

Person-Centred Care: Impact on the Effectiveness of Palliative Care in Patients with Alzheimer's Disease

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Abstract

The increasing prevalence of Alzheimer's disease (AD) underscores the need for care models that preserve identity, autonomy, and comfort throughout disease progression. Person-Centred Care (PCC), which emphasizes individual biography, preferences, and relational context, is conceptually aligned with palliative care (PC); however, its impact on palliative outcomes in AD patients requires integrated synthesis. This review evaluated the effects of PCC-based interventions on the effectiveness of PC in patients with AD, focusing on clinical outcomes, health service utilization, medication use, and caregiver experience. Systematic searches were conducted in PubMed and SciELO to identify observational and interventional studies assessing the integration of PCC into PC. Sixteen eligible studies with heterogeneous designs were included, and owing to methodological and outcome variability, the results were synthesized narratively. Overall, PCC integration was consistently associated with improved quality of life, reduced agitation and neuropsychiatric symptoms, decreased use of antipsychotics and benzodiazepines, fewer avoidable hospitalizations and emergency department visits, greater caregiver satisfaction, and improved concordance with advance care planning. Outcomes were assessed using validated clinical scales, medication utilization data, health service indicators, and caregiver-reported measures. Although the effect sizes varied and were limited by small samples sizes, short follow-up periods, and heterogeneity, the available evidence supports the systematic incorporation of PCC into PCs for patients with AD to improve patient-centered outcomes and caregiver experience.

1. Introduction

Population aging, a contemporary phenomenon, has led to a marked increase in the incidence of chronic and degenerative diseases¹. Within this clinical landscape, Alzheimer's disease (AD) stands out as one of the greatest challenges in modern medicine. As a progressive condition with an irreversible outcome that critically impairs cognition and autonomy, it becomes evident that appropriate care must extend beyond mere symptom control. The primary urgency, therefore, lies in safeguarding patient dignity and overall well-being².

Within this complex care context, Person-Centred Care (PCC) emerges as a prominent approach. By advocating the appreciation of the individual's biography, choices, and identity, this philosophy places the patient at the center of the care process³. For individuals with AD in particular, recognition of these dimensions is essential; indeed, careful attention to the affective sphere and the strengthening of interpersonal bonds contribute to the optimization of the clinical experience^{4,5}.

In parallel, the early integration of Palliative Care (PC) is highly valuable. Its implementation from the time of diagnosis enables earlier and more effective symptom management, reduces potentially avoidable hospitalizations, and provides families with continuous support throughout the entire course of the disease⁶.

In light of the above, this article aims to outline the foundations and examine the impact of PCC and PC in the context of AD. It highlights the advantages inherent to an integrated care model and discusses the practical challenges that currently persist in the full implementation of this humanized care paradigm.

2. Methods

This study is a scoping review, conducted in accordance with the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses⁷. This method was selected to ensure methodological transparency, reproducibility, and rigor in identifying, screening, and synthesizing eligible studies. This review aimed to evaluate the impact of structured PCC interventions on clinical outcomes in patients with advanced or terminal AD receiving PC.

The research question was developed using the PICOS framework (Population, Intervention, Comparator, Outcomes, Study design), which is widely recommended for framing clinical review questions. The question guiding this review was as follows: *What is the impact of structured PCC interventions on clinical outcomes for patients with advanced Alzheimer's disease in palliative care settings?*

2.1 Searching databases

The literature search was conducted in October 2025, using two major electronic databases: PubMed/MEDLINE and Scopus. These databases were chosen for their comprehensive coverage of peer-reviewed biomedical and health-related literature. The research strategy was developed to identify studies that simultaneously addressed three core concepts: Alzheimer's disease, person-centered care, and palliative care.

Controlled vocabulary (MeSH terms) and free-text keywords were combined with Boolean operators to maximize sensitivity and specificity. Each research strategy was adapted to the unique syntax and indexing of the respective database.

2.2 Research strategy used in each database

Chart 1 - Research strategy used in each database with their number of results.

Database	Research strategy	Results
PubMed	("Alzheimer Disease"[Mesh] OR "Alzheimer's" OR "Dementia"[Mesh] OR dementia) AND ("Person-Centered Care"[Mesh] OR "person-centered care" OR "patient-centered care" OR "client-centered care" OR "individualized care") AND ("Palliative Care"[Mesh] OR "palliative care" OR "supportive care" OR "end-of-life care" OR "terminal care")	88
Scopus	TITLE-ABS-KEY("Alzheimer's disease" OR "Alzheimer Disease" OR dementia) AND TITLE-ABS-KEY("person-centered care" OR "patient-centered care" OR "individualized care" OR "client-centered care") AND TITLE-ABS-KEY("palliative care" OR "supportive care" OR "end-of-life care" OR "terminal care")	151

All the retrieved references were exported to the Rayyan platform for systematic screening and duplicate removal.

2.3 Eligibility and screening criteria

After 63 duplicate articles were removed, a total of 176 unique records were screened. The screening process was conducted in two phases: (1) title and abstract screening and (2) full-text review. Screening was performed independently by two reviewers, with disagreements resolved through consensus.

Articles were included if they met all the following eligibility criteria:

Population (P): Adults (≥ 18 years) with a confirmed diagnosis of AD in advanced or terminal stages, defined by validated clinical criteria (e.g., Diagnostic and Statistical Manual of Mental Disorders, 5th Edition - DSM-5, National Institute of Neurological and Communicative Disorders and Stroke [NINCDS]-Alzheimer's Disease and Related Disorders Association [ADRDA]) or functional measures (e.g., FAST ≥ 7). Studies with mixed dementia populations were included only if the results for Alzheimer's patients were reported separately or represented $\geq 80\%$ of the sample; Intervention (I): Structured PCC interventions directly applied to patients. Eligible interventions required a clear description of their components, implementation protocol, delivery method, and professionals involved. Interventions solely focused on staff education, caregiver support, theoretical PCC frameworks, or policy-level recommendations were excluded; Comparator (C): Usual care, standard PC, or another structured care model; Outcomes (O): At least one quantifiable clinical outcome, including but not limited to quality of life (e.g., Quality of Life - Alzheimer's Disease - QoL-AD, QUALIDEM), symptom burden (e.g., Pain Assessment in Advanced Dementia - PAINAD, Neuropsychiatric Inventory - NPI), comfort at end of life (e.g., Comfort Assessment in Dying – End-of-Life in Dementia - CAD-EOLD), concordance with care preferences, or healthcare utilization (e.g., hospitalizations, Intensive Care Unit [ICU] use); Study design (S): Randomized controlled

trials, non-randomized trials, analytical observational studies (cohort or case-control), mixed-methods studies, or systematic reviews with extractable data from primary studies.

The exclusion criteria included purely qualitative studies, case reports, protocols without results, narrative or scoping reviews, opinion papers, and those without patient-focused interventions or without PC context.

2.4 Screening results and data extraction

Of the included studies, 7 originated from the Scopus database and 9 from PubMed, totaling 16 eligible studies. Each study was reviewed in detail, and relevant data were extracted using a standardized spreadsheet in Google Sheets. Extracted variables included: authorship, publication year, country, study design, sample size and characteristics, detailed description of the PCC intervention, outcomes assessed, and main findings.

Instead, a scoping synthesis was conducted, grouping the findings by intervention type and primary outcomes reported.

3. Findings

The database search resulted in the identification of 239 records. After removing 63 duplicates, 176 studies were screened by title and abstract. Of these, 160 were excluded, remaining 16 articles, which were assessed for eligibility, and all 16 met the predefined criteria and were included in this scoping review, as illustrated in Fig. 1.

3.1. Foundations of Person-Centered Care

PCC emerged as a fundamental model in redefining the quality of healthcare delivery, representing a profound shift from the traditional disease-centered medical model to an integrated approach that places the patient at the core of the care process⁸. This model is particularly applied in chronic conditions, such as AD, in which the preservation of identity and human dignity becomes the primary goal of care⁹.

The concept of PCC is intrinsically linked to People-Centred Integrated Care, as proposed by the World Health Organization (WHO)¹⁰. The WHO emphasizes PCC as a cornerstone for strengthening health systems by reorganizing care delivery in a comprehensive, accessible, and coordinated manner, promoting health and well-being. In the context of AD, this perspective encompasses psychosocial, spiritual, and practical dimensions of care.

3.1.1. Principles of Person-Centered Care

The principles of PCC constitute an interdependent foundation for clinical practice. Individualization is the primary principle, recognizing each person as a unique being with a distinct life history, values, and

needs, thereby requiring a personalized care plan ⁸.

From this, it derives respect for autonomy, which involves honoring the patient's right to choice even in advanced stages of the disease, engaging family members as essential partners in care ¹¹.

Furthermore, empathy is also essential, understood as the ability to understand and share the feelings of another, allowing caregivers to comprehend the patient's perspective and validate their emotions, thus establishing a genuine therapeutic connection ¹².

Finally, active listening and effective communication extend beyond verbal language, requiring attention to nonverbal cues, patience, and the creation of a safe environment for people to express themselves ^{13,14}. Additionally, there are six elements of positive care (identity, occupation, inclusion, comfort, attachment, and bonding) which sustain the humanization of care, preserving dignity and identity.

3.1.2. Distinction Between PCC and Disease-Centered Care

As discussed in the foundations of PCC, this model differs substantially from disease-centered care. While the latter focuses primarily on diagnosis, management of physical symptoms, and the application of technical protocols, the former emphasizes the subjective experience of living with the disease. This approach does not deny the importance of treating pathology but rather subordinates it to the overarching goal of promoting global well-being, dignity, and quality of life ⁸.

3.1.3. Applicability of PCC in Chronic and Degenerative Diseases

The application of PCC in chronic and degenerative diseases, such as AD is essential. At this stage, cure may no longer be possible, and continuous follow-up is required in the face of progressive losses ¹⁵. PCC focuses on preserved abilities rather than lost functions, creating a supportive environment that minimizes disorientation and provides psychological support ¹⁶.

Studies demonstrate that PCC implementation in dementia care is associated with improved outcomes, including reduced challenging behaviors, lower use of psychotropic medications, increased family satisfaction, and, critically, improved quality of life as perceived by the patient. ^{9,17}.

3.2. Palliative Care in the Context of Alzheimer's Disease

3.2.1. Definition and Timing of Palliative Care Introduction

The PC approach is widely recommended in AD due to its progressive and incurable nature, which leads to significant functional impairment ¹⁸. Unlike models traditionally associated with oncology, PC in dementia should be introduced from the early stages of the disease, shortly after diagnosis, and evolve concurrently with disease progression, as opportunities for intervention exist from diagnosis until death ^{19,20}. This integration enables proactive symptom management, advance care planning, and continuous

support, aligning with PCC principles, since PC is most beneficial before the terminal phase of the disease²¹.

3.2.2. Specific Challenges in the Application of Palliative Care

The implementation of PC in AD faces challenges directly related to its pathophysiology. As the disease progresses, cognitive decline compromises communication abilities, making it difficult to assess symptoms such as pain, hunger, thirst, anxiety, and distress²².

This communication barrier often leads to undertreatment of pain, as professionals may rely on general practitioners due to their medical expertise and familiarity with patients, while being unaware of observational pain assessment tools²¹. Consequently, behavioral and psychological manifestations, such as agitation and aggression, frequently represent expressions of unrecognized discomfort^{19, 23, 24}. This reinforces the importance of early PC, requiring both clinical teams and family members to become highly skilled in interpreting nonverbal cues such as facial expressions and body posture for effective assessment^{23, 25}.

3.2.3. Shared Decision-Making and Advance Care Planning

As patients' decision-making capacity declines, choices should be guided by previously established directives, when available, and by known patient preferences, involving family members or legal representatives²⁶. Shared decision-making and advance care planning constitute a fundamental pillar of care.

Complex end-of-life decisions become frequent, including the management of acute comorbidities and the definition of limits for non-beneficial interventions²⁶. Limiting care transitions and staff turnover is crucial, as continuity of relationships allows professionals to maintain a long-term understanding of the individual, essential for decisions aligned with patient values¹⁹. This planning stage also underpins ethical discussions addressed in subsequent sections, such as respect for patient preferences (3.4.2) and the use of protocols (3.5.4).

3.2.4. Palliative Approach to Common Situations in Advanced Disease

In advanced AD, several clinical situations explicitly require a palliative approach. Pain management demands continuous assessment using validated tools for non-communicative patients, such as PACSL-2 and the Abbey Pain Scale, along with appropriate pharmacological and non-pharmacological treatments¹⁹. Neuropsychiatric symptoms, such as agitation, should primarily be addressed through environmental and psychosocial interventions²⁷, as antipsychotic use is associated with increased risks of cerebrovascular events and mortality in this population²⁸.

Nutritional changes and dysphagia require support for safe oral feeding for as long as possible, accompanied by ethical discussions regarding the benefits and burdens of tube feeding, which often does not improve survival or comfort and may increase aspiration risk ²⁶. Beyond physical aspects, recognizing and addressing existential and spiritual suffering is essential, providing comfort through presence, music therapy, family connection, and validation of the person beyond the disease, thereby promoting dignity-centered care ¹⁸.

3.3. Effects of PCC on Quality of Life

3.3.1. Improvement in Patient Quality of Life

Care for individuals with AD should prioritize quality of life as its primary goal, given the limited scope of curative medical treatment. As quality of life is an individual perception, studies advocate its promotion through PCC, grounded in respect and dignity ²⁹.

PC institutions have recognized the need to move beyond strictly medical care and establish PCC to create a favorable psychosocial environment for people with dementia, of whom an estimated 50% to 70% have AD as the underlying cause of cognitive decline ^{29, 30}.

Aligned with PCC, PC can alleviate physical and psychosocial symptoms, provide comfort, and achieve holistic care, particularly by enabling patient engagement in meaningful activities ^{31, 32}. Studies involving 19 clinical trials with 3,985 participants demonstrated that PCC in long-term care facilities and home settings improves quality of life, reduces agitation, neuropsychiatric symptoms, and depression when applied over extended periods ²⁸.

Additional studies indicate that healthcare team knowledge of PCC positively impacts care quality and service delivery, reducing incidents, psychotropic use, and readmissions. Thus, PCC not only improves clinical outcomes but also enhances patient experience and healthcare system efficiency ³³.

3.3.2. Improvement in Family and Healthcare Team Satisfaction

PCC can also be designed to maintain the well-being of caregivers and family members of patients with AD, who often experience significant personal and emotional strain ^{29, 34}. Behavioral and psychological symptoms of dementia are particularly distressing for informal caregivers and healthcare staff, especially when their stress is not validated and communication skills are insufficient ^{30, 35, 36}.

This underscores the importance of PCC for all stakeholders in the AD care context. Studies demonstrate reduced stress, lower burnout, and increased job satisfaction among teams implementing PCC. Therefore, caregiver education focused on individualized care can yield positive and sustained effects over time ²⁸. Similarly, this approach is effective within families assuming daily caregiving

responsibilities. Psychoeducational interventions enhance knowledge and coping skills, increasing satisfaction and perceived competence³⁷.

3.4. Impact on Clinical Outcomes and Humanization of Care

3.4.1. Improvement in Clinical Outcomes

PCC demonstrates measurable impacts on clinical practice in AD patients receiving PC. Evidence suggests reductions of up to 37% in avoidable hospitalizations and 41% in emergency department visits among older populations receiving integrated, PCC ^{38, 39, 40}.

Additionally, studies show that individualized behavioral strategies reduce physical restraint use by approximately 21% compared with units lacking specialized protocols ^{41,42}. A decrease in futile interventions in advanced disease stages is also observed; for instance, enteral feeding is replaced by assisted hand-feeding in up to 48% of cases, and prolonged antibiotic use is reduced by 35%, aligning care with comfort-focused goals ^{41, 43}. These findings reinforce that aligning therapeutic plans with care goals improves outcomes and promotes more humanized care ⁴³.

3.4.2. Respect for Patient Preferences

PCC is particularly effective in ensuring respect for patient preferences, even in advanced stages of AD. Studies indicate that systematic implementation of advance directives and structured advance care planning discussions increases concordance between received treatment and previously expressed wishes by 33% to 40% compared with traditional approaches ^{44, 45}.

Beyond biomedical needs, this model incorporates biographical aspects such as personal values, cultural traditions, and family bonds, strengthening individualized care ⁴⁶. This integration contributes to a 25% to 30% reduction in ethical conflicts faced by care teams during end-of-life decision-making ⁴⁷ and is associated with significantly higher family satisfaction ⁴⁸.

3.4.3. Integrated Multidisciplinary Approach

The effectiveness of PCC relies fundamentally on coordinated action among professionals from multiple disciplines, including medicine, nursing, psychology, occupational therapy, social work, and spiritual care ⁴⁹. Evidence shows that interdisciplinary teams increase comprehensive needs assessment by up to 45%, simultaneously addressing physical, psychological, social, and spiritual dimensions ^{50, 51}.

Regular clinical meetings and the use of standardized multidimensional assessment tools are associated with significant improvements in quality indicators such as symptom control, effective communication, and alignment of care with patient values ^{27, 51}. Consistent application of PCC ethical

principles (respect for autonomy, dignity preservation, and active listening) is identified as a determinant of more humanized care, greater patient comfort, and reduced caregiver burden^{50, 52}.

3.5. Barriers and Facilitators to Implementation

3.5.1. Healthcare System Overload

Mental illness is among the conditions that most limit individuals' lives and often requires continuous care, placing a substantial burden on caregivers. Family members, friends, and healthcare professionals frequently experience overload and illness due to caregiving responsibilities, especially in the absence of adequate guidance⁵³. This burden is exacerbated when healthcare teams must manage multiple competing demands, directly impacting both caregivers and patients.

3.5.2. Inequalities in Access to Palliative Care

Although health is recognized as a global right, access to PC remains unequal. In many countries, particularly low-income settings, essential pain control medications, including opioids, are not consistently available²². Cultural, educational, and structural barriers hinder implementation, and public policies and clear protocols for dementia care are often lacking⁵⁴. While some national initiatives aim to align with international guidelines, coverage and funding gaps persist^{27, 55}.

3.5.3. Lack of Professional Training in Person-Centered Care

Specific training in PC and person-centered approaches remains insufficient in many regions. Short or online courses offer flexibility but often fail to prepare professionals for the complexity of end-of-life care⁵⁵. Practical experience is frequently limited, reinforcing the need for supervised activities and structured clinical exposure. International studies highlight that training must extend beyond technical skills to include communication, team collaboration, and emotional preparedness to support patients and families^{27, 56}.

In summary, PCC-based interventions yield clear benefits: they reduce agitation, neuropsychiatric symptoms, and depression; improve quality of life; decrease antipsychotic use; and increase staff satisfaction. The focus lies in building meaningful relationships with patients, particularly those institutionalized long-term⁵⁷. Evidence shows that staff training lasting 6 to 12 months leads to substantial improvements, further strengthened by continuous supervision and feedback^{28, 58}).

3.5.4. Person-Centered Protocols and Advance Care Planning

The use of person-centered protocols and advance care planning is a major facilitator of care quality, as discussed previously (3.2.3). This planning aligns care decisions with patient values and preferences, personalizes care, and prevents last-minute decisions that may not reflect patient wishes. Evidence

indicates that it improves end-of-life care, patient and family satisfaction, and reduces stress, anxiety, and depression among bereaved relatives ⁵⁹.

However, the lack of Alzheimer's-specific protocols remains a significant barrier. According to experts from the European Association for Palliative Care (EAPC), the course of dementia is long and unpredictable, with no clear transition point to PC, complicating guideline development ²⁷. This uncertainty limits standardization and consistent application of best practices.

3.5.5. Family Involvement and Psychosocial Support

The role of the family is central. Family caregivers are often the primary providers of care for individuals with advanced disease, and supporting them is essential ⁵⁶. The Program to Support the Institutional Development of the Unified Health System (PROADI-SUS) Palliative Care Manual emphasizes that support should include clear information, emotional assistance, and active participation in care processes, respecting values and beliefs ⁶⁰. Integrating families into the multidisciplinary team not only reduces caregiver burden but also strengthens the person-centered approach, benefiting both patients with AD and their support networks ⁶¹.

4. Discussion

Regarding the treatment of AD in the context of PC, it is important that care extends beyond technical intervention, incorporating ethical values, dignity, and recognition of the person beyond the disease, that is, a person constituted by a unique life trajectory ^{61, 62}. Within this context, PCC emerges as a fundamental element by shifting the focus of attention from a strictly biomedical model to a holistic approach guided by the individual's singularity, since disease-centered care model effectiveness is reduced in scenarios of clinical irreversibility, as it neglects relevant dimensions of illness at the end of life: subjective, relational and existential.. The analyzed literature consistently demonstrates that the adoption of PCC is associated with greater acceptance among patients, families, and healthcare professionals, in addition to positively impacting the quality and effectiveness of PC ^{63, 64}.

In the specific context of AD, as the cognitive decline progresses, difficulties in verbal communication and marked personality changes become frequent, compromising the patient's ability to express needs, imposing substantial ethical and clinical challenges to care, reinforcing the need for approaches that transcend purely biomedical assessment ⁶⁵. Among the observed outcomes are a reduction in ethical conflicts, greater clarity in defining therapeutic goals, and a decrease in potentially disproportionate or futile interventions, such as the indiscriminate use of physical restraints, repeated hospitalizations, and the initiation of artificial nutritional support in advanced stages of the disease, when clinical benefits are limited ⁶⁶. By aligning therapeutic decisions with the patient's previously expressed preferences, and personal values, PCC contributes to the autonomy and dignity preservation, while fostering more harmonious relationships among healthcare teams, patients, and families ^{67, 68, 69}.

In this context of verbal communication loss, structured communication tools such as Question Prompt Lists (QPLs) are perceived as acceptable and effective strategies aligned with person-centered care in palliative care for individuals with dementia, as they facilitate dialogue, reduce communication asymmetry, and promote shared decision-making^{68, 69}. QPLs also strengthen advance care planning (ACP) by enabling earlier discussions about prognosis, care goals, and end-of-life preferences, which is particularly important in Alzheimer's disease due to the progressive loss of decision-making capacity^{70 – 73}. ACP lies primarily in the construction of a continuous, relational, and person-centered process. PCC, in this sense, constitutes the ethical and methodological foundation that allows ACP to remain a living process, adjusted according to clinical evolution⁷⁴.

Convergently, the studies included in this review indicate that PC for people with AD and similar dementias is linked to fewer aggressive end-of-life measures, regardless of whether the care is specialized or not, emphasizing the importance of PCC in matching decisions with prognosis and objectives of care^{75, 76}. The absence of notable differences in comfort, symptom management, and satisfaction between specialized and non-specialized PC reinforce PCC elements as critical factors in care quality rather than formal specialization, like effective communication, collaborative decision-making, and family engagement⁷⁷. Specialized PC can offer extra advantages in complicated clinical situations, such as enhanced care coordination and fewer emergency visits, especially in later stages of AD. Thus, PCC should be understood as a dynamic and graduated approach, capable of articulating with different levels of care complexity throughout the disease trajectory^{78, 79}.

Despite the widely described benefits, the implementation of PCC remains limited because of structural, educational, and workforce limitations, significant caregiver stress, and a lack of adequate resources^{80, 81, 82, 83}. Socioeconomic disparities, disparities in access to PC services, and financial constraints impede PCC consolidation, highlighting the necessity for supportive public policies⁸⁴. Moreover, the absence of standardized PC protocols for AD leads to postponed integration, frequently limited to the later stages of the disease^{85, 86}.

4.1. Limitations and Future Directions

This study is limited by the scarcity of research specifically addressing PCC in PC for individuals with AD, as most literature treats dementia as a homogeneous condition. Additionally, the scoping review design precludes causal inference and quantitative synthesis. Future studies should evaluate structured person-centered interventions, communication strategies, and early PC integration models. Also, interdisciplinary research remains essential to strengthen person-centered palliative care across the AD trajectory.

5. Summary

Based on the scoping review conducted, PCC, when integrated into PC for individuals with AD, demonstrates relevant clinical and ethical benefits. The available evidence indicates improved alignment of therapeutic decisions with patients' preferences and values, a reduction in potentially disproportionate end-of-life interventions, fewer avoidable hospitalizations, and greater satisfaction among family members and healthcare professionals. Structured communication strategies, such as question prompt lists, emerge as promising tools to operationalize PCC and facilitate advance care planning. Despite the methodological limitations of the existing literature, the findings support the recommendation for early and systematic integration of PCC into PC within the context of AD.

Abbreviations

ACP

advance care planning

AD

Alzheimer's disease

ADRDA

Alzheimer's Disease and Related Disorders Association

CAD-EOLD

Comfort Assessment in Dying – End-of-Life in Dementia

DSM-5

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

EAPC

European Association for Palliative Care

ICU

Intensive Care Unit

NINCDS

National Institute of Neurological and Communicative Disorders and Stroke

NPI

Neuropsychiatric Inventory

PAINAD

Pain Assessment in Advanced Dementia

PCC

Person-Centred Care

PC

Palliative care

PICOS

Population, Intervention, Comparator, Outcomes, Study design

PROADI-SUS

Program to Support the Institutional Development of the Unified Health System

QoL

Quality of Life - Alzheimer's Disease

QPL

Question Prompt Lists

WHO

World Health Organization

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

COMPETING INTERESTS

The authors declare that they have no competing financial or non-financial interests related to this study. Furthermore, the authors declare that there are no other interests that could be perceived to have influenced the results or discussion reported in this manuscript.

DUAL PUBLICATION

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Author Contribution

A.H.B., D.N.S.A., M.E.A.S., J.M.D., and S.F.C.A. jointly conceived the study, developed the research question, and contributed to the study design. All authors participated in the literature search in the PubMed and Scopus databases, study screening and selection, data extraction, data analysis, interpretation of the findings, manuscript preparation and critical revision. A.H.B., M.E.A.S., and S.F.C.A. took the lead in developing the search strategy, defining the search terms and eligibility criteria, preparing the data extraction tables, designing the PRISMA flow diagram, preparing the manuscript tables, conducting the final literature review, and drafting the first version of the manuscript. L. C. S. and P.V.M.G. critically reviewed the manuscript, provided scientific guidance throughout the study, and supervised all stages of the research. All authors read and approved the final manuscript and agree to be accountable for all aspects of the work.

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DATA AVAILABILITY

This study used exclusively data derived from previously published scientific studies identified through systematic searches of the PubMed and Scopus databases. All data analyzed during this study are presented in this article and are available in the references cited in this manuscript. No new datasets were generated during this study.

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Figures

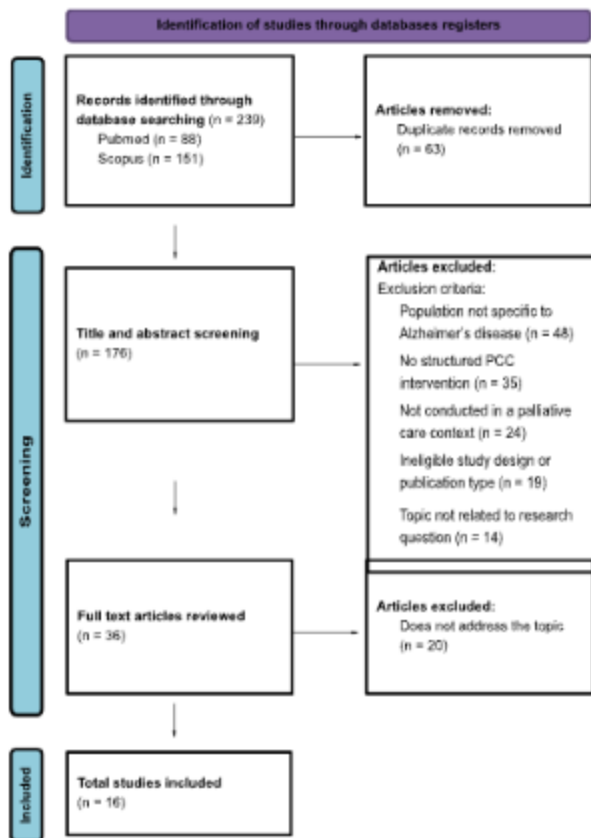


Figure 1

Screening of articles using the systematic review flowchart (PRISMA).