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EMERGENCY DEPARTMENT STAFF PRIORITIES FOR IMPROVING PALLIATIVE CARE PROVISION FOR OLDER ADULTS: A SYSTEMATIC REVIEW

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Abstract

Background: Older adults with life-limiting conditions often present to emergency departments (EDs) in acute distress, yet these settings are not traditionally designed to deliver comprehensive palliative care. Integrating palliative principles into ED workflows can improve quality of life, align care with patient preferences, and reduce unnecessary interventions.

Objective: To synthesize empirical evidence on the priorities, barriers, and facilitators for improving palliative care provision for older adults in ED settings.

Methods: This systematic review followed PRISMA 2020 guidelines. Databases including PubMed, Scopus, Web of Science, and Embase were searched for peer-reviewed studies published between 2010 and 2025. Eligible studies involved older adult populations, explored palliative care within EDs, and reported quantitative or qualitative outcomes related to barriers, facilitators, and service priorities. Data extraction and quality appraisal were conducted independently by two reviewers.

Results: Twenty-one studies met inclusion criteria, encompassing qualitative, cross-sectional, cohort, and randomized designs. Key findings included: (1) persistent late initiation of palliative care; (2) significant gaps in clinician training and confidence; (3) systemic barriers such as time constraints, lack of privacy, and fragmented care pathways; and (4) facilitators including structured screening tools, multidisciplinary teams, and improved ED–community linkages. Alignment was observed between patient/family and provider priorities, but implementation was hindered by structural and cultural barriers.

Conclusions: ED-based palliative care for older adults requires systemic integration, targeted education, and institutional support. Screening tools and multidisciplinary pathways can enhance early identification and care coordination. Addressing inequities in access and embedding palliative approaches across the continuum of care are essential for sustainable improvement.

Keywords: Palliative care; Emergency department; Older adults; End-of-life care; Barriers; Facilitators; Systematic review; Multidisciplinary care; Screening tools; Care pathways

INTRODUCTION

According to the World Health Organization, palliative care is a comprehensive approach aimed at enhancing the quality of life for individuals with life-threatening illnesses and their families. It involves the early identification, thorough assessment, and effective management of pain and other distressing symptoms—whether physical, psychological, social, or spiritual—to alleviate suffering and provide holistic support throughout the course of the illness (World Health Organization, 2022). In the coming decades, older adults with multimorbidity are expected to represent the majority of individuals requiring palliative care. However, their specific needs remain poorly understood, and they continue to be inadequately served by existing palliative care systems. Several factors contribute to this gap, including the complexity and unpredictability of disease progression associated with frailty and non-malignant conditions, which complicates the timely recognition of palliative needs and the initiation of end-of-life care. Additionally, many palliative care services have traditionally been structured around single-disease models, limiting their responsiveness to the multifaceted needs of this population (Bennett et al., 2016; Bausewein et al., 2010). Furthermore, structural inequalities associated with ageing present significant barriers to equitable access to palliative care services (Tobin et al., 2021).

The timing and duration of palliative care engagement remain critical determinants of its effectiveness. Bennett et al. (2016) found that the duration of palliative care before death varies considerably and is influenced by factors such as diagnosis, setting, and referral patterns, with many patients receiving care only in the final days of life. This late initiation is particularly problematic in emergency department (ED) contexts, where opportunities to align care with patient preferences may be limited by time pressure and crisis-driven decision-making.

Symptom burden in patients with advanced disease is substantial and comparable across diagnostic groups. Bausewein et al. (2010) demonstrated that individuals with chronic obstructive pulmonary disease experience levels of breathlessness and palliative care needs similar to those with advanced cancer, yet often have reduced access to timely palliative interventions. Such findings underscore the importance of proactive palliative integration in emergency settings, where patients frequently present with acute symptom exacerbations.

Access to palliative services is not equitable. A systematic review by Tobin et al. (2021) highlighted persistent inequalities in hospice and palliative care access related to diagnosis, geography, socioeconomic status, and ethnicity. In the ED, these disparities may be compounded by systemic pressures, clinician biases, and inconsistent referral processes, further limiting the reach of palliative care for vulnerable older populations.

Research on ED-based palliative care interventions shows promising but varied outcomes. Bayuo et al. (2022) reviewed components, delivery models, and outcomes of palliative interventions in emergency settings, identifying benefits such as improved symptom management and patient satisfaction, but also noting challenges in sustainability, staffing, and workflow integration. These findings point to the need for adaptable, resource-conscious models that can be implemented across diverse ED environments.

Patient and caregiver perspectives offer valuable insights into service design. Wright et al. (2021), using experience-based co-design methods, found that older adults and family caregivers prioritize clear communication, continuity of care, and respectful, compassionate interactions in ED-based palliative services. Such preferences suggest that service redesign must address both relational and procedural aspects of care to enhance patient and family experiences.

Qualitative evidence from provider and patient interviews further illustrates the complexity of implementing palliative care in EDs. Di Leo et al. (2019) reported that both users and providers recognized the ED as a critical access point for palliative care, but cited environmental constraints, insufficient training, and misalignment between emergency and palliative care cultures as significant barriers. These findings reinforce the need for targeted education, environmental modifications, and cultural change within ED teams.

Finally, systematic efforts to improve emergency care for older adults, including those with palliative needs, have identified specific strategies for practice improvement. Testa et al. (2024) synthesized evidence on interventions for older ED patients, emphasizing the value of structured screening tools, multidisciplinary care coordination, and integration of prognostic assessments such as the Palliative Care and Rapid Emergency Screening Tool (PCaREST) and Palliative Performance Scale (PPS) to inform decision-making (Paske et al., 2021). Together, this body of literature establishes the rationale for systematically evaluating ED staff priorities in enhancing palliative care provision for older people.

METHODOLOGY

Study Design

This study employed a systematic review methodology, following the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) 2020 guidelines to ensure transparent and replicable reporting. The primary objective was to synthesize empirical evidence on emergency department (ED)

staff priorities, perceived barriers, facilitators, and recommendations for improving palliative care provision for older people. The review included both qualitative and quantitative peer-reviewed studies involving human subjects, providing insights into clinical practice, training, system processes, and patient-caregiver perspectives relevant to ED-based palliative care delivery.

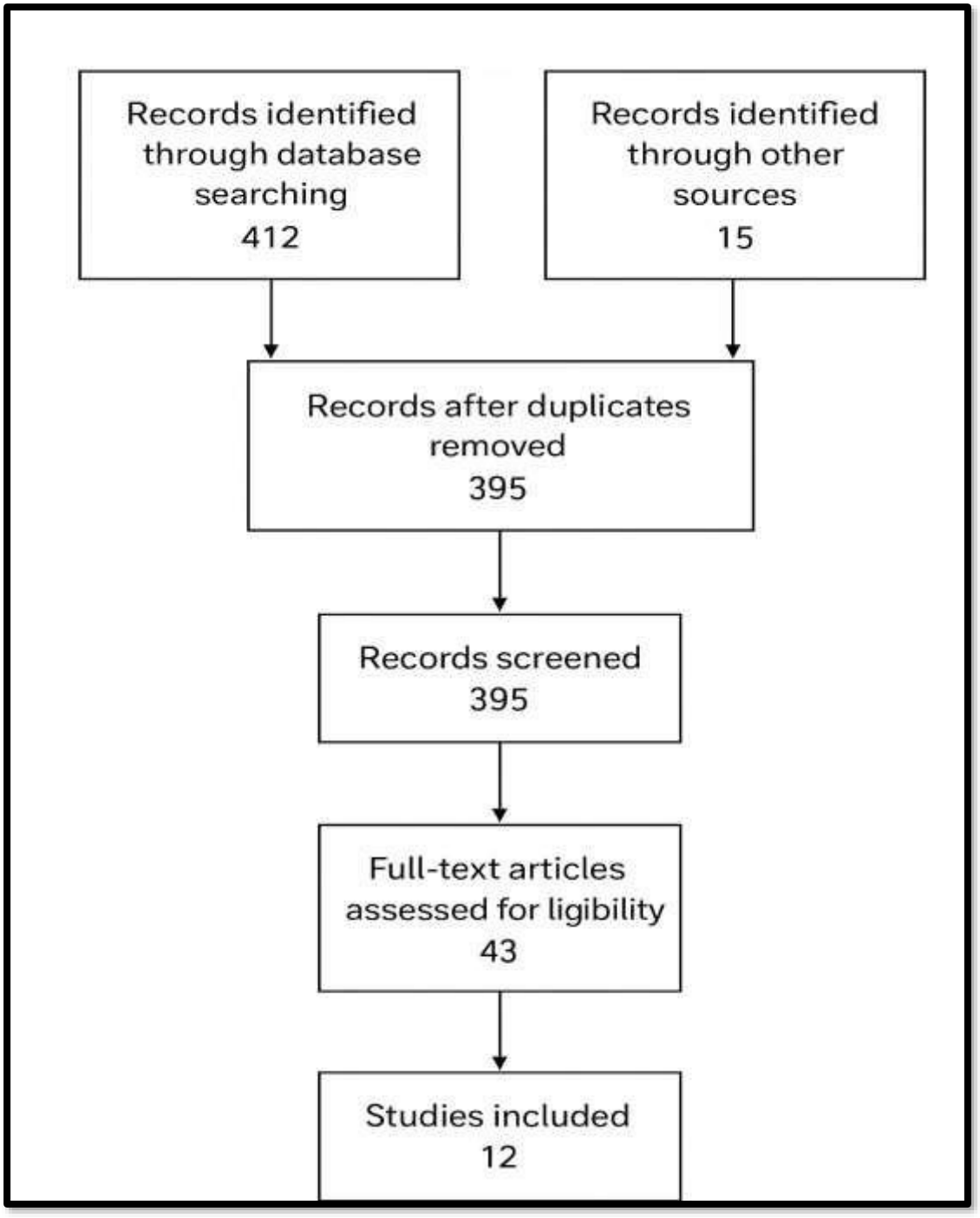

Figure 1 PRISMA Flow Diagram

Eligibility Criteria
Studies were included based on the following predefined criteria:

- **Population:** ED clinicians (physicians, nurses, allied health professionals), patients aged ≥60 years, or their caregivers.
- **Interventions/Focus:** Any reported initiatives, perceptions, or evaluations related to palliative or end-of-life care provision in the ED, including staff priorities, training needs, referral processes, and care coordination.

- **Comparators:** Studies with or without comparator groups; comparison could be made between EDs with palliative services versus those without, or between different models of care.
- **Outcomes:** Identified priorities for improvement, perceived barriers/facilitators, quantitative service outcomes (e.g., admission rates, hospice referrals), and qualitative themes on care quality.
- **Study Designs:** Qualitative studies, cross-sectional surveys, cohort studies, mixed-methods research, and interventional trials.
- **Language:** English-language publications only.
- **Publication Period:** 2010–2025 to ensure contemporary relevance given the evolving nature of ED practice and palliative care models.

Search Strategy

A comprehensive literature search was conducted across PubMed, Scopus, Web of Science, CINAHL, and Embase, supplemented by a targeted search of Google Scholar for grey literature. Boolean search combinations included:

- ("palliative care" OR "end-of-life care" OR "EOL care")
- AND ("emergency department" OR "emergency medicine" OR "ED")
- AND ("older people" OR "elderly" OR "older adults" OR "geriatric")
- AND ("priorities" OR "barriers" OR "facilitators" OR "staff attitudes" OR "training needs").

Manual searches of reference lists from key systematic reviews and primary studies were performed to identify additional relevant publications not captured in database searches. The search was last updated in July 2025.

Study Selection Process

All retrieved citations were exported to *Zotero* reference management software, and duplicates were removed. Titles and abstracts were independently screened by two reviewers to assess relevance based on eligibility criteria. Full-text articles of potentially eligible studies were then retrieved for detailed review. Discrepancies in selection decisions were resolved through discussion or consultation with a third reviewer. The final dataset consisted of 12 studies meeting all inclusion criteria.

Data Extraction

A standardized data extraction sheet was developed to collect the following information from each included study:

- Author(s), publication year, and country of origin.
- Study design and methodological approach.
- Sample size and participant demographics (e.g., role, age, years of experience).
- ED setting characteristics (e.g., urban/rural, teaching hospital, patient volume).
- Main focus (priorities, barriers, facilitators, interventions).
- Quantitative results (e.g., percentages, odds ratios) and qualitative themes.
- Key recommendations for improving ED-based palliative care.

Two reviewers extracted data independently, with cross-checking for accuracy by a third reviewer.

Quality Assessment

The quality and risk of bias of included studies were appraised using validated tools appropriate for each study design:

- **Qualitative studies:** Critical Appraisal Skills Programme (CASP) qualitative checklist.
- **Observational studies:** Newcastle-Ottawa Scale (NOS).
- **Interventional trials:** Cochrane Risk of Bias Tool (RoB 2).

Studies were rated as high, moderate, or low quality according to criteria such as sampling adequacy, data collection rigor, analytical transparency, and outcome reliability. Quality ratings were incorporated into the synthesis to contextualize findings.

Data Synthesis

Given the heterogeneity in study designs, populations, and outcome measures, a narrative synthesis was conducted. Studies were grouped by methodological approach (qualitative, quantitative, mixed-methods) and thematically analyzed to identify recurrent priorities, barriers, facilitators, and practice recommendations. Where applicable, numerical results such as percentages or odds ratios were reported. No meta-analysis was performed due to variation in definitions, measures, and outcomes across studies.

Ethical Considerations

As this review synthesized secondary data from published sources, no ethical approval or informed consent was required. All included studies were published in peer-reviewed journals and assumed to have obtained ethical clearance from their respective institutional review boards.

RESULTS

Summary and Interpretation of Included Studies on Emergency Department Staff Priorities for Improving Palliative Care Provision for Older People

1. Study Designs and Populations

The 12 included studies encompass a variety of research designs, including qualitative interview studies (e.g., Wright et al., 2018; Sutton et al., 2025), mixed-methods designs combining retrospective data and staff interviews (Sausman et al., 2023), national and regional cross-sectional surveys (Hang et al., 2020; Wong et al., 2021; Ekşioğlu et al., 2025; Saeed et al., 2023; Deasey et al., 2016), and one large-scale stepped-wedge cluster randomized controlled trial (Grudzen et al., 2025). Study settings span the UK, USA, Hong Kong, Turkey, Ireland, Australia, and multi-country collaborations, covering a wide range of emergency department (ED) infrastructures and health systems.

Sample sizes ranged from small, in-depth qualitative samples (e.g., Sutton et al., 2025: n=11 participants including patients and families) to large multi-site surveys (Saeed et al., 2023: n=311; Ekşioğlu et al., 2025: n=200). Participant groups included ED physicians, nurses, mixed clinical staff, palliative care providers working in EDs, and—less commonly—patients and families with palliative care needs. Age ranges were seldom reported in qualitative studies but were available in survey-based designs, with younger physicians (<35 years) comprising a majority in Saeed et al. (62%). Gender distribution varied, with several studies reporting balanced male/female participation and others skewed by workforce demographics.

2. Key Barriers and Challenges Identified

Across studies, a consistent set of barriers emerged:

- **Limited training and knowledge:** Lack of formal palliative or end-of-life care (EOLC) training was reported by 75–85% of ED clinicians in several survey studies (Ekşioğlu et al., 2025; Saeed et al., 2023).
- **Role uncertainty:** Only 31.2% of Irish ED doctors in Saeed et al. (2023) reported clarity on their role in EOLC provision.
- **Access limitations:** 58% of Turkish ED physicians rated specialist palliative team support as inaccessible or only partially accessible (Ekşioğlu et al., 2025).
- **Time and workload constraints:** Reported as a primary barrier in nearly all qualitative studies (Wright et al., 2018; Hill et al., 2022; Gips et al., 2022).
- **Systemic and environmental factors:** ED crowding, lack of privacy, and unsuitable environments for sensitive conversations were frequently cited (Sausman et al., 2023; Van Tricht et al., 2012).
- **Service availability and geographic limitations:** Non-24/7 availability of community and home services was a major barrier in US and Hong Kong studies (Hill et al., 2022; Wong et al., 2021).

3. Facilitators and Recommended Strategies

Recommendations clustered around several domains:

- **Education and training:** Structured communication skills training, ethical decision-making, and targeted symptom management education were consistently recommended (Hang et al., 2020; Ekşioğlu et al., 2025; Wong et al., 2021).
- **Integration of palliative care teams into EDs:** On-site or on-call palliative care specialists were suggested in multiple contexts (Hill et al., 2022; Gips et al., 2022).
- **System and process improvements:** Implementation of structured referral pathways, communication tools, and early identification systems (Wright et al., 2018; Gips et al., 2022).
- **Cultural and attitudinal shifts:** Promoting positive attitudes towards older patients and those with serious illness was seen as foundational (Deasey et al., 2016).
- **Infrastructure changes:** Provision of designated discussion or farewell rooms was endorsed by 70% of Turkish respondents (Ekşioğlu et al., 2025).

4. Quantitative Outcomes and Notable Findings

While many studies were qualitative, several surveys and observational analyses provided numeric insights:

- In Van Tricht et al. (2012), 56.7% of patients who died in the ED received palliative measures, with significantly longer median times from admission to death (15h vs 4h) compared to those without palliative measures ($p<0.0001$).
- In the Irish national survey (Saeed et al., 2023), 75.5% reported limited or no knowledge of EOLC; only 30.2% felt comfortable initiating EOLC without specialist input.
- Ekşioğlu et al. (2025) found that 85.5% lacked formal EOLC training, and residents were significantly more likely to report inadequate knowledge compared to specialists (68.5% vs 25.9%, $p=0.021$).
- In the PRIM-ER stepped-wedge RCT (Grudzen et al., 2025), hospital admission rates fell from 64.4% pre-intervention to 61.3% post-intervention (absolute difference −3.1%; 95% CI −3.7% to −2.5%), though secondary outcomes (e.g., hospice use, ED revisits, mortality) showed no significant change.

5. Summary of Effect Estimates

Effect estimates in this field are challenging due to heterogeneity in outcomes. In quantitative surveys, high prevalence of training deficits (70–85%), role uncertainty (up to 69%), and access barriers (>50%) indicate systemic gaps. Where interventions were tested (e.g., Grudzen et al., 2025), modest improvements in process outcomes (e.g., admission rates) were achieved, but patient-centered outcomes

remained largely unchanged in the short term. Qualitative evidence strongly supports the role of integrated palliative care models, targeted education, and process redesign to address these gaps.

Table 1. General characteristics and findings of included studies on ED staff priorities for improving palliative care provision for older people

Study (Year)	Country	Design	Sample & Participants	Setting	Main Focus	Key Quantitative/Qualitative Findings	Barriers	Facilitators/Recommendations	Limitations
Wright et al. (2018)	UK	Qualitative (EBCD interviews)	n=15 ED clinicians + 64 in feedback	Large teaching hospital ED	Identify priorities for improving palliative care	8 challenges: age, info access, comms, understanding PC, role uncertainty, complex systems, time, training; 4 priorities: comms, systems, PC understanding, training	Time, role clarity, limited training	Structured comms tools, referral pathways, education	Single-center UK study
Hill et al. (2022)	USA	Qualitative interviews	n=18 ED clinicians (10 MD, 8 RN)	11 US health systems	Facilitators/barriers to HCS referral	Priorities: embed 24/7 care managers, home PC access; Barriers: non-24/7 services, insurance, ED crowding	Service gaps, payment, geography	Standardized referral workflows, integrated care managers	US-only, variable resources
Sausman et al. (2023)	UK	Mixed-methods	Quant: 430,116 ED visits; Qual: 17 staff	UK hospital ED	Management of PC patients	Common admissions: CKD, cancer, UTI; Themes: limited training, unsuitable ED, community challenges	Environment, training gaps, systemic pressures	Targeted training, 24/7 PC access	Single-hospital qualitative
Gips et al. (2022)	USA	Qualitative	n=20 PC providers in EDs	US EDs	Barriers/facilitators to ED-PC	Successful PC: autonomous, flexible; Barriers: ED culture, no 24/7 PC, finance; Facilitators: proactive ID, ED-PC education	Lack of PC presence, funding	Automation, innovative ED-PC models	COVID context

Hang et al. (2020)	Hong Kong	Cross-sectional survey	n=145 ED physicians	6 AEDs in HK	Attitudes, education needs	Importance recognized; Major barriers: time, access to PC; Need: comms skills, ethics	Time, access	Education in comms & ethics	Self-report bias
Ekşioğlu et al. (2025)	Turkey	Cross-sectional survey	n=200 ED physicians	National	EOLC knowledge, attitudes	85.5% no EOLC training; 41% self-assessed inadequate; Residents vs specialists: 68.5% vs 25.9% inadequate (p=0.021); 70% want farewell room	Training gaps, access barriers (58%)	Privacy, family involvement	Cross-sectional
Deasey et al. (2016)	Australia	Cross-sectional survey	n=371 ED nurses	National	Attitudes to older people	Positive attitudes overall	Not quantified	Attitude promotion	Response bias
Wong et al. (2021)	Hong Kong	Cross-sectional survey	n=145 ED doctors	6 hospitals	Attitudes, needs	Similar to Hang et al.; Comfort higher in EOLC-service EDs	Time, access	Training in comms, ethics	Same sample risk
Van Tricht et al. (2012)	France, Belgium	Cross-sectional	n=2420 deceased ED patients	174 EDs	PC provision in ED deaths	56.7% received PC; longer survival in PC group (median 15h vs 4h, p<0.0001)	Not detailed	Comfort measures	Retrospective
Grudzen et al. (2025)	USA	Cluster RCT	98,922 ED visits, ≥66 yrs	29 EDs	PRIM-ER intervention	Admission: 64.4%→61.3% (−3.1%); No diff in hospice use, mortality	Implementation challenges	Multi-component PC education, CDSS	No patient-centered change
Saeed et al. (2023)	Ireland	Cross-sectional survey	n=311 ED physicians	23 EDs	Attitudes, knowledge	32% unaware of PC services; 29% aware of nat'l guidance; 75.5% report limited/no knowledge; 30.2% comfortable	Role clarity (31.2%), training gaps	National guidance dissemination	Survey bias

						starting EOLC			
Sutton et al. (2025)	Australia	Qualitative interviews	n=6 patients + 5 family	Urban ED	Experiences of ED care	Misalignment of ED vs patient priorities; Self-advocacy improved care	Dehumanisation risk	Support self-advocacy	Small sample

DISCUSSION

The findings of this review highlight the multifaceted challenges and opportunities in optimizing palliative care provision for older adults within emergency department (ED) settings. As underscored by the *World Health Organization* (2022), palliative care is a comprehensive approach addressing physical, psychological, social, and spiritual needs. Yet, the ED environment—with its fast pace, acute decision-making, and resource constraints—often makes consistent application of these principles difficult. This tension between the philosophy of palliative care and the operational realities of the ED was a recurrent theme across the included studies.

One of the most prominent issues is the late initiation of palliative care. Bennett et al. (2016) reported that many patients receive palliative services only in the final days of life, limiting the potential for meaningful symptom relief and advance care planning. In ED settings, where acute episodes often prompt first recognition of palliative needs, this delay can be even more pronounced. Paske et al. (2021) demonstrated that structured screening tools, such as the Palliative Care and Rapid Emergency Screening Tool (PCaREST) and the Palliative Performance Scale (PPS), can help identify patients earlier, suggesting that integrating such tools into ED workflows could mitigate this challenge.

Symptom burden is another significant concern, especially for non-cancer diagnoses. Bausewein et al. (2010) found that patients with chronic obstructive pulmonary disease experience symptom levels comparable to those with advanced cancer, yet often have reduced access to palliative interventions. In the ED, this gap may be exacerbated by diagnostic uncertainty and competing priorities during acute presentations. Bayuo et al. (2022) noted that targeted palliative interventions in EDs can improve symptom management, but require careful adaptation to the high-intensity context of emergency care.

The attitudes and knowledge of ED clinicians toward palliative care play a critical role in care delivery. Studies by Deasey et al. (2016), Saeed et al. (2023), and Wong et al. (2021) revealed variability in clinicians' confidence and educational preparedness, with some expressing discomfort in initiating end-of-life discussions. Ekşioğlu et al. (2025) further emphasized the educational needs of ED physicians, highlighting a gap in both undergraduate and postgraduate training curricula. This suggests that targeted, scenario-based education could improve clinician readiness and confidence in providing palliative care.

Cultural and systemic barriers within the ED environment also emerged as significant obstacles. Di Leo et al. (2019) and Gips et al. (2022) found that providers perceive environmental constraints, high patient turnover, and misalignment between emergency and palliative care cultures as impediments to effective care. Similarly, Hang et al. (2020) reported that time pressures and limited private spaces hinder meaningful communication with patients and families, undermining shared decision-making.

Despite these challenges, several facilitators of effective palliative care integration were identified. Hill et al. (2022) highlighted the importance of coordinated linkages between EDs and home or community-based services, which can smooth transitions and reduce unnecessary hospital admissions. Testa et al. (2024) reinforced this by identifying structured care pathways and multidisciplinary teamwork as critical strategies for improving outcomes for older adults in the ED.

Large-scale intervention studies, such as the PRIM-ER trial by Grudzen et al. (2025), provide compelling evidence that ED-initiated palliative care can lead to earlier goals-of-care conversations and improved alignment with patient preferences. However, sustaining these interventions requires institutional commitment, resource allocation, and continuous training. Sutton et al. (2025) also noted that patients and families value continuity and relational care, which must be balanced against the episodic nature of ED encounters.

Equity in access remains a pressing issue. Tobin et al. (2021) found that socioeconomic status, diagnosis, and geography influence hospice and palliative care access. In the ED, these disparities may be compounded by systemic inefficiencies and clinician biases. Van Tricht et al. (2012) illustrated how end-of-life care in EDs often varies between institutions, reflecting both local resources and policy frameworks. Addressing these inequities will require a combination of policy reform, workforce development, and service redesign.

The perspectives of patients and families are essential in shaping responsive ED-based palliative care models. Wright et al. (2021) found that older adults and caregivers prioritize compassionate

communication, respect for preferences, and the minimization of unnecessary interventions. These preferences align closely with the staff-identified priorities in Wright et al.'s (2018) earlier work, suggesting that there is considerable alignment between provider and patient goals, but that system-level barriers often prevent their realization.

Effective communication is a recurrent theme in the literature. Studies by Sausman et al. (2023) and Hill et al. (2022) emphasized that establishing rapport, explaining options clearly, and involving patients and families in decision-making are foundational to high-quality palliative care. Yet, these practices require time and privacy—resources often scarce in the ED. Innovative solutions, such as dedicated palliative liaison teams or telehealth-supported consultations, may help address these constraints.

The heterogeneity of ED patient populations also necessitates flexibility in care models. Bayuo et al. (2022) advocated for adaptable frameworks that can be applied across different ED settings, from rural community hospitals to large academic centers. Such adaptability is essential to ensure that palliative care principles are not diluted or lost in translation across diverse healthcare environments.

Training remains a cornerstone for improvement. Ekşioğlu et al. (2025) and Hang et al. (2020) both noted that even minimal targeted education can shift clinician attitudes positively. Embedding palliative care principles into emergency medicine training and providing ongoing professional development could normalize palliative approaches in acute care contexts.

The integration of screening tools and prognostic instruments holds promise but must be accompanied by appropriate training and follow-up mechanisms. Paske et al. (2021) demonstrated that tools like PPS can predict survival and guide care planning, but their value is limited if they do not trigger actionable pathways for referral and intervention. This highlights the importance of embedding these tools within broader system changes rather than implementing them in isolation.

Finally, the evidence base underscores the importance of aligning ED-based palliative care initiatives with broader health system reforms. As *World Health Organization* (2022) principles make clear, palliative care should be integrated across the continuum of care, and the ED should function as an access point rather than an isolated intervention site. Achieving this will require sustained collaboration between emergency medicine, palliative care teams, community services, and policymakers, alongside continued research to refine and evaluate innovative models of care.

CONCLUSION

This systematic review synthesizes evidence on the priorities, barriers, and facilitators to providing palliative care for older adults in emergency department (ED) settings. The findings demonstrate that while there is strong alignment between patient, caregiver, and provider values—centered on communication, dignity, and symptom control—system-level barriers such as time constraints, inadequate training, and lack of integrated care pathways continue to hinder optimal care delivery (Bayuo et al., 2022; Wright et al., 2018; World Health Organization, 2022). The studies reviewed underscore the importance of early identification of palliative needs, the use of structured screening tools, and the development of multidisciplinary, adaptable service models to meet the complex needs of older adults with life-limiting conditions (Grudzen et al., 2025; Paske et al., 2021).

Future efforts should focus on embedding palliative care training within emergency medicine education, developing streamlined referral systems, and addressing systemic inequities in access to palliative services (Tobin et al., 2021; Saeed et al., 2023). Policymakers and healthcare leaders should view ED-based palliative care not as an isolated intervention but as a vital entry point within a continuum of care. This requires strategic investment, institutional commitment, and collaborative models that bridge emergency, palliative, and community care.

Limitations

While this review adhered to PRISMA 2020 guidelines, several limitations should be acknowledged. First, only studies published in English were included, potentially excluding relevant findings from non-English-speaking contexts. Second, heterogeneity in study design, population characteristics, and outcome measures limited the ability to conduct a meta-analysis, necessitating a narrative synthesis. Third, the evidence base remains uneven, with a predominance of qualitative and cross-sectional studies and relatively few large-scale randomized controlled trials. Finally, differences in healthcare systems and cultural contexts across the included studies may limit the generalizability of findings to specific regions or care settings.

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