Athens Journal of Health & Medical Sciences – Volume 13, Issue 3, September 2026 – Pages 173-188

Registered Nurses' Experiences with Family Members of Patients Receiving End-of-Life Care in Health Centre Wards: A Descriptive Qualitative Study

By Anu Soikkeli-Jalonen, Johanna Saarinen-Nassar±, Anne Isoniemi°, Anne Kuusisto• & Elina Haavisto♦*

Aims and objectives: *To describe registered nurses' experiences of interactions with family members of patients receiving end-of-life care in health centre wards.* ***Methods:*** *A descriptive qualitative study following the Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist to ensure proper reporting. Data were collected using individual semi structured interviews with registered nurses (n = 20) working in health centre wards and analysed using inductive content analysis.* ***Results:*** *Registered nurses' experiences with family members were described as providing comprehensive support to family members, including emotional and informational support for families and understanding the importance of a registered nurse's expertise in this support. Additionally, experiences were described as facilitating family involvement in patient care by supporting both family participation in the patient's daily care and family involvement in care decisions.* ***Conclusions:*** *Healthcare systems should support family-centred end-of-life care by promoting education, clinical support, mentorship, and access to experienced nursing expertise, while addressing organisational barriers that may limit family involvement. Clear guidelines are needed to support communication and decision-making in situations involving disagreements regarding care or conflicts between patients' wishes and family members' needs.*

Keywords: *nursing, qualitative research, end-of-life care, palliative care, family-centred care, inpatients, primary care*

Introduction

Palliative and end-of-life care are essential for enhancing the quality of life of patients with serious, life-limiting illnesses. End-of-life care, as the final stage of palliative care, is family-centred and aims to improve the overall quality of life for both the patient and their family by addressing physical, psychosocial, and spiritual needs (Bökberg et al. 2019, Ullrich et al. 2021). Therefore, supporting both the patient and their family is an integral part of comprehensive care (Hasson et al. 2020, Chambers et al. 2019), particularly in the end-of-life context (Yıldız et al. 2024, Kennedy et al. 2025).

*Postdoctoral Researcher, Tampere University, Finland.
±Postdoctoral Researcher, Tampere University, Finland.
°Graduate Student to Master of Health Sciences, Tampere University, Finland.
•Postdoctoral Researcher, University of Turku, Finland.
♦Professor, Tampere University, Finland.

https://doi.org/10.30958/ajhms.13-3-3 doi=10.30958/ajhms.13-3-3

End-of-life care can be distressing for family members due to the diverse symptoms and evolving needs of the patient, which become more complicated as their condition deteriorates (Pun et al. 2023). Family members often experience fear, anxiety, stress, guilt, and a sense of unpreparedness for various situations (Çatıker et al. 2023). Despite this, few studies have been conducted concerning family-centred care, especially in the context of end-of-life care in health centres (Hasson et al. 2020). Recent evidence also highlights that communication challenges between healthcare professionals and family members may contribute to emotional distress and difficulties in end-of-life decision-making (Korsah et al. 2026, Peerboom et al. 2025, Setyawan et al. 2026).

Although the importance of family-centred end-of-life care is well recognized, recent studies continue to report challenges related to communication with family members, family involvement in care, and the emotional demands placed on nurses, indicating a need for further research in different care settings (Korsah et al. 2026, Aschale et al. 2025). Therefore, this study aimed to describe registered nurses' (RNs') experiences of interacting with family members of patients receiving end-of-life care in health centre wards. The study focused on nurses' experiences of providing informational and emotional support to family members and facilitating their participation in patient care.

This paper first outlines the background of family-centred end-of-life care and the role of RNs in supporting family members. It then describes the qualitative study conducted to explore RNs' experiences of interactions with family members in health centre wards. Finally, the paper presents the experiences described by RNs and discusses their implications for end-of-life care practice.

Literature Review

Family members are important resources in end-of-life care, and their involvement and presence enhance the patient's well-being (Ahmadi and Shahboulaghi 2025). With the patient's consent, they can participate in treatment planning and be involved in end-of-life care (Saarinen et al. 2023a, Lemetti et al. 2020). Families also serve as a crucial link between the patient and healthcare staff, particularly in facilitating discussions and planning for care during the final stages of life (Peerboom et al. 2025, Kennedy et al. 2025). Family-centred care recognizes patients and their family members as the unit of care and emphasizes partnership, information sharing, participation, and shared decision-making between families and healthcare professionals (Kokorelias et al. 2019). In palliative and end-of-life care, it seeks to address the physical, psychosocial, spiritual, and practical needs of both patients and their families throughout the illness trajectory and during bereavement (Kokorelias et al. 2019, Kim and Kim 2024).

Providing adequate, clear, and timely information, as well as support to family members regarding the patient's symptoms and treatment progression, can reduce their distress and facilitate their involvement in end-of-life care (Yıldız et al. 2024, Walker et al. 2023, Setyawan et al. 2026). Families often need practical guidance both during and after the patient's end-of-life phase (Saarinen et al. 2023a, 2023b, Zhu et al. 2023, Setyawan et al. 2026). However, in such situations, many family

members experience considerable emotional strain (Walker et al. 2023), such as feeling upset and uneasy about the patient's condition, experiencing fear of loss, and feeling unprepared and uncertain about the future (Cheng et al. 2022, Peerboom et al. 2025). Family members do not always receive sufficient support during the end-of-life care phase and feel forced to make significant decisions with incomplete information (Walker et al. 2023, Cheng et al. 2022). Moreover, in many cases, information about the patient's care or condition is not readily offered and needs to be explicitly requested from the healthcare staff (Zhu et al. 2023, Soikkeli-Jalonen et al. 2022, 2025).

Adequately supporting the families of patients both during and after their end-of-life care period at health centre wards requires healthcare staff, particularly nurses, to genuinely engage with and support the family (Walker et al. 2023). In the context of end-of-life care, a nurse's role is multifaceted, with high demands for knowledge and skills competence (Soikkeli-Jalonen et al. 2020, Setyawan et al. 2026, Korsah et al. 2026). Nurses need to be capable of comprehensive care management and interaction with families, working in a multidisciplinary team (Kesonen et al. 2024, Hökkä et al. 2020), and simultaneously addressing the evolving needs of both patients and family members (Melender et al. 2022).

Although nurses' experiences of providing end-of-life care have been examined in home settings (Walker et al. 2026) and intensive care settings (Setyawan et al. 2026), less is known about nurses' experiences of interacting with family members in health centre wards.

Given the crucial role nurses play in supporting families during end-of-life care, the current study explored their experiences supporting families in health centre wards, where a significant amount of end-of-life care is provided.

Methods

Study Design

This descriptive qualitative study was conducted using individual semi-structured interviews with RNs. The study followed the Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist to ensure all essential research stages and factors affecting reliability and objectivity were covered (Tong et al. 2007).

Setting

This study was conducted in five health centre wards in a university hospital district in *country blinded for review*. In *country blinded for review*, a three-tiered organisational model based on the complexity of patient needs and the required healthcare staff competence is followed for palliative care and end-of-life care services: basic, special, and demanding special levels. Basic-level units, such as wards at community health centres and hospitals, integrate end-of-life care with general

healthcare services as part of their routine operations (Finnish Institute for Health and Welfare 2023).

Participants

The participants were 20 purposively selected RNs providing end-of-life care with ≥6 months of work experience in end-of-life care.

Data Collection

Each unit had a designated contact person responsible for recruiting interviewees and providing written information about the research objectives, the interviewers' role, and the importance of informed consent. RNs had 2 weeks to sign up for interviews by filling out a paper form on background information. A written informed consent was obtained prior to the interviews.

Interview times were coordinated with the ward manager to accommodate the RNs' work schedules. Virtual interview links were provided to designated contact persons who forwarded them to the interviewees. Data were collected through individual semi-structured interviews conducted remotely using a remote access application (Microsoft Teams) between September and November 2021. The interviews were conducted by a master level female health sciences student, who also was a registered nurse but had no professional relationship with the interviewees. Only the interviewer and the interviewee were present, and all interviews were audio-recorded with the participants' permission. The semi-structured interview guide used was based on the following themes from previous research on end-of-life care and family interactions: 1) providing informational support to family members (Anderson et al. 2019, Karbasi et al. 2018), 2) providing emotional support (Soikkeli-Jalonen et al. 2020, Haavisto et al. 2022, Wang et al. 2018), and 3) family participation in the care (Saarinen et al. 2021, Mackie et al. 2019). Follow-up questions were asked to allow participants to share their experiences freely. Interviews lasted 45–60 min. Data collection continued until saturation was reached, confirmed by two additional interviews that revealed no new information.

Data Analysis

The data were analysed using inductive content analysis by two researchers, followed by comments from the research group. The interviews were transcribed verbatim, resulting in a 45-page transcript, which was thoroughly reviewed multiple times to identify original expressions relevant to the research aim (Elo and Kyngäs 2008). These expressions were then condensed while preserving their original meanings. Numeric codes were assigned to the condensed expressions for traceability. A total of 355 original expressions were identified, which were further simplified. These simplifications were then organised into subcategories describing similar themes, which were then combined to form broader categories, ultimately forming the main themes.

Ethical Considerations

The study adhered to established best practices recognised by the scientific community (The World Medical Association 2018). Each participating organisation's relevant protocols were followed to obtain the necessary permissions for conducting the research. According to *country blinded for review* law and ethical guidelines, a separate ethical review is not necessary if a study involves only healthcare staff who are not considered to be in a vulnerable position (Finnish National Board on Research Integrity TENK 2023); our study met these criteria.

During recruitment, it was emphasised that study participation was entirely voluntary and that any information disclosed during the interview would remain confidential. Participant anonymity was maintained throughout the study, ensuring that they could not be identified from the research data, results, or reports; moreover, the specific health centre where each respondent worked was not revealed. The participants also received detailed explanations of how the data would be used, stored, and published.

Results

Participant Characteristics

Twenty RNs participated in the study (average career length: 14.1 years), with 12 having received specialised training in end-of-life care.

RNs' Experiences with Family Members of Patients Receiving End-of-Life Care

The RNs' experiences with family members were categorised into two main themes: *providing comprehensive support to family member*s and *facilitating family involvement in patient care* (Table 1).

Table 1. *Registered Nurses' Experiences with Family Members of Patients Receiving End-of-life Care*

Subcategory	Category	Main category
Discussions with family members	Emotional support to family members	Providing comprehensive support to family members
Considering family well-being		
Empathetic approach to family members		
Information related to the patient's condition	Informational support to family members	
Meeting specific informational needs related to end-of-life care		
Registered nurses' ability to support family members in challenging end-of-life care situations	Importance of a registered nurse's expertise in supporting family members	

A registered nurses management of their own emotions when interacting with family members		
Enabling family presence in the care unit	Supporting family participation in the patient's daily care	Facilitating family involvement in patient care
Supporting family members' choices to participate in patient care		
Guiding family members in patient care		
Supporting family participation in decision-making	Family involvement in care decisions	
Considering family members' wishes in patient care decisions		

Providing Comprehensive Support to Family Members

The main category of *providing comprehensive support to family members* included the following themes: *emotional support to family members, informational support to family members,* and *importance of a nurse's expertise in supporting family members* (Table 1).

Emotional support to family members involved having *discussions with family members* during the end-of-life care period, ensuring information exchange. The RNs felt a great deal of conflict when the ward's hectic pace prevented them from attending adequately to the family's needs or creating a supportive care environment. Nevertheless, they actively asked about family members' desires to discuss any concerns and tried to find time for these conversations.

> "Unfortunately, there's just too little time. When the wards are always full and it's busy, the lack of time is really unfortunate because you can't always have as many conversations as you'd like." (ID8)

The RNs pointed out that family members could also seek support through discussions with other healthcare professionals, such as doctors, especially given that many family members often feel the need to discuss the patient's condition with a doctor. Additionally, multidisciplinary collaboration expanded access to support; for example, the RNs could contact hospital chaplains and deacon workers for conversational support.

> "Our work is multidisciplinary, so you can get help from the hospital chaplain or the deacon worker. If I can't or don't have time to talk, there are other resources available." (ID4)

Emotional support also included *considering family well-being*. The RNs considered not only the overall situation of family members and their level of exhaustion but also tried to ensure that they were coping and reminded them to take care of themselves.

> "It's also part of our job to make sure that the family member is coping." (ID11)

An *empathetic approach to family members* was expressed by the RNs as an essential part of their support, leading the family members through difficult

circumstances by being genuinely present with them, showing understanding, gently touching them, and remaining calm in any situation. Furthermore, the RNs felt it crucial to remain respectful and patient, even when family members exhibited difficult emotions or behaviours.

> "You can be compassionate and offer words of comfort and be empathetic in the situation, but you still need to be the one who is calm and composed, who maintains the order in that situation." (ID5)

Informational support to family members included informational support concerning the patient's condition, such as symptoms and changes in their health status, which could deteriorate rapidly. The RNs felt that family members sought detailed information and frequent updates about the patient's condition, and as a result, they made efforts to communicate proactively whenever major changes occurred.

> "We quickly contact the family member if there are any changes in the patient's condition or other important information to share, so we keep the family well-informed." (ID20)

In particular, family members sought information about pain management. The RNs explained how pain medications helped and justified their use for the patient's benefit. In general, family members understood the importance of effective pain management in the final stages of life, but some believed painkillers negatively affected their interactions with the patient or caused drowsiness. This resistance made it challenging for the RNs to address the patient's pain management needs.

> "(We ask) if they (family members) have any preferences about it (pain medication). We reach a pretty good understanding, even when they are strongly against the pain medication. We discuss it quite openly and directly with them." (ID10)

The end-of-life care situation requires *meeting specific informational needs related to end-of-life care,* that the RNs felt they must address. The RNs found it easy to communicate with family members, but establishing good communication required time, and they had to consider the sensitivity of the topics. Family members sought detailed information about what end-of-life care entailed, including the prognosis, timeline, and expected changes in the patient's condition over the coming weeks or days. The RNs described this aspect of care as particularly demanding, mentally burdensome, and time consuming. They described devoting a significant portion of their workday to these discussions but still feeling unable to spend enough time with families because of other duties. Additionally, family members were not always emotionally prepared to accept information about the approaching death, and their distress prevented them from absorb and process what they were told.

> "We need to explain how things have been going, how the patient has been doing, and what might happen in the coming days. But if you notice that the family member is having a hard time letting go and hasn't fully processed everything, it can be quite demanding for the nurse." (ID12)

Importance of an RN's expertise in supporting family members emerged as an aspect of *providing comprehensive support to family members*. The RNs highlighted the importance of an *RN's ability to support family members in challenging end-of-life care situations*—particularly, the skills and capability to understand and empathise with their feelings as well as to interpret and respond to their needs. These skills were described as developing over time through experience in end-of-life care, which gave the RNs the confidence to engage in difficult conversations and to offer empathetic support to families.

> "As a newly graduated nurse, I definitely wasn't ready to have those kinds of conversations. But maybe life experience, work experience, and doing various tasks have, in a way, given me the tools to have those discussions." (ID7)

The RNs emphasised the importance of a *nurse's management of their own emotions when interacting with family members.* They sometimes found these interactions with family members, especially those dealing with their grief and anxiety, to be painful and challenging—even more so than the interactions with the patients themselves. Confronting the impending death could also be uncomfortable for the RNs. Family members might vent their distress to the RN or feel frustrated with the RN due to the late detection of the serious illness's progression. In such challenging situations, the RNs relied on the help of their colleagues to manage their emotions. They also tried not to take the harsh comments from family members personally, recognising that family members react differently in the context of end-of-life care.

> "You have to be quite flexible and patient when you see the family member's emotions, situation, and emotional turmoil." (ID10)

Facilitating Family Involvement in Patient Care

The second main category was *facilitating family involvement in patient care*, which included the following themes: *supporting family participation in the patient's daily care* and *family involvement in care decisions* (Table 1).

Supporting family participation in the patient's daily care was considered important by the RNs. They deemed it essential to *enable family presence in the care unit* and encouraged family members to be part of the patient's daily end-of-life care as much as possible, as it was beneficial for not only patients but also family members and RNs. Family members' presence from the beginning of end-of-life care was perceived as helping family members cope with the approaching death. From the RNs' perspective, family members also provided support to the patient and practical help to the nursing staff. The RNs appreciated having family members close by, as it was good for the patient's care, and therefore, family members' desires

to be present were supported as much as possible. According to the RNs, family members also had the opportunity to be by the patient's side around the clock, even overnight.

> "It's actually a great relief for us if a family member is present with the patient because then the patient doesn't need to call a nurse for small things. Having their loved one there is a big help sometimes." (ID11)

> "The possibility of being there around the clock during the final moments is important. Once the decision for end-of-life care is made, family members are given the opportunity to stay overnight and be close as death approaches." (ID2)

The RNs considered it important to *support family members' choice to participate in patient care*, allowing them to decide whether and in which tasks they wanted to be involved. Although some family members actively participated in all care activities, others found it difficult to engage in basic care or were hesitant to touch the patient. The RNs respected and supported both behaviours. They did not encourage family members to participate in intimate hygiene care, which they viewed as their own responsibility and a matter of the patient's privacy.

> "Some (family members) participate very intensively, while others are really scared (to participate). Then there are those who don't participate at all, or maybe just call to check in but don't get involved in any other way." (ID15)

The RNs *guided family members in patient care* that they felt was appropriate, such as maintaining the patient's hygiene, ensuring the patient's nutrition, or changing the patient's position in bed.

> "They participate in feeding, giving something to drink, even things like applying lotion to the feet—basic tasks like these. But they might not be involved much beyond that in care. Some may help with changing the patient's position." (ID12)

Additionally, the RNs supported the family's participation in preparing the deceased immediately after death and guided them on what tasks they could perform and how they could take care of the patient in the health centre setting.

Family involvement in care decisions was also described as an essential part of their relationship with their patients' families. The RNs supported family participation in care decisions by engaging in discussions and clearly explaining the factors influencing such decisions. Major care decisions were made in the family's presence, but it was not uncommon for family members to find it difficult to accept the transition to end-of-life care; the finality of such decisions was often hard for them to process. The RNs also noted that the absence of family members during decision-making could pose challenges later, such as misunderstandings and resistance, particularly if the patient's condition worsened. To mitigate this, family participation in decision-making was strongly encouraged.

> "It is sometimes difficult to determine the line when someone else decides for the patient. It is not always clear, and it can be a problem. There may be decisions made about limiting treatments and not providing intensive care or intravenous fluids, and the next day, a relative comes and insists on overturning everything." (ID3)

The RNs also *considered family member's wishes in patient care decisions* and end-of-life care decisions. However, some felt that the patient's preferences should take precedence. The RNs described situations in which family members were making demands regarding care and questioned whether all treatment options had been explored, the right choices had been made, and if everything possible had been done to prevent death. In such situations, the RNs tried to consider the family members' wishes as much as possible, and care decisions were justified to family members as being in the patient's best interest.

> "If it is not recommended to provide any intravenous hydration (to the patient), but often it causes a lot of anxiety for the family members. So, we decided that, okay, we will provide a small amount of intravenous hydration for a couple of days and observe the response. If there is no response, it will stop. These are the kinds of concessions we can make to consider both the family members and the patient as much as we can." (ID2)

Discussion

In this study RNs experiences of interactions with family members of patients receiving end-of-life care in health centre wards were described as encompassing two main roles: *providing comprehensive support to family members* and *facilitating their involvement in patient care*. The importance of providing comprehensive emotional and informational support to family members and the importance of the RNs' expertise in these interactions were consistently emphasised. The facilitation of family involvement in patient care was implemented through their participation in daily care and in care-related decision-making. Few previous studies have examined family-centred care during the end-of-life phase of patients in health centre settings (Hasson et al. 2020). This study provides a novel insight into registered nurses' perspectives on their work in health centre wards, where end-of-life care is commonly provided (Finnish Institute for Health and Welfare 2023).

The RNs reported the need for skills in providing emotional and informational support and empathy to family members. As noted in other studies, adequate quality and quantity of encounters, guidance, and communication about the patient's care support family members' ability to cope in difficult situations (Yıldız et al. 2024, Walker et al. 2023, Peerboom et al. 2025). However, while the RNs' in the current study were aware of family members' needs for communication and support and of the ways to meet these needs, they cited limited resources and lack of time as the primary barriers to providing sufficient support. End-of-life care is demanding for RNs, requiring them to simultaneously address the evolving needs of both patients and family members (Melender et al. 2022). The findings of the current study suggest that systemic limitations, particularly insufficient resources, can significantly hinder RNs from delivering the level of care they aspire to provide. Healthcare systems should address these structural issues

by allocating adequate resources and time to support RNs in their multifaceted roles, thereby enhancing the quality of care and support provided to patients receiving end-of-life care and their families.

The RNs in this study also emphasised the importance of their professional competence in identifying, understanding, and responding to the families' emotions and needs while managing their own. They underscored the value of work experience, which provided them with the confidence to interact with families and guided their behaviour in emotionally complex situations in the end-of-life context. Previous studies have consistently indicated that RNs require a broad range of competencies in navigating end-of-life care necessitates (Soikkeli-Jalonen et al. 2020, Setyawan et al. 2026). The results of the current study suggest that the development of these competencies is a gradual process cultivated primarily through practice. RNs are expected to be highly competent not only in managing symptoms but also in collaborating with patients, families, and other team members (Kesonen et al. 2024, Hökkä et al. 2020). To ensure sufficient support and high-quality interactions, it may be beneficial to place greater emphasis on valuing the work experience of RNs. Recognising and appreciating the experiential knowledge that RNs bring to their roles could enhance the overall quality of care provided to patients and their families.

Supporting family involvement in patient care emerged as a crucial aspect of the RNs experiences with the families of patients receiving end-of-life care. Family members were actively encouraged to be present in the care unit and to participate in the patient's daily care. They were viewed not only as valuable resources in patient care but also as sources of emotional support for the patient. This finding is strongly supported by earlier literature reviews, which have highlighted that family presence is meaningful for healthcare staff in patient care and provides significant mental support to patients (Saarinen et al. 2023a, Kennedy et al. 2025). This study and others provide evidence that RNs see family members as valuable contributors to patient care, offering significant emotional support; this benefits the patient and strengthens the connection between healthcare staff and patients, fostering a more holistic and supportive care environment.

The RNs emphasised their efforts to support family participation and respect for their wishes in decision-making, even though the views of patients and healthcare staff on care planning and goals often differed from those of family members. Notably, family presence during the decision-making process often prevented confrontations with families later. As a result, the RNs encouraged family participation to ensure that they understood and agreed with the decisions made. Studies have confirmed the relevance of considering family members' perspectives in end-of-life care–related decision-making (Saarinen et al. 2023a, Zhu et al. 2023, Kennedy et al. 2025). Consistently, RNs in the present study recognised family participation in decision-making as essential and highlighted the importance of considering the family's perspective, even when it did not align with the views of healthcare staff or the patient. They also noted that in such situations, it is crucial to balance family members' well-being with the patient's best interests. Ultimately, the patient has the right to make decisions as long as they are capable, even if these decisions contradict the family's wishes.

Strengths and Limitations

This study's trustworthiness was evaluated using the criteria established by Graneheim and Lundman (2004). Credibility was ensured through a robust methodology involving interviews with participants with the most relevant experience in the subject. The researchers' diverse backgrounds were considered to mitigate personal biases and subjective insights. Rich data and ample participant quotes were gathered to ensure accurate representation of the phenomenon, and interviews included open-ended questions to ensure the participants' opinions were fully expressed. Data collection continued until saturation indicated that sufficient data had been gathered (Hennink et al. 2017). Transferability of the findings was defined by noting the study's context in *country blinded for review* health centre wards: The findings may be relevant to similar healthcare settings providing end-of-life care. Dependability was ensured by careful planning of data collection and the use of a semi structured interview guide for consistency. Table 1 presents the detailed analytical framework, with the research group reviewing and discussing the analysis to further strengthen dependability.

Cultural, organisational, and resource-specific factors should be considered when applying the results to other settings and contexts. For the busy situation at the wards and anonymity of the data collection, the transcripts of the interviews were not returned to participants for comments.

Conclusions

The findings suggest that RNs require adequate organisational support, training, and resources to effectively meet families' informational and emotional needs and to facilitate meaningful participation in patient care. Education and clinical support should particularly address communication during the transition to end-of-life care, emotionally demanding situations, disagreements regarding care, and the conflict, criticism, and ethical challenges that may arise in interactions with family members.

The findings highlight the importance of experienced RNs in supporting family members during end-of-life care. Incorporating their clinical expertise into staff education, mentoring, care planning, and the development of end-of-life care practices may strengthen the quality of family-centred care. Given the emotional and clinical complexity of end-of-life care, healthcare organisations should ensure that nurses have access to experienced colleagues and sufficient support when providing family-centred end-of-life care.

Because families are vital to patient support and the care process, healthcare systems should establish policies that enable family involvement. They should also address organisational barriers, such as lack of time and resources that prevent RNs from providing family-centred care. RNs are often required to balance family members' needs with patients' wishes and best interests, which can create anxiety and conflict. Care guidelines should emphasise this balance and provide clear procedures for handling conflicting situations, thus facilitating decision-making and offering justification to both families and patients.

Acknowledgments

Artificial intelligence (AI) was utilized for preliminary language editing to enhance the clarity and coherence of the text before submitting it for official language proofreading. The Microsoft Copilot was employed for this purpose.

References

Ahmadi M, Shahboulaghi FM (2025) Concept Analysis of Family Participation in Hospitalized Patient Care: Using Hybrid Models. *Iranian Journal of Nursing and Midwifery Research* 30(3): 332–342.

Anderson RJ, Bloch S, Armstrong M, Stone PC, Low JTS (2019) Communication between healthcare professionals and relatives of patients approaching the end-of-life: A systematic review of qualitative evidence. *Palliative Medicine* 33(8): 926–941.

Aschale A, Gishu T, Mengist S, Tsehay M (2025) Experiences of intensive care unit nurses in providing end-of-life care in public hospitals: a phenomenological study. *BMC Nursing* 24(1): 1185.

Bökberg C, Behm L, Ahlström G (2019) Next of kin's quality of life before and after implementation of a knowledge-based palliative care intervention in nursing homes. *Quality of Life Research* 28(12): 3293–3301.

Çatıker A, Uğur HG, Bülbül İ, Koçer E (2023) The relationship between caregiver burden and anger level of informal caregivers of patients in palliative care centre. *International Journal of Palliative Nursing* 29(8): 385–392.

Chambers E, Gardiner C, Thompson J, Seymour J (2019) Patient and carer involvement in palliative care research: An integrative qualitative evidence synthesis review. *Palliative Medicine* 33(8): 969–984.

Cheng Q, Xu B, Ng MSN, Zheng H, So WKW (2022) Needs assessment instruments for family caregivers of cancer patients receiving palliative care: a systematic review. *Supportive Care in Cancer* 30(10): 8441–8453.

Elo S, Kyngäs H (2008) The qualitative content analysis process. *Journal of Advanced Nursing* 62(1): 107–115.

Finnish Institute for Health and Welfare (2023) *Organising palliative care*. Available at: https://thl.fi/en/topics/ageing/end-of-life-care/organising-palliative-care.

Finnish National Board on Research Integrity TENK (2023) *The Finnish Code of Conduct for Research Integrity and Procedures for Handling Alleged Violations of Research Integrity in Finland.* Publications of the Finnish National Board on Research Integrity TENK 4/2023.

Graneheim UH, Lundman B (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today* 24(2): 105–112.

Haavisto E, Eriksson S, Cleland Silva T, Koivisto J-M, Kausamo K, Soikkeli-Jalonen A (2022) Palliative Care Cancer Patients' Experiences of Encounters with Healthcare Professionals in Palliative Care Inpatient Units: A Qualitative Explorative Study. *Omega Journal of Death and Dying*.

Hasson F, Nicholson E, Muldrew D, Bamidele O, Payne S, McIlfatrick S (2020) International palliative care research priorities: A systematic review. *BMC Palliative Care* 19(1): 16.

Hennink MM, Kaiser BN, Marconi VC (2017) Code Saturation Versus Meaning Saturation. *Qualitative Health Research* 27(4): 591–608.

Hökkä M, Martins Pereira S, Pölkki T, Kyngäs H, Hernández-Marrero P (2020) Nursing competencies across different levels of palliative care provision: A systematic integrative review with thematic synthesis. *Palliative Medicine* 34(7): 851–870.

Karbasi C, Pacheco E, Bull C, Evanson A, Chaboyer W (2018) Registered nurses' provision of end-of-life care to hospitalised adults: A mixed studies review. *Nurse Education Today* 71(Dec): 60–74.

Kennedy A, Mockler D, Walsh C, McQuillan R, Ryan K, Guinan E, et al. (2025) Relational nature of decision-making between patients with advanced illness and their caregivers in palliative care: a systematic review and narrative synthesis. *BMJ Supportive and Palliative Care* 0: 1–12.

Kesonen P, Salminen L, Kero J, Aappola J, Haavisto E (2024) An Integrative Review of Interprofessional Teamwork and Required Competence in Specialized Palliative Care. *Omega (Westport)* 89(3): 1047–1073.

Kim Y, Kim D-H (2024) Interventions for family involvement enhance end-of-life care for hospitalized patients: an integrative review. *BMC Nursing* 23(1): 917.

Kokorelias KM, Gignac MAM, Naglie G, Cameron JI (2019) Towards a universal model of family centered care: a scoping review. *BMC Health Services Research* 19(1): 564.

Korsah EK, Schmollgruber S, Abukari AS (2026) Caring Amid Complexity: Intensive Care Nurses' Perceptions and Experiences of End-of-Life Care—A Qualitative Study. *Nursing in Critical Care* 31(1): e70278.

Lemetti T, Partanen E, Hupli M, Haavisto E (2020) Cancer patients' experiences of realization of relatives' participation in hospital care: a qualitative interview study. *Scandinavian Journal of Caring Sciences* 35(3): 979–987.

Mackie BR, Mitchell M, Marshall AP (2019) Patient and family members' perceptions of family participation in care on acute care wards. *Scandinavian Journal of Caring Sciences* 33(2): 359–370.

Melender H-L, Hökkä M, Kaakinen P, Lehto JT, Hirvonen O (2022) Palliative-care nurses' and physicians' descriptions of the competencies needed in their working units. *International Journal of Palliative Nursing* 28(1): 38–50.

Peerboom FBAL, Friesen-Storms JHHM, van der Steen JT, Janssen DJA, Meijers JMM (2025) What matters in end-of-life communication with nursing staff: an interview study among older people and their family caregivers. *BMC Nursing* 24(1): 1205.

Pun J, Chow JCH, Fok L, Cheung KM (2023) Role of patients' family members in end-of-life communication: an integrative review. *BMJ Open* 13(2): e067304.

Saarinen J, Mishina K, Soikkeli-Jalonen A, Haavisto E (2023a) Family members' participation in palliative inpatient care: An integrative review. *Scandinavian Journal of Caring Sciences* 37(4): 897–908.

Saarinen J, Mishina K, Soikkeli-Jalonen A, Konradsen H, Haavisto E (2023b) 'Participation in inpatient care from the perspective of family members of palliative care patients', *International Journal of Palliative Nursing* 29(9): 446–454.

Setyawan YD, Susanti IA, Kosasih CE, Haroen H (2026) Nurses' Experience in Providing End-of-Life Care in Intensive Care Unit: A Scoping Review. *Healthcare (Switzerland)* 14(3): 417.

Soikkeli-Jalonen A, Stolt M, Hupli M, Lemetti T, Kennedy C, Kydd A, et al. (2020) Instruments for assessing nurses' palliative care knowledge and skills in specialised care setting: An integrative review. *Journal of Clinical Nursing* 29(5): 736–757.

Soikkeli-Jalonen A, Mishina K, Virtanen H, Charalambous A, Haavisto E (2022) Family members' experiences of psychosocial support in palliative care inpatient units: A descriptive qualitative study. *European Journal of Oncology Nursing* 61(Dec): 102201.

Soikkeli-Jalonen A, Mishina K, Saarinen-Nassar J, Kesonen P, Virtanen H, Karukivi M, et al. (2025) Family Members' Psychosocial Support in Palliative Inpatient Care: A Cross-Sectional Study. *Journal of Family Nursing* 31(4): 245–256.

The World Medical Association (2018) *WMA International Code of Medical Ethics*, Available at: https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/.

Tong A, Sainsbury P, Craig J (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care* 19(6): 349–357.

Ullrich A, Marx G, Bergelt C, Benze G, Zhang Y, Wowretzko F, et al. (2021) Supportive care needs and service use during palliative care in family caregivers of patients with advanced cancer: a prospective longitudinal study. *Supportive Care in Cancer* 29(3): 1303–1315.

Walker W, Efstathiou N, Jones J, Collins P, Jennens H (2023) Family experiences of in-hospital end-of-life care for adults: A systematic review of qualitative evidence. *Journal of Clinical Nursing* 32(9–10): 2252–2269.

Walker W, Collins P, Jones J, Winfield J, Efstathiou N (2026) Family members' experiences of end-of-life care in the home: a systematic review and qualitative content analysis. *British Journal of Community Nursing* 31(3): 128–140.

Wang T, Molassiotis A, Chung BPM, Tan J-Y (2018) Unmet care needs of advanced cancer patients and their informal caregivers: a systematic review. *BMC Palliative Care* 17(1): 29–96.

Yıldız M, Terzioğlu C, Ayhan F (2024) Psychosocial interventions aimed at family members caring for patients with cancer in the palliative period: A systematic review. *International Journal of Nursing Knowledge* 35(2): 136–151.

Zhu Y, Pei X, Chen X, Li T (2023) Family Caregivers' Experiences of Caring for Advanced Cancer Patients: A Qualitative Systematic Review and Meta-synthesis. *Cancer Nursing* 46(4): 270–283.