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# Screening instruments for early identification of unmet palliative care needs: a systematic review and meta-analysis

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## ABSTRACT

**Background** The early detection of individuals who require palliative care is essential for the timely initiation of palliative care services. This systematic review and meta-analysis aimed to (1) Identify the screening instruments used by health professionals to promote early identification of patients who may benefit from palliative care; and (2) Assess the psychometric properties and clinical performance of the instruments.

**Methods** A comprehensive literature search was conducted in PubMed, Embase, CINAHL, Scopus, CNKI and Wanfang from inception to May 2023. We used the COnsensus-based Standards for the Selection of Health Measurement INstruments to assess the methodological quality of the development process for the instruments. The clinical performance of the instruments was assessed by narrative summary or meta-analysis. Subgroup analyses were conducted where necessary. The quality of included studies was assessed using the Newcastle-Ottawa Scale and the Cochrane Collaboration's risk of bias assessment tool.

**Results** We included 31 studies that involved seven instruments. Thirteen studies reported the development and validation process of these instruments and 18 studies related to assessment of clinical performance of these instruments. The content validity of the instruments was doubtful or inadequate because of very low to moderate quality evidence. The pooled sensitivity (Se) ranged from 60.0% to 73.8%, with high heterogeneity (I<sup>2</sup> of 88.15% to 99.36%). The pooled specificity (Sp) ranges from 70.4% to 90.2%, with high heterogeneity (I<sup>2</sup> of 96.81% to 99.94%). The Supportive and Palliative Care Indicators Tool (SPICIT) had better performance in hospitals than in general practice settings (Se=79.8% vs 45.3%, p=0.004; Sp=59.1% vs 97.0%, p=0.000).

## WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ Early palliative care can improve the quality of life for patients with non-communicable diseases in advanced stages.
- ⇒ However, it is difficult to identify patients with palliative care needs early and at the right time for reasonable palliative care.

## WHAT THIS STUDY ADDS

- ⇒ Seven screening instruments were identified, but none comprehensively assessed the patient's physical, psychological and spiritual distress, and their need for social support.
- ⇒ The overall methodological quality of the evidence ranged from very low to moderate.
- ⇒ In hospitals, Supportive and Palliative Care Indicators Tool has better clinical performance than Necesidades Paliativas (Palliative Needs) and Taiwanese version Palliative Care Screening Tool, with a pooled sensitivity of 79.8% (95% CI 72.6% to 85.5%).

## HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

- ⇒ Future studies should focus on validating screening instruments against relevant criteria for referring patients to palliative care rather than solely against their ability to predict mortality.
- ⇒ Additional efforts are required to enhance the comprehensiveness of existing instruments by encompassing a broader spectrum of concerns, including those related to the physical, psychological, social and spiritual dimensions
- ⇒ The applicability of these instruments in different healthcare settings should be validated to improve their clinical performance.

**Conclusion** The clinical performance of existing instruments in identifying patients with palliative care needs early ranged from poor to reasonable. The SPICt is used most commonly, has better clinical performance than other instruments but performs better in hospital settings than in general practice settings.

## BACKGROUND

More than 50 million people die from non-communicable diseases (eg, cancer, cardiovascular diseases, and respiratory diseases) globally each year—equivalent to 71% of all deaths.<sup>1 2</sup> People with life-limiting illnesses may experience a significant degree of physical, psychological and spiritual distress.<sup>3</sup> For them, palliative care is an approach to preventing and alleviating symptoms and improving quality of life through early identification and appropriate management of symptoms.<sup>4 5</sup> The need for palliative care continues to grow as a result of the ageing population and the incidence of non-communicable diseases.

Early palliative care is associated with improved symptom control, satisfaction with healthcare, quality of life and survival.<sup>6 7</sup> It may also reduce hospital stays, the use of aggressive treatments close to death and healthcare expenditure.<sup>8 9</sup> However, most people still only receive palliative care in their last few days or weeks of life. Delayed access to palliative care can contribute to negative outcomes including ineffective medical interventions, higher healthcare costs,<sup>10</sup> inappropriate use of treatment modalities,<sup>11</sup> and insufficient support for patients and their families.<sup>12</sup>

The early detection of individuals who require palliative care is essential for the timely initiation of palliative care services.<sup>13</sup> Several screening instruments have been developed to identify individuals who would benefit from palliative care so that healthcare professionals (HCPs) can tailor palliative care to the specific needs and preferences of patients.<sup>14–19</sup> Five reviews have been conducted to evaluate these instruments but were limited to narrative summaries of the main characteristics or psychometric properties of screening instruments. They did not conduct a meta-analysis to pool the clinical performance of the instruments.<sup>19–23</sup> Additionally, existing reviews only included instruments used within a single type of setting, such as primary care settings or hospital settings.<sup>19–21 23</sup> Therefore, it is unclear how screening instruments were used across different settings, and whether variations exist in their clinical performance across these instruments and different settings.

To address the gap, this systematic review aimed to (1) Identify existing screening instruments for early identification of individuals who are in need of palliative care, irrespective of setting of care; (2) Describe the key characteristics and psychometric properties of screening instruments, including validity and reliability;

and (3) Pool and compare their clinical performance in identifying patients with palliative care needs early.

## METHODS

This systematic review was registered in PROSPERO (CRD42022335942) and followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement.<sup>24</sup>

### Search methods

We conducted two rounds of literature searches. First, we performed a systematic search using four English databases (PubMed, CINAHL, Embase and Scopus) and two Chinese databases (CNKI and Wanfang), from inception to May 2023. After identifying the instruments, we used their name to search for additional relevant studies. A detailed search strategy is provided in online supplemental appendix S1.

### Study selection process

All retrieved articles were imported into the software Covidence to facilitate citation management. After removing duplicates, two researchers independently screened by titles and abstracts of the included citations. Full-text reading was then performed by the same researchers against the pre-established criteria. After that, the researchers completed quality evaluation, data extraction and analysis. Discrepancies between researchers were resolved by a third author when necessary.

### Inclusion/exclusion criteria

#### Target population

We included instruments targeting: (1) Adults aged 18 years or older; and (2) Patients with any advanced non-communicable diseases such as cancer, heart disease, dementia, organ failure and so on.

#### Instruments

Screening instruments were used to identify patients with palliative care needs early. We excluded screening instruments designed for a specific disease because our objective was to identify generic instruments for multiple diseases and settings. We excluded screening instruments specifically for intensive care units and emergency departments. It was because the rapid change in patient conditions in these settings makes long-term palliative care needs prediction challenging.<sup>25</sup> We excluded screening instruments that were primarily used in the last few days or weeks of life because these instruments are not suitable for the early identification of palliative care patients.

#### Outcomes

The outcomes of interest were the development, validation and clinical performance of screening instruments. For development of the instruments, we examined aims and methodology. With regards to key characteristics

and psychometric properties of screening instruments, we explored the number of items, responses format, time frame, scope of population, settings for use and content. The clinical performance indicators included sensitivity, specificity, positive likelihood ratio (LR+), negative likelihood ratio (LR-), positive predictive values (PPV), negative predictive values (NPV) and diagnostic OR (DOR).

#### Types of studies

We included studies published in peer-reviewed journals in either the English or Chinese language because the research team members are fluent in both languages. We excluded protocols, conference abstracts, reviews, commentaries, letters to the editor, oral presentations, case reports and studies for which full texts were not available.

We divided the included studies in two groups. Group 1 was the studies describing the development of the included instruments (development and validation studies); group 2 referred to the studies aiming at examining the clinical performance of the included instruments (clinical performance studies).

#### Assessment of methodological quality of included instruments

We used COnsensus-based Standards for the Selection of Health Measurement INstruments (COSMIN) to assess the methodological quality of the development of screening instruments.<sup>26</sup> COSMIN assesses design quality, test quality, content validity and construct validity, using a 4-point rating scale (1=very good, 2=sufficient, 3=doubtful, 4=inadequate). Results from all studies were qualitatively summarised to determine the overall relevance, comprehensiveness, understandability and content validity of the screening instrument, with each aspect rated as adequate (+), insufficient (-), inconsistent ( $\pm$ ) or inconclusive (?).<sup>27</sup> Finally, the quality of the evidence was graded as 'high', 'moderate', 'low' or 'very low', using the revised Grading of Recommendations, Assessment, Development and Evaluation methodology.<sup>27</sup>

#### Risk of bias of the included studies

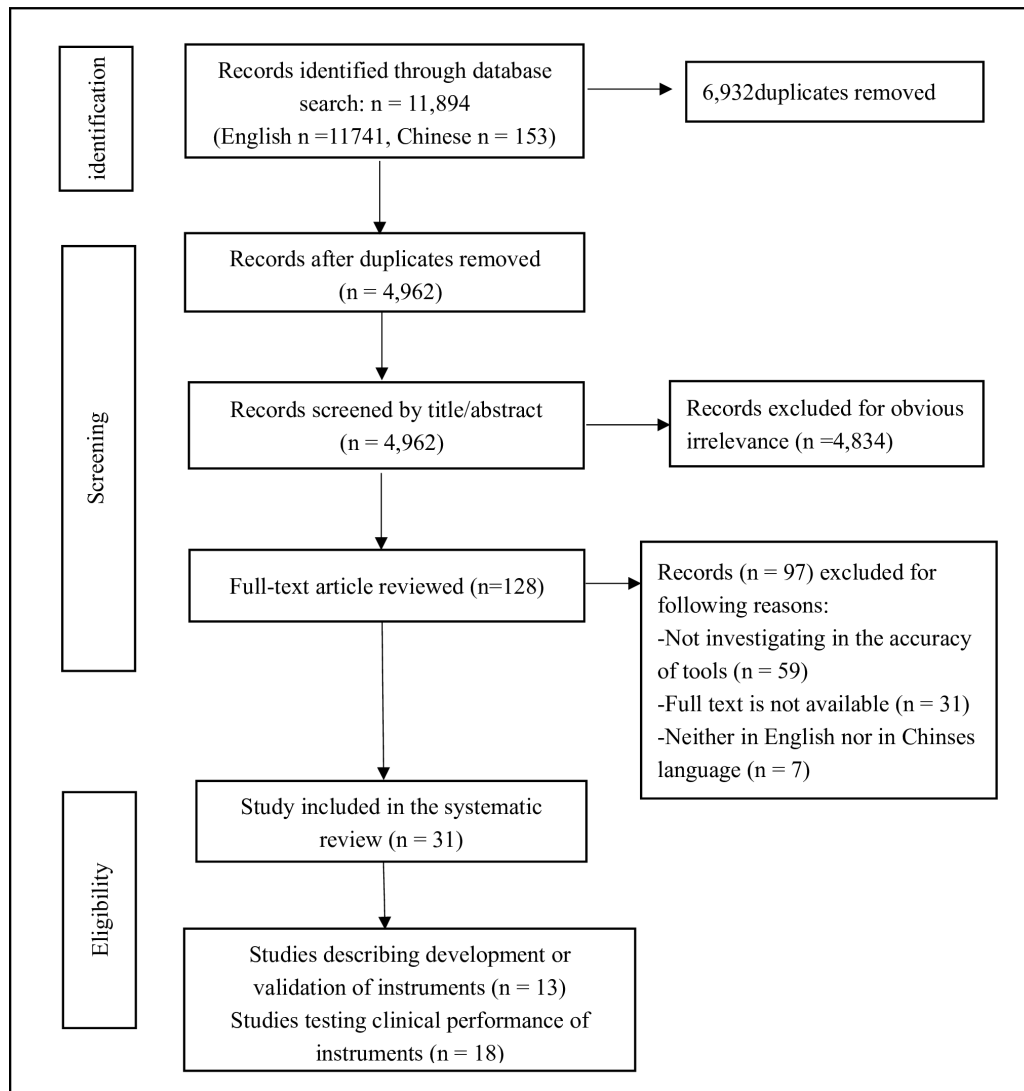
We assessed the risk of bias using the Newcastle-Ottawa Scale for observational studies and Cochrane Collaboration's risk of bias assessment tool for randomised clinical trials (RCTs). The Newcastle-Ottawa Scale rates bias on three dimensions: selection, comparability and outcome, resulting in low (less than 5 points), medium (6–7 points) and high (8–9 points).<sup>28</sup> The Cochrane Collaboration's risk of bias assessment tool assesses seven possible sources of bias, including selection bias, performance bias, detection bias, attrition bias, reporting bias and other bias, and has three responses (ie, 'High risk', 'Low risk' and 'Unclear') for each item.<sup>29</sup>

#### Data extraction

Three predefined data extraction forms were used to extract information. The first table extracted the basic features of screening instruments from development and validation studies (eg, year of development, country, language, target populations, users of the instrument, numbers of items, format of responses, psychometric properties, survival time predicted by the instruments, settings for use and contents). The second table extracted information about the clinical performance studies, including study design, instrument used, setting and number of subjects. For each clinical performance study, we also developed a third table, the 2×2 table, to calculate sensitivity, specificity, LR+, LR-, PPV, NPV and DOR. The sensitivity is the ratio of correctly identified deaths (true positive results) to the total number of actual deaths (positive results). The specificity is the ratio of correctly identified non-deaths (true negative results) to the total number of non-deaths (negative results). The DOR, the ratio of disease positive rate to the non-disease positive rate (LR+ divided by LR-), ranges from 0 to infinity, with higher values indicating better discriminatory test performance.<sup>30</sup> We also recorded the area under the curve for each instrument. If necessary, researchers contacted the authors for more data to calculate clinical performance. Data were extracted by one researcher and double-checked for accuracy by a second researcher.

#### Data synthesis and analysis

The key features of screening instruments were described in a narrative synthesis. We performed a meta-analysis to pool the sensitivity, specificity, LR+, LR- and DOR using Meta-Disc 2.0 and Stata 17.0. The threshold heterogeneity in clinical performance among studies for each instrument was determined by the Spearman correlation coefficient between the logarithm of sensitivity and 1-specificity. If  $p < 0.05$  of the Spearman correlation coefficients reveals heterogeneity of threshold effect, the summary receiver operating characteristics (SROC) curve was used to combine the statistics from which the specificity and sensitivity of the group of studies were obtained. The SROC curve is an integrated receiver operating characteristics curve based on the weighting of the diagnostic advantage ratio in individual diagnostic tests.<sup>31</sup> We used I<sup>2</sup> measures to report non-threshold effect heterogeneity in the summary estimates of diagnostic performance ( $I^2 < 50\%$  for low,  $50\% \leq I^2 < 75\%$  for moderate, and  $I^2 \geq 75\%$  for high).<sup>32</sup> If significant heterogeneity existed ( $I^2 > 50\%$ ), the random effects model was used; otherwise, the fixed effects model was applied. Subgroup analyses were performed by the age groups of included populations or healthcare settings ( $p < 0.05$ ). Publication bias was assessed using the asymmetry regression test described by Deek's, with a symmetrical plot indicating no publication bias.<sup>33</sup> A



**Figure 1** Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart of the study selection.

narrative synthesis was completed if data associated with the clinical performance of screening instruments was insufficient for meta-analysis.

## RESULTS

As shown in [figure 1](#), a total of 11 894 articles were initially retrieved, and 4962 articles remained after removing duplicates. After title and abstract screening, 128 articles remained. Following a full-text review, 31 articles were included, reporting seven screening instruments: the Gold Standards Framework Prognostic Indicator Guidance (GSF-PIG), the RADboud indicators for Palliative Care needs (RADPAC), the Taiwanese version Palliative Care Screening Tool (TW-PCST), the Necesidades Paliativas (Palliative Needs) (NECPAL), the Supportive and Palliative Care Indicators Tool (SPICT), Rainone and AnticiPal. Out of the 31 articles, 13 reported the development and validation of these instruments,<sup>17 18 34–44</sup> while the other 18 articles focused on the clinical performance of the instruments.<sup>14 15 45–60</sup> The content validity of

these seven screening instruments was doubtful or inadequate because of very low to moderate quality evidence. The quality of the clinical performance articles ranged from 6.5 to 8 (online supplemental appendix S2). There was no evidence for publication bias in the funnel plot (online supplemental appendix S3).

As indicated in [table 1](#), the majority of the studies (17 studies, 94%) were observational. Follow-up times varied across the studies. No studies on the clinical performance of AnticiPal were retrieved.

We identified six studies that reported the clinical performance of SPICT in either hospital or primary care settings with follow-up periods of 6 months or 12 months. Among studies on SPICT, one was an RCT, and the remaining five were observational studies.<sup>14 56–60</sup> SPICT was used by a range of HCPs, including specialists, general practitioners, nurses and doctors.

Four observational studies evaluated the clinical performance of NECPAL in multiple settings (eg, hospital, nursing home and primary care centre)

Table 1 Characteristics of the clinical performance articles

Reference	Country	Study design	Versions of screening instruments used	Setting	Months of prognosis	Target diagnostic groups	Evaluators	Number of patients assessed	Age of patients (years) (mean±SD)	Per cent of patients identified by instruments as positive (%)
Rainone F <i>et al</i> 2007 <sup>15</sup>	USA	A prospective observational study	Rainone	Primary care	NR	Any diagnosis	Family medicine staff	839	NR	25.9
Haga K <i>et al</i> 2012 <sup>45</sup>	UK	A cohort study	GSF-PIG	NR	12	Chronic heart failure	NR	138	77±10.0	87.0
O'Callaghan A <i>et al</i> 2014 <sup>46</sup>	New Zealand	A prospective cohort study	GSF-PIG	Acute hospital	12	Any diagnosis	Two palliative care experts (doctor and a nurse)	501	70.5±15.3	19.8
Raubenheimer P <i>et al</i> 2019 <sup>47</sup>	South Africa	A cohort study	GSF-PIG	Hospital	12	Any diagnosis	Clinicians	822	52, IOR: 37–67	27.0
Gómez-Batiste X <i>et al</i> 2017 <sup>48</sup>	Spain	A prospective cohort study	NECPAL	Three primary care centres, an acute bed hospital, four nursing homes and an intermediate care centre	24	Respiratory diseases	HCPs (doctors and nurses)	1059	81.4	73.7
Calsina-Berna A <i>et al</i> 2018 <sup>49</sup>	Spain	A cohort study	NECPAL	Hospital	24	Advanced chronic disease	HCPs (doctors and nurses)	236	68.2±14.7	85.6
Gastelurrutia P <i>et al</i> 2019 <sup>50</sup>	NR	A cohort study	NECPAL	Heart failure clinic	12	Heart failure	NR	972	69.3±12.2	24.3
Tabernero Huguet E <i>et al</i> 2021 <sup>51</sup>	Spain	A prospective cohort study	NECPAL	Hospital respiratory unit	12	Respiratory diseases	Respiratory diseases	363	76±11.0	73.7
Wang SS <i>et al</i> 2019 <sup>52</sup>	China Taiwan	A prospective cohort study	TW-PCST	Hospital	6	Any diagnosis	Nurses	21596	58.8±24.5	27.0
Yen YF <i>et al</i> 2020 <sup>53</sup>	China Taiwan	A cohort study	TW-PCST	Hospital	3	Any diagnosis	NR	47153	61.7±19.3	25.0
Yen YF <i>et al</i> 2022 <sup>54</sup>	China Taiwan	A prospective cohort study	TW-PCST	Hospital	12	Any diagnosis	Nurses	21109	62.8±19.0	11.1
Yen YF <i>et al</i> 2022 <sup>55</sup>	China Taiwan	A cohort study	TW-PCST	Hospital	6	Any diagnosis	Primary care nurses	111483	60.9±19.1	4.5
De Bock <i>et al</i> 2017 <sup>57</sup>	Belgium	A retrospective cohort study	SPICT	Hospital acute geriatric unit	12	Any diagnosis	Medical staff	435	84, IOR: 80–88	54.7
Mitchell GK <i>et al</i> 2018 <sup>56</sup>	Australia	A randomised controlled trial	SPICT	NR	12	Any diagnosis	General practitioners	4365	79.1±6.9	33.6
van Wijmen MPS <i>et al</i> 2020 <sup>58</sup>	The Netherlands	A prospective cohort study	SPICT-NL	General practice	12	Any diagnosis	General practitioners	3640	NR	13.7
Piers R <i>et al</i> 2021 <sup>60</sup>	Belgium	A prospective cohort study	SPICT-FR and SPICT-NL	Hospital acute geriatric units and cardiology unit	12	Any diagnosis	Geriatrician	AGUs: 209 CUs: 249	NR	AGUs: 53.9 CUs: 40.6
Low J <i>et al</i> 2022 <sup>14</sup>	UK	A prospective cohort study	SPICT	Hospital liver unit	12	Liver	Three expert palliative care/hepatology specialists	117	52.3±15.9	52.0
Chan AS <i>et al</i> 2022 <sup>59</sup>	USA	A retrospective cohort study	SPICT	Community hospital	6	Advanced cancer	NR	227	66±9.7	60.0

AGUs, acute geriatric units; CUs, cardiology units; GSF-PIG, Gold Standards Framework Prognostic Indicator Guidance; HCP, healthcare professional; IOR, interquartile range; NECPAL, Necesidades Paliativas (Palliative Needs); NR, not reported; SPICT, Supportive and Palliative Care Indicators Tool; SPICT-FR, the French version of the Supportive and Palliative Care Indicators Tool; SPICT-NL, the Dutch version of the Supportive and Palliative Care Indicators Tool; TW-PCST, Taiwanese version Palliative Care Screening Tool.



**Table 2** Main features of the identified screening instruments

	GSF-PIG	RADPAC	NECPAL	SPICT	TW-PCST	Rainone	AnticiPal
Year of development	2004	2012	2012	2011	2017	2007	2015
Country of development	UK	The Netherlands	Spain	UK	China	USA	UK
Methodology	NR	A procedure consisting of three steps: literature review, focus group, and modified and Delphi	Building on GSF-PIG and SPICT, a multidisciplinary panel of experts conducted semistructured interviews.	A literature review, peer review and prospective case investigation	NR	Multidisciplinary expert assessments	An iterative software development life-cycle approach for application creation
Application settings	All	Primary care	All	All	Hospital	General practice	General practice
Language of original version	English	Dutch	Spanish	English	Chinese	NA	NA
Languages of adapted versions	NR	NR	Portuguese, Israeli	Thai, Spanish, Italian, German, Swedish, Indonesian, Danish, Japanese, Nepali, Dutch, French, Greek, Portuguese	NR	NA	NA
Targeted diagnostic groups	All	Patients with COPD, congestive heart failure and cancer	All	All	All	All	All
Forms (traditional paper-based or electronic instruments)	Paper-based	Paper-based	Paper-based	Paper-based	Paper-based	Electronic instruments	Electronic instruments
Prognosis	NR	NR	NR	SPICT: Few minutes; SPICT-LIS: An average of 3.3 min; SPICT-ES: An average of 4 min and 45 s; SPICT-DE: An average of 7.5 min	An average of 5 min	NR	NR
Number of indicators	73 indicators in total, comprising 12 general indicators and 12 sets of specific indicators	21 indicators in total, distributed across 3 domains, with 6–8 items in each	59 indicators in total, comprising 12 general indicators and 9 sets of specific indicators	34 indicators in total, comprising 6 general indicators, 23 specific clinical indicators and 5 recommended indicators	26 indicators in total	6 indicators in total	NA
Inclusion of SQ	Yes	No	Yes	No	No	Yes	NA
Criteria for positive	The SQ response was 'No', 'No' and who presented $\geq 1$ general indicator or $\geq 1$ specific indicator	NR	The SQ response was 'No' and also the person presented with $\geq 1$ other positive criterion	$\geq 2$ general indicators and $\geq 1$ clinical indicators	The sum of the four parts scores $\geq 2$ or 4 points	The SQ response was 'No' and/or answer affirmatively to any of items 2–5.	NR
COPD, chronic obstructive pulmonary disease; GSF-PIG, Gold Standards Framework Prognostic Indicator Guidance; NA, not applicable; NECPAL, Necesidades Palliativas (PalliativeNeeds); NR, not reported; RADPAC, RADbound indicators for Palliative Care needs; SPICT, Supportive and Palliative Care Indicators Tool; SPICT-DE, the German version of the Supportive and Palliative Care Indicators tool; SPICT-ES, the Spanish version of the Supportive and Palliative Care Indicators tool; SPICT-LIS, The Supportive and Palliative Care Indicators Tool for Low-income setting; SQ, surprise question; TW-PCST, Taiwanese version Palliative Care Screening Tool.							

with follow-up periods of 12 months or 24 months. NECPAL was used by either physicians or nurses.<sup>49–51</sup>

Four observational studies reported the clinical performance of TW-PCST.<sup>52–55</sup> These studies were conducted in hospitals settings, with follow-up periods ranging from 3 months to 12 months. TW-PCST was used by nurses in these studies.

Three observational studies used GSF-PIG to predict the 12-month prognosis of patients in hospitals, with the evaluators being specialists and clinicians.<sup>45–47</sup>

A prospective observational study on Rainone was conducted in primary care settings, and patients were evaluated by family medical staff. The study did not report follow-up times.<sup>15</sup>

**Development process of the screening instruments**

Among the seven identified instruments, five were in the format of traditional paper-based screening instruments (SPICT, NECPAL, RADPAC, GSF-PIG and TW-PCST),<sup>16–18 39 52</sup> and two were in the format of electronic screening instruments (AncitiPal and Rainone).<sup>15 61</sup> Development of the traditional paper-based screening instruments involved a combination of literature review, expert consultation, focus group interviews and clinical trials. SPICT was developed in the UK through a literature review, peer expert review and prospective case finding. It is the most widely used instrument and is now available in 15 languages (eg, Italian, Thai, German, Spanish, Swedish, Danish and Indonesian).<sup>34–38 40 42 43 62 63</sup> The development of NECPAL was based on GSF-PIG and SPICT. NECPAL has been translated into Portuguese and Chilean.<sup>41 44</sup> RADPAC was developed through a process that included literature review, focus group discussions and a modified Rand Delphi approach. GSF-PIG was originally developed in English and translated into Italian in 2014.<sup>64</sup> We did not find detailed development information about GSF-PIG and TW-PCST. As for the electronic instruments, AncitiPal used an iterative software development life-cycle approach and analysed retrospective cases to create a computer software algorithm for the automatic identification of individuals with palliative care needs. Rainone used electronic medical records to identify the most common factors affecting inpatient mortality and built identification criteria on that basis, but detailed development information was not reported.

**Characteristics of the screening instruments**

The detailed characteristics of the seven screening instruments are shown in table 2. More detail information about the instruments can be found in online supplemental appendix S4. Except for RADPAC, all instruments include both general and disease-specific palliative care indicators.<sup>15 16 18 39 52 61</sup> All instruments are appropriate for patients with cancer, chronic obstructive pulmonary disease and congestive heart failure. All the included instruments except RADPAC

**Table 3** Summary of psychometric properties of the identified screening instruments

Development study	Content validity		Comprehensiveness		Comprehensibility		Structural validity		Internal consistency		Cross-cultural validity		Reliability		Measurement error		Criterion validity	
	MQ	QR	QR	Quality of evidences	QR	Quality of evidences	QR	Quality of evidences	QR	Quality of evidences	QR	Quality of evidences	QR	Quality of evidences	QR	Quality of evidences	QR	Quality of evidences
GSF-PIG	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
RADPAC	3	-	-	Very low	-	Very low	-	Very low	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NECPAL	3	+	±	Low	±	Low	±	Low	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
SPICT	3	+	±	Moderate	±	Moderate	±	Moderate	+	Moderate	+	Moderate	+	Moderate	NR	NR	NR	NR
TW-PCST	4	-	-	Very low	-	Very low	-	Very low	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Rainone	4	-	-	Very low	-	Very low	-	Very low	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
AncitiPal	3	+	+	Moderate	-	Moderate	-	Moderate	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

±, inconsistent; -, insufficient; +, sufficient; 1, very good; 2, sufficient; 3, doubtful; 4, inadequate; GSF-PIG, Gold Standards Framework Prognostic Indicator Guidance; MQ, measurement quality; NECPAL, Necesidades Paliativas (Palliative Needs); NR, not reported; QR, quality rating; RADPAC, RADboud indicators for Palliative Care needs; SPICT, Supportive and Palliative Care Indicators Tool; TW-PCST, Taiwanese version Palliative Care Screening Tool.

are also appropriate for patients with cardiac, respiratory, neurological, liver and kidney disorders, and frailty. Three instruments (GSF-PIG, NECPAL and Rainone) include the surprise question (SQ) which asks the assessing clinician to consider likely death within a specified timeframe.<sup>15 18 18</sup> Four instruments (GSF-PIG, NECPAL, TW-PCST and AnticiPal) include indicators related to comorbidity.<sup>16 18 52 61</sup> Three instruments include psychological indicators (NECPAL, TW-PCST and Rainone).<sup>15 18 52</sup> GSF-PIG and NECPAL assess the occurrence of adverse events.<sup>16 18</sup> NECPAL considers request of palliative care service from both the patients and their families.<sup>18</sup> GSF-PIG is the only instrument that evaluates the financial conditions of patients.<sup>16</sup> SPICT provides recommendations for future care plans based on the results of assessment.<sup>39</sup>

**Psychometric properties of the included instruments**

The quality of evidence related to the development process and content validity was generally poor (table 3). Specific information regarding the quality of evidence can be found in online supplemental appendix S5. Only the articles of SPICT and NECPAL provided data on reliability or content validity of the instruments. Five studies reported the reliability of different versions of SPICT, with a range of 0.35–0.97 on the Kuder-Richardson formula 20,<sup>37 38 42</sup> a Kappa range of 0.66–0.98<sup>36 38 42</sup> and a Cronbach’s alpha of 0.84.<sup>63</sup> The Content Validity Index (CVI) was only reported for the Italian-SPICT, which was 0.86.<sup>36</sup> One study reported a Kappa-adjusted CVI of 0.96 for the Israeli-NECPAL.<sup>44</sup> The reliability and content validity of TW-PCST, GSF-PIG, RADPAC and Rainone was not reported. According to the COSMIN methodology, no studies reported construct validity, cross-cultural validity assessment, measurement error and criterion validity of the identified instruments.

**Clinical performance of the included instruments**

Eighteen studies reported clinical performance for five instruments (GSF-PIG, SPICT, NECPAL, TW-PCST and Rainone). Detailed information on the clinical performance of each instrument can be found in online supplemental appendix S6. We found that different studies used different positive cut-off values (scores  $\geq 2$  or  $\geq 4$ ) for TW-PCST. In the meta-analysis, the Spearman correlation coefficient of TW-PCST was not statistically significant ( $\rho=0.8$ ,  $p=0.200>0.05$ ), indicating that there was no heterogeneity of threshold effect in the studies for TW-PCST.

A meta-analysis of pooled sensitivity (Se), pooled specificity (Sp), LR+, LR–, area under the receiver operating characteristics curve and DOR for each instrument revealed high heterogeneity (table 4). To identify the source of heterogeneity, we conducted a subgroup analysis of sensitivity, specificity, LR+, LR– and DOR, taking into account the setting and age of the population (table 5). The results indicated

**Table 4** Details of clinical performance of the identified screening instruments

Screening instruments	Sensitivity % (95% CI) P value	Heterogeneity (I <sup>2</sup> , %) (95% CI)	Specificity % (95% CI) P value	Heterogeneity (I <sup>2</sup> , %) (95% CI)	LR+ (95% CI) P value	Heterogeneity (I <sup>2</sup> , %) (95% CI)	LR– (95% CI) P value	Heterogeneity (I <sup>2</sup> , %) (95% CI)	PPV (95% CI)	NPV (95% CI)	AUC (95% CI)	DOR (95% CI)
SPICT*	71.7 (57.5–82.6) p=0.000	94.06 (91.04 to 97.08)	78.0 (55.1–91.1) p=0.000	99.51 (99.40 to 99.62)	3.25 (1.64–6.47) p=0.000	97.66 (97.66 to 98.86)	0.36 (0.27–0.49) p=0.000	96.04 (94.27 to 97.82)	20.5 to 66.4	80.0 to 99.6	0.80 (0.76 to 0.83)	8.96 (4.67 to 17.20)
NECPAL*	73.8 (56.1–86.2) p=0.000	88.15 (83.09 to 93.02)	70.4 (47.4–86.3) p=0.000	96.81 (95.89 to 97.72)	2.50 (1.51–4.13) p=0.000	93.77 (93.77 to 96.82)	0.37 (0.26–0.52) p=0.000	77.97 (66.82 to 89.11)	21.9 to 72.2	61.9 to 96.2	0.78 (0.75 to 0.82)	6.73 (4.49 to 10.08)
TW-PCST*	60.0 (44.3–73.9) p=0.000	99.36 (99.13 to 99.58)	90.2 (82.3–94.7) p=0.000	99.94 (99.93 to 99.95)	6.10 (4.15–8.95) p=0.000	99.77 (99.77 to 99.85)	0.44 (0.32–0.61) p=0.000	98.83 (98.33 to 99.33)	22.8 to 34.1	94.9 to 98.1	0.85 (0.82 to 0.88)	13.71 (10.80 to 17.45)
GSF-PIG	63–83	NA	22–92	NA	1.06–7.73	NA	0.30–0.77	NA	33.0 to 67.7	75.0 to 93.0	NR	1.38 to 18.85
RADPAC	NR	NA	NR	NA	NR	NA	NR	NA	NR	NR	NR	NR
Rainone	94.0	NA	97.0	NA	31.33	NA	2.00	NA	36.0	99.0	NR	15.67
AnticiPal	NR	NA	NR	NA	NR	NA	NR	NA	NR	NR	NR	NR

\*Pooled results in meta-analysis.

AUC, area under the receiver operating characteristics curve; DOR, diagnostic OR; GSF-PIG, Gold Standards Framework Prognostic Indicator Guidance; LR+, positive likelihood ratio; LR–, negative likelihood ratio; NA, not applicable; NECPAL, Necesidades Psicológicas (Palliative Needs); NPV, negative predictive value; NR, not reported; PPV, positive predictive value; RADPAC, RADboud indicators for Palliative Care needs; SPICT, Supportive and Palliative Care Indicators Tool; TW-PCST, Taiwanese version Palliative Care Screening Tool.



**Table 5** Clinical performance of SPICT across setting and age of population

Subgroup		Sensitivity % (95% CI)	P value	Specificity % (95% CI)	P value	LR+ (95% CI)	LR- (95% CI)	DOR (95% CI)
Setting	Hospital	79.8 (72.6 to 85.5)	0.004	59.1 (52.2 to 65.1)	0.000	1.95 (1.64 to 2.32)	0.34 (0.24 to 0.48)	5.70 (3.51 to 9.28)
	Non-hospital	45.3 (30.2 to 61.4)		97.0 (95.7 to 97.9)		15.07 (8.97 to 25.34)	0.56 (0.42 to 0.76)	26.75 (12.44 to 57.41)
Age of population	Elderly patients	72.7 (55.5 to 85.0)	0.964	71.0 (44.1 to 88.4)	0.247	2.51 (1.34 to 4.69)	0.38 (0.29 to 0.52)	6.52 (3.71 to 11.48)
	Non-elderly patients	72.0 (42.4 to 90.0)		90.2 (60.4 to 98.2)		7.33 (1.93 to 27.82)	0.31 (0.15 to 0.66)	23.64 (8.90 to 62.77)

DOR, diagnostic OR; LR-, negative likelihood ratio; LR+, positive likelihood ratio; SPICT, Supportive and Palliative Care Indicators Tool.

a significant difference in the sensitivity and specificity of the SPICT-setting subgroup ( $p=0.004 < 0.05$ ), but significant heterogeneity was not presented for the age of the population. The clinical performance of SPICT was found to be better than other instruments (NECAPAL and TW-PCST) in hospital settings. In hospital settings, SPICT demonstrated a Se of 79.8% (95% CI 72.6% to 85.5%), a Sp of 59.1% (95% CI 52.2% to 65.1%), and a pooled DOR of 5.70 (95% CI 3.51 to 9.28). In contrast, when used in non-hospital settings, SPICT exhibited a Se of 45.3% (95% CI 30.2% to 61.4%), a Sp of 97.0% (95% CI 95.7% to 97.9%) and a pooled DOR of 26.75 (95% CI 12.44 to 57.41). However, due to the limited number of studies, we were not able to identify the source of heterogeneity for NECPAL and TW-PCST.

The clinical performances of GSF-PIG and Rainone were narratively summarised because of the small number of studies (table 4). The sensitivity of GSF-PIG ranged from 62.6% to 83%, specificity ranged from 22% to 91.9%, and DOR was between 1.38 and 18.85, which showed a wide variation in clinical performance. In the case of Rainone, an observational study reported a sensitivity of 94.0%, specificity of 97.0%, LR+ of 31.33, LR- of 2.00 and DOR of 15.67.<sup>15</sup>

## DISCUSSION

The systematic review identified and assessed psychometric properties and the clinical performance of seven screening instruments for early identification of patients with palliative care needs. The overall methodological quality of evidence related to the reliability and validity of screening instruments ranged from very low to moderate. Notably, the quality of evidence about NECPAL was rated as low, which is consistent with findings of previous reviews.<sup>20–22</sup> The quality of evidence regarding the content validity of SPICT was rated as ‘moderate’ in this review, but was rated as very low by Teike’s review.<sup>20</sup> One possible reason for this discrepancy is that we included the validation studies of all versions of SPICT, but Teike’s review only included the development study of the original version of SPICT. Additionally, we found that none of

the screening instruments demonstrated high clinical performance, with a Se ranging from 60.0% (poor) to 73.8% (moderate).

This review found that none of the included instruments assessed all of the physical, psychological, social and spiritual domains of care. Palliative care is described as a holistic approach to care which addresses the needs of the whole individual.<sup>65</sup> According to the biopsychosocial-spiritual model, individuals’ relationships should be considered when assessing holistically. Illness poses a disruption to the biological relationships, which in turn impacts all the other relational aspects of a person. Genuinely holistic healthcare will address the totality of the patient’s relational existence—physical, psychological, social and spiritual concerns.<sup>65–66</sup> Palliative care screening instruments should identify the breadth of these concerns to effectively address the corresponding needs of patients. Second, psychological distress is multifaceted, but is also reflective of the interactions of the biopsychosocial-spiritual model. Many patients with advanced non-communicable diseases experience physical suffering leading to high levels of psychological distress.<sup>67–68</sup> Psychological distress may also stem from uncertainty about the future and fear of death.<sup>69</sup> Third, spiritual distress including deep internal questioning and struggles is prevalent in this group of patients,<sup>70</sup> which may frustrate attempts to treat physical and psychological symptoms and adversely affect the quality of life.<sup>67–71</sup> Finally, the social needs of an individual are crucial as the end of life approaches.<sup>72</sup> The need for support can affect the patient’s physical functioning, quality of life, and psychological and spiritual status throughout the course of the disease. However, the need for social and spiritual support, and to a lesser extent psychological support are often overlooked in the evaluated instruments due to a focus on physical symptoms.<sup>73</sup> If a screening instrument only assesses one or two of these domains of care, patients may miss the optimal time to receive palliative care. To ensure timely access to palliative care that is responsive to the biopsychosocial-spiritual model, we recommend that screening instruments comprehensively assess physical, psychological, social and spiritual concerns.

To ensure the integrity of the content, it is equally important to select an appropriate theoretical framework such as the biopsychosocial-spiritual model to guide the development of instruments for palliative care.

In general, screening instruments are meant to have high sensitivity and high specificity. The SPICT used in hospital settings was the best performing screening instrument. In the included articles, SPICT and NECPAL were evaluated by physicians and nurses, whereas TW-PCST was solely evaluated by nurses. However, it is unclear whether physicians are more accurate than nurses in identifying patients in need of palliative care. The sensitivity of SPICT was better than that of NECPAL in hospitals maybe because SPICT does not include the SQ. The SQ relies on HCPs' subjective intuition and is largely influenced by patients' disease trajectory and depends on the HCP's skill in prognostication.<sup>74</sup> The palliative care population involves patients with cancer and non-cancer patients, including those with frailty and dementia.<sup>5 75</sup> The trajectories of both cancer and non-cancerous diseases are highly variable, and the prognosis is often difficult to estimate.<sup>76 77</sup> A previous meta-analysis claimed that the ability to identify the palliative care population SQ was slightly better among patients with cancer compared with patients not diagnosed with cancer.<sup>74</sup> Another reason is the unreliability of HCPs' subjective judgements. The judgements are often based on clinical experience,<sup>56</sup> but some HCPs do not have sufficient clinical experience to make reliable judgements. The use of SQ increases 'false positives', suggesting that a large number of patients who do not necessarily need palliative care are identified as positive.<sup>78</sup>

The clinical performance of the included instruments was assessed based on mortality/prognosis prediction. However, identifying those individuals who would benefit from palliative care should be focused on recognising unmet needs in a holistic needs-based assessment rather than on predicting the rate of physical deterioration or projected survival.<sup>23</sup> When prognosis is used as a contributing characteristic to identify the need for palliative care, the complex and diverse disease trajectories pose difficulties for HCPs in identifying those who could potentially benefit from palliative care needs. On the other hand, use of a mortality/prognosis prediction model may encourage clinicians to focus on when to start 'planning for death' and may lead to delayed reviews of unmet needs and care of goals until the very last stages of a patient's life.<sup>39 76 79</sup> Furthermore, use of mortality/prediction as an indicator of the clinical performance could also mistakenly screen out some patients with palliative care needs.

This review emphasises that the screening instrument is intended to provide a framework for raising HCPs' awareness of the increasing disease burden in patients and to identify patients with potential palliative care needs early. This approach motivates both patients and

clinicians to consider palliative care as an option and to conduct holistic assessments at any point the need arises. It ensures that patients receive the appropriate care at the right time, according to their wishes and preferences.

This review focuses on the content, reliability, validity and clinical performance of existing screening instruments for the early identification of people in need of palliative care. Our study has identified instruments which can be applied in various settings, including hospitals, communities and homes. Because there is no uniform reference standard to evaluate whether screening instruments have the ability to identify people with genuine palliative care needs, we used sensitivity and specificity to evaluate the clinical performance of these instruments. Our study showed that the sensitivity of SPICT is the highest performing of the extant screening instruments when used within hospital settings. Palliative care has long been practised in non-hospital settings (eg, community and home), however, only a small number of studies of SPICT have reported its application in these settings.

#### Strengths and weaknesses

To our knowledge, this is the first comprehensive systematic review focusing on the clinical performance of screening instruments for the early identification of patients with palliative care needs. We used a comprehensive strategy to identify relevant research, including a secondary search using instrument names. We used sensitivity as a reference to compare the clinical performance of the screening instruments.

However, our study has some limitations. First, this review only included studies published in peer-reviewed journals in English or Chinese. Therefore, instruments and studies published in other languages were omitted. Second, the meta-analysis only included a small number of high-quality studies. Therefore, this result should be interpreted with caution. Subgroup analysis was only performed for SPICT based on different care settings and age groups. It is unclear whether there are other factors that can influence the clinical performance of the instrument. More studies are clearly needed to validate these instruments for the early identification of patients with palliative care needs.

#### CONCLUSION

The seven included instruments in this study have a low to moderate clinical performance and none comprehensively assess physical, psychological, social and spiritual problems. SPICT is the most commonly used instrument and has a relatively better ability to identify patients' palliative care needs early in the hospital setting compared with other settings and other instruments. To better support early identification of palliative care patients, further work is needed to refine the content of the existing instruments to more

systematically and accurately assess patients. Moreover, early identification of palliative care patients should shift from estimating when a patient will die to identifying the unmet palliative care needs.

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## REFERENCES

- 1 Noncommunicable diseases: world health organization. 2021. Available: <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases> [Accessed 10 Dec 2022].
- 2 Connor SR. Global Atlas of palliative care at the end of life London. 2nd edn. England, 2020. Available: <https://www.thewhpc.org/resources/global-atlas-on-end-of-life-care>
- 3 Chidiac C. The evidence of early specialist palliative care on patient and caregiver outcomes. *Int J Palliat Nurs* 2018;24:230–7.
- 4 Harrop E, Morgan F, Longo M, *et al.* The impacts and effectiveness of support for people bereaved through advanced illness: A systematic review and thematic synthesis. *Palliat Med* 2020;34:871–88.
- 5 Palliative care: world health organization. 2020. Available: <https://www.who.int/news-room/fact-sheets/detail/palliative-care> [Accessed 10 Dec 2022].
- 6 Franciosi V, Maglietta G, Degli Esposti C, *et al.* Early palliative care and quality of life of advanced cancer patients—a multicenter randomized clinical trial. *Ann Palliat Med* 2019;8:381–9.
- 7 Mah K, Chow B, Swami N, *et al.* Early palliative care and quality of dying and death in patients with advanced cancer. *BMJ Support Palliat Care* 2023;13:e74–7.
- 8 Seow H, Barbera LC, McGrail K, *et al.* Effect of early palliative care on end-of-life health care costs: a population-based, propensity score-matched cohort study. *JCO Oncol Pract* 2022;18:e183–92.
- 9 Zaborowski N, Scheu A, Glowacki N, *et al.* Early palliative care consults reduce patients' length of stay and overall hospital costs. *Am J Hosp Palliat Care* 2022;39:1268–73.
- 10 Margolis B, Chen L, Accordino MK, *et al.* Trends in end-of-life care and health care spending in women with uterine cancer. *Am J Obstet Gynecol* 2017;217:434.
- 11 Lindsay J, Dooley M, Martin J, *et al.* Reducing potentially inappropriate medications in palliative cancer patients: evidence to support deprescribing approaches. *Support Care Cancer* 2014;22:1113–9.
- 12 Temel JS, Greer JA, El-Jawahri A, *et al.* Effects of early integrated palliative care in patients with lung and GI cancer: a randomized clinical trial. *J Clin Oncol* 2017;35:834–41.
- 13 Gómez-Batiste X, Murray SA, Thomas K, *et al.* Comprehensive and integrated palliative care for people with advanced chronic conditions: an update from several European initiatives and recommendations for policy. *J Pain Symptom Manage* 2017;53:509–17.
- 14 Low J, Carroll C, Wilson J, *et al.* Do screening tools assess palliative care needs and 12-month mortality in patients admitted to hepatology in-patient wards? *Frontline Gastroenterol* 2022;13:211–7.
- 15 Rainone F, Blank A, Selwyn PA. The early identification of palliative care care patients, preliminary processes and estimates from urban, family medicine practices. *Am J Hosp Palliat Care* 2007;24:137–40.
- 16 The Gold Standards Framework. The gold standards framework-new updated Proactive identification guidance 2016. 6th edn. 2022. Available: <https://goldstandardsframework.org.uk> [accessed 18 Nov 2022].
- 17 Thoosen B, Engels Y, van Rijswijk E, *et al.* Early identification of palliative care patients in general practice: development of Radboud indicators for palliative care needs (RADPAC). *Br J Gen Pract* 2012;62:e625–31.
- 18 Gómez-Batiste X, Martínez-Muñoz M, Blay C, *et al.* Identifying patients with chronic conditions in need of palliative care in the general population: development of the NECPAL tool and preliminary prevalence rates in Catalonia. *BMJ Support Palliat Care* 2013;3:300–8.
- 19 Maas EAT, Murray SA, Engels Y, *et al.* What tools are available to identify patients with palliative care needs in primary care: a systematic literature review and survey of European practice. *BMJ Support Palliat Care* 2013;3:444–51.
- 20 Teike Lüthi F, MacDonald I, Rosselet Amoussou J, *et al.* Instruments for the identification of patients in need of palliative care in the hospital setting: a systematic review of measurement properties. *JBI Evid Synth* 2022;20:761–87.
- 21 Walsh RI, Mitchell G, Francis L, *et al.* What diagnostic tools exist for the early identification of palliative care patients in general practice a systematic review. *J Palliat Care* 2015;31:118–23.
- 22 Cole CS, Roydhouse J, Fink RM, *et al.* Identifying nursing home residents with unmet palliative care needs: a systematic review of screening tool measurement properties. *J Am Med Dir Assoc* 2023;24:619–28.



- 23 ElMokhallalati Y, Bradley SH, Chapman E, *et al.* Identification of patients with potential palliative care needs: a systematic review of screening tools in primary care. *Palliat Med* 2020;34:989–1005.
- 24 Page MJ, McKenzie JE, Bossuyt PM, *et al.* The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *Syst Rev* 2021;10.
- 25 Cotogni P, De Luca A, Evangelista A, *et al.* A simplified screening tool to identify seriously ill patients in the emergency department for referral to a palliative care team. *Minerva Anesthesiol* 2017;83:474–84.
- 26 Terwee CB, Prinsen CA, Chiarotto A, *et al.* COSMIN-methodology-for-content-validity-user-manual-v1. 2018. Available: <https://www.cosmin.nl/wp-content/uploads/COSMIN-methodology-for-content-validity-user-manual-v1.pdf>
- 27 Prinsen CAC, Mokkink LB, Bouter LM, *et al.* COSMIN guideline for systematic reviews of patient-reported outcome measures. *Qual Life Res* 2018;27:1147–57.
- 28 Wells GA, Shea B, O'Connell D, *et al.* *The Newcastle-Ottawa Scale (NOS) for assessing the quality of nonrandomised studies in meta-analyses.* Oxford, 2000.
- 29 Higgins JPT, Altman DG, Gotzsche PC, *et al.* The cochrane collaboration's tool for assessing risk of bias in randomised trials. *BMJ* 2011;343:d5928.
- 30 Glas AS, Lijmer JG, Prins MH, *et al.* The diagnostic odds ratio: a single indicator of test performance. *J Clin Epidemiol* 2003;56:1129–35.
- 31 Moses LE, Shapiro D, Littenberg B. Combining independent studies of a diagnostic test into a summary ROC curve: data-analytic approaches and some additional considerations. *Stat Med* 1993;12:1293–316.
- 32 Higgins J, Thomas J, Chandler J, *et al.* *Cochrane Handbook for Systematic Reviews of Interventions version 6.3 (updated February 2022).* Cochrane, 2022. Available: <https://training.cochrane.org/handbook/PDF/v6.3>
- 33 Egger M, Davey Smith G, Schneider M, *et al.* Bias in meta-analysis detected by a simple, graphical test. *BMJ* 1997;315:629–34.
- 34 Afshar K, Feichtner A, Boyd K, *et al.* Systematic development and adjustment of the German version of the supportive and palliative care indicators tool (SPICT-DE). *BMC Palliat Care* 2018;17:27.
- 35 Bergenholtz H, Weibull A, Raunkjaer M. Supportive and palliative care indicators tool (SPICT) in a Danish healthcare context: translation, cross-cultural adaptation, and content validation. *BMC Palliat Care* 2022;21:41.
- 36 Casale G, Magnani C, Fanelli R, *et al.* Supportive and palliative care indicators tool (SPICT): content validity, feasibility and pre-test of the Italian version. *BMC Palliat Care* 2020;19:79.
- 37 Effendy C, Silva J, Padmawati RS. Identifying palliative care needs of patients with non-communicable diseases in Indonesia using the SPICT tool: a descriptive cross-sectional study. *BMC Palliat Care* 2022;21:13.
- 38 Fachado AA, Martínez NS, Roselló MM, *et al.* Spanish adaptation and validation of the supportive & palliative care indicators tool - SPICT-ESTM. *Rev Saude Publica* 2018;52:3.
- 39 Hight G, Crawford D, Murray SA, *et al.* Development and evaluation of the supportive and palliative care indicators tool (SPICT): a mixed-methods study. *BMJ Support Palliat Care* 2014;4:285–90.
- 40 Pham L, Arnby M, Benkel I, *et al.* Early integration of palliative care: translation, cross-cultural adaptation and content validity of the supportive and palliative care indicators tool in a Swedish Healthcare context. *Scand J Caring Sci* 2020;34:762–71.
- 41 Santana MTEA, Gómez-Batiste X, Silva LMG da, *et al.* Cross-cultural adaptation and semantic validation of an instrument to identify palliative requirements in Portuguese. *Einstein (São Paulo)* 2020;18.
- 42 Sripaew S, Fumaneeshoat O, Ingviya T. Systematic adaptation of the Thai version of the supportive and palliative care indicators tool for low-income setting (SPICT-LIS). *BMC Palliat Care* 2021;20:35.
- 43 Oishi A, Hamano J, Boyd K, *et al.* Translation and cross-cultural adaptation of the supportive and palliative care indicators tool into Japanese: a preliminary report. *Palliat Med Rep* 2022;3:1–5.
- 44 Fisher G, Shadmi E, Porat-Packer T, *et al.* Identifying patients in need of palliative care: adaptation of the necesidades paliativas CCOMS-ICO® (NECPAL) screening tool for use in Israel. *Palliat Support Care* 2022:1–7.
- 45 Haga K, Murray S, Reid J, *et al.* Identifying community based chronic heart failure patients in the last year of life: a comparison of the gold standards framework prognostic indicator guide and the seattle heart failure model. *Heart* 2012;98:579–83.
- 46 O'Callaghan A, Laking G, Frey R, *et al.* Can we predict which hospitalised patients are in their last year of life? A prospective cross-sectional study of the gold standards framework prognostic indicator guidance as a screening tool in the acute hospital setting. *Palliat Med* 2014;28:1046–52.
- 47 Raubenheimer PJ, Day C, Abdullah F, *et al.* The utility of a shortened palliative care screening tool to predict death within 12 months - a prospective observational study in two South African hospitals with a high HIV burden. *BMC Palliat Care* 2019;18:101.
- 48 Gómez-Batiste X, Martínez-Muñoz M, Blay C, *et al.* Utility of the NECPAL CCOMS-ICO((C)) tool and the surprise question as screening tools for early palliative care and to predict mortality in patients with advanced chronic conditions: a cohort study. *Palliat Med* 2017;31:754–63.
- 49 Calsina-Berna A, Martínez-Muñoz M, Bardés Robles I, *et al.* Intrahospital mortality and survival of patients with advanced chronic illnesses in a tertiary hospital identified with the NECPAL CCOMS-ICO® tool. *J Palliat Med* 2018;21:665–73.
- 50 Gastelurrutia P, Zamora E, Domingo M, *et al.* Palliative care needs in heart failure. a multicenter study using the NECPAL questionnaire. *Rev Esp Cardiol (Engl Ed)* 2019;72:870–2.
- 51 Taberero Huguete E, Ortiz de Urbina Antia B, González Quero B, *et al.* Prevalence and mortality of patients with palliative needs in an acute respiratory setting. *Arch Bronconeumol (Engl Ed)* 2021;57:345–50.
- 52 Wang S-C, Huang C-M, Feng R-C, *et al.* Validation of a concise screening tool for the identification of palliative care needs among inpatients: a prospective study in hospital setting. *J Formos Med Assoc* 2019;118:883–90.
- 53 Yen Y-F, Lee Y-L, Hu H-Y, *et al.* An Interventional study for the early identification of patients with palliative care needs and the promotion of advance care planning and advance directives. *J Pain Symptom Manage* 2020;59:974–82.
- 54 Yen Y-F, Lee Y-L, Hu H-Y, *et al.* Early palliative care: the surprise question and the palliative care screening tool-better together. *BMJ Support Palliat Care* 2022;12:211–7.
- 55 Yen Y-F, Hu H-Y, Lai Y-J, *et al.* Comparison of intuitive assessment and palliative care screening tool in the early identification of patients needing palliative care. *Sci Rep* 2022;12:4955.
- 56 Mitchell GK, Senior HE, Rhee JJ, *et al.* Using intuition or a formal palliative care needs assessment screening process in general practice to predict death within 12 months: A randomised controlled trial. *Palliat Med* 2018;32:384–94.
- 57 De Bock R, Van Den Noortgate N, Piers R. Validation of the supportive and palliative care indicators tool in a geriatric population. *J Palliat Med* 2018;21:220–4.
- 58 van Wijmen MPS, Schweitzer BPM, Pasma HR, *et al.* Identifying patients who could benefit from palliative care by

- making use of the general practice information system: the surprise question versus the SPICt. *Fam Pract* 2020;37:641–7.
- 59 Chan AS, Rout A, 'Adamo CRD, *et al.* Palliative referrals in advanced cancer patients: utilizing the supportive and palliative care indicators tool and Rothman index. *Am J Hosp Palliat Care* 2022;39:164–8.
- 60 Piers R, De Brauwier I, Baeyens H, *et al.* Supportive and palliative care indicators tool Prognostic value in older hospitalised patients: a prospective multicentre study. *BMJ Support Palliat Care* 2021.
- 61 Mason B, Boyd K, Murray SA, *et al.* Developing a computerised search to help UK general practices identify more patients for palliative care planning: a feasibility study. *BMC Fam Pract* 2015;16:99.
- 62 Krause R, Barnard A, Burger H, *et al.* A delphi study to guide the development of a clinical indicator tool for palliative care in South Africa. *Afr J Prim Health Care Fam Med* 2022;14:e1–7.
- 63 Farfán-Zuñiga X, Zimmermann-Vildoso M. Cultural adaptation and validation of the SPICt-ES instrument to identify palliative care needs in Chilean older adults. *BMC Palliat Care* 2022;21:223.
- 64 Scaccabarozzi G, Amodio E, Pellegrini G, *et al.* "The ARIANNA" project: an observational study on a model of early identification of patients with palliative care needs through the integration between primary care and Italian home palliative care units". *J Palliat Med* 2018;21:631–7.
- 65 Rego F, Nunes R. The interface between psychology and spirituality in palliative care. *J Health Psychol* 2019;24:279–87.
- 66 Sulmasy DP. A Biopsychosocial-spiritual model for the care of patients at the end of life. *Gerontologist* 2002;42 Spec No 3:24–33.
- 67 Walker ZJ, Xue S, Jones MP, *et al.* Depression, anxiety, and other mental disorders in patients with cancer in Low- and lower-middle-income countries: a systematic review and meta-analysis. *JCO Glob Oncol* 2021;7:1233–50.
- 68 Cerullo G, Videira-Silva A, Carrancho M, *et al.* Complexity of patient care needs in palliative care: a scoping review. *Ann Palliat Med* 2023;12:791–802.
- 69 Seven A, Sert H. Anxiety, dyspnea management, and quality of life in palliative care patients: a randomized controlled trial. *Florence Nightingale J Nurs* 2023;31:S13–21.
- 70 Batstone E, Bailey C, Hallett N. Spiritual care provision to end-of-life patients: a systematic literature review. *J Clin Nurs* 2020;29:3609–24.
- 71 Fradelos EC. Spiritual well-being and associated factors in end-stage renal disease. *ScientificWorldJournal* 2021;2021:6636854.
- 72 Langford CP, Bowsher J, Maloney JP, *et al.* Social support: a conceptual analysis. *J Adv Nurs* 1997;25:95–100.
- 73 Wang X, Mo Y, Yuan Y, *et al.* Exploring the influencing factors of unmet palliative care needs in Chinese patients with end-stage renal disease undergoing maintenance hemodialysis: a cross-sectional study. *BMC Palliat Care* 2023;22:113.
- 74 Downar J, Goldman R, Pinto R, *et al.* "The 'surprise question' for predicting death in seriously ill patients: a systematic review and meta-analysis". *CMAJ* 2017;189:E484–93.
- 75 Brighton LJ, Bone AE, Maddocks M. Supportive and palliative care for people with chronic respiratory disease and frailty. *Curr Opin Support Palliat Care* 2020;14:206–12.
- 76 Gardiner C, Ingleton C, Gott M, *et al.* Exploring the transition from curative care to palliative care: a systematic review of the literature. *BMJ Support Palliat Care* 2015;5:335–42.
- 77 Bausewein C, Booth S, Gysels M, *et al.* Individual breathlessness Trajectories do not match summary trajectories in advanced cancer and chronic obstructive pulmonary disease: results from a longitudinal study. *Palliat Med* 2010;24:777–86.
- 78 White N, Kupeli N, Vickerstaff V, *et al.* "How accurate is the 'surprise question' at identifying patients at the end of life? A systematic review and meta-analysis". *BMC Med* 2017;15:139.
- 79 Boyd K, Murray SA. Recognising and managing key transitions in end of life care. *BMJ* 2010;341.