فصلنامه یافته های نوین درعلوم انسانی، علوم اجتماعی و روانشناسی سال 1405 - شماره 2- دوره3- صفحات162-140
Journal of New Findings in Social Sciences, Educational Sciences and Psychology
ISSN 3060-611X

# Nursing Roles in Palliative and End-of-Life Care for Older Adults: A Critical Narrative Review Across Clinical, Relational, Ethical, and Organizational Domains

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**Abstract**

Background ana Objective: Population aging, multimorbidity, frailty, dementia, and progressive chronic illness increase the need for palliative approaches that address physical, psychological, social, and spiritual suffering. Nurses are central to recognizing palliative needs, managing symptoms, facilitating communication, supporting families, and coordinating care across settings. To critically synthesize evidence on the clinical, relational, ethical, and organizational roles of nurses in palliative and end-of-life care for older adults across healthcare settings.

Methods: A critical narrative review was conducted using iterative, targeted, web-assisted retrieval of PubMed-indexed records, accessible PubMed Central full texts, official publisher pages, and reference lists. The retrieval was not exhaustive, and planned searches were not fully executed and logged across all relevant bibliographic databases. Eligible sources included primary studies and evidence syntheses concerning nursing in palliative or end-of-life care for older adults or relevant mixed-age populations. Findings were integrated thematically. The review did not involve independent duplicate screening, a formal study-level risk-of-bias assessment, a GRADE assessment, or meta-analysis.

Results: The selected literature covered seven interconnected domains: recognition and assessment of palliative needs; symptom assessment and comfort-focused care; communication and advance care planning; person-centered and ethical practice; family and caregiver support; coordination across settings; and professional and organizational conditions. The literature consistently described nurses as key relational and coordinating professionals. Intervention findings were less consistent. Advance care planning interventions increased documentation in nursing-home trials, but these gains did not consistently translate into higher family-rated satisfaction or demonstrated goal-concordant care. Dementia-focused studies described both the potential value and the limitations of structured pain assessment and nurse-led programs. Staffing, available time, education, specialist access, and moral distress were recurring contextual influences.

Conclusions: Nurses contribute through comprehensive assessment, symptom relief, communication, advocacy, family support, care coordination, and preservation of dignity. The evidence base is heterogeneous and frequently descriptive. Improvements in care processes should not be assumed to produce better comfort or more goal-concordant care. Further research focused specifically on older adults is needed, particularly in home and long-term-care settings.

**Keywords:** Aged; Palliative Care; Terminal Care; Nursing Care; Nurse’s Role; Advance Care Planning; Dementia; Frailty.

## 1. Introduction

Population aging is changing the epidemiology of serious illness and dying. A global projection study estimated that by 2060 approximately 48 million people each year—47% of all deaths worldwide—will experience serious health-related suffering, an 87% increase from 2016. The projected increase is greatest among people aged 70 years or older (183%), while dementia has the largest proportional increase among the conditions examined (264%) [36]. The World Health Organization has also reported that more than 55 million people were living with dementia worldwide and projected that this number could reach 139 million by 2050 [37]. These estimates indicate growing demand for palliative and end-of-life care across specialist services, nursing homes, community settings, and general hospital wards. For many older adults, serious illness follows a prolonged and unpredictable course rather than a brief, clearly defined terminal phase. Palliative care should therefore not be reserved for the final days of life. It can be introduced alongside disease-directed treatment and adapted as needs change. Contemporary definitions emphasize the prevention and relief of serious health-related suffering through early identification, careful assessment, and treatment of physical, psychosocial, and spiritual concerns, while also addressing the needs of families and caregivers [1-2].

Terminological boundaries matter. Palliative care is the broadest concept and may be introduced at any stage of serious illness alongside disease-directed treatment. End-of-life care generally refers to care provided as death approaches, although the relevant time frame is not standardized across health systems or studies. Terminal care commonly describes the final phase of life but is not a universally defined time-based category. Hospice refers to a particular service model or philosophy of care, with eligibility criteria and organizational arrangements that vary by jurisdiction; it is not synonymous with all palliative care. This review follows the terminology used in the cited sources while distinguishing the broader palliative trajectory from care delivered in the final days or hours of life [1-3].

Older adults often experience several symptoms and vulnerabilities simultaneously. Pain, dyspnea, fatigue, sleep disturbance, anorexia, constipation, anxiety, depression, delirium, loneliness, and existential distress may occur alongside cognitive impairment, sensory loss, polypharmacy, reduced mobility, and dependence in activities of daily living. Determining the cause and clinical significance of a symptom can be difficult when communication is impaired or when several chronic conditions contribute to the same presentation. Advanced dementia illustrates this challenge: a person may be unable to describe pain reliably, while behavioral changes may be interpreted as agitation, fear, or disease progression rather than as signs of untreated discomfort [3-4].

The setting of care also influences the needs of older adults and how those needs are addressed. Palliative care may be delivered in acute hospitals, primary care, patients' homes, nursing homes, hospices, or across transitions between these settings. In long-term care, staff may develop sustained relationships with residents and families, although staffing shortages, time constraints, and limited resources can restrict the care available. In acute hospitals, rapid changes in clinical condition and decisions about treatment escalation may complicate timely goals-of-care

discussions. In home-based care, continuity depends particularly on coordination, caregiver capacity, access to medicines, and the ability to respond promptly to deterioration [5-7,28].

Nurses are central to this continuum. Their frequent contact with patients allows them to observe changes over time and connect patients and families with the wider clinical team. Their responsibilities extend beyond clinical assessment and symptom management to include listening, emotional support, advocacy, preparation for dying, facilitation of decisions, coordination of care, and support after death. A scoping review of 55 papers mapped nursing contributions across seven professional-practice domains. Person-centered, interpersonal, and direct nursing-care activities were prominent, whereas evidence-based practice, safety, environmental management, and leadership were less visible in the included literature [13]. This pattern may indicate gaps in practice, but it may also reflect the under-documentation of relational work and the difficulty of measuring it using conventional indicators.

Existing reviews have examined nurses' contributions to palliative care more broadly, end-of-life practice in long-term care, communication in advance care planning, community-based services, and person-centered models in institutional settings [5,13,15,27-28]. More recent work has addressed competencies across the palliative nursing workforce and integrated approaches to care for older people living with frailty [29,35]. The present review does not claim to be the first to examine nursing in palliative care. Its purpose is to bring together issues specific to older adults across care settings and distinguish nursing processes from intermediate care outcomes and outcomes that matter directly to older adults and their families.

This review addresses the following question: What are the principal clinical, relational, ethical, and organizational roles of nurses in palliative and end-of-life care for older adults across healthcare settings, and which factors influence the quality and continuity of that care? Its objectives are to describe nursing contributions to comprehensive assessment and symptom relief; examine communication, advance care planning, and shared decision-making; analyze care needs associated with frailty, dementia, and multimorbidity; consider family support and bereavement; and identify professional and organizational factors that shape care delivery.

## 2. Methods

### 2.1. Review design and reporting approach

A critical narrative review was selected because the topic encompasses diverse forms of evidence, including qualitative accounts of nursing practice, observational studies, randomized and cluster-randomized trials, evidence syntheses, consensus recommendations, and methodological publications. The purpose was to interpret and integrate findings across these forms of evidence rather than estimate a single intervention effect, consistent with established guidance for narrative evidence synthesis [33]. The review is therefore presented as a critical narrative review, not as a systematic review, scoping review, or meta-analysis. SANRA informed attention to topic importance, review aims, search transparency, referencing, and presentation of evidence; no formal SANRA score was calculated [32].

### 2.2. Sources and search approach

An iterative, targeted, web-assisted retrieval process was undertaken on 12 November 2026 to identify PubMed-indexed records, accessible full-text articles in PubMed Central, and article pages hosted by official publishers. Retrieval was guided by concepts and free-text terms relating to palliative care, terminal care, hospice care, nursing, the nurse's role, older adults, aging, frailty, dementia, nursing homes, advance care planning, symptom assessment, family caregiving, and end-of-life communication. These concepts informed the targeted retrieval and the preparation of draft database strategies; they do not indicate that controlled-vocabulary terms were systematically entered and tested in every database. Reference-list checking was used to identify foundational studies and guidance cited in relevant reviews.

The retrieval process should be distinguished from a formal search executed and archived directly in the PubMed interface. The PubMed string in Appendix 1 is a proposed strategy for future execution, not a record of an archived search history. Draft strategies were also prepared for CINAHL, the Cochrane Library, Scopus, and Web of Science, but complete direct searches and exportable result sets from these databases were not obtained. No Embase search strategy or result set is documented in the materials available for this review. ScienceDirect was consulted as a publisher platform for selected article records, not as a substitute for a bibliographic database. PRISMA-S informed the intended description of search methods, but the review does not claim to have fulfilled PRISMA-S reporting requirements [34].

### 2.3. Eligibility and scope

The conceptual population comprised older adults, generally defined as people aged 60 years or older or 65 years or older, depending on the source and setting. No single age threshold was imposed across all sources because definitions of older age vary by country and research context. Cohorts explicitly described by the original authors as older or geriatric were also considered. English-language primary studies and evidence syntheses were considered; foundational publications predating the main contemporary evidence period were retained where needed to define palliative care, advance care planning, or established clinical tools.

Studies involving mixed-age populations were used when findings for older adults were reported separately or when the source was clearly relevant to nursing practice across the older-adult care continuum. Eligible source types included primary qualitative, quantitative, and mixed-methods research; randomized and nonrandomized intervention studies; systematic, scoping, and integrative reviews; consensus papers; and relevant clinical or methodological guidance. The concept of interest was the professional contribution of registered nurses and nursing staff to palliative or end-of-life care. Relevant settings included acute hospitals, nursing homes and long-term-care facilities, home care, community services, and hospice. Sources lacking a clear connection to nursing, older adults, or palliative care were not used to support substantive conclusions.

### 2.4. Data charting and thematic organization

For each source, the available bibliographic record and abstract or accessible full text were examined for study design, setting, population, participant group, nursing role, outcomes, principal findings, and reported limitations. Evidence was organized into seven domains: (1) comprehensive

assessment and recognition of palliative needs; (2) symptom assessment and comfort-focused care; (3) communication, advance care planning, and shared decision-making; (4) person-centered, ethical, cultural, and spiritual care; (5) family and caregiver support; (6) coordination and continuity across settings; and (7) professional competencies and organizational conditions.

Review articles were treated as secondary evidence and were not counted as independent primary studies. They were used to map the field and identify relevant primary research; primary studies were cited separately where their details could be verified. Overlap between reviews was not interpreted as independent replication. When a full text was unavailable, interpretation was limited to information supported by the bibliographic record or abstract. Numerical findings and effect estimates are reported as presented by the cited authors and were not recalculated for this review.

### 2.5. Critical appraisal and synthesis

No formal study-by-study risk-of-bias assessment was performed, and no GRADE certainty ratings were assigned by the authors of this narrative review. Study design, sample characteristics, setting, outcome type, and reported limitations were considered when interpreting findings. Randomized trials were treated as intervention evidence, qualitative studies as sources of insight into experiences and potential mechanisms, and reviews as maps or syntheses of existing evidence rather than proof of intervention effectiveness. Where a cited review reported its own risk-of-bias or GRADE assessment, that assessment is attributed to the review authors.

No pooled effect estimates were calculated because the studies differed in intervention content, setting, population, measurement instruments, and outcome definitions. The qualitative judgments in the evidence tables are author interpretations and should not be read as GRADE ratings. This design-aware approach does not replace formal critical appraisal. Independent duplicate screening, independent duplicate data extraction, and formal risk-of-bias procedures were not undertaken.

### 2.6. Registration and ethics

The narrative review was not prospectively registered. No new data involving human participants were collected; consequently, institutional ethics approval was not sought for the literature synthesis itself. Journal-specific requirements concerning review registration, protocol availability, and declarations should be checked after a target journal has been selected.

## 3. Findings

### 3.1. Comprehensive assessment and early identification of palliative needs

Recognizing when an older adult may benefit from a palliative approach is a core nursing responsibility, including when the person is not in a clearly terminal phase. Early identification is particularly relevant in nonmalignant illness, multimorbidity, and frailty, where disease trajectories are often variable and difficult to predict. Instruments such as the Supportive and Palliative Care Indicators Tool (SPICT), NECPAL, and the Surprise Question can support this process, but they should prompt clinical review rather than serve as definitive prognostic judgments. An umbrella review published in 2026 identified 29 instruments across 11 previous systematic reviews. Only eight instruments had clinical-performance data, and evidence concerning prognostic accuracy and effects on patient-centered outcomes was inconsistent [31].

Screening is only one component of a comprehensive nursing assessment. Assessment should encompass symptom burden, functional status, cognition, frailty, nutrition, medication burden, psychological distress, social support, caregiver capacity, spiritual concerns, and the patient's understanding and priorities. Because symptoms and goals may change as illness progresses, assessment should be repeated over time. Self-report remains central when patients can communicate reliably. In advanced dementia or delirium, nurses may need to combine observation, knowledge of the person's usual behavior, information from relatives, and validated observational instruments [3,20-23,25].

The nursing contribution extends beyond completing a standardized instrument. Nurses interpret findings in context, recognize changes and patterns, escalate concerns, document uncertainty, and coordinate further assessment. The 2025 European Association for Palliative Care (EAPC) consensus framework on frailty recommends an integrated palliative, geriatric, and rehabilitative approach across 11 domains and 34 recommendations. It emphasizes holistic person-centered care, communication, shared decision-making, comfort, dignity, and support for family carers [35]. This framework supports an approach in which nurses help preserve function and capacity while addressing suffering. Palliative care should not be taken to mean that rehabilitation or all disease-directed treatment must cease.

### 3.2. Symptom assessment and comfort-focused care

Symptom management is a core clinical component of palliative nursing. Pain, breathlessness, nausea, fatigue, constipation, sleep disturbance, anxiety, depression, and delirium require systematic assessment, with attention to interactions among symptoms, comorbidities, medications, and functional status. Older adults may present atypically, have altered pharmacokinetic and pharmacodynamic responses, or experience adverse effects that complicate standard treatment. Nursing assessment therefore involves repeated evaluation of symptom severity, functional impact, response to interventions, and treatment burden, followed by timely communication with prescribers and specialist services.

Pain assessment in dementia illustrates the challenges of identifying and managing symptoms when verbal self-report is limited. McAnee and colleagues identified 15 articles concerning tools for assessing pain near the end of life in dementia. They concluded that several formal tools were available but called for more robust research on pain measurement and management [21]. De Wolf-Linder and colleagues identified 37 articles relating to more than 2,600 nurses. Pain dominated the assessment literature, while relatively few studies addressed the broader range of palliative needs in dementia [22]. The 2025 scoping review by Overen and colleagues mapped pain-assessment processes in nursing homes, where communication impairment and limited opportunities for self-report complicate recognition [23].

A scoping review of pain assessment among nursing-home residents with dementia described a process involving awareness that pain may be present, suspicion of pain, and subsequent pain mapping. This account emphasizes repeated observation and interpretation rather than reliance on a single assessment score [23]. A review of nurses' experiences of pain management in end-of-life dementia care also identified gaps in education, difficulties recognizing pain, and challenges in using assessment tools [55].

Observational instruments such as the Pain Assessment in Advanced Dementia (PAINAD) scale can structure assessment when verbal self-report is unavailable [25]. They are aids to clinical judgment, not diagnostic gold standards. Scores need to be interpreted alongside baseline behavior, possible causes of distress, contextual information, and the person's response to a carefully monitored intervention. In a qualitative study involving 13 nurses from 12 Swedish nursing homes, Lundin and Godskesen described uncertainty in distinguishing pain from anxiety, challenges in balancing the potential benefits and harms of morphine, and the importance of knowing the resident, maintaining relationships with relatives, and having sufficient time [20]. Another qualitative study involving 24 nurses across nursing homes, hospices, and acute hospitals identified difficulties with analgesic administration and nurse–physician relationships, as well as a need for interactive learning and pharmacological support [24].

Intervention evidence supports the importance of recognizing and treating pain, although its applicability to end-of-life care requires careful interpretation. In a cluster-randomized trial involving 352 nursing-home residents with moderate-to-severe dementia and behavioral disturbance, a systematic, stepwise pain-treatment protocol reduced agitation compared with usual care [26]. The trial did not specifically examine care during the final days of life. It therefore supports structured pain assessment and treatment in dementia but does not establish that the same protocol improves end-of-life comfort in every palliative context.

A systematic review of nurse-led palliative interventions in advanced dementia included 23 studies from 12 countries (eight cluster-randomized trials, nine individual randomized trials, and six nonrandomized studies). The review authors reported improvements in care planning, communication, pain detection, caregiver support, and selected behavioral outcomes. Reported findings included care-planning documentation rates of at least 75%, reductions in caregiver decisional conflict of 20%–30%, increases in pain detection of 41%, reductions in pain scores of up to 30% with validated tools, and reductions in agitation of up to 25% with psychosocial interventions. Multicomponent models were also reported to reduce emergency visits and increase advance-directive completion by more than 40% [40]. These figures summarize heterogeneous interventions and outcomes; they should not be interpreted as a single pooled treatment effect. The review authors used RoB 2 and ROBINS-I and reported GRADE certainty ranging from high for advance care planning completion to moderate or low-to-moderate for other outcomes. They also identified variation in interventions and nurse preparation, limited fidelity monitoring, few resident-reported outcomes, and limited long-term caregiver data [40].

Comfort-focused nursing also involves nonpharmacological measures, including repositioning, mouth care, skin care, assistance with toileting, environmental modification, calm presence, sleep-promoting routines, and support for family presence. These measures do not replace indicated medication; they complement appropriate pharmacological treatment and may help reduce distress and preserve dignity. In a study of perspectives on end-of-life care in nursing homes, Tappen and Sopcheck found that residents, family members, and staff all valued comfort, although they described different concerns and approaches to achieving it [19].

### 3.3. Communication, advance care planning, and shared decision-making

Communication in palliative care is an ongoing process, not a single conversation initiated only when death is imminent. Through routine interactions, nurses may recognize when a patient is ready to discuss future care, identify changes in priorities, clarify information needs, and help ensure that the patient's values are communicated across the clinical team. International consensus statements define advance care planning (ACP) as a continuing process through which individuals clarify goals and preferences for future treatment and care, discuss them with family members and clinicians, and record and revise them as circumstances change [38-39]. ACP should remain voluntary and revisable, with the timing and depth of discussion adapted to the person's readiness and decision-making capacity.

A qualitative meta-synthesis of nurses' views on ACP for older people found that nurses generally considered themselves well placed to initiate or facilitate these discussions. Reported barriers included limited time, gaps in team knowledge, difficulties with teamwork, the care environment, language and cultural differences, and patients' or families' readiness. Education and organizational support were recurring needs [51].

The 2023 scoping review by Peerboom and colleagues examined end-of-life communication from the perspectives of nursing staff, older people, and family caregivers [15]. Subsequent qualitative research involving 17 nursing staff members across home, nursing-home, and hospital settings emphasized preparation, opportunities for open discussion, understandable language, sensitivity to different phases of a conversation, and interprofessional collaboration [16]. A 2025 interview study involving eight older people and four family caregivers identified conversational readiness, relational safety, recognition of the older person, and attention to caregiver well-being as important considerations [17]. These small qualitative samples provide insight into experience but cannot establish how common particular preferences are across older populations. Taken together, the studies indicate that communication depends on timing, trust, responsiveness, and adaptation to the older person's circumstances rather than adherence to a rigid script.

Intervention studies show that structured nursing involvement can improve some care-planning processes. In a randomized effectiveness trial involving 759 adults aged 65 years or older with multimorbidity and cognitive or physical impairment and/or frailty, a nurse navigator-led ACP pathway resulted in more newly documented ACP discussions in the electronic health record than usual care (42.2% versus 3.7%; $P<0.001$) [10]. The outcome was ACP documentation; it did not directly demonstrate improved symptom control, goal-concordant treatment, or quality of life.

A systematic review and meta-analysis of nine nursing-home trials involving 2,905 participants found that ACP interventions increased documentation of end-of-life preferences (odds ratio 1.95; 95% confidence interval 1.64–2.32), but did not significantly improve family-rated satisfaction (standardized mean difference 0.08; 95% confidence interval −0.08 to 0.23) [53]. Most interventions involved staff education or train-the-trainer approaches. Because the review excluded studies in which ACP formed part of a broader multicomponent intervention, it could not isolate the contribution of nurses within more complex programs [53].

A separate systematic review of randomized trials involving 3,646 adults older than 65 years across healthcare settings found that ACP interventions were generally well received and had positive effects on selected planning outcomes. The authors called for stronger evaluations of economic impact and quality of care in nursing homes [52]. A review of seven motivational-interviewing-based ACP interventions in older adults reported that this approach was feasible and could improve engagement in ACP. It also identified the feasibility of training lay counselors to deliver motivational-interviewing-based ACP in community settings; the review did not find an effect on health-service utilization [54].

A randomized trial of facilitated ACP involving 309 legally competent medical inpatients aged 80 years or older found that, among the 56 patients who died during follow-up, end-of-life wishes were more likely to be known and followed in the intervention group than in the control group (86% [25/29] versus 30% [8/27]; P<0.001) [9]. Family members of intervention-group patients who died also reported lower stress, anxiety, and depression. Although this was not a nurse-only intervention, the findings support the potential value of structured conversations and documentation, in which nurses may have an important facilitating and coordinating role. An earlier randomized nursing-home trial of the Let Me Decide program found fewer hospital admissions and lower health-service costs in intervention homes, with no significant differences in resident or family satisfaction or mortality [12].

In advanced dementia, family members or legally authorized representatives may need to participate in decisions because the person may no longer be able to communicate complex preferences. Nurses can help identify previously expressed wishes, explain clinical changes in accessible language, support surrogate decision-makers, and advocate for care that reflects the person's values. Legal standards governing capacity, substitute decision-making, and surrogate authority vary across jurisdictions. Nurses should therefore follow applicable law and institutional policy rather than assume that the nearest relative automatically has legal authority to make decisions. A goals-of-care intervention trial in advanced dementia is relevant to this issue, although the intervention was multidisciplinary rather than exclusively nurse-led [11].

### 3.4. Person-centered care, dignity, and ethical practice

Person-centered care requires that older adults be understood as individuals with histories, identities, relationships, preferences, and sources of meaning, rather than solely as recipients of symptom-control interventions. Nursing practice includes asking what matters most to the person, supporting autonomy where possible, protecting privacy, respecting cultural and spiritual practices, and adapting routines to individual preferences. Cognitive impairment does not mean that a person has no preferences or cannot participate in any aspect of care. When direct participation is limited, nurses should consider previously expressed wishes, known values, behavioral cues, and appropriate input from surrogates, while continuing to attend to the person's present comfort and responses.

The 2026 integrative review of person-centered palliative care models for institutionalized older adults included nine empirical studies. Shared decision-making, respect for individual values, family involvement, autonomy, and holistic care were recurring principles. Reported barriers included limited staff qualifications, time pressure, poor working conditions, and insufficient

institutional support. Leadership, staff motivation, and continuing education were identified as facilitators [27]. The evidence was limited by heterogeneity, the predominance of studies from Sweden, and limited representation of older adults' own perspectives. The nine included studies were identified by that review and should not be mistaken for the number of sources in the present narrative review.

Qualitative research on older adults dying in nursing homes has identified physical discomfort, loneliness, depression, and limited spiritual support as concerns that may coexist near the end of life [6]. These findings draw attention to social connection, meaningful activity, family presence, and existential concerns even when curative treatment is no longer appropriate. The EAPC consensus on palliative care in dementia similarly emphasizes personhood, shared decision-making, and care tailored to the particular challenges associated with dementia [3].

Long-term-care studies provide further detail on how nurses enact dignity in practice. A grounded-theory study based on interviews with 22 nurses from eight Japanese long-term-care settings described end-of-life nursing as guiding and rebuilding a care community around the dying resident. The process involved assessing the resident's stage, aligning care with the dying process, supporting community members, and helping them find meaning in their contribution [43]. A qualitative study of 12 nurses in long-term-care facilities identified nine categories and 30 subcategories of nursing roles, including care planning, clinical judgment, multidisciplinary coordination, support for caregivers when nurses were absent, and reflection on care [44]. These findings are context-specific and should not be generalized uncritically beyond the settings studied.

Ethical challenges also arise from the emotional and organizational consequences of care. A systematic review of geriatric nurses' experiences described moral distress, grief, compassion fatigue, and burnout, although the underlying studies were generally small, with samples ranging from 6 to 126 nurses [41]. A systematic review of 22 studies on ethical issues in nursing decision-making at the end of life identified challenges in communication, autonomy, beneficence, and the involvement of patients in decisions, alongside a need for education and organizational support [42]. A separate review of 13 studies grouped ethical challenges in palliative nursing into communication with patients and families, decision-making involving autonomy and dignity, and moral distress [61]. These reviews were not restricted to older adults and therefore provide contextual rather than geriatric-specific evidence.

In a qualitative study involving 19 nurses working in long-term-care wards, acute-care wards, and hospice services in western Japan, nurses described the challenge of balancing patients' daily-life quality with life-sustaining treatment under uncertainty about individual preferences. The study also found that nurses' evaluations of their own care were influenced by families' responses after the patient's death [45]. Ethical nursing practice therefore involves balancing autonomy and protection, responding to uncertainty about decision-making capacity, addressing family disagreement, avoiding non-beneficial treatment, and managing moral distress. Moral distress may occur when nurses believe that a course of care conflicts with a patient's interests or preferences but feel unable to influence decisions because of professional hierarchy, limited authority, staffing pressures, or organizational constraints [29,41-42,61]. Ethical reflection, access to senior

consultation, transparent communication, and organizational support are relevant to the conditions under which safe and person-centered care can be delivered.

### 3.5. Family, spiritual, and informal caregiver support

Families and informal caregivers often provide essential practical, emotional, and informational support to older adults living with advanced illness. Their needs may include clear information about disease progression, symptom management, medication use, signs of dying, available services, and appropriate responses to distress or deterioration. Nurses can assess caregiver strain, identify information gaps, facilitate family meetings, support appropriate participation in care, and provide guidance before and after death.

Auclair and Bourbonnais explored caregiver involvement in end-of-life care in a single long-term-care home through a qualitative case study involving seven participants, including nurses and relatives [18]. Their findings draw attention to contributions that extend beyond formal care planning, such as being present, providing comfort, sharing knowledge about the older person, and participating in everyday care. The single-site setting and small sample provide contextual insight but limit transferability. The 2025 Peerboom study also highlights the need to recognize family caregivers' well-being and their role in communication, rather than treating them solely as sources of information [17].

Family involvement must be negotiated in accordance with the older person's preferences and circumstances. Confidentiality, decision-making capacity, family relationships, and the availability of relatives may vary considerably. Nurses should not assume that all family members are available, supportive, or legally authorized to make decisions. Support should also include realistic expectations and clear boundaries. Relatives should not be expected to provide professional-level care without appropriate information, preparation, and support.

Spiritual and existential concerns form part of person-centered palliative care. A systematic review of 11 studies found that spiritual care was shaped by nurses' holistic perspectives, personal spirituality, life experience, and professional practice with dying people. The review identified time, relationships that allow patients to disclose needs, and supportive work environments as conditions for spiritual care [58]. A separate review of 42 studies involving 4,712 nurses identified personal, organizational, and patient-related determinants of spiritual and existential care and reported that nurses provided such care less often than patients desired [59]. Both reviews included mixed-age populations; their findings should therefore be treated as contextual evidence rather than as estimates specific to older adults.

Care after death is part of the broader palliative trajectory. Nurses may prepare family members for expected changes, provide opportunities to say goodbye, explain immediate practical arrangements, and acknowledge grief reactions. A 2026 systematic review of nurses' roles during death and bereavement included 22 studies and described nursing activities and challenges during this period [30]. Its findings were not limited to older-adult populations and are used here as contextual evidence.

A systematic review of family grief, loss, and bereavement in residential aged care identified 2,023 records and included 35 studies (28 qualitative and seven quantitative intervention studies). Family

experiences were influenced by the quality of care before and after death, communication about decline, involvement in care, and preparation for death. Educational interventions showed potential benefits, but relatively few interventions were identified, and the review was not nursing-specific [60]. Direct evidence on nurse-delivered bereavement interventions for families of older adults remains limited.

### 3.6. Coordination and continuity across care settings

Older adults with advanced illness may move between care settings, and these transitions can disrupt symptom management, medication reconciliation, documentation of preferences, and communication with families. Nurses contribute to continuity by communicating changes in condition, transferring care plans, coordinating referrals, preparing families for discharge, clarifying whom to contact, and ensuring that patients' goals and treatment preferences are communicated across services.

A 2026 scoping review of community-based palliative care for older adults included 16 studies describing 17 initiatives and encompassing 56,581 older adults. Most initiatives were multidisciplinary and home-based; all included symptom management, care coordination, and ACP. Implementation strategies and determinants operated at multiple levels, including alignment with older adults' needs, organizational readiness, coordination across sectors, workforce capacity, and intervention characteristics [28]. As a scoping review intended to map service models, it did not formally appraise the methodological quality of the included studies. Its findings describe service components and implementation patterns rather than comparative effectiveness.

A systematic review of nursing-home palliative-care interventions, which was not specific to nursing, found that three trials involving specialist palliative-care consultation teams reported reductions in potentially burdensome care, including emergency-department visits and hospital transfers. Other trials improved selected aspects of palliative-care delivery and symptom assessment, although effects on additional outcomes were less clearly demonstrated [46]. These findings suggest a possible contribution from specialist consultation, but they do not isolate the effect of nursing interventions.

In acute inpatient settings, nursing responsibilities include recognizing palliative needs alongside active treatment, communicating changes in prognosis and goals, coordinating specialist input, and supporting safe transitions. A 2025 scoping review of palliative nursing in acute inpatient settings mapped a broad range of nursing functions and identified the need for role clarity and institutional support [14]. The broader contribution of nurses across the palliative continuum was also mapped in the 2024 review by Moran and colleagues [13].

### 3.7. Professional competencies, education, and organizational conditions

Palliative nursing competence encompasses clinical assessment, symptom management, communication, ethical reasoning, psychosocial and spiritual care, teamwork, leadership, documentation, and evidence-informed practice. A systematic review published online on 11 September 2026 included 23 original studies comprising approximately 11,600 participants from 12 countries. The evidence was predominantly cross-sectional and concentrated in hospital, intensive-care, and oncology settings. The review identified gaps in ACP, spiritual care, ethical

decision-making under moral distress, and leadership; reliance on self-reported measures limited confidence in estimates of objective competence [29]. The review was not restricted to older adults, so its findings inform general palliative nursing competence but cannot be assumed to represent geriatric-specific competence.

Education is necessary, but its effects may be limited when it is not accompanied by changes in the working environment. A systematic review of staff-training interventions in nursing homes included 16 cluster-randomized trials. The higher-quality trials provided little evidence of improvement in resident quality of life or quality of dying, although one higher-quality trial reported fewer hospitalizations [8]. An earlier systematic review also called for more rigorous evaluation of education and training interventions, including outcomes for residents, families, staff, and health-service costs [56].

A cluster-randomized trial in 20 long-term-care wards in Helsinki recruited 324 residents with a possible need for end-of-life care and provided staff with four small-group educational sessions, each lasting four hours. The intervention did not improve residents' health-related quality of life or reduce hospital use; total hospital costs were similar between groups [57]. The PACE cluster-randomized trial likewise found no statistically significant improvement in resident comfort during the last week of life (adjusted mean difference, −0.55; 95% confidence interval −1.71 to 0.61; P=0.35), despite a statistically significant but clinically small increase in staff knowledge [7]. These findings indicate that education alone may be insufficient to improve resident-level outcomes. Educational interventions need to be accompanied by mentoring, protected time, leadership support, clear clinical pathways, access to specialist advice, and mechanisms for evaluating outcomes that matter to patients.

Long-term-care research also illustrates the relationship between nursing responsibilities and organizational authority. Nasu and colleagues synthesized 20 qualitative studies and identified multidimensional roles in helping residents die with dignity, the need for resources and support to sustain professional commitment, and a mismatch between nurses' responsibilities and their power in multidisciplinary teams [5]. Findings from Japanese long-term-care settings similarly describe the need for nurses to coordinate information, support families, guide staff, and reflect on care [43-44]. Expectations placed on nurses should therefore be matched by appropriate authority, staffing, access to prescribers, and reliable interprofessional collaboration.

Community and home-based evidence adds further detail. A scoping review of nursing care for people whose preferred place of death was home included 13 studies, 11 qualitative and two combining qualitative and quantitative methods. It identified staff shortages, limited resources, educational gaps, flexibility, collaboration, and family caregiving as central issues [47]. An integrative review of community palliative nursing emphasized the need for a skilled workforce and specialized training in difficult conversations and service coordination, while noting the lack of evidence on how nurses manage the stressors of this work [48].

An integrative review of 55 studies on nursing activities in palliative home care identified six themes: creating meaningful relationships, providing medical information, promoting self-care throughout the illness trajectory, offering emotional support, involving professional or community services, and supporting change. The review found that nursing activities focused mainly on

individual circumstances and direct care; the relationship with the wider community was less developed. People with cognitive impairment were excluded, which limits application to some older populations [49]. A review of nurse-delivered telehealth in home-based palliative care included 34 papers describing 29 primary studies and identified roles in coordination, coaching, navigation, and case management, alongside multilevel implementation facilitators and barriers [50]. Telehealth may support continuity, but its suitability for older people facing sensory, cognitive, or digital-access barriers requires specific evaluation.

Time, staffing, and resources recur across settings. They are described as scarce in the broader review of nursing roles [13], as barriers to home-based care [47], as constraints on ACP conversations [51], and as conditions for spiritual care [58-59]. The COVID-19 pandemic further exposed the dependence of end-of-life care on staffing, family access, and staff well-being. A mixed-methods review of care homes found that visiting restrictions were among the most frequently reported changes and that staff often lacked adequate emotional support and time to grieve [62]. These findings illustrate how system-level disruption can intensify existing weaknesses in communication and continuity.

### 3.8. Summary matrix of the evidence

Table 2 summarizes the nursing functions described in the selected literature and proposes indicators that could be used in practice evaluation and future research. The indicators are candidates for evaluation, not validated measures or outcomes established by the present review.

**Table 1. Selected evidence informing the review**

| Source | Design / population | Contribution to synthesis | Interpretive limitation |
|---|---|---|---|
| Nasu et al., 2020 [5] | Qualitative systematic review; 20 studies; long-term care for older adults | Nurses perform multidimensional work to preserve dignity; resource constraints and limited role authority recur. | Geriatric and nursing focused; underlying evidence is qualitative. |
| Moran et al., 2024 [13] | Scoping review; 55 papers; mixed palliative populations | Person-centered, interpersonal, and direct nursing-care contributions were prominent; evidence on assessment, intervention, and evaluation was less visible. | Broad palliative population; not restricted to older adults. |
| Gabbard et al., 2021 [10] | Randomized effectiveness trial; 759 older adults with multimorbidity or vulnerability | A nurse navigator-led ACP pathway increased documentation of ACP discussions (42.2% vs 3.7%). | Documentation is a process outcome, not proof of goal-concordant care or quality-of-life benefit. |
| PACE trial, 2020 [7] | Cluster-randomized trial; 78 nursing homes in 7 countries | No significant improvement in comfort in the last week of life; staff knowledge increased by a statistically significant but clinically small amount. | Implementation and contextual constraints may influence effects. |
| Lundin & Godskesen, 2021 [20] | Qualitative interviews; 13 nurses in 12 Swedish nursing homes | Pain assessment in advanced dementia is complicated by communication and relational challenges; familiarity and family involvement may help. | Small qualitative sample; transferability is context dependent. |
| de Wolf-Linder et al., 2022 [22] | Scoping review; 37 articles relating to more than 2,600 nurses | Nursing needs assessment in dementia focuses heavily on pain, with less attention to other palliative needs. | Included evidence and assessment methods varied by setting. |

| Source | Design / population | Contribution to synthesis | Interpretive limitation |
|---|---|---|---|
| Pujante et al., 2025 [40] | Systematic review; 23 studies from 12 countries | Review authors reported improvements in care planning, communication, pain detection, caregiver support, and selected behavioral outcomes. | Heterogeneous interventions and measures; limited long-term and resident-reported outcomes. |
| Ng et al., 2022 [53] | Systematic review and meta-analysis; 9 nursing-home trials; 2,905 participants | ACP increased documentation of preferences (OR 1.95; 95% CI 1.64–2.32) but not family-rated satisfaction (SMD 0.08; 95% CI −0.08 to 0.23). | Process gains did not establish improved care concordance or family experience. |
| Peerboom et al., 2025 [17] | Qualitative interview study; 8 older people and 4 family caregivers | Relational safety, recognition, readiness, and caregiver well-being were relevant to end-of-life communication. | Small qualitative sample; does not estimate prevalence of preferences. |
| Xie et al., 2026 [28] | Scoping review; 16 studies, 17 initiatives, 56,581 older adults | Community models integrated symptom management, care coordination, and ACP; implementation depended on multilevel factors. | Scoping review mapped models and did not formally appraise included study quality. |
| Marques et al., 2026 [27] | Integrative review; 9 institutional-care studies | Person-centered care was associated with autonomy, family involvement, communication, leadership, and workforce support. | Heterogeneity and limited representation of older adults' own perspectives. |
| Khalilzadeh-Farsangi & Fallah-Karimi, 2026 [29] | Systematic review; 23 studies; approximately 11,600 participants | Competency gaps were reported in ACP, spiritual care, ethical reasoning, and leadership. | Most studies were cross-sectional and not geriatric specific; self-report predominated. |
| Lamppu et al., 2021 [57] | Cluster-randomized trial; 324 residents in 20 long-term-care wards | Four staff education sessions did not improve resident quality of life or hospital use. | Single trial in a specific health system; educational intervention alone may not represent broader implementation models. |
| Carpenter et al., 2020 [46] | Systematic review of nursing-home palliative-care interventions | Three trials of specialist palliative-care consultation teams reported reductions in potentially burdensome care. | Review was not nursing-specific; effects cannot be attributed to nurses alone. |

*Abbreviations: ACP, advance care planning; CI, confidence interval; OR, odds ratio; SMD, standardized mean difference.*

## Table 2. Nursing roles and candidate indicators for practice and research

| Domain | Nursing actions | Candidate indicators | Key caution |
|---|---|---|---|
| Need recognition | Screening followed by comprehensive geriatric and palliative assessment; repeat review as condition changes. | Needs recognized, documented, and escalated appropriately. | Tools support but do not replace clinical assessment or prognostic judgment. |
| Symptom relief | Use self-report where possible; use observational assessment when communication is limited; reassess treatment response. | Pain and distress relief, comfort, adverse effects, functional burden. | Dementia and multimorbidity can obscure symptom expression. |
| Communication and ACP | Explore values and readiness; explain options; document preferences and surrogate information; revisit decisions. | Communication quality, ACP documentation, concordance between preferences and care. | Documentation alone does not demonstrate concordance or benefit. |
| Dignity and ethics | Respect identity, privacy, autonomy, culture, spirituality, and known wishes. | Perceived dignity, respect, trust, and ethical consistency. | These outcomes are difficult to quantify and may be under-recorded. |
| Family support | Assess caregiver needs; provide information and emotional support; invite appropriate participation. | Caregiver understanding, strain, confidence, and bereavement support. | Family roles and capacity vary; avoid assuming uniform preferences. |
| Coordination | Handover, medication reconciliation, referral, discharge planning, and continuity of goals. | Reduced fragmentation, timely access, and continuity of care. | Requires service integration and clear role accountability. |

| Domain | Nursing actions | Candidate indicators | Key caution |
|---|---|---|---|
| Professional and system support | Education, mentoring, reflective practice, leadership, adequate staffing, and specialist access. | Competence, staff confidence, reduced moral distress, and reliable care processes. | Education alone may not improve resident-level outcomes. |

## 4. Discussion

This critical narrative review brings together evidence on the clinical, relational, ethical, and organizational functions of nurses in palliative and end-of-life care for older adults. Nurses recognize changing needs, assess symptoms, support comfort, facilitate communication, advocate for patients' preferences, involve families, coordinate transitions, and help preserve dignity. These activities extend across the illness trajectory and are not confined to the final days of life. Some aspects of nursing practice remain under-represented in formal measurement: direct interventions and documentation are relatively easy to record, whereas presence, trust-building, attentive listening, and adaptation to a person's values are more difficult to capture using conventional indicators [13].

A key distinction is that between improvements in care processes and improvements in outcomes experienced by patients and families. The Gabbard trial found that a structured nurse navigator pathway increased documentation of ACP discussions [10]. The Detering trial suggests that facilitated ACP can increase the likelihood that end-of-life wishes are known and followed, although the intervention was not nurse-only [9]. The nursing-home ACP meta-analysis found increased documentation but no significant improvement in family-rated satisfaction [53]. The PACE trial did not demonstrate improved comfort during the last week of life despite a small increase in staff knowledge [7], and the review of nursing-home training interventions found little evidence of resident-level benefit across higher-quality trials [8]. These findings do not support the assumption that education, documentation, or implementation of a care pathway will automatically improve comfort, quality of life, or goal-concordant care.

The PACE findings should not be interpreted as evidence that palliative nursing programs are ineffective. Rather, they illustrate the difficulty of translating broad educational and organizational interventions into measurable patient outcomes. The program addressed a broad care trajectory, whereas its primary comfort outcome focused on the final week of life. The trial also identified contextual limitations, including staff turnover and workload, and raised the possibility that standardized intervention components may not fit every nursing-home context [7]. The separate Helsinki trial similarly found no improvement in resident quality of life or hospital use after staff education [57]. Future programs should retain core standards while allowing local adaptation, ensure that staff have sufficient time and authority to respond to identified needs, and provide specialist support for complex symptoms.

Dementia makes the importance of person-specific nursing knowledge particularly apparent. When verbal self-report is limited, nurses must interpret behavior, compare it with the person's usual pattern, obtain information from relatives, and use observational instruments when appropriate [20-25,55]. Distinguishing pain from fear, anxiety, delirium, or other forms of distress requires contextual assessment and repeated evaluation. Continuity of staff and adequate time may

strengthen the reliability of these assessments. Conversely, staff turnover and fragmented care can undermine the relational knowledge on which interpretation depends.

The nurse-led dementia review reported improvements across care planning, communication, pain detection, and caregiver-related outcomes, but the interventions and outcome measures were heterogeneous [40]. The review also noted that few studies assessed whether documented preferences were reflected in care actually delivered. Its findings are therefore promising but do not establish that all nurse-led programs produce durable improvements in comfort or goal-concordant care. Future studies should report intervention fidelity, adverse effects, resident-reported outcomes where possible, and longer-term caregiver outcomes.

Frailty and multimorbidity call for integrated care. The 2025 EAPC white paper supports combining palliative care with geriatric and rehabilitative approaches, taking account of both care needs and remaining capacities [35]. Comfort and function should not be treated as competing objectives. Palliative care may involve symptom relief, prevention of avoidable complications, mobility support, and decisions about nutrition and hydration that reflect the person's goals, as well as the maintenance of meaningful activity. Nurses help align these measures with the person's priorities and changing clinical condition.

Communication and shared decision-making should not be treated as tasks reserved exclusively for physicians. Nurses may identify concerns, prepare patients and families for discussions, clarify information already provided, recognize discrepancies between stated preferences and current care plans, and support continuity in decision-making. Role clarity and scope of practice nevertheless remain important. Nurses can facilitate discussion and advocate for patients while ensuring that complex prognostic and treatment decisions are addressed by the clinicians responsible for them. Family involvement should be encouraged when consistent with the patient's preferences and applicable legal authority; relatives should not automatically be presumed to speak for every older person.

Family support is both an ethical responsibility and a practical component of continuity of care. Relatives may provide information about a person's history and usual behavior, help interpret nonverbal signs of distress, and contribute to decisions where appropriate. They may also experience caregiver burden, uncertainty, anticipatory grief, and bereavement. Nurses can address information gaps and help families prepare for changes in the patient's condition, but they cannot compensate on their own for inadequate service capacity or insufficient community support. Evidence from residential aged care suggests that the quality of care before and after death, communication about decline, and family involvement influence grief experiences [60].

Professional competence is inseparable from organizational capacity. The mismatch between responsibility and authority identified in qualitative nursing research [5], together with competency gaps described in the 2026 systematic review [29], suggests that additional training alone is unlikely to be sufficient. Education needs to be embedded in supportive systems that provide mentoring, interprofessional learning, access to specialist advice, time for communication, psychologically safe escalation processes, and leadership that recognizes relational care as part of clinical practice. Evaluation should extend beyond task completion to include patient comfort, whether documented preferences are respected, family experience, continuity of care, and staff well-being.

### 4.1. An integrative model for practice

The findings can be organized into a practical model comprising four mutually reinforcing layers. The first concerns the older adult's needs and capacities, including symptoms, function, cognition, frailty, values, relationships, and social context. The second represents the nurse's direct contribution through assessment, comfort measures, communication, advocacy, family support, and coordination. The third comprises the interprofessional and service environment, including prescriber availability, specialist palliative care, primary care, rehabilitation, social care, and community support. The fourth is the organizational foundation: staffing, education, role clarity, leadership, documentation systems, and quality improvement. A weakness in any layer may interrupt the translation of nursing activities into improved outcomes. This model is a conceptual synthesis developed by the authors of the present review; it has not been independently validated.

### 4.2. Implications for clinical practice

- Integrate recognition of palliative needs into routine geriatric assessment. Initiate a comprehensive review when there is progressive decline, recurrent crisis-related service use, increasing symptom burden, advanced frailty, or concern expressed by the patient or family.
- In dementia, combine patient self-report where possible with observation, validated assessment tools, and information from family members. Document uncertainty and reassess the response to treatment.
- Offer ACP as a voluntary, iterative process that explores values and preferences, records information about surrogate decision-makers, and is revisited after major changes in health status.
- Protect time for relational care and communication with families, including preparation for the dying phase and support after death.
- Link education with case-based mentoring, interprofessional review, specialist referral pathways, and organizational authority to act on identified needs.
- Evaluate care processes and patient outcomes separately. For example, assess ACP documentation alongside concordance between preferences and care, and evaluate staff training in relation to comfort, symptom burden, and family outcomes.

### 4.3. Implications for research

Future research should prioritize older-adult-specific samples and report findings separately for dementia, frailty, multimorbidity, cancer, and noncancer conditions. Prospective studies are needed to examine whether identifiable nursing practices—such as repeated symptom assessment, continuity with a named nurse, structured family communication, and nurse-coordinated transitions—are associated with changes in patient comfort, symptom burden, goal-concordant care, caregiver outcomes, or avoidable acute-care use.

Studies should use validated outcome measures, distinguish self-reported from proxy-reported outcomes, and report implementation fidelity and contextual factors. Qualitative research should continue to include older adults' own perspectives, particularly those of cognitively intact people who remain underrepresented in institutional studies. Greater attention should also be given to cultural and socioeconomic diversity. Table 3 presents research priorities derived from the gaps identified in the selected literature.

**Table 3. Research priorities derived from the identified evidence gaps**

| Priority | Evidence-based rationale | Suggested design |
|---|---|---|
| Effectiveness of nursing contributions in older populations | ACP trials show process benefits, while the nursing-home meta-analysis did not demonstrate higher family satisfaction [53]; nurse-led dementia interventions are heterogeneous [40]. | Cluster-randomized or stepped-wedge trials with process evaluation, implementation-fidelity monitoring, and patient-centered outcomes. |
| Concordance between documented wishes and delivered care | The dementia intervention review found that only a small number of included studies assessed whether documented preferences were reflected in care [40]. | Prospective cohort or intervention study combining record audit with patient or proxy interviews. |
| Core outcome set including resident- and proxy-reported outcomes | Resident-reported outcomes were limited in dementia intervention studies, while ACP documentation did not consistently improve family-rated satisfaction [40,53]. | Consensus study, such as a Delphi process, followed by psychometric validation. |
| Interventions addressing staffing, moral distress, and nurse well-being | Moral distress and inadequate organizational support recur in nursing evidence [41-42,61-62]; stand-alone training has shown limited resident-level effects [7,57]. | Pilot randomized or quasi-experimental studies with mixed-methods process evaluation. |
| Home, community, family, and bereavement support for older adults | Home-care reviews identify workforce and coordination constraints [47-50]; few studies evaluate nurse-delivered bereavement support [60]. | Mixed-methods feasibility studies, service evaluations, and prospective registries. |
| Settings beyond high-income countries | Dementia intervention evidence is concentrated in well-resourced settings [40], limiting transferability. | Context-adapted implementation studies with explicit reporting of health-system and cultural factors. |

## 5. Limitations

This review has several methodological limitations. First, the retrieval process was targeted and web-assisted rather than exhaustive. It relied on PubMed-indexed records identified through web-assisted searching, accessible PubMed Central material, publisher pages, and reference-list checking. It did not include a complete search executed and logged directly in the PubMed interface. Draft strategies were prepared for CINAHL, the Cochrane Library, Scopus, and Web of Science, but complete result sets from these databases were not retrieved and deduplicated. Embase was not searched as part of the documented retrieval. The selected sources should therefore not be interpreted as a complete or unbiased representation of all relevant literature, and the review cannot claim comprehensive database coverage.

Second, study selection and data charting were not conducted independently by two reviewers. The number of sources cited should not be interpreted as the result of a formal, exhaustive screening process. No PRISMA flow diagram or screening denominator is presented. Third, full texts were not available for every source. Where only an abstract or bibliographic record could be accessed, interpretation was restricted to the information reported in that material.

Fourth, no formal study-level risk-of-bias assessment or GRADE evaluation was undertaken by the authors of this review. The synthesis uses design-aware interpretation but does not provide quantitative ratings of evidence certainty. Fifth, primary studies and reviews differed substantially in setting, population, interventions, outcomes, and methodological quality, precluding a defensible meta-analysis. Finally, some sources addressing general palliative nursing competence, spiritual care, ethics, community nursing, and bereavement involved mixed-age populations or were not

nursing-specific. These sources are used as contextual evidence and should not be regarded as direct evidence of geriatric-specific effects.

## 6. Conclusion

Nurses contribute to palliative and end-of-life care for older adults through comprehensive assessment, symptom relief, communication, advance care planning, advocacy, family support, care coordination, and preservation of dignity. Dementia, frailty, and multimorbidity make individualized assessment and continuity of relationships particularly important. Nurse-led approaches can improve care processes, including ACP documentation, but such improvements do not necessarily lead to better comfort or quality of life. Translation into patient benefit depends on adequate staffing, appropriate professional authority, interprofessional collaboration, access to specialist support, and systematic outcome monitoring. Further research focused specifically on older adults is needed to identify nursing practices that improve comfort, goal-concordant care, caregiver well-being, and continuity across settings.

## 7. Declarations

### Authors' Contributions

All authors contributed to the preparation of this manuscript.

### Conflict of Interest

The authors declare that there is no conflict of interest regarding the publication of this article.

### Funding

This work received no financial support from any funding agency in the public, commercial, or non-profit sectors.

**Data availability:** No new datasets were generated for this narrative review. The cited publications constitute the evidence base. If the search is expanded before submission, the final search log and source-extraction file should be archived and made available in accordance with journal policy.

**Ethics statement:** Ethical approval was not required for this review of published literature; confirm this statement against the target journal's policy.

### Acknowledgments

The authors would like to express their sincere appreciation to all individuals who provided guidance and assistance during the preparation of this manuscript.

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