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Original Article

Perceptions of quality of life among elderly people in palliative care*

Percepções sobre a qualidade de vida de pessoas idosas em cuidados paliativos

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ABSTRACT

Objective: to understand perceptions of quality of life among elderly people receiving palliative care. **Methods**: a qualitative study was conducted in two charitable hospitals involving elderly people receiving palliative care, considering the Peaceful End of Life Theory. The Convergent Care Research technique was used, with interviews. The textual corpus was processed using IRaMuTeQ software. **Results:** twenty-nine elderly people (aged 66–70), mainly men, retired, married, diagnosed with chronic renal failure or cancer, participated. It was identified that interpersonal relationships, spirituality, hope, and leisure activities sustain quality of life and help individuals cope with pain and finitude. **Conclusion:** the perception of quality of life involves multiple dimensions of living and dying, which corroborate the assumptions of the Peaceful End of Life Theory. **Contributions to practice:** the study supports nursing in the qualification of palliative care practices for the elderly, particularly in emotional support, symptom management, and therapeutic communication.

Descriptors: Palliative Care; Aged; Quality of Life; Death; Nursing Theory.

RESUMO

Objetivo: compreender as percepções sobre a qualidade de vida de pessoas idosas em cuidados paliativos. **Métodos:** estudo qualitativo, conduzido em duas instituições hospitalares filantrópicas, envolvendo pessoas idosas em cuidados paliativos, à luz da Teoria do Final de Vida Pacífico. Utilizou-se a técnica de Pesquisa Convergente Assistencial, com entrevistas. O *corpus* textual foi processado pelo *software* IRaMuTeQ. **Resultados:** participaram 29 pessoas idosas (66–70 anos), principalmente homens, aposentados, casados, com diagnóstico de insuficiência renal crônica ou câncer. Identificou-se que relações interpessoais, espiritualidade, esperança e práticas de lazer sustentam a qualidade de vida e favorecem o enfrentamento da dor e da finitude. **Conclusão:** a percepção de qualidade de vida envolve múltiplas dimensões do viver e do morrer, o que corroborou os pressupostos da Teoria do Final de Vida Pacífico. **Contribuições para a prática:** o estudo subsidia a enfermagem na qualificação de práticas de cuidado paliativo à pessoa idosa, sobretudo no apoio emocional, manejo de sintomas e comunicação terapêutica.

Descritores: Cuidados Paliativos; Idoso; Qualidade de Vida; Morte; Teoria de Enfermagem.

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Introduction

The aging process is a unique experience for each person, particularly when associated with loss of functionality, autonomy, and independence. The ways of coping with this stage of life are influenced by biographical, cultural, and social factors, which require an individualized approach, especially in contexts of illness(1).

In the face of chronic or life-threatening clinical conditions, it is essential that the multidisciplinary team provide sensitive care that goes beyond the clinical dimension and recognizes that senescence is not synonymous with senility(2). From this perspective, care should be grounded in active listening, promoting autonomy, and valuing quality of life(3).

Quality of life is a multidimensional, subjective, and unique construct of human experience in health, encompassing not only physical, functional, emotional, and cognitive dimensions but also personal aspects such as work activities, social relationships, and other elements of daily routine(4).

Given this expanded understanding of care, palliative care is fundamental, supported by comprehensive and humanized care, especially in situations and limitations imposed by serious or progressive diseases(5). This approach helps to minimize suffering, promote physical and emotional comfort, and provide a welcoming environment. In addition, it is based on the principles of pain relief, construction of meaning, the preservation of dignity, and the valuing of interpersonal relationships(6).

In this context, the Peaceful End of Life Theory (PELT) is a relevant theoretical framework because it converges with the principles of palliative care. The theory originated from doctoral research in nursing, supervised by Moore. It provides professionals with the foundations for providing care to people in the terminal phase(7).

This theory emphasizes the importance of not feeling pain, experiencing comfort, maintaining dignity and respect, being at peace, and being close to loved ones. Linked to the nursing metaparadigm, it enables understanding of the person as a subject of unique experiences; it assigns nursing the responsibility of providing humanized and respectful care; it understands health as the pursuit of well-being through the relief of discomfort; and it conceives the environment as a space that favors tranquility and welcome. Thus, the Theory is useful for guiding practices that value subjectivity and quality of life in this phase of finitude(8-10).

However, there is still little research exploring perceptions of quality of life among elderly people in palliative care from the perspective of PELT. Given this scenario, the following guiding question emerges: what perceptions do elderly people in palliative care have about quality of life? Thus, this study aimed to understand perceptions of quality of life among elderly people receiving palliative care.

Methods

Type of study

Qualitative study based on the Convergent Care Research (CCR) methodological approach, considering PELT. The conduct of this study and the preparation of its report complied with the principles of the Consolidated Criteria for Reporting Qualitative Research (COREQ). CCR integrates scientific research with healthcare practice, linking subjects' social situations with implemented care practices.

The research is characterized by dialogicity, immersibility, simultaneity, and expansibility, attributes that guide CCR. The five phases recommended by CCR were followed: conception, instrumentation, scrutiny, analysis, and interpretation. In the conception phase, the area of interest, theme, justification, and objective were defined, aligned with the researcher's professional practice in palliative care for the elderly(11). Dialogicity was facilitated by prior contacts with professionals from the institutions, which enabled the identification of care needs and ensured that the research was relevant and aligned with them.

The CCR was applied in the diagnostic/interpretative stage, while the musical intervention is part of a broader project described in a future study.

Location and period

The study was conducted in two medium-sized philanthropic hospitals in João Pessoa, Paraíba, that provide palliative care to elderly people by multidisciplinary teams. Data collection took place between September and November 2023.

At this stage, methodological procedures, selection criteria, field access strategies, and collection methods were defined, considering the multidimensional nature of palliative care. It contemplated physical, emotional, spiritual, and social aspects of the elderly person, which guided interviews and observations.

Immersibility, a central attribute of CCR, was manifested in the researcher's active insertion into the institutions' daily routines, with regular presence in the units, participation in care activities, and observation of care dynamics. This process enabled us to understand the clinical and subjective demands of the elderly, broadening our understanding of the context and the articulation between research and practice.

Population

The study population consisted of elderly people receiving palliative care services at the institutions during the data collection period, comprising 30 elderly people admitted to institution A and 260 registered at institution B, for a total of 290 participants.

Inclusion and exclusion criteria

The following inclusion criteria were adopted for selecting study participants: age 60 years or older; eligibility for palliative care, according to the Palliative Care Manual(12); good verbal communication and self-reported hearing; preserved functionality, according to a score ≥ 50% obtained by the Palliative Performance Scale (PPS)(13) and favorable cognitive condition to respond to the interview script items, assessed using the Mini Mental State Examination (MMSE) – The following cut-off points were considered: 13 points or more for participants with no schooling, 18 points or more for those with low or medium schooling and 26 points or more for individuals with high schooling, in order to exclude possible dementia among the participants(14). Individuals with a scheduled discharge during the collection period or with severe pain at the time of the interview, as assessed using the Visual Analogue Scale (VAS)(15), were excluded.

Potential participants were identified through an analysis of medical records, including diagnoses, general clinical conditions, and pain records. Sampling was non-probabilistic, obtained for convenience, considering the eligibility criteria, accessibility, and consent of participants and family members. Among the 290 elderly people, 35 were accessible during the data collection period and were invited by the researcher to participate in the study. Of these, six refused to participate because they were too shy to answer the items in the instruments. However, 29 elderly individuals fully met the eligibility criteria, and the responses obtained through the application of the data collection instruments reached the criterion of theoretical saturation, which occurs when the responses collected by the researcher become repetitive and do not offer new and substantial information for qualitative analysis, without prejudice to the understanding of the phenomenon under investigation(16), thus composing the final sample.

It should be noted that patients and family members were informed about the purpose of the study and ethical aspects of the research, and consent was obtained through the Free and Informed Consent Form.

Data collection tool

The CCR screening stage involves data collection strategies integrated into healthcare practice, thereby intensifying the researcher's workload and highlighting the simultaneity between care and research. To confirm eligibility, the MMSE, PPS, and VAS were administered: the MMSE assesses cognitive function(14); the PPS measures functional status(13); and the VAS quantifies pain intensity(15).

The interviews were guided by a semi-structured script consisting of two parts: the first, objective part included sociodemographic, economic, self-reported, and clinical health variables, as well as subjective aspects derived from the adaptation of the World Health Organization Quality of Life Group Elderly instrument(17). It consisted of 14 open-ended questions addressing physical, spiritual, social, and emotional dimensions, including pain, desires, interpersonal relationships, spirituality, the meaning of life, leisure, musical preferences, and perceptions of death. The instrument aimed to capture perceptions, feelings, and experiences related to coping with incurable disease and quality of life. The script was submitted for apparent validation by three palliative care specialists.

Operationalization of data collection

The researcher conducted individual interviews, recorded with a cell phone (iPhone 11), at the bedside, after routine care, and according to the availability of the participants, prioritizing morning and afternoon shifts.

Communication was accessible and respectful, with verbal and nonverbal responses recorded in a field diary, including behavioral observations and facial expressions, to capture subjective dimensions that would enrich the qualitative analysis. The expandability of CCR was achieved through continuous adaptation of instruments and objectives, thereby enabling the integration of clinical data and the subjective experiences of elderly people in palliative care, maintaining sensitivity to care demands.

Data analysis

During the analysis and interpretation phase, the interviews were transcribed in full and organized in Microsoft Excel spreadsheets. Textual analysis was performed using the software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRaMuTeQ), which employed the Descending Hierarchical Classification (DHC) technique, enabling the organization of textual segments by words and their respective Chi-square values, resulting in a dendrogram(18). The dendrogram, shown in the results, revealed four classes of text segments, characterized according to their central ideas, based on PELT. The classes were grouped into two analytical categories, discussed later in line with the specialized literature and PELT principles. Finally, the interpretation phase promoted the integration between empirical evidence and the theoretical framework. This process guided the development of the interpretive model based on PELT.

Ethical considerations

To preserve anonymity, participants were identified by pseudonyms inspired by singers and musical styles of their choice (e.g., R. Carlos, M. Mendonça, among others). The study was approved by the Research Ethics Committee of the Health Sciences Center of the Federal University of Paraíba, under opinion number 5,540,436/2022 and Certificate of Presentation for Ethical Appraisal 60470722.7.0000. 5188, in accordance with the ethical precepts of Resolution No. 466/2012 of the National Health Council.

Results

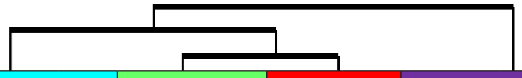
Twenty-nine elderly people participated, most of whom were men, 16 (55%), aged between 66 and 70 years, 19 (55%); retired, 26 (90%); married, 16

(55%); with incomplete or complete elementary education, 17 (58%). Regarding race/ethnicity, 13 (45%) participants self-identified as Black. The other participants did not record any other self-declaration of race/color in their medical records or during the interview. The predominant income was between 1 and 2 minimum wages 21 (72%), and the number of children ranged from one and three 15 (51%). Of the elderly, 20 (68%) lived with partners and children.

Regarding clinical conditions, 25 (86%) had a diagnosis of chronic renal failure, and four (14%) had cancer; 15 (52%) had been undergoing treatment for approximately 18 months; 16 (55%) used one or two types of analgesics; and the majority, 26 (90%), underwent hemodialysis. Regarding hearing acuity, 25 (86%) had preserved hearing, and all had preserved cognition, as assessed by the MMSE. The PPS assessment showed that 18 (62%) had scores between 80% and 100%. Pain intensity, measured by VAS, showed that 14 (48%) reported moderate pain and 10 (34%) were pain-free.

Based on the semi-structured interviews, a textual corpus was constructed consisting of 29 texts and 540 Text Segments (TS), with 72.04% utilization in the IRaMuTeQ software. A total of 12,762 occurrences were identified, distributed across 1,234 lemmas and 1,110 active forms, of which 351 had a frequency ≥ 3. Forms detected only once (hapax) totaled 1,010, corresponding to 7.91% of occurrences.

The Descending Hierarchical Classification (DHC) identified four thematic classes in the analyzed corpus. Class 3, with 37.5%, highlighted elements of spirituality, desires, and hopes, linked to the dimensions of dignity and respect. Class 2, with 22.1%, addressed interpersonal relationships, emphasizing the importance of significant others' presence, as recommended by the Theory. Class 1, accounting for 23.4% of the material, encompassed content related to death and pain, aligning with the PELT's principle of the absence of suffering. Class 4, representing 17%, covered topics of leisure and distractions, associated with comfort and well-being (Figure 1).



Class 3		Class 2		Class 1		Class4	
Word	X^2	Word	X^2	Word	X^2	Word	X^2
God	81.72	Give	29.62	Arrive	23.09	Listen	188.08
Love	76.36	Leave	28.12	Come	20.26	Like	151.13
Life	62.86	Friend	27.11	Say	19.82	Love	38.86
Catholic	44.65	Willingness	25.59	World	19.49	Television	36.28
Hope	44.4	Hospital	21.47	Son	18.85	Hear	33.83
Happy	42.02	Mom	21.47	Fear	17.77	Play	28.84
Feel	40.71	People	21.3	Already	17.05	Dance	24.79
Approach	37.07	Search	16.75	Doctor	16.07	Old	24.79
Very	31.31	Walk	16.58	There	15.01	Watch	24.56
Grace	26.73	Machine	14.28	Pain	14.31	Roberto Carlos	23.91
Ask	24.82	Force	14.28	Leave	13.76	Live music	19.78
Faith	22.6	Drink	14.24	Person	13.21	Evangelical	18.28
Yes	16.93	Water	14.24	Today	11.94	Leonardo	14.8
Heal	15.45	Forget	14.24	No	11.92	Record	14.8
Pray	13.23	Family	14.24	Really	11.74	Cheesy	14.8
Pray	13.23	Home	13.47	Time	11.5	Agnaldo Timóteo	14.8
Happiness	13.23	Situation	13.27	Death	11.08	Singer	14.29
Good	13.05	Illness	13.27	To die	10.88	I play	9.66
Day	14.84	Desire	13.27	Now	10.88	Church	6.91
Awesome	14.44	Example	10.65	Here	10.23	Singing	6.33
Help	12.21	Grandson	10.07	To stay	9.69	Guitar	5.3
Wonderful	12.22	Husband	10.07	To look	9.47		
Strength	12.22	Old man	9.86	Bad	8.43		
Live	11.13	Form	9.86	To tell	8.43		
Process	9.9	Problem	9.83	Until	8.13		
Trust	9.9	Chat	7.87	Time	8.04		
Mean	9.9	Mainly	7.03	After	7.41		
Spirituality	9.9	Never	7.03	Sir	6.94		
Mass	9.18	Take	5.46	See	6.73		
Health	9.06	Find	4.97	Sit	6.73		
Transplant	9.06	Also	4.52	Take	6.73		
Remove	9.06	Better	4.52	Study	6.73		
Walk	6.97	Hand	4.22	Solve	6.73		
Give thanks	6.37	No	4.04	Reality	6.73		
Participate	6.37	Thing	3.9	Right	6.73		
Next	6.01			Surgery	6.73		
Beautiful	6.01			Happen	6.73		
Church	5.74			Begin	6.36		
Moment	4.72			Think	6.36		
				Exam	5.45		
				Want	5.25		

Figure 1 – Dendrogram of the textual corpus and distribution of classes derived from the perceptions of elderly people in palliative care. João Pessoa, PB, Brazil, 2023

Based on the analysis of the above classes, grounded in PELT, four thematic categories emerged, namely: 1) Elderly people's perceptions of life linked to spirituality, desires, and hope; 2) The importance of interpersonal relationships for older adults in palliative care; 3) Elderly people's perceptions of death and the experience of pain in palliative care; and 4) Elderly people's involvement in leisure activities and distractions in palliative care.

Category 1: Older adults' perceptions of life linked to spirituality, desires, and hope

Most participants described life as a divine gift and, given its magnitude, the desire to live increasingly emerged, with spirituality as the foundation of their lives: *God will heal me, and they thought, I think it's a miracle from God* (V. Neri). *Life is everything, it's perfect. I have a lot of hope to live each day that dawns. I thank God for every moment in my life, I am very happy* (N. Gonçalves). *I have a lot of faith in God. I ask him to give me many years of life and that I stay on this machine for a long time, because I have seen people here in their 20s on hemodialysis, and I know that I will always need it* (Z. Camargo).

Despite their health conditions, they considered themselves very happy, full of desire and hope for life. Furthermore, belief in a transcendent being, whether religious or spiritual, acts as a source of support and reframes the experience of finitude, which makes them believe in life and improvement: *My hope is to improve this treatment, because if I improve, I will get off the machine* [hemodialysis] (C. Veloso). *But I want to do everything, I want to go for walks, go to the beach, and go to parties* (A. Barros). *What I really wanted was to drink water* (P. Fábio).

Spirituality was recognized as a fundamental dimension of human beings, offering comfort, hope, faith, and the assurance of not being alone: *I have great faith in God. I ask him to give me many years of life. It is Jesus who gives me strength. Even though I have no one around me, I have him, and that is enough* (Z. Camargo). *I am evangelical, and I think that faith does help, because as evangelicals we have two purposes: to serve Jesus and to forget the old* things (L. Gonzaga).

Category 2: The importance of interpersonal relationships for elderly people in palliative care

The satisfaction of elderly people was observed when they had friends and family around, as this companionship provided them with support during the process of illness: *I have my two children, they worry a lot about me, they drop me off, pick me up, they don't want me to walk alone, from here to there, they always walk with me* (A. Barros). *My family, especially my husband and daughter, always give me their best...* (G. Rocha). *Sometimes we get together with friends on the sidewalk to talk, to catch up on things* (W. Alencar).

Gratitude emerged in the statements describing the support of friends in the health-illness process, which revitalized the elderly and reaffirmed their sense of existence: *I have friends who drive me around, I have friends who help me a lot. Whatever I need, they do for me. If I need medicine, I just call her, she goes, buys it, and has it delivered to my house.* I am grateful to God for that (E. Ribeiro).

In contrast, some interviewees reported loneliness due to a lack of connections or attention, which they associated with unhappiness, dissatisfaction, discouragement, and despondency. They expressed feelings of uselessness when they are ill, realizing that they are only sought after when they are well or can offer something: *I come and go, and no one even asks what happened. When I get home, I'm the one who says whether I'm well or not, because no one asks* (R. Rossi). *There are no friends, they only exist when you have money, are drinking, or partying, then you have lots of friends. Some family members understand your situation and come to see you, but others are unaware* (A. Timóteo).

There was a comparison between friends and family members, highlighting that the support of the former was more significant. This finding indicates that the idea of family can include bonds chosen throughout life: *It's very sad to have to say this, but friends are more supportive than family members. I have an example, because I have a friend who we practically grew up together, because he called my mother "mom" and I called his mother "mom." For me, they are my family, they care about me* (P. Fábio).

The fragility of emotional ties also emerged in the reports, pointing to the fear of returning to her own home due to the risk of aggression and violence, which made her consider it safer to remain in a long-term care facility: *I'm not going back there* [her daughter's house], *I'm going to stay right here, in a support home, in the name* *of Jesus. She* [daughter] *said she's not coming to see me because she has back pain. I think it's better that way. I don't want to live with her* [daughter] anymore. *I'm afraid of being beaten again* (P. Possi).

Category 3: Older adults' perceptions of death and the experience of pain in palliative care

The highlighted words revealed the understanding of elderly people in palliative care about death, dying, and pain. Some reported an absence of fear, considering it an expression of divine will and occurring only at the appointed time, a perception that favors coping with clinical frailties: *I think there are some actions that help us talk more about the subject. I myself have no fear of dying. If death comes, it is because it is time. I used to be very afraid, I used to want to live a lot, but today I don't have that desire* (E. Ramalho*). I'm not afraid to die, because death is inevitable. No one lives forever, sometimes a person goes to sleep and doesn't wake up. I think we need to talk more about this topic, because people are afraid, and they don't need to be* (F. José).

One of the participants revealed the importance of faith to accept the events of life and leave in peace, reassuring their loved ones. The statements show that the association between faith and death intensifies the acceptance of the process and favors a positive perspective on what is to come: *I am not afraid of dying, because my certainty is in God, because in this world everything will perish, but we have Jesus. It is as the Bible says, that Jesus was and will prepare the place for those who wait on him* (A. Barros). *Death is natural, just like when we are born. The person who has God in his heart knows that we are going to life, he comes from dust and from dust we will return* (R. Miranda).

Furthermore, one of the statements shows a denial of impending death, as the person believes that this is far from happening, since there are still things to accomplish: *I don't want to die now, because I think I still have something to accomplish here and it's not my time yet, but I'm not afraid* (Daniel).

Participants also reported discomfort due to pain, which demonstrated the importance of alleviating it through interventions or even conversation and attention: *I improved a little. Before, the pain was so bad that I vomited, felt nauseous, and couldn't eat properly. When I started treatment, I began to eat and improve* (K. Patrício). *The pain is always there, it's a lot of pain, my dear, but when I take something, it eases up* (R. Miranda). *It hurts so much that I cry and lie down. Now, when there is someone like you paying attention, we even try to forget the pain, even though it is still there* (M. Mendonça).

Category 4: Involvement of elderly people in palliative care in leisure activities and distractions

Leisure activities and distractions promote autonomy, alleviate suffering, and improve quality of life by promoting pleasure, subjective expression, and strengthening bonds: *This television distracts us, we even forget that we are here in the machine, we also forget the pain* (A. Barros). *I really enjoy listening to music and watching television* (Amazan).

The reports indicated that, in addition to television and conversation, music was among the primary forms of distraction in palliative care. These activities, as emotional comfort strategies, proved effective in providing relief and pleasure and brief forgetfulness of pain, as evidenced by the following statements: *I love music, I really like the old songs, and I also like talking to friends. I always try to stay close to them here in the hemodialysis room, to see if I can talk, distract myself, and make the time pass more quickly* (N. Gonçalves). *I like recorded music or live music, but I think live music would be much better and would help us forget this machine a little bit* (Amazan*). Music would be effective for distracting me and helping me forget the pain I feel* (R. Carlos*). I really like music, so when I listen to it, it brings me comfort, it's like medicine, the pain goes away* (Leonardo).

The choice of songs is tied to memories of the past, moments lived, and people who have passed away, which bring comfort to the soul: *I love music; I really like the old songs that remind me of the past, of people who are no longer with us* (N. Gonçalves). *I like listening to music because it brings back memories of past* loves (A. Barros). *My wife passed away two months ago, and when I listen to our song, it feels like she is close to me* (Amazan). *I really like country music. Actually, I listen to all kinds of music, but what I listen to most is country, mainly because it reminds me of a love I had in my childhood* (Leonardo).

Discussion

The organization of the testimonies into four categories revealed how elderly people in palliative care attribute meaning to life, illness, finitude, and the relief of suffering. The lexical classes revealed the complexity and complementarity of these experiences.

A strong connection was observed among the four classes, in which leisure mediated existential, emotional, and physical dimensions, reinforcing interpersonal bonds and associations with spirituality, pain, and death.

Spirituality favored the understanding of suffering and uncertainties, especially when associated with religiosity, which contributes to the quality of life(19). Even in the face of finitude, patients maintained hope and made plans sustained by faith(20). This finding aligns with PELT, which posits that "being at peace" involves resorting to spirituality to reduce concerns and mitigate the impact of the disease(21).

Family and friendship ties are fundamental to perceptions of care, belonging, and appreciation, whereas their fragility intensifies feelings of abandonment, uselessness, and vulnerability. PELT underscores the importance of the support network in palliative care, whose presence offers tranquility, encouragement, and comfort, being essential in the final stage of life(21-22). However, some participants reported family violence and neglect, recognized as markers of vulnerability in aging and associated with poorer quality of life, lower satisfaction, and greater risk of institutionalization(23).

In palliative care, older adults with limiting illnesses accumulate factors such as isolation, fragility, and dependence, which increase their exposure to violence. In these contexts, the multidisciplinary team, particularly nurses, plays a central role in screening, identifying, reporting, and referring cases, thereby ensuring safe interventions(24).

PELT also advocates adopting a sensitive and responsive approach to patients' needs by family members, friends, and professionals, which promotes well-being(22). Meanwhile, palliative care promotes a more serene understanding of finitude, consistent with PELT, which seeks to provide a sense of overall well-being even in the face of vulnerability(10). The statements indicated that understanding finitude offers comfort, although the fear of leaving family members helpless makes it difficult to talk about death.

Pain relief, related to the PELT concept of "being pain-free," was highlighted as essential to avoiding physical, emotional, and sensory suffering, since intense pain compromises the patient's integrity and consciousness(9).

Some activities, such as listening to music, watching television, and maintaining social interactions, contribute to pain relief. Although simple, these practices improve quality of life by reducing stress, distress, and loneliness, which promotes comfort and fulfillment.

PELT recognizes that, for many patients, television is a common form of distraction, that helps to alleviate distress and divert attention from the challenges that accompany the disease(21). Television can act as a social substitute, but can also intensify loneliness, whereas music has proven to be a relevant strategy for alleviating physical, emotional, and social suffering(25-26).

The four classes were interdependent: spirituality sustains the confrontation of pain and death; interpersonal relationships modulate the perception of finitude; the experience of pain reinforces the need for emotional and spiritual support; and leisure strengthens all these dimensions. This integration highlights the importance of interventions that not only treat the clinical condition, but also subjective experiences and relationships, consolidating comprehensive care for the elderly person.

Study limitations

The limitations are mainly related to the composition and context of the sample, which consisted of elderly people hospitalized in two charitable institutions in a single capital city in northeastern Brazil, which limits the transferability of the findings.

The clinical and demographic homogeneity, predominantly elderly patients on hemodialysis, may have reduced the diversity of perceptions. The use of IRaMuTeQ, although it strengthens the analysis, may attenuate the subjective nuances typical of qualitative research and depends on rigorous corpus preparation. The exclusive use of interview data precluded methodological triangulation, which would have increased the depth of interpretation. Nevertheless, the immersion provided by CCR, with observations and field diary records, partially mitigated this limitation.

Contributions to practice

The study presents direct contributions to palliative care nursing for the elderly person. Highlighting that quality of life involves emotional, spiritual, social, and relational dimensions, the need to integrate them into the care plan is reinforced. The importance of continuous assessment of pain and overall suffering is highlighted, as well as the acceptance of narratives, recognizing them as clinical indicators. Early detection of loneliness, neglect, or violence is an essential component of the practice.

The findings also show the relevance of simple interventions, such as music, leisure, conversation, and the presence of loved ones, which strengthen bonds and promote emotional relief. The central role of nursing in coordinating person-centered care, and mediating among family members and teams in creating welcoming environments consistent with the values and desires of the elderly, is evident.

By recognizing that everyday, low-cost actions affect well-being, the study reaffirms nursing's potential to promote quality of life even in the face of irreversible illness. Such practices reinforce sensitive, creative, and intentional care, aligned with the Theory of Peaceful End of Life and the ethical commitment to dignity, autonomy, and humanization in the dying process.

Conclusion

It was concluded that the quality-of-life experiences of elderly people in palliative care are influenced by emotional, spiritual, and relational aspects that go beyond the control of physical pain. Considering the Peaceful End of Life Theory, it was found that emotional bonds, spirituality, hope, and simple activities, such as listening to music, are fundamental to well-being in the dying process. It was also evident that leisure strategies, especially therapeutic music, contribute significantly to coping with physical and existential challenges, underscoring the importance of a comprehensive approach and the need for further research on the application of the Theory in different healthcare contexts.

Authors' contribution

Conception and design or analysis and interpretation of data; Manuscript writing or critical revision of intellectual content; Final approval of the version to be published; Agreement to be accountable for all aspects related to the accuracy or integrity of any part of the manuscript being investigated and resolved appropriately: **Araújo EMNF, Freire MEM**. Writing of the manuscript or critical review of the intellectual content; Final approval of the version to be published; Agreement to be responsible for all aspects related to the accuracy or integrity of any part of the manuscript being investigated and resolved appropriately: **Lordão AV, Costa ICP, Agra G, Alves AMPM, Batista PSS**.

Data availability

The authors declare that the data are fully available in the body of the article.

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