BMC Nursing

RESEARCH

Open Access

A qualitative study on ICU nurses' perceptions of palliative care

Mina Omidi[1], Alireza Abdi[2,3*] and Maryam Rezaei[4*]

Abstract

Introduction Providing palliative care is one of the most essential responsibilities of nurses toward patients and their families. To fulfill this role effectively, nurses require specific skills to understand patients better and gain their trust. Given the necessity of delivering palliative care and the limited studies available in Intensive Care Units (ICUs), this study aimed to explore the perceptions of nurses working in ICUs in Kermanshah Province.

Methods This qualitative study employed a descriptive phenomenological approach. Data were collected through purposive sampling via semi-structured interviews with 13 ICU nurses employed at hospitals affiliated with Kermanshah University of Medical Sciences. The interviews were recorded, transcribed verbatim, and analyzed using the Collaizi method, with data management conducted through MAXQDA-10 software.

Results Of the 13 participating nurses, 9 were female and 4 were male, with a mean age and work experience of 29.69, and 6.54 years, respectively. Four main themes and nine sub-themes emerged from the qualitative analysis. The primary themes included: "Understanding the meaning and concept of palliative care," "Nurses' perception of the types of palliative care," "Strengthening the foundations of palliative care for ICU nurses," and " Factors contributing to palliative care".

Conclusion The findings highlighted several critical factors necessary for the effective provision of palliative care in ICUs, including nurses' understanding, patience, required knowledge, and a strong work ethic. These factors collectively enhance the quality of palliative care provided to patients. Given the pivotal role of palliative care in improving nursing care for critically ill patients, it is recommended that further qualitative studies be conducted to deepen nurses' understanding of palliative care in ICUs.

Clinical trial number
Not applicable.

Keywords Nurses, Palliative care, Intensive care units (ICUs)

*Correspondence:
Alireza Abdi
A_abdi61@yahoo.com
Maryam Rezaei
nasim_nina72@yahoo.com

Full list of author information is available at the end of the article

Introduction

Intensive Care Units (ICUs) are specialized settings where medical personnel and advanced equipment are utilized to treat and manage critically ill patients. The primary goals in ICUs are to save patients' lives, restore them to a functional state, maintain vital functions for prolonged survival, and reduce mortality rates. Delivering up-to-date and appropriate care in these units significantly impacts the course of illness and patient outcomes [1–3]. Modern medical staff, equipped with advanced technologies, can now help patients sustain life in ICUs for extended periods [1, 3, 4].

Despite these efforts and advancements, ICU mortality rates remain high across different geographical regions. Therefore, healthcare providers need adequate knowledge and skills related to end-of-life care and support to ensure a dignified death for patients [2].

Healthcare professionals must address all dimensions of pain comprehensively and receive training in effective pain management and the provision of palliative care [5]. Palliative care is a globally recognized interdisciplinary approach aimed at improving quality of life—not only at the end of life but also during the management of chronic illnesses over the remaining years of life [6, 7]. Palliative care seeks to establish effective communication with patients and their families, alleviate distressing symptoms, provide physical and psychosocial support, and educate both patients and families [8].

Providing palliative care to patients and their families is among the most critical professional and legal responsibilities of nurses. Nurses receive training in palliative care during their academic education through lectures, clinical practice, and mentorship from instructors. This training focuses on developing the necessary skills, knowledge, and values essential for delivering high-quality palliative care [8, 9].

However, several organizational factors may influence the delivery of palliative care services, such as staff shortages, long shifts, and nurses' dissatisfaction due to a lack of organizational support [8]. On the other hand, environmental interventions, such as reducing stressors and addressing workplace challenges, can improve patient satisfaction, enhance staff well-being, and facilitate effective palliative care. For instance, managing environmental factors like noise and lighting in ICUs can aid nurses in providing both physical and psychosocial palliative care [10].

Among all healthcare professionals, nurses play the most significant role in palliative care. They must develop the necessary skills to build trust and foster satisfaction among patients and their families. By understanding their patients and establishing effective communication, nurses can create meaningful and impactful relationships [11].

In Iran, limited studies have been conducted on palliative care in hospital settings, and specialized palliative care teams are generally absent in these facilities. With the growing demand for palliative care worldwide, including in Iran, healthcare providers—physicians, nurses, and other medical professionals—must enhance their knowledge and capabilities in this area to deliver the best possible care to patients and their families. Given the high mortality rates in ICUs, the urgent need for palliative care, and the lack of research in this domain, the present study aimed to explore ICU nurses' perceptions of palliative care.

Methods

This qualitative study, employing a descriptive phenomenological approach, was conducted between 2021 and 2022 in Kermanshah, Iran [9]. The study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist as a guideline [10].

Participants

The study involved intensive care unit (ICU) nurses who were purposefully selected from hospitals across Kermanshah Province. To participate, nurses had to meet specific inclusion criteria: they needed to express a willingness to share their experiences with palliative care, have a minimum of six months of experience in a critical care unit, and possess direct, hands-on experience in caring for critically ill patients. Before their involvement, all participants provided written informed consent, which also included permission for audio recordings during the interviews. To ensure the quality and reliability of the data, exclusion criteria were carefully applied. Nurses with language or communication difficulties that could hinder their ability to engage effectively in the interview process were excluded. This approach was essential to guarantee that the data collected was both accurate and meaningful, as clear and effective communication is pivotal for eliciting valid and insightful responses.

Data collection

Data were collected through face-to-face, in-depth, semi-structured interviews using open-ended questions. The interviews were conducted exclusively for this study. Demographic data, including job title, work experience, workplace, and educational background, were also gathered. After initial open-ended questions, key questions such as the following were posed: "What is your understanding of palliative care in ICUs?", "Have you personally encountered palliative care for patients in ICUs?". Follow-up probing questions such as "How?", "Why?", and "Can you give me an example?" were used to gain deeper insights into participants' responses.

The first author conducted data collection with assistance from ICU staff in Kermanshah. Each interview was audio-recorded using a Samsung Galaxy A5 smartphone and transcribed verbatim on the same day. The interview location was determined by the participants. The study's objectives were discussed with participants before the interviews, which lasted between 30 and 60 min (average: 45 min).

Data analysis

Data were analyzed using the seven-step framework proposed by Colaizzi, as outlined by Wirihana et al. [12]. MAXQDA-10 was used to manage the data analysis process. 1-Familiarization: The audio recordings were listened to multiple times, transcribed verbatim, and the transcripts were repeatedly reviewed. 2-Significant Statements: Meaningful statements about palliative care for ICU patients were extracted from the data. 3-Formulated Meanings: Key phrases and statements were analyzed to identify underlying meanings, which were then coded. 4-Clustering Themes: Related codes were grouped into subthemes, and themes were formed by integrating similar subthemes. 5- Exhaustive Description: A comprehensive definition of the phenomenon was developed by synthesizing the findings into larger thematic categories. 6- Model Evaluation: A fundamental model of palliative care was assessed in its most basic form. 7-Verification: The credibility of the findings was confirmed through member checking and peer debriefing.

Trustworthiness

To ensure credibility, data collection spanned six months, with a diverse sample of participants in terms of age and work experience. The rigor of the study adhered to Lincoln and Guba's methodology [13]. The generated themes and codes were subjected to validation through member checking and peer review. To ensure credibility, the opinions of research colleagues were sought regarding the interview process and data analysis. The interview transcripts, along with the extracted codes and subthemes, were shared with several participants, one PhD in nursing and one MSc in nursing, both experienced in qualitative research, to confirm the accuracy and relevance of the findings. To establish reliability, the data were reviewed by an external observer who was familiar with both the clinical environment and qualitative research but was not part of the research team. Any discrepancies identified in the coding process or the formation of categories were addressed and corrected based on their feedback. Confirmability was assessed by providing different sections of the themes to two independent researchers with expertise in qualitative research. Their interpretations and evaluations were compared, resulting in a high level of agreement, further supporting the rigor and trustworthiness of the findings. A detailed description of the data collection, analysis, and theme extraction processes was provided to ensure transparency and allow for external audits. During the analysis, the researcher maintained neutrality by bracketing pre-existing beliefs. To enhance transferability, the findings were shared with ICU staff not involved in the study but whose experiences aligned with the results.

Table 1 Demographic characteristics of the participants

Participant number	Gender	Marital status	Age (year)	Education	Work history
1	Male	Single	28	BSc	6 year
2	Female	Married	31	BSc	8 year
3	Female	Single	26	MSc	3 year
4	Female	Single	27	MSc	4 year
5	Female	Married	26	BSc	2.5 year
6	Female	Single	29	BSc	6 year
7	Female	Single	24	BSc	6 months
8	Female	Married	39	BSc	15 years
9	Female	Married	27	BSc	4 years
10	Male	Single	30	MSc	7 years
11	Male	Single	26	BSc	2 years
12	Male	Married	44	MSc	21 years
13	Female	Married	29	BSc	6 years

BSc: Bachelor of Sciences, MSc: Master of Sciences

Ethical considerations

This study was approved by the Ethics Committee of Kermanshah University of Medical Sciences (Ethics Code: [IR.KUMS.REC.1400.493]). Ethical considerations included obtaining oral and written informed consent, ensuring data confidentiality, and granting participants the freedom to withdraw at any stage by transparently outlining the study's purpose and process at the beginning of the interviews.

Findings

Among the 13 nurses who participated in the study, 9 were female, and 5 were married. Nine participants held a bachelor's degree in nursing, while 4 held a master's degree. The mean age of the participants was 29.69 ± 5.66 years, and the mean work experience was 6.54 ± 5.64 years (Table 1).

The data analysis yielded four main themes: "Understanding the meaning and concept of palliative care", "Nurses' perception of different types of palliative care", "Strengthening the foundations of palliative care for ICU nurses", and "Factors contributing to palliative care".

These themes were further divided into nine subthemes, highlighting the various dimensions of palliative care as perceived and practiced by ICU nurses (Table 2).

Table 2 Extracted them and subthemes of the study

Themes	Subthemes
Understanding the meaning and concept of palliative care	The Meaning of Palliative Care The Humanistic View of the Patient
Nurses' perception of different types of palliative care	Physical Palliative Nursing Care Psychological and Emotional Palliative Nursing Care Family-Related Palliative Nursing Care
Strengthening the foundations of palliative care for ICU nurses	Optimizing Palliative Care Education Organizational and Physical Environment Supporting Palliative Care
Factors contributing to palliative care	Perceived Characteristics of Nurses in Palliative Care Judgment and Decision-Making Abilities in Palliative Care

Understanding the meaning and concept of palliative care

This theme emerged from the responses of 13 nurses, with 28 relevant codes identified. Nurses believe that palliative care involves awareness of all the fundamental actions and ethical principles to alleviate the physical, psychological, social, and spiritual pain and suffering of both the patient and their family. The theme was divided into two subthemes: "The Meaning of Palliative Care" and "The Humanistic View of the Patient."

The meaning of palliative care

All 13 nurses referenced the meaning of palliative care, resulting in 18 codes. They viewed it as a set of activities aimed at alleviating the patient's pain and distressing symptoms, ultimately improving the quality of life for both the patients and their families, and bringing comfort and satisfaction to them. Participant 1 stated in this context:

> *The definition of palliative care is those measures that are taken to make the patient suffer less pain and suffering. Personally, pain relief comes to mind more, measures that are taken to make the patient comfortable.*

Participant 3 shared the following statement:

> *Palliative care is a series of interventions, both invasive and non-invasive, aimed at improving a patient's quality of life and the progression of their illness.*

Additionally, participants identified palliative care as involving not only physical care but also psychological and emotional support for the patient. Participant 5 emphasized:

> *The first thing that comes to mind is the pain and suffering a patient might experience while being hospitalized. This pain and suffering can be both physical and psychological. In palliative care, the efforts to reduce the pain and suffering the patient undergoes are the primary focus. That's what I think of in this context.*

Participant 11 also added:

> *I believe that palliative care may extend beyond medication. It involves actions a nurse can take, whether psychological or therapeutic, to reduce the pain, discomfort, and distress of the patient in any form. It can be physical or emotional pain, and I feel that might be what palliative care is about.*

The humanistic view of the patient

Six nurses expressed their perspectives on this theme, with 10 codes extracted from their responses. They highlighted that in palliative care, there is an inseparable connection between the body and emotions, leading to a holistic understanding of the human being. This is referred to as "integrity," which aims to improve both the nurse's and patient's well-being by considering human values and the various dimensions of health. Additionally, some nurses indicated that further education, especially at advanced levels, changed their understanding of the patient.

Participant 2 emphasized the importance of seeing the patient as a human being:

> *I want them to feel that, as a human, I am looking at them. The patient might be the breadwinner of a family, just like me, and they have the right to live. I want to look at them through that humanitarian lens.*

Participant 3 discussed the reciprocal nature of providing palliative care:

> *You see them(patients) calm down. Aside from the nursing work, it's a pleasant experience for the person. It brings a sense of satisfaction, and it lightens your conscience. If we can establish a connection, it has a two-way effect. There's a sense of calm (for nurses), and you could say that it increases the motivation to perform the task.*

Participant 11 spoke about the impact of higher education on their perception of patients:

> *When you go on to study at a higher level… your perspective broadens. Honestly, it wasn't like this before, but when I attended classes, I started to understand certain things better.*

Participant 13 highlighted the significant role of work experience in delivering palliative care with a humanistic approach, stating, *"Work experience in this field is 100% helpful."*

Nurses' perception of different types of palliative care

This theme was derived from the perspectives of 11 nurses and 272 codes. The nurse's understanding of various forms of palliative care refers to their awareness and recognition of all aspects of palliative care. Adopting this holistic approach aims to enhance the quality of life for both patients and their families, addressing both physical and psychological well-being. Three sub-themes emerged under this category: "Physical Palliative Nursing Care," "Psychological and Emotional Palliative Nursing Care," and "Family-Oriented Palliative Nursing Care."

Physical palliative nursing care

Seven participants explicitly addressed this topic, leading to the identification of 79 codes in this area. As indicated by the title of this sub-theme, physical palliative care involves identifying and assessing patients in need of physical palliative services, and providing care and support tailored to the patient's condition as a fundamental human right. This includes identifying issues, pain, and distress symptoms, administering appropriate medications and treatments to alleviate pain, as well as providing palliative care aligned with the progression of the illness.

In this context, three participants mentioned different methods of physical palliative care. Participant 2 stated: *"The patient might be in an uncomfortable position, or their foot might be stuck under something; with a simple movement, I could reduce their pain. If necessary, we might have to use invasive methods, such as administering narcotics."* Participant 3 described: *"The deep breathing exercises and inhalation techniques I teach can enhance oxygenation."* Additionally, Participant 7 remarked: *"For physical pain, there are medications—if the pain is severe, we use narcotics to ease it and provide tranquilizers to reduce the discomfort."*

Participant 14 also emphasized the importance of pain relief following the physician's orders, stating, *"They (the patients) tell us about their pain, and we get medications from the doctor (order) and relieve them with that."*

Psychological and emotional palliative nursing care

For this sub-theme, 162 codes were extracted from the statements of six participants. The nurses believed that psychological-emotional palliative nursing care consists of a range of spiritual, emotional, and psychological palliative interventions aimed at reducing patient stress and anxiety. These interventions include psychological counseling, empathetic communication with patients, creating a calming environment, and non-pharmacological methods such as massage or music therapy.

Six participants mentioned various approaches to psychological-emotional care. Among them,

Participant 1 highlighted the positive impact of having a companion on a patient's well-being, stating, *"His wife or mother comes and talks to him, and he really calms down. His pain subsides without needing painkillers."* Participant 2 stated, *"I personally talk to unconscious patients. I go to their bedside, call their name, gently touch them, and ask how they are doing. I don't see it as unnecessary just because their consciousness level is low. I usually talk to my patients like this."* The same participant also discussed music therapy, saying, "*Sometimes, I read poetry or sing songs for them. I feel that even if they are not fully aware, it may provide some psychological comfort."* Participant 3 remarked, *"In palliative care, we can offer massage therapy or skin care treatments."*

Participant 11 also shared, "*I would use my phone to contact their family, sometimes making video calls through WhatsApp so the patient could see their family and wave at them."* Similarly, Participant 12 emphasized, *"We need to make sure they don't lose their spirit. We should offer psychological support, reassuring them with stories of other patients who came with similar symptoms but recovered well, helping reduce the anxiety that comes with being in the ICU."*

Family-related palliative nursing care

This sub-theme emerged from the perspectives of four participants, with 31 codes extracted. It refers to supportive and palliative care directed towards the patient's family, acknowledging that, when a family member is ill, the families are significantly affected in various dimensions: emotional, psychological, economic, and social. Nurses must be prepared to provide care not only for the patient but also for their family in such circumstances.

Participant 1 stated, "*Even just a phone call can calm the family. We always try to boost the family's spirits, but beyond offering emotional support, there isn't much else we can do for them."* Participant 2 shared, "*I've been in contact with ICU families for over a year. We often talk to the patient's family, reassuring them that life is in God's hands and we are doing everything we can, from medical treatment to anything else they need. We tell them not to worry and to reduce their stress."* Participant 3

emphasized the importance of empathy, stating, "*We put ourselves in the family members' shoes, knowing that something like this could happen to us as well. This mindset makes us realize they need explanations and reassurance.*"

Participant 13 shared experiences of building close connections with patients' families, stating, "*There were many times when a patient's family member has become close to me, confiding in me and even sharing personal family issues. I have helped them as much as my knowledge allows.*"

Strengthening the foundations of palliative care for ICU nurses

Palliative care in intensive care units (ICUs) involves specialized interventions aimed at alleviating the suffering of both patients and their families. While these care activities are carried out by nurses and other members of the healthcare team, nurses play a central role in delivering this care. To strengthen the foundations of palliative care for ICU nurses, two sub-themes emerged: "Optimizing Palliative Care Education" and "Organizational and Physical Environment Supporting Palliative Care." These sub-themes were derived from the statements of nine participants and based on 122 codes.

Optimizing palliative care education

The participants in the interviews believed that optimizing education in palliative care could enhance nurses' self-efficacy in this area. This view emerged from the responses of nine participants and 26 codes. It was found that nurses with a higher sense of self-efficacy are more responsible and perform better in delivering palliative care. Therefore, educational interventions in palliative care can lead to an improved attitude and better performance in nurses.

For example, Participant 3 emphasized the importance of training during nursing education: *"A nurse should practice creating the simplest connection with the patient during their student years, and attention should be given to communication skills during clinical practice and internships."*

Participant 7 pointed out that during their education, the focus was more on theoretical knowledge than practical skills, saying: *"In our student years, we were given a large amount of theoretical information, but when you provide a lot of information, it's hard for a person to absorb everything. Information should be useful and concise."*

Participant 11 discussed the influence of educational staff in shaping practical knowledge, stating: *"A lot of what have been said here, especially regarding things like video calls, was shared with me by an instructor. For example, he (the instructor) suggested that if a patient is anxious or stressed, why not sit with them for a couple of minutes or show them a funny video on your phone?"*

Furthermore, Participant 12 suggested that a dedicated course on palliative care could enhance their understanding, adding: "*We have mental health courses, and it would be beneficial to have a course specifically focused on palliative care, where we can apply the knowledge gained in mental health to patients in various conditions and diseases.*"

Participant 13 emphasized the need for palliative care education for nurses, stating, *"This (education program) should be included in periodic and ongoing training in hospitals, meaning that a training class should be held for hospital personnel every six months or every four months."*

Organizational and physical environment supporting palliative care

This theme emerged from 47 codes and the views of 8 participants, revealing that one of the key nursing skills in the ICU is environmental monitoring. Environmental monitoring refers to transforming the ICU environment into a calm space with minimal stress for both the patient and the nurse. This can be achieved by reducing stress-inducing factors such as controlling lighting, noise, and the presence of family members, and providing social support for the patient. Ultimately, this approach positively impacts patient recovery, the satisfaction of the healthcare team, and the family's experience.

Participant 1 emphasized the importance of a calming physical environment: *"Even in this enclosed space, if fresh air is allowed to flow, or if there are more windows with an external view, it would be better. The lighting is insufficient."*

Participant 2 highlighted the need to reduce the psychological burden of administrative tasks on nursing staff, stating, *"I was trying to ease the psychological pressure on the staff by removing unnecessary tasks. These cards (checklists and patient record forms) keep nurses so busy with paperwork that they hardly have time to care for the patient."*

Participant 8 suggested increasing staff numbers to improve the quality of palliative care: *"The workload is too much. We're so busy that we don't have time to sit and talk to the patients, to explain things. If there were more staff, one nurse could focus on one patient and provide better palliative care."*

Participant 9 shared the challenges of interacting with supervisors due to the work environment: *"I feel uncomfortable when I go to the nursing office. Many times, I've wanted to talk to the head nurse, but I'm unsure if they're available or whether they're too busy. There's often a cold atmosphere between the staff and management, which makes it hard to approach them for discussions."*

Factors contributing to palliative care

This theme was derived from the views of 9 participants and 233 codes, encompassing two sub-themes: *"Perceived Characteristics of Nurses in Palliative Care"* and *"Nurses' Judgment and Decision-Making Process in Palliative Care"*.

Perceived characteristics of nurses in palliative care

This sub-theme was derived from the views of 7 participants and 66 codes. Given that palliative care involves multiple dimensions, including physical and technical aspects, emotional-psychological care, and social and relational support, the characteristics of nurses should reflect these diverse aspects. Key qualities of nurses in palliative care include patience, good behavior, and effective communication.

One participant (Participant 1) described the importance of patience in their role: *"The patient has gotten out of bed ten times and has fallen each time. Even though they (the patients) were upset, we helped them back each time. The more patient you are, the better the response."* Participant 4 emphasized treating all patients equally: *"As a nurse, I treat everyone equally—whether they're male or female, old or young."* Participant 6 shared an experience about the power of communication, even with unconscious patients: *"I had a patient who was unconscious and on a ventilator due to a brain hemorrhage. We allowed his family to speak to him without restriction. Despite being unresponsive, they continued talking to him, and eventually, the patient regained consciousness. It was a remarkable experience that I witnessed firsthand, and it had a significant impact."* Participant 12 discussed the role of reassurance in patient care, saying, *"We can calm the patient down, for example, by saying, 'If this is due to the side effects of the medication, it's nothing to worry about, you'll be fine."*

These qualities—patience, good behavior, and effective communication—are crucial for nurses to provide comprehensive and compassionate palliative care, especially in the challenging and emotionally charged ICU environment.

Judgment and Decision-Making abilities in palliative care

Based on 100 codes derived from the perspectives of 11 participants, it was clear that the judgment and decision-making abilities of nurses in delivering palliative care are fundamental skills that significantly enhance the quality of care and result in more favorable outcomes.

Participant 6 discussed the negative impact of physical restraints on patients, especially those with delirium. They stated, *"Physical restraint actually worsens the situation. Imagine a semi-conscious patient, between full consciousness and unconsciousness, which is common in delirium. If you tie their hands or feet, it aggravates their condition because it stimulates this state."*

Participant 4 emphasized the positive impact of providing patients with clear information about their care: *"Another important aspect is when you personally feel satisfied because the patient is satisfied. There's a sense of reward in knowing you've done well. In my opinion, one of the best forms of feedback is when the patient shows satisfaction after being informed in advance about what's happening."*

Participant 7 highlighted that when patients are informed about their conditions, they are more likely to cooperate with care procedures: *"When patients know the purpose of what we're doing, they cooperate better because they understand it benefits them. It makes our work easier, and procedures move forward more smoothly. Patients having awareness about their condition is generally very helpful."* In this regard, participant 12 also stated: *"The more information you give to the patient, the more cooperation the patient will have."*

These insights illustrate how effective judgment, informed decision-making, and clear communication with patients are key elements for optimizing palliative care, fostering cooperation, and ensuring patient satisfaction in the ICU.

Discussion

This study explored ICU nurses' perceptions of palliative care, focusing on two main topics. The first centered on the meaning of palliative care as an approach to improving the quality of life for patients with life-threatening illnesses and their families. In line with other studies, palliative care involves managing pain and addressing physical, emotional, and psychological needs, prioritizing quality over quantity of life while recognizing death as a natural part of the life cycle [6–8, 12]. Radbruch et al. (2020) redefined palliative care as "active holistic care" which comprises all aspects and comprehensive care [14]. The second topic, "Humanistic View of the Patient," emphasized the ethical foundation of palliative care, compassion, and dignity. In Liu et al. (2023) "patient-centered care" is raised as humanistic nursing care [15]. Coghlan declared that with the rise in chronic illnesses, integrating palliative care into healthcare and humanitarian efforts is increasingly vital, highlighting the need for an ethical, patient-centered perspective to reduce suffering [16]. Findings align with existing research, showing nurses view palliative care as a means to improve patient's quality of life through pain management and psychosocial support. Beyond clinical practice, these insights reinforce palliative care as a fundamental humanitarian effort, underscoring its role in promoting compassion and alleviating suffering [6–8, 12, 16].

Critically ill patients need compassionate, holistic care during the end-of-life phase. Commitment to core principles significantly shapes caregiving and influences patient outcomes. Family involvement, such as being present during a patient's final moments, enhances satisfaction and reinforces the patient-centered focus of palliative care. Personal attributes of nurses, like social and emotional intelligence, are essential for holistic care, enabling nurses to address patients' needs effectively. This approach not only brings fulfillment to nurses but also helps patients accept the end-of-life process, aligning with palliative care goals [17].

This study revealed that ethical practices and a humanistic approach are essential in enhancing nurse-patient communication and care quality in palliative settings. Nurses' ethical characteristics and self-driven humanitarian actions foster trust, dignity, and respect, significantly improving patients' quality of life. Patients emphasized the importance of respectful care that meets their needs without humiliation, highlighting the influence of physical and emotional well-being on communication and care delivery [18, 19]. Physical pain often leads to insecurity and feelings of burden among patients, underscoring the need for carefully prescribed medications to alleviate suffering and improve quality of life [20, 21]. Beyond pharmacological interventions, holistic methods such as music therapy, massage therapy, and family involvement emerged as effective strategies for enhancing psychological well-being. Music therapy, tailored to patient preferences, has been shown to reduce pain, anxiety, and stress while promoting emotional integration [22, 23]. Similarly, massage therapy not only improves physical relaxation and hemodynamic parameters but also fosters patient awareness when performed by family members [24, 25]. Family involvement in palliative care plays a crucial role in both patient recovery and family well-being. Active participation provides emotional, psychological, and social support, significantly aiding recovery and reducing stress. However, caregiving responsibilities often impose psychological and physical challenges on families, necessitating healthcare providers' support. Studies have highlighted the importance of accessible palliative care for family members, emphasizing psychological, emotional, financial, and social support systems to improve overall care outcomes [26–29]. This research reinforces the value of humanistic care, ethical nursing practices, and comprehensive support for both patients and families in palliative settings. By integrating holistic interventions and prioritizing family-centered care, nurses can effectively address the multifaceted needs of critically ill patients and their caregivers.

The sub-theme of optimizing palliative care education underscores the necessity of equipping nurses with the knowledge and skills to provide effective palliative care, manage pain, and communicate compassionately with patients and families. As key caregivers closely involved with patients, nurses require ongoing education, practice, and support to fulfill their commitment to high-quality care [30]. Research has consistently highlighted that nurses, as the largest providers of palliative care globally, play a pivotal role in improving care delivery, making their education and professional development essential [31]. This study also emphasizes the importance of environmental factors in enhancing palliative care. Improving air quality, ventilation, and temperature regulation in care areas is critical but often challenging [32]. Anderson's 2014 study further demonstrated that enhancing the aesthetics and views in patient spaces can significantly reduce stress and anxiety, positively influencing recovery [33]. In line with prior findings, this research highlights the dual importance of nurse education and environmental optimization in palliative care. By investing in continued education and creating patient-centered environments, healthcare systems can reduce stress, improve patient outcomes, and ensure holistic care delivery [30–33]. Designing a human-centered environment in critical care units requires attention to key environmental factors such as lighting, sound, and color, which significantly impact patients' quality of life. Nurses play a vital role in managing these elements to create a supportive care setting [34].

In line with the subtheme of "perceived characteristics of nurses in palliative care, " conscience is a cornerstone of palliative care nursing. Nurses, with patience and dedication, strive to provide the highest quality care to patients and their families. Research indicates that nurses with heightened awareness and a strong sense of duty deliver more professional and compassionate palliative care, underscoring the importance of education and strategies that foster their commitment and perseverance [35]. Effective palliative care relies on nurses demonstrating behaviors that enhance care quality. Studies confirm that compassionate interactions and strong communication skills are critical in delivering optimal palliative care. Both families and nurses highlight the significance of effective communication in ensuring patient and family-centered care [36].

Research consistently shows that unconscious patients may retain some level of awareness and perceive their surroundings, even when they appear unresponsive. Evidence suggests that speaking to unconscious patients can influence brainstem function, potentially accelerating recovery and fostering pre-awareness. These studies highlight the therapeutic value of verbal communication with unconscious patients, an often overlooked aspect of care. These findings align with previous research, emphasizing that communication may positively impact

recovery and patient outcomes, even in states of diminished consciousness [37].

Nurses' attitudes significantly influence decisions regarding palliative care measures e.g. the use of physical restraints in the ICU, as they are often the primary decision-makers. Research highlights the need for a thorough understanding of physical restraints, as their use can increase stress and irritability in patients [38–40]. The findings of this study emphasize the essential role of nurses in delivering high-quality palliative care by ensuring that patients and their families are well-informed about the treatment process. Nurse-led education is crucial in improving patient understanding and involvement in their care, creating a sense of worth, and reinforcing the principles of patient-centered care [41]. Moreover, nurses act as advocates for patients, playing an instrumental role in securing informed consent and enhancing understanding, which helps minimize the risk of treatment-related disputes [42]. Although previous studies align in recognizing the importance of communication and education in enhancing palliative care, they differ in the methods through which these outcomes are achieved. These differences may arise from variations in study design, contextual factors, or patient populations. Therefore, further research is needed to identify the most effective nurse-patient communication strategies in palliative care settings.

Limitations

A limitation of this study was the lack of participant cooperation, which may have been influenced by factors such as fatigue and burnout common in the high-pressure environment of intensive care units. Participants may also have been hesitant to engage due to concerns about the interview process, fear of identity disclosure, or apprehension about providing inaccurate responses. To address these challenges, the interview schedule was organized in advance to accommodate participants' preferences, and efforts were made to establish effective communication, ensuring that they felt comfortable and fully informed. Additionally, participants were reassured about the confidentiality of their responses and the ethical management of their data. Another limitation of this study was the restricted geographical scope of nurse recruitment and the relatively small sample size. Future studies are recommended to replicate this research in diverse regions with a larger sample size to enhance the generalizability of the findings.

A key strength of the study lies in its innovative focus, which was appreciated by many participants. Throughout the interview and analysis, participants reflected on the importance of palliative care for critically ill patients, with several noting that the interview served as a valuable reminder to prioritize this aspect of care in their professional practice. Our findings expand the perspective on the role of nurses in ICUs and can contribute to the development of evidence-based guidelines and the cultivation of a palliative care culture within intensive care settings. Given that palliative care is inherently multidisciplinary, further studies involving other healthcare professionals engaged in ICU palliative care are essential to ensure a comprehensive understanding and effective implementation.

Conclusion

In this study, nurses' perceptions of palliative care in intensive care units (ICUs) were explored. Nurses viewed palliative care as a series of activities performed from a humanistic perspective, aimed at reducing the patient's pain and suffering, ultimately improving their quality of life. They emphasized that palliative care encompassed both physical and psychological aspects, addressing the needs of the patient as well as their family. To strengthen the foundation of palliative care in ICUs, nurses suggested optimizing education and organizing appropriate physical environments for providing such care. Nurses who demonstrated qualities like patience, good behavior, and communication with patients were found to deliver more effective palliative care. Additionally, nurses were identified as playing a key role in making judgments and decisions related to palliative care for patients.

Abbreviations

ICUs	Intensive care units
COREQ	Consolidated Criteria for Reporting Qualitative Research
KUMS	Kermanshah university of medical sciences

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12912-025-03164-z.

Supplementary Material 1
Supplementary Material 2
Supplementary Material 3
Supplementary Material 4
Supplementary Material 5
Supplementary Material 6
Supplementary Material 7
Supplementary Material 8
Supplementary Material 9
Supplementary Material 10
Supplementary Material 11
Supplementary Material 12
Supplementary Material 13

Acknowledgements
This study resulted from a project approved by Kermanshah University of Medical Sciences with approval code 4000510 and research ethics committee No.IR.KUMS.REC.1400.493. We appreciate the cooperation of the intensive care unit nurses, the nursing and midwifery school officials, and the research and technology deputy of KUMS. **AI-assisted**: In the preparation of this article, I utilized ChatGPT, an AI language model, to assist with editing and refining the text. The AI contributed to enhancing the clarity, grammar, and overall flow of the manuscript. However, it is important to note that ChatGPT does not contribute to the original ideas or research presented in the article.

Author contributions
A.A and M.O contributed in designing the study, M.O and M.R collected the data, and analyzed by M.O and A.A, the final report and article were written by M.O, M.R, and A.A, and the paper were read and approved by all the authors.

Funding
The study was funded by Kermanshah University of Medical Sciences.

Data availability
The datasets generated and/or analyzed during the current study are not publicly available due to they are written in Persian and entered into MAXQUDA software, but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
The study was approved by the research ethics committee of Kermanshah University of Medical Sciences, and all methods were performed according to the guidelines and regulations of the Declaration of Helsinki. Written informed consent was taken from the participants before starting the interviews.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Author details
[1]Department of Nursing, School of Nursing and Midwifery, Kermanshah University of Medical Sciences, Kermanshah, Iran
[2]Department of Emergency and Critical Care Nursing, School of Nursing and Midwifery, Kermanshah University of Medical Sciences, Kermanshah, Iran
[3]Social Development & Health Promotion Research Center, Health Institute, Kermanshah University of Medical Sciences, Kermanshah, Iran
[4]Department of Emergency and Critical Care Nursing, Student Research Committee, School of Nursing and Midwifery, Kermanshah University of Medical Sciences, Kermanshah, Iran

Received: 16 November 2024 / Accepted: 5 May 2025
Published online: 13 May 2025

References

1. Diaz JV, Riviello ED, Papali A, Adhikari NKJ, Ferreira JC. Global critical care: moving forward in Resource-Limited settings. Annals Global Health. 2019;85(1):3. https://doi.org/10.5334/aogh.2413.
2. Mercadante S, Gregoretti C, Cortegiani A. Palliative care in intensive care units: why, where, what, who, when, how. BMC Anesthesiol. 2018;18:1–6.
3. Esper AM, Arabi YM, Cecconi M, Du M, Evangelos J, Bourboulis G. and Systematized and efficient: organization of critical care in the future. Crit Care. 2022;26(366).
4. Meissen H, Gong MN, Wong AI, Zimmerman JJ, Nadkarni N, Kane-Gil SL. The future of critical care: optimizing technologies and a learning healthcare system to potentiate a more humanistic approach to critical care. Crit Care Explor. 2022;4(3):e0659. https://doi.org/10.1097/CCE.0000000000000659.
5. Grunauer M, Mikesell C. A review of the integrated model of care: an opportunity to respond to extensive palliative care needs in pediatric intensive care units in under-resourced settings. Front Pead. 2018;6:3.
6. Singh GK, Davidson PM, Macdonald PS, Newton PJ. The perspectives of health care professionals on providing end of life care and palliative care for patients with chronic heart failure: an integrative review. Heart Lung Circulation. 2019;28(4):539–52. https://doi.org/10.1016/j.hlc.2018.10.009.
7. Gayatri D, Efremov L, Kantelhardt EJ, Mikolajczyk R. Quality of life of cancer patients at palliative care units in developing countries: systematic review of the published literature. Qual Life Res. 2020;30:315–43.
8. Areia NP, Góngora JN, Major S, Oliveira VD, Relvas AP. Support interventions for families of people with terminal cancer in palliative care. Palliat Supportive Care. 2020;18(5):1–9. https://doi.org/10.1017/S1478951520000127.
9. Zoladl M, Dehbanizadeh A, Nouhi E. Practice and procedural errors and their management methods by nurses. Payavard Salamat. 2018;12(2):128–37. (Persian).
10. Ulrich B, Barden C, Cassidy L, Varn-Davis N. Critical care nurse work environments 2018:findings and implications. Crit Care Nurse. 2019;39(2):67–84. https://doi.org/10.4037/ccn2019605.
11. Ghiyasvandian S. Improving therapeutic communication skills based on the COMFORT communication curriculum. Iran J Cancer Care (IJCA). 2022;1(3):48–52.
12. Wirihana L, Welch A, Williamson M, Christensen M. Using Colaizzi's method of data analysis to explore the experiences of nurse academics teaching on satellite campuses. Nurse Res. 2018;25(4):30–4. https://doi.org/10.7748/nr.2018.e1516.
13. Ghafouri R, Ofoghi S. Trustworth and rigor in qualitative research. Int J Adv Biotechnol Res. 2016;7(4):1914–22.
14. Radbruch L, De Lima L, Knaul F, Wenk R, Ali Z, Bhatnaghar S, Blanchard C, Bruera E, Buitrago R, Burla C, Callaway M. Redefining palliative care—a new consensus-based definition. J Pain Symptom Manag. 2020;60(4):754–64.
15. Liu Y, Zhang F, Guan C, Song B, Zhang H, Fu M, Wang F, Tang C, Chen H, Guo Q, Fan L. Patient satisfaction with humanistic nursing in Chinese secondary and tertiary public hospitals: a cross-sectional survey. Front Public Health. 2023;11:1163351.
16. Coghlan R. Palliative care in humanitarian crises: innovation or radical reclaiming of roots? The Humanitarian Leader. 2019: Paper 002-Sept 2019.
17. Bryk A, Roberts G, Hudson P, Harms L, Gerdtz M. The concept of holism applied in recent palliative care practice: A scoping review. Palliat Med. 2023;37(1):26–39.
18. Atashzadeh-Shoorideh F, Mohtashami J, Farhadzadeh M, Sanaie N, Zadeh EF, Beykmirza R et al. Humanitarian care: facilitator of communication between the patients with cancer and nurses. Nurs Pract Today. 2021.
19. Muntlin Athlin Å, Brovall M, Wengström Y, Conroy T, Kitson AL. Descriptions of fundamental care needs in cancer care—An exploratory study. J Clin Nurs. 2018;27(11–12):2322–32.
20. Holmberg B, Hellström I, Norberg A, Österlind J. Assenting to exposedness–meanings of receiving assisted bodily care in a nursing home as narrated by older persons. Scand J Caring Sci. 2019;33(4):868–77.
21. Hedman C, Frisk G, Björkhem-Bergman L. Deprescribing in palliative cancer care. Life. 2022;12(5):613.
22. Pérez-Eizaguirre M, Vergara-Moragues E. Music therapy interventions in palliative care: a systematic review. J Palliat Care. 2021;36(3):194–205.
23. Warth M, Koehler F, Brehmen M, Weber M, Bardenheuer HJ, Ditzen B, et al. Song of life: results of a multicenter randomized trial on the effects of biographical music therapy in palliative care. Palliat Med. 2021;35(6):1126–36.
24. Jagan S, Park T, Papathanassoglou E. Effects of massage on outcomes of adult intensive care unit patients: a systematic review. Nurs Crit Care. 2020;19(6):414–29.
25. 25, Demir B, Saritas S. Effects of massage on vital signs, pain, and comfort levels in liver transplant patients. Since Direct. 2020;16(3):178–84. https://doi.org/10.1016/j.explore.2019.10.004.
26. Wong P, Redley B, Digby R, Correya A, Bucknall T. Families' perspectives of participation in patient care in an adult intensive care unit: A qualitative study. Since Direct. 2020;33(4):317–25. https://doi.org/10.1016/j.aucc.2019.06.002.
27. Asadi N, Salmani F. The experiences of the families of patients admitted to the intensive care unit. BMC Nurs. 2024;23:430.
28. Wang C, Bi S, Lu Y, Li Y, Han B, Xu M et al. Availability and stability of palliative care for family members of terminally ill patients in an integrated model of health and social care. BMC Palliat Care. 2024;23.

29. Chua GP, Pang GSY, Yee ACP, Neo PSH, Zhou S, Lim C, et al. Supporting the patients with advanced cancer and their family caregivers: what are their palliative care needs? BMC Cancer. 2020;20:1–15.
30. Malloy P, Takenouchi S, Kim HS, Lu Y, Ferrell B. Providing palliative care education: showcasing efforts of Asian nurses. Asia-Pacific J Oncol Nurs. 2018;5(1):15–20.
31. Rosa WE, de Campos AP, Abedini NC, Gray TF, Huijer HA-S, Bhadelia A, et al. Optimizing the global nursing workforce to ensure universal palliative care access and alleviate serious health-related suffering worldwide. J Pain Symptom Manag. 2022;63(2):e224–36.
32. Saran S, Gurjar M, Baronia A, Sivapurapu V, Ghosh PS, Raju GM, Maurya I. Heating, ventilation and air conditioning (HVAC) in intensive care unit. SpringerNature. 2020;24:194. https://doi.org/10.1186/s13613-020-00779-x.
33. Anderson DC, Hamilton DK. Rx: window bed. J Am Geriatr Soc. 2014;62(2):378–9.
34. Tronstad O, Zangerl B, Patterson S, Flaws D, Yerkovich S, Szollosi I, et al. The effect of an improved ICU physical environment on outcomes and post-ICU recovery—a protocol. Trials Ncbi Nlm Nih Gov. 2024;25:376. https://doi.org/10.1186/s13063-024-08222-6.
35. Özden G, Parlar Kılıç S. Compassion in action: exploring the relationship between nurse conscientious intelligence and palliative care. Nurs Crit Care. 2024;29(4):695–705.
36. Mrayyan MT, Al-Atiyyat N, Ashour A, Alshraifeen A, Algunmeeyn A, Al-Rawashdeh S, Sawalha M, Abu Khait A, Alfayoumi I, Sayaheen M, Odeh M. Nurses' perceptions of the Obstacles and supportive behaviors of end-of-life care in intensive care units. Elsevier. 2024;35(1):23–34. https://doi.org/10.1016/j.enfie.2023.04.001.
37. Lawrence MM, Ramirez RP, Bauer PJ. Communicating with unconscious patients: an overview. Dimens Crit Care Nurs. 2023;42(1):3–11. https://doi.org/10.1097/DCC.0000000000000561.
38. Akbas M, Oztunc G, Torun S. Nurses' knowledge, attitudes and practices towards the use of physical restraints and their affecting factors: A multicentre cross-sectional study. Int J Caring Sci. 2019;12(2):1–11.
39. Abraham J, Kupfer R, Behncke A, Berger-Höger B, Icks A, Haastert B, et al. Implementation of a multicomponent intervention to prevent physical restraints in nursing homes (IMPRINT): A pragmatic cluster randomized controlled trial. Int J Nurs Stud. 2019;96:27–34.
40. LeLaurin JH, Shorr RI. Preventing falls in hospitalized patients: state of the science. Clin Geriatr Med. 2019;35(2):273–83.
41. Tobiano G, Bucknall T, Marshall A, Guinane J, Chaboyer W. Nurses' views of patient participation in nursing care. J Adv Nurs. 2015;71(12):2741–52.
42. Strini V, Schiavolin R, Prendin A. The role of the nurse in informed consent to treatments: an Observational-Descriptive study in the Padua hospital. Clin Pract. 2021;11(3):472–83.

Publisher's note