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Assessment Instruments in Individuals at the End-of-Life: An Integrative Review

Instrumentos de evaluación en personas al final de la vida: revisión integrativa

Instrumentos de avaliação em pessoas no final da vida: revisão integrativa

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Abstract: Introduction: The clinical assessment of individuals at the terminal stage of illness requires valid and reliable instruments to identify complex needs in highly vulnerable contexts. International evidence shows conceptual and methodological heterogeneity among available tools and limited adaptation to Latin American settings. Objective: To identify, classify, and analyze the characteristics and psychometric properties of instruments used in the healthcare of people at the end of life. Methodology: An integrative review was conducted following INTEGRA criteria. The search was performed between September 2024 and May 2025 in PubMed, Scopus, Web of Science, and EBSCO, including studies published between 2015 and 2025. Study selection followed PRISMA 2020 guidelines, and methodological quality was assessed using MMAT. Data were synthesized through thematic categorization. Results: Fourteen articles were included, reporting 28 instruments applied to end-of-life populations. Tools focused primarily on functional status, clinical condition, and psychological dimensions, whereas spirituality, existential needs, interpersonal relationships, and advanced-care planning were less represented. Most instruments demonstrated acceptable validity and reliability, although variability was observed in theoretical foundations, development processes, and cross-cultural validation. Conclusions: Although a wide range of assessment instruments is available for terminal care, their practical use is limited by conceptual heterogeneity, lack of standardization, and insufficient cultural adaptation. Strengthening comprehensive assessment through locally validated instruments is essential to improve end-of-life care quality.
Keywords: terminally ill; terminal care; surveys and questionnaires; psychometrics.

Resumen: Introducción: La evaluación clínica de personas en etapa terminal requiere instrumentos válidos y confiables para identificar necesidades complejas en contexto de alta vulnerabilidad. La evidencia internacional muestra heterogeneidad conceptual y metodológica en las herramientas disponibles y escasa adaptación a realidades latinoamericanas. Objetivo: Identificar, clasificar y analizar las características y propiedades psicométricas de los instrumentos utilizados en la atención de salud en personas al final de la vida. Metodología: Revisión integrativa conforme a criterios INTEGRA. La búsqueda se efectuó entre septiembre 2024 y mayo 2025 en PubMed, Scopus, Web of Science y EBSCO, considerando estudios publicados entre 2015-2025. La selección se realizó según PRISMA 2020 y la calidad metodológica se evaluó mediante MMAT. La síntesis se desarrolló mediante categorización temática. Resultados: Se analizaron 14 artículos que reportaron 28 instrumentos utilizados en personas al final de la vida. Predominaron herramientas orientadas a evaluar funcionalidad, estado clínico y dimensiones psicológicas. En contraste, espiritualidad, necesidades existenciales, relaciones interpersonales y planificación anticipada fueron menos representadas. La mayoría de los instrumentos presentó niveles adecuados de validez y confiabilidad, aunque con variabilidad en fundamentos teóricos, procesos de desarrollo y validación transcultural. Conclusiones: Existe amplia disponibilidad de instrumentos, pero su aplicación se limita por heterogeneidad conceptual, escasa estandarización y baja adaptación cultural. Fortalecer la evaluación integral con instrumentos validados localmente es esencial para fortalecer la calidad del cuidado al final de la vida.
Palabras clave: enfermo terminal; cuidado terminal; encuestas y cuestionarios; psicometría.

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Resumo: Introdução: A avaliação clínica de pessoas em fase terminal requer instrumentos válidos e confiáveis para identificar necessidades complexas em contexto de alta vulnerabilidade. A evidência internacional demonstra heterogeneidade conceitual e metodológica nas ferramentas disponíveis e escassa adaptação às realidades latino-americanas. Objetivo: Identificar, classificar e analisar as características e propriedades psicométricas dos instrumentos utilizados na atenção à saúde de pessoas no final da vida. Metodologia: Revisão integrativa conforme aos critérios INTEGRA. A busca foi realizada entre setembro de 2024 e maio de 2025 nas bases PubMed, Scopus, Web of Science e EBSCO, considerando estudos publicados entre 2015 e 2025. A seleção foi realizada seguindo as diretrizes PRISMA 2020 e a qualidade metodológica foi avaliada por meio do MMAT. A síntese foi desenvolvida mediante categorização temática. Resultados: Foram analisados 14 artigos que reportaram 28 instrumentos aplicados a pessoas no final da vida. Predominaram ferramentas orientadas a avaliar funcionalidade, estado clínico e dimensões psicológicas. Em contrapartida, espiritualidade, necessidades existenciais, relações interpessoais e planejamento antecipado foram menos representados. A maioria dos instrumentos apresentou níveis adequados de validade e confiabilidade, embora com variabilidade nos fundamentos teóricos, nos processos de desenvolvimento e na validação transcultural. Conclusões: Existe ampla disponibilidade de instrumentos, mas sua aplicação é limitada pela heterogeneidade conceitual, pela escassa padronização e pela baixa adaptação cultural. Fortalecer a avaliação integral com instrumentos validados localmente é essencial para aprimorar a qualidade do cuidado no final da vida.
Palavras-chave: doente terminal; cuidado terminal; inquéritos e questionários; psicometria.

Introduction

The sustained increase in people passing through advanced states of chronic and progressive illnesses that lead to terminal illness (TI) has generated a growing demand for palliative care at a global level. [1] The World Health Organization (WHO) has documented that this phenomenon is associated with the ageing of the population and the increase in chronic advanced pathologies, which has intensified the need for strategies for end-of-life care. [2] At a regional level, the Pan American Health Organization (PAHO) [3] and the Latin American Association of Palliative Care (ALCP) [4] have indicated important gaps in access, coverage, and development of palliative care, especially in Latin America, which underlines the need to strengthen planning and evaluation in care in this stage of life.

In this context, it is essential to distinguish between people who need wide-ranging palliative care and those who are specifically in the terminal stage. This latter condition is understood as an advanced, progressive, incurable illness with scarce response to treatment and limited prognosis, generally weeks or months. [5] This differentiation is crucial as it determines clinical priorities, orients complex ethical decisions, and demands interventions centered on comfort, accompaniment, and end-of-life quality.

In this scenario, the assessment instruments used internationally in the care of people at the end of life are understood as structured, validated, and reliable tools, designed to measure clinical, functional, psychological, spiritual, relational, and quality-of-life dimensions that characterize the terminal stage. [6] The literature indicates that these instruments are central inputs for clinical practice, management of services, and research, as long as they have solid psychometric foundations and rigorous transcultural adaptations for the contexts where they are applied. [7]

However, a series of relevant gaps have been reported, among which the following are highlighted: the dispersion of the instruments, conceptual variability between regions, transcultural differences in the comprehension of the terminal phase, and the scarce adaptation of these tools to Latin American contexts. [8, 9] This heterogeneity makes them difficult to apply clinically and represents an additional barrier for professionals in the healthcare area, who, due to care demands, have little time to search for, select, and apply instruments that allow them to evaluate specific health parameters. [10]

Therefore, the objective of this study is to identify, classify, and analyze the psychometric properties of the instruments used internationally in the healthcare of people at the end of life in order to orient clinical practice and favor evidence-based decisions, as well as contribute to the development and selection of culturally pertinent instruments for the care of people in the terminal stage.

Method

This is a systematic review, the objective of which is to synthesize research or literature with heterogeneous study designs. [11] To conduct this review, we followed the recent INTEGRA methodological update principles for integrative reviews, [12] which consist of the following phases: (I) research idea or problem: the central problem was identified as the dispersion and psychometric

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variability of the instruments; (N) research question or objective: the objective was formulated to identify, classify, and analyze the psychometric properties of these instruments; (T) search strategy: a structured strategy was designed using MeSH and DeCS vocabulary and free-text terms, combined with Boolean operators, to maximize search sensitivity and specificity; (E) search execution: the search was conducted by four researchers over a 9-month period in selected databases, covering the past 10 years; (G) quality assessment of results: evaluated using the Mixed Methods Appraisal Tool (MMAT), [13] to ensure the methodological soundness of the evidence; (R) filtered results: applying the guidelines of the PRISMA 2020 statement, [14] the authors independently conducted the screening process by title and abstract, followed by full-text evaluation; (A) Analysis and discussion: the results were analyzed through a thematic categorization process, which allowed for a structured and coherent synthesis. The sequential application of this methodological framework ensured the transparency of the process, the logical coherence of the analysis, and the quality of the results obtained.

To formulate the research question the acronym PIO [15] was used, incorporating the following terms: (P) Population: people at the end of life; (I) Intervention: assessment tools used in their clinical care; (O) Outcome: characteristics, uses, and properties of these tools. This exercise led to the following research question: What are the instruments used internationally in the health care of people at the end of life, published between 2015 and 2025, and what are their characteristics, assessed dimensions, and psychometric properties?

To answer this research question, the search strategy was designed systematically and reproducibly. A search was made for relevant studies on the Scopus, Web of Science (WOS), PubMed, and EBSCO electronic databases, selected for their multidisciplinary coverage and their relevance in the healthcare area. For the retrieval of evidence, a combination of controlled terms from Medical Subject Headings (MeSH) and *Descriptores en Ciencias de la Salud (DeCS)* were used, combined with free terms and OR and AND Boolean operators, adapting the syntax to the specific requirements of each database (Table 1). Filters were applied to restrict the results to studies published between the years 2015 and 2025, with complete text available in English or Spanish, and carried out on an adult population. The search was executed by the authors between September 2024 and June 2025.

Table 1

Database search strategy

Database	**Search strategy**
PubMed	("Terminally Il"[MeSH Terms] OR "terminally ill"[tiab]) AND ("Health Status Indicators"[MeSH Terms] OR "health status indicators"[tiab] OR "health risk appraisal"[tiab]) AND ("Delivery of Health Care"[MeSH Terms] OR "Patient Care"[MeSH Terms] OR "informal care"[tiab]) AND ("Terminal Care"[MeSH Terms] OR "Hospice Care"[MeSH Terms] OR "end-of-life care"[tiab] OR "bereavement care"[tiab])
Scopus	TITLE-ABS-KEY("terminally ill" AND ("health status indicators" OR "health risk appraisal") AND ("delivery of health care" OR "patient care" OR "informal care") AND ("terminal care" OR "hospice care" OR "end-of-life care" OR "bereavement care"))
WoS	ALL=("terminally ill" AND ("health status indicators" OR "health risk appraisal") AND ("delivery of health care" OR "patient care" OR "informal care") AND ("terminal care" OR "hospice care" OR "end-of-life care" OR "bereavement care"))
EBSCO	TX("terminally ill" AND ("health status indicators" OR "health risk appraisal") AND ("delivery of health care" OR "patient care" OR "informal care") AND ("terminal care" OR "hospice care" OR "end-of-life care" OR "bereavement care"))

The following inclusion criteria were established in this review: complete articles available electronically in English or Spanish, that dealt with assessment instruments applied to adults in the terminal stage of their illness or end of life in an intra or extra-hospital context, with a quantitative or mixed design. On the other hand, articles of care of patients that were not in the condition of a terminal illness, i.e., not in the final stage of life, review articles, gray literature, and articles with pediatric populations were excluded.

The process of identification, selection, and inclusion of the studies was represented through a flowchart (Figure 1) based on the PRISMA 2020 [14] guidelines. This flowchart allows us to visualize

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sequentially the number of records identified, duplicates, studies excluded following reading of the title and abstract, evaluation of the full text, and the final inclusion of the analyzed articles. The studies were selected by 4 researchers independently and simultaneously, who evaluated first by title and abstract and then by complete text applying the eligibility criteria. The discrepancies in any of the phases were resolved through discussion and it was not necessary to refer them to a consultant.

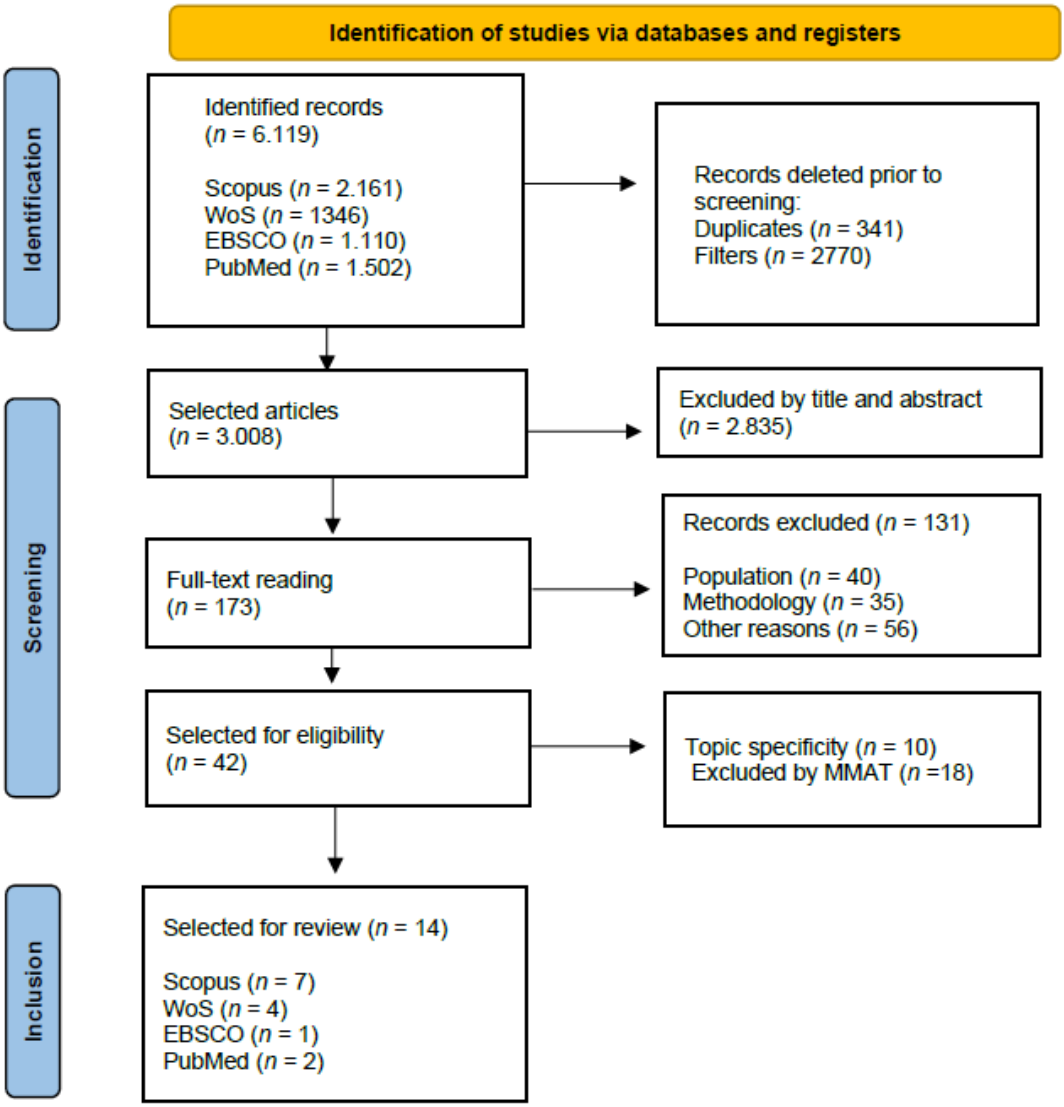


Figure 1. Flowchart of selection of publications based on the PRISMA 2020 declaration. [14]

For the data extraction, an adaptation was used of the data collector suggested by the International Network of Nursing in Occupational Health (RedENSO), [16] collecting the following variables: author, title in its original language, year, journal/quality, database, key words, place of study, study objective, specific objectives, design, sample and instruments, and study conclusions.

The methodological quality of the studies included was evaluated using the scale of the Mixed Methods Appraisal Tool (MMAT). [13] This tool permitted the evaluation of the empirical research using studies with qualitative, quantitative, and mixed approaches. Each study was evaluated with 7 items, 2 common and 5 specific ones for each of the designs. Each item is responded to with a "yes", "no", or "cannot be determined", thus obtaining a percentage of quality determined by the number of affirmative responses obtained in the evaluation items. The authors decided to include in the review all those articles that met more than 90 % of the methodological quality criteria established by MMAT. To guarantee the robustness and reliability of the review and the MMAT process, the 4 authors evaluated

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their studies methodologically, with additional random verification to ensure consistency. Differences were resolved by consensus.

Finally, the analysis of the selected articles was conducted by the four researchers, who participated actively and collaboratively in all stages of the analysis, under the supervision of two faculty researchers. Once the selection process was complete, a thematic analysis was carried out using categorization to identify, organize, and synthesize the assessment tools used internationally in end-of-life care. To avoid conceptual ambiguities, a "person in the terminal/end-of-life stage" was defined as an individual with an advanced and irreversible illness, unresponsive to treatment, and with a limited life expectancy, distinguishing this from the broader category of palliative care, which was not the focus of this study.

Following this, the findings were compared and consensus was reached in group work sessions, which allowed the construction of final thematic categories that support the presentation of the results. Each dimension was constructed grouping instruments that shared a main measuring objective and conceptual nucleus, in accordance with the evaluated variables and the purpose declared in the original studies. Along these lines, the dimension of *functionality, clinical state, and cognitive decline* includes instruments aimed at evaluating functional performance, clinical seriousness and compromise in people at the end of life. The dimension of *end-of-life psychology* encompasses tools designed to measure emotional distress, anxiety, depression, and coping mechanisms in the face of the dying process. The dimension of *quality of life, quality of dying, and well-being* includes instruments that comprehensively assess the subjective perception of well-being and the end-of-life experience. The dimension of *interpersonal relationships, social support, and therapeutic bond* brings together instruments that explore the quality of meaningful relationships and perceived support. The dimension of *preferences, advance decisions, and care planning* includes tools to identify values, wishes, and decisions related to end-of-life care. The dimension of *spirituality, meaning, and existential needs* groups together instruments aimed at assessing transcendence, meaning of life, and spiritual needs. Finally, the dimension of *sedation, agitation, and neuropsychiatric symptoms* comprises instruments designed to assess behavioral disturbances characteristic of the advanced stages of the dying process.

Results

Following the exhaustive review of the literature, Table 2 presents the 14 articles in which the instruments used for care of the terminal patient were found.

Table 2

Characteristics of the articles included in the review

N.	Authorship	Study Objective	Care Context	Country Year	Sample	Design	MMAT Quality	Journal/ Impact Factor	Conclusions
1	Lin HM et al. [17]	To analyze factors associated with the decision to sign a Do-not-resuscitate order (DNR) to improve the use of resources and the quality of the end-of-life process.	Public hospital in Taipei, family palliative clinic.	Taiwan 2021	2144 users ≥20 years	Retro.	High	*Multidisciplinary Digital Publishing Institute (MDPI)* / Q1	Family palliative consults, TW-PCST punctuation, type of room, and duration of hospital stay are significantly associated with signing a DNR.
2	Prigerson HG et al. [18]	To evaluate the relationship between the use of chemotherapy and end-of-life quality, according to the functional state of the patient.	Six oncological out-patient clinics.	USA 2015	312 users ≥18 years	Coho. Long.	High	*JAMA Oncology*/ Q1	Chemotherapy did not improve quality of life.

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3	Luo X et al. [19]	To explore the efficacy of combining end-of-life letters of demand (ELDCG) and recovery based on mindfulness (MBCR) in reducing anxiety when facing death, depression, and stress in patients with advanced lung cancer.	Oncological ward of the Hospital Affiliated with the Zunyi Medical University.	China 2025	77 users ≥18	RCT.	High	*Frontiers* / Q1	The intervention combining ELDCG + MBCR was effective in significantly reducing anxiety when facing death, anxiety, depression, and stress.
4	Bendel Y et al. [20]	To develop and initially validate a scale to measure expectations about communication about end-of-life (EOLC-E).	General population.	Germany 2022	307 users ≥18 years	Validate scale	High	*Omega: Journal of Death and Dying* / Q2	The EOLC-E was shown to be valid and reliable to assess expectations in conversations about death.
5	Bovero A et al. [21]	To validate the Italian version of the Sinclair Compassion Questionnaire (SCQ) and to evaluate psychometric properties in patients with terminal cancer and life expectancy less than 4 months.	Hospital and hospice (palliative).	Italy 2024	131 users ≥18 years	Validate scale	High	*Palliative and Supportive Care* / Q2	The SCQit was shown to be a valid and reliable tool to measure perceived compassion in patients with terminal cancer.
6	Pi SH et al. [22]	To develop and validate a self-assessment tool (LED-GDI) so that patients with terminal cancer can value if they are approaching a "good death".	Hospitalization units of palliative and oncological care.	Taiwan 2024	144 users ≥18 years	Mixed	High	*Journal of Multidisciplinary Healthcare*/ Q1	LED-GDI is valid and reliable to evaluate from the perspective of whether the patient is achieving a good death.
7	Davies A et al. [23]	To analyze the clinical characteristics of the "death rattle" in patients with end-of-life cancer, using data from trials of assisted hydration.	Palliative care in 4 oncological centers and 8 hospices.	United Kingdom 2024	200 users ≥55 years with cancer	Anal.	High	*Supportive Care in Cancer*/Q1	The death rattle increases in prevalence in the last hours of life, but not always presents in the moment of death. Its course is variable.
8	Evans HE et al. [24]	To study how attachment tendencies can influence communication results at the end of life in a sample of adults.	University of New South Wales.	Australia 2024	80 and 90 users in both experiments ≥18 years	RCT.	High	*Plos One* /Q1	The induction of attachment does not increase the general disposition to talk about the end of life.
9	Hasse HT et al. [25]	To describe how health related quality of life (HRQoL) evolves in patients with cancer up to the moment of their death.	Oncology Department of the Odense University Hospital.	Denmark 2025	256 users ≥55 years	Long. Pros.	High	*Quality of Life Research*/Q1	Showed evidence of a significant fall in quality of life in the last three months of life.

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10	Zhou P et al. [26]	To study the level of good death in patients with delirium, the factors that influence it, and the correlation between anxiety, palliative care needs, and the achievement of a good death.	General hospital (Zhongnan Hospital of Wuhan University).	China 2025	263 relatives of defunct patients with terminal delirium ≥60 years	Trans.	High	*BMC Palliative Care* /Q1	A significant negative correlation was found between level of anxiety from terminal delirium (TDDS) and quality of death (GDI).
11	Tomas B et al. [27]	To determine if dexmedetomidine is superior to midazolam in maintaining sedation levels without agitation in terminal-phase patients.	Palliative care services in 3 New South Wales hospitals.	Australia 2024	52 users ≥18 years	RCT.	High	*JMIR Publication*/Q1	In evaluation.
12	Peralta T et al. [28]	To analyze the prescription pattern of a palliative care unit from user admission to the day of death.	Poverella Palliative Care Unit, Braga.	Portugal 2022	115 users ≥18 years	Anal. Long. Obs.	High	*BMC Palliative Care*/Q1	A reduction in medication was observed for comorbidities and an increase in medication for symptom control.
13	Niemeyer MJS et al. [29]	To study the rate of withdrawal of life supporting treatment (WLST) and compare the clinical results in patients with isolated cranioencephalic trauma in two level I trauma centers.	Two level I trauma centers (UMC Utrecht and UMC Rotterdam), Netherlands.	Netherlands 2024	596 users ≥18 years	Coho. Retros.	High	*European Journal of Trauma and Emergency Surgery* /Q1	Demonstrated a high level of WLST in patients with CET. The differences between the centers were minimal in terms of clinical results.
14	Joung JH et al. [30]	To study the effects of anxiety related to death and social support in end-of-life care preferences in elderly adults residing in long-term care hospitals.	Long-term care hospitals in Daegu.	South Korea 2024	155 elderly adults	Transv.	High	*Journal of Korean Gerontological Nursing*/ Q4	Anxiety, social support, experience in intensive care, and the seriousness of the illness significantly influenced preferences for terminal care.

Note. Quant: quantitative; RCT: randomized clinical trial; quasi: quasi-experimental; coho: cohort; prosp: prospective; long: longitudinal; transv: transversal; retros: retrospective; observ: observational; anal: analytical.

The review included a total of 14 articles, [17-30] published between 2015 and 2025, coming from ten countries, all of which focused on terminal-stage patients. The predominant grouping was research developed in Asia, mainly China, Taiwan, and Japan, which together represented 46 % of the total. It was observed that 66 % of the articles were published in the years 2024-2025, which reflects a highly up-to-date bibliography that is coherent with contemporary trends in end-of-life care.

It is worth noting that the majority of the clinical assessments and clinical decisions with patients in the terminal stage were done in hospital surroundings (66 %), followed by hospices (20 %), and residential care homes (6.7 %). In terms of methodological designs, observational and analytical studies dominated (53 %), followed by clinical trials and instrument validation studies (40 %), while 6.7 % corresponded to mixed studies. In relation to the size of the sample, 46 % of the studies included between 101-300 participants, 33 % evaluated populations equal to or below 100 persons, and 20 % were more than 300 participants. It is relevant to highlight that the majority of the articles were

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published in journals located in Q1 (73 %), followed by 20 % in Q2, and only 6.7 % in Q4. All of the articles have high methodological quality according to the MMAT instrument. Finally, the population under study corresponded mainly to adults in the terminal stage, with 20 % of the studies centered in elderly adults, consistent with the epidemiology of the end of life.

In relation to meeting the objectives, 28 instruments used in the healthcare of the terminally ill patient were found, and they are laid out in Table 3.

Table 3

Instruments used internationally in healthcare of the patient in the terminal stage

N.°	Name of the instrument/ Acronym	Type of measurement	Evaluated dimension	Instrument subdimensions	Use	Response	Time of application	Original language
1	Death related anxiety DADDS-G	Self. Interview	Anxiety related to death or the process of dying.	Existential fear. Fear of the process of dying. Concern for the future.	CDHI	Likert	5 to 10 minutes	English
2	Canadian Health Care Evaluation Project Lite Questionnaire CANHELP Lite	Self. Interview	Satisfaction with care at the end of life.	Quality of care. Emotional wellbeing. Relationships. Decision making.	CHI	Likert	10-15 minutes	English
3	Quality of Life Questionnaire of the European Org. for Cancer Research and Treatment EORTC-QL Q-C30	Self. Interview	Quality of life related with the health of cancer patients.	Physical, emotional, social, and cognitive functions. Symptoms.	CDHI	Likert + dichotomic items	10-15 minutes	English
4	Sinclair Compassion Questionnaire SCQit	Self. Interview	Perceived compassion.	Care. Presence. Comprehension. Authenticity.	CHI	Likert	5-10 minutes	English
5	Spiritual needs questionnaire SNQ	Self. Interview	Spiritual needs.	Inner peace. Connection. Transcendent forgiveness.	CDHI	Likert	10-20 minutes	German
6	Depression Anxiety Stress Scales - 21 items DASS-21	Self Interview	Depression, anxiety, and stress during final week.	Depression. Anxiety. Stress.	CDHI	Likert	5-10 minutes	English
7	Eastern Cooperative Oncology Group ECOG	PA	Functional state in cancer patients.	Level of functionality. Physical activity.	CHI	Ordinal	< 2 minutes	English
8	Richmond Agitation-Sedation Scale RASS- PAL	PA	Level of agitation or sedation (adapted version for palliative care).	Level of consciousness. Agitation. Sedation.	CHI	Ordinal	1-2 minutes	English
9	Modified Richmond Agitation-Sedation Scale m-RASS	PA	Level of agitation or sedation (modified version).	Level of consciousness. Agitation. Sedation.	CHI	Ordinal	1-2 minutes	English

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10	Anguish scale related to terminal delirium TTDS	PA	Anguish associated with terminal delirium.	Fear. Desperation. Confusion. Isolation.	CHI	Likert	5-10 minutes	English
11	Templer Death Related Anxiety Scale T-DAS	Self. Interview	Death related anxiety.	Fear. Avoidance.	CDHI	Likert	5-10 minutes	English
12	Hospital Anxiety and Depression Scale HADS	Self. Interview	Anxiety and depression in a hospital context.	Anxiety. Depression.	CDHI	Likert	5-10 minutes	English
13	Social Support Scale MOS-SSS	Self. Interview	Level of social support received.	Emotional, instrumental, informative, social support.	CDHI	Likert	5-10 minutes	English
14	End-of-Life Conversation Scale EOLC-E	Self. Interview	End-of-life expectations.	Wishes. Expectations. Discussions.	CDHI	Likert	5-10 minutes	English
15	Perceived Stress Scale CPSS	Self. Interview	Level of perceived stress.	Uncontrollability. Overload. Unpredictability.	CDHI	Likert	5-10 minutes	English
16	Experience in Close Relationships Scale ECR-R	Self. Interview	Quality of close relationships.	Abandonment anxiety. Avoidance of attachment.	CHI	Likert	10-15 minutes	English
17	Preference of Care at the End-of-Life Scale PCEOL	Self. Interview	Personal preferences about end-of-life care.	Treatment wishes. Place of death. Invasive measures.	CDHI	Likert	5-10 minutes	English
18	Palliative Performance Scale PPS	PA	Functional state in palliative care.	Functional state. Level of activity. Self-care. Intake. Consciousness.	CDHI	Ordinal	5 minutes	English
19	Quality of Life Evaluation EQ-5D-5 L	Self. Interview	Quality of life related to health.	Mobility Pain. Pain/Discomfort. Self-care. Daily activities. Anxiety. Depression.	CDHI	Dichotomic + Likert	5 minutes	English
20	Glasgow Coma Scale GCS	PA	Level of consciousness following trauma or brain damage.	Ocular opening. Verbal response. Motor response.	CHI	Ordinal	< 2 minutes	English
21	Palliative Care Screening Tool TW-PCST	PA Hetero.	Detection of need for palliative care.	Need for palliative care. Functional state. Symptoms.	CHI	Dichotomic	2-5 minutes	Manda-rin

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22	LED Good Death Index LED-GDI	Self. Interview	Quality and dignity in death.	Quality of death. Dignity. Control. Suffering.	CDHI	Likert	5-10 minutes	Japanese
23	Memorial Delirium Assessment Scale MDAS	PA	Assessment of delirium.	Seriousness of delirium. Cognition. Retention. Behavior.	CHI	Likert	5-10 minutes	English
24	Mini-Mental Scale MMSE	PA Hetero.	Assessment of cognitive state.	Orientation. Memory. Attention. Calculation. Language. Praxis.	CDHI	Ordinal	10-15 minutes	English
25	Need for Advance Care Planning ACP-Screening	Self. Interview	Need for advance care planning.	Identification of the need to plan advance care.	CDHI	Dichotomic / Likert	5 minutes	English
26	Quality of Death and Dying Scale QOD	Self. Interview	Quality of dying.	Quality of dying. Pain. Dignity. Support.	CDHI	Likert	5-10 minutes	English
27	Revised Trauma Score RTS	PA	Rapid assessment of trauma state.	Level of consciousness. Blood pressure. Respiratory frequency.	CDHI	Ordinal / numeric	2-5 minutes	English
28	Care Evaluation Scale-Short Form CES	Hetero.	Quality of end-of-life care (Chinese version).	Physical care from doctors, nurses, psycho-existential care, explanations from doctor to patient, family, surroundings, cost, consideration of family health, availability, coordination and coherence.	CDHI	Likert	10-15 minutes	English

Note. PA: professional assessment; CDHI: clinical, domiciliary, hospital, investigation; CHI: clinical, hospital, investigation; hetero: hetero-applied; self: self-applied.

In terms of the general characteristics of the instruments, diversity was observed in the mode of application. Approximately 67.8 % of the instruments are self-applied or administered through interviews, reflecting a tendency to measure perceptions, symptoms, and experiences directly from the terminal patient. 31 % require professional assessment and observation.

In relation to type of measurement, Likert type scales dominate (71.4 %), with dichotomic formats in a lesser proportion (3.6 %), which shows a preference for tools that are sensitive to nuances, experiences, and terminal symptomatology. In relation to the dimensions evaluated, psychological and emotional constructs are highlighted with 35.7 % of the instruments oriented towards measuring death related anxiety, stress, depression, and attitudes towards death, while 25 % are centered in quality of life and death, 21 % are directed to valuing functionality, cognitive state, and only 17 % of the instruments dealt with relational and spiritual dimensions. In terms of application times, 75 % require between 5 and 10 minutes, demonstrating the need for brief, clinically feasible instruments. Finally, in

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the analysis of the original language, there was a clear predominance of English, showing a theoretical development in Anglo-Saxon and European contexts.

Table 4 presents the classification of the 28 instruments analyzed, according to the thematic categories that were developed following the analysis of the selected articles.

Table 4

Instruments categorized by thematic dimensions

Thematic Category	**Instruments Included**
Functionality, clinical state, and cognitive decline (assess function, physical/cognitive decline, clinical seriousness).	ECOG / PPS / GCS / RTS / TW-PCST / MDAS / MMSE
End-of-life psychology (assess negative emotions, affective processes, coping mechanisms or perceptions before end-of-life).	DADDS-G / DASS 21 / T- DAS / HADS / CPSS / TTDS
Quality of life, quality of dying, and well-being (assess global perception of life or of the dying process).	EORTC-QLQ-C30 / EQ-5D-5L / LED-GDI / QOD /CES
Interpersonal relationships, social support, and therapeutic bond (assess quality of relationships, support, or bonds relevant to the end-of-life).	MOSS-SSS / ECR-R / CANHELP Lite
Preferences, advance decisions, and care planning (assess preferences, values, and advance decisions).	PCEOL / EOLC -E / ACP - Screening
Spirituality, meaning, and existential needs (assess compassion, spirituality, and existential needs).	SNQ / SCQit
Sedation, agitation, and neuropsychiatric symptoms (assess sedation state and neuro-behavioral response).	RASS-PAL / m-RASS

Table 4 reveals a heterogeneous distribution that is nonetheless consistent with the most relevant conceptual domains of end-of-life care. The most frequently represented dimension was *functionality, clinical status, and cognitive decline*, accounting for 25 % of the total, which indicates that the assessment of functional and cognitive decline remains a priority for clinical decision-making at the end of life. Second, the *end-of-life psychology* dimension accounted for 21 % of the instruments, highlighting the growing importance attributed to emotional components such as stress, anxiety, etc. Third, the *quality of life, quality of dying, and well-being* dimension accounted for 17 % of the instruments, confirming the importance of measuring the patient's subjective experience. Meanwhile, the dimensions of *interpersonal relationships, social support, and therapeutic bond*, as well as *preferences, advance decisions, and care planning*, each accounted for 10 % of the instruments. Finally, the least represented dimensions were *spirituality, meaning, and existential needs*, and *sedation, agitation, and neuropsychiatric symptoms*, with 7 % each, despite the fact that both constitute critical components of comprehensive end-of-life care.

Table 5 presents the instruments included in this literature review according to their psychometric properties, primarily reliability and validity.

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Table 5

Psychometric properties of the instruments used in terminal stage healthcare

Category	Instruments	Authorship	Reliability	Validity
End-of-life psychology	DADDS-G	Vehling S et al.	Cronbach's Alpha: 0.89; Test-retest: 0.84.	Co. Const. Crit.
	DASS 21	Lovibond SH et al.	Test-retest >0.80	Co. Const. Crit.
	T-DAS	Templer D.	Cronbach's Alpha: 0.80-0.90; Test-retest 0.75-0.85	Co. Const.
	HADS	Zigmond AS et al.	Cronbach's Alpha: 0.80-0.90; Test-retest 0.70-0.85	Co. Const. Crit.
	CPSS	Foa EB et al.	Cronbach's Alpha: 0.89; Test-retest >0.80	Const.
	TTDS	Templer D.	Not reported	Co. Const.
	DAS	Templer D.	Cronbach's Alpha: 0.83; Test-retest 0.76	Const.
Functionality, clinical state, and cognitive decline	ECOG	Oken MM et al.	Cohen's Kappa 0.70-0.90	Co. Const.
	PPS	Anderson F et al.	Cohen's Kappa 0.66–0.96; Test-retest: >0.80	Co. Const. Crit.
	GCS	Jennett B & Bond M.	Kappa: 0.75–0.90	Co. Const. Crit.
	RTS	Champion H et al.	Kappa: > 0.80	Co. Const. Crit.
	TW-PCST	Huang CM et al.	Cronbach's Alpha: 0.82, Test-retest 0.79–0.91; Kappa > 0.80	Co. Const. Crit.
	MDAS	Breitbart W et al.	Cronbach's Alpha: 0.91; Test-retest > 0.80; Kappa 0.76–0.91	Co. Const. Crit.
	MMSE	Marshal FF et al.	Cronbach's Alpha: 0.70-0.95; Test-retest >0.80	Co. Const. Crit.
Quality of life, quality of dying and well-being	EORT-QLQ	European Organization for Research and Treatment of Cancer.	Cronbach's Alpha: entre 0.70 y 0.90; Test-retest: >0.80	Co. Const. Crit.
	EQ-5D-5L	Herdman M et al.	Test-retest 0.70-0.90	Const.
	LED-GDI	Miyashita M et al.	Cronbach's Alpha: 0.81–0.94; Test-retest 0.83	Co. Const. Crit.
	QOD	Robin K et al.	Cronbach's Alpha: 0.80- 0.90; Test-retest 0.70 - 0.85	Co.
	CES	Morita T et al.	Cronbach's Alpha: 0.98; Test-retest 0.57	Const.
Interpersonal relationships, social support, and therapeutic bond	MOS-SSS	Sherbourne CD et al.	Cronbach's Alpha: > 0.91	Const.
	ECR-R	Fraley RC et al.	Test-retest 0.86 a 0.91	Co. Const. Crit.
	CANHELP Lite	Heyland DK et al.	Cronbach's Alpha: 0.88-0.96. Test-retest >0.80	Co. Const. Crit.
Preferences, advance decisions, and care planning	PCEOL	Curtis JR et al.	Cronbach's Alpha: 0.86	Co. Const. Crit.
	EOLC-E	Bendel Y et al.	Cronbach's Alpha: 0.96	Co. Const. Crit.
	ACP-Screening	Sudore RL et al.	Cronbach's Alpha: >0.80	Co. Const. Crit.

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Spirituality, meaning, and existential needs	SNQ	Büssing A et al.	Cronbach's Alpha: 0.86–0.95	Co. Const. Crit.
	SCQit	Sinclair S et al.	Cronbach's Alpha: 0.98; Test-retest >0.80	Co. Const. Crit.
Sedation, agitation, and neuropsychiatric symptoms	RASS-PAL	Bush SH et al.	Inter-assessor reliability 0.95	Co. Const. Crit.
	m- RASS	Shirley H et al.	Cohen's Kappa 0.88-0.96	Co. Const. Crit.

Note. Co.: content; Const.: construct; Crit.: criteria.

According to the evidence found, 100 % of the instruments report at least one psychometric property (reliability, validity, or both), which suggests a minimum psychometric base for their application in the context of terminal-stage patients.

In relation to reliability, the most reported measure was Cronbach's Alpha with 71 % of the instruments, suggesting a robust evaluation of internal consistency. This is followed, with 57 % of the instruments, by measures of temporal stability through Test-retest, with coefficients above 0.80, which indicates acceptable stability between measurements. In the same vein, Cohen's Kappa coefficient was reported in 21 % of the instruments, reporting coefficients above 0.75, showing an adequate level of Inter-assessor concordance.

In relation to validity, validity of the content was the most frequently used (85 %), present in 24 instruments, validity of the construct was observed in 85 % of the instruments, while the validity of the criteria was reported in 53 %, generally in scales that sought to correlate with diagnostic or clinical standards.

Therefore, the evidence shows that the instruments have a solid psychometric foundation, although there is variability in the depth of the validation processes reported in the different themes.

Discussion

This literature review offers a comprehensive view of internationally used instruments in the healthcare of people in the terminal stage, which is a phase characterized by elevated clinical, emotional, and decisional complexity. In this way, this review responds to the urgent need to optimize clinical assessment in a scenario in which chronic and terminal illness are on the rise around the globe. [31] In this context, the results of this integrative review show the diversity of instruments used internationally in the care of the person at the end of life, with a predominance of tools centered in the assessment of functionality, clinical state, and psychological aspects. This pattern is consistent with the bibliography developed in high-income countries, mainly in Asia, Europe, and North America, where functional and clinical assessment have been historically prioritized in models of palliative care attention. [8, 9]

In the same vein, the findings show a lesser representation of instruments oriented towards relational, spiritual, and advance care planning dimensions. This gap has been previously indicated in reports and recommendations from international organizations, such as the WHO and PAHO, that highlight the need to incorporate more holistic assessments that are centered on the person in order to improve quality of end-of-life care. [32, 33]

When contrasting the results of this review with the international literature, it is relevant to consider the geographical and institutional contexts of the studies included. The selected literature is composed mainly of research carried out in high-income countries, mainly in Asia (China, Taiwan, South Korea), Europe (England, Germany, Italy, Denmark, and Portugal), Australia, and the United States, which are contexts where instruments centered on functional and clinical assessment of the person at the end of life predominate, with emphasis on prognosis and symptom control. On the other hand, reports emitted by the WHO, PAHO, and the Latin American Association of Palliative Care (ALCP) contribute a conceptual framework that makes the gaps existing in Latin America visible and emphasizes the need for multi-dimensional and culturally pertinent instruments, especially in contexts where palliative care and thus, end-of-life care present gaps in access and development. This diversity

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of approaches reinforces the importance of interpreting the results considering the origin of the evidence and its applicability in different healthcare contexts.

While it is true that the literature retrieved reports a wide range of instruments used internationally in the care of the patients in the terminal stage, the identified diversity confirms a fragmented and not very systematic use of these tools, where multiple scales coexist without a standardized selection framework or global recommendations for clinical usage. [1] In this context, the instruments that predominate are self-applied or administered through interviews, which reflects a view leaning towards subjective assessment of patient wellbeing and symptoms. However, the wide variety of purposes, application times, and assessed dimensions of the instruments indicates the absence of a homogenous measuring route, which makes it difficult to compare studies and, in this way, limits the establishment of international standards, as has been indicated by EAPC (European Association for Palliative CARE) [34] and IASP (International Association for the Study of Pain). [35] In relation to this, it is important to highlight that the majority of the articles are concentrated in high-income countries, while the evidence coming from low- and middle-income countries continues to be scarce. This characteristic limit the global applicability of the results, as has been reported by other authors. [36]

The characterization of the instruments included in this review made it possible to organize them into seven main categories, based on their purposes and implementation. It was shown that there exists a predominance of tools centered on managing the global state of functionality, clinical state, and cognitive decline, as well as the end-of-life psychology of the terminal-stage person. These results coincide with previous studies that report that the functional assessment and the emotional impact of the end of life constitute the most consolidated pillars in the international literature. [37] In spite of this, critical dimensions for truly holistic care were shown, including spirituality, existential needs, and advance planning, although they showed a markedly smaller representation. These results align with recent authors that emphasize the invisibilization of these domains in contemporary research. [38] This observed conceptual dispersion reinforces the need to move towards an integrating care model, overcoming the biomedical view that still predominates in current tools.

In terms of the psychometric properties of the instruments, it was shown that all the instruments reported at least one validity or reliability property, which is a relevant strength. The predominance of Cronbach's Alpha suggests that the authors are concerned with evaluating internal consistency, although it is not always with a robust factorial analysis. In the same vein, the frequent use of test-retest and Kappa coefficients reflects efforts to guarantee temporal stability and reliability among assessors. However, criteria validity, which is key to evaluating correlation with diagnostic or clinical standards, was less frequent. These reports coincide with other authors who warn of insufficient comparative evaluation between instruments and objective clinical parameters. [39] On the other hand, the evidence emphasizes the importance of transcultural adaptation of the instruments in the healthcare area, ensuring their linguistic and cultural pertinence in order to guarantee the reliability and validity of the measurements, [40, 41] and this is an element that also emerges as a need in the findings of this review.

From a clinical perspective, these results have significant implications. The predominance of functional and psychological instruments to the detriment of the spiritual and advance planning dimensions can limit the healthcare team in providing holistic care, as well as affecting decision making, communication, and emotional preparation of the patient and their family. Along the same lines, the absence of transcultural validations limits the applicability of several instruments in Latin American contexts where there are sociocultural factors that influence the meaning of a terminal illness.

Among the relevant limitations of this review is, firstly, in the design of the integrative review because while it does allow the synthesis of heterogeneous studies, it does not include procedures for meta-analysis nor comparative quantitative estimations. This limits the probability of evaluating the magnitude of the effects of the instruments identified. Secondly, the temporal cut-off point applied to the search, restricted to studies published between 2020 and 2025, could have excluded instruments developed before this period but that are still being used in clinical practice. In the same way, the inclusion of articles only in Spanish and English can generate a language bias, potentially excluding instruments developed in other linguistic contexts. Additionally, the review was based solely on indexed databases and this implies a possible publication bias from not considering gray literature nor non-

indexed reports. Finally, some psychometric properties of the instruments were not reported in depth, and this could restrict a more exhaustive analysis.

From these findings, it is suggested that future research could advance in the transcultural validation of the instruments, especially in Latin American contexts where the evidence is scarce. In the same way, future studies could develop tools that integrate the under-represented dimensions like spirituality, advance planning, and family needs. The creation of international consensus to orient the selection and use of instruments, as well as comparative studies that evaluate sensitivity to change and real clinical usefulness would constitute essential steps in strengthening the holistic assessment of the terminal-stage patient.

Finally, this review contributes to systematizing a fragmented field, identifying available instruments, their central dimensions, and psychometric bases. However, challenges remain to achieve holistic, culturally pertinent, and clinically applicable assessments. This highlights the need to advance towards frameworks of measurement that are consensual and sensitive to the diversity of end-of-life paths.

Conclusion

This integrative review has allowed us to identify and classify instruments used internationally in the care of end-of-life patients, showing a wide heterogeneity of approaches to assessment, dimensions dealt with, and psychometric properties reported. The data retrieved confirms that the majority of the instruments concentrate on measuring functionality, clinical state, and psychological aspects, while the dimensions of spirituality, existential needs, and advance planning remain scarcely represented.

From a clinical practice perspective, by providing a structured overview, these findings can guide healthcare professionals in making informed choices about assessment tools, taking into account their purpose, dimensions, and psychometric validity. In the same vein, the thematic classification proposed here facilitates the identification of relevant tools, according to the specific clinical needs of the end-of-life person, contributing to more holistic, person-centered care. From a research perspective, gaps are revealed in the availability of validated and culturally adapted instruments, which opens lines of future research oriented towards the development, transcultural adaptation, and psychometric assessment of the instruments used with end-of-life people.

References

1. Runzer Colmenares F, Parodi J, Perez-Agüero C, Echegaray K, Samamé JC. Las personas con enfermedad terminal y la necesidad de cuidados paliativos: una deuda pendiente de los servicios de salud. Acta Médica Peruana [Internet]. 2019 [cited 2025 Jun 26];36(2):134-144. Available from: http://www.scielo.org.pe/scielo.php?script=sci_arttext&pid=S1728-59172019000200010&lng=es&nrm=iso&tlng=es

2. Worldwide Hospice Palliative Care Alliance; World Health Organization. Global Atlas of Palliative Care [Internet]. 2da ed. London: WHPCA; 2020 [cited 2025 Dec 15]. Available from: https://www.paho.org/es/node/75063

3. Pan American Health Organization; World Health Organization. Cuidados Paliativos-OPS/OMS [Internet]. Washington, DC: PAHO/WHO; 2015-2019 [cited 2025 Dec 13]. Available from: https://www.paho.org/es/temas/cuidados-paliativos

4. Asociación Latinoamericana de Cuidados Paliativos. Atlas de Cuidados Paliativos en Latinoamérica 2020 [Internet]. 2da ed. Houston: IAHPC Press; 2021 [cited 2025 Dec 16]. Available from: https://cuidadospaliativos.org/uploads/2021/8/Atlas%20de%20Cuidados%20Paliativos%20en%20Latinoamerica%202020.pdf

5. Sociedad Española de Cuidados Paliativos. Cuidados paliativos: definición de enfermedad terminal [Internet]. Madrid: SECPAL; 2005 [cited 2026 Apr 15]. Available from: https://www.bioeticaweb.com/cuidados-paliativos-recomendaciones-de-la-sociedad-espaapola-de-cuidados-paliativos-secpal/

Enfermería: Cuidados Humanizados, January-June 2026; *15*(1), e4825
DOI: 10.22235/ech.v15i1.4825

6. Bausewien C, Daveson BA, Currow Dc, Dowing J, Deliens L, Radbruch L, et al. EAPC White paper on outcome measurement in palliative care: improving practice, attaining outcomes and delivering quality services. Recommendations from the European Association for Palliative care (EAPC) Task Force on Outcome Measurement. Palliat Med [Internet]. 2026 [cited 2025 Dec 16];30(1):6-22. doi: 10.1177/0269216315589898

7. Gomez CB, Marcelino PAW, Capelas ML. Compassion assessment instruments in palliative care: a scoping review of available tools and their psychometric characteristics. BMC Palliat care [Internet]. 2025[cited 2025 Dec 16]; 24:118. doi: 10.1186/s12904-025-01870-8

8. Albers G, Echteld MA, De Vet HC, Onwuteaka-Philipsen BD, Van Der Linden MH, Deliens L. Evaluation of quality-of-life measures for use in palliative care: a systematic review. Palliat Med [Internet]. 2010 [cited 2025 Dec 14];24(1):17-37. doi: 10.1177/0269216309346593

9. Antunes B, Rodrigues PP, Higginson IJ, Ferreira PL. Outcome measurement-a scoping review of the literature and future developments in palliative care clinical practice. Ann Palliat Med [Internet]. 2018 [cited 2025 Dec 14];7(Suppl 3):S196–206. doi: 10.21037/apm.2018.07.03

10. Hurley E, May P, Matthews S, Normand C, Johnston BM. What gets measured in palliative care? A review and synthesis of routine data collection in 16 countries. Health Policy Open [Internet]. 2025 [cited 2025 Dec 14]; 8:100141. doi: 10.1016/j.hpopen.2025.100141

11. Knafl K, Whittemore R. Top 10 tips for undertaking synthesis research. Res Nurs Health [Internet]. 2017 [cited 2025 May 20];40(3):189-193. doi: 10.1002/nur.21790

12. Valencia-Contrera M, Vilchez-Barboza V, Do Carmo Cruz Robazzi ML, Quintana-Zavala M, Castro-Bastidas J, Ardiles-Irarrazabal R-A, et al. INTEGRA methodology for the development of integrative reviews: origins, guidelines, and recommendations. Data and Metadata [Internet]. 2024 [cited 2025 Mar 15];3. doi: 10.56294/dm2024.401

13. Hong QN, Fàbregues S, Bartlett G, Boardman F, Cargo M, Dagenais P, et al. The Mixed Methods Appraisal Tool (MMAT) version 2018 for information professionals and researchers. Education for Information [Internet]. 2018 [cited 2025 Mar 18];34(4):285-291. doi: 10.3233/EFI-180221

14. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. The BMJ [Internet]. 2021 [cited 2025 Jun 11];372. doi: 10.1136/bmj.n71

15. Sánchez-Martín M, Pedreño Plana M, Ponce Gea AI, Navarro-Mateu F. And, at first, it was the research question… The PICO, PECO, SPIDER and FINER formats. Espiral Cuadernos del Profesorado [Internet]. 2023 [cited 2025 Mar 16];16(32):126-136. doi: 10.25115/ecp.v16i32.9102

16. Marziale MHP. Instrumento para recolección de datos revisión integrativa [Internet]. 2015 [cited 2025 Nov 26]. Available from: https://gruposdepesquisa.eerp.usp.br/sites/redenso/wp-content/uploads/sites/9/2019/09/Instrumiento_revision_litetarura_RedENSO_2015.pdf

17. Lin HM, Liu CK, Huang YC, Ho CW, Chen M. Investigating key factors related to the decision of a do-not-resuscitate consent. Int J Environ Res Public Health [Internet]. 2022 [cited 2025 Sep 15];19(1). doi: 10.3390/ijerph19010428

18. Prigerson HG, Bao Y, Shah MA, Elizabeth Paulk M, LeBlanc TW, Schneider BJ, et al. Chemotherapy use, performance status, and quality of life at the end of life. JAMA Oncol. [Internet]. 2015 [cited 2025 Sep 11];1(6):778-784. doi: 10.1001/jamaoncol.2015.2378

19. Luo X, Miao X, Ding N, Fu Z, Wang X, Li Y. Application of the end-of-life demands card game and mindfulness-based cancer recovery program for reducing negative emotion in patients with advanced lung cancer: a randomized controlled trial. Front Psychol [Internet]. 2025 [cited 2025 Jul 26];16. doi: 10.3389/fpsyg.2025.1476207

20. Bendel Y, Pinquart M, Schulz-Quach C, von Blanckenburg P. Expectations in the Communication About Death and Dying: Development and Initial Validation of the End-of-Life Conversations – Expectations Scale. Omega (United States) [Internet]. 2022 [cited 2025 Dec 16];90(2), 710-725. doi: 10.1177/00302228221110726

21. Bovero A, Fraoni A, Urru S, Berchialla P, Cotardo F, Di Girolamo I, et al. Measuring compassion in end-of-life cancer patients: The Italian validation of the Sinclair Compassion Questionnaire (SCQit). Palliat Support Care [Internet]. 2024 [cited 2025 Nov 16];22(5). doi: 10.1017/s1478951524001202

22. Pi SH, Li IF, Li PY, Lai YL, Fang CK. Psychometric Evaluation of the Good Death Index from Patients with Terminal Cancer's Perspectives: A Mixed-Methods Study. J Multidiscip Healthc [Internet]. 2024 [cited 2025 Mar 11]; 17:6031-6041. doi: 10.2147/jmdh.s464198

23. Davies A, Waghorn M, Skene S. Clinical features of audible upper airway secretions ("death rattle") in patients with cancer in the last days of life. Supportive Care in Cancer [Internet]. 2024 [cited 2025 Jun 11];32(7):423. doi: 10.1007/s00520-024-08634-9

24. Evans HE, Sansom-Daly UM, Bryant RA. Attachment as a mechanism influencing end-of-life communication: An analogue investigation. PLoS One [Internet]. 2024 [cited 2025 Dec 16];19(7):e0303652. doi: 10.1371/journal.pone.0303652

25. Hasse HT, Kjær T, Kristensen SR. Trajectory of quality of life among patients with cancer at the end of life: a longitudinal survey study. Quality of Life Research [Internet]. 2025 [cited 2025 Jun 6];34:1695-1707. doi: 10.1007/s11136-025-03923-0

26. Zhou P, Tang C, Wang J, Zhang C, Zhong J. Assessing the relationship between the distress levels in patients with irreversible terminal delirium and the good quality of death from the perspective of bereaved family. BMC Palliat Care [Internet]. 2025 [cited 2025 Oct 26];24(1):14. doi: 10.1186/s12904-025-01652-2

27. Thomas B, Barclay G, Lo WSA, Mullan J, Mansfield K. Dexmedetomidine Versus Midazolam for End-of-Life Sedation and Agitation: Protocol for a Randomized Controlled Trial (The DREAMS Trial). JMIR Res Protoc [Internet]. 2024 [cited 2025 Mar 16];13:e55129. doi: 10.2196/55129

28. Peralta T, Castel-Branco MM, Reis-Pina P, Figueiredo IV, Dourado M. Prescription trends at the end of life in a palliative care unit: observational study. BMC Palliat Care [Internet]. 2022 [cited 2025 Mar 16];21(1):65. doi: 10.1186/s12904-022-00954-z

29. Niemeyer MJS, Jochems D, Van Ditshuizen JC, de Kanter J, Cremers L, van Hattem M, et al. Clinical outcomes and end-of-life treatment in 596 patients with isolated traumatic brain injury: a retrospective comparison of two Dutch level-I trauma centers. European Journal of Trauma and Emergency Surgery [Internet]. 2024 [cited 2025 Jun 16];50(4):1249-1259. doi: 10.1007/s00068-023-02407-5

30. Joung JH, Park H. The effects of death anxiety and social support on the preferences for care near the end of life in older adults staying at long-term care hospitals: A cross-sectional, descriptive study. Journal of Korean Gerontological Nursing [Internet]. 2024 [cited 2025 Oct 16];26(1):102-112. doi: 10.17079/jkgn.2023.00199

31. Zaalberg T, Barten DG, van Heugten CM, Klijnsma P, Knarren L, Hiemstra Y, et al. Prevalence and risk factors of burden among caregivers of older emergency department patients. Sci Rep [Internet]. 2023 [cited 2025 Nov 6];13(1):7250. doi: 10.1038/s41598-023-31750-1

32. Organización Panamericana de la Salud. Cuidados paliativos [Internet]. Washington, DC: OPS; 2023 [cited 2026 Apr 15]. Available from: https://www.paho.org/es/temas/cuidados-paliativos

33. Worldwide Hospice Palliative Care Alliance; World Health Organization. Global atlas of palliative care the end of life [Internet]. Geneva: WHO; 2014 [cited 2025 Dec 16]. Available from: https://www.iccp-portal.org/sites/default/files/resources/Global_Atlas_of_Palliative_Care.pdf

34. European Association for Palliative Care. About us - EAPC [Internet]. [cited 2025 Oct 26]. Available from: https://eapcnet.eu/about-us/

Enfermería: Cuidados Humanizados, January-June 2026; *15*(1), e4825
DOI: 10.22235/ech.v15i1.4825

35. International Association for the Study of Pain. International Association for the Study of Pain [Internet]. [cited 2025 Jun 6]. Available from: https://www.iasp-pain.org/

36. World Health Organization. World health statistics 2021: monitoring health for the SDGs, sustainable development goals [Internet]. 2021 [cited 2025 Mar 6]. Available from: https://www.who.int/publications/i/item/9789240027053

37. Bezerra TPP, Nobre TTX, Pennafort VP dos S, Graça JRV da, Barra IP, Holanda G de OM, et al. Instrumentos para Avaliacao de pacientes Hospitalizados en Cuidados Paliativos: Revisao Integrativa. Cogitare Enfermagem [Internet]. 2024 [cited 2025 Dec 6];29:e95032. doi: 10.1590/ce.v29i0.95032

38. Büssing A. The Spiritual Needs Questionnaire in Research and Clinical Application: a Summary of Findings. J Relig Health [Internet]. 2021 [cited 2025 Mar 1];60(5):3732-3748. doi: 10.1007/s10943-021-01421-4

39. Jimam NS, Ismail NE, Dayom WD. Evaluation of Psychometric Quality of EQ-5D-5L Scale for Assessing Health-Related Quality of Life of Malaria Patients. Value Health Reg Issues [Internet]. 2020 [cited 2025 Jul 6];22:15-22. doi: 10.1016/j.vhri.2019.08.478

40. Lira MT, Caballero E. Adaptación transcultural de instrumentos de evaluación en salud: historia y reflexiones del por qué, cómo y cuándo. Rev Méd Clín Condes [Internet]. 2020 [cited 2025 Nov 1];31(1):85-94. doi: 10.1016/j.rmclc.2019.08.003

41. Rodríguez Acelas AL, Cañon Montañez W. Contribuciones de las escalas en salud como herramientas que influencian decisiones en el cuidado de los pacientes. Revista Cuidarte [Internet]. 2018 [cited 2025 Dec 16];9(1):1949. doi: 10.15649/cuidarte.v9i1.498

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