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REVIEWS

Nurses' self-efficacy in the care of palliative care patients: a scoping review

Autoeficacia de enfermeros en la atención a pacientes en cuidados paliativos: revisión de alcance

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ABSTRACT:
Introduction: Self-efficacy is a professional's belief in their own capacity to act in challenging situations. In end-of-life care, it relates to how nurses handle decisions and conduct with the patient and the family, and to the confidence with which they act.
Objective: To identify in the literature how the self-efficacy of nurses has been evaluated in the care of patients in palliative care and the factors associated with it.
Methods: A scoping review was conducted following the methodology of the Joanna Briggs Institute and reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews guidelines. The guiding question was: "How is the self-efficacy of nurses evaluated in providing care to patients in palliative care?" The search was conducted in seven databases and in grey literature. Two independent reviewers performed the screening with the help of the Rayyan platform, and discrepancies were resolved by a third reviewer.
Results: A total of 2,043 studies were identified, of which 13 comprised the final sample. Asian studies predominated, with a cross-sectional design and quantitative approach. Thirteen different scales for assessing self-efficacy were found. The most frequently related factors were knowledge and specific training in palliative care.
Practice implications: Understanding the factors that influence self-efficacy supports educational strategies and strengthens qualified, safe, and humane care practices in palliative care.

Keywords: Nurses; Self-efficacy; Palliative Care.

RESUMEN:
Introducción: La autoeficacia es la creencia del profesional en su propia capacidad de actuar en situaciones desafiantes. En el cuidado al final de la vida, se asocia al modo en que el enfermero conduce decisiones y conductas junto al paciente y a la familia, y a la seguridad con que actúa.
Objetivo: Identificar, en la literatura, cómo se ha evaluado la autoeficacia de los enfermeros en la asistencia a pacientes en cuidados paliativos y los factores asociados a ella.
Métodos: Se realizó una revisión de alcance, conducida conforme a la metodología del *Joanna Briggs Institute* y reportada según las directrices *Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews*. La pregunta orientadora fue: "¿Cómo se evalúa la autoeficacia de los enfermeros en la prestación de asistencia a pacientes en cuidados paliativos?" La búsqueda se realizó en siete bases de datos y en la literatura gris. Dos revisores independientes realizaron la selección con la ayuda de la plataforma Rayyan, y las divergencias fueron resueltas por un tercer revisor.
Resultados: Se identificaron 2.043 estudios, de los cuales 13 compusieron la muestra final. Predominaron estudios asiáticos, de diseño transversal y enfoque cuantitativo. Se encontraron 13 escalas diferentes para la evaluación de la autoeficacia. Los factores más frecuentemente relacionados fueron el conocimiento y la formación específica en cuidados paliativos.
Implicaciones para la práctica: Comprender los factores que influyen en la autoeficacia subsidia estrategias educativas y fortalece prácticas asistenciales calificadas, seguras y humanizadas en cuidados paliativos.

Palabras clave: Enfermeros; Autoeficacia; Cuidados paliativos.

INTRODUCTION

The growing demand for palliative care (PC) reflects the need for interventions aimed at promoting the quality of life of patients and families facing health conditions that threaten the continuity of life. This care is based on the early identification of needs, the prevention and relief of suffering, as well as the assessment and management of pain and other symptoms of a physical, psychological, social, and spiritual nature[1,2].

In 2022, approximately 56 million people required PC worldwide, of which 25 million were in the terminal phase. Projections indicate that by 2060, this global demand will exceed 100 million individuals[3].

In this context, the nurse's role stands out. It encompasses the technical dimension of care, identifying patients' needs and implementing strategies to prevent and relieve suffering, pain, and other symptoms. The nurse also attends to psychological distress, arranges social support, and mediates communication among the team, the patient, and the family[4,5]. Working this way calls for specific theoretical and practical training in PC[6].

In Albert Bandura's Social Cognitive Theory[7], self-efficacy is an individual's belief in their capacity to carry out actions that achieve given outcomes. Personal, behavioral, and environmental factors modify one another reciprocally. Professionals with high self-efficacy face challenges and perform tasks more competently; when this belief weakens, the development of individual potential is compromised[8,9]. In the context of PC, assessing and understanding this construct is therefore essential to strengthening the competencies that qualified care requires.

No review with an objective similar to this one was found in the databases consulted or in the Open Science Framework (OSF) study registry. How nurse's self-efficacy has been assessed in PC therefore remains a gap, and filling it can inform training strategies and strengthen nurse's competencies in this care.

In light of this scenario, the scope review aimed to map how the self-efficacy of nurses in assisting patients in palliative care has been evaluated, as well as its associated factors.

METHODOLOGY

This is a review of the scope, whose protocol was previously registered on the OSF platform, with DOI identification number: 10.17605/OSF.IO/JPDBM, conducted according to the methodological guidelines of the Joanna Briggs Institute (JBI)[10,11].

Its execution involves nine main steps: identifying the research question; defining inclusion and exclusion criteria; identifying relevant sources of evidence; developing the search strategy; selecting the evidence; extracting the data; analyzing and presenting the data; discussing the results; and concluding with implications for practice and research[10].

The formulation of the research question was guided by the acronym PCC – Population, Concept, and Context – according to the methodological recommendations[10]. It was defined as follows: P (Population) – nurses; C (Concept) – self-efficacy; and C (Context) – palliative care. Thus, the proposed question was: "How has the self-efficacy of nurses in caring for patients in palliative care been evaluated, and what are its associated factors?"

The search strategy, focusing on high sensitivity, was developed with the support of a specialized librarian and followed three steps recommended by the JBI[10]. Initially, descriptors related to the elements of the PCC acronym were identified by consulting standardized vocabularies in the Health Sciences Descriptors (DeCS), Medical Subject Headings (MeSH), and Embase Subject Headings (EMTREE). From this, a preliminary search strategy was developed, incorporating synonyms in Portuguese, English, and Spanish, with the aim of broadening the scope of identifying relevant studies.

In the next step, a pilot test was conducted in the Medical Literature Analysis and Retrieval System Online (Medline®), via PubMed®, to adjust the agreement among reviewers. This test consisted of screening titles and abstracts to verify the most recurring terms in the literature, validate the selected descriptors, and identify publications aligned with the review's objective. All articles considered potentially eligible were accessed in full by two independent reviewers.

Based on the validation of the test, the search strategy was refined and adapted for each database, respecting their terminological particularities. Boolean operators were used – AND to combine distinct concepts and OR to group synonyms – ensuring cohesion and consistency in the formulations.

After defining the descriptors and their equivalents in different controlled vocabularies, an electronic mapping of the literature was conducted in May 2025 across the following databases: MEDLINE (via PubMed), Scopus (Elsevier), Embase (Excerpta Medica Database), Web of Science (Clarivate Analytics), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Nursing Database (BDENF), Latin American and Caribbean Literature in Health Sciences (LILACS). Access to these databases was made through the CAPES Periodicals Portal, using authentication via the Federated Academic Community (CAFe), in order to standardize data collection. For the search in the gray

literature, the Brazilian Digital Library of Theses and Dissertations (BDTD), maintained by the Brazilian Institute of Information in Science and Technology, and the CAPES Catalog of Theses and Dissertations were consulted.
The search strategies applied in the selected databases are presented in Chart 1 below:

Chart 1. Search strategies used in each selected database. João Pessoa/PB, Brazil, 2025.

Database	Search Strategy	Results
Medline / PubMed	("Self efficacy"[MeSH Terms] OR " Self efficacy"[All Fields]) AND ("Nursing"[MeSH Terms] OR "Nursing"[All Fields] OR "Nurses"[MeSH Terms] OR "Nurse"[All Fields]) AND (“Palliative Care”[MeSH Terms] OR “Palliative Care”[All Fields] OR “Palliative Treatment”[All Fields] OR “Palliative Therapy”[All Fields] OR “Therapy, Palliative”[All Fields] OR “Palliative Medicine”[Mesh Terms] OR “Palliative Medicine”[All Fields] OR “Hospice and Palliative Care Nursing”[Mesh Terms] OR “Palliative Nursing”[All Fields] OR “Palliative Care Nursing”[All Fields] OR “Hospice Nursing”[All Fields] OR “Hospice Care”[Mesh Terms] OR “Hospice Care”[All Fields] OR “Hospice Programs”[All Fields] OR “Bereavement Care”[All Fields] OR “Terminal Care”[Mesh Terms] OR “Terminal Care”[All Fields] OR “End of Life Care”[All Fields] OR “Hospices”[Mesh Terms] OR “Hospices”[All Fields])	299
Embase	('self concept'/exp OR 'self efficacy') AND ('nursing'/exp OR 'nursing' OR 'nurse'/exp OR 'nurse') AND ('palliative therapy'/exp OR 'palliative care' OR 'palliative treatment' OR 'palliative therapy' OR 'therapy, palliative' OR 'palliative therapy'/exp OR 'palliative medicine' OR 'palliative nursing'/exp OR 'palliative nursing' OR 'palliative care nursing' OR 'hospice nursing' OR 'hospice care'/exp OR 'hospice care' OR 'hospice programs' OR 'bereavement care' OR 'terminal care'/exp OR 'terminal care' OR 'end of life care' OR 'hospice'/exp OR 'hospices')	1.353
Scopus	TITLE-ABS-KEY("self-efficacy") AND (TITLE-ABS-KEY("nursing") OR TITLE-ABS-KEY("nurse")) AND (TITLE-ABS-KEY("palliative care") OR TITLE-ABS-KEY("palliative treatment") OR TITLE-ABS-KEY("palliative therapy") OR TITLE-ABS-KEY("palliative medicine") OR TITLE-ABS-KEY("hospice care") OR TITLE-ABS-KEY("bereavement care") OR TITLE-ABS-KEY("terminal care") OR TITLE-ABS-KEY("end of life care"))	186
Web of Science	TS=("self-efficacy" OR "self efficacy") AND TS=("nursing" OR "nurse") AND TS=("palliative care" OR "palliative treatment" OR "palliative therapy" OR "palliative medicine" OR "hospice care" OR "bereavement care" OR "terminal care" OR "end of life care")	134

Database	Search Strategy	Results
CINAHL (EBSCO)	(MH "Self-efficacy" OR KW "Self-efficacy") AND (MH "Nursing" OR KW "Nursing") AND (MH "Palliative care" OR KW "Palliative care" OR KW "Hospice care")	40
LILACS	("self efficacy" OR autoeficácia OR autoeficacia:de) AND (nursing OR Enfermería OR enfermagem OR enfermagem:de OR “Enfermeiras e Enfermeiros” OR “Enfermeiro e Enfermeira” OR nurses OR nurse OR Enfermeras y Enfermeros) AND (“Palliative Care” OR “cuidados paliativos” OR cuidados paliativos:de OR cuidados terminais:de OR “Palliative Treatment” OR “Palliative Therapy” OR “Therapy, Palliative” OR “Assistência Paliativa” OR “Cuidado Paliativo” OR “Cuidado Paliativo de Apoio” OR “Tratamento Paliativo” OR “Enfermagem de Cuidados Paliativos na Terminalidade da Vida” OR “Enfermagem de Cuidados Paliativos” OR “Hospice and Palliative Care Nursing” OR “Hospice Nursing” OR “Hospice Nursings” OR “Nursing, Hospice” OR “Nursings, Hospice” OR “Palliative Care Nursing” OR “Palliative Nursing” OR “Enfermería de Cuidados Paliativos al Final de la Vida” OR “Medicina Paliativa” OR “Palliative Medicine” OR “Medicine, Palliative” OR “Medicine, Palliative Care” OR “Palliative Care Medicine” OR “Hospice Care” OR “Cuidados Paliativos na Terminalidade da Vida” OR “Cuidado Paliativo a Doentes Terminais” OR “Cuidados Paliativos al Final de la Vida” OR “Hospice Programs” OR “Bereavement Care” OR “Terminal Care” OR “Assistência Terminal” OR “Cuidado Terminal” OR “Assistência na Terminalidade da Vida” OR “Cuidados de Fim de Vida” OR “End of Life Care” OR “Hospices” OR “Hospitais para Doentes Terminais” OR “Hospitales para Enfermos Terminales”) AND (db:"LILACS")	13
BDENF	("self efficacy" OR autoeficácia OR autoeficacia:de) AND (nursing OR Enfermería OR enfermagem OR enfermagem:de OR “Enfermeiras e Enfermeiros” OR “Enfermeiro e Enfermeira” OR nurses OR nurse OR Enfermeras y Enfermeros) AND (“Palliative Care” OR “cuidados paliativos” OR cuidados paliativos:de OR cuidados terminais:de OR “Palliative Treatment” OR “Palliative Therapy” OR “Therapy, Palliative” OR “Assistência Paliativa” OR “Cuidado Paliativo” OR “Cuidado Paliativo de Apoio” OR “Tratamento Paliativo” OR “Enfermagem de Cuidados Paliativos na Terminalidade da Vida” OR “Enfermagem de Cuidados Paliativos” OR “Hospice and Palliative Care Nursing” OR “Hospice Nursing” OR “Hospice Nursings” OR “Nursing, Hospice” OR “Nursings, Hospice” OR “Palliative Care Nursing” OR “Palliative Nursing” OR “Enfermería de Cuidados Paliativos al Final de la Vida” OR “Medicina Paliativa” OR “Palliative Medicine” OR “Medicine, Palliative” OR “Medicine, Palliative Care” OR	10

Database	Search Strategy	Results
	“Palliative Care Medicine” OR “Hospice Care” OR “Cuidados Paliativos na Terminalidade da Vida” OR “Cuidado Paliativo a Doentes Terminais” OR “Cuidados Paliativos al Final de la Vida” OR “Hospice Programs” OR “Bereavement Care” OR “Terminal Care” OR “Assistência Terminal” OR “Cuidado Terminal” OR “Assistência na Terminalidade da Vida” OR “Cuidados de Fim de Vida” OR “End of Life Care” OR “Hospices” OR “Hospitais para Doentes Terminais” OR “Hospitales para Enfermos Terminales”) AND (db:"BDENF")	
Biblioteca Digital Brasileira de Teses e Dissertações (BDTD)	(autoeficácia) AND (enfermagem OR enfermeiro) AND ("cuidados paliativos" OR "cuidados terminais")	05
CAPES Catalog of Theses and Dissertations	Autoeficácia AND enfermagem AND "cuidados paliativos"	03

Source: Prepared by the authors, 2025.

The research question guided the definition of the eligibility criteria, based on the acronym PCC (Population, Concept, and Context), presented below in Chart 2.

Chart 2: Inclusion and exclusion criteria based on the acronym PCC. João Pessoa/PB, Brazil, 2025.

Mnemonic	Inclusion Criteria	Exclusion Criteria
Population	Original studies that include nurses of both genders who work in assisting patients in palliative care, at any of the three levels of health care.	Studies involving nursing students, caregivers, other health team members, or other professionals.
Concept	Investigation into nurses' self-efficacy in assisting patients in palliative care, understood as the perception of confidence or belief in one's ability to provide such care.	Studies that exclusively address knowledge, performance, or quality indicators, as well as those focused on development. Validation, translation, or adaptation of instruments. That address self-efficacy in contexts unrelated to palliative care.
Context	Studies that explore palliative care for patients at the end of life, conducted in clinical contexts (primary, secondary, or tertiary care), in different countries or health systems.	Studies conducted in non-clinical settings, such as schools, universities, laboratories, or simulations.

Source: Prepared by the authors, 2025.

Furthermore, studies published in scientific journals in the last ten years, available in full electronic format, in Portuguese, English, and Spanish, with any methodological design and from different countries, as long as they address the research question, were included. The temporal cut is justified by the recent nature of scientific production on self-efficacy in palliative care, considering that the first specific scale was published in 2011[12] and that studies focused on nurses are even more recent. Dissertations and

theses were also included. Editorials, reviews, letters to the editor, notes, conference proceedings, revisions, case studies, book chapters, and undergraduate thesis works were excluded.

The data extraction stage was conducted independently by two reviewers in May 2025, with conflict resolution by a third researcher. To assist in managing the references and promote greater organization and control during the process, Rayyan® was used. Initially, duplicates were removed, followed by the screening of titles and abstracts based on the previously defined inclusion and exclusion criteria. The reading of the full texts allowed for the final definition of the sample[13].

The entire selection process was systematically documented, ensuring the traceability of the decisions made, as guided by the PRISMA-ScR model (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews), adapted to the recommendations of the Joanna Briggs Institute[10,14].

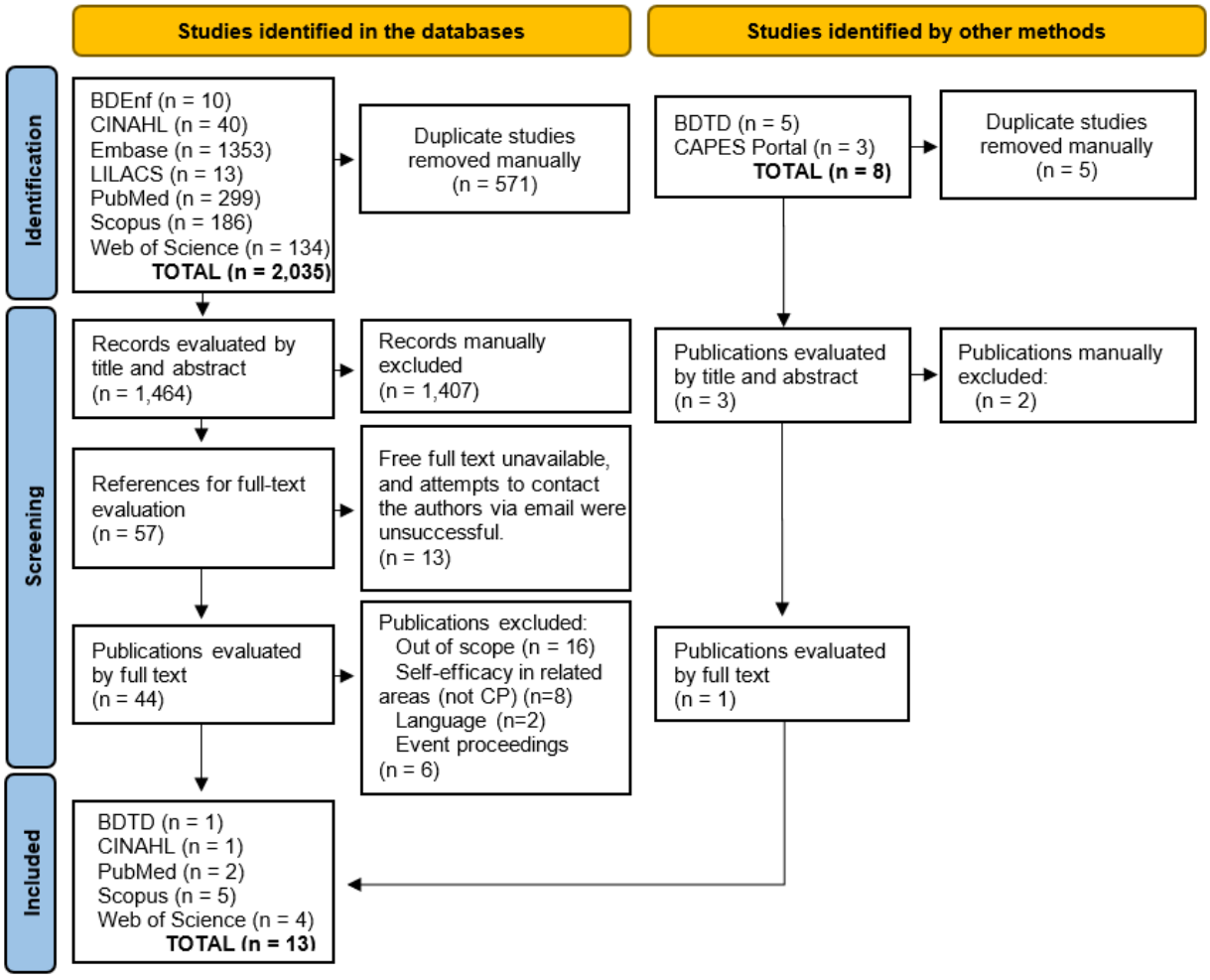
The information extracted from the included studies was organized into a structured form, previously developed by the authors. This instrument included the following data: publication identification (title, authors, year, country, journal, database, language, type of publication), study objectives, methodological design, participant profile, instruments used to assess self-efficacy, and main findings.

To ensure the consistency and relevance of the form, a pilot test was conducted that allowed for necessary adjustments, contributing to the standardization of data collection. The results were presented through graphical representations and descriptive narrative. The review process was completed in July 2025.

RESULTS

The initial search identified 2,043 records. After eliminating 576 duplicates and screening titles and abstracts, which led to the exclusion of 1,409 studies that did not meet the previously defined criteria, 58 articles were selected for full reading. Of these, 13 could not be fully assessed because they were not freely accessible. The authors of these studies were contacted by email, but no reply was received by the time the manuscript was completed. Other studies were excluded for the following reasons: out of scope (n=16), addressed self-efficacy in contexts other than the main focus (n=8), presented an abstract in a language different from the full text and were therefore considered ineligible (n=2), or were conference proceedings abstracts (n=6). At the end of the process, 13 studies were considered compatible with the objective of the review and made up the final sample. The flowchart of the selection process, following the PRISMA-ScR guidelines, is presented in Figure 1.

Figure 1: PRISMA-ScR® flowchart of the search and selection process of publications in the literature. João Pessoa, PB, Brasil, 2025.

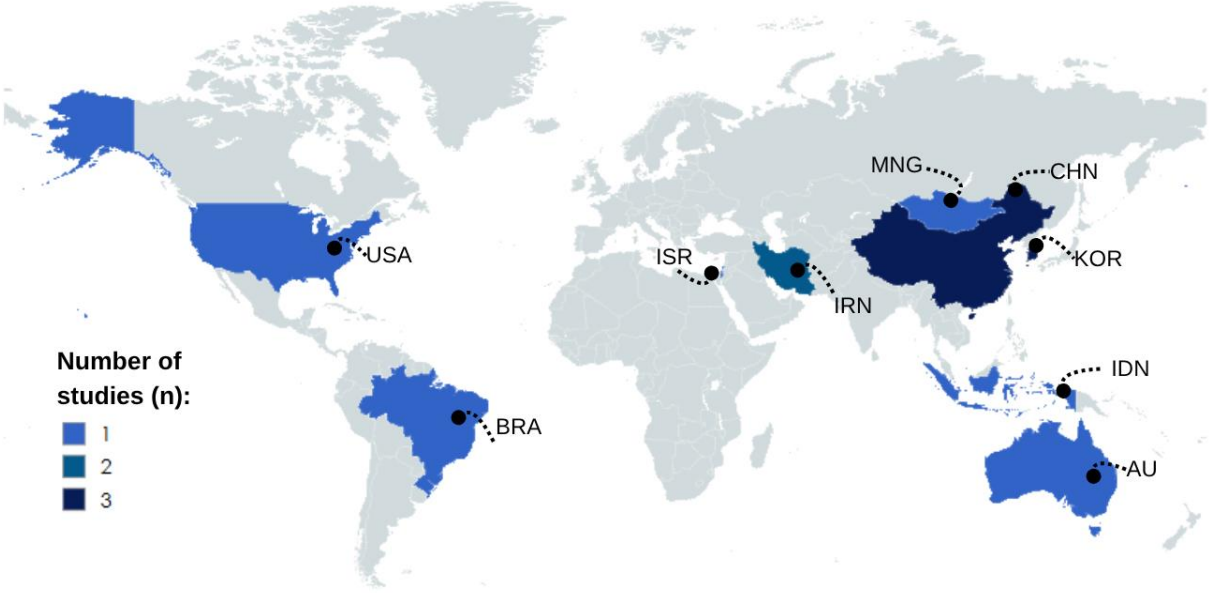


Source: Adapted[14] and prepared by the authors, 2025.

The selected publications date from 2019 to 2025, with the following distribution by year: 2025 (n=1)[15], 2024 (n=1)[16], 2023 (n=1)[17], 2022 (n=2)[18,19], 2021 (n=3)[20–22], 2020 (n=3)[23–25] e 2019 (n=2)[26,27]. The studies were identified in the following literature sources: *Web of Science*[18,20,21,24], Scopus[16,17,19,22,26], PubMed[15,23], CINAHL[25] and gray literature (BDTD)[27]. The final composition included 12 scientific articles and one doctoral thesis[27]. Regarding the language, 12 documents were published in English and one in Portuguese[27].

The 13 studies included in the review were conducted in nine countries, which reflects the global reach of the concern with nurses' self-efficacy in PC. South Korea accounted for three[17,18,20], followed by China[19,22] and Iran[16,24] with two each; one multinational study was conducted simultaneously in Australia and China[21]. Figure 2 presents a thematic map in choropleth format, illustrating proportional geographical distribution of the included studies, according to the countries where they were carried out.

Figure 2: Thematic map of the geographical distribution of the articles. João Pessoa, PB, Brazil, 2025.



Legend:

AU: Australia	IDN: Indonesia	KOR: South Korea
BRA: Brazil	IRN: Iran	MNG: Mongolia
CHN: China	ISR: Israel	USA: United States

Note: Australia and China[21]; Brazil[27]; China[19,22]; South Korea[17,18,20]; USA[15]; Indonesia[26]; Iran[16,24]; Israel[25]; Mongolia[23].
Source: Prepared by the authors, 2025.

Among the studies included in the review, a predominance of cross-sectional design was observed (n=11), while two studies adopted a quasi-experimental design, using pre-test and post-test strategies to evaluate educational interventions, utilizing materials such as app and educational manual[20] or workshop[24]. There were multicenter studies[15–17,21] – involving two or more hospitals, including up to five metropolitan institutions – although single-center studies predominated[18–20,22–27]. Regarding the methodological approach, 12 publications used a quantitative approach, and one used a mixed approach[27], organizing the *corpus* of data through the *WebQda* software and conducting the analysis in light of Katherine Kolcaba's Comfort Theory.

Chart 3 summarizes the objectives, sociodemographic and professional profile of the participants, and a synthesis of the main findings of the studies, highlighting the data collection instruments focusing on the self-efficacy assessment scales in palliative care.

Chart 3: Summary of the studies included in the scope review. João Pessoa, PB, Brazil, 2025 (n=13)

Authors, year	Objective	Characterization of the sample (predominance) / Scales used to measure self-efficacy	Main Results
Kotula et al, 2025[15]	Examine the factors that influence the frequency of self-reported palliative care (PC*) practices by nurses in the acute care environment.	Women (84.3%); Age range of 36-45 (28%); Training in PC* during undergraduate studies (51.1%); Cared for terminal patients (61.5%). **Scale:** *Palliative Care Self-Reported Practices* – English version (Unpublished validation pilot)	Self-efficacy was assessed as a predictor of PC* practices; Demographic variables (gender, age, self-efficacy, and attitudes towards caring for terminal patients) significantly influenced the frequencya of self-reported PC practices.
Fadaei et al, 2024[16]	Compare knowledge and self-efficacy in PC* between Intensive Care Unit (ICU†) nurses and general unit nurses in university hospitals affiliated with Kerman University of Medical Sciences.	Women (84% and 74%); Average age: 33.02 (±6.36) years - ICU† and 31.55 (±6.35) years - general units; No training in PC* (66.7% and 83.3%). **Scale:** *Palliative Care Self-Efficacy* – Persian version (Dehghani et al, 2020)	There was no significant difference between ICU nurses and general unit nurses regarding self-efficacy in palliative care; Self-efficacy was considered low in both groups (ICU: 28.01 ± 10.29; general units: 27.98 ± 10.33); Self-efficacy was influenced by factors such as age, training, and prior knowledge in palliative care.
Kim et al, 2023[17]	Investigate the moderating effect of attitudes towards the Guidelines Advance Directives in the relationship between knowledge and self-efficacy in palliative care among Korean nurses.	Women (90.8%); Average age 30.3 (±6.1) years; No training in palliative care (67.7%); Experience with palliative care assistance (63.5%); Worked in palliative care (15.6%). **Scale:** *Self-Efficacy in Palliative Care* – Korean version (Heo et al., 2022)	Younger, single nurses with lower education levels showed lower self-efficacy in palliative care; Knowledge in palliative care ($p<0.05$) and positive attitudes ($p<0.001$) correlated significantly with higher self-efficacy.
Choi et al, 2022[18]	Analyze the relationship between end-of-life care stress, anxiety about death, and self-efficacy among South Korean clinical nurses.	Age between 25-34 years (68.5%); Up to 10 years of experience (72.6%); Generalist nurses (95.2%); Training in palliative care (35.5%). **Scale:** *Specific Self-Efficacy, adapted from the Bonner Palliative Knowledge Test* (BPW‡) for long-term care nurses (Lee, 2019).	The self-efficacy of nurses had an average of 29.83; There was a difference in self-efficacy between direct care nurses (average 29.72) and administrative nurses (average 32.17).

Authors, year	Objective	Characterization of the sample (predominance) / Scales used to measure self-efficacy	Main Results
Lin et al, 2022[19]	Analyze the self-efficacy of nurses in dealing with the death of patients and identify their influencing factors.	Women (99.5%); Average age: 32.4 (±7.1) years; Majority (73.1%) ≥10 years of clinical experience; No CP* training (38.5%). **Scale:** *Death-coping self-efficacy scale* - Taiwanese version (Chang, Cheng, Wang, 2006)	The influencing factors (educational background, CP* courses, attitudes, and experience in dealing with death) were assessed as predictive variables that affected the scores on the scale regarding CP* and self-efficacy in coping with death (outcome);
Yang, Shin, 2021[20]	To develop and evaluate a mobile CP* program for ICU nurses†, analyzing its effects on knowledge, self-efficacy, and compassion.	Women (79.1%); Average age: 26.14 years; Training in CP* (25.6%). **Scale:** *Korean self-efficacy* (Yang, 1999)	In the pre-test, there were no significant differences between the control and experimental groups regarding knowledge, self-efficacy, and compassion in end-of-life care. After the intervention, the experimental group showed significant improvement in self-efficacy and compassion in end-of-life care.
Zheng et al, 2021[21]	To investigate the perception of newly graduated Chinese nurses regarding their ability to cope with death and its relationship with self-efficacy and anxiety in the face of death	Women (89.3%); Average age: 22.7 years; Professional experience: 4.5 months; No training in CP* (86.6%); Witnessed patient death (75.8%). **Scale:** *Death Self-efficacy Scale* (Robbins, 1991)	The average self-efficacy in facing death was 259.1; Self-efficacy in facing death correlated positively with coping (r = 0.61) and negatively with anxiety (r = -0.21).
Liu et al, 2021[22]	To understand the attitudes of frontline clinical nurses regarding CP* during COVID-19, aiming to support educational and training actions in hospitals.	Women (98.66%); Age between 18 and 35 years (21.48%); Graduatess (95.97%); Senior nurse (68.64%). **Scale:** General Self-Efficacy Scale (Scholz et al., 2002)	There was a positive correlation between attitudes in CP* (102), empathy (95), and self-efficacy (2.80); The main factors that influenced positive attitudes towards CP* were: age, knowledge about the subject, empathy, and self-efficacy.

Authors, year	Objective	Characterization of the sample (predominance) / Scales used to measure self-efficacy	Main Results
Kim, Kim, Gelegjamts, 2020[23]	Investigate knowledge, attitudes, self-efficacy, and their predictors in end-of-life care among Mongolian nurses.	Women (98.6%); Average age: 37.5 years; Average years of nursing experience (10.5); Palliative care course (16.3%); Continuing education in PC* (63.6%); Direct experience in end-of-life care (87.9%). **Scale:** *Palliative Care Self-Efficacy* – Mongolian version (Unpublished validation pilot)	The median knowledge of nurses was 8; Nurses exhibited positive attitudes towards end-of-life care (77.2%); The average self-efficacy was 33.8/48, with no significant differences by sociodemographic characteristics.
Dehghani et al, 2020[24]	Evaluate the impact of PC* on the self-efficacy perceived by nurses.	Women (85%); Average age: 38.6 years; Average years of professional experience (14.25). **Scale:** *Perceived Palliative Care Self-efficacy Questionnaire* – Persian version (Dehghani et al., 2020)	There was no significant difference in self-efficacy between ICU† nurses and general ward nurses (28.01 ± 10.29 and 27.98 ± 10.33, respectively; $p = 0.98$); Knowledge was influenced by experience with terminal patients, workplace, and duration of practice (9.2% of variance); Self-efficacy was predicted by age, training, and knowledge (21% of variance).
Scheinberg-Andrews, Ganz, 2020[25]	Describe and compare knowledge, attitudes, self-perceived behaviors, and practices regarding end-of-life care among ICU† and oncology nurses.	Women (91.26%); Practice a religion (93.65%); Average age: 48 years (oncology) / 50 years (ICU†); Professional experience: 12 and 18 years, respectively; Course in PC*; 56% and 17%; Personal experience with PC*: 58% and 23%. **Scale:** *End-of-Life Care - Intensive Care Unit* (EOL-ICU§) by Montagnini et al. (2012) Adapted for the context of oncology (by the authors).	Nurses with training and personal experience in palliative care (PC*) reported a higher self-perception of knowledge in end-of-life care; Knowledge levels, attitudes, and self-perception were moderate among the groups; The degree of religiosity influenced the acceptance of death.
Kurnia, Trisvani, Prawesti, 2019[26]	Analyze the relationship between perceptions and self-efficacy of nurses in	Women (73.2%); Age between 26-45 years (86.6%); Without training in PC* (75.6%). **Scale:** *Palliative Care Nursing Self-competence* (Desbiens,Gagnon, Fillion, 2012)	About 56.7% reported high self-efficacy in PC*, but 52% had a negative perception of their competence; A significant correlation between perception

Authors, year	Objective	Characterization of the sample (predominance) / Scales used to measure self-efficacy	Main Results
	implementing PC* in the ICU†.		and self-efficacy (p-value = 0.000) indicated the need for training.
Spineli, 2019[27]	Transculturally adapt and validate the BPW‡ instrument for the Brazilian context, assessing knowledge and self-efficacy of primary care (PC¶) nurses in PC*, as well as exploring experiences and identifying ongoing education needs.	Women (92.7%); Average age: 35.5 years; Predominantly Catholic (77.5%); Treated patients in PC* (74.4%); With training in PC* (5.5%). **Scale:** *Bonn Palliative Care Knowledge Test* (BPW‡) – culturally adapted version for the Brazilian context	Correlation between knowledge and self-efficacy (using the BPW) is of low magnitude (± 1% variance), negative and inversely proportional ($r = -0.10$; $p<0.05$) → the lower theknowledge, the higher the self-efficacy (suggesting overestimation); The correlation between "training in PC*" (socio-professional variable) and self-efficacy (BPW) showed a different result → nurses with training in PC* exhibited higher self-efficacy; The qualitative analysis indicated that limited knowledge hinders the proper practice of PC* in primary care (PC¶).

Note: PC*: palliative care; ICU†: Intensive Care Unit; BPW‡: *Bonn Palliative Care Knowledge Test*; EOL-ICU§: Scale - *End-of-Life Care - Intensive Care Unit*; AP¶: Primary Care.
Source: Prepared by the authors, 2025.

The analyzed studies demonstrated that self-efficacy in palliative care is significantly influenced by multiple factors, distributed across five main categories: personal, professional, educational, contextual, and attitudinal. Figure 3 presents a visual summary of these categories.

Figure 3: Factors influencing self-efficacy in palliative care.



Source: Prepared by the authors, 2025.

Educational factors were the most prevalent, present in ten of the 13 studies[16-20,22-25,27], particularly prior knowledge and specific training in PC. Attitudinal factors appeared in nine publications[15,17,19-23,25-26] and brought together empathy, coping with death, attitudes towards advance directives, perception of competence, anxiety, stress, religiosity, and acceptance of the dying process.

Personal factors, cited in six studies[15-18,22,24], were limited to age and gender, influencing self-perception and willingness to provide end-of-life care, albeit to a lesser extent. Contextual factors, in four[16,18,19,24], referred to the work environment, access to training, institutional support, and the possibility of participating in courses on PC; the absence of support policies and work overload were the barriers recorded.

Finally, professional factors were described in a single study[25] and included variables related to prior experience with palliative care patients, length of service, area of work (ICU, ward, primary care), position held (clinical or administrative), and work hours. Such elements influence the level of security and confidence in executing palliative practices, especially in managing complex situations.

DISCUSSION

The growing recognition of the relevance of palliative care accompanies demographic transformations, especially population aging and the advance of chronic diseases, which demand more complex and humanized approaches to care. The 13 studies came from nine countries and from markedly different health systems, which suggests that the perception of self-efficacy is also shaped by local cultural and organizational factors[28].

The predominance of Asian studies may be related to accelerated aging of the population and the higher incidence of chronic diseases. In China, the population over 65 is estimated to reach 400 million by 2050, and research on the subject in that setting is still scarce, which makes it essential to assess how nurses act in providing PC, given their relevance in this process[5].

Twelve of the 13 documents were published in English and one in Portuguese[27], a proportion consistent with the role of this language as the main vehicle for scientific dissemination, favoring the spread of knowledge and international collaboration [29]. However, investigations into the self-efficacy of other health professionals in the context of palliative care have been conducted in different languages and countries. A study conducted in Argentina analyzed skills and distinctions in the perception of self-efficacy among medical and non-medical professionals[30], and research assessing the self-efficacy of nursing students and other health professionals is also available in Portuguese-speaking contexts, in Lusophone countries such as Brazil and Portugal[9,31].

Methodologically, the included studies were predominantly cross-sectional, descriptive, and correlational. Although useful for mapping perceptions and associated factors, such designs limit the analysis of the evolution of self-efficacy over time and the assessment of the impact of interventions. The scarcity of qualitative or mixed studies highlights the need to deepen subjective and contextual dimensions.

Thirteen distinct instruments were identified to assess self-efficacy. Except for the Palliative Care Nursing Self-Competence[32], which categorizes scores – where positive perceptions indicate high self-efficacy and negative perceptions indicate low self-efficacy – the others use Likert-type scales, usually from 1 to 10 points, with higher scores associated with greater self-efficacy.

The reliability of the instruments varied between 0.704 and 0.965, as evidenced in the Persian version of the Perceived Palliative Care Self-Efficacy Questionnaire[24] and the Korean version of the Self-Efficacy in Palliative Care Scale[17]. Recent studies have validated similar scales and adopted similar instruments, with comparable Cronbach's alpha coefficients[9,33], evidencing a global trend in descriptive analyses aimed at understanding self-efficacy.

The study of self-efficacy in palliative care requires in-depth reflection on professional practice and its sociocultural influences. Self-efficacy is a dynamic concept that involves motivation, organization of cognitive resources, and management of specific situations, being constructed not only through individual skills but also through vicarious learning, observational learning, and social persuasion, factors strongly influenced by the professional context[34].

Self-reported accounts are essential for investigating this construct, as they demonstrate the interaction between personal and systemic factors[15,25]. Personal factors such as age influence self-efficacy: younger and newly graduated professionals tend to exhibit lower levels. A study corroborated the findings of one of the included articles in the review[21] by reporting a mean score of 36.7 (±8.4) on a 48-point Palliative Care Self-Efficacy scale among new nurses[35]. This data suggests that early-career professionals may feel less confident in their abilities to handle end-of-life situations, highlighting a possible gap in training and preparation to work in this context.

In the professional context, years of experience, area of expertise, and contact with terminal patients correlate with greater knowledge and self-efficacy, as proposed by Bandura[34]. Specific training in palliative care – through graduate courses or continuing education – proves essential, although there are indications of a dissociation between formal knowledge and perceived self-efficacy[27]. In a recent study, 60% of nurses declared themselves capable of working in palliative care, but they showed significant gaps in knowledge, highlighting the need for more solid training aligned with the demands of clinical practice[36].

Two of the included interventions tested digital resources and active methodologies: an app with an educational manual[20] and a workshop[24] enabled the development of practical and emotional skills. A similar result was obtained in a quasi-experimental study with an online educational program, in which the median score on the Palliative Care Self-Efficacy Scale increased from 38 to 43.5 ($p < 0.001$; $r = -0.76$)[6].

The training deficit in PC is not exclusive to nursing. Among medical students in Brazil, the average agreement in a self-efficacy questionnaire was 64.75%, even after theoretical training during undergraduate education[37], and physicians, even experienced ones, report nascent knowledge and difficulties in providing comprehensive care[38]. Including PC in curricula without supervised practical practice is insufficient to develop confident attitudes in end-of-life care[39].

A multiple regression study found a positive correlation between self-efficacy and the type of clinical unit of work, suggesting that exposure to terminal situations strengthens nurses' self-confidence[35]. In the included studies, the work setting (ICU, ward, primary care), had a variable effect, smaller than that of individual preparation.

Attitudinal and psychosocial aspects, such as empathy, religiosity, resilience, and mindfulness, were identified as important positive predictors of self-efficacy. On the other hand, extreme stress events, such as the Covid-19 pandemic, negatively impacted these attributes[22]. A study revealed a 34% reduction in empathy among ICU nurses, associated with emotional overload and ethical dilemmas experienced during the health crisis[40].

The interaction between knowledge and attitudes exerted a moderating effect on the perception of self-efficacy. In a study with 1,829 nurses, education, interaction with the elderly, and specific training influenced attitudes and, consequently, the self-efficacy of these professionals. Even so, 72.5% of participants reported insecurity or reluctance to work in the field[41].

The five categories identified correspond to the three axes of Albert Bandura's Social Cognitive Theory[34]: personal and attitudinal factors related to individual characteristics and emotional states; educational and professional factors, related to mastery experiences and knowledge acquisition; and contextual factors, related to organizational and environmental conditions. This conceptual integration therefore broadens the understanding of self-efficacy in PC by showing that its construction depends not only on formal knowledge but also on a multifactorial and dynamic interaction.

This review has limitations. A scarcity of experimental, quasi-experimental, and longitudinal designs was observed, and only two studies tested an intervention, which prevents the analysis of the evolution of self-efficacy and the impact of interventions over time. No multinational studies were identified beyond the one conducted in

Australia and China[21]. The predominance of hospital contexts restricts the understanding of the phenomenon in primary care and home care, where palliative demand is also present.

The 13 instruments found did not always present rigorous validation or the publication of the cultural adaptation process, which compromises the comparison between studies. The consolidation of consistent and widely accepted instruments is therefore needed. The ten-year time frame may have reduced the number of publications included. However, this choice is justified by the recent scientific production on the subject, especially in studies involving nurses.

The findings point to the need for educational strategies, such as training programs, that combine technical knowledge, attitude development, communication skills, and emotional competencies. Future investigations should also consider organizational factors, such as workload, institutional policies, and team support, which influence professional practice and were little addressed in the included studies.

CONCLUSIONS

The self-efficacy of nurses in providing PC has been assessed with numerous and poorly convergent instruments: 13 distinct scales across 13 studies, most of them cross-sectional and concentrated in Asian countries. The associated factors fall into five categories, with educational factors predominating. Identifying them makes it possible to direct both training strategies and institutional decisions about the organization of work.

The map also shows where the literature has not reached. No longitudinal study; only two with an intervention; none outside the hospital context; and a single one in a language other than English. To this is added the dispersion of instruments: without rigorous validation and without published cultural adaptation processes, the results cannot be compared with one another. These are the open fronts for nursing research.

For nursing education, the consequence is direct: training in PC needs to include active methodologies, such as supervised practice, clinical simulation, and experiences integrated into interprofessional education, which foster critical reflection and sustain the nurses' confidence in caring for patients at the end of life.

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