Cogitare Enfermagem

REVIEW

# INSTRUMENTS FOR THE ASSESSMENT OF HOSPITALIZED PATIENTS IN PALLIATIVE CARE: INTEGRATIVE REVIEW*

## HIGHLIGHTS

1. Sixteen (16) tools were identified for people in palliative care.
2. They assess functionality, physical and psychological symptoms and old age.
3. The Palliative Performance Scale (PPS) was the most frequently used tool.
4. These instruments assist in palliative care planning.

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## ABSTRACT

**Objective:** to identify the instruments used to assess patients hospitalized in palliative care. **Method:** integrative literature review carried out in January 2024 on the online data platforms: National Library of Medicine and Latin America and the Caribbean Literature on Health Sciences (LILACS) and the virtual library Scientific Electronic Library Online. Twelve scientific articles were analyzed. **Results:** Sixteen instruments were identified, seven of them generic, four specific for people in palliative care, four specific for oncology patients and one for the diagnosis of COVID-19. The Palliative Performance Scale and Edmonton Symptom Assessment were the most used instruments in the studies and the most relevant aspects to be evaluated in patients receiving palliative care were functional capacity, physical and psychological symptoms and old age. **Conclusion:** The instruments were useful as they guided health professionals, assessed patients, and planned care and decision-making.

**KEYWORDS:** Palliative care; Health assessment; Patient care; Quality of Health Care; Death.

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## INTRODUCTION

Palliative Care (PC) is defined by the World Health Organization (WHO) as an approach to improve the quality of life of patients and their families facing the problems associated with potentially life-threatening illness. PC aims to prevent and alleviate suffering, focusing on controlling pain and other symptoms of a physical, psychosocial and spiritual nature[1-2].

According to the WHO, in 2019, seven of the 10 leading causes of death were Chronic Noncommunicable Diseases (NCDs). This is directly related to increased human longevity, which promotes the advancement of chronic diseases. When these diseases reach advanced stages, they compromise the functionality and quality of life of patients, demanding specialized and individualized care[2].

The purpose of PCs is the relief of suffering at all stages of the disease, and they are not limited to end-of-life care and can be provided alongside curative or life-prolonging treatments. PC provides quality of life and respect for the dignity of human beings until the last moments of their lives[3].

The majority of adults who require PC suffer from some chronic disease, such as cardiovascular diseases (38.5%), cancer (34%), Chronic Respiratory Diseases (10.3%), Human Immunodeficiency Syndrome (AIDS) (5 .7%) and Diabetes Mellitus (4.6%). Many other conditions may require PC, such as kidney failure, chronic liver disease, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, neurological diseases, dementia, birth defects, and drug-resistant tuberculosis[2].

Palliative care assistance, as recommended in the definition itself, must be carried out in an integrated manner by different professional occupations, and at different levels of care. The group of patients over 65 years of age is responsible for the highest rate of use of emergency services compared to other age groups. However, only a minority of patients with advanced chronic diseases and life-threatening illnesses have well-established knowledge about PC, due to the difficulty in accessing primary care services and the scarcity of multidisciplinary teams prepared for PC[4].

The researcher's role as a palliative care physician in a hospital environment, as well as the observation of gaps in the evaluation process and indication of this treatment modality, motivated the development of this study. It aimed to identify the instruments used to assess hospitalized patients in palliative care.

## METHOD

This is an integrative literature review carried out in January 2024. An integrative review promotes investigation focused on a clearly defined question, which aims to identify, select, assess and synthesize the relevant evidence available. The study comprised the following stages: elaboration of the guiding question; establishment of objectives and criteria for selecting studies; definition of the information to be extracted; selection of studies to be included in the review; analysis of results; discussion of findings[5].

The research design was carried out using the mnemonic PCC, which refers to Participants, Concept and Context (PCC), with P (Participants) – People who need PC; C (Concept) – Clinical assessment; C (Context) – Hospital environment. Therefore, the guiding question of this study was as follows: What are the instruments used to assess patients who require palliative care in a hospital environment?

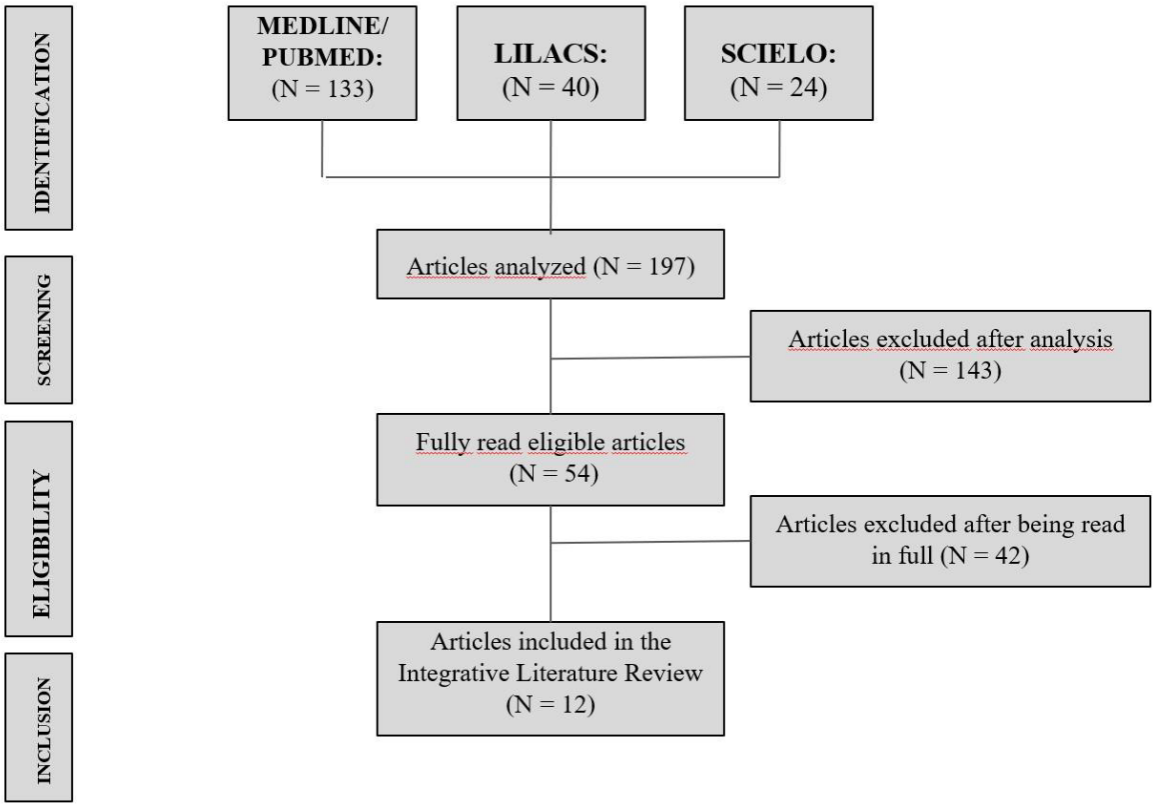
Primary research was obtained on online database platforms: National Library of Medicine and Latin America and the Caribbean Literature on Health Sciences (LILACS) and the virtual library Scientific Electronic Library Online (SciELO). The descriptors registered in the Health Sciences Descriptors (DeCS), in Portuguese, English and Spanish, were used to select the publications. Crossings were made using the Boolean moderator "AND" between the descriptors, using the form for the advanced search: "*Cuidados paliativos*", "Palliative care", "*Cuidados Paliativos*", AND "*Assistência ao paciente*", "Patient care", "*Atención al Paciente*" AND "*Avaliação em saúde*", "Health Evaluation", "*Evaluación en Salud*".

To refine the searches, the following inclusion criteria were established: original articles, available in full text format and free access, in English, Portuguese and Spanish, published from 2017 onwards. Articles that did not elucidate the research question were excluded.

In the search strategy, 197 studies were retrieved from the platforms, 133 from PubMed, 40 from LILACS and 24 from SciELO.

After the reading of titles and abstracts, 143 articles were excluded, as they were duplicated in more than one data source (28), and were not in line with the topic covered and/or did not use instruments for evaluating patients undergoing PC. (115). Thus, 54 articles were considered eligible for a thorough reading of the full text, of which 42 were excluded for not contributing to elucidating the research question, 12 articles were selected to compose the sample for the integrative literature review. The organizational chart (Figure 1) outlines the various steps carried out.

**Figura 1 -** Organizational chart of the steps carried out in the Integrative Review. Natal (RN), Brazil, 2024.



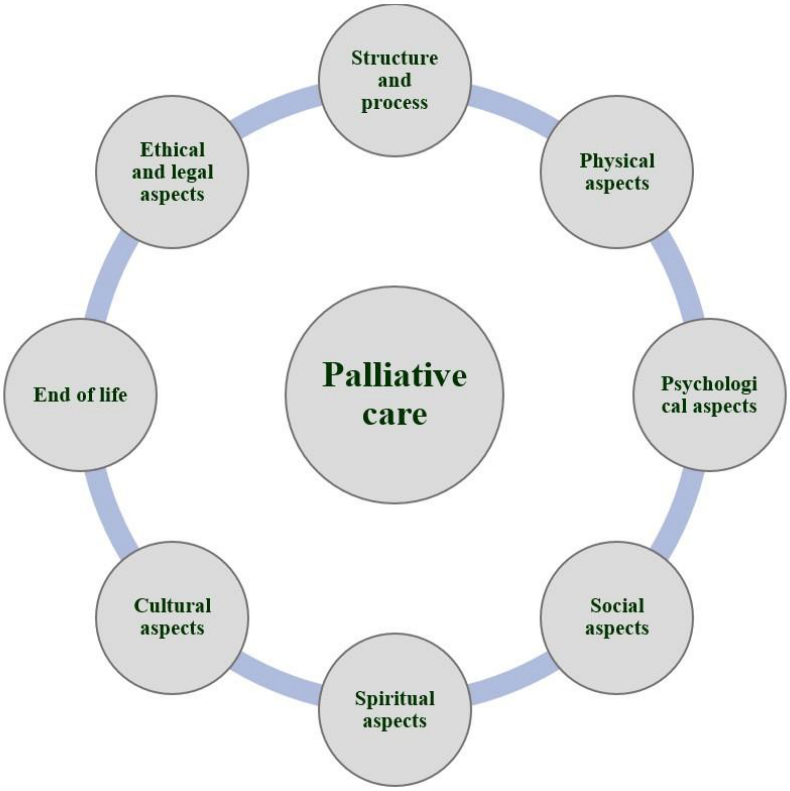

Source: Prepared by the authors (2024).

To classify the level of evidence of the selected articles, the following recommendations[6] were used for classifying levels of scientific evidence: I - Evidence from meta-analysis or

randomized trials; II - Systematic, descriptive or qualitative reviews; III - Evidence from clinical trials; IV - Cohort studies; V - Control case study; VI - Evidence from a single descriptive/ qualitative study, the Methodological Study; VII - Opinion or report from a scholar in the area in question.

In addition, the document Assessment Tools for Palliative Care[7] was used, whose elaboration was organized by Johns Hopkins University, in order to identify the domains covered and the clinical criteria of patients in PC prevalent in the papers included in the review (Figure 2).

**Figura 2 -** Domínios encontrados no relatório *Assessment Tools for Palliative Care*. Natal (RN), Brasil, 2024.




Fonte: Aslakson (2017)[7]

## RESULTS

The sample analyzed in this study consisted of 12 articles, which were categorized according to the variables: article number, level of evidence, authors, title, journal and year of publication (Chart 1).

**Chart 1 -** Distribution of selected articles according to level of evidence, authors, title, periodical and year of publication. Natal (RN), Brazil, 2024.

| n. | AUTHORS | TITLE | PERIODICAL/ YEAR OF PUBLICATION | LEVEL OF EVIDENCE |
|---|---|---|---|---|
| 1 | Sanvezzo VMS, Montandon DS, Esteves LSF.[8] | *Instruments for the functional assessment of elderly persons in palliative care: an integrative review.* | Revista Brasileira de Geriatria e Gerontologia / 2018 | II |

| | | | | |
|---|---|---|---|---|
| 2 | Cabianca CAM, Menegueti GG, Bernardi ICP, Gurgel SJT.[9] | Comparação entre Escala de Performance de Karnofsky e Escala de Avaliação de Sintomas de Edmonton como determinantes na assistência paliativa. | Revista Sociedade Brasileira de Clínica Médica / 2017 | IV |
| 3 | Castôr KS, Moura ECR, Pereira EC, Alves DC, Ribeiro TS, Leal PCKS.[10] | *Palliative care: epidemiological profile with a biopsychosocial look on oncological patients.* | Brazilian Journal of Pain / 2019 | IV |
| 4 | Allgar VL, Chen H, Richfield MB, Currow D, Jonhson MJ Allgar VL.[11] | *Psychometric Properties of the Needs Assessment TooldProgressive Disease Cancer in U.K. Primary Care.* | Journal of Pain and Symptom Management / 2018 | - |
| 5 | Idrobo MF, Muñoz PO, Vargsd-Escobar LM, Buenhombre MCR.[12] | *Necesidades de cuidado paliativo del paciente con falla cardiaca: un estudio mixto.* | Revista Cuidart / 2023 | II |
| 6 | Yang GM, Pang GSY, Lee GL, Neo PSH, Wong YY, Qu DL. *et al.*[13] | *Validation of the Comprehensive Needs Assessment Tool in Patients with Advanced Cancer.* | Indian Journal of Palliative Care / 2019 | IV |
| 7 | Cheng L, DeJesus AY, Rodriguez MA.[14] | *Using Laboratory Test Results at Hospital Admission to Predict Short-term Survival in Critically Ill Patients with Metastatic or Advanced Cancer.* | Journal of Pain and Symptom Management / 2017 | IV |
| 8 | Conen K.[15] | *Symptom trajectories of non-cancer patients in the last six months of life: Identifying needs in a population-based home care cohort.* | Journal Pone / 2021 | IV |
| 9 | Milani L.; Silva MM.[16] | A enfermagem e os cuidados paliativos na atenção primária à saúde. | Revista de Pesquisa Cuidado é Fundamental Online / 2021 | II |
| 10 | Clara MGS, Silva VR, Alves R, Coelho MCR.[17] | *The Palliative Care Screening Tool as an instrument for recommending palliative care for older adults.* | Revista Brasileira de Geriatria e Gerontologia / 2019 | IV |
| 11 | Fusi-Schmidhauser T. *et al.*[18] | *Conservative Management of COVID-19 Patients-Emergency Palliative Care in Action.* | Journal of Pain and Symptom Management / 2020 | VI |
| 12 | Alba JAL; García DMJ; Gamba NCR.[20] | Validade de conteúdo do NECPAL CCOMS-ICO© em espanhol para identificar necessidades paliativas em crianças e adolescentes com câncer. | Investigación y Educación en Enfermería / 2022 | IV |

Source: Elaborated by the authors (2024).

After the analysis of the selected articles, several methodological approaches used by the authors were identified, such as: retrospective cohort studies; cross-sectional cohort, including a study that used more than one methodological approach (descriptive, analytical, retrospective, documentary with a quantitative approach), and another with a mixed methodology (application of scales in the quantitative phase and focus groups in the quantitative phase); studies with a longitudinal, prospective, observational and quantitative approach; and integrative review studies. Validation studies and development of new assessment tools were also identified. Regarding the location where the studies were carried out, we mention five studies that were carried out in Brazil, two in Colombia, one in the United Kingdom, one in Switzerland, one in South Korea, one in the United States and one in Canada.

Sixteen instruments were identified that assist health professionals in carrying out patient assessments, seven of which are generic, four specific for PC assessment, four specific for oncology patients and one for patients diagnosed with COVID-19, as shown in Table 1.

**Table 1 -** Distribution of instruments used in the studies analyzed. Natal (RN), Brazil, 2022.

| INSTRUMENT | ABBREVIATION | STUDY | n | % |
|---|---|---|---|---|
| *Edmonton Symptom Assessment* | ESAS | 5, 6, 1, 2, 7 | 5 | 20,86 |
| *Palliative Perfomance Scale* | PPS | 6, 3, 1 | 3 | 12,56 |
| *Palliative Care Screening Tool* | PCST | 5, 11 | 2 | 8,33 |
| *Karnofsky Perfomance Scale* | KPS | 5, 6 | 2 | 8,33 |
| *Brief Pain Inventory* | BPI | 5 | 1 | 4,16 |
| *The Rotterdam Sympton Checklist* | RSCL | 5 | 1 | 4,16 |
| *Palliative Care Outcome Scale* | POS | 5 | 1 | 4,16 |
| *Resident Assessment Instrument for Home Care* | RAI-HC | 12 | 1 | 4,16 |
| *3D-Ticino 2019-nCov Score* | - | 9 | 1 | 4,16 |
| *The 59-item Comprehensive Needs Assessment Toll in Cancer* | CNAT | 8 | 1 | 4,16 |
| *The Needs Assessment Tool Progressive Disease – Cancer* | NAT: PD – C | 10 | 1 | 4,16 |
| *Rapid Desabillity Rating Scale* | RDRS | 3 | 1 | 4,16 |
| *World Health Organization Quality of Life* | WHOQOL | 3 | 1 | 4,16 |
| Índice de Lawton & Brody | - | 3 | 1 | 4,16 |
| Índice de comorbidade de Elixhauser | - | 4 | 1 | 4,16 |
| *Functional Assessment of Chronic Illness Therapy - Spiritual Well-Being* | FACIT-Sp-12 | 2 | 1 | 4,16 |
| *Total* | | | 24 | 100,0 |

Source: Elaborated by the authors (2024).

## DISCUSSION

Palliative care is important in the context of population aging, as it provides improvements in the symptoms and quality of life of people approaching the end of their lives[8]. Therefore, the use of clinical assessment tools for people who require PC is of great importance, as it allows identifying the appropriate moment to start palliative therapy and, in addition, makes it possible to monitor the progression of chronic diseases.

Therefore, knowing the profile of patients in PC allows health professionals to plan and develop new assessment tools and implementation strategies and care assistance, in a targeted manner, providing quality of life for patients and their families[9-10].

The identification of patients in need of PC and the early integration of this care can improve the quality of life of patients and families, which can generate increased satisfaction with lower costs and reduced use of hospital equipment in patients at the end of life. Therefore, it is recommended that an assessment of palliative needs be carried out, with the use of some tools being very helpful, such as functionality scales and others that indicate clinical conditions.

Each illness has its trajectory, natural history. Therefore, knowing the trajectory of illnesses, and identifying where patients are in this trajectory or course, helps health professionals in planning care that integrates disease-modifying treatment into the PC approach. One of the main markers used to define the course of each chronic disease is functionality. Assessment of the presence and intensity of symptoms is also very useful in PC, and the Edmonton Symptom Assessment Scale (ESAS) is the most used for this purpose.

Among the most used instruments, the Palliative Performance Scale (PPS), the Palliative Care Screening Tool (PCST) and the Karnofsky Performance Status (KPS), which are quick and easy to apply instruments, widely used in PC[11], also deserve mention.

Castôr *et al.*10 identified the epidemiological profile of 100 cancer patients undergoing PC treated in a hospital. The authors found that the most frequent age group was those between 51 and 60 years old (34%), female (77%), mixed ethnicity (51%), steady partner (67%), evangelical religion (62%), educational level – Incomplete primary education (40%), living in the countryside (73%), not working (92%) and having a caregiver (94%).

Furthermore, assessing the physical capacity of patients along with the number of symptoms presented revealed the best time to initiate palliative intervention. This is what studies[9-10] showed, when using the Palliative Performance Scale (PPS), an instrument that assesses the severity of the disease and the capacity for self-care, and the Edmonton Symptom Assessment (ESAS), an instrument used to assess and monitor physical and psychological symptoms. These instruments assess patients' performance through physical capacity and self-sufficiency, and the presence and intensity of various symptoms, such as pain, depression, anxiety and others, respectively.

As reported by Cabianca *et al.*[9], the greater the patients' degree of independence, the greater the number of symptoms and the more expressive the complaints of individuals who met the criteria for receiving PC. The authors emphasized that cardiovascular diseases were present in 100% of the patients evaluated.

It is clear that the loss or decrease in functional capacity in elderly people is part of the aging process and is associated with chronic diseases. To assess the functionality of elderly people receiving PC, a study showed which instruments can be used for this evaluation. The study identified scales that assess the functionality and physical performance of patients undergoing PC and scales that assess quality of life, and in their domains they have indexes that assess functionality[8].

Age, pathophysiology, comorbidities and nutritional status influence the experience of symptoms. Idrobo *et al.*[12] identified palliative care needs of people with heart failure, through the application of the ESAS scale. When using the Functional Assessment of Chronic Illness Therapy - Spiritual Well-Being (FACIT-Sp) scale, the authors observed that 93% of patients felt fatigued, with lack of energy, which indicates the occurrence of symptoms related to heart rate disorders.

Regarding the assessment of the functional capacity of elderly people receiving PC, a study highlighted the following tools: the Palliative Performance Scale (PPS), which consists of a unidimensional scale and includes the dimensions of mobility, activity, evidence of disease, self-care, levels of intake and level of consciousness. The Lawton & Brody index and the Rapid Disability Rating Scale (RDRS) assess Instrumental Activities of Daily Living (IADL) such as using the telephone, shopping, preparing meals, among others[8].

To assess functional capacity, Castôr *et al.*[10] used the Karnofsky Performance Scale (KPS), which describes increasing levels of activity and independence, and found that 52% have a Karnofsky index between 70% and 90%, of which 31% have a Karnofsky score of 90%, which means that these patients are able to carry out normal activities, with minimal signs and symptoms of the disease. The authors found that although more than half of the

population had positive results on the Karnofsky index and the PPS scale, almost all patients did not perform physical activity, even though they were fit. It is known that physical activity improves the quality of life of cancer patients undergoing PC.

The same study reported that 87% of patients were unaware of the palliative diagnosis. Regarding the use of pain medication, 52% reported not forgetting to take them; 57% reported that they did not stop taking pain medication when they felt better; 56% reported taking medications on their own and 78% did not use an alarm clock to alert them to the medication schedule. The authors also reported that patients' lack of knowledge about PC, education, origin and irregular use of drugs to control pain were factors that directly influenced the implementation of PC[10].

Another assessment tool for people receiving PC: The Needs Assessment Tool: Progressive Disease – Cancer (NAT:PD-C) was developed for the multidisciplinary assessment of PC needs of cancer patients and caregivers. This instrument has been reviewed and validated for the UK social and cultural context. The aspects listed in the instrument (NAT:PD-C) for the clinical assessment of these patients are patient's well-being (assessment of physical and psychological symptoms, spiritual issues, concerns, financial resources and daily life activities); need for a caregiver; caregiver/family well-being[11].

In turn, a study carried out in Singapore with patients with advanced cancer validated an assessment tool for the English version of The 59-item Comprehensive Needs Assessment Tool in Cancer (CNAT), which assesses seven factors: (1) information and education, (2) psychological problems, (3) healthcare team, (4) physical symptoms, (5) hospital facilities and services, (6) social and religious/spiritual support, and (7) practical support. The factors with the highest scores were factors (6) social and religious/spiritual support and (3) health team. Higher scores indicate higher levels of unmet needs[13].

It can be said that accurately estimating the life expectancy of critically ill patients with metastatic or advanced cancer is important for determining patients' treatment options and for planning PC and support. Another study, also with patients with metastatic or advanced cancer, evaluated the results of commonly available laboratory tests, carried out in the first two days of hospital admission, to determine the short-term prognoses of critically ill cancer patients[14].

For this assessment, multivariable predictors of the risk of death within 14 days of hospital admission were determined. The authors selected the following factors: laboratory tests that were routinely performed, such as serum creatinine, blood urea nitrogen (BUN), total serum albumin, serum lactate dehydrogenase (LDH), hematocrit, white blood cell count (WBC) and platelet count. In addition to the results of the aforementioned exams, the following independent variables were used as predictive factors: age and Elixhauser comorbidity14[14].

PC is an approach that improves patients' experience of death, providing them with well-being, symptom control, quality of life and satisfaction with the care received. The need for PC is not restricted to patients with advanced cancer. Patients diagnosed with chronic obstructive pulmonary disease and congestive heart failure may also require similar care at the end of life. However, many people eligible for palliative treatment receive insufficient hospital care, due to the various difficulties in implementing PC in health services[15-16].

Regarding the risk of death of hospitalized patients, Cheng *et al.*[14] showed that the risk of death within 14 days after hospital admission increased significantly with increasing age (65 years or older), LDH levels and cell count of leukocytes, and with a decrease in albumin levels and platelet count. Almost half (45%) of patients died within 14 days of admission. As for the levels of BUN, creatinine and hematocrit levels and the values of Elixhauser comorbidity index they were not associated with the risk of death within 14 days after hospital admission.

With the aim of describing the symptoms of non-cancer patients in the last six months of life, the researchers used the Resident Assessment Instrument for Home Care (RAI-HC) to carry out the assessment. Study patients were grouped into four categories: cardiovascular, neurological, respiratory and kidney disease. The RAI-HC is composed of items that assess patients' functional status, psychosocial well-being, physical health and care needs. The patients' symptoms in the last six months of life, according to the group, were moderate to severe pain in patients with cardiovascular (57.2%), neurological (42.7%), kidney (61.0%) and respiratory (58.3%) problems. However, patients with kidney disease were more likely to report moderate to severe pain, while female patients were significantly more likely to report uncontrolled pain[15].

With regard to shortness of breath, this was reported in 70% to 85% of patients grouped with respiratory problems. Patients with neurological disease, compared to those without neurological disease, are 9.65 times more likely to have impaired cognitive performance and there are 56% more chances of caregivers suffering. There was also an increase in symptoms every week in the last six months of life, in all groups of non-cancer diseases, such as: moderate to severe uncontrolled pain, mild to severe cognitive impairment and caregiver suffering. Moderate to severe pain was the symptom reported in more than half of the sample. In addition, there was a prevalence of shortness of breath in all four groups of the disease in the last six months of life. Among the factors associated with the outcome shortness of breath in the last six months of life, the most notable were being older and having a decline in cognitive performance[15].

Regarding the instruments that measure quality of life, the World Health Organization Quality of Life (WHOQOL) and the WHOQOL-old, modified for the elderly, were identified, which assess quality of life through six domains: assessment of sensory functioning, autonomy, present, past and future activities, social participation, death and dying and intimacy[8].

Autonomy and functionality appear as significant points for the well-being of people receiving PC. A study demonstrated that it is practically impossible to dissociate physical functionality from social and psychological aspects. Based on this understanding, the authors stated that when functional capacity is assessed, quality of life is also assessed[8].

In Brazil, the hospitalization of elderly people in the Intensive Care Unit (ICU) accounts for 52% in public services. Therefore, it is important to assess whether all these patients require admission to the ICU, and whether they have serious chronic illnesses, as their quality of life could be improved from the perspective of palliative care[17].

Among the instruments administered, the Palliative Care Screening Tool (PCST) was identified, which is used to measure palliative care needs in elderly people admitted to the ICU. This tool evaluates four criteria: underlying diseases, associated diseases, the patient's functional condition and the patient's personal conditions. When the score obtained with the sum of the four criteria is greater than or equal to four points, it is considered that the patient needs PC[17].

Clara *et al.*[17] analyzed 594 medical records and reported that the causes of hospitalizations among the elderly were cardiovascular diseases (26.8%), neoplasms (20.2%) and renal failure (16.8%). The administration of the PCST scale revealed that of the total number of medical records analyzed, 218 obtained scores greater than or equal to four, that is, with an indication for palliation. However, 144 did not receive PC.

In the context of the COVID-19 pandemic, many patients required PC because of the large number of symptoms experienced, the rapid potential for deterioration, and the need for clear and open communication with patients and their families. Thus, Fusi-Schmidhauser *et al*[18] developed a specific assessment instrument for patients with COVID-19, the 3D-Ticino 2019-nCov Score. This instrument aims to assist and guide the management of PC according to the patients' disease stage, considering the main symptoms observed, namely dyspnea,

anguish and discomfort (pain). Other aspects evaluated are pressure areas and the need to use relief devices.

The implementation of PC not only requires the execution of techniques, humanized and comprehensive care, but also shared care with the multidisciplinary team, providing an improvement in the quality of life of the patient and their families. Thus, end, validated instruments that facilitate the adequate assessment of signs and symptoms, to avoid overestimating patients' symptoms[16].

According to the study conducted by Milani and Silva[16], the Palliative Care Screening Tool (PCST) helped to identify people eligible for PC, as it allowed the detection of individuals with good functionality, but who faced life-limiting conditions. For the assessment of people receiving PC, the same study highlighted the following instruments: Karnosfky Performance Scale (KPS), which allows the functional classification of people; Edmonton Symptom Assessment System (ESAS), which assesses nine symptoms (pain, tiredness, nausea, depression, anxiety, drowsiness, lack of appetite, shortness of breath, well-being) and Brief Pain Inventory (BPI) short form, which quickly assesses the severity of pain and its impact on individuals' functioning.

There is also The Rotterdam Symptom Checklist (RSCL), which assesses quality of life in four domains: physical symptom disorders, psychological distress, activity level and global quality of life and the Palliative Care Outcome Scale (POS), which assesses the quality of life and encompasses biopsychosocial, spiritual and practical aspects[16].

These findings point to the importance of understanding the course of symptoms and factors associated with the development of more complex problems, helping to identify patients in need of PC early, when the benefits of a multidisciplinary approach to treating and managing symptoms are considered[11,15,19-20].

Alba, Garcia and Gamba[19] validated the content of the NECPAL CCOMS-ICO© instrument to identify palliative needs in Colombian children and adolescents aged eight to 17 years with cancer. In this study, the ESAS instrument was considered valid as a component of the NECPAL CCOMS-ICO© due to the persistence and refractoriness of symptoms in a child with cancer, such as pain, weakness, anorexia, dyspnea and digestive problems. Furthermore, the family and social assessment was accepted by experts, as they understood that socio-family vulnerability and emotional discomfort are determining factors in the course of the disease.

Despite the large number of instruments for evaluating people with cancer, it was found that there are few studies in the literature regarding instruments that help doctors identify patients in need of PC, which is therefore a limitation of this study and a gap for future studies in this area.

## CONCLUSION

The implementation of the assessment should be guided by instruments, which can be specific and/or generic, as long as they are focused on the care of patients who require palliative care in a hospital environment. The most used instruments to assess and monitor the physical symptoms of individuals in palliative care were the Edmonton Symptom Assessment (ESAS) and the Palliative Performance Scale (PPS).

The aspects of assessment for people in palliative care most used in studies were functional capacity, physical and psychological symptoms and old age. Other aspects were also highlighted, such as activities of daily living, cardiovascular diseases, elevated LDH

and leukocytes, low albumin levels and low platelet count, psychosocial aspects and the need for a caregiver.

The instruments for assessment assisted health professionals in care planning and decision-making. Furthermore, they provide adequate, effective and efficient assistance.

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