

Interprofessional Collaboration among Nurses, Pharmacists, and Dental Professionals in the Management of Complex Palliative Care Needs

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Abstract

Complex palliative care frequently requires simultaneous management of symptoms, medication burden, oral-health problems, communication needs, changing goals of care, and transitions across services. Nurses, pharmacists, and dental professionals may each contribute distinct expertise, yet the extent to which their work is coordinated, overlapping, or separated by professional and organizational boundaries has not been mapped comprehensively. To map the available evidence on nursing, pharmacy, and dental or oral-health roles in complex palliative care; identify areas of shared responsibility; examine medication, oral-health, communication, referral, and patient-participation interfaces; and characterize barriers, facilitators, models of care, and evidence gaps. A scoping review was conducted using JBI-informed methods and PRISMA-ScR-compatible reporting. Searches conducted on 16 September 2026 identified 69 records across four executed source blocks. After removal of two duplicate records, 67 records underwent title and abstract screening. Forty-one reports were sought and assessed, 12 were excluded after report-level assessment, and 29 evidence units were included. The evidence depicts collaboration as an interface between differentiated professional roles rather than a uniform team configuration. Dental and oral-health evidence was smaller and more setting-specific but identified clinically distinctive needs requiring specialist assessment, treatment, and escalation. Shared responsibility was most visible in recognition of problems, information exchange, referral, monitoring, and alignment of care with patient priorities. Current evidence supports coordinated but differentiated professional contributions to complex palliative care. The strongest synthesis is that collaboration depends on making professional boundaries permeable enough for timely communication and escalation while retaining the expertise needed for medication, oral-health, symptom, and continuity-related decisions.

Keywords: Palliative care, Interprofessional collaboration, Nursing, Clinical pharmacy, Oral health, Medication management

Introduction

Palliative care addresses interacting physical, psychological, social, communication, and decision-making needs that frequently exceed the scope of any single profession. It concerns how responsibilities are distributed, where responsibility overlaps, and what happens when a problem crosses professional or service boundaries [1, 2]. Existing evidence describes interprofessional collaboration as a combination of role understanding, communication, teamwork, shared values, and coordinated action, although the composition and function of collaborative practice vary considerably across palliative populations and settings [3-6]. Transitions between hospitals, specialist palliative services, primary care, and community settings make these dependencies particularly visible [7, 8].

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Evidence on palliative oral-health promotion identifies gaps in knowledge, routine assessment, referral pathways, and access to professional dental care [9, 10]. These gaps are important because oral-health work may begin with bedside recognition by nurses but require diagnostic or procedural expertise outside nursing practice.

Dental professionals occupy a less consistently integrated position, although palliative-care clinicians recognize potential roles for dentists in assessing and treating oral disease and contributing to multidisciplinary care [11-14]. The review examined professional roles and overlap; the organization of medication, oral-health, communication, referral, and participation interfaces; barriers and facilitators; care configurations; and remaining evidence gaps.

Materials and Methods

Scoping review methodology is particularly appropriate when the purpose is to characterize a field, clarify concepts, map available evidence, and identify evidence gaps rather than answer a narrowly specified comparative-effectiveness question [15]. Cited methodological and contextual literature was kept analytically separate from the evidence units counted in the review.

Protocol and reporting framework

Conduct and charting were informed by updated JBI methodological guidance for scoping reviews, including use of population, concept, and context to establish eligibility and systematic charting of evidence characteristics [16, 17]. Reporting followed PRISMA-ScR principles for transparent documentation of identification, screening, eligibility, and inclusion.[18, 19] The review was not designed as a meta-analysis, and formal risk-of-bias scores were not used as exclusion criteria because the objective was evidence mapping rather than estimation of a pooled treatment effect.

Eligibility criteria

Eligible evidence published during 2017–2026 involved nursing, pharmacy, dental or oral-health practice, or a directly relevant interprofessional process. Reports lacking extractable role or collaboration content were excluded; contextual oncology sources were not counted unless they otherwise met eligibility criteria.

Information sources

Searches were executed on 16 September 2026 through two reproducible routes: PubMed-indexed scholarly records identified using site-restricted searches and the BMC Palliative Care publisher corpus. Subsequent PubMed and publisher-page checks were used to verify bibliographic metadata and DOI information; these verification checks were not counted again as newly identified records.

Search strategy

Search blocks combined palliative care with interprofessional collaboration, nursing, pharmacy, medication management, dentistry, oral health, communication, coordination, and patient or family participation.

Evidence selection

Records were screened in two stages. First, titles and available abstracts were assessed against the date, population, concept, context, and publication-type criteria. Reports retained after this stage underwent report-level eligibility assessment. Duplicate manifestations were removed before screening. Publications used only for methodology or contextual interpretation were separated from included review evidence rather than being counted as evidence units.

Data charting

Charting captured design, setting, population, professional groups, clinical and organizational processes, methods, findings, limitations, applicability boundaries, and the level of claim supported by each source.

Evidence was grouped by profession-specific work, shared responsibility, communication, referral, patient participation, organizational boundaries, collaboration facilitators, and interprofessional care models.

Results and Discussion

The included qualitative, intervention, service, medication-management, educational, oral-health, and review evidence varied in whether collaboration was the primary construct or a component of broader clinical work.

Study selection

The searches surfaced 69 records: 20 from the nursing and interprofessional block, 14 from the dental and oral-health block, 16 from the pharmacy block, and 19 from the BMC Palliative Care publisher block. Two duplicate

manifestations were removed, leaving 67 unique records for title and abstract screening. Twelve reports were excluded after report-level assessment, resulting in 29 included evidence units.

The selection process is summarized in **Figure 1**.

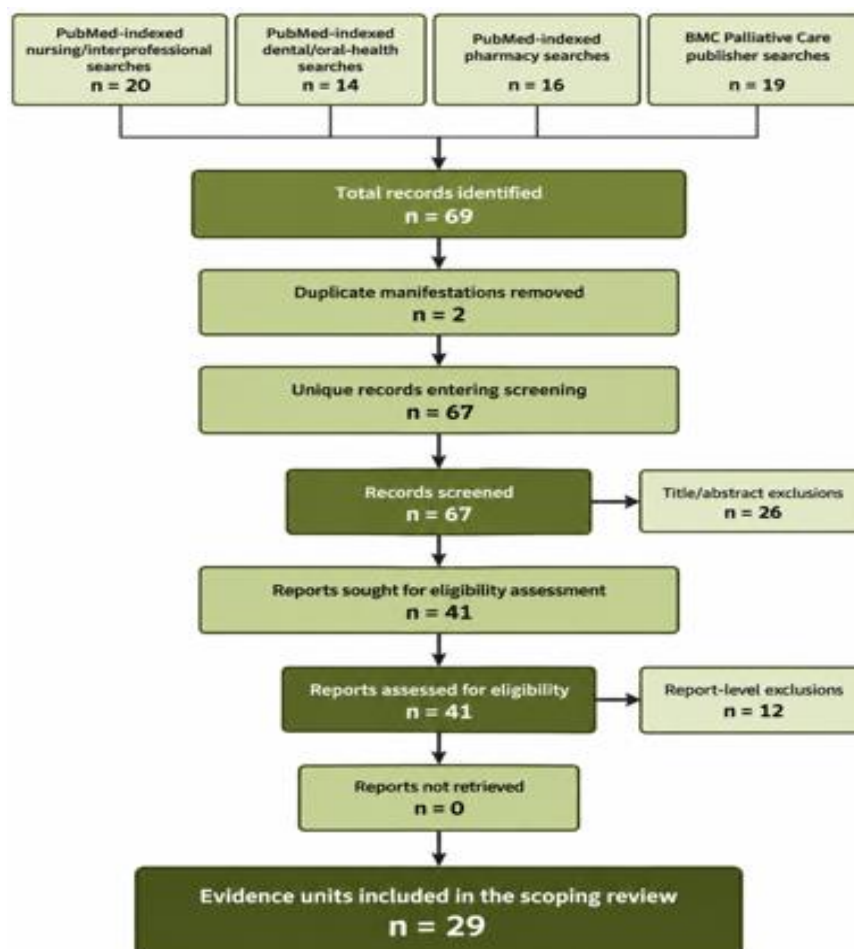


Figure 1. PRISMA-ScR-Compatible Selection of Evidence on Nursing, Pharmacy, Dental, and Interprofessional Palliative Care

Characteristics of included evidence

The evidence base encompassed direct palliative-care studies, advanced-cancer and serious-illness studies with clear palliative relevance, interprofessional educational interventions, service-development studies, and profession-specific clinical investigations. Several studies treated collaboration as a primary construct, while others revealed collaborative processes through examination of a particular profession or clinical task.

Qualitative evidence from palliative teams, for example, demonstrates that patient-centered care can depend on contributions that remain professionally distinctive even when goals are shared [20, 21] Similarly, intervention and service-model studies varied in whether they examined team functioning, access, referral, communication, or a defined clinical activity.

Table 1. Methodological and Contextual Profile of the Included Palliative-Care Evidence

Evidence family	Typical care context	Principal analytical contribution	Professional emphasis	Main interpretive constraint
Qualitative professional-experience studies	Hospital, community, specialist palliative services	Roles, communication, coordination, decision participation, boundary problems	Nursing and interprofessional teams	Experiences and perceptions cannot establish comparative effectiveness
Evidence syntheses	Palliative dementia, transitions, pharmacy practice, oral-health promotion	Breadth of existing evidence, recurring processes, role categories and gaps	Interprofessional, pharmacy, oral health	Heterogeneous primary evidence limits causal synthesis

Educational and team-development interventions	Primary care, oncology, clinical training	Team learning, collaboration, readiness and communication practice	Interprofessional teams	Provider-level or process outcomes may not translate directly to patient outcomes
Medication-management studies	Specialist palliative care and cancer-related supportive care	Medication review, deprescribing, pain management and monitoring	Pharmacy with medical and nursing interfaces	Implementation or feasibility findings do not establish universal clinical benefit
Oral-health and dental studies	Inpatient palliative units, terminal cancer and related oncology contexts	Oral assessment, specialist management, referral and symptom-related oral care	Dental professionals and nursing interfaces	Evidence is relatively concentrated in small or single-center settings
Quality-improvement and service-model studies	Health systems, palliative services and serious-illness care	Organization of access, referral, communication and care models	Interprofessional	Local infrastructure and resources limit transferability

Nursing roles

In community-based team development, interprofessional education was associated with improved measures of partnership, cooperation, and coordination, suggesting that collaboration can be strengthened when teams explicitly work on shared practices. [22, 23] A subsequent randomized evaluation similarly reported improvement in collaboration measures following the CAPACITI program, while finding no basis for treating one delivery format as uniquely superior. [24, 25]

District nurses describe palliative work as involving continuing relationships, practical problem solving, and repeated adjustment to the realities of community care.[26, 27] Resource nurses in community and nursing-home contexts have been described as supporting knowledge, continuity, and coordination, although such roles depend strongly on local organization.[28, 29] Nurses also participate in treatment and palliative decision processes by communicating with patients, identifying concerns, and helping preserve patient involvement, while remaining constrained by the authority structures within which final medical decisions are made.[30, 31]

It does not support treating nurses as substitutes for pharmacy or dental expertise when a problem crosses into medication-specific or specialist oral-health decision-making.

Table 2. Nursing Functions and Their Interfaces with Other Professional Responsibilities in Complex Palliative Care

Nursing function	Primary contribution	Interface with pharmacy	Interface with dental/oral-health care	Context sensitivity	Inference limit
Continuous assessment	Detects changes in symptoms, function and care needs across encounters	Identifies medication-related concerns requiring review	Recognizes oral symptoms that may require specialist assessment	Strongly affected by staffing, continuity and care setting	Recognition does not establish diagnosis or specialist treatment authority
Communication and information continuity	Connects patient, family and professional observations	Transfers medication-use, tolerance and adherence information	Communicates oral symptoms, intake problems and response to basic care	Transition points increase risk of information loss	Better communication cannot be assumed to produce all clinical outcomes
Coordination	Organizes responses across professionals and services	Supports timely pharmacist or prescriber involvement	Supports access and referral to dental care when available	Depends on service configuration and referral pathways	Coordination is not equivalent to control of other professionals' decisions
Participation in shared decisions	Clarifies patient concerns and helps sustain participation	Conveys treatment burden and medication experience	Conveys symptom priorities and treatment acceptability	Professional hierarchy and timing of decisions matter	Nursing participation does not imply sole decisional authority
Resource and educational support	Builds team capability and local palliative knowledge	Reinforces safe medication-related communication	Supports routine oral-care recognition and referral awareness	Requires organizational support and protected role capacity	Education alone cannot resolve structural barriers

Pharmacist roles

Specialist palliative-care medication review can identify potentially inappropriate or burdensome therapies and translate medication histories into recommendations for deprescribing or modification [32]. These recommendations remain part of an interprofessional decision process because prognosis, symptom priorities,

withdrawal risk, and patient preference may alter whether a medication judged theoretically inappropriate should actually be stopped.

International expert consensus further demonstrates that deprescribing near the end of life requires medication-specific judgment rather than a blanket reduction in medicine use [33]. Some classes lend themselves to stronger consensus than others, and the rationale for discontinuation depends on expected time to benefit, treatment burden, current indication, risk of withdrawal, and immediate symptom consequences.

A multicenter feasibility-pilot trial examined pharmacist involvement in cancer pain management, illustrating the potential for pharmacy expertise to be integrated into complex symptom care while also showing the need for larger and more contextually diverse evaluations [34]. An outpatient palliative-care pilot likewise demonstrated that pharmacists can operationalize individualized opioid tapering through repeated follow-up, although the clinical context of patients in cancer remission differs substantially from actively dying populations [35].

Dental and oral-health roles

A longitudinal study comparing nurse-led oral care with dental-professional oral-health management in terminally ill patients demonstrates that these approaches represent related but non-identical forms of care [36]. Bedside nursing can support daily oral care and identify deteriorating symptoms, whereas dental professionals bring diagnostic and procedural expertise for conditions that exceed routine bedside management.

Direct integration of dentistry into a multidisciplinary palliative-care team has also been examined in inpatient care, showing that bedside dental assessment and treatment can be incorporated into specialist palliative services [37]. Such evidence establishes feasibility and clinical relevance within the studied setting; it does not justify assuming that dental integration produces the same outcomes in every palliative population or that a single model should be adopted universally.

Patients, caregivers, and professionals have described oral health as important to comfort and quality of life while also identifying difficulties related to awareness, access, referral, and integration of dental services [38]. These findings help explain why oral problems can remain within the informal responsibility of nurses or physicians even when specialist dental assessment would be clinically appropriate.

In a large cancer cohort, substantial dental treatment requirements were identified during oral-health assessment [39]. This establishes that oral disease and treatment need can be clinically significant in cancer populations, but it cannot be assumed that the same prevalence or treatment profile applies to patients receiving palliative care.

Areas of shared responsibility

Shared responsibility emerged most clearly at points where a clinical problem must be recognized, communicated, interpreted, and transferred rather than completely managed by one profession. Assessment is one example. Nurses may be first to observe a new oral symptom, swallowing difficulty, medication adverse effect, or decline in self-care; pharmacists may recognize medication-related contributors or treatment burden; dental professionals may determine whether oral disease requires specialist intervention. Shared responsibility therefore refers to connected stages of work, not identical scopes of practice.

Communication is another shared domain. Interprofessional competence includes understanding professional roles and communicating information in ways that allow other team members to act on it [4]. This becomes especially important when a symptom has several plausible causes.

Patient participation also crosses professions. Nurses may identify what the patient is experiencing or prioritizing; pharmacists may explain medication burden or deprescribing options; dental professionals may clarify the feasibility and burden of oral procedures. The underlying expertise, however, remains profession-specific.

The evidence therefore supports a model of shared responsibility based on connected observation, information transfer, referral, consultation, and monitoring.

Medication management

It includes reconciliation of what is actually being taken, identification of treatment burden, consideration of time to benefit, assessment of adverse effects, evaluation of symptom medications, recognition of potentially inappropriate treatment, discussion of patient priorities, communication with prescribers, and monitoring after a decision is implemented.

Pharmacist-led review can contribute systematically to this process by identifying medicines that warrant reconsideration and by formulating recommendations for the wider clinical team [32]. Consensus work on end-of-life deprescribing further indicates that medication discontinuation is conditional: the same drug may be burdensome in one clinical situation and necessary in another when it is contributing to current symptom control [33].

Nursing information is often essential to those judgments because medication records do not fully represent real-world use, tolerance, adherence, swallowing ability, symptom response, or caregiver burden.

Nurses often supply longitudinal observation; pharmacists contribute medication-specific analysis and monitoring; prescribers retain legal and clinical authority for many treatment changes; patients and families contribute preferences, lived treatment burden, and willingness to continue or discontinue therapy.

Oral and symptom management

Patient-focused palliative evidence shows that dry mouth should be assessed in terms of what patients themselves find burdensome rather than solely through clinician observation [40]. Oral symptoms can therefore affect comfort in ways that may be underestimated when routine symptom assessment concentrates on pain, nausea, dyspnea, or bowel function.

Pharmacists can assess whether medicines with anticholinergic, sedating, drying, or other adverse effects plausibly contribute to the symptom pattern. Dental professionals can determine whether caries, periodontal disease, infection, mucosal pathology, prosthetic problems, or another oral condition requires specialist treatment.

Cancer-care evidence outside strictly palliative populations also demonstrates that hospitalized patients may have dental treatment needs that cannot be resolved by routine mouth care alone [41]. Such evidence should not be used to estimate the prevalence of dental disease in palliative populations, but it reinforces an important clinical distinction: recognition of an oral problem and treatment of its cause are separate functions.

Evidence from palliative settings supports retaining both nursing and dental contributions instead of treating them as competing alternatives [36]. Direct bedside dental integration demonstrates one feasible route for specialist involvement, [37] while qualitative evidence indicates that access and referral remain practical barriers [38].

Table 3. Cross-Professional Integration of Oral and Symptom Management in Palliative Care

Clinical trigger	Nursing contribution	Pharmacist contribution	Dental/oral-health contribution	Shared coordination requirement	Downstream care implication
New or worsening oral discomfort	Detects symptoms, provides basic oral care, documents change	Reviews medicines that may contribute to dryness, irritation or sedation	Assesses for oral disease requiring specialist treatment	Share symptom onset, medication changes, examination findings and patient priorities	Determines whether supportive care, medication adjustment, dental intervention or combined management is appropriate
Dry mouth or difficulty maintaining oral moisture	Assesses patient-reported burden, intake and ability to perform oral care	Reviews xerogenic and anticholinergic medication burden where clinically relevant	Evaluates oral consequences and specialist management needs	Avoid attributing the symptom to a single cause prematurely	Supports a cause-sensitive rather than purely symptomatic response
Reduced eating, swallowing difficulty or oral functional decline	Monitors intake, comfort and functional change	Reviews formulation, administration burden and medication-related contributors	Assesses oral pain, dentition, prosthetic or mucosal factors	Coordinate findings before changing therapy	May alter medication formulation, oral-care intensity, referral or goals of intervention
Suspected infection, structural disease or persistent focal oral problem	Recognizes warning signs and escalates	Evaluates treatment interactions and medication implications	Provides diagnostic and procedural expertise	Establish a clear referral route and urgency threshold	Prevents specialist oral disease from remaining within nonspecialist management
Symptom change after an intervention	Tracks response and new burden over time	Monitors medication effects and adverse effects	Reassesses oral condition when specialist treatment was provided	Feed follow-up information back across professions	Allows modification or discontinuation of ineffective or burdensome interventions
Patient declines or limits intervention	Clarifies comfort priorities and practical burden	Explains medication options and consequences	Clarifies expected burden and benefit of oral procedures	Align recommendations with patient and family preferences	Preserves goal-concordant care even when clinically available interventions are not pursued

Communication and information sharing

In palliative-care transitions, patients, caregivers, and clinicians have described difficulties when discharge information is incomplete, inaccessible, delayed, or poorly aligned with what community professionals need to continue care [42]. These problems are particularly important when medication changes, symptom priorities, oral-health concerns, and future escalation plans are distributed across several professionals.

Studies of interprofessional rounding indicate that real-time communication and visibility of professional roles can facilitate exchange, while workflow arrangements can exclude relevant expertise even when all required professions are nominally available [43]. Collaboration therefore depends partly on whether information reaches the professional capable of acting on it before the clinical situation changes.

Structured serious-illness communication training provides evidence that communication practices themselves can be developed [44]. Such training does not resolve fragmented records, staffing limitations, or unavailable services, but it can improve the consistency with which difficult issues are raised and documented.

Referral and escalation

Team-based interventions in oncology have shown that barriers to initiating palliative involvement can occur at both individual and team levels, including uncertainty about roles, expectations, and when escalation should occur [45].

Comparable problems arise in oral health. Nurses may recognize persistent oral pain, mucosal changes, impaired intake, or deterioration despite basic mouth care, yet specialist dental involvement depends on referral pathways, availability, transport, procedural feasibility, and the patient's goals [37, 38].

Escalation should therefore be understood as a sequence: recognition of a need, interpretation of its likely significance, identification of the appropriate professional, transfer of sufficient information, and confirmation that responsibility has been accepted.

Patient and family participation

Nursing evidence indicates that nurses can facilitate patient involvement by clarifying concerns, sustaining communication, and helping patients participate in discussions about treatment and palliative priorities [30]. Oral-health studies similarly show that patients and caregivers may value relief of oral symptoms while weighing the burden of examination, transfer, or procedures differently from clinicians [38].

Advance-care-planning initiatives demonstrate that goal-concordant care also requires organizational mechanisms capable of recording, communicating, and retrieving patient preferences [46]. A preference known to one professional but unavailable to another cannot reliably guide interprofessional action [42].

In complex palliative care, a patient may prioritize comfort over medication prevention targets, decline a burdensome dental intervention, or prefer continuation of a familiar medicine despite a theoretical deprescribing rationale.

Organizational barriers

District nurses describe workload and service conditions that shape how relational and palliative work can be performed in practice [26, 47]. Transition studies similarly show that communication failures can reflect fragmented systems rather than simply poor individual communication [42].

Qualitative evidence from Switzerland identified coordination challenges arising where responsibility crossed service boundaries [48]. Such barriers may involve unclear ownership of tasks, mismatched availability, different documentation systems, delayed communication, and uncertainty about which service should respond when needs change.

Dental access may add another layer because dental professionals are often organizationally separate from the services delivering routine palliative care. Organizational design therefore determines whether professional expertise is continuously available, episodically consulted, or functionally absent.

Professional boundary challenges

Professionals working in palliative care identify role understanding as an important component of collaborative competence [4]. Dental evidence illustrates the consequences of weak visibility: clinicians may recognize that oral health matters while remaining uncertain about when dental expertise is necessary or how it should be accessed [14].

Evidence from multidisciplinary palliative teams shows that professions may contribute distinct forms of expertise to a common patient-centered goal [20]. Team-rounding research similarly suggests that communication improves when professional contributions are visible and included in real-time discussion [43].

They must remain sufficiently defined that medication expertise, nursing continuity, dental diagnosis, prescribing authority, and other specialized responsibilities are not treated as interchangeable.

Facilitators of collaboration

A metasynthesis of interprofessional community-care interventions found recurrent importance of trust, respect, communication, and a shared vision [49]. These conditions provide a relational basis for collaboration but should not be interpreted as sufficient by themselves.

The CAPACITI pilot documented improvement in measures of partnership, cooperation, and coordination after participation in an interprofessional educational program [22]. Its later randomized evaluation also found

improvement in collaboration measures, although differences between delivery approaches did not establish a uniquely preferable educational format [24].

Effective collaboration therefore appears to require a combination of role knowledge, communication opportunities, reciprocal professional recognition, and organizational capacity [50]. Conversely, a formally integrated service may underperform if professionals do not understand one another's responsibilities or do not communicate when responsibilities intersect.

Interprofessional models of care

Specialty-aligned palliative services represent one approach in which palliative expertise is configured around the needs of particular clinical populations and institutional services [51]. Such models illustrate how team design can respond to local patterns of need without demonstrating that specialty alignment is universally preferable.

Advanced-practice-nurse-led early palliative care provides another configuration in which nursing leadership expands access and coordinates connections with broader oncology and palliative resources [52]. Community educational models emphasize strengthening existing primary-care teams, whereas other approaches rely more heavily on specialist consultation or dedicated palliative services [7].

A model with ready pharmacist access may manage complex medication questions differently from a team that depends on external pharmacy consultation; similarly, routine dental access may fundamentally change how persistent oral symptoms are escalated.

The synthesis therefore supports a field of context-dependent professional configurations rather than a single optimal model. **Figure 2** maps how role-specific expertise, shared responsibilities, and organizational boundaries interact across the evidence base.

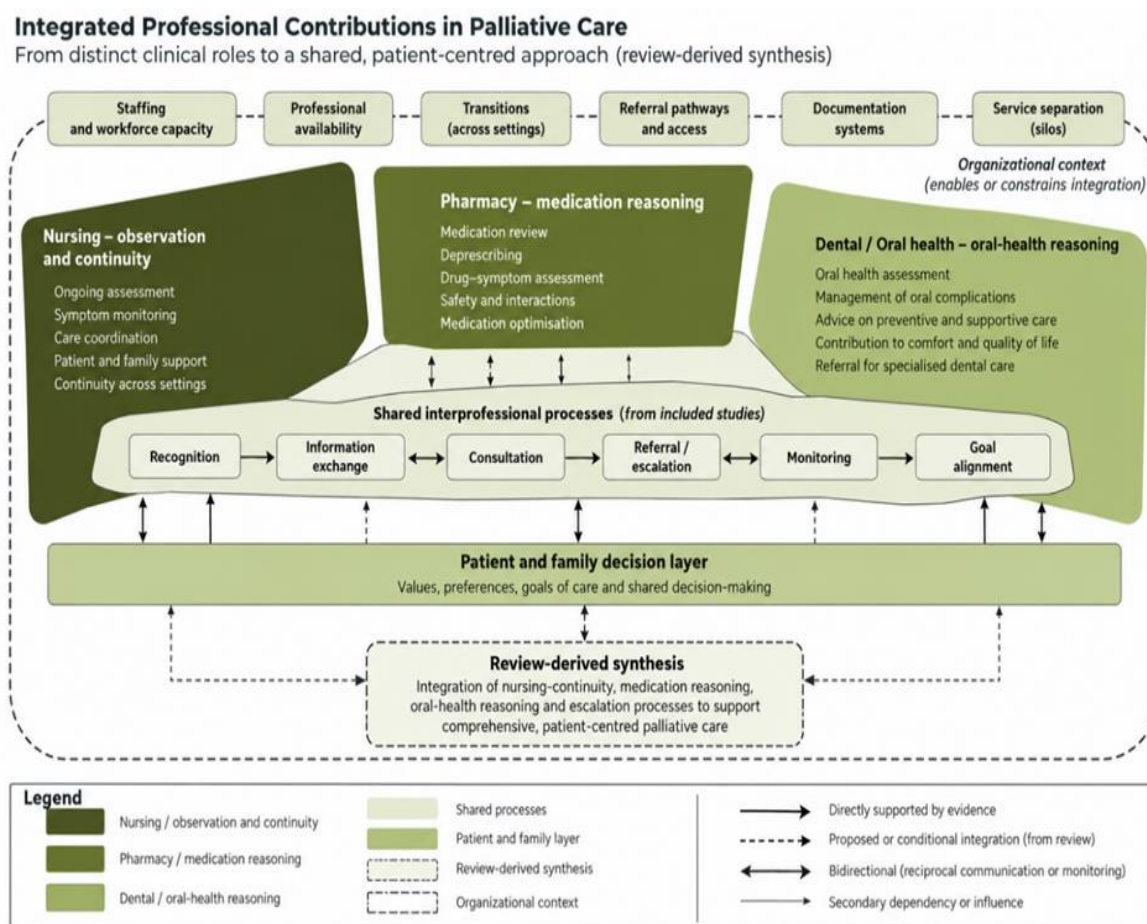


Figure 2. Interprofessional Responsibility Field for Medication, Oral-Health, Symptom, and Coordination Needs in Complex Palliative Care

Evidence gaps

Sustained dental participation, comparative service configurations, referral thresholds, failed referrals, unavailable services, and coordination work transferred to patients or caregivers remain insufficiently studied [9, 13].

Table 4. Evidence Gaps and Research Needs in Interprofessional Palliative Care

Unresolved evidence area	What the current evidence can establish	What remains uncertain	Research approach most capable of reducing the uncertainty	Interpretation safeguard
Sustained dental integration in palliative teams	Dental expertise can address clinically distinctive oral-health needs and can be integrated in selected services	Which patients, settings, referral thresholds and service models gain most from routine dental access	Multisite prospective implementation studies with patient-centered oral and symptom outcomes	Low evidence volume must not be interpreted as low clinical importance
Pharmacist integration beyond medication review	Pharmacists can contribute to review, deprescribing, monitoring and symptom pharmacotherapy	How pharmacist input interacts with nursing observation, prescriber decisions and patient goals over time	Longitudinal team-process studies and pragmatic service evaluations	Medication implementation outcomes should not be treated as global patient benefit
Nursing–dental escalation pathways	Nurses can recognize oral deterioration and dental professionals can provide specialist assessment	When basic oral care should trigger specialist escalation and what happens when dental access is unavailable	Prospective referral-pathway studies with explicit escalation criteria	Recognition, referral and treatment are separate stages
Medication–oral symptom interaction	Medication exposure can plausibly contribute to symptoms such as dry mouth and treatment burden	How often medication adjustment versus dental intervention changes patient-important symptoms	Cross-disciplinary clinical cohorts with linked medication and oral-health assessment	Association should not be converted into a single-cause explanation
Patient and caregiver coordination burden	Patients and caregivers report communication and transition difficulties	How much interprofessional fragmentation transfers organizational work to families	Qualitative longitudinal and mixed-method transition research	Family participation should not be confused with unpaid substitution for missing coordination
Comparative team configurations	Several viable models of palliative organization exist	Whether particular configurations are more suitable for defined populations or settings	Comparative implementation studies with contextual process measures	Contextual suitability is different from universal superiority
Workforce preparation	Role clarity and communication skills can be strengthened through education	Which combinations of education, staffing and organizational redesign produce durable collaboration	Longitudinal workforce and team-development evaluations	Training alone should not be assumed to correct structural barriers

Trust, respect, and shared vision facilitate collaboration [49], but service configuration must also fit the population, workforce, setting, and available expertise [7, 13, 36, 51].

Implications for practice

Pharmacist involvement is most useful when medication review is connected to current symptoms, prognosis, treatment burden, and patient goals rather than treated as an isolated technical exercise [32]. Dental pathways should distinguish routine oral care from conditions that require specialist assessment and make referral feasible when escalation is clinically appropriate [37].

Where patients move between specialist, hospital, primary, hospice, and community services, essential information should specify medication changes, unresolved symptoms, relevant oral-health concerns, care priorities, and pending referrals [42]. Organizational responsibility for these processes should be explicit because unclear service interfaces can create coordination failures even when individual professionals communicate well [48].

Education and workforce implications

Interprofessional education can improve collaboration measures [22, 24], while serious-illness communication training can strengthen difficult clinical conversations [4].

Limitations

Scoping methodology permits inclusion of heterogeneous evidence but does not convert qualitative, observational, pilot, quality-improvement, and review findings into a common causal estimate [15].

The executed search used reproducible PubMed-indexed and publisher-domain search routes rather than claiming coverage of databases that were not actually searched. Although systematic charting followed JBI-informed principles, [16] relevant evidence not surfaced through the executed routes may therefore exist.

No quality threshold or journal quartile was used to determine review eligibility, and evidence was not removed solely because its design carried a greater risk of bias [19].

Finally, some contextual oncology evidence informed interpretation of oral-health and serious-illness problems without being counted as included palliative-care evidence.

Conclusion

Complex palliative care brings nursing, medication, oral-health, communication, and decision-making needs into contact, but the available evidence does not support treating professional roles as interchangeable or one team configuration as universally preferable. The most defensible model is therefore conditional: collaboration is strongest when professional boundaries remain clear enough to preserve expertise yet permeable enough for responsibility to move safely when a patient's needs cross them.

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