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ORIGINAL RESEARCH

Multi-Sensory Comfort Care in Hospice Wards: A Qualitative Study of Healthcare Professionals' Experiences and Challenges

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Purpose: This study is to explore the real experience, effect perception and practical dilemma of multi-sensory comfort care implemented by healthcare professionals in hospice care wards, and to provide an empirical basis for optimizing the quality of hospice care services.

Participants and Methods: Using a descriptive qualitative research design, a semi-structured interview was conducted with 15 healthcare professionals (including 2 doctors, 6 nurses, 3 social workers, 2 psychotherapists, and 2 caregivers) from hospice care wards in 3 medical institutions in Chongqing through purposive sampling. Targeted content analysis was used for data analysis.

Results: Two themes and nine sub-themes were extracted, namely, the practical experience and effect perception of multi-sensory comfort care (visual intervention to create a healing environment, tactile intervention to convey emotional support, olfactory intervention to regulate physical and mental state, auditory intervention to relieve emotions, and taste intervention to connect physical and mental pleasure), and the practical challenges of multi-sensory comfort care (lack of policy guarantee, imbalance of resource allocation, gaps in professional competence, and low receptivity).

Conclusion: The results show that the clinical value of multi-sensory comfort care has been widely recognized by healthcare professionals, but its comprehensive promotion still faces significant challenges. In order to break through the current bottleneck, it is urgent to provide solid support for its development by constructing a "policy-resource-talent" trinity support system, innovating public education models and other comprehensive strategies.

Keywords: hospice care, multi-sensory comfort care, healthcare professionals, practice experience, qualitative research

Background

With the acceleration of China 's population aging process, the proportion of elderly people over 60 years old has reached 21.1% by the end of 2023.[1] In addition, chronic diseases such as cancer and cardiovascular and cerebrovascular diseases are high, and the demand for hospice care in end-stage patients is becoming more and more urgent. Hospice care upholds the core concept of "respecting life, alleviating physical and mental pain, and improving the quality of life at the end of life, " and is committed to enhancing patient comfort and overall well-being.[2,3] China's hospice care industry started relatively late, and although it has developed rapidly, it still faces multiple challenges. In practice, key criteria such as care scales and patient admission are not yet clear; The relevant policies and regulations, cultural support, and medical system also need to be improved. At the same time, the development of hospice care services is uneven between urban and rural areas and regions, and is generally constrained by a shortage of resources such as funding, technology, and professional talents.[4] In recent years, in order to promote the standardization and normalization of China's hospice care industry, the national level has successively issued multiple key policy documents, including the "Basic Standards and Management Norms for Hospice care Centers (Trial)" and the "Hospice care Practice Guidelines", which provide

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authoritative practical frameworks and quality standards for medical institutions at all levels to carry out corresponding services.[5,6] In August 2025, the National Health Commission officially released the " Practice Guide for Hospice Care (2025 Edition), " which replaced the old version piloted in 2017, further clarified the service concept of " focusing on end-stage patients and their families, " and emphasized that holistic care should be implemented through a multi-disciplinary collaborative model.[6] Compared with the 2017 trial version, the 2025 version emphasizes the importance of comfortable care and humanistic care on the basis of continuing professionalism and practicality, reflecting the deepening and development of China's hospice care service concept.

As the core content of hospice care, comfort care aims to maximize the comfort of patients and help them experience a sense of relaxation, pleasure and detachment through multi-dimensional interventions of physiology, psychology, social culture and environment.[7] However, the influence of traditional Chinese "filial piety" culture and the current medical model that still centers on disease treatment have led professionals to often focus more on the physiological comfort of patients, with insufficient attention to psychological, spiritual, socio-cultural, and environmental aspects.[8,9] Foreign scholars have effectively promoted the physical and mental comfort of patients by providing personalized sensory care in the practice of hospice care, thus improving the quality of hospice care services.[10] At present, research on sensory interventions for end-stage patients in China mainly focuses on the efficacy verification of single sensory stimulation on patients,[11–13] and there is still a lack of in-depth exploration from the perspective of the core implementers of care practice (healthcare professionals), including their personal practical experience, specific implementation difficulties, and structural barriers in carrying out integrated and multidimensional sensory comfort care in clinical work. As key implementers of multisensory comfort care, the practical experience of healthcare professionals directly affects the quality of service implementation and intervention effectiveness. Therefore, this study focuses on the perspective of healthcare professionals and adopts qualitative research methods to systematically explore the implementation process and practical challenges of multi-sensory comfort care, providing empirical evidence for optimizing hospice care practice models.

Method

Research Design

This study adopts a descriptive qualitative research design with the aim of collecting, organizing, and presenting the experiences and perspectives of participants in a specific field of practice. In the field of nursing, this paradigm is often used to explore subjective perceptions and specific behavioral experiences related to healthcare. Descriptive qualitative research mainly involves detailed description and thematic induction of observable and reportable experiential content in practical contexts. This study aims to conduct a descriptive analysis of the specific practical process and challenges encountered by healthcare professionals in hospice wards in implementing multi-sensory comfort care through semi-structured interviews, in order to form a structured understanding of this clinical practice.

Participants

Objective sampling method was used to recruit health care professionals (including doctors, nurses, social workers, psychotherapists and caregivers) from hospice wards of three medical institutions in Chongqing from May to June 2025. The sampling process follows the principle of maximum variation, and comprehensively considers factors such as occupational category, gender, age, educational background and clinical work experience to ensure the representativeness of the sample.

Inclusion criteria are as follows: (1) engaged in hospice care work time≥1 year; (2) Having training or learning experience related to multi-sensory comfort care (such as in-house training, participation in continuing education projects or related academic conferences); (3) Voluntary participation in the survey. Exclusion criteria are as follows: (1) rotation, internship, training personnel, etc.; (2) during the investigation due to sick leave, leave, study and other reasons are not on duty.

Interview Outline Design

The research team consulted relevant literature based on the research objectives, drafted an interview outline, and conducted pre-interviews with two healthcare professionals who met the inclusion criteria.

According to the results of the pre-interview, the final draft was revised under the guidance of two experts in the field of hospice care. The content is as follows: (1) When assessing the comfort needs of patients, will they pay attention to the sensory experience? (2) Multi-sensory includes vision, touch, smell, hearing and taste. Does it provide interventions for patients from these senses? How to implement it? (3) What is the effect of sensory stimulation on patients? Does it improve comfort? (4) The experience and main challenges of implementing multi-sensory comfort care? (5) The main obstacles to the implementation of multi-sensory stimulation? (6) What support would you like to receive to improve multi-sensory comfort care?

Data Collection

The data collection of this study was performed by two researchers who had received systematic qualitative research methods training, one of whom was a nursing teacher with a doctorate and the other was a graduate student. Before the formal interview, each interviewee was informed of the research purpose, significance, process, and core concepts. After completing the basic information filling and informed consent procedures, they entered the one-on-one in-depth interview stage. The interview will be conducted in a quiet and independent conference room, with full recording and a duration of 20 to 30 minutes. The interview strictly follows non directive principles, and the researchers do not guide, prompt, or evaluate. They are committed to creating an atmosphere that allows the interviewees to express themselves freely, and simultaneously observe and record their emotions, expressions, tone, and nonverbal cues. All recorded data were transcribed into text by two researchers within 24 hours after the end of the interview and organized together with on-site notes. The final generated text data is independently numbered and archived according to N1 to N15.

Data Analysis

This study used NVivo 12.0 software to systematically organize and manage interview recording transcripts and on-site notes recorded during the same period. The data analysis adopts the targeted content analysis method,[14] in which two researchers independently and repeatedly read the text, and synchronously refer to the on-site notes for understanding and coding. After the initial coding is completed, any disagreements that arise during the coding process are resolved through consensus discussions to ensure coding consistency. In the encoding process, nonverbal information is regarded as important contextual clues to assist in interpreting verbal content, especially when encountering semantic ambiguity or inconsistent expressions. In addition to directly verifying with the interviewee, contextual judgments are also made by comparing on-site notes.

Results

In this study, the sample size was determined based on the principle of information saturation.[15] In order to ensure data saturation, after the completion of the 10th interview, the researchers began to conduct preliminary data analysis, and then each additional 1–2 interviews were conducted to evaluate whether new codes or topics appeared. When no new coding or theme appeared in three consecutive new interviews, the research team unanimously judged that information saturation had been reached after discussion, and then stopped sample recruitment. Finally, 15 research subjects (numbered N1-N15) were included, and their basic data are shown in Table 1. Through in-depth analysis of interview data, we have summarized and extracted two main themes and nine corresponding sub themes. This result systematically reveals the practical connotation of this care model and the complex challenges it faces. The theme framework is shown in Table 2.

Theme 1: Practical Experience and Effect Perception of Multi-Sensory Comfort Care

Visual Intervention Creates a Healing Environment

After recognizing the therapeutic relationship between ward environment and patient comfort, healthcare professionals have practiced multi-sensory nursing practices that integrate natural elements with a homely atmosphere, marking the evolution of their understanding of the "environmental comfort" paradigm. As they gradually realize that natural traits

Table 1 Basic Data of Healthcare Professionals (n=15)

Number	Sex	Age	Educational Attainment	Marital Status	Occupation	Work Experience (Years)	Hospice Care Experience (Years)
N1	Female	23	Undergraduate	Unmarried	Psychotherapist	1~4	1
N2	Male	32	Undergraduate	Married	Doctor	5~10	2
N3	Female	47	Undergraduate	Married	Nurse	>10	1
N4	Female	26	Undergraduate	Unmarried	Nurse	1~4	1
N5	Female	29	Undergraduate	Married	Nurse	5~10	2
N6	Female	25	Undergraduate	Unmarried	Social worker	1~4	2
N7	Female	32	Junior college	Married	Caregiver	1~4	2
N8	Female	48	Undergraduate	Married	Nurse	>10	4
N9	Female	39	Junior college	Married	Caregiver	5~10	1
N10	Female	25	Junior college	Unmarried	Nurse	1~4	3
N11	Female	26	Undergraduate	Unmarried	Psychotherapist	1~4	3
N12	Male	23	Undergraduate	Unmarried	Social worker	1~4	2
N13	Female	26	Undergraduate	Married	Social worker	1~4	3
N14	Female	35	Undergraduate	Married	Nurse	5~10	5
N15	Female	48	Undergraduate	Married	Doctor	>10	3

Table 2 Multi-Sensory Comfort Care in Hospice Wards: The Perspective of Healthcare Professionals

Summary of Multi-Sensory Comfort Care Core	Themes	Sub-Themes
Practical content	Practical experience and effect perception of multi-sensory comfort care	Visual intervention creates a healing environment
		Tactile intervention delivers emotional support
		Olfactory intervention regulates physical and mental states
		Auditory intervention to soothe emotions
		Taste intervention connects physical and mental pleasure
Practical challenges	Multidimensional challenges of multi-sensory comfort care	Lack of policy guarantee
		Imbalance in resource allocation
		Gaps in professional competence
		Low receptivity

and warm environments can alleviate the physical and mental pain of end-stage patients through visual, psychological, and other means, environmental optimization work is increasingly developing towards specialization and humanization.

In terms of environment, we will place some green plants in the ward, and the color of the ward will mainly be warm and soft yellow. (N1)

The visual measure is to place flowers and plants in the ward. There is a small garden outside our department where patients can sit and bask in the sun, enjoy the breeze, and relax. (N3)

We will decorate the ward very warmly, create a monastic atmosphere, display some photos of themselves and their families, and also regularly send flowers. (N7)

We will also hire professionals to design the color scheme of the room, such as hand drawing on the wall, in order to divert patients' attention from pain. (N8)

Tactile Intervention Delivers Emotional Support

As a non-verbal communication method, tactile intervention plays an important role in alleviating patients' anxiety and delivering emotional support. This study found that nurses and social workers often use a variety of tactile strategies to improve the psychological comfort of patients. Specific measures include providing rehabilitation balls, soft items for patients to grasp, and hand and foot care through gentle touches, local massage or the use of aromatic essential oils.

We will have the patient hold an elastic rehabilitation ball and continue to pick it up and rebound, which can alleviate their anxiety and unease. (N1)

We will have gentle physical contact during the conversation, such as touching the shoulders and shaking hands, which makes the patient feel warm and comfortable (N7)

In addition, our social workers will alleviate patients' discomfort through touch or essential oil massage. (N10)

When we perform various nursing operations, our movements are gentle and careful to avoid pulling, rubbing, and causing discomfort to patients. (N13)

Olfactory Intervention Regulates Physical and Mental States

Olfactory intervention, with aromatherapy as the core implementation pathway, serves as an auxiliary intervention method to regulate the physical and mental state of end-stage patients. In clinical practice, essential oil aromas are often diffused through aromatherapy machines or traditional Chinese medicine incense is used to exert its effects through the olfactory pathway, thereby alleviating symptoms such as anxiety, insomnia, nausea, and vomiting in patients.

Aromatherapy is the most commonly used olfactory intervention, which helps alleviate nausea and vomiting. (N9)

The use of humidifiers with added essential oils in the room can help patients fall asleep. (N10)

In terms of smell, we mainly use aromatherapy. We will prepare essential oils based on the patient's symptoms and then smoke them in the ward to help alleviate anxiety. (N15)

Auditory Intervention to Soothe Emotions

Auditory intervention has been proven to be a non-pharmacological method for alleviating patient anxiety and improving compliance by utilizing personalized auditory stimuli. This study found that playing their favorite music or audiobooks according to the patient 's personal preferences can effectively alleviate the patient 's irritability and promote physical and mental relaxation. The intervention measures not only improve the emotional state of patients, but also help to promote doctor-patient communication and improve the cooperation of patients in the treatment process.

We use a small speaker to play songs that patients like, with a comfortable volume. When patients gradually relax in familiar melodies, their emotional states such as irritability and anxiety are significantly relieved, and subsequent care or treatment will also be more coordinated with us. (N6)

Our department is equipped with small speakers that sometimes play music or audiobooks according to the patient's interests, such as classic old songs, popular songs, or storytelling programs. Through observation, we can clearly feel that their emotions have relaxed more after listening and they are more willing to actively communicate with us. (N15)

Taste Intervention Connects Physical and Mental Pleasure

Taste intervention, as a gentle auxiliary method, aims to alleviate discomfort such as dry mouth, nausea, and taste changes caused by treatment or disease status in patients through oral sensory stimulation, and to some extent, improve psychological comfort by satisfying their taste preferences.

If the taste is stimulated, we do not have any special intervention measures. If the condition allows, we can use flavored water to moisten the lips. (N7)

We have done relatively little in this area, but we use honey water, tea water, or lemon water for oral care to alleviate symptoms of discomfort in the patient's mouth. (N13)

We will encourage patients to try their favorite foods in the past, whether spicy or sweet, as long as they are within an acceptable range for the body. (N14)

Theme 2: Practical Challenges of Multi-Sensory Comfort Care

Lack of Policy Guarantee

Although the National Health Commission actively encourages the inclusion of hospice care in the scope of medical insurance, related service items have not been clearly included in the medical insurance reimbursement system, and there is a lack of unified payment and fee standards. Due to the lack of corresponding medical insurance policies, multi-sensory comfort care is regarded as a "cost center" rather than a formal "service project" in departmental operations. Some specialized consumables required for this type of intervention, such as high-quality essential oils, audio equipment, and specific soothing tools, are facing procurement difficulties as they cannot be included in the reimbursement scope. Therefore, whether patients can receive such care largely depends on their ability to pay out of pocket or charitable investment from institutions, rather than based on uniform clinical needs assessment criteria. This situation affects the accessibility and fairness of care services, which may lead to differences in access to care opportunities among patients with different economic conditions. Most respondents believe that multi-sensory comfort care, as an auxiliary treatment for hospice care, requires more policy support and urgently needs to develop targeted charging standards.

At present, many treatment projects in our department are done at the department 's own expense, because there is no way to charge patients for this part of the cost. The hospital will give some subsidies, but the burden is still too heavy. It is hoped that the relevant treatment will be included in the medical insurance or set the charging standard, so as to reduce the pressure of the department and reduce the cost. (N2)

The cost of essential oils required for aromatherapy is high, but due to the lack of a recognized fee standard, we are unable to charge for it, resulting in these costs being borne by our department. (N3)

In order to alleviate the pressure on the department, we try to charge partial fees for aromatherapy and other services. Patients with better economic conditions will actively request this treatment, but most patients with average economic conditions are unwilling to pay for it and refuse it. So the country should introduce policies to solve the problem of fees, and it is urgent to include sensory intervention projects in the medical insurance reimbursement catalogue. (N14)

Imbalance of Resource Allocation

This study found that imbalanced resource allocation is a major structural obstacle facing hospice care services in China. The current service pricing system fails to fully cover key services such as psychological and social support, death education and some multi-sensory interventions. These projects are currently provided by pilot institutions in a free form. At the same time, due to the differences in the level of institutions providing services, the quality of service is significantly uneven. Large tertiary hospitals usually have better resources, including professional equipment and multi-disciplinary team configuration; in contrast, specialized hospitals or pension institutions are faced with problems such as lack of equipment and insufficient financial subsidies, which makes it difficult to effectively implement innovative service models such as multi-sensory comfort care. Even if some hospice care services can be provided by institutions, many families still have to bear higher out-of-pocket costs, especially sensory intervention and supplementary services that are not included in the basic medical insurance reimbursement, and the full cost is often paid by the patient 's family. The economic threshold formed by this payment structure essentially constitutes a screening mechanism based on the ability to pay, making it difficult for families with limited resources to equally obtain relevant services. The disconnect between price and cost has caused significant financial pressure, limiting the sustainability of services.

The implementation of multi-sensory comfort care requires professional equipment, such as visual intervention with projection or VR, which is more effective. However, this is beyond the regular budget of our grassroots institutions, which directly leads to the gap between the service effect we can provide and the large tertiary hospitals. (N1)

Our hospital is a tertiary hospital, providing strong support, including the formation of multidisciplinary teams, providing financial subsidies to purchase professional equipment and consumables. But the key problem is that because there is no fee standard, the department has no income, these services are all supported by the hospital and are provided without compensation, and the model is difficult to sustain. (N9)

At present, some projects are provided free of charge by institutions. Whether the project that needs patients' own expenses can be carried out depends entirely on the patient's own economic level. (N10)

Gaps in Professional Competence

The application of multi-sensory comfort care in clinical practice in China is still in the initial exploration stage, and its development is significantly constrained by the shortage of professional talents and the imperfect training system, manifested in fragmented service implementation and insufficient professional depth.

Although our department has attempted to introduce music therapy and aromatherapy, due to the lack of qualified professional therapists to guide us, the related work is mostly carried out by doctors or nurses after short-term training. The operating procedures are not yet standardized, and our professional abilities need to be further improved. (N5)

Although our hospital has organized hospice related training, the quality of the training content varies greatly, especially in the application of psychological support techniques such as love cards and sand table games, where there is insufficient professional guidance, which affects the effectiveness of intervention measures. (N8)

From the perspective of overall training supply, there is still a lack of specialized training resources for multi-sensory care in China. Taking workshops such as "Beautiful Hands and Feet" and music therapy as examples, their frequency of implementation is limited and the coverage of personnel is narrow, which makes it difficult for the learned skills to form a scale effect in clinical practice and cannot meet the actual needs of a large number of patients. (N12)

Low Receptivity

As a non-pharmacological intervention method, the promotion and application of multi-sensory comfort care in clinical practice mainly face dual acceptance barriers from patients and their families. At the family level, some family members have limited understanding of this intervention measure and are skeptical about its necessity and actual effectiveness in the end-stage of the disease, possibly viewing it as a "non-essential" service. At the same time, under the dual pressure of emotions and economy, family members tend to make more conservative decisions, which directly affects their support and cooperation with intervention measures. At the patient level, due to the progression of the disease, physical function decline, sensory impairment, or communication barriers often make it difficult for patients to respond actively or significantly to sensory stimuli, resulting in physiological difficulties in acceptance. This objective situation not only increases the difficulty of implementing intervention measures, but also puts higher demands on the professional evaluation ability of nursing staff; Secondly, some patients may experience resistance or apathy due to a lack of understanding of the intervention or negative emotions related to the disease.

The cooperation between patients and their families is generally not high, and they often consider such interventions to be "useless". Some family members even believe that patients in the terminal stage of the disease are unable to perceive these stimuli, and therefore lack sufficient understanding and trust in treatment. Some patients are unwilling to accept reality and will refuse all treatment. (N10)

The active feedback from hospice care patients is usually very weak, and most of us can only judge whether intervention is appropriate by observing subtle changes in their facial expressions. This poses a significant challenge to our observation and judgment. (N11)

Discussion

Emphasize the Clinical Value of Multi-Sensory Comfort Care

This study found that healthcare professionals generally agree that multi-sensory comfort care has a positive impact on improving the comfort of end-stage patients. By integrating multi-sensory interventions such as vision, hearing, and touch, it helps to improve patients' physiological and psychological states, thereby enhancing their overall quality of life. This finding is consistent with existing research conclusions.[16,17] Specifically, tactile interventions such as touch, essential oil massage, and auditory interventions such as personalized music can effectively relieve physical discomfort such as pain and body edema; visual intervention by creating a family atmosphere and olfactory intervention with soothing fragrance can help reduce patients' negative emotions such as anxiety and loneliness. However, in the current

clinical practice, the application of multi-sensory comfort care still faces several challenges, mainly manifested in the lack of unified standards for the operation process, and the effect evaluation mechanism has not been systematically established. These limitations may be related to the lack of systematic and standardized clinical practice guidelines for multi-sensory comfort care in China,[11] which in turn affects the standardized promotion and in-depth application of this model. Therefore, in the future, we should focus on building a multi-sensory comfort care program with local characteristics and operability on the basis of fully considering the disease characteristics, cultural background and individual needs of end-stage patients in China. Specifically, it is necessary to further clarify its intervention content, implementation process and effect evaluation system, so as to promote the standardized and systematic application of this model in clinical practice, so as to effectively improve the comfort and quality of life of end-stage patients.

Build A Policy-Resource-Talent Trinity Support System

Constructing a policy-resource-talent trinity system support system is the key path to solve the dilemma of multi-sensory comfort care in the field of hospice care in China. At present, this field is faced with structural obstacles such as lack of policy guidance, weak resource support and lack of professional talents, which restricts its transformation from concept identification to normative practice.[18]

At the policy and resource level, the lack of institutional guarantee is particularly prominent. The medical insurance payment system is seriously insufficient to cover multi-sensory comfort care projects. Non-drug interventions such as music therapy, aromatherapy, and tactile intervention have not been systematically included in the reimbursement scope, which increases the economic burden of patients and weakens the sustainability of service supply.[19,20] Therefore, in order to promote the standardized implementation and sustainable promotion of multi-sensory comfort care, it is necessary to systematically promote it from two aspects: system design and resource guarantee. First, we should strengthen the top-level system planning and improve the payment and evaluation system. Specifically, it includes: promoting the inclusion of core intervention projects into the medical insurance catalogue and establishing stable payment channels; coordinating the formulation of detailed charging standards and service specifications to achieve charging evidence-based; and develop a localized evaluation tool in line with China ‘s clinical practice to provide evidence-based basis for payment decision-making and quality monitoring. Secondly, it is necessary to simultaneously build a long-term resource supply mechanism. The initial investment of professional equipment and consumables can be compensated by setting up financial special projects. In the existing package payment model, it clearly calculates and covers its service cost, reflecting its professional value; at the same time, priority should be given to the development and promotion of low-cost and easy-to-implement standardized intervention service packages to improve service accessibility, inclusiveness and fairness.

At the level of talent system construction, structural contradictions are particularly prominent. Compared to the model led by certified aromatherapy therapists, music therapists, and other professionals abroad,[21,22] China currently relies more on clinical nurses and other healthcare professionals to take on part-time roles, resulting in unclear role positioning, incomplete professional knowledge system, and fragmented skill training, ultimately leading to uneven intervention effects and difficulty in ensuring service quality. Therefore, it is necessary to strive to build a specialized and systematic talent training and certification channel. Short term strategies can rely on and upgrade the existing hospice care training framework, introduce internationally authoritative courses and adapt them locally, and develop a modular training system that covers theoretical teaching, practical supervision, and ethical reflection. In the medium to long term, it is necessary to explore the establishment of specialized vocational skills certification for sensory comfort care, and actively promote the establishment of relevant minor directions or micro majors in the higher education system, in order to reserve professional talents from the source.[23]

Innovating Public Education Models to Enhance Acceptance

Although significant progress has been made in the construction of a service system for hospice care in China,[24,25] the public’s understanding of its core concepts and service models is still relatively limited, and its social acceptance and willingness to actively utilize it are generally low. This to some extent restricts the promotion and application of non-pharmacological interventions, including multi-sensory comfort care.[26] As an important auxiliary means in hospice care,

multi-sensory comfort care alleviates the physical and mental pain of end-stage patients through environmental improvement, music, and aromatherapy.[27,28] However, as the disease progresses, patients often experience sensory dysfunction and decreased tolerance to stimuli, leading to doubts about its necessity and effectiveness from some family members and even the patients themselves, which in turn affects their willingness to accept and cooperate. To break through this bottleneck, it is necessary to change the traditional one-way propaganda model and build a multi-level and highly interactive new paradigm of public education.[29] Firstly, in terms of communication channels and forms, we should fully rely on digital carriers such as social media and health science popularization platforms to transform the neuroscience principles, psychological and physiological effects, and clinical application scenarios of multi-sensory comfort care into high-quality short videos, science popularization animations, and information graphs, achieving precise knowledge dissemination and efficient outreach.[30,31] Secondly, in terms of content construction and narrative strategy, the key lies in achieving a transition from "knowledge infusion" to "emotional resonance" and "situational understanding". By systematically presenting real patient cases before and after intervention, analyzing in detail the process of improving their physical and mental state, or designing immersive role-playing simulations, family members can personally experience the considerations and operational details of intervention decisions, thereby bridging the cognitive gap and building a solid foundation of trust.

Limitations

This study conducted qualitative interviews with healthcare professionals to explore the field of comfort management for end-stage patients, providing new insights for related research systems. The research findings present multidimensional challenges, including lack of policy guarantee, imbalance of resource allocation, gaps in professional competence, and low receptivity. However, there are certain limitations to this study, as only healthcare professionals from hospice wards in three medical institutions in Chongqing were interviewed. The small sample size limits the generalizability and external validity of the research results. In addition, the topic classification conducted by researchers during data analysis may introduce subjectivity and potential bias, such as excessive focus on data related to the research question. In subsequent research, it is recommended to further expand the sample coverage and survey population, include multiple perspectives of patients and their families, and enhance the reliability and validity of the study through methods such as triangulation, in order to enrich the evidence base of multi-sensory comfort care practice and promote the in-depth development of this field.

Conclusion

This study is based on the perspective of healthcare professionals and explores the practical value and practical challenges of multi-sensory comfort care models in hospice care units. The results show that most healthcare professionals agree that this care model helps to improve the comfort of end-stage patients. However, its further promotion still faces many challenges, mainly including the lack of policy guarantees, imbalanced resource, gaps in professional competence, and low receptivity. To promote the standardized development and widespread application of multi-sensory comfort care models, efforts should be made in the following areas in the future: improving medical insurance reimbursement and related fee policies, optimizing resource allocation and investment mechanisms, building a systematic professional training and certification system, and actively exploring diversified public education paths.

Research Contribution Statement

This study theoretically fills the gap in the existing literature: previous studies have focused more on the impact of multi-sensory interventions on patients, and less on practical experience and obstacles in the implementation process from the perspective of health care professionals. At the practical level, the core challenges and adaptation experience extracted from the research can be directly transformed into the construction of standardized multi-sensory comfort care programs, the design of targeted clinical training and the optimization basis of relevant health policies, thus laying a foundation for promoting the localization, standardization and sustainable development of multi-sensory comfort care.

Data Sharing Statement

The data supporting the results of this study can be obtained from the corresponding author upon reasonable request.

Ethics Approval and Consent to Participate

This study was conducted in accordance with the Helsinki Declaration and approved by the Ethics Committee of the First Affiliated Hospital of Chongqing Medical University in China (No. 2024-344-01). All participants signed a written informed consent form, which includes publishing anonymous responses/direct citations.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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Disclosure

The authors declare that there is no conflict of interest in this work.

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