparation for direct and continuous contact with the patient and their family members is necessary. This role goes beyond technical assistance and involves skills such as communication, empathy, compassion, and management of suffering, which underscores the importance of the nurse. However, the studies also pointed to gaps related to the level of knowledge of nurses and nursing teams regarding palliative care. Candido *et al.*[19] demonstrated that many professionals have doubts regarding the use of palliative sedation, which may compromise the quality of care and generate insecurities for both the professional and the family. This reality is perceptible in other studies, such as that of Huppes *et al*.[21], which pointed to a lack of preparation especially in moments of difficult decision-making, such as the suspension of feeding. These authors showed in their studies that the need for investment in training and a more effective approach, both in undergraduate education and in specializations, is fundamental.

Alves and Oliveira[25] point out that, despite advances in the recognition of the importance of palliative care, there remains a shortage of resources and specific training that directly impacts the quality of care. This gap between theory and practice was exacerbated during the COVID-19 pandemic, as stated by Júnior *et al.*[20] and Rocha *et al.*[23], who addressed how structural and resource limitations, as well as social isolation, hindered the provision of care, requiring adaptations that were insufficient to guarantee the required quality standard.

According to Radbruch *et al.*[3], professionals trained in PC are a limited resource in countries of different income levels. Most of this care is provided by non-specialist professionals, such as general clinicians, other physicians, nurses, and other healthcare workers. In view of this scenario, the Lancet Commission recommends that all healthcare professionals involved in the care of seriously ill patients receive basic training in palliative care during their academic education.

In this regard, the assessment of the impact of nursing care on promoting the quality of life of terminally ill patients and their family members also proved to be a central point. Perão *et al.*[27] and Tripodoro *et al.*[28] stated that humanized care for the relief of suffering and the welcoming of emotional needs are of fundamental contribution to a less traumatic experience for those involved in the PC process, namely patients and their family members. Therefore, such care should be provided by trained professionals, so that they may assist patients in the best possible way.

Therefore, the results and discussions raised thus far reinforced that the nurse's role in palliative care goes beyond technical practice and clinical management, making emotional preparation, assertive communication, and a humanized perspective indispensable. Thus, identifying the team's level of knowledge, promoting training, aligning care practices with scientific guidelines, and understanding the positive impact of such care on the lives of patients and family members are fundamental to ensuring that the end of life is experienced with dignity for all.

Conclusion

This study originated from concerns experienced during the nursing residency, especially during the rotation through the medical ward, where it was possible to follow patients in palliative care in the terminal phase of life. In this care setting, it was observed that many professionals faced difficulties in managing the care of these patients and their families, revealing fragility in care delivery. Furthermore, it became extremely important to recognize the need to introduce palliative care from the moment of diagnosis of an incurable or life-threatening illness, and not only in the final phase, enabling appropriate therapeutic planning, early symptom control, and better organization of care. Thus, conducting this study allowed for reflection on the nurse's performance, reinforcing the importance of knowledge on this topic.

Regarding the limitations and challenges of the study, it is noted that the articles referenced in the research address the topic broadly, presenting many concepts about palliative care, its phases, and a focus on oncology. Furthermore, relevant materials may have been excluded due to restrictions regarding the choice of databases, as well as the defined time frame, the approach to specific descriptors, and the methodological variety of the analyzed studies.

The present research work contributes to the expansion of understanding regarding the nurse's role in palliative care during the terminal phase of life, evidencing that it is essential to promote comfort, dignity, and quality in care for patients and their families. However, it was analyzed that, although the literature has shown significant advances regarding the importance of early introduction of palliative care, there are gaps in the levels of knowledge of nurses, as well as of nursing teams, in addition to challenges regarding the practical application of protocols.

The literature on the topic proved to be extensive, especially regarding the influence of technical and emotional preparation on patient care and the welcoming of family members experiencing the process of this delicate moment. A deficit in knowledge on the topic was also perceived during undergraduate nursing education. Thus, the study pointed to continuing education (Lato Sensu and/or Stricto Sensu), the formulation of more public policies, the strengthening of care protocols, the development of advanced directives (AD), and the humanization of care as essential strategies to better enable care for these patients. Therefore, the main results, perceptions, and analyses of this study reinforced the need for effectiveness in palliative care, associated with the professional training of nurses, grounded in the ethical principles of autonomy, beneficence, non-maleficence, and justice, as well as the provision of comprehensive, welcoming, and empathetic care, ensuring quality in health care and respect for the patient's rights and dignity.

References

1. Pissini L. Lidando com pedidos de eutanásia: a inserção do filtro paliativo. Rev Bioet. 2010;18(3):549-60. Disponível em: https://revistabioetica.cfm.org.br/revista_bioetica/article/view/584/590
2. Fernandes MA, et al. Percepção dos enfermeiros sobre o significado dos cuidados paliativos em pacientes com câncer terminal. Cienc Saude Colet. 2013;18(9):2589-96. https://doi.org/10.1590/S1413-81232013000900013
3. Radbruch L, et al. Redefining palliative care: a new consensus-based definition. J Pain Symptom Manage. 2020;60(4):754-64. https://doi.org/10.1016/j.jpainsymman.2020.04.027
4. Hermes HR, Lamarca ICA. Cuidados paliativos: uma abordagem a partir das categorias profissionais de saúde. Cienc Saude Colet. 2013;18(9):2577-88. https://doi.org/10.1590/S1413-81232013000900012
5. Brasil. Ministério da Saúde. Resolução nº 41, de 31 de outubro de 2018. Dispõe sobre as diretrizes para a organização dos cuidados paliativos, à luz dos cuidados continuados integrados, no âmbito Sistema Único de Saúde (SUS) [Internet]. Diário Oficial da União. 2018 [citado em 17 fev 2026]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/cit/2018/res0041_23_11_2018.html
6. Brasil. Ministério da Saúde. Portaria GM/MS nº 3.681, de 7 de maio de 2024. Política Nacional de Cuidados Paliativos - PNCP no âmbito do Sistema Único de Saúde [Internet]. Diário Oficial da União. 2024 [citado em 19 fev 2026]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2024/prt3681_22_05_2024.html
7. D'Alessandro MPS, et al. Manual de cuidados paliativos [Internet]. 2ª ed. São Paulo: Hospital Sírio-Libanês; Ministério da Saúde; 2023 [citado em 17 fev 2026]. Disponível em: https://www.conass.org.br/wp-content/uploads/2023/10/manual-paliativos_HSL-Digital_Set23-1.pdf
8. Carlo M. Brasil está entre os últimos no ranking global sobre cuidados paliativos [Internet]. Jornal da USP. 2025 jun [citado em 17 fev 2026]. Disponível em: https://jornal.usp.br/campus-ribeirao-preto/brasil-esta-entre-os-ultimos-no-ranking-global-sobre-cuidados-paliativos/
9. Rodrigues LF, et al. Cuidados paliativos: percurso na atenção básica no Brasil. Cad Saude Publica. 2022;38(9):e00130222. https://doi.org/10.1590/0102-311X00130222
10. Munis JGL, et al. Palliative care network in Brazil. In: Palliative care [Internet]. London: IntechOpen; 2019 [citado em 12 jun 2025]. Disponível em: https://www.intechopen.com/chapters/66427

11. Valentino TCO, et al. Impact of palliative care on quality of end-of-life care among Brazilian patients with advanced cancers. J Pain Symptom Manage. 2020;59(1):39-48. https://doi.org/10.1016/j.jpainsymman.2019.09.004
12. Charruf RMM, Silveira CC, Silva KV. Manual de cuidados paliativos na atenção primária e atenção domiciliar. 1ª ed. Rio de Janeiro: Atheneu; 2025.
13. Soares CB, et al. Revisão integrativa: conceitos e métodos utilizados na enfermagem. Rev Esc Enferm USP. 2014;48(2):335-45. https://doi.org/10.1590/S0080-6234201400002000020
14. Galvão TF, et al. Epidemiologia e Serviços de Saúde. Rev Saude Publica. 2022;56:48. https://doi.org/10.11606/s1518-8787.2022056004236
15. Brunt BA, Morris MM. Nursing professional development evidence-based practice [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 [citado em 22 mar 2026]. Disponível em: https://www.ncbi.nlm.nih.gov/books/NBK589676/
16. Page MJ, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ. 2021;372:n71. https://doi.org/10.1136/bmj.n71
17. Diaz MH, et al. Quimioterapia al final de la vida es compatible con muerte digna y cuidados paliativos. Rev Fac Cienc Med Cordoba. 2023;80(2):93-8. https://doi.org/10.31053/1853.0605.v80.n2.37489
18. Gomes AM, et al. Ações de autocuidado realizadas por adultos em cuidados paliativos: revisão integrativa. Rev Enferm UFPE On Line. 2023;17(1):e254216. https://doi.org/10.5205/1981-8963.2023.254216
19. Candido MS, et al. Conhecimento e percepção de enfermeiros frente à sedação paliativa na oncologia. REME Rev Min Enferm. 2023;27:e1519. https://doi.org/10.35699/2316-9389.2023.42121
20. Júnior JMM, et al. Cuidados paliativos da enfermagem no cenário pandêmico conforme a teoria de final de vida pacífico. Rev Pesqui Cuid Fundam Online. 2023;15:e12037. https://doi.org/10.9789/2175-5361.rpcfo.v15.12037
21. Huppes B, et al. Manter ou suspender a alimentação em fase final de vida? Scoping review. Rev Pesqui Cuid Fundam Online. 2023;15:e12767. https://doi.org/10.9789/2175-5361.rpcfo.v15.12767
22. Torquato ACCS, et al. Perfil clínico-epidemiológico dos pacientes em cuidados paliativos atendidos em um serviço de urgência geral. Medicina (Ribeirao Preto). 2022;55(3):e194445. https://doi.org/10.11606/issn.2176-7262.rmrp.2022.194445
23. Rocha OYF, González GMC, Romero NR. Cuidados paliativos, cuidados de fin de vida y COVID-19: revisión de alcance. Cuidarte. 2022;13(3):e2601. https://doi.org/10.15649/cuidarte.2601
24. Bacigalupo CM, Vega PV, Rodriguez RG. Resignificar el cuidado al final de la vida, experiencias de familiares en cuidados paliativos. Rev Chil Enferm. 2022;4(2):12-36. https://doi.org/10.5354/2452-5839.2022.66661
25. Alves RSF, Oliveira FFB. Cuidados paliativos para profissionais de saúde: avanços e dificuldades. Psicol Cienc Prof. 2022;42:e238471. https://doi.org/10.1590/1982-3703003238471
26. Cordeiro FR, et al. Perfil clínico e sociodemográfico de adultos hospitalizados em cuidados paliativos. Rev Enferm UFPI. 2021;10(1):e766. https://doi.org/10.26694/reufpi.v10i1.766
27. Perão OF, et al. Representações sociais de conforto para familiares de pacientes em cuidados paliativos na terapia intensiva. Rev Gaúcha Enferm. 2021;42:e20190434. https://doi.org/10.1590/1983-1447.2021.20190434
28. Tripodoro VA, et al. Análisis de los resultados de un programa de calidad en cuidados paliativos para los últimos días de vida: diez años de experiencia. Medicina (B Aires). 2019;79(6):468-76. Disponível em: https://www.scielo.org.ar/pdf/medba/v79n6/v79n6a07.pdf
29. Sanhueza JR, et al. Preparación para la muerte de personas mayores: perspectivas de equipos de salud primaria, familiares y cuidadoras principales. Cad Saude Publica. 2024;40(10):e00171023. https://doi.org/10.1590/0102-311XPT171023