Review

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Prevalence and Incidence of Pressure Injuries in Palliative Care Settings: A Systematic Review Update

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Abstract

Introduction. Pressure injuries (PIs) are a frequent complication among patients receiving palliative and end-of-life (EoL) care. However, epidemiological estimates vary widely across clinical settings, and the understanding of pressure-related skin damage in palliative populations has evolved considerably in recent years. This systematic review aimed to update the evidence on the prevalence, incidence, and risk factors associated with PIs in palliative care settings.
Methods. A systematic review was conducted according to the PRISMA 2020 guidelines. PubMed/MEDLINE, CINAHL, Embase, and Scopus were searched to identify studies reporting the prevalence and/or incidence of PIs in palliative care or EoL care settings. Eligibility criteria were defined using the CoCoPop framework. Risk of bias was assessed using design-specific critical appraisal tools, and results were synthesised narratively.
Results. The search identified 443 records, of which eight studies met the inclusion criteria. Studies were conducted across multiple palliative care settings, including home care services, hospice facilities, and hospital-based palliative care units. Reported PI prevalence ranged from 9.0% to 34.1%, while incidence ranged from 3.9% to 26.5%. Most lesions were stage 1 or 2 and commonly located in the sacral region. Identified risk factors included advanced age, reduced mobility, impaired nutritional status, comorbidities, and the presence of medical devices such as urinary catheters.
Discussion. PIs remain a common complication in palliative

and EoL care populations. Their development reflects the multifactorial interaction between clinical deterioration, functional decline, and skin failure. Preventive strategies should therefore be integrated with comfort-focused care and careful clinical assessment, recognising that some PIs may be unavoidable in patients approaching the EoL.

Keywords: Palliative Care, Pressure Injuries, End-of-Life Care, Prevalence, Incidence

Introduction

End-of-life (EoL) care requires a multidisciplinary, multi-professional approach due to the complexity of patients' clinical and psychosocial needs (Radbruch et al., 2020). Globally, the World Health Organization (WHO) estimates that an estimated 56.8 million people require palliative care, the majority of whom are adults aged 50 or older (World Health Organization, 2021). Increasing life expectancy and the growing prevalence of chronic and degenerative diseases have led to a rise in the number of patients requiring complex care during the final stages of life (Cerullo et al., 2024).

At the EoL, progressive deterioration of organ function exposes individuals to multiple risk factors that may further worsen their clinical condition (Stoian et al., 2025). Among these, skin failure has increasingly been recognised as a clinically relevant phenomenon associated with systemic decline (Levine et al., 2022). Skin failure refers to the loss of normal skin integrity and function resulting from hypoperfusion, multiorgan failure, and metabolic alterations in advanced illnesses (Levine et al., 2022). In this context, pressure injuries (PIs), previously known as pressure ulcers, are a frequent complication among patients receiving palliative and EoL care (Kwan et al., 2024).

Despite increasing research interest, epidemiological evidence on the incidence, prevalence, and risk factors for PIs in palliative and EoL care remains heterogeneous. In 2019, a systematic review examined the epidemiology of PIs among patients receiving palliative care (Ferris et al., 2019). The review reported considerable variability in prevalence, incidence, and associated risk factors across studies (Ferris et al., 2019).

In recent years, the understanding of pressure-related skin damage in EoL care has evolved substantially. International clinical practice guidelines emphasise that the primary goal of care often shifts from wound healing to symptom management, comfort, and preservation of dignity (EPUAP/NPIAP/PPPIA, 2019). The guidelines also recognise that, due to progressive clinical deterioration and skin failure, some PIs may be unavoidable in patients approaching the EoL. Consequently, prevention strategies must be balanced with patient comfort and individual care goals (EPUAP/NPIAP/PPPIA, 2019). At the same time, increasing attention has been paid to distinguishing PIs from other skin lesions that occur during the dying process, such as Kennedy Terminal Ulcers and other EoL skin changes. (Latimer et al., 2019). Misclassification of these lesions may lead to inappropriate prevention strategies, unrealistic clinical expectations, and medico-legal concerns for healthcare professionals. (Levine et al., 2022).

Although a systematic review on the prevalence and incidence of PIs is available (Ferris et al., 2019), its publication more than seven years ago may limit the applicability of its findings to current clinical practice. Changes in patient demographics, palliative care models, and the evolving conceptualisation of skin failure and unavoidable skin breakdown highlight the need for updated epidemiological data. Additionally, the conceptualisation and classification of PIs have evolved considerably in recent years, with the introduction of the term "pressure injury" and updates to staging systems in international guidelines (EPUAP/NPIAP/PPPIA, 2019). Furthermore, recent studies from a broader range of palliative and EoL care settings have become available, warranting an updated synthesis of the current evidence. Therefore, providing an updated synthesis of the evidence is essential to better understand the current epidemiology of PIs in palliative and EoL care and to support healthcare professionals in developing appropriate care strategies for patients approaching the EoL.

Aim

The purpose of this systematic review was to summarise the available evidence on the prevalence, incidence, and associated risk factors of PIs in palliative and EoL care settings since 2018, thereby updating and extending the findings of a previously published systematic review.

Materials and methods

Study design

The review was conducted and reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 statement (Page et al., 2021). The protocol was registered on the International Prospective Register of Systematic Reviews (PROSPERO) (identification number: CRD42023394468).

Eligibility criteria

We defined eligibility criteria according to the CoCoPop (Condition, Context, Population) framework, which is recommended for systematic reviews of prevalence and incidence data (Munn et al., 2015). The condition of interest was PIs, the population comprised adults (≥18 years) receiving palliative or EoL care, and the context included the healthcare settings where palliative or EoL care was delivered (e.g., home care, hospice, and hospital-based palliative care units). We included primary studies reporting the prevalence and/or incidence of PIs among adults receiving palliative or EoL care across any care setting, including home palliative care, hospice, hospital-based palliative care units, and other specialised EoL care settings. Moreover, only studies published from January 2018 onwards were included, in order to update evidence from a previously published systematic review (Ferris et al., 2019). We excluded studies involving paediatric samples, studies not focusing on palliative care, and studies not reporting prevalence or incidence data for PIs. Secondary studies (e.g., literature reviews), studies published in languages other than English, and conference abstracts or other reports for which a full text was not available were excluded.

Information sources

We searched the databases PubMed (MEDLINE), CINAHL, Embase, and Scopus. We also searched grey literature sources, including Google Scholar and the websites of the World Health Organization (WHO) and the Italian National Institute of Health (ISS). We also screened the reference lists of included studies to identify potential additional relevant articles. The literature search was conducted in January 2026.

Search strategy

The search strategy was developed for the PubMed database and subsequently adapted for CINAHL, Embase, and Scopus; it was iteratively refined to maximise sensitivity and specificity. The search combined controlled vocabulary terms (e.g., MeSH terms and database-specific subject headings such as Prevalence, Incidence, Pressure Ulcer, Terminal Care, and Palliative Care) with free-text terms related to prevalence, incidence, pressure injuries ("pressure ulcer", "pressure ulcers", "bedsore", "bed sore", "pressure sore", and "decubitus ulcer"), and palliative or EoL care. The terms "pressure injury" and "pressure injuries" were covered through the controlled vocabulary (the MeSH term Pressure Ulcer, whose entry terms include "Pressure Injury" and "Pressure Injuries", and the corresponding subject headings in CINAHL and Embase) but were not added as free-text terms (see Limitations). Search terms were adapted to the controlled vocabulary and syntax of each database. Boolean operators (AND, OR) were used to combine search terms. The full search strategies for each database are reported in Supplementary Material 1.

Selection process

Search records were imported into the Rayyan® web-based software, whose automatic duplicate-detection function was used to identify potential duplicate records. All records flagged by Rayyan as possible duplicates were manually checked by two reviewers (GG and LB), who compared title, authors, year of publication, journal, and DOI, and were removed only after confirmation. Overall, 201 duplicate records were removed. Two reviewers (GG and LB) independently screened the titles and abstracts of the retrieved

studies. When eligibility could not be determined from the title and abstract alone, the study was retained for further evaluation at the full-text stage. Disagreements between reviewers were resolved through discussion and consensus; therefore, consultation with a third reviewer was not required. The full texts of potentially eligible studies were then assessed to determine final inclusion. Grey literature sources were also screened for eligibility.

Data collection process

Data extraction was performed independently by two authors (GG and LB) using an ad hoc data extraction sheet developed for this review. Extracted variables included key study characteristics as well as prevalence and incidence of PIs. The first three studies were jointly extracted to calibrate the extraction process among the reviewers. If necessary, the study authors would have been contacted to obtain missing or unclear information.

Data items

The primary outcomes of interest were the prevalence and incidence of PIs in palliative and EoL care settings. Additional data extracted from each study included the author, the number of patients, the study design, the care setting, and the reported risk factors significantly associated with PI development. Risk factors were extracted as secondary outcomes from studies meeting the eligibility criteria for prevalence and/or incidence reporting. A summary of each study was also recorded.

Risk of bias assessment

The methodological quality and risk of bias of the included studies were assessed using tools appropriate to the specific study design. Observational studies (prospective and retrospective cohort designs) were assessed using the Joanna Briggs Institute (JBI) critical appraisal checklist for cohort studies, and the quasi-experimental study was assessed using the JBI checklist for quasi-experimental studies (Barker et al., 2024). The study with a pre–post design and no control group was assessed using the Quality Assessment Tool for Before–After (Pre–Post) Studies With No Control Group (National Heart, Lung, and Blood Institute, n.d.). Risk of bias assessment was performed independently by two reviewers, and disagreements were resolved through discussion until consensus was reached.

Effect measures

For each included study, prevalence and incidence proportions of PIs were extracted and reported when available.

Synthesis methods

A narrative synthesis of the included studies was performed. A summary of the results is presented in Table 1.

Reporting bias assessment

Reporting bias was considered qualitatively as part of the methodological quality assessment. The completeness and transparency of the reported methods and results were evaluated during the critical appraisal process. The results of the methodological quality assessment for each study are presented in Supplementary Material 2.

Results

Characteristics of the included studies

The database search yielded 443 records, of which 85 were identified in PubMed, 78 in CINAHL, 180 in Embase, and 100 in Scopus. Of these, 201 were removed as duplicates. After screening titles and abstracts, 188 records were excluded, leaving 54 full-text articles for eligibility assessment. Of these, 46 were excluded for the following reasons: publication date outside the eligibility criteria (n = 24), conference abstracts for which no full text was available (n = 10), non-English language (n = 2), inclusion of paediatric patients (n = 1), inappropriate study design or not reporting prevalence or incidence of PIs (n=9). Overall, eight studies were included in the final synthesis. The study selection process is illustrated in Figure 1.

The included studies were published between 2018 and 2026 and conducted in Italy (Artico et al., 2020; Artico, Dante, et al., 2018; Artico, D'Angelo, et al., 2018; Jakobsen et al., 2020), Turkey (Kaya & Şimşek, 2025), Japan (Marutani et al., 2019), the United Kingdom (Raine, 2021), and Australia (Ven et al., 2026). Most studies adopted observational

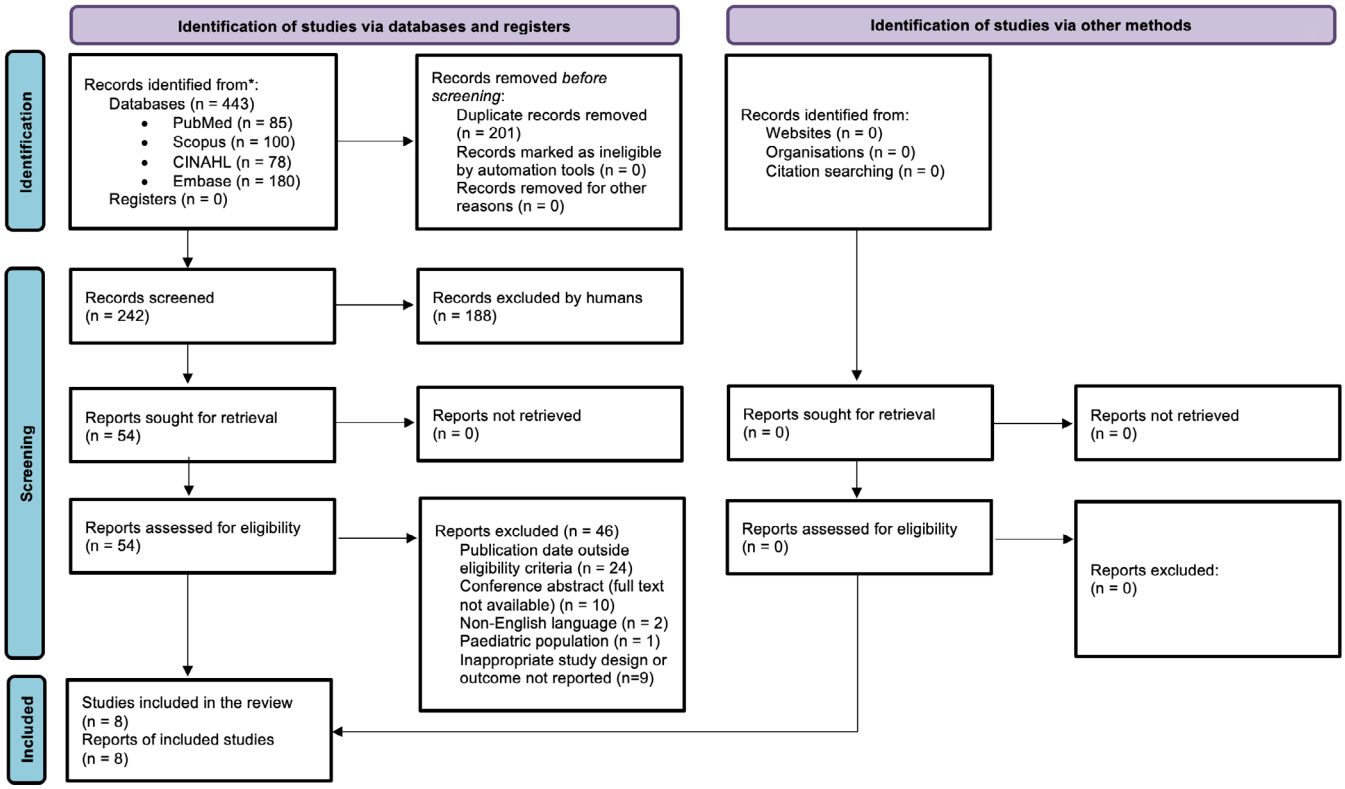

Figure 1. PRISMA 2020 flow diagram for study selection

designs. Two studies were retrospective chart reviews conducted in home palliative care settings (Artico, Dante, et al., 2018; Artico, D'Angelo, et al., 2018), one was a retrospective observational study conducted in a palliative care unit (Kaya & Şimşek, 2025), one was a multicentre prospective cohort study conducted in hospices (Jakobsen et al., 2020), and one was a multicentre prospective longitudinal study involving 13 residential hospices in Italy (Artico et al., 2020). Additional designs included a retrospective observational study in an acute palliative care unit (Ven et al., 2026), a pre–post study conducted in an EoL care setting (Raine, 2021), and an interventional study evaluating support surfaces among patients with advanced cancer receiving palliative care (Marutani et al., 2019).

The included studies covered a broad range of palliative and EoL care settings, including home palliative care services, hospice facilities, hospital-based palliative care units, and specialised EoL care contexts.

Methodological quality and risk of bias

The methodological quality of the included studies was assessed using appropriate appraisal tools, depending on the study design. Overall, the methodological quality of the studies was considered satisfactory. Most studies clearly described the study population, setting, and outcome measures, and applied appropriate statistical analyses. However, some limitations were identified.

The observational studies (Artico et al., 2020; Artico, Dante, et al., 2018; Artico, D'Angelo, et al., 2018; Jakobsen et al., 2020; Kaya & Şimşek, 2025; Ven et al., 2026) were appraised using the JBI checklist for cohort studies. In these studies, exposures (i.e., candidate risk factors) and outcomes (PIs) were generally measured in a valid and reliable way, using validated instruments and recognised classification systems, and appropriate statistical analyses were applied; in the studies examining associated factors, confounding factors were identified and addressed through multivariable analyses. The main limitations concerned the retrospective designs, particularly with regard to the completeness of follow-up and the reporting of the follow-up period. In particular, the retrospective chart review by Artico et al (Artico, D'Angelo, et al., 2018) did not report whether follow-up was complete for the whole sample or whether strategies were used to address incomplete follow-up. Additionally, in the study by Kaya et al. (Kaya and Şimşek, 2025) the follow-up period was not clearly reported,

Table 1. Characteristics of the included studies.

Author	Country, Year	Sample	Study design	Setting	Prevalence (%)	Incidence (%)	Key findings
Artico	Italy, 2020	992	Prospective multicentre longitudinal	Residential hospices	34.1	26.5	PIs frequently occurred during hospice stay and were associated with advanced age, Braden score and clinical deterioration.
Artico	Italy, 2018	574	Retrospective chart review	Home palliative care	13.1	13.0	BMI, Braden score and Karnofsky Performance Status predicted PI development.
Artico	Italy, 2018	669	Retrospective chart review	Home palliative care	23.4	NR	Nutritional status and caregiver characteristics influenced PI progression and healing.
Jakobsen	Italy, 2020	440	Prospective cohort	Hospice	25.5	17.3	Older age and longer hospice stay were associated with PI development.
Kaya	Turkey, 2025	339	Retrospective observational	Palliative care unit	33.6	NR (early onset reported)	Multiple comorbidities and functional decline were associated with PI development.
Marutani	Japan, 2019	73 (52) analysed)	Interventional	Hospital palliative care	NR	13.0–17.2	Air-cell mattresses improved comfort but did not significantly reduce PI incidence.
Raine	UK, 2021	145	Pre–post study	End-of-life care	9.0	47.0 (baseline)	Sub-epidermal moisture monitoring improved early detection of pressure damage.
Ven	Australia, 2026	78	Retrospective observational	Acute palliative care unit	NR	3.9	Hospital-acquired PIs occurred during clinical deterioration phases.

NR = not reported

which prevented the derivation of an incidence estimate, and no formal sample size calculation was reported. The quasi-experimental interventional study by Marutani et al. (Marutani et al., 2019) demonstrated acceptable methodological quality, although some issues were inherent to the study design, including the absence of randomisation and blinding.

The pre–post study conducted by Raine et al. (Raine, 2021) was considered of good methodological quality. Nevertheless, some items could not be clearly evaluated, including whether the participants were representative of the target population and whether loss to follow-up was adequately addressed. Furthermore, outcome assessors were not blinded to the intervention.

Descriptive statistics

Across the eight included studies, sample sizes ranged from 73 to 992 participants. Overall, the studies included patients receiving palliative care in different settings. Age was reported in most studies; when available, the mean or median age was generally around the seventh decade of life, reflecting the typical demographic characteristics of palliative care populations. The definition of palliative care varied across studies and was not always explicitly reported; only a few studies clearly specified the clinical criteria used to identify palliative care patients, such as advanced cancer or EoL conditions (Jakobsen et al., 2020; Marutani et al., 2019).

Prevalence and incidence of PIs

The reported prevalence of PIs varied across the included studies, ranging from 9.0% to 34.1%. The lowest prevalence (9.0%) was reported by Raine (2021) in an EoL care setting. In home palliative care populations, prevalence ranged from 13.1% to 23.4% (Artico, Dante, et al., 2018; Artico, D'Angelo, et al., 2018). Higher estimates were reported in hospice and palliative care unit settings. In particular, Artico et al. (2020) reported a prevalence of 34.1% among patients admitted to residential hospices, while Kaya et al. (2025) reported a prevalence of 33.6% in a palliative care unit. Similarly, Jakobsen et al. (2020) found that 25.5% of hospice patients had a PI at admission.

The incidence of PIs also showed variability. Among the observational and interventional studies, reported incidence ranged from 3.9% to 26.5% (Artico et al., 2020; Jakobsen et al., 2020; Marutani et al., 2019; Ven et al., 2026). The highest incidence was observed in the multicentre hospice study by Artico et al. (2020), in which 26.5% of patients developed a new PI during the hospice stay. Comparable estimates were reported by Jakobsen et al. (2020), who found an incidence of 17.3% among hospice patients. Lower incidence rates were observed in studies conducted in hospital-based palliative care units, such as the retrospective analysis by Ven et al. (2026), which reported an incidence of 3.9% of hospital-acquired PIs. In the interventional study by Marutani et al. (2019), the incidence of PIs ranged from 13.0% to 17.2% across mattress types. In the pre–post quality improvement study by Raine (2021), the baseline incidence of PIs before the implementation of sub-epidermal moisture (SEM) monitoring was 47.0%, which decreased following SEM implementation; as this estimate refers to the pre-intervention period of a quality improvement study, it was not included in the incidence range reported above.

Characteristics of PIs

Reporting of PI characteristics was heterogeneous across the included studies. The included studies involved adult patients receiving palliative or EoL care across hospice, home care and hospital-based settings and comprised both point-prevalence assessments and longitudinal observational designs. Risk assessment was most commonly performed using validated instruments such as the Braden Scale, and PIs were classified using internationally recognised systems, including the National Pressure Injury Advisory Panel (NPIAP)/European Pressure Ulcer Advisory Panel (EPUAP) classifications. (Artico et al., 2020) (Jakobsen et al., 2020; Kaya & Şimşek, 2025; Ven et al., 2026). Among studies reporting anatomical location, the sacral or coccygeal region was the most frequently reported site for PI development, followed by the heels and, less commonly, the trochanteric region. (Jakobsen et al., 2020; Ven et al., 2026). PI severity varied across studies because different staging systems were adopted, and severity distributions were inconsistently reported. Early-stage PIs (stage 1 or 2) predominated in some hospice cohorts, whereas other studies reported a higher proportion of deep tissue injuries or used alternative classification systems. (Artico et al., 2020; Jakobsen et al., 2020; Kaya & Şimşek, 2025; Ven et al., 2026). Where reported, PIs generally developed during palliative care rather than being present at admission, although the time to onset varied across settings. Ven et al. (2026) reported a median time of 6 days from admission to hospital-acquired PI, whereas hospice studies generally described injuries developing during hospice stay without consistently reporting the exact timing. (Artico et al., 2020; Jakobsen et al., 2020).

Risk factors associated with PIs

Overall, the available evidence suggests that PI development in palliative care may be influenced by nutritional status, functional decline, comorbidities, and clinical care factors. However, the identified risk factors were heterogeneous, and the strength and consistency of the reported associations varied across studies. Artico, Dante, et al. (2018) reported that BMI was significantly associated with PI development. Similarly, in their other article (Artico, D'Angelo, et al., 2018), the authors identified artificial nutrition and BMI as factors influencing PI progression and healing. Measures of functional status and clinical vulnerability were also associated with PI risk. Artico, Dante, et al. (2018) found that both the Braden Scale and the Karnofsky Performance Status were significant predictors of PIs in home palliative care patients. Lower scores on Braden subscales, reflecting greater

clinical vulnerability, were also associated with increased risk in the study by Kaya et al. (2025).

Immobility and reduced functional capacity were frequently reported as relevant risk factors. The pre–post study by Raine (2021) highlighted the role of limited mobility and impaired skin inspection in increasing PI risk in EoL care populations. Age and disease severity were also associated with the development of PIs. In their study, Jakobsen et al. (2020) reported that patients who developed PIs were significantly older than those who did not, and that longer hospice stays were associated with increased risk.

Additional clinical factors were identified in several studies. For example, Artico et al. (2020) found that non-cancer diagnoses, urinary catheter use, drowsiness, and artificial nutrition were associated with higher PI risk in hospice patients. In their study conducted in a palliative care unit, Kaya et al. (2025) identified several comorbidities, including stroke, gastrointestinal disease, paraplegia, hypertension, coronary artery disease, arrhythmia, and heart failure, as significant predictors of PI development.

Discussion

The present systematic review aimed to update the evidence on the prevalence, incidence, and risk factors associated with PIs in palliative and EoL care settings since the publication of the previous review (Ferris et al., 2019). The broad range of care settings represented in the included studies provides a more comprehensive overview of the epidemiology of PIs across the continuum of palliative and EoL care, while also contributing to the observed heterogeneity of the findings. Overall, the findings of our review confirm that PIs remain a frequent complication in patients receiving palliative care. The prevalence reported in the included studies ranged from 9.0% to 34.1%, while incidence estimates ranged from 3.9% to 26.5% in the observational and interventional studies, with a higher baseline incidence (47.0%) reported in a single pre–post study before the implementation of SEM monitoring (Raine, 2021); estimates varied depending on the care setting and patient population. These results are broadly consistent with previous epidemiological analyses reporting substantial variability in PI prevalence across clinical contexts (Ferris et al., 2019; Li et al., 2020). This variability should be interpreted with caution, as it is likely influenced by substantial methodological and clinical heterogeneity across the included studies, including differences in care settings, study designs, patient characteristics, observation periods, PI assessment methods, and diagnostic criteria. Consequently, direct comparisons of prevalence and incidence estimates between studies should be made cautiously.

In line with previous literature, the sacral region emerged as the most common anatomical site for PI development, and most lesions were classified as stage 1 or 2, suggesting that early-stage PIs are the most common clinical presentation in palliative populations (Artico et al., 2020; Jakobsen et al., 2020). Several factors were associated with increased risk of PI development, including advanced age, reduced mobility, impaired nutritional status, comorbidities, and the presence of medical devices such as urinary catheters (Artico et al., 2020; Artico, Dante, et al., 2018; Kaya & Şimşek, 2025). These findings reinforce the multifactorial nature of PI development in patients approaching the EoL.

However, PIs occurring in palliative care should be interpreted within the broader context of skin failure and systemic deterioration. Progressive decline in perfusion and metabolic function may compromise skin integrity and reduce tissue tolerance to pressure (Jaul et al., 2018; Levine et al., 2022). Consequently, in advanced illness, some skin breakdown may occur despite appropriate preventive care. International guidelines increasingly recognise that certain PIs may be unavoidable in patients approaching the EoL, particularly when prevention measures conflict with comfort-focused care goals (EPUAP/NPIAP/PPPIA, 2019). Nevertheless, recognising that some PIs may be unavoidable should not diminish the importance of appropriate prevention, careful skin assessment, accurate documentation, symptom management, and individualised care planning based on the patient's goals and clinical condition (EPUAP/NPIAP/PPPIA, 2019).

Another important theme concerns the ability to distinguish PIs from other skin lesions that may occur at the EoL, such as Kennedy Terminal Ulcers and Trombley–Brennan terminal tissue injuries. These lesions are considered manifestations of acute skin failure associated

with the dying process and may develop rapidly despite appropriate preventive care (Latimer et al., 2019). Similar phenomena have also been described under the broader concept of Skin Changes at Life's End (SCALE), which reflects the progressive failure of the skin as an organ during the terminal phase of illness (Roca-Biosca et al., 2021).

From a clinical perspective, the management of PIs in palliative care should balance prevention strategies with patient comfort and individual goals of care (EPUAP/NPIAP/PPPIA, 2019). Aggressive preventive interventions, such as frequent repositioning, may not always be appropriate in patients experiencing severe pain, dyspnoea, or haemodynamic instability. Instead, care plans should prioritise symptom control, dignity, and quality of life, while still implementing feasible preventive measures when consistent with the patient's overall condition (EPUAP/NPIAP/PPPIA, 2019).

Failure to distinguish between these types of lesions may lead to inappropriate prevention strategies, unrealistic expectations regarding wound healing, and potential medico-legal concerns (Levine et al., 2022). For this reason, increasing attention has been devoted to improving the clinical recognition of EoL skin changes. In recent years, international research has focused on developing assessment tools to identify EoL wounds and help clinicians distinguish them from PIs. One example is the End-of-Life Wound Assessment Tool, proposed by Latimer and colleagues, which aims to guide healthcare professionals in recognising skin failure and other terminal skin changes in palliative care patients (Latimer et al., 2023). Accurate assessment and clinical judgement remain essential when evaluating skin breakdown in patients approaching the EoL.

Limitations

This review has several limitations. First, the available evidence is largely based on observational studies, which may be subject to residual confounding, selection bias, and variability in data reporting. Experimental studies in EoL populations remain limited due to ethical and practical challenges in conducting interventional research in this particularly vulnerable group. Second, substantial heterogeneity was observed across the included studies in terms of study design, patient populations, care settings, and outcome reporting. This heterogeneity precluded a quantitative meta-analysis and limited the possibility of directly comparing results across studies. Third, not all studies clearly distinguished PIs from other EoL skin lesions, such as those related to skin failure. In addition, only English-language studies were included, potentially excluding relevant evidence published in other languages. Although a comprehensive search strategy combining controlled vocabulary and free-text terms was used, studies employing alternative terminology may not have been identified. In particular, the terms "pressure injury" and "pressure injuries" were captured through the controlled vocabulary but were not included as free-text terms; although the included studies adopting this terminology were retrieved, records not indexed under the relevant subject headings (especially in Scopus, which relies on free-text searching) may have been missed. Finally, not all included studies reported all outcomes of interest, and some studies lacked detailed clinical information on PI characteristics (e.g., stage, anatomical site, timing of lesion development, and healing outcomes), limiting the depth of the narrative synthesis. These factors might limit the comparability of the available data and the generalisability of the findings across different palliative care contexts.

Conclusions

The prevalence of PIs in patients receiving palliative and EoL care across diverse settings remains substantial, although, although estimates vary widely depending on care settings and patient characteristics. These findings highlight the clinical relevance of this phenomenon and the need for appropriate care strategies tailored to the palliative care context. Future research should adopt standardised definitions and assessment criteria, clearly distinguish PIs from other EoL skin changes, and report PIs present at admission separately from those developing during care to improve the comparability and interpretation of epidemiological evidence. Overall, clinical management should include regular risk assessment using validated tools, ongoing reassessment, and care strategies that balance

preventive measures with patient comfort, dignity, and quality of life throughout the EoL trajectory.

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